Algoma
PUBLIC HEALTH
Santé publique Algoma

BOARD OF HEALTH MEETING

March 28, 2018

Sault Ste. Marie Community Rooms A

www.algomapublichealth.com

March 28, 2018 - Board of Health Meeting Book

Algoma Public Health Board of Health Meeting Table of Contents

d. Adoption of previous in-committee minutes dated January 24, 2018

12. Open Meeting

13. Resolutions Resulting From In Committees

14. Announcements

a. Finance and Audit Committee - April 11, 2018

b. Governance Standing Committee - April 12, 2018

c. Board of Health Meeting - April 25, 2018

15. Adjournment

ALGOMA PUBLIC HEALTH
BOARD OF HEALTH MEETING
MARCH 28, 2018 @ 5:00 PM
SAULT STE MARIE ROOM A, SSM
A*G*E*N*D*A

1.0 Meeting Called to Order — Mr. Ian Frazier, Board Chair

a. Declaration of Conflict of Interest

2.0 Adoption of Agenda Items — Mr. Ian Frazier, Board Chair

Resolution
THAT the agenda items dated March 28, 2018 be adopted as circulated.

3.0 Adoption of Minutes of Previous Meeting — Mr. Ian Frazier, Board Chair

a. February 28, 2018

b. January 24, 2018

Resolution
THAT the Board of Health minutes for the meetings dated February 28, 2018 and January 24, 2018 be adopted as circulated.

4.0 Delegations/Presentations.

a. Population Health Assessment & Effective Public Health Practice — Dr. Jennifer Loo, AMOH

5.0 Business Arising from Minutes

6.0 Reports to the Board

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

i. February 2018
ii. March 2018

Resolution
THAT the report of the Medical Officer of Health and CEO for the months of February and March 2018 be adopted as presented.

b. Finance and Audit Committee Report — Mr. Sergio Saccucci Committee Chair

i. Committee Chair Report for February 2018
ii. Draft Financial Statements for the Periods Ending
- December 31, 2017
- January 31, 2018

Resolution
THAT the Finance and Audit Committee report for the month of February 2018 be adopted as presented; and

THAT the Financial Statements for the Period Ending December 31, 2017 be approved as presented; and

THAT the Financial Statements for the Period Ending January 31, 2018 be approved as presented.

iii. Housing Budgets
- Mental Health & Addictions Rent Supplement Housing Budget
- Transformation Supportive Housing Program Budget

Resolution:
THAT the Board of Health approves the Mental Health and Addictions Rent Supplement Housing Budget and the Transformation Supportive Housing Program Budget as presented.

iv. Insurance Policy Update

v. Approved Minutes November 8, 2017 **– *for information only***

c. Governance Standing Committee Report — Mr. Lee Mason, Committee Chair

i. Committee Chair Report for February 2018

Resolution
THAT the Governance Standing Committee report for the month of February 2018 be adopted as presented.

ii. 02-05-030 – Code of Conduct Policy

Resolution:
THAT the Board of Health approves the changes to policy 02-05-030 Code of Conduct as presented.

iii. Performance Evaluation for MOH CEO
- 02-05-080 – Performance Evaluation for MOH CEO Policy
- MOH/CEO Performance Appraisal Evaluation Form

Resolution:
THAT the Board of Health approves the new policy 02-05-080 Performance Evaluation for MOH CEO as presented.

iv. 02-05-010 – Board Minutes/Packages – Posting/Circulation/Retention
- 02-05-010 – Board Minutes/Packages – Proposed Combined Revisions
- 02-05-010 – Board Minutes / Posting – Original Policy
- 02-05-070 – In-Committee Material – Original Policy

Resolution:
THAT the Board of Health approves the combining of policy 02-05-010 Board Minutes/Packages Posting/Circulation/Retention with 02-05-070 In-Committee Material Posting – Circulating Retention as presented and archiving policy 02-05-070..

v. 02-05-060 – Meetings and Access to Information

Resolution:
THAT the Board of Health approves the changes to policy 02-05-060 Meetings and Access to Information as presented.

vi. 02-05-085 – Orientation – Board Members

Resolution:
THAT the Board of Health approves the new policy 02-05-085 Orientation – Board Members as presented.

vii. 02-04-030 – Procurement Policy

Resolution:
THAT the Board of Health approves the changes to policy 02-04-030 with the understanding that the chairs would meet with the MOH/CEO and CFO to define exemptions.

viii. Approved Minutes October 30, 2017 – ***for information only***

7.0 New Business/General Business

a. Signing Authority — Mr. Ian Frazier, Board Chair

Resolution

WHEREAS By-Law 95-2 identifies that 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; and

SO BE IT RESOLVED that signing authority is provided to the ***insert name*** as the one other Board member, designated by Resolution until the next election of Officers.

8.0 Correspondence — Mr. Ian Frazier, Board Chair

a. Alcohol Retail Sales
- i. Letter to Minister Hoskins from Grey Bruce Health Unit dated February 15, 2018

b. Annual Service Plan
- i. Letter to Minister Jaczek from Haliburton, Kawartha, Pine Ridge District Health Unit dated March 13, 2018

c. Community Development Initiative
- i. Letter of Support to Mayor Provenzano from Algoma Public Health dated February 15, 2018

d. Expert Panel
- i. Letter to Algoma Public Health from Town of Blind River dated January 18 2018

e. Food Costing / Food Insecurity
- i. Letter to Minister Hoskins from Middlesex-London Health Unit dated February 1, 2018
- ii. Letter to Premier Wynne from Grey Bruce Health Unit dated February 15, 2018
- iii. Food Security Press Release from United Way dated March 8, 2018

f. Income Security
- i. Letter to Minister Jaczek from Northwestern Health Unit dated January 5, 2018

g. Repeal of Section 43 of the Criminal Code
- i. Resolution from Haliburton, Kawartha, Pine Ridge District Health Unit dated December 7, 2017

h. Smoke-Free Modernization
- i. Letter to Minister Hoskins from Grey Bruce Health Unit dated February 15, 2018

i. Tobacco and Smoke-Free Campuses
- i. Letter to Post-Secondary Presidents from Public Health Sudbury & Districts dated February 27, 2018

j. Vaccine Recommendations for Childcare Workers
- i. Letter to Premier Wynne from Grey Bruce Health Unit dated February 15, 2018

9.0 Items for Information

a. 2016 Annual Report of the Chief Medical Officer of Health of Ontario to the Legislative Assembly of Ontario – ***Improving the Odds Championing Health Equity in Ontario***

10.0 Addendum

11.0 That The Board Go Into Committee — Mr. Ian Frazier, Board Chair

Resolution
THAT the Board of Health goes into committee.

Agenda Items:

a. Adoption of previous in-committee minutes dated January 24, 2018
b. Litigation or Potential Litigation
c. Labour Relations and Employee Negotiations

12.0 That The Board Go Into Open Meeting — Mr. Ian Frazier, Board Chair

Resolution
THAT the Board of Health goes into open meeting

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

14.0 Announcements: — Mr. Ian Frazier, Board Chair

Next Committee Meetings:

Finance and Audit Committee
April 11, 2018 @ 4:30 pm
Prince Meeting Room, 3rd Floor

Governance Standing Committee
April 12, 2018 @ 4:30 pm
Prince Meeting Room, 3rd Floor

Next Board Meeting:
April 25, 2018 @ 5:00pm
Sault Ste. Marie, Room A

15.0 That The Meeting Adjourn — Mr. Ian Frazier, Board Chair

Resolution
THAT the Board of Health meeting adjourns

Population Health Assessment
&
Effective Public Health Practice

March 28, 2018
Presentation to APH Board of Health

Jennifer Loo MD MSc CCFP FRCPC
Associate Medical Officer of Health

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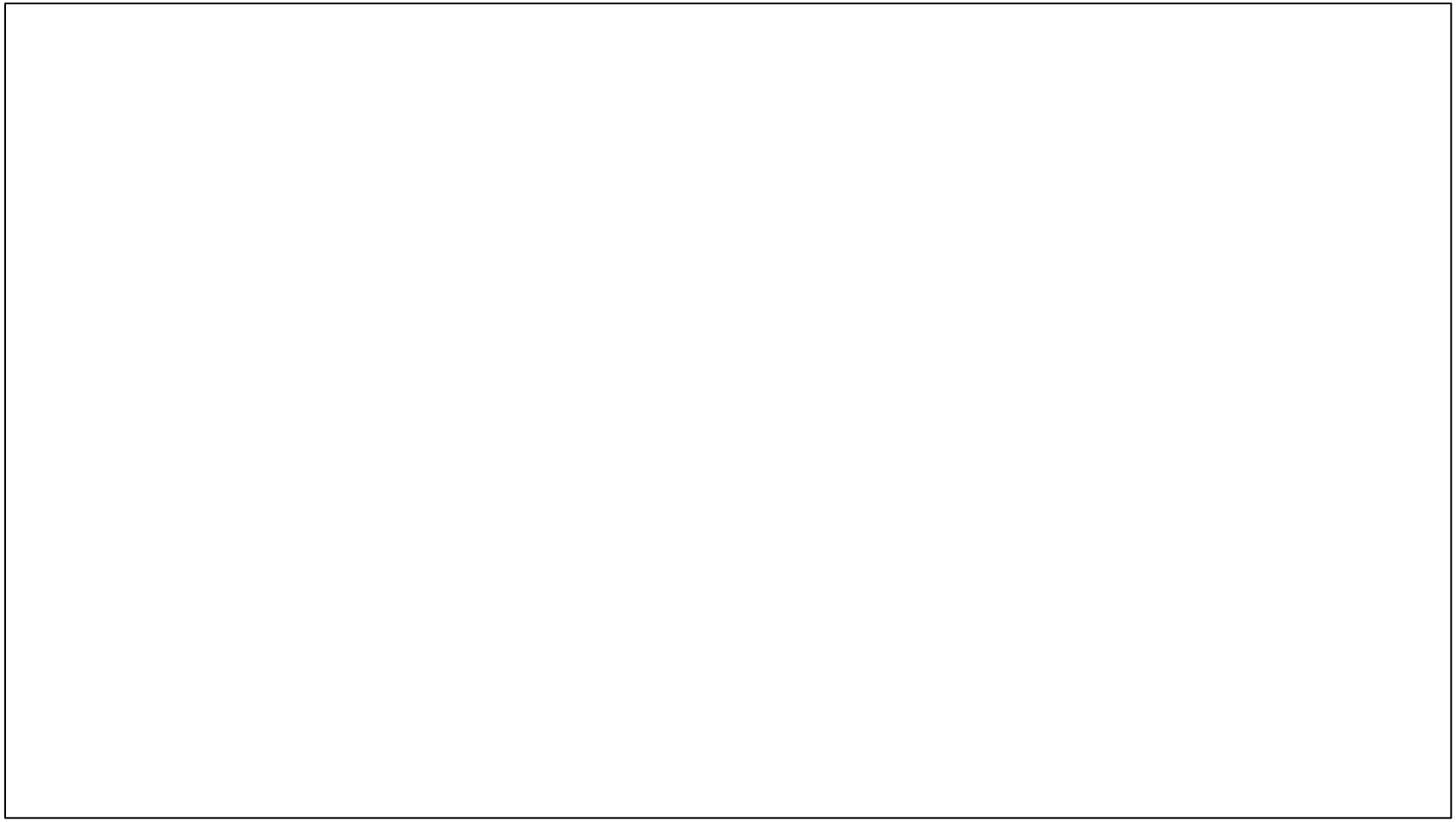


Institute for a Healthy Society. (2013, Sept 25). Introduction to Upstream. [Video file]. Retrieved from: http://www.thinkupstream.net


SUCCESS

Local Public Health: The Goal

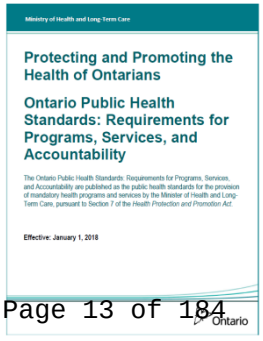
- To **improve and protect the health** and well-being of the **population** of Ontario and **reduce health inequities**

Population Health Outcomes

✓ Improved health and quality of life

✓ Reduced morbidity and premature mortality

✓ Reduced health inequity among population groups

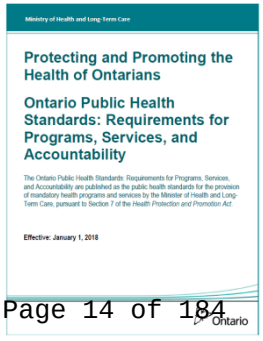


Ministry of Health and Long-Term Care. 2018. The Ontario Public Health Standards: Requirements for Programs, Services, and Accountability. Queen's Printer of Ontario.

How do (should) we ***do*** public health?

- Public health programs and services that are **informed by evidence** are the foundation for effective public health practice.

- Evidence-informed practice is **responsive to the needs and emerging issues of the health unit's population** and uses the best available evidence to address them



Ministry of Health and Long-Term Care. 2018. The Ontario Public Health Standards: Requirements for Programs, Services, and Accountability. Queen's Printer of Ontario.

SOAP Note

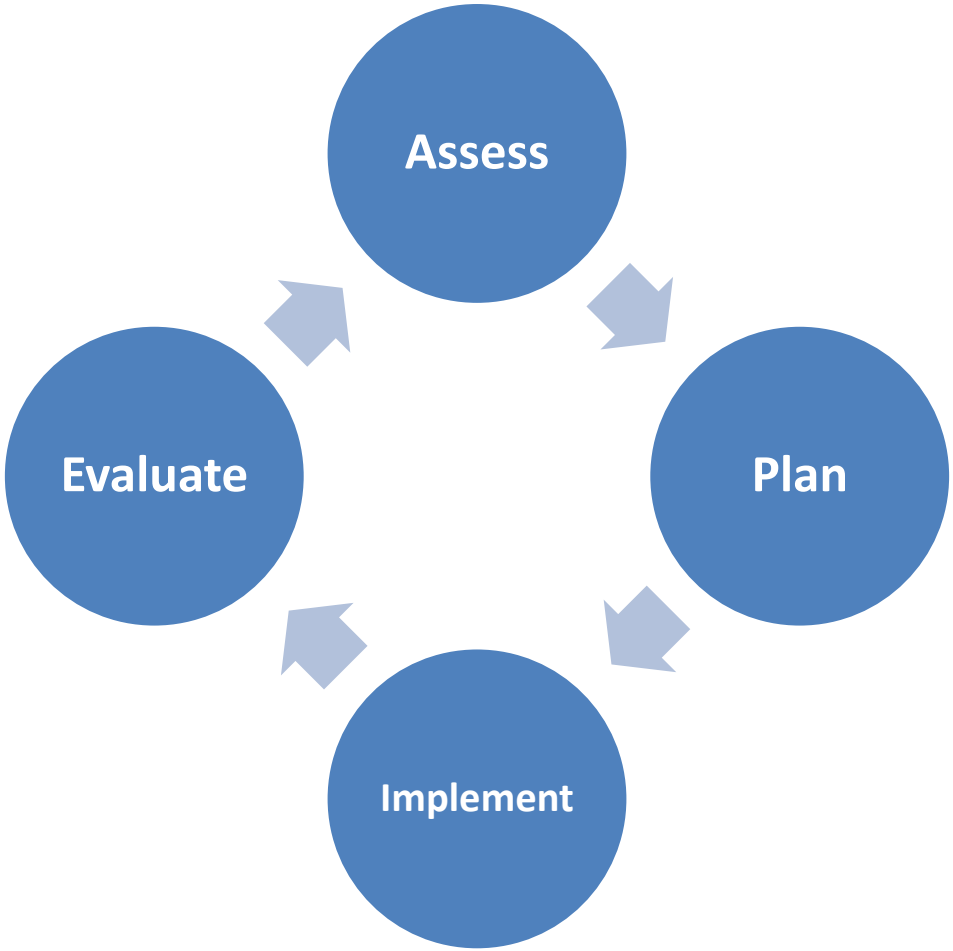
Subjective

Objective

Assessment

Plan

APIE



We Are FASST

- **Foundations and Strategic Support Team**
  - Public Health Physician
  - Epidemiologist
  - Planning and Evaluation Specialist
  - Research and Policy Analyst

- **Foundations** for effective public health practice
- **Strategic support** to achieve public health goals

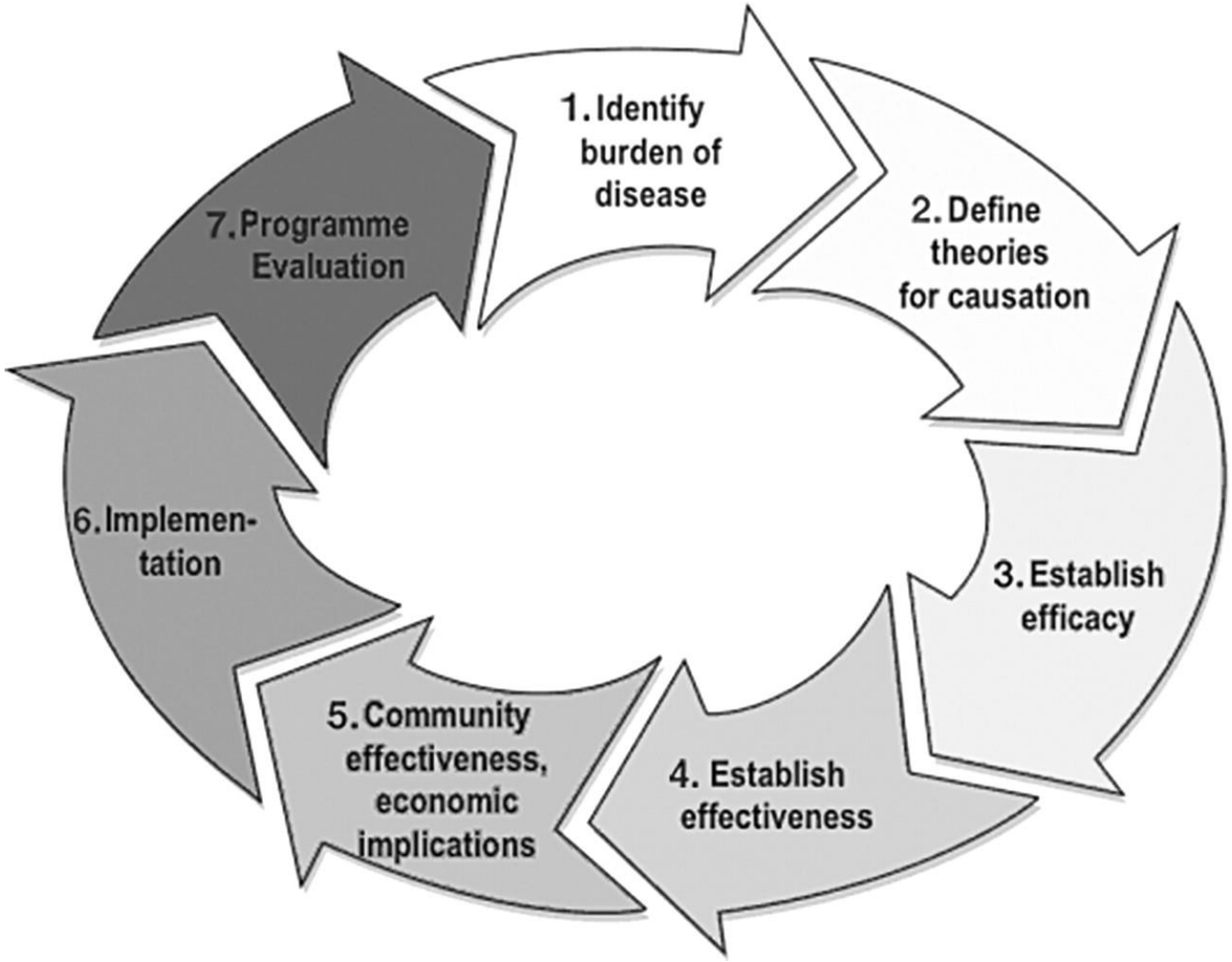
AMOH – Public Health Physician

- What makes our communities healthier?
- What is making our communities sick?

- Is this a public health problem?
- Is this a priority public health problem?

- How can we address this public health issue?
- How should we address this public health issue?

- Is our intervention working?
- How much of the problem are we tackling?
- What else should we do?



Tugwell P et al. The measurement iterative loop: a framework for the critical appraisal of need, benefits and costs of health interventions. J Chronic Dis. 1985; 38(4):339-51.

Epidemiologist

- How can we measure and describe the public health problem?

- How has this problem changed over time?
- Is the problem different in different places?

- Who is affected by this problem?
- Are some people more affected than others?

Fruit and Vegetable Consumption Core Indicators - Algoma

Initial working draft, data and content subject to change

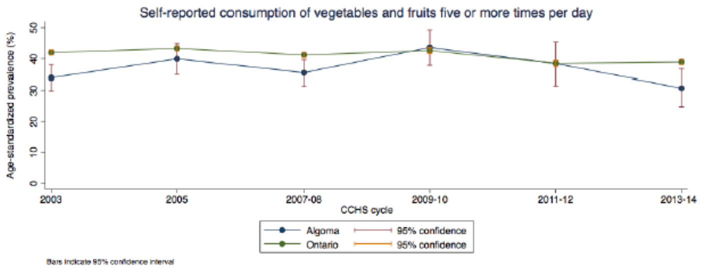
Introduction:

A series of Core Indicator sheets has been produced for Algoma Public Health to support the internal development of data literacy and quality. The following Core Indicator sheet contains information regarding self-reported dietary habits from the Canadian Community Health Survey access through Public Health Ontario Snapshots. A healthy diet helps protect against malnutrition in all its forms, as well as noncommunicable diseases, including diabetes, heart disease, stroke and cancer(1).
Data presented here are not intended for use externally. Should you require to use any data externally, please contact the epidemiologist. Prior to interpretation, please read the Data Caveats section of this document.

Data Caveats:

-Data were extracted from the Public Health Ontario Snapshots on January 24, 2018.
-Survey respondents who did not answer, refused to answer or had a response of 'don't know' or 'not stated', were excluded from the calculations.

Algoma Data:



Algoma

Cycle	Age adjusted prevalence (%)	Lower 95% confidence interval	Upper 95% confidence interval	Sample size
2003	33.9	29.7	38.1	287
2005	39.9	34.9	44.8	305
2007-08	35.5	31.3	39.6	277
2009-10	43.6	37.8	49.3	334
2011-12	38.4	31.4	45.4	259
2013-14	30.7	24.7	36.7	220

January 2017

2017 Algoma Community Bulletin: Hepatitis C in Algoma

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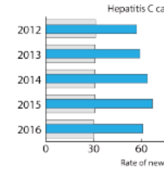
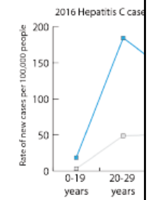
Hepatitis C is a viral disease that affects the liver. Left untreated, it can result in liver damage or cancer.

Hepatitis C is found in an infected person's blood and is spread through blood or body fluids. The virus is spread by sharing needles, personal care items, piercing equipment or having unprotected sex.

Between 2012 and 2016 the rate of new cases of hepatitis C in Algoma has increased 7.2%, compared to a decrease in the province of 4.0%.

During 2016, new cases of hepatitis C were most common in 20-29 year olds in Algoma. The rate of new cases in this age group was 3.8 times higher in Algoma than in the province. Algoma also had a higher rate of new cases of hepatitis C in 0-19, 30-39 and 40-49 year olds.





How to reduce your risk:

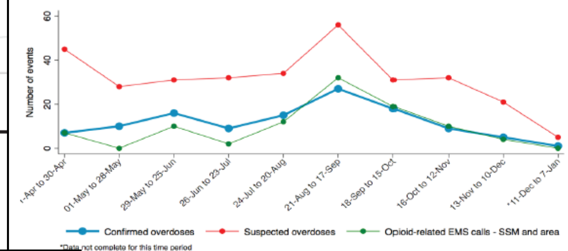
Data updated as of: Jan 2 2018

Opioid Overdose Surveillance: December 2017

Algoma PUBLIC HEALTH Santé publique Algoma

This report summarizes local opioid overdose surveillance conducted by Algoma Public Health, in partnership with Sault Ste Marie EMS, with the support of the Ministry of Health and Long-Term Care.
Please note that data shown from different sources are not directly comparable because they measure different aspects of the emergency response to overdose. Information shown represents the most recent available data, which is subject to change.

Summary of Opioid Overdoses in Algoma



…id Overdose Weekly Averages, Thresholds and Alerts

	Weekly average	Alert Threshold
…es	8.5	15.0
…es	3.2	8.8
	2.6	10.5

Summary of Recent Alerts

- For the week of Sept 11-17th, all three data sources detected events that exceeded alert thresholds.

As additional data becomes available for the District of Algoma, future information bulletins may include data related to naloxone distribution, drug type and deaths.

…kly count surpasses this threshold, or if …unusual opioid-related activity, please …forming all surveillance partners to …community action if needed.

…ional Ambulatory Care Reporting System (NACRS), Canadian Institute for Health Information. Acute Care Enhanced Suruivellance, KFL&A Public …cy Medical Services Calls, Sault Ste. Marie Fire Services.
…ation bulletin contains institutional data from various agencies and is shared among Algoma first responders and frontline service providers for the … surveillance and early warning to inform community action. For general information related to this topic, please visit algomapublichealth.com or …omapublichealth.com

October 2017

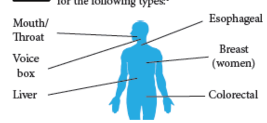
2017 Community Bulletin: Alcohol and Cancer

Algoma PUBLIC HEALTH Santé publique Algoma

Did you know?

- Drinking alcohol is directly linked to several types of cancer;
- Just one drink a day can raise your alcohol-related cancer risk; and,
- Drinking less or not at all is the best way to reduce your risk.

Having 1-3 drinks a day can increase your risk of cancer compared to non-drinkers for the following types:[1]



Between 2010 and 2012 in Algoma, estimates show alcohol use is responsible for:[2,3]

173 new cases of cancer

63 deaths from cancer

Self-reported alcohol use in 2013/2014 by Algoma residents

30.2% of Algoma residents 19+ self-report having 1-3 drinks a day.[4]

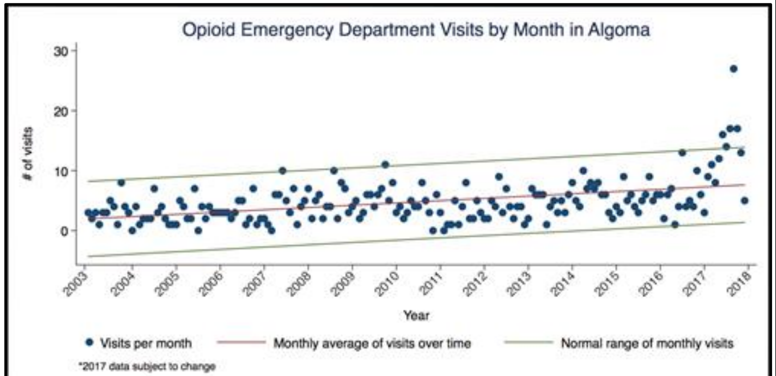
48.6% of Algoma residents 19+ self-report exceeding the Low Risk Drinking Guidelines.[4]

Manage your alcohol-related cancer risk

- Know and follow Canada's Low-Risk Alcohol Drinking Guidelines
- Track your drinking - be familiar with standard drink sizes
- If you don't drink, don't start.
- Check out Rethink Your Drinking for more information
- Follow up with healthcare provider for recommended cancer screening

Data sources: [1]Bagnardi, V. et al. Alcohol consumption and site-specific cancer risk: a comprehensive dose-response meta-analysis. Br J Cancer. 2015 Feb 3; 112(3): 580-93. [2]Praud, D. et al. Cancer incidence and mortality attributable to alcohol consumption. Int J Cancer. 2016 Mar 15; 138(6): 1380-7. [3] CCO SEER*Stat Package Release 10 - OCR (Aug. 2015). Pop Est Summary (Statistics Canada, Ontario Ministry Finance), Fall 2014 release, based on the 2011 Census. [4]Canadian Community Health Survey [2013/2014], Statistics Canada, Share File, Ontario MOHLTC

Together with our communities, Algoma Public Health is a leader in promoting and protecting health and well-being

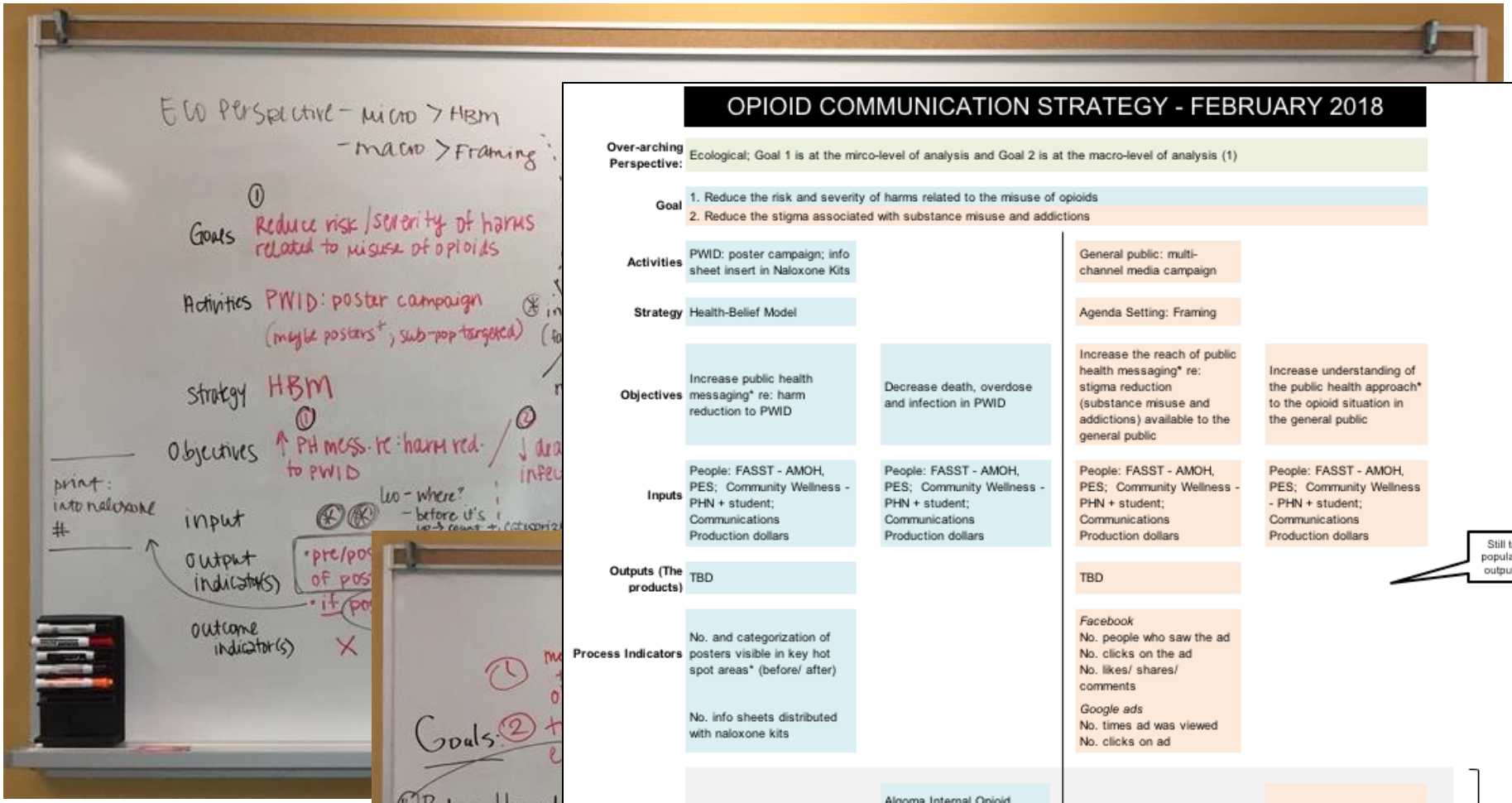


Coming soon in 2018!

Community Health Profile for Algoma

Planning and Evaluation Specialist

- What are we doing to address the public health problem?
- How are we going to do it?
- Is it working?



OPIOID COMMUNICATION STRATEGY - FEBRUARY 2018

Over-arching Perspective:	Ecological; Goal 1 is at the mirco-level of analysis and Goal 2 is at the macro-level of analysis (1)			
Goal	1. Reduce the risk and severity of harms related to the misuse of opioids 2. Reduce the stigma associated with substance misuse and addictions			
Activities	PWID: poster campaign; info sheet insert in Naloxone Kits		General public: multi-channel media campaign	
Strategy	Health-Belief Model		Agenda Setting: Framing	
Objectives	Increase public health messaging* re: harm reduction to PWID	Decrease death, overdose and infection in PWID	Increase the reach of public health messaging* re: stigma reduction (substance misuse and addictions) available to the general public	Increase understanding of the public health approach* to the opioid situation in the general public
Inputs	People: FASST - AMOH, PES; Community Wellness - PHN + student; Communications Production dollars	People: FASST - AMOH, PES; Community Wellness - PHN + student; Communications Production dollars	People: FASST - AMOH, PES; Community Wellness - PHN + student; Communications Production dollars	People: FASST - AMOH, PES; Community Wellness - PHN + student; Communications Production dollars
Outputs (The products)	TBD		TBD	
Process Indicators	No. and categorization of posters visible in key hot spot areas* (before/ after) No. info sheets distributed with naloxone kits		*Facebook* No. people who saw the ad No. clicks on the ad No. likes/ shares/ comments *Google ads* No. times ad was viewed No. clicks on ad	
Outcome Indicators		Algoma Internal Opioid Surveillance Summary Report: No. ED visits from MOHLTC, No. ED visits from ACES, No. Emergency calls from EMS No. cases of Hep C		Public event "pulse" (Checklist*) Social media discourse "pulse" (Qualitative content analysis*)

Still to populate outputs

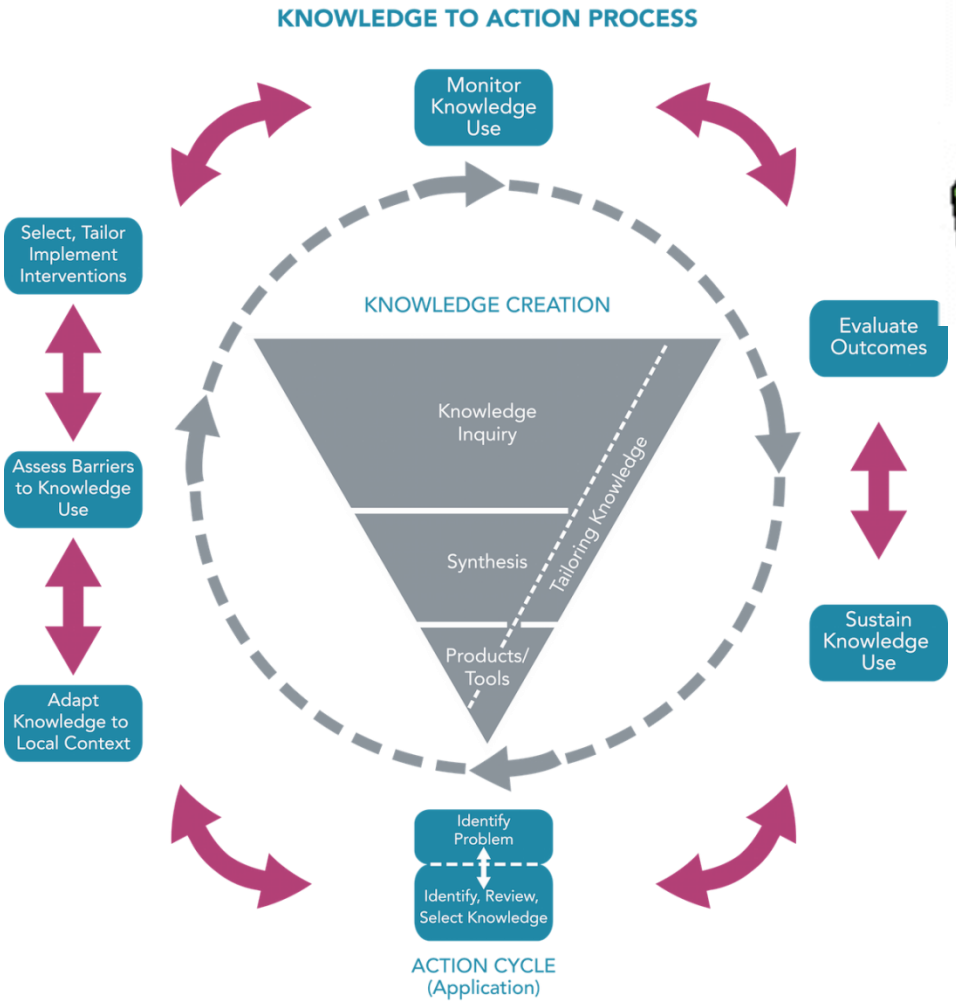
EXTERNAL INFLUENCES

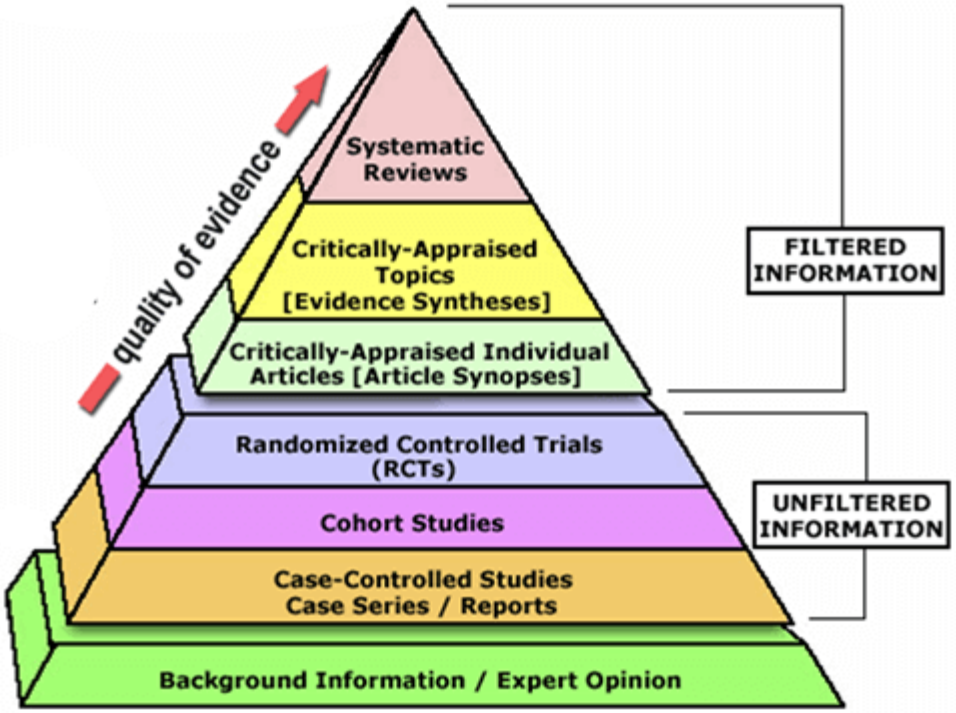
* These items are framed in supporting documentation and based on the Canadian Drugs and Substances Strategy (Health Canada, 2016)

Reference:
(1) Glanz, Rimer & Viswanath (2008). Health Behavior and Health Education: Theory, Research and Practice (4th Edition).

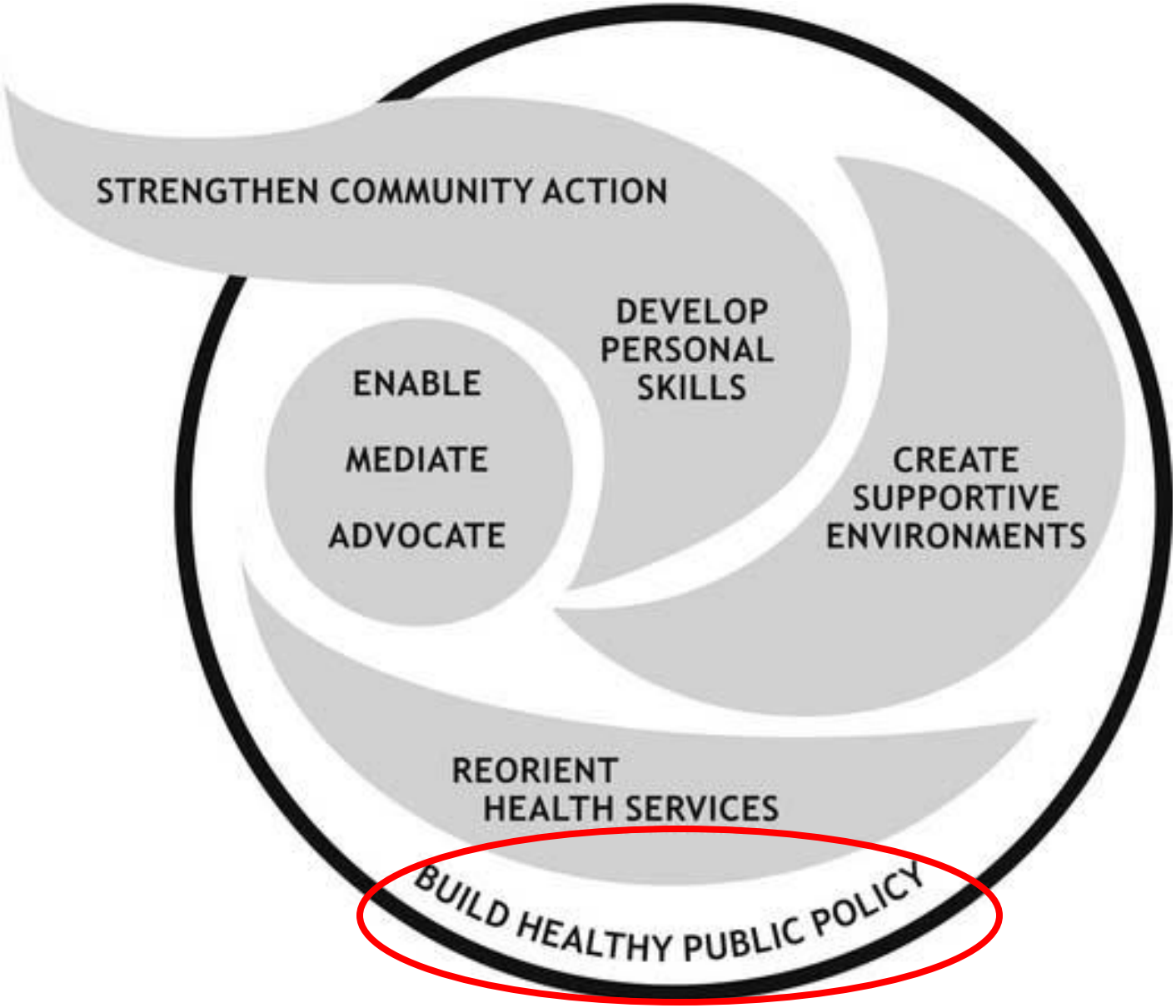
Research and Policy Analyst

- What does the research evidence tell us about what causes this public health problem?
- What does the research evidence tell us about **what public health interventions are effective**?
- What avenues are available to address the problem through **healthy public policy**?





- ✓ Critical appraisal
- ✓ Evidence briefs
- ✓ Rapid reviews
- ✓ Briefing notes



World Health Organization. The Ottawa Charter for Health Promotion. First International Conference on Health Promotion, Ottawa, November 21, 1988. http://www.who.int/healthpromotion/conferences/previous/ottawa/en/index4.html

Healthy Public Policy

7.0 New Business/General Business

a. Plain and Standard Tobacco Packaging and Products

Dr. Spruyt spoke to the briefing not provided in the agenda package on Plain and Standard Tobacco Packaging and Products. The Canadian Coalition for Tobacco is requesting the Board of Health's endorsement for plan and standardized packaging all tobacco products in Canada

2017-74 Moved: H. O'Brien
Seconded: K. Raybould

WHEREAS Tobacco use is still the number one cause of preventable death in Canada; and

WHEREAS Tobacco advertising bans restrict much of the promotion of tobacco products but tobacco packages and products are currently not included in these bans; and

WHEREAS The tobacco industry recognizes that the product and its package are valuable marketing spaces used to communicate many messages; and

WHEREAS The primary impacts of plain and standardized packaging include, diminished appeal of tobacco products; increased effectiveness of the health warnings; and reduced ability of the product and its packaging to mislead consumers about the harmful effects of tobacco use.; and

WHEREAS Plain and standardized packaging has already reduced tobacco use in Australia, and should have the same effect in Canada; and

WHEREAS Plain and standardized tobacco packaging and products was part of the Federal Liberal Party's 2015 election platform and included in Prime Minister Trudeau's mandate letter to the Minister of Health.

NOW THEREFORE BE IT RESOLVED THAT the Board of Health of Algoma endorses the Canadian Coalition for Tobacco recommendation for plain and standardized packaging of all tobacco products in Canada;

AND FURTHER that Algoma Public Health supports ongoing public education and awareness of this issue in Algoma;

AND FURTHER; that Algoma Public Health in keeping with its endorsement continues to monitor the progress of this issue and the need for any further action to support the Canadian Coalition for Tobacco recommendations of plain and standardized packaging of all tobacco products in Canada.

CARRIED

b. Governance Training Workshop

Mr. Frazier and Ms. Raybould attended a governance training workshop hosted by the United Way. A brief summary was provided on making more interactive meetings and high level and visual agenda packages. The presentation also addressed the difference between governance and operations and they will share with the governance committee some written material.

HOME > LOCAL NEWS

Algoma Public Health pushes for crackdown on tobacco packaging

Brand colours, logos and graphics would be prohibited

37 shares

Oct 1, 2017 9:29 PM by: David Helwig

Proposed standardized packaging would prohibit all promotional features, but health warnings would remain and become more noticeable

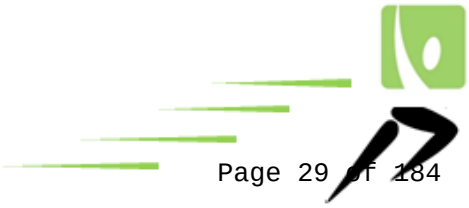
Algoma Public Health wants the federal Liberals to follow through on their election promise to introduce plain and standardized tobacco packaging and products.

While advertising restrictions have reduced the promotion of tobacco products, the health unit is concerned that the restrictions don't apply to packaging.

Public Health Workforce Development

- **FASST consultant capacity**: working to help teams
  - Access, understand, use population health data
  - Incorporate local health data into program planning and evaluation
  - Implement effective public health interventions that are grounded in evidence
  - Expand health promotion reach by building healthy public policy
- **Grand Rounds**: promoting culture of learning
- **OnCore**: core skills for public health practice

Questions?



Algoma
PUBLIC HEALTH
Santé publique Algoma

MEDICAL OFFICER OF HEALTH/CHIEF EXECUTIVE OFFICER
BOARD REPORT
FEBRUARY 2018

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

and the Leadership Team

In Celebration of Algoma Public Health's 50th Anniversary a Free Community Skate was held on January 20, 2018 at the John Rhodes Arena

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APH AT-A-GLANCE

Annual Service Plan submission is well underway and has taken up a significant time from managers and finance. This is the first year we have to submit our budget in this new format which combines request for funding dollars with specific activities that will be delivered under each of the new public health program standards. Since this is the first year we are building capacity with our mangers to develop work plans in this format and hope that all be a lot easier in the following years.

As part of the implementation process for the new program standards we had an all staff meeting on the morning of February 12 as the first groups of employees were being moved to their new program and/or manager. This was followed by team meetings for the newly created teams to engage all staff in the transition process and assist in identifying where gaps might exist and to develop solutions going forward. Additional staff will continue to move every 2 weeks and the transition should be complete by April.
In addition our 2nd all staff "Grand Rounds" was held on February 14 with the topic of Healthy Eating- A Harm Reduction Approach.

Our new Executive Assistant and Secretary to the Board Tania Caputo started employment with us on Feb 12 and Christina remains partially in the role to support the transition. The timing of her arrival allowed us to send her to the EA conference provided by alPHa just prior to the MOH and BOH meetings. Jennifer Loo and I will both be travelling to attend the alPHa meeting in Toronto on February 23.

In the Sault Ste. Marie area attention was drawn to the opioid issue particularly by media after the airing of the W5 documentary Steeltown Down. We have attended meetings with other partners to reinforce the message that this is a complex problem and cannot be solved by a single intervention. All partners need to work together to provide the 4 pillar approach of Prevention, Treatment, Harm Reduction and Enforcement

PROGRAM HIGHLIGHTS

ANNUAL REPORT 2017 ON ONTARIO BUILDING CODE

Director: Sherri Cleaves, Director of Health Protection and Prevention

Topic: Ontario Building Code / Septic Systems

Public Health Goal:

- To prevent or reduce the burden of water-borne illnesses related to drinking and recreational water.

Ontario Building Code Requirements:

- To inspect and verify that all new sewage systems installed in Algoma district adhere to current regulations to protect ground and surface water.

Program Standard Requirements addressed in this report:

- Requirements under the Ontario Building Code (OBC) related to Sewage Systems which APH is mandated to administer

2015-2020 Strategic Priorities addressed in this report: Be Accountable

Key Messages:

- All new sewage systems under 10, 000 litres/day must meet required legislation, be inspected and approved by APH.
- All legislation including local municipal by-laws must be addressed when approving a sewage system.
- Application fees were increased in 2018 for cost recovery of expenses.

Introduction

Under Part VIII of the Ontario Building Code, Algoma Public Health is responsible for issuing permits for the construction and use of the 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 disposal viewpoint. As such, APH is responsible for the enforcement of the provisions of the OBC 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 flow under 10, 000 litres/day. Systems over that volume fall under the responsibility of the Ministry of Environment and Climate Change. The Land Control program is funded through fees generated from applications and is planned to be a revenue neutral program.

The Code and Act can be found at: https://www.ontario.ca/laws/regulation/120332

- APH inspectors review, inspect, approve or reject all sewage system applications within the required time frames set by the OBC.
- APH continues to work with municipalities, building inspectors and contractors to reduce the number of systems installed without approval. If a homeowner or contractor constructs a sewage system without notifying APH and without obtaining a permit, it may only be discovered when we receive a complaint
- Some municipalities in the district of Algoma have enacted by-laws increasing the setback distances for septic systems from surface water. APH is working with municipalities to ensure we are notified if these by-laws are passed.

A sewage system is a means to return the waste generated through black or grey water disposal safely back into the environment. The requirements of the OBC include placement of the system to protect the ground water and surface water from any sewage contamination. Typical operation involves a septic tank and leaching field sized to accommodate the expected maximum daily sewage flow and on site soil drainage conditions. Homeowners and contractors are required to submit completed applications to APH with applicable fees prior construction of sewage systems. The inspectors review the applications and conduct inspections to verify that the application and construction adhere to the building code, current regulations and standards.

Evaluation of 2017

As illustrated in the table below, the majority of the systems installed in Algoma are the Class 4 system which is either a filter bed or leaching bed with septic tank. The program addressed 380 requests/applications of the various types in 2017. The table provides an overview of the distribution of applications across the Algoma district showing most of the work occurs out of the Sault Ste. Marie and Blind River offices.

Land Control Statistics for 2017 (number of applications and total fees)

Office	Class 2 Leaching Pit	Class 4 (complete system)	Class 4 (tank only)	Class 4 (bed replace /alteration)	Class 5 (holding tank)	File Searches	Perf. Level Reviews	Other services *
SSM	8	104	4	13	5	56 - $75 6 - $150	19	SEV – 19 PDA – 2 DECOM – 1
Blind River	0	30	4	3	0	27 - $75 1 - $150	16	SEV - 1
Elliot Lake	0	12	0	0	0	1 - $75	0	
Wawa	0	5	0	2	0	1 - $75 1 - $150	3	
Totals	**8**	**187**	**8**	**18**	**5**	**85 & 8**	**38**	**23**

Other services include; pre-development audits (PDA), applications for consent (SEV), zoning amendments and minor variance applications, by-law amendments (BLA) and Decommissioning (DECOM).

In 2017 revenues increased from $130,650 in 2016 to $150,125 in 2017. The program expenses were $143,000 for salary and benefits and $8000.00 for operating costs resulting in a slight deficit of $875.00.

Next steps:
APH continues to work with municipal offices, building inspectors and contractors reminding them of the responsibility to notify APH prior to construction of any sewage system to reduce the number of illegally installed systems. The new fee structure initiated in January 2018 was implemented to better reflect actual costs of administering the land control program and will work towards full cost recovery moving forward. A geographic map outlining specification is each region will assist APH in meeting municipal by-law setbacks.
Respectfully submitted
Sherri Cleaves

CHILD AND FAMILY SERVICES

Director: Laurie Zeppa
Manager: Leslie Wright

Topic: Algoma Preschool Speech and Language Services

Public Health Goal:
The goal of the Algoma Preschool Speech and Language Service (APSLS) is to provide an opportunity for all preschool children (0-6 years of age) reach their full speech, language and communication potential.

Note: APSLS is funded by the Ministry of Children and Youth Services. Algoma Public Health (APH) is one of approximately 13 public health units in Ontario acting as the lead agency for the Preschool Speech and Language Service (PSLS).

Program Requirements - Deliverables:

- 45% of all initial assessments are provided to children under 30 months (focus on early intervention)
- 50 % of children access their initial assessment within 3 months from date of referral
- 75 % of children will receive their first intervention within 8 months from the date of referral
- 75 % of children (aged 0 – 30 months) receive Parent Training, Parent Training Former Definition, Hanen Parent Program, Group Treatment - SLP, Group Treatment - Mediator, or Home Programming at some point during their total period of service delivery

- 75% of Children over 18 months will have had Outcome Measures completed before or at some time during their first intervention
- 75% of children over 18 months of age who received an Outcome Measures Tool completed at a minimum of every 6 months (completed at the beginning/end or intervention periods or at scheduled reassessments)

2015-2020 Strategic Priorities addressed in this report:

- Improve Health Equity
- Collaborate Effectively

Key Messages:

- APSLS values "early" identification of children with speech and language difficulties.
- APSLS values the role of parents in the therapy process. Parents play a central role in facilitating change in their child's communication development.
- APSLS appreciates the importance of speech and language skills in contributing to successful transition to school and school readiness.
- APSLS is committed to partnering with community agencies such as school boards, child care centres and community programs to build capacity with staff working with children with communication difficulties.

Introduction:

The APSLS is an "early" intervention program targeting children (0-6 years) with communication disorders. APH and Thrive Children Development Center (Thrive) jointly deliver APLS with APH having the additional role of lead agency. The lead agency ensures the program is implemented as per ministry guidelines and protocols. APH provides financial and statistical reports to the ministry, maintains the database and assumes responsibility for the achievement of the deliverables. APH also is responsible for representing the program at local children services planning tables.

Partnerships with parents and providers (i.e. child care and schools) are critical to the delivery of the program. A range of evidence based interventions that respect and involve the parents, are key to the children's success in the program. The local child care settings provide space for the program delivery and in addition child care setting activities are integrated into the intervention plans that are created for each child. A number of Indigenous child care settings have invited the program to offer services onsite. For example, Waabinong Head Start child care centre, has created space for the staff one day a week with close to half of the children in the center receiving speech and language intervention. A partnership with local school boards allows the program to provide speech and language services to children up to age 6 in all schools adding to the transition of these children from community to school.

Staff complement for the program consists of 3 Speech Language Pathologists (SLP) (2 FTEs at APH and 1 FTE at Thrive) and 2.6 Communicative Development Assistants (1.8 FTE at APH and 0.8 FTE at Thrive.)

Population Health Snapshot:

- Globally one in 10 children (0-6 years) needs help developing normal speech and language skills.
- In 2015, the percentage of children not ready for school in Sault Ste. Marie is 6.8%; in the District is 9.7%; this is in comparison to Ontario at 6.1%,
- Parent reach: All Parents of children under 3 years (who are enrolled in APSLS) are offered or participate in parent training.

Sources: Ontario Ministry of Children and Youth Services; 2016 Best Start Network Report (Volume 3) District of Sault Ste. Marie: Our Children 2015 and Algoma District Best Start Network Building Opportunities Creating Success (Volume 3)

Program Interventions:

Assessment:
Every child referred to PSLS receives an assessment by a speech and language pathologist, who evaluates the child's communication skills (i.e., social communication, play skills, receptive language, expressive language, speech production, fluency, and voice and literacy skills). In addition parents complete a validated clinical outcome tool called "Focus on the Outcomes of Communication under Six" (FOCUS) at initial assessment and reassessments at minimum every 6 months to determine changes in the child's communication/participation skills.

Intervention:
A variety of interventions are offered to parents and children in PSLS including: parent training, group therapy, individual therapy, child care consultation, home programming, and transition to school and monitoring**.**

Examples:

Wee talk

- Parent training group
- For children aged 1 ½ to 2 ½ years old

Toddler Talk

- For children aged 2 ½ to 3 ½ years old
- Program is tailored to your child's needs
- Requires a partnership with parents

Group Therapy

- Children are grouped according to speech/language concerns
- Facilitated by communicative disorders assistant and/or SLP

March Break/Summer Camp

- Intensive therapy for children who will be entering school
- Children are grouped according to speech/language concerns
- Program is offered at an elementary school in the community or at APH

Evaluation:
The program works with families and partners to improve and provide effective interventions for the children. The addition of group assessments and school classroom assessments has expanded our reach to children.

In the fiscal year 2016, 743 children received interventions compared to 616 in 2015. For the first three quarters of the 2017 fiscal year we have provided service to 617 children.
As noted below, the program is meeting the indicator targets set out by the ministry. Outcome Measurement tool underwent changes in 2016, the Integrated Services for Children Information System (ISCIS) data base has not been update to capture this data. We are anticipating this data will provide indicators of success related to "improvement" in speech and language.

Indicators	**2016** **April 1, 2015-March 31, 2016**	**2017** **April 1, 2016- to date**
1. 45% of initial assessment provided to children under 30 month	39%	40%
2. 50% of children who accessed their Initial Assessment within 3 months from date of referral	29%	45%
3. 75% of children will receive their first intervention within 8 months from the date of referral	63%	68 %
4. 75% of children (aged 0 – 30 months) who received Parent Training, Parent Training Former Definition, Hanen Parent Program, Group Treatment - SLP, Group Treatment - Mediator, or Home Programming at some point during their total period of service delivery = X %...	75%	75%
5. 75% of Children over 18 months will have had Outcome Measures completed before or at some time during their first intervention	XX Outcome measurement tool is revised	XX ISCIS report has not been update to reflect revisions
6. 45% of children over 18 months of age who received an Outcome Measures Tool completed at a minimum of every 6 months (completed at the beginning/end or intervention periods or at scheduled reassessments)	XX Outcome measurement tool is revised	XX ISCIS report has not been update to reflect revisions

Data source: Ontario Ministry of Children and Youth Services, Integrated Services for Children Information System (ISCIS). Report Run February, 2018

INDICATORS

2017 Health Protection Indicators

	Third Quarter (July - September)					4th Quarter (October - December)					YTD - TOTAL
	WW	SSM	BR	EL	Total	WW	SSM	BR	EL	Total	
Safe Water											
Private Wells – Adverse DW	3	65	30	3	**101**	2	76	32	1	**111**	**232**
Regulated Premise – ADW (O.reg.319)	6	8	2	4	**20**	0	3	0	0	**3**	**25**
BWA issued	3	1	1	0	**5**	0	2	0	0	**2**	**11**
DWA issued	1	1	0	0	**2**	0	1	0	0	**1**	**3**
Beach closures	0	3	3	0	**6**	N/A	N/A	N/A	N/A	**0**	**8**
Rabies											
#Rabies risk Investigations Initiated	2	62	12	5	**81**	2	29	5	2	**38**	**217**
Food Safety											
Special Event Permits issued	1	73	30	18	**122**	0	25	10	2	**37**	**268**
Food Handler Training (#persons)	0	44	9	0	**53**	9	90	15	0	**114**	**411**
Farmer's Market Approvals	0	8	5	0	**13**	0	5	0	0	**5**	**108**
Health Hazard											
Complaint/Investigations all types	0	63	7	0	**70**	0	29	4	1	**34**	**228**
Land Control – OBC											
Applications/Permits – Class IV	1	46	15	0	**62**	2	16	9	1	**28**	**145**
Communicable Disease Control											
#Institutional outbreaks	0	4	1	0	**5**	0	2	2	0	**4**	**26**
Total outbreak days in quarter	0	67	42	0	**109**	0	18	40	0	**58**	**424**
Gonorrhea	0	2	0	3	**5**	0	7	0	3	**10**	**40**
Chlamydia (6 cases-location not identified)	0	52	1	7	**61**	1	72	2	9	**86**	**291**
BBI (Hep B, C, HIV)	N/A	N/A	N/A	N/A	**22**	N/A	N/A	N/A	N/A	**13**	**85**
Other Reportable Diseases	0	26	1	3	**30**	0	26	2	0	**28**	**124**
Confirmed Influenza Cases	0	0	0	0	**0**	0	2	0	0	**2**	**87**

2017 Prevention and Promotion Performance Indicator Report

	July - September 2017					October - December 2017					
HBHC POSTPARTUM	**WW**	**SSM**	**BR**	**EL**	**Total**	**WW**	**SSM**	**BR**	**EL**	**Total**	**YTD-Total**
Phone Calls	9	129	13	10	**161**	4	127	13	19	**163**	**621**
Home Visits	2	51	6	3	**62**	0	56	4	3	**63**	**244**

COMMUNITY MENTAL HEALTH	**July - September 2017**	**October - December 2017**	**YTD TOTAL**	**NOTES**
CMH New Clients: Individuals receiving 1st service	56	54	**209**	Individuals receiving 1st service are the number of new clients to CMH who have been referred, received an intake, are eligible for psychiatric case management services and have been assigned a case manager.
CMH non registered: Client interactions	319	278	**1182**	Unidentified client interactions are the number of interactions with individuals who are not registered with the program. This includes program inquiries and brief service provision. These interactions require program staff intervention either by phone or in person.

	July to September 2017					October to December 2017					
COMMUNITY ALCOHOL DRUG ASSESSMENT PROGRAM	**WW**	**SSM**	**BR**	**EL**	**Total**	**WW**	**SSM**	**BR**	**EL**	**Total**	**YTD - Total**
Additions - Overdose Prevention											
• Naloxone trainings completed - with at risk individuals	4	69	-	1	**74**	11	105	1	9	**126**	**200**
Addictions - Harm Reduction											
• Needles out - distributed	-	72446	0	560	**73006**	100	72236	0	1590	**73926**	**293382**
• Needles in thru APH/JHS sites	-	9351	0	250	**9601**	100	12229	0	50	**12379**	**70649**
• Needles returned thru drop bins in SSM - estimate*	-	39000	n/a	n/a	**39000**	n/a	40440	n/a	n/a	**40440**	**151440**
Back on track Remedial Measures - individuals trained											
• Partnership with CAMH and MTO	-	20	-	-	**20**	n/a	35	n/a	n/a	**35**	**117**
***Bins emptied 1 – 2X per week X 8 weeks = 2000 sharps per full bin X 2 bins**											

CONTRACEPTIVE PURCHASES	July - September, 2017					October - December, 2017					
	WW	SSM	BR	EL	Total	WW	SSM	BR	EL	Total	YTD Total
14-19 years	pending	91	pending	pending	91	pending	99	pending	pending	99	**394**
20-24 years	pending	157	pending	pending	157	pending	131	pending	pending	131	**631**
25-29 years	pending	198	pending	pending	198	pending	168	pending	pending	168	**764**
30+ years	pending	173	pending	pending	173	pending	161	pending	pending	161	**712**
Total	pending	**619**	pending	pending	**619**	pending	**559**	pending	pending	**559**	**2501**

Calls to the Sexual Health Phone Line	January 1 – March 31, 2017	March 31 – June 30, 2017	July 1 – September 30, 2017	October 1 - December 31, 2017	Total for 2017
	889	**908**	**1125**	**1188**	**4110**

TOBACCO CESSATION	July - September 2017			October - December 2017			YTD Total
	SSM	District	Total	SSM	District	Total	
Number of APH clients assessed or reassessed for tobacco use using Brief Contact Interventions (BCI)	573	127	**700**	457	73	**530**	**2953**
Number of clients referred by staff to further intensive smoking cessation supports at APH during BCI	151	included in SSM number	**151**	94	included in SSM number	**94**	**548**
Number of clients receiving clinic or in-home intensive tobacco cessation services from APH staff	-	-	**54**	42	28	**70**	**264**

Respectfully submitted,
Dr. Marlene Spruyt

Algoma
PUBLIC HEALTH
Santé publique Algoma

MEDICAL OFFICER OF HEALTH/CHIEF EXECUTIVE OFFICER BOARD REPORT MARCH 28, 2018

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

and the Leadership Team

APH AT-A-GLANCE

Well, we all breathed a sigh of relief when we were able to submit our Annual Service Plan to the Ministry by the deadline of March 1, 2018. This new process took considerable time from our program managers and Finance team during the months of January and February. In the past, the BOH has approved a budget which allocates funding to some general program delivery areas. This new process requires providing much more detail of what we plan to do with that funding. They requested we use the structure of the new program standards which were only just finalized in January 2018; indicate our service/at-risk population and our desired outcome for that population and then identify the unique interventions and activities that we planned to engage in to achieve the desired outcome. We were also requested to indicate the number of FTE aligned to particular activities. Our work has not always been tracked in this way so much of the FTE alignment was based on estimates. As we go forward we are looking at systematically collecting this information to better determine the costs of delivering various public health interventions and how effective that intervention is.

Every year in March, Public Health Ontario (PHO), Association of Local Public health Agencies (alPHa) and the Ontario Public health Association (OPHA) host The Ontario Public Health Convention (TOPHC). Several APH folks are in attendance as I write this report (March 21-23). We have 2 poster projects that were accepted for presentation, one on the difficulties of dealing with a rural pertussis outbreak of 2016 and the other on vector-borne diseases.

As we continue celebrating our upcoming APH 50th Anniversary we launched a Get Active in Algoma challenge using the Goosechase App. There has been excellent uptake with 160 teams registering during the first week. The challenge runs for 2 months with at least 2 missions added each week. Anyone or any group of people can enter from anywhere in the district. You can join at any time and catch up on previous challenges so I encourage you and your family and friends to download the free App and join our game.

PROGRAM HIGHLIGHTS

INFECTIOUS DISEASES
Director: Sherri Cleaves
Manager: Jonathon Bouma

Topic: Communicable Disease Annual Report

This report addresses the following requirements of the Ontario Public Health Standards (OPHS) and the Infectious Diseases Protocol, 2018:

OPHS Requirement 1: The board of health shall conduct population health assessment and surveillance regarding infectious and communicable diseases and their determinants.

OPHS Requirement 11: The board of health shall provide public health management of cases, contacts, and outbreaks to minimize the public health risk in accordance with the *Infectious Diseases Protocol, 2018*

New Protocol Requirement:
The board of health shall analyze and interpret infectious disease data, and data related to factors influencing their occurrence, in an annual report to its target audience that describes, at a minimum, the following:

a. The incidence (morbidity and mortality) of diseases of public health significance;

b. The distribution of demographic and disease-specific factors influencing infectious disease incidence, including vector data;

c. Populations at risk of exposure to infectious diseases in the community and in specific settings such as long-term care homes, hospitals, and child care centres (as defined in the Child Care and Early Years Act, 2014);8 and

d. Trends over time in the incidence of diseases of public health importance, which may include antimicrobial resistant indicators

This report addresses the following Strategic Directions: Be Accountable

Ontario Public Health Standards Goal:
To reduce the burden of communicable diseases and other infectious diseases of public health importance

Introduction:
Infectious diseases are diseases caused by bacteria, viruses or parasites which can spread from person to person, from animals to people, from contaminated food or water to people and from exposure to our environment. Diseases of public health significance are those diseases that can adversely affect the health of the population. The Infectious Diseases (ID) team conducts surveillance of these types of diseases to identify trends and outbreaks, works with partners (such as hospitals and long-term care homes) to help control the spread of infectious diseases, and conducts the investigation into cases and treatment of contacts of disease.

Summary of activities in 2017

Health promotion:
A campaign was conducted for Grade 7 students about Hepatitis C. The main message was that there is no vaccine for this particular form of hepatitis. All students received information on Hepatitis in general and we provided them with a pen & card with a link to our website for further information.

A second health promotion strategy was directed towards adults born between 1945 and 1965. At various community events, they were encouraged to get screened for Hepatitis C. This population cohort has been identified as a group of individuals who might have engaged in high-risk behaviours in the past during their youth before the hepatitis C virus was identified.

Travel Clinics:
APH provides consultation and immunization service for people who will be travelling outside of Canada and may need travel health advice about the risk of exposure to various diseases in other areas of the world. Sometimes they require updating of routine vaccines but for vaccines not on the Ontario publicly funded schedule the client is charged for the cost of the vaccine. (e.g. yellow fever, rabies, Japanese encephalitis) In 2017 we completed 187 travel consults.

Tuberculosis (TB):
Although the number of annual active TB cases remains low in Algoma, APH provides TB Skin Testing as part of a public health program service delivery. Most tests are administered to those seeking employment in a healthcare field and as they are not publically funded we charge a fee for this service. Individuals who require testing because of a risk of exposure or to attend school are covered by public funding. In Sault Ste. Marie, we completed 803 tests and 43 in the district offices.

Tuberculosis (TB) follow-up was done on 2 active TB cases in 2017, one of which we provided Directly Observed Therapy (DOT) for the duration of treatment. Five clients were engaged in follow-up for Medical Surveillance for TB (referred from Immigration Services), which is up from less than 2 cases in past years. The program also followed 18 clients identified with latent tuberculosis infection.

Public Education requests:
The ID team answered 357 phone calls from the public and healthcare agencies on a variety of topics. The majority were related to information in regards to non-reportable communicable diseases such as head lice. In addition, the staff are continually following up on any reportable infectious disease results and conduct investigations and case management.

Information sessions were provided to all Paramedics in Sault Ste. Marie regarding minimizing blood-borne infections.

Reducing exposure risk in the community:
The program has also supports Harm Reduction (for Blood-borne diseases) through the needle exchange program which expanded to all district offices in 2017 and although not related to infection control the Naloxone distribution integrates well with needle exchange and is also supported by staff from this team.

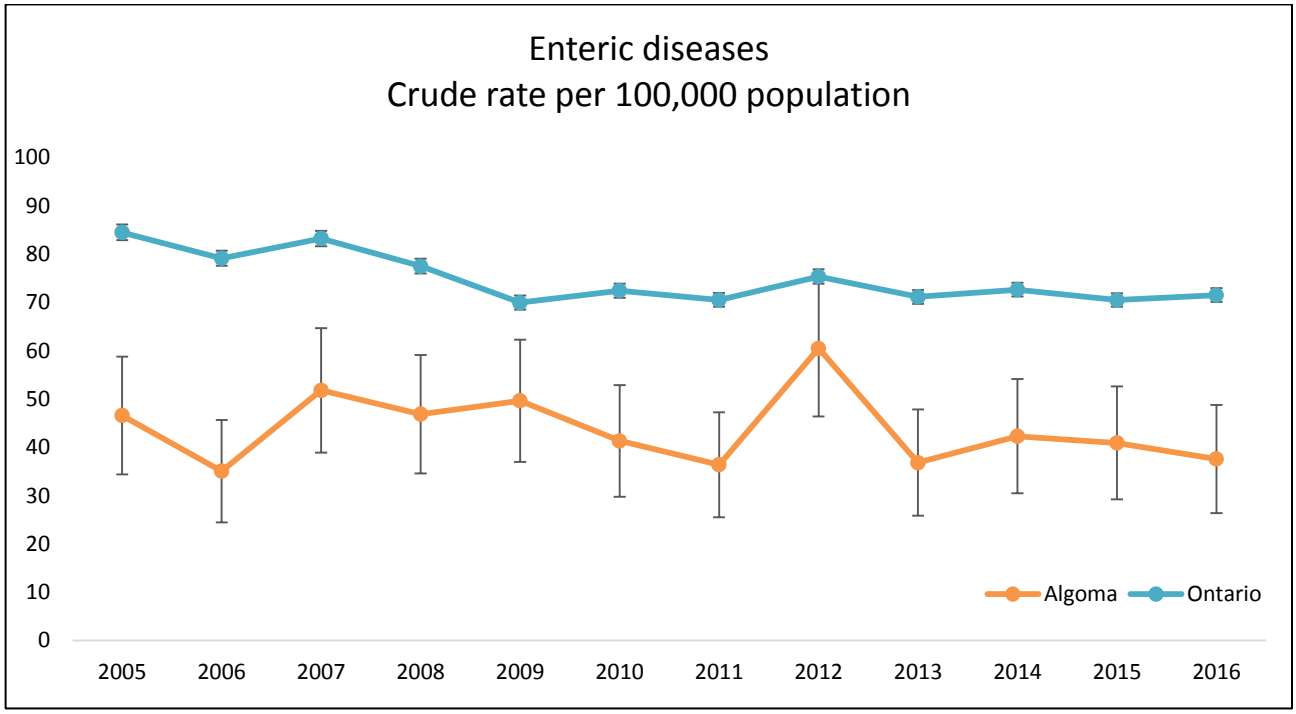
Case management: The goal of disease case management is to reduce the spread of the disease in the community.

After receiving a positive lab confirmation of diseases of public health significance our staff interview the person and provide education to reduce the further spread of disease. This involves discussing actions to limit transmission of infection for close family members living in the same location and to those in the broader community. Sometimes our primary intervention is to provide them with access to medications as prompt treatment will minimize spread in the community. This is the historical context for access to free medications for treatment for chlamydia and gonorrhea.

Algoma Statistics

Enteric diseases:

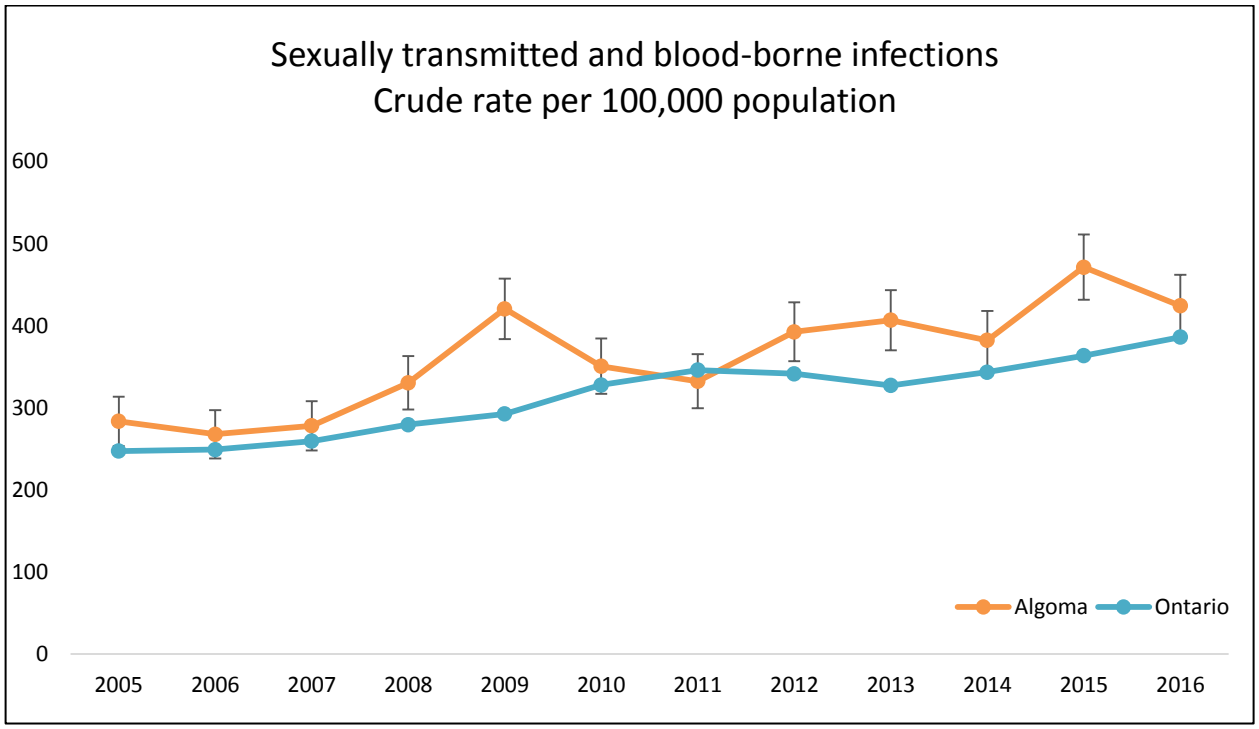
There are many enteric /gastrointestinal diseases however a few key ones represent the majority of case investigations and public health risk. *Salmonella, Campylobacter*, and *Giardia* comprise 79 percent of our cases in 2017. These infections are usually related to exposure to food and water contamination. As shown below the rates overall have been fairly consistent in the last six years. Prevention strategies range from providing safe food handler certification, inspection of food/water/pool/spa premises, education on proper water testing and treatment and public education regarding the importance of handwashing.



Enteric diseases include: amebiasis, botulism, Campylobacter enteritis, cholera, cryptosporidiosis, cyclosporiasis, food poisoning all causes, giardiasis, hepatitis A, listeriosis, paratyphoid fever, salmonellosis, shigellosis, trichinosis, typhoid fever, verotoxin producing E. coli including HUS, and yersiniosis (56 total cases reported in 2017)

Sexually transmitted and Blood-borne infections - As you can see in the graph below, both the chlamydia and gonorrhea infections decreased from 2015/2016. Chlamydial cases fell from 319 cases in 2016 to 292 cases in 2017; gonorrhea decreased to 39 cases in 2016 from 95 reported cases in the previous year. Hepatitis C, however, increased to 84 new cases in 2017 compared to 70 in 2016. Algoma consistently has a higher than the provincial average infection rate of Hepatitis C and continues to work on the education strategies outlined above on a risk-based approach to youth and to those in older populations who may have been exposed in the past.

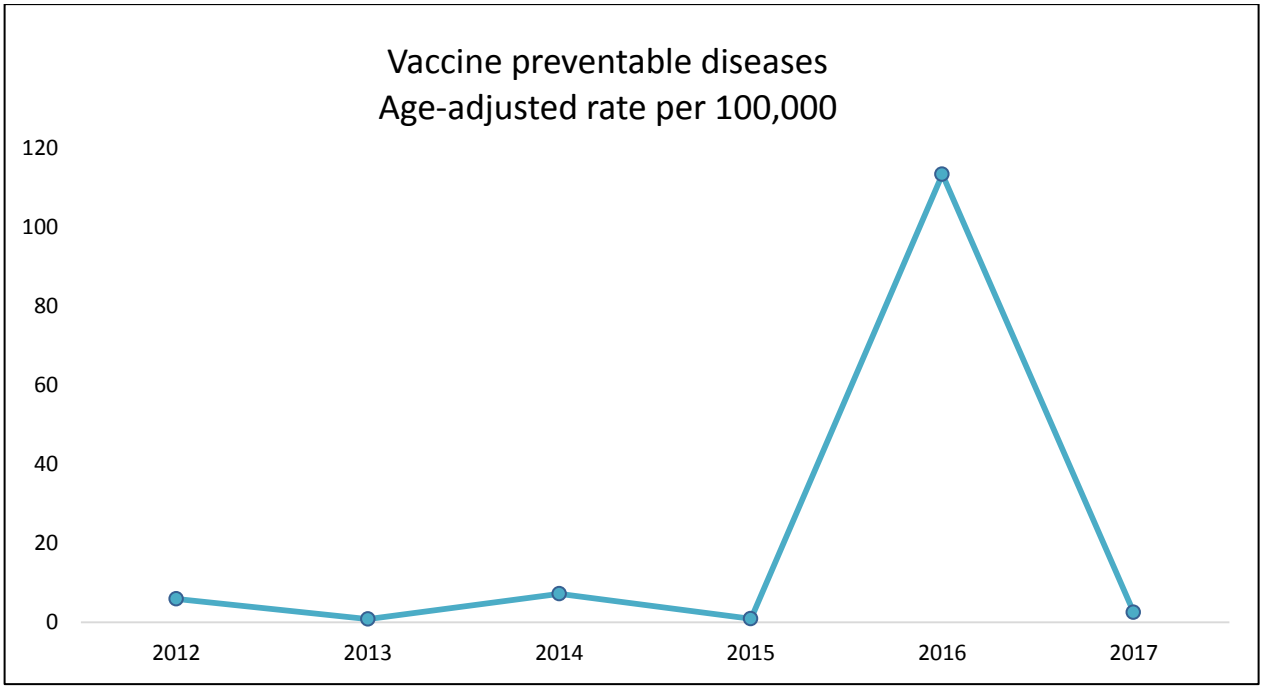
Prevention strategies range from educational presentations, working with Sault College and Algoma University to have displays during HIV/AIDS awareness month and increasing awareness for testing.



STI and blood-borne category includes: chlamydial infections, gonorrhea (all types), neonatal group B streptococcal disease, HIV/AIDS, hepatitis C (421 total cases in 2017)

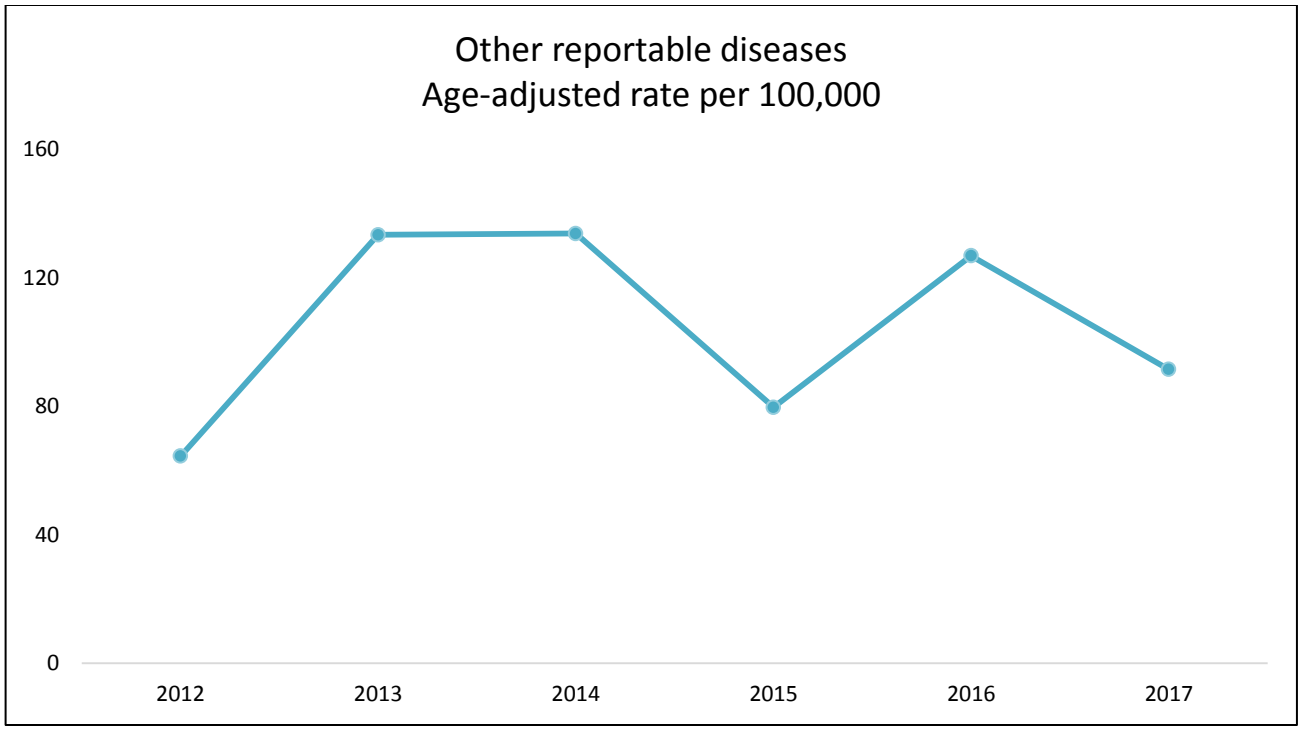
Vaccine preventable disease - overall, Algoma has a very low rate of disease in this category owed in large part to the protection of vaccines. Exceptions can occur as seen in 2016 in the East Algoma area with a large pertussis outbreak in a significant portion of the population that had incomplete vaccine coverage.

Education strategies continue to be essential in the area of immunization to keep the immunization protection rates up in the population with the increased public concern of potential adverse vaccine effects.



Vaccine preventable disease (VPD) category includes: chickenpox (varicella), diphtheria, invasive Haemophilus influenzae b disease, hepatitis B, measles, invasive meningococcal disease, mumps, pertussis (whooping cough), rubella, congenital rubella syndrome, and tetanus. (3 in 2017, 113 in 2016 due to large pertussis outbreak)

Other diseases of note - these diseases include serious pathogens such as group A streptococcal disease but in terms of volume, influenza is the significant disease in our population and is responsible for the yearly variation in the graph below. Lab reported influenza only represents a portion of the actual burden of this viral disease in our region. APH offers influenza immunizations each fall along with healthcare practitioners and pharmacies to increase vaccine coverage to prevent infection.

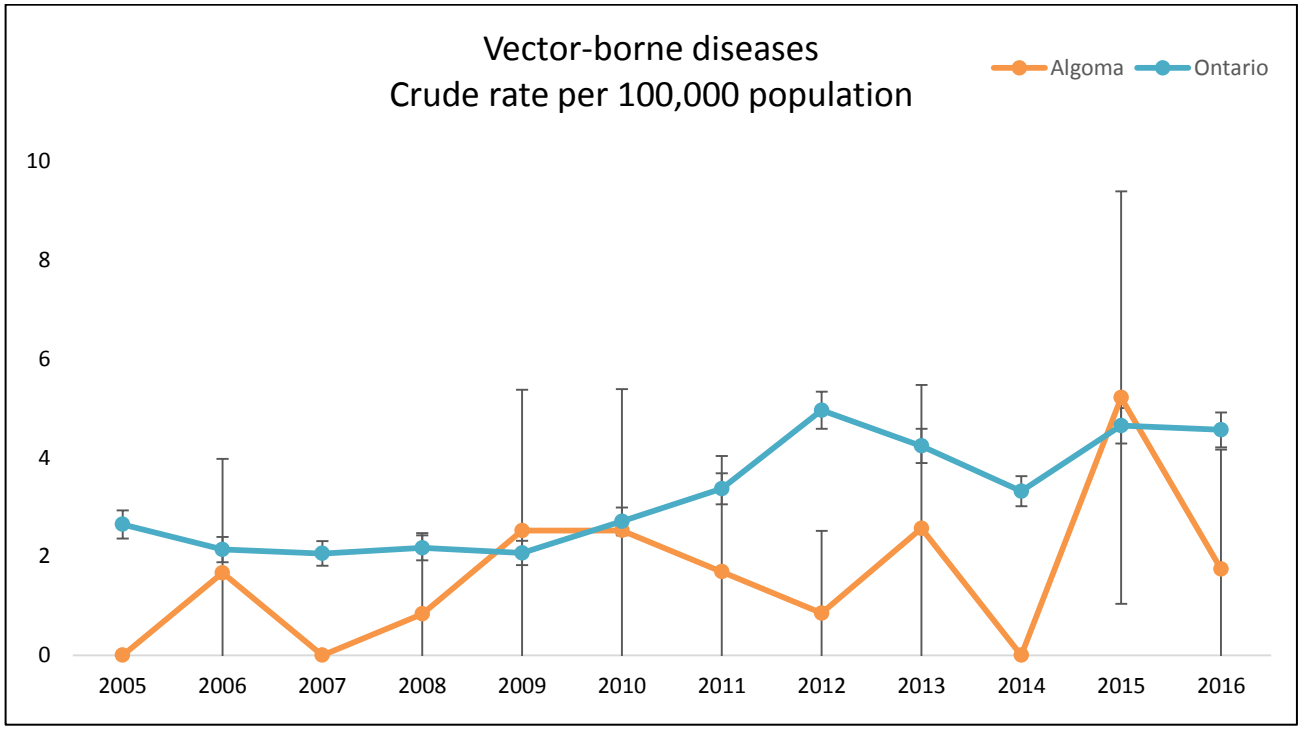


Other category includes: encephalitis with meningitis, invasive group A streptococcal disease, influenza, legionellosis, meningitis, invasive Streptococcus pneumoniae (121 total in 2017)

Vector-borne disease (Lyme disease / West Nile virus) – Although vector-borne disease in Algoma is rare and infrequent, these diseases are followed closely with surveillance efforts to identify any increase in scope or nature of the vector involved. Lyme disease, in particular, is attracting concern. A warming climate could change our region into an endemic area for the black-legged tick, *Ixodes scapularis*, which is responsible for the transmission of the disease.

Prevention strategies continue to be education and health promotion for the general public along with educational seminars to various interested outdoor workers such as Ontario Hydro and Ministry of Transportation.

Surveillance is conducted every summer season for the mosquitos (WNv) and for ticks (Lyme diseases)

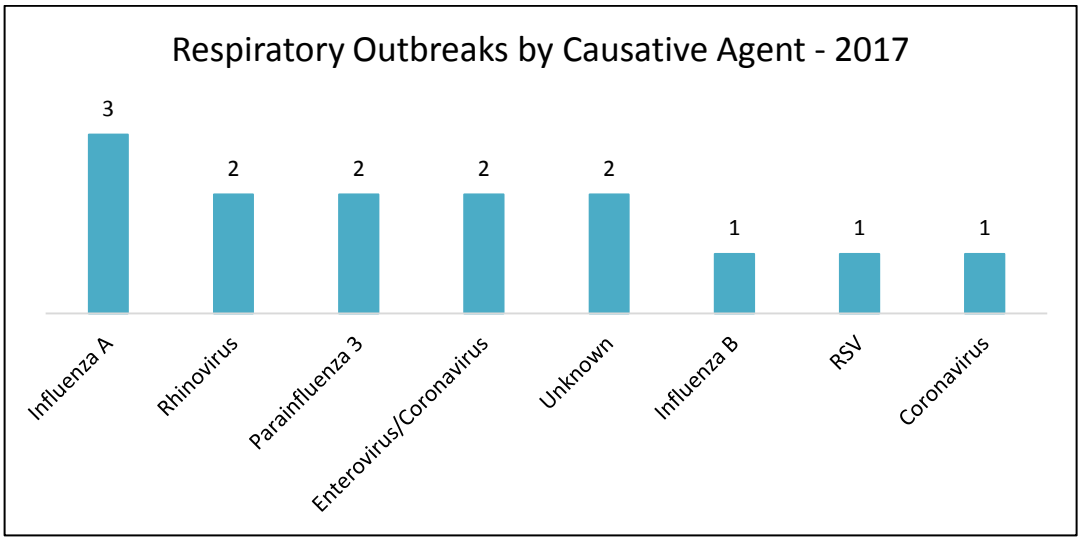


Vector-borne category includes: Lyme disease, Malaria, West Nile virus. (2 total cases of vector-borne diseases were reported in Algoma in 2017)

Outbreaks - vary in scope and nature but are usually associated with more than the expected number of positive cases in a specific time frame, location or other pattern. Public health conducts surveillance of all diseases of public health significance and works with other agencies when outbreaks are declared in their institutions.

In 2017, Algoma experienced 26 outbreaks; mainly gastrointestinal (primarily norovirus) and respiratory in nature (respiratory break down below).

- Gastrointestinal – 11 Outbreaks
  (6 norovirus, 1 community outbreak of cryptosporidiosis, 3 suspect norovirus (no lab confirmation), 1 C.difficile at a hospital)
- Antibiotic Resistant Organisms (AROs) – 1 outbreak
  (Carbopenamase-resistant Enterobacteriaceae at a hospital)
- Respiratory – 14 outbreaks (breakdown is in the graph below)



Surveillance and monitoring are done continually at institutions by their infection prevention and control teams and APH works in conjunction with the teams to help mitigate the spread of the infection and reduce the time of the outbreak.

References:

1. Ontario. Ministry of Health and Long-Term Care, integrated Public Health Information System (iPHIS) database. Date extracted March 5, 2018.
2. Population estimates 2012-2016. Ontario. Ministry of Health and Long-Term Care, IntelliHEALTH Ontario. Date extracted: January 11, 2018
3. Population projections 2017. Ontario. Ministry of Health and Long-Term Care, IntelliHEALTH Ontario. Date extracted: January 11, 2018
4. Public Health Ontario. Reportable Disease Trends in Ontario. 2005-2016. Toronto, ON: Ontario Agency for Health Protection and Promotion; 2017 December 12 [cited 2018 March 29]. Available from: https://www.publichealthontario.ca/en/DataAndAnalytics/pages/rdto2016.aspx#/4
5. Internal intake CDC forms

MENTAL HEALTH AND ADDICTIONS

Director: Sherri Cleaves
Manager: Jan Metheany

Topic: Intensive Case Management

Goal: Assist Individuals 16 and older, living with severe & persistent mental illness, through the provision of Intensive Psychiatric Case Management Services, to improve quality of life, improve mental health outcomes, and maintain community tenor (keeping people out of hospital).

Program Funder: North East Local Health Integration Network (NE LHIN)

Program Standard Requirements addressed in this report:
The MOHLTC provides Intensive Psychiatric Case Management (ICM) Standards to guide program work. In addition, service targets are set by and required by the NE LHIN through Multi-Service Sector Accountability Agreement, aimed at achieving the above-stated goals.

2015-2020 Strategic Priorities addressed in this report:

- Improve Health Equity
- Collaborate Effectively
- Be Accountable

Key Messages:

- Living with mental illness significantly increases risks of functional disability, poverty, homelessness, substance use, chronic disease, social isolation, criminal justice involvement, hospitalization and higher use of emergency services.
- Intensive psychiatric case management services are a key part of the continuum of community based mental health services and support for people with serious mental illness, and have been found much more cost effective than hospitalization.

Health Snapshot:
People with serious mental illnesses are more likely to face health inequities and barriers to accessing primary health care. The barriers are complex and range from the impact of stigma, reduced access to health-promoting environments, poverty and marginalization to individual functional disability and symptomology.

People living with serious mental illnesses face a greater risk of developing a range of chronic physical conditions compared to the general population. The life expectancy of persons with serious mental illness is an alarming 25–30 years less than that of the general population. The main cause of this early mortality is cardiovascular disease associated with modifiable risk factors such as obesity, sedentary lifestyle, poor diet and smoking.

Mental health and addictions clients can be health care "cost-drivers" as they are a strong contributor to frequent visits to hospital emergency rooms.

Mental health and addictions needs in North East Ontario are also generally higher than provincial averages reflected in hospitalizations for mental illness and hospital patient days, readmission rates for mental illness, suicides and self-inflicted injuries rates.

APH - Intensive Psychiatric Case Management Program (ICM)

Referral, **Assessment & Admission:**
Referrals for ICM are accepted from any source, including self-referral. Eligibility is determined through comprehensive intake assessment. Intake assessments are completed by program staff at all 4 APH office sites. Eligibility Criteria include: Physician confirmed diagnosis of Severe Mental Illness which is defined as having an axis I diagnosis (e.g., Schizophrenia, Major Mood Disorder, Anxiety Disorder, PTSD); significant and persistent duration of illness, and a marked level of functional disability. If found eligible, there is no wait-list for services. The program provides services to about 1000 individuals per year.

Support Services:
The ICM Program provides direct community based-clinical supports and system navigation (coordinating other required services from across mental health and other service systems (i.e., housing, social services, criminal justice, developmental services, and addictions).

ICM staff work toward building a trusting and productive relationship with assigned clients. They provide resources to help the client achieve self-identified goals, stabilize his/her life, improve his/her quality of life and avoid/reduce the need for hospitalization by providing direct support in the following areas:

- advocacy,
- medication assistance,
- mental health status and mood monitoring,
- recovery planning,
- linkage and referral,
- transportation,
- support with activities of daily living, and
- skills development teaching

The program is delivered in the client's place of choice (e.g., client's homes, grocery stores, doctor's offices, day treatment services), and within a shared care model, often engaging and working with multiple health & social services team members involved in each client's care.

The frequency of contact and service provision fluctuates according to client stabilization status, service needs, and ability to self-manage care and recovery journey. Therefore, the intensity of service can range from multiple weekly interactions to monthly, as needed.

Program Graduation:
The ICM program works with clients towards building client independence in managing activities of daily living, personal health care, goals setting and obtainment, and maintaining community tenor. In order to achieve these aims, special focus is given to helping clients engage, enhance, and maintain natural support systems (family, friends, employers, community participation, and peers (others with lived experience of mental illness). Clients successful in meeting self-management goals, graduate from the program. Graduated clients can access periodic short-term assistance when necessary, or may need to be re-admitted to ongoing Intensive Case Management Services.

Evaluation:
The Program is monitored regularly through NELHIN reporting requirements, MOHLTC program standards adherence reviews, and the Ontario Perception of Care Survey (client engagement). In addition, the program developed an internal evaluation tool which compares the relationship between length of service (how long an individual has been a client) and the number of co-occurring (same time frame) days that client was admitted to hospital. The report aggregates data of all clients within pre-set time frames. All measures continue to reflect positive evaluation.

MOHLTC- Intensive Case Management Program Standards Evaluation (Internal):

Standard	17/18 (Q3)APH-ICM Standard Adherence
Intensive Case Manager/Client ratio of no more than 1:20.	ICM/client ratio 1:23
>50% of interaction happens in the community rather than in offices.	95% of client interaction happened in the community
>30% of clients are seen at least once per week.	65% of clients were seen at least once per week

NELHIN 17/18 Service Targets Compliance Report (Mandatory)

Description	17/18 Target	Q3 Report	Q4 Projection
Visits	11,830	9,863	13,150
Not Uniquely Identified Service Recipient Interactions	200	900	1200
Individuals Served	840	688	917
Group Sessions	200	366	488
Group Participant Attendances	500	1,967	2,622
Service Provider Group Interactions	150	382	509

Ontario Perception of Care Survey (Mandatory)

Gives clients an opportunity to participate in an anonymous provincial survey of their perceptions of the care (services) they have received from our program. The survey utilizes a Likert Scale to measure the level of satisfaction with services across a variety of domains (e.g., access to services, services provision, staff, environment, participant's rights, discharge or completion). Our program receives a summary of aggregate data. Our latest summary, January 30 - October 30, 2017, had a 95% response rate and over 90% strongly agreed or agreed with satisfaction with our services overall.

APH-ICM Program: Program Hospitalization Days per year Trend Analysis Report (Internal). Run: 02:2018

Program Tenor Cohort	Average# of hospital days/year
1-2yrs	27 days
3-6yrs	18 days
7-10yrs	10 days
10+yrs	6 days

This report reflects a trend: On average, the longer clients participate in the ICM program, the less time (days) per year they experience hospitalization. This is consistent with the literature regarding rationales on the effectiveness of intensive psychiatric case management services.

PARTNERSHIPS

The Algoma Leadership Table which is comprised of the Executive Directors of numerous health and providing social services to residents of the region has been approached by the City of SSM to lead activities with respect to the Social Equity pillar of their recently released community development plan.

We have committed to sharing resources to hire a project manager to lead the work in this area. In addition, this table has recently also focused its attention on substance misuse due to recent local attention on the opioid issue. The emerging data provided by our surveillance work has provided evidence to inform their planning process.

Respectfully submitted,
Dr. Marlene Spruyt

Save the Date

Bridges out of Poverty

Inspiring Action for Change:

Addressing the Challenge of Poverty

Strategies for Professionals & Communities

When: May 16th 1:00pm-4:30pm *(refreshments included)*
Where: Sault Ste. Marie

Algoma Public Health / Santé publique Algoma
Bridges out of Poverty
PublicHealth Wellington-Dufferin-Guelph Stay Well.
Social Services | Services Sociaux Zhawenimi-Anokiitaagewin Sault Ste. Marie District

What is Bridges out of Poverty?

Bridges out of Poverty is a framework designed to educate community partners, service providers and professionals on:

- The social and economic impact that poverty has on individuals and communities.
- The realities experienced by individuals living in poverty.
- The barriers individuals face when attempting to move themselves out of poverty.

Why should I attend?

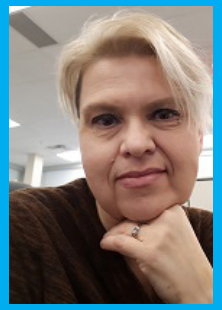
Evaluation has shown that participation in Bridges training can:

- Change individual attitudes related to poverty.
- Foster cultural humility and compassion.
- Encourage organizations to address service barriers and factors that contribute to systemic oppression.
- Influence agency organizational changes that improve service outcomes.

About the Facilitator:

Elaine Weir, PHN Bridges Facilitator & Circles Coordinator/Coach

Elaine Weir is a Public Health Nurse with Wellington-Dufferin Guelph Public Health and certified Bridges out of Poverty facilitator. Elaine brings over 33 years of experience and expertise to the Bridges initiative and has worked in a variety of organizations including hospitals, communities and educational settings.



Louise Brooks, Health Promotion Specialist, MPR

Louise Brooks is a Health Promotions Specialist with Wellington-Dufferin Guelph Public Health who brings 20+ years of experience as a public relations practitioner and health communicator to the Bridges and Circles Guelph Wellington initiative, as well as co-chairing the Bridges component. Her skill sets have given her expertise and passion that she brings to her current poverty reduction and health equity work.

Algoma
PUBLIC HEALTH
Santé publique Algoma

50th Anniversary Upcoming Events

This year, Algoma Public Health turns 50. To celebrate, we will honor this milestone with events for the public, staff, partners and stakeholders. Events will take place throughout the year & throughout the Algoma district.

Free Public Skate – Wawa

There will be free public skate on Friday March 16, 2018 from 6-8 pm at the Michipicoten Memorial Community Centre. Everyone is welcome.

Cross Country Lantern Ski – Blind River

Partnering with the Blind River Cross Country Ski Club, we will be having a cross country ski event on March 16, 2018 from 6:30-8:30 pm. Rentals of skis, boots and poles will be available for free.

GooseChase – Algoma District

Promoting a healthy lifestyle is an essential part of public health. To engage our district in a healthier lifestyle, we are developing a 2-month long Get Active Algoma campaign using the app GooseChase (available on iPhone or Android).

GooseChase is a mobile application that allows individuals or teams to complete a mission and then upload the evidence with a photo, video or text based answer.

Examples of missions:

Mission - make a snowman! It can be challenging figuring out what to do with the family in the colder months – but rather than fighting Mother Nature, embrace nature's winter wonderland! This is a great way to spend a day with your family. Upload a picture of your snowman. *100 bonus points to the best decorated snowman.*

Mission – take a hike! Visit your nearest park or trail and hike with your family or friends. Upload one photo of the beautiful scenery you saw.

Algoma Public Health Finance and Audit Committee Report

Date of Meeting: February 13, 2018

Attendance: Serge Saccucci, Ian Frazier, Lee Mason, Adrienne Kappes, Dr. Marlene Spruyt, Dr. Jennifer Loo, Justin Pino, Joel Merrylees, Chrisitina Luukkonen

Meeting Summary

The first order of business was the KPMG audit planning report delivered by Lead Audit Engagement KPMG Partner Michael Marinovich. The process of the audit for the December 31, 2017, year-end was discussed and explained. Items of discussion included materiality, areas of focus when audit is performed, the use of computer assisted audit techniques, introduction of audit members, cost of audit, and projected timetable for audit completion. Overall, the audit approach explained by KPMG representative will satisfy the organization's audit requirements.

Insurance representative Patrick Policicchio from Brokerlink provided a summary of the insurance policy including the cyber insurance aspect of the policy. The representative thoroughly provided a summary of coverage items and their respective limits and deductibles. Aside form the cyber insurance; the policy is very similar to the previous year. The new aspect of the policy is the cyber insurance that covers an agency's liability for data breach involving sensitive information. The acquisition of the cyber insurance is a prudent first step in minimizing financial repercussions with the unlawful use of private and sensitive organizational information. The committee approved the purchase of cyber insurance and the renewal of the policy.

Justin Pino explained financial statements for the period ending December 31, 2017. The financial statements continue to trend in a positive manner with no concerns noted. The supportive housing budget submission was also discussed and approved whereby all costs of the program are 100% funded; there is no expected shortfall.

Justin Pino explained the procurement policy updates. Senior leadership requested amendments that enable organizational efficiency while continuing to hold accountability. Feedback was provided and it was decided the Governance committee will also provide input at their next meeting and the procurement policy would then be an agenda item for passing at the next Board meeting.

Sergio Saccucci, Chair

Algoma Public Health
(Unaudited) Financial Statements December 31, 2017

Algoma Public Health
Statement of Operations
December 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	$ 3,484,786	$ 3,484,786	$ 0	$ 3,484,786	0%	100%
Provincial Grants - Public Health 75% Prov. Funded	7,309,200	7,309,200	-	7,309,200	0%	100%
Provincial Grants - Public Health 100% Prov. Funded	2,962,225	2,962,225	(0)	2,962,224	0%	100%
Fees, other grants and recovery of expenditures	593,952	670,476	(76,523)	670,476	-11%	89%
Provincial Grants - Funding for Prior Yr Expenses	0	0	-	-		
Total Public Health Revenue	$ 14,350,164	$ 14,426,687	$ (76,523)	$ 14,426,686	-1%	99%
Expenditures						
Public Health 75% Prov. Funded Programs	$ 10,543,245	$ 11,464,463	$ 921,218	$ 11,464,463	-8%	92%
Public Health 100% Prov. Funded Programs	2,785,382	2,962,225	176,843	2,962,225	-6%	94%
Total Public Health Programs Expenditures	$ 13,328,627	$ 14,426,688	$ 1,098,061	$ 14,426,688	-8%	92%
Excess of Rev. over Exp. 75% Prov. Funded	$ 844,693	$ (1)	$ 844,694	$ 0		
Excess of Rev. over Exp. 100% Prov. Funded	176,843	(0)	176,843	(2)		
Provincial Grants for Prior Yr Expenses	-	-	-	-		
Total Rev. over Exp. Public Health	$ 1,021,536	$ (1)	$ 1,021,538	$ (2)		
Public Health Programs - Fiscal 17/18						
Provincial Grants and Recoveries	$ 100,650	67,100	(33,550)	164,324		
Expenditures	29,048	53,943	(24,895)	164,324		
Excess of Rev. over Fiscal Funded	71,602	13,157	58,445	-		
Community Health Programs						
Calendar Programs						
Revenue						
Provincial Grants - Community Health	$ 1,068,011	$ 1,068,011	$ -	$ 1,068,011	0%	100%
Municipal, Federal, and Other Funding	326,455	326,455	-	326,455	0%	100%
Total Community Health Revenue	$ 1,394,466	$ 1,394,466	$ -	$ 1,394,466	0%	100%
Expenditures						
Healthy Babies and Children	$ 1,068,011	$ 1,068,011	$ (0)	$ 1,068,011	0%	100%
Child Benefits Ontario Works	24,135	24,135	-	24,135	0%	100%
Algoma CADAP programs	295,768	302,319	6,551	302,319	-2%	98%
One-Time Funding programs	0	0	-	-	#DIV/0!	#DIV/0!
Total Calendar Community Health Programs	$ 1,387,914	$ 1,394,465	$ 6,551	$ 1,394,465	0%	100%
Total Rev. over Exp. Calendar Community Health	$ 6,552	$ 1	$ 6,551	$ 1		
Fiscal Programs						
Revenue						
Provincial Grants - Community Health	$ 4,158,585	$ 4,157,533	$ 1,052	$ 5,573,206	0%	100%
Municipal, Federal, and Other Funding	594,271	607,890	(13,619)	754,703	-2%	98%
Other Bill for Service Programs	42,432		42,432			
Total Community Health Revenue	$ 4,795,288	$ 4,765,423	$ 29,865	$ 6,327,909	1%	101%
Expenditures						
Brighter Futures for Children	81,334	82,085	751	114,447	-1%	99%
Infant Development	471,155	480,327	9,171	640,434	-2%	98%
Preschool Speech and Languages	463,444	460,692	(2,753)	614,256	1%	101%
Nurse Practitioner	102,275	105,315	3,040	139,753	-3%	97%
Genetics Counseling	355,404	275,930	(79,474)	614,255	29%	129%
Community Mental Health	2,523,735	2,586,724	62,988	3,445,648	-2%	98%
Community Alcohol and Drug Assessment	522,681	543,117	20,436	724,157	-4%	96%
Healthy Kids Community Challenge	147,881	161,350	13,469	161,350	-8%	92%
Stay on Your Feet	77,064	75,000	(2,064)	100,000	3%	103%
Bill for Service Programs	41,718	-	(41,718)	-		
Misc Fiscal	4,242	11,100	6,858	11,100		
Total Fiscal Community Health Programs	$ 4,790,933	$ 4,781,640	$ (9,294)	$ 6,565,401	0%	100%
Total Rev. over Exp. Fiscal Community Health	$ 4,354	$ (16,217)	$ 20,571	$ (237,492)		

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

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

Algoma Public Health
Revenue Statement
For the Twelve Months Ending December 31, 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	2,422,972	2,422,972	0	2,422,972	0%	100%	2,362,846	2,362,846	0
Levies Vector Bourne Disease and Safe Water	59,433	59,433	0	59,433	0%	100%	59,433	59,433	0
Levies District	1,002,381	1,002,381	0	1,002,381	0%	100%	977,512	977,512	0
Total Levies	**3,484,786**	**3,484,786**	**0**	**3,484,786**	**0%**	**100%**	**3,399,791**	**3,399,791**	**0**
MOH Public Health Funding	7,130,900	7,130,900	(0)	7,130,900	0%	100%	7,130,900	7,130,900	0
MOH Funding Vector Borne Disease	108,700	108,700	0	108,700	0%	100%	108,700	108,700	0
MOH One Time Funding Dental Health	0	0	0	0		0%	0	0	0
MOH Funding Safe Water	69,600	69,600	0	69,600	0%	100%	69,600	69,600	0
Total Public Health 75% Prov. Funded	**7,309,200**	**7,309,200**	**(0)**	**7,309,200**	**0%**	**100%**	**7,309,200**	**7,309,200**	**0**
MOH One Needle Exchange	50,700	50,700	0	50,700	0%	100%	50,700	50,700	0
MOH Funding Haines Food Safety	24,600	24,600	0	24,600	0%	100%	24,600	24,600	0
MOH Funding CINOT/Healthy Smiles	769,900	769,900	0	769,900	0%	100%	769,900	769,900	0
MOH Funding - Social Determinants of Health	180,500	180,500	0	180,500	0%	100%	180,500	180,500	(0)
MOH Funding - MOH / AMOH Top Up	100,725	100,725	0	100,725	0%	100%			
MOH Funding Chief Nursing Officer	121,500	121,500	0	121,500	0%	100%	121,500	121,500	0
MOH Enhanced Funding Safe Water	15,500	15,500	0	15,500	0%	100%	15,500	15,500	0
MOH Funding Unorganized	530,400	530,400	0	530,400	0%	100%	515,100	515,100	0
MOH Funding Infection Control	312,400	312,400	0	312,400	0%	100%	312,400	312,400	0
MOH Funding Diabetes	150,000	150,000	0	150,000	0%	100%			
MOH Funding Northern Ontario Fruits & Veg.	117,400	117,400	0	117,400	0%	100%			
Funding Ontario Tobacco Strategy	433,600	433,600	0	433,600	0%	100%	428,623	433,600	(4,977)
MOH Funding Harm Reduction	150,000	150,000	0	150,000	0%	100%			
One Time Funding	5,000	5,000	0	5,000					
Total Public Health 100% Prov. Funded	**2,962,225**	**2,962,225**	**0**	**2,962,225**	**0%**	**100%**	**2,418,823**	**2,423,800**	**(4,977)**
Funding for Prior Yr Expenses	**0**	**0**	**0**	**0**		**0%**	**194,800**	**0**	**194,800**
Recoveries from Programs	10,060	10,060	0	10,060	0%	100%	27,309	10,061	17,248
Program Fees	227,447	249,744	(22,296)	249,743	-9%	91%	229,289	247,143	(17,854)
Land Control Fees	142,703	160,000	(17,297)	160,000	-11%	89%	127,290	160,000	(32,710)
Program Fees Immunization	146,955	179,500	(32,545)	179,500	-18%	82%	195,244	160,000	35,244
HPV Vaccine Program	15,003	12,500	2,503	12,500	0%	120%	12,427	10,000	2,427
Influenza Program	20,775	40,000	(19,225)	40,000	-48%	52%	38,635	60,000	(21,365)
Meningococcal C Program	7,140	8,000	(860)	8,000	0%	89%	7,888	10,000	(2,112)
Interest Revenue	19,093	10,672	8,421	10,672	79%	179%	11,274	2,000	9,274
Other Revenues	4,777	0	4,777	0	0%	100%	76,571	165,000	(88,429)
Total Fees, Other Grants and Recoveries	**593,953**	**670,476**	**(76,523)**	**670,475**	**-11%**	**89%**	**725,928**	**824,204**	**(98,276)**
Total Public Health Revenue Annual	**$ 14,350,164**	**$ 14,426,687**	**$ (76,523)**	**$ 14,426,686**	**-1%**	**99%**	**$ 14,048,542**	**$ 13,956,995**	**$ 91,547**
Public Health Fiscal									
Panorama	55,575	37,050	18,525	74,100		75%	55,944	29,840	
Smoke Free Ontario NRT	22,500	15,000	7,500	30,000		75%	22,500	12,000	
Practicum	7,500	5,000	2,500	10,000		75%	7,506	4,000	
Other One Time Fiscal Funding	15,075	10,050	5,025	50,224			21,672	14,450	
Total Provincial Grants Fiscal	**$ 100,650**	**$ 67,100**	**$ 33,550**	**$ 164,324**		**61%**	**$ 107,622**	**$ 60,290**	**$ -**

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 Twelve Months Ending December 31, 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	7,786,485	8,652,095	$ 865,610	$ 8,652,095	-10%	90%	$ 7,895,272	$ 8,392,979	$ 497,707
Benefits	1,937,347	2,036,464	99,117	2,036,464	-5%	95%	1,824,174	2,093,629	269,455
Travel - Mileage	87,209	127,861	40,652	127,861	-32%	68%	116,045	145,695	29,651
Travel - Other	89,236	93,242	4,006	93,242	-4%	96%	76,142	95,301	19,160
Program	611,204	750,528	139,324	750,528	-19%	81%	805,772	583,252	(222,520)
Office	130,023	135,250	5,227	135,250	-4%	96%	132,163	92,750	(39,413)
Computer Services	673,949	699,518	25,570	699,518	-4%	96%	1,012,423	861,936	(150,487)
Telecommunications	346,152	325,994	(20,158)	325,994	6%	106%	306,183	220,653	(85,530)
Program Promotion	137,349	170,797	33,448	170,797	-20%	80%	108,900	227,454	118,554
Facilities Expenses	855,089	800,350	(54,739)	800,350	7%	107%	813,781	821,424	7,643
Fees & Insurance	330,650	242,096	(88,554)	242,096	37%	137%	379,475	391,305	11,830
Debt Management	460,900	460,900	(0)	460,900	0%	100%	425,665	456,000	30,335
Recoveries	(116,966)	(68,408)	48,558	(68,408)	71%	171%	(94,227)	(140,883)	(46,656)
	$ 13,328,627	$ 14,426,688	$ 1,098,061	$ 14,426,688	-8%	92%	$ 13,801,766	$ 14,241,495	$ 439,729

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 – December 2017

Reporting Period

The draft December 2017 financial reports include twelve 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 nine 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 December 31st, 2017, Public Health programs are reporting a $1.0M positive variance.

Total Public Health Revenues are indicating a negative $77k variance. This is primarily a result of Fees, Other Grants & Recoveries being less than budgeted. Land Controls Fees, Program Fees Immunization and Influenza Program are driving this negative variance.

There is a positive variance of $1.1M related to Total Public Health expenses being less than budgeted.

The $921k positive variance associated with the Public Health 75% Provincially Funded Programs is primarily attributed to Salary & Wages expense being less than budgeted. The $866k positive variance associated with Salary and Wages expense is a result of the inherent time lag in filling positions within the agency. The 2017 Public Health Operating budget assumed collectively bargained wage increases for CUPE and ONA staff members from April 2017 through to the end of the calendar year. An accrual has been incorporated in the Financial Statements to reflect the projected impact of wages for ONA employees as the collective agreement has not been settled.

In addition, the 2017 Public Health Operating Budget included the new positions of Associate Medical Officer of Health (AMOH) and Human Resource (HR) Manager for the full budget year. The HR Manager position was vacant until the end of March 2017 while the AMOH position was vacant until the end of August 2017. Also, the Environmental Health team has experienced staff turnover this year resulting in unfilled vacancies; a Clerical position has been reduced through attrition, and a Communications position which was built into the budget has yet to be filled. Due to recent changes in the Ontario Public Health Standards, Management decided to leave some positions unfilled in the interim to help align resources according to the new Standards.

Travel – Mileage, Program, and Program Promotion expenses are also contributing to the positive variance.

The province funds 75% of the approved allocation to administer mandatory cost-shared programs. As contributing municipalities within the District of Algoma currently contribute more than 25%, the positive variance does not necessary reflect funds that will be returned to the province. Based on Q4 reporting submitted to the Ministry, it is anticipated that the Board of Health will be returning approximately $79k to the Province related to cost-shared programs.

Notes Continued...

100% Provincially Funded Programs typically relate to specific Public Health initiatives and are prescriptive as to what is an eligible expense. The $176k positive variance associated with Public Health 100% Provincially Funded Programs is a result of funding related to the Harm Reduction program received in September 2017. Furthermore, Smoke Free Ontario is contributing to the noted positive variance as a portion of the budget is allocated for legal fees associated with prosecution costs. If no prosecution costs are required, funding is returned. Healthy Smiles Programs is contributing to the noted positive variance as a result of inherent vacancies within the program.

Community Health Calendar programs are operating within budget.

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

Genetics Counseling is showing a negative $79k variance. APH management is utilizing deferred revenue associated with the program by increasing the program FTE compliment by 0.2; by Public Health increasing the charges associated with the Genetics program for general administration support to more accurately reflect actual usage; and by hiring the successful candidate for a retiring employee prior to the retirement date as a means of fostering training and mitigating risk to the program delivery.

Public Health Revenue (see page 2 for details)

Public Health funding revenues are showing a negative $77k variance.

The municipal levies are within budget.

Provincial Grants are within budget.

Fees, Other Grants & Recoveries are showing a negative variance of $77k. This is a result of fees associated with Land Control Fees, Program Fees Immunization and the Influenza program being less than budgeted.

Public Health Expenses (see page 3)

Salary & Wages

Salary & Wages expense is indicating a positive variance of $866k. The inherent time lag in filling positions within the agency is primarily contributing to the positive variance associated with the Salary & Wages expense. The 2017 Public Health Operating budget assumed collectively bargained wage increases for CUPE and ONA staff members from April 2017 through to the end of the calendar year. An accrual has been incorporated in the November 2017 Financial Statements to reflect the projected impact of wage increases. Furthermore, the 2017 Public Health Operating Budget included the new positions of Associate Medical Officer of Health (AMOH) and Human Resource (HR) Manager for the full budget year. In addition, the Environmental Health team has experienced staff turnover this year

resulting in vacancies; a Clerical position has been reduced through attrition, and a Communications role which was built into the budget has yet to be filled.

Travel-Mileage
Travel – Mileage expense is indicating a positive variance of $41k. Management believes a positive variance will be realized at year-end. Management has adjusted the Travel-Mileage budget for 2018 to more accurately reflect actual Travel-Mileage expenses.

Program
Program expense is indicating a positive variance of $139k. This is a result of Program Materials and Supplies expense being less than budget, specifically vaccine purchases. Management has adjusted the Program expense budget for 2018 to more accurately reflect actual Program expenses.

Program Promotion
Program Promotion expense is indicating a positive $33k variance. Staff professional development and Promotional expenses are below budget. Management has adjusted the Program Promotion budget for 2018 to more accurately reflect actual Program Promotion expenses.

Fees & Insurance
Fees & Insurance expense is showing a negative $89k variance. This is a result of higher than anticipated legal fees associated with various matters.

Recoveries
Recoveries are indicating a positive $49k variance. This is a result of Public Health increasing the charges associated with Genetics and Other Community programs for general administration support to more accurately reflect actual usage.

Notes Continued…

Financial Position - Balance Sheet (see page 8)

APH's liquidity position continues to be stable and the bank has been reconciled as of December 31st, 2017. Cash includes $525k in short-term investments as a result of the Board of Health decision to contribute $200k into reserves in November 2017.

Long-term debt of $5.23 million is held by TD Bank @ 1.95% for a 60 month term (amortization period of 180 months) and matures on September 1, 2021. $325k 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. APH is working with one municipality with respect to late levy payment.

Algoma Public Health

Statement of Financial Position

(Unaudited)

Date: As of December 2017	**December 2017**	December 2016
Assets		
Current		
Cash & Investments	$ **2,933,015**	$ 2,146,361
Accounts Receivable	**471,639**	509,998
Receivable from Municipalities	**30,768**	9,159
Receivable from Province of Ontario		
Subtotal Current Assets	**3,435,422**	2,665,518
Financial Liabilities:		
Accounts Payable & Accrued Liabilities	**1,436,795**	1,587,880
Payable to Gov't of Ont/Municipalities	**99,834**	321,402
Deferred Revenue	**510,565**	494,864
Employee Future Benefit Obligations	**2,550,458**	2,550,458
Term Loan	**5,903,861**	5,903,861
Subtotal Current Liabilities	**10,501,514**	10,858,466
Net Debt	**-7,066,092**	-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	**14,747,365**	13,620,509

Algoma Public Health
(Unaudited) Financial Statements January 31, 2018

Algoma Public Health
Statement of Operations
January 2018
(Unaudited)

	Actual YTD 2018	Budget YTD 2018	Variance Act. to Bgt. 2018	Annual Budget 2018	Variance % Act. to Bgt. 2018	YTD Actual/ YTD Budget 2018
Public Health Programs						
Revenue						
Municipal Levy - Public Health	$ 875,545	$ 875,545	$ 0	$ 3,502,179	0%	100%
Provincial Grants - Cost Shared Funding	609,100	609,100	-	7,309,200	0%	100%
Provincial Grants - Public Health 100% Prov. Funded	234,782	249,747	(14,965)	2,996,951	-6%	94%
Fees, other grants and recovery of expenditures	33,750	52,230	(18,481)	699,214	-35%	65%
Provincial Grants - Funding for Prior Yr Expenses	0	0	-	-		
Total Public Health Revenue	$ 1,753,177	$ 1,786,622	$ (33,446)	$ 14,507,544	-2%	98%
Expenditures						
Public Health Cost Shared	$ 955,631	$ 949,342	$ (6,288)	$ 11,573,776	1%	101%
Public Health 100% Prov. Funded Programs	214,936	242,431	27,495	2,933,768	-11%	89%
Total Public Health Programs Expenditures	$ 1,170,567	$ 1,191,773	$ 21,207	$ 14,507,544	-2%	98%
Excess of Rev. over Exp. Cost Shared Funding	$ 562,764	$ 587,533	$ (24,769)	$ (63,182)		
Excess of Rev. over Exp. 100% Prov. Funded	19,846	7,316	12,530	63,182		
Provincial Grants for Prior Yr Expenses	-	-	-	-		
Total Rev. over Exp. Public Health	$ 582,610	$ 594,849	$ (12,239)	$ (0)		
Healthy Babies Healthy Children						
Provincial Grants and Recoveries	$ 89,300	89,001	(299)	1,068,011	0%	100%
Expenditures	96,058	89,001	7,057	1,068,011	8%	108%
Excess of Rev. over Fiscal Funded	(6,758)	-	(6,758)	-		
Public Health Programs - Fiscal 17/18						
Provincial Grants and Recoveries	$ 50,079	82,100	32,021	164,324		
Expenditures	34,980	92,073	(57,093)	164,324		
Excess of Rev. over Fiscal Funded	15,099	(9,973)	25,072	-		
Community Health Programs						
Calendar Programs						
Revenue						
Provincial Grants - Community Health	$ -	$ -	$ -	$ -	#DIV/0!	#DIV/0!
Municipal, Federal, and Other Funding	15,500	27,708	(12,208)	332,500	-44%	56%
Total Community Health Revenue	$ 15,500	$ 27,708	$ (12,208)	$ 332,500	-44%	56%
Expenditures						
Child Benefits Ontario Works	421	2,042	1,621	24,500	-79%	21%
Algoma CADAP programs	24,562	25,667	1,105	308,000	-4%	96%
One-Time Funding programs	0	0	-	-	#DIV/0!	#DIV/0!
Total Calendar Community Health Programs	$ 24,983	$ 27,708	$ 2,725	$ 332,500	-10%	90%
Total Rev. over Exp. Calendar Community Health	$ (9,483)	$ (0)	$ (9,483)	$ 0		
Fiscal Programs						
Revenue						
Provincial Grants - Community Health	$ 4,748,342	$ 4,729,180	$ 19,162	$ 6,646,205	0%	100%
Municipal, Federal, and Other Funding	646,884	670,902	(24,018)	816,353	-4%	96%
Other Bill for Service Programs	42,722		42,722			
Total Community Health Revenue	$ 5,437,948	$ 5,400,082	$ 37,866	$ 7,462,558	1%	101%
Expenditures						
Brighter Futures for Children	86,480	92,872	6,392	114,447	-7%	93%
Infant Development	523,552	533,696	10,144	640,434	-2%	98%
Preschool Speech and Languages	514,784	511,880	(2,905)	614,256	1%	101%
Nurse Practitioner	118,100	117,037	(1,063)	139,753	1%	101%
Genetics Counseling	394,596	306,556	(88,040)	367,806	29%	129%
Community Mental Health	2,822,937	2,874,349	51,412	3,449,598	-2%	98%
Community Alcohol and Drug Assessment	584,698	603,464	18,766	724,157	-3%	97%
Healthy Kids Community Challenge	167,818	185,900	18,082	223,000	-10%	90%
Stay on Your Feet	85,092	83,333	(1,759)	100,000	2%	102%
Bill for Service Programs	44,186	-	(44,186)	-		
Misc Fiscal	7,904	17,100	9,196	21,100		
Total Fiscal Community Health Programs	$ 5,350,147	$ 5,326,186	$ (23,961)	$ 6,394,552	0%	100%
Total Rev. over Exp. Fiscal Community Health	$ 87,800	$ 73,895	$ 13,905	$ 1,068,006		

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 Month Ending January 31, 2018
(Unaudited)

	Actual YTD 2018	Budget YTD 2018	Variance Bgt. to Act. 2018	Annual Budget 2018	Variance % Act. to Bgt. 2018	YTD Actual/ YTD Budget 2018	Comparison Prior Year: YTD Actual 2017	YTD BGT 2017	Variance 2017
Levies Sault Ste Marie	606,441	606,441	0	2,425,762	0%	25%	605,743	605,743	0
Levies Vector Bourne Disease and Safe Water	14,858	14,858	0	59,433	0%	25%	14,858	14,858	0
Levies District	254,246	254,246	0	1,016,984	0%	25%	250,595	250,595	0
Total Levies	**875,545**	**875,545**	**0**	**3,502,179**	**0%**	**25%**	**871,197**	**871,197**	**0**
MOH Public Health Funding	594,242	594,242	0	7,130,900	0%	8%	594,242	594,242	0
MOH Funding Vector Borne Disease	9,058	9,058	0	108,700	0%	8%	9,058	9,058	0
MOH Funding Safe Water	5,800	5,800	0	69,600	0%	8%	5,800	5,800	0
Total Public Health Cost Shared Funding	**609,100**	**609,100**	**0**	**7,309,200**	**0%**	**8%**	**609,100**	**609,100**	**0**
MOH Funding Needle Exchange	4,226	5,392	(1,167)	64,700	-22%	7%	4,226	4,225	1
MOH Funding Haines Food Safety	2,050	2,050	0	24,600	0%	8%	2,050	2,050	0
MOH Funding Healthy Smiles	64,158	64,158	0	769,900	0%	8%	64,158	64,158	(0)
MOH Funding - Social Determinants of Health	15,042	15,041	1	180,500	0%	8%	15,042	15,042	0
MOH Funding - MOH / AMOH Top Up	9,236	10,537	(1,301)	126,451	-12%	7%	0	0	0
MOH Funding Chief Nursing Officer	10,126	10,125	1	121,500	0%	8%	10,126	10,125	1
MOH Enhanced Funding Safe Water	1,292	1,291	1	15,500	0%	8%	1,292	1,292	0
MOH Funding Unorganized	44,200	44,200	0	530,400	0%	8%	42,926	42,925	1
MOH Funding Infection Control	26,034	26,034	0	312,400	0%	8%	26,034	26,033	1
MOH Funding Diabetes	12,500	12,500	0	150,000	0%	8%	12,500	12,500	0
MOH Funding Northern Ontario Fruits & Veg.	9,784	9,784	0	117,400	0%	8%	0	0	0
Funding Ontario Tobacco Strategy	36,134	36,134	0	433,600	0%	8%	36,133	36,133	0
MOH Funding Harm Reduction	0	12,500	(12,500)	150,000	-100%	0%	0	0	0
One Time Funding									
Total Public Health 100% Prov. Funded	**234,782**	**249,746**	**(14,965)**	**2,996,951**	**-6%**	**8%**	**214,487**	**214,483**	**4**
Funding for Prior Yr Expenses	**0**	**0**	**0**	**0**		**0%**	**0**	**0**	**0**
Recoveries from Programs	838	833	5	27,450	1%	3%	838	838	0
Program Fees	19,568	20,314	(746)	237,764	-4%	8%	22,750	20,812	1,938
Land Control Fees	500	13,333	(12,833)	160,000	-96%	0%	2,950	13,333	(10,383)
Program Fees Immunization	10,396	15,417	(5,021)	185,000	-33%	6%	16,517	14,958	1,559
HPV Vaccine Program	0	0	0	20,000	0%	0%	0	0	0
Influenza Program	0	0	0	25,000	0%	0%	0	1,000	(1,000)
Meningococcal C Program	0	0	0	10,000	0%	0%	0	0	0
Interest Revenue	2,448	1,167	1,281	14,000	110%	17%	1,146	889	256
Other Revenues	0	1,167	(1,167)	20,000	0%	0%	0	0	0
Total Fees, Other Grants and Recoveries	**33,750**	**52,231**	**(18,481)**	**699,214**	**-35%**	**5%**	**44,201**	**51,831**	**(7,630)**
Total Public Health Revenue Annual	**$ 1,753,176**	**$ 1,786,622**	**$ (33,446)**	**$ 14,507,544**	**-2%**	**12%**	**$ 1,738,985**	**$ 1,746,611**	**$ (7,626)**
Public Health Fiscal									
Panorama	61,749	52,050	9,699	74,100	19%	83%	62,160	44,760	17,400
Smoke Free Ontario NRT	25,000	15,000	10,000	30,000	67%	83%	25,047	18,000	7,047
Practicum	8,332	5,000	3,332	10,000	67%	83%	8,340	6,000	2,340
Other One Time Fiscal Funding	16,747	10,050	6,697	50,224	67%	33%	24,080	14,450	9,630
Total Provincial Grants Fiscal	**$ 111,828**	**$ 82,100**	**$ 29,728**	**$ 164,324**	**36%**	**68%**	**$ 119,627**	**$ 83,210**	**$ 36,417**

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 Month Ending January 31, 2018

(Unaudited)

	Actual YTD 2018	Budget YTD 2018	Variance Act. to Bgt. 2018	Annual Budget 2018	Variance % Act. to Bgt. 2018	YTD Actual/ YTD Budget 2018	*Comparison Prior Year:* YTD Actual 2017	YTD BGT 2017	Variance 2017
Salaries & Wages	$ 712,842	$ 736,313	$ 23,471	$ 8,868,132	-3%	8%	$ 662,929	$ 701,414	$ 38,486
Benefits	188,110	175,318	(12,792)	2,105,552	7%	9%	168,707	163,656	(5,051)
Travel - Mileage	5,019	9,972	4,953	120,775	-50%	4%	5,265	10,655	5,390
Travel - Other	7,979	6,250	(1,729)	75,000	28%	11%	5,854	6,495	641
Program	48,381	53,918	5,537	669,715	-10%	7%	18,811	55,247	36,436
Office	17,569	9,742	(7,826)	116,909	80%	15%	3,451	11,146	7,694
Computer Services	87,358	56,323	(31,035)	700,881	55%	12%	41,312	58,293	16,981
Telecommunications	1,797	25,275	23,478	303,304	-93%	1%	22,791	20,566	(2,225)
Program Promotion	2,949	13,658	10,709	167,223	-78%	2%	1,248	14,233	12,985
Facilities Expenses	59,648	66,250	6,602	795,000	-10%	8%	65,545	66,696	1,150
Fees & Insurance	9,198	9,038	(161)	228,450	2%	4%	(15)	12,258	12,273
Debt Management	38,408	38,408	0	460,900	0%	8%	38,408	38,408	0
Recoveries	(8,691)	(8,691)	(0)	(104,297)	0%	8%	(6,144)	(5,701)	444
	$ 1,170,567	$ 1,191,773	$ 21,207	$ 14,507,544	-2%	8%	$ 1,028,162	$ 1,153,367	$ 125,205

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 – January 2018

Reporting Period

The January 2018 financial reports include one month 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 ten 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 January 31st, 2018, Public Health programs are reporting a $12k negative variance.

Total Public Health Revenues are indicating a negative $33k variance. This is a result timing of receipts of 100% Provincially Funded Grants, and Fees, Other Grants & Recoveries. Harm Reduction Funding and 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 $21k related to Total Public Health expenses being less than budgeted. The $6k negative variance associated with the Public Health Cost Shared Programs expenses is being offset by the positive $27k variance associated 100% Provincially Funded Program expenses.

Community Health Calendar programs are operating within budget.

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

Genetics Counseling is showing a negative $88k variance. APH management is utilizing deferred revenue associated with the program by increasing the program FTE compliment by 0.2; by Public Health increasing the charges associated with the Genetics program for general administration support to more accurately reflect actual usage; and by hiring the successful candidate for a retiring employee prior to the retirement date as a means of fostering training and mitigating risk to the program delivery.

Healthy Kids Community Challenge is indicating a positive $18k variance. Funds are received quarterly from the City of Sault Ste. Marie related to Healthy Kids Community Challenge based on expenses incurred.

Public Health Revenue (see page 2)

Public Health funding revenues are showing a negative $33k variance.

The municipal levies are within budget.

Cost Shared Funding is within budget.

Notes Continued...

100% Provincially Funded Grants are showing a negative $15k variance as a result of timing of receipt associated with the Harm Reduction Program. Harm Reduction funding has yet to be received.

Fees, Other Grants & Recoveries are showing a negative variance of $18k. This is primarily a result timing of receipts of Fees, Other Grants & Recoveries. Land Control Fees are driving this negative variance. APH typically captures the bulk of its fees between the spring and fall months.

Public Health Expenses (see page 3)

Salary & Wages
The $23k positive variance associated with Salary and Wages expense is a result of the inherent time lag in filling positions within the agency.

Benefits
Benefits expense is indicating a negative $13k variance. This is a result of employer contributions associated with Canada Pension Plan and Employment Insurance. As the year progresses this negative variance is expected to reduce.

Computer Services
Computer Services is showing a negative $31k variance. As noted in the Board approved 2018 Operating Budget, APH is utilizing an additional MicroAge resource to help with IT requests. This payment was made in January.

Telecommunications
Telecommunications is indicating a positive $23k variance. This is a result of the timing of payment of telecommunication invoices.

Financial Position - Balance Sheet (see page 7)

APH's liquidity position continues to be stable and the bank has been reconciled as of January 31st, 2017. Cash includes $525k in short-term investments plus $3M in APH's operating account.

Long-term debt of $5.46 million is held by TD Bank @ 1.95% for a 60 month term (amortization period of 180 months) and matures on September 1, 2021. $319k 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.

Notes Continued…

Correction: The draft December 31st, 2017 Financial Statements indicated long-term debt of $5.23 million. Long-term debt as of December 31st, 2017 should have read $5.56 million. The $5.23 million noted related only to the portion of the long-term debt associated with the 294 Willow Avenue facility.

NOTES:
Similar to previous years, the Balance Sheet as of January 31st, 2018 (page 7) is not included as APH is currently completing year-end audit requirements. Once the 2017 annual audited Financial Statements are completed, the Balance Sheet will be provided.

Included in the January Financial Statements is a reconciliation of the 2018 Annual Operating Budget that was approved by the Board of Health in November 2017 and 100% Provincially Funded Program budgets. The reason for budget differences is a result of Ministry funding changes after the 2018 Operating Budget was approved by the Board of Health. Budget figures have been revised moving forward.

2018 Annual Operating Budget

	2017 Annual Budget	2018 Annual Budget	Inc as %	Board approved Budget	Variance	MOH/AMOH Top up	Unorganized Territories	Needle Exchange
Revenues Summary								
Province Portion of Cost Shared Funding	$ 7,309,200	$ 7,309,200	0.0%	$ 7,309,200				
100% Provincially Funded Programs	2,573,800	2,996,952	16.4%	2,904,468	92,484	63,184	15,300	14,000
Municipal Levies	3,484,786	3,502,179	0.5%	3,502,179				
Other Recoveries and Fees	670,476	699,214	4.3%	699,214				
Total	14,038,262	14,507,545	3.3%	14,415,061	92,484	63,184	15,300	14,000
Expenses:								
Salaries and Wages	8,416,973	8,868,136	5.4%	8,819,022	49,113	49,113		
Benefits	1,987,528	2,105,550	5.9%	2,091,478	14,071	14,071		
Travel	205,803	195,775	-4.9%	195,775				
Program	662,961	657,715	-0.8%	643,715	14,000			14,000
Equipment	37,250	25,000	-32.9%	25,000				
Office	133,750	128,909	-3.6%	128,909				
Computer Services	662,268	675,881	2.1%	675,881				
Telecommunications	325,994	303,304	-7.0%	303,304				
Program Promotion	170,797	167,223	-2.1%	151,923	15,300		15,300	
Facilities Leases	153,850	160,000	4.0%	160,000				
Building Maintenance	646,500	635,000	-1.8%	635,000				
Fees & Insurance	242,096	228,450	-5.6%	228,450				
Expense Recoveries	(68,408)	(104,296)	52.5%	(104,296)				
Debt Management (I & P)	460,900	460,900	0.0%	460,900				
Total	14,038,262	14,507,545	3.3%	14,415,061	92,484	63,184	15,300	14,000

Algoma
PUBLIC HEALTH
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www.algomapublichealth.com

MEMORANDUM

Date: January 29, 2018

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

From: Jan Metheany, Program Manager
Algoma Public Health-Community Mental Health& Community Alcohol and Drug Assessment Programs

RE: **1) 2018/2019 Supportive Housing Operating Budget Submission**
2) 2018/2019 Transformation Housing Initiative Operating Budget Submission

1) The Program (#1536) administers five Supportive Housing Rent Supplement funding initiatives:

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

Service Enhancement ..... $ 97,932

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

Mental Health & Addiction 1000 (years2&3) Initiative ..... $ 46,200

Mental Health & Addiction 1150…….. $ 17,300

Total 2018/19 Rent Supplement Budget Request:	**$ 359,600**

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

Kingsford Place Supportive Housing Initiative ..... $ 128,000

Total 2018/19 Transformation Housing Budget Request:	**$ 128,000**

Total 2018/19 Algoma Public Health - Program # 1536 Supportive Housing Initiative(s) Budget Requests:	**$ 487,600**

I have attached both the Supportive Housing Rent Supplement Operating Budget & Transformation Housing Operating Budget submission for the 2018/2019 fiscal year. Please contact me if you have any questions.

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

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

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

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

Ministry of Health and Long-Term Care
Strategic Policy and Planning Division
Mental Health and Addictions Branch
80 Grosvenor Street, 8th Floor
Toronto ON M7A 1R3

Ministère de la Santé et des Soins de longue durée

Ontario

MENTAL HEALTH & ADDICTIONS
RENT SUPPLEMENT HOUSING BUDGET

IDENTIFICATION

Corporation name
Algoma Public Health - Ministry Program Number 1536

Year ended
31-Mar-19

Corporation address	Mailing address
Algoma Public Health	Algoma Public Health
294 Willow Ave	294 Willow Ave
Sault Ste Marie, ON PB6 0A9	Sault Ste Marie, ON PB6 0A9

Program:	# Units Occupied	# Clients
MH Rent Supp	59	62
Service Enhancement	37	37
Addictions	14	16
MH & A Strategy (1000 units)	17	19
MH & A Strategy (1150 units)	7	7
Seniors at Home		
Forensic MH		

Program Contact	Position	Telephone number	e-mail address
Jan Metheany	Program Manager	705-759-3935	jmetheany@algomapublichealth.com
Finance Contact	**Position**	**Telephone number**	**e-mail address**
Justin Pino	Chief Finacial Officer	705-942-4646 ext 5232	jpino@algomapublichealth.com
Board Chair/President	**Position**	**Telephone number**	**e-mail address**
Ian Frazier	Chair	705-759-5421	ifrazier@algomapublichealth.com
Executive Director/CEO	**Position**	**Telephone number**	**e-mail address**
Dr. Marlene Spruyt	MOH/CEO	705-759-5421	mspruyt@algomapublichealth.com

MANAGEMENT DECLARATION BY BOARD OF DIRECTORS

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

Signature	Name	Board Position	Date
	Ian Frazier	Chair	

Signature	Name	Board Position	Date
	Sergio Saccucci	1st Vice-Chair	

This form should be used by agencies which administer Ministry of Health & Long-Term Care Rent Supplement (incl. Capital Homeless) programs.

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

Ministry of Health and Long-Term Care
Strategic Policy and Planning Division
Mental Health and Addictions Branch
80 Grosvenor Street, 8th Floor
Toronto ON M7A 1R3

Ministère de la Santé et des Soins de longue durée

Ontario

TRANSFORMATION SUPPORTIVE HOUSING PROGRAM BUDGET

IDENTIFICATION

Corporation name
Algoma Public Health - Ministry Program Number 1536

Year ended
March 31 2019

Corporation address	Mailing address
Algoma Public Health 294 Willow Ave Sault Ste Marie, ON P6B 0A9	Algoma Public Health 294 Willow Ave Sault Ste Marie, ON P6B 0A9

Program Contact	Position	Telephone number	e-mail address
Jan Metheany	Program Manager	705-759-3935	jmetheany@algomapublichealth.com
Finance Contact	**Position**	**Telephone number**	**e-mail address**
Justin Pino	Chief Financial Officer	705-942-4646 ext 5232	jpino@algomapublichealth.com
Board Chair/President	**Position**	**Telephone number**	**e-mail address**
Ian Frazier	Chair	705-759-5421	ifrazier@algomapublichealth.com
Executive Director/CEO	**Position**	**Telephone number**	**e-mail address**
Dr. Marlene Spruyt	MOH/CEO	705-759-5421	mspruyt@algomapublichealth.com
		Facsimile	**705-759-2105**

MANAGEMENT DECLARATION BY BOARD OF DIRECTORS

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

Signature	Name	Board Position	Date
	Ian Frazier	Board Chair	

Signature	Name	Board Position	Date
	Sergio Saccucci	Board 1st Vice-Chair	

Instructions

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

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

BASE OPERATING COSTS FOR TRANSFORMATION SUPPORTIVE HOUSING

(One budget must be submitted for each project)

Project's address:
(fill in the attached shedule for a project with scattered units)

Kingsford Place-258 Kingsford Rd,
Sault Ste. Marie ON P6C 2W1

OPERATING COSTS:

Housing Related Costs				
Rent For Housing Units/Head Lease Expense			21,600	
Maintenance - Salaries, Materials and Contracted Services			3,568	
Utilities :				
Electricity				
Fuel				
Water and Sewage				
Total Utilities			0	
Other Costs				
Total Housing Related Costs				25,168
Support Related Costs				
Staff Salaries and Benefits			121,920	
Administration Costs			2,000	
Food Costs	**250.00/mnth per unit(6)+250/mnth program costs**		21,000	
Tenant Personal Needs, Tenant Travel, Tenant Recreation			8,000	
Other Costs	**Cable-phone - Internet**		2,400	
Total Support Related Costs				155,320
TOTAL OPERATING COSTS				180,488
REVENUE:				
Rental Revenue	6 # of Units	479 x 12 mos Rent	34,488	
Less: Vacancy Loss				
Net Rental Revenue				34,488
Other Revenue	**Food(250.00/per mnth-per unit)**			18,000
Ministry Subsidy				128,000
TOTAL REVENUE				180,488
SHELTER SURPLUS/ (DEFICIT)				0

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

ALGOMA PUBLIC HEALTH
FINANCE AND AUDIT COMMITTEE MEETING
NOVEMBER 8, 2017 @ 4:00pm
PRINCE MEETINGROOM, 3RD FLOOR, SSM
MINUTES

COMMITTEE MEMBERS PRESENT: Patricia Avery Ian Frazier Lee Mason Dennis Thompson

APH STAFF PRESENT:	Dr. Marlene Spruyt	Medical Officer of Health
	Justin Pino	Chief Financial Officer
	Joel Merrylees	Manager of Accounting and Budgeting
	Christina Luukkonen	Recording Secretary

1) CALL TO ORDER:
Mr. Frazier called the meeting to order at 4:02pm

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

3) ADOPTION OF AGENDA ITEMS
The committee agreed to discuss 7b) APH 2018 Public Health Operating & Capital Budget first.

FC2017-31 Moved: L. Mason
Seconded: P. Avery

THAT the agenda items for the Finance and Audit Committee dated November 8, 2017 be adopted as circulated; and
THAT the Finance and Audit Committee accepts the item on the addendum.
CARRIED.

4) ADOPTION OF MINUTES

FC2017-32 Moved: L. Mason
Seconded: P. Avery

THAT the minutes for the Finance and Audit Committee dated September 13, 2017 be adopted as circulated.
CARRIED.

5) FINANCIAL STATEMENTS

a. Financial Statements for the Period ending September 30, 2014
Mr. Pino spoke to the draft financial statements that were provided in the agenda package. Questions were answered to the satisfaction of the committee.

FC2017-33 Moved: D. Thompson
Seconded: L. Mason

THAT the Finance and Audit Committee recommends the draft Financial Statements for the Period ending September 30, 2017 and put forth to the Board of Health for approval.
CARRIED.

6) BUSINESS ARISING FROM MINUTES: None

7) NEW BUSINESS/GENERAL BUSINESS

a) 2017 Contribution to APH Reserve Fund

Mr. Pino spoke to the briefing not that was provided in the agenda package. The committee discussed increasing the contribution.

FC2017-34 Moved: L. Mason
Seconded: P. Avery

THAT the Finance and Audit Committee recommends that the Board of Health approve a contribution of $200,000 into the Reserve Fund from Algoma Public Health's operating account.
CARRIED.

b) APH 2018 Public Health Operating & Capital Budget

Mr. Pino reviewed the draft 2018 draft budget submission. A copy of the draft budget was provided in the agenda package. The committee discussed the proposed .05% levy increase to municipalities and the 0% increase from the Ministry.

FC2017-35 Moved: L. Mason
Seconded: P. Avery

THAT the Finance and Audit Committee recommends and put forth to the Board of Health for approval the draft 2018 Public Health Operating and Capital Budget.
CARRIED.

8) Addendum

a) Renewal of Service Contract with the Innovation Centre

A briefing note was provided on the service renewal with the SSM Innovation Centre along with the sole source procurement justification form.

FC2017-36 Moved: L. Mason
Seconded: P. Avery

THAT the Finance and Audit Committee recommends and put forth to the Board of Health for approval:

i) The Sault Ste. Marie Innovation Centre (SSMIC) to continue to provide a geographic information system (GIS) and other information management services to APH.
ii) Approve the contract renewal between APH and SSMIC

CARRIED.

The Finance and Audit Committee meeting recessed at 5:33pm for the Special Meeting of the Board.
The Finance and Audit Committee meeting reconvened at 5:52pm following the adjournment of the Special Meeting of the Board.

9) IN-COMMITTEE

The Finance and Audit Committee added item b) Labour Negotiation.

FC2017-37 Moved: L. Mason
Seconded: D. Thompson

THAT the Finance and Audit Committee goes in-committee at 5:53pm
Agenda items:

a. Adoption of in-committee minutes: September 13, 2017

b. Labour Negotiation

CARRIED.

10) OPEN MEETING

FC2017-39 Moved: L. Mason
Seconded: P. Avery

THAT the Finance and Audit Committee goes into open meeting at 6:01pm.

CARRIED.

Prior to adjourning the meeting the committee asked for an update regarding the Insurance presentation that was received at the last meeting. This is an agenda item for the February 2018 meeting to look at our current insurance plan and what other options are available in time for the next renewal.

Mr. Pino also addressed the media stories on APH not presenting to SSM City council on our budget. Our budget has not been approved yet by the board so there was nothing to present at that time.

11) NEXT MEETING: Wednesday, February 14, 2018

12) THAT THE MEETING ADJOURN:

FC2017-40 Moved: L. Mason
Seconded: P. Avery

THAT the meeting of the Finance and Audit Committee adjourns at 6:17pm.

CARRIED.

Algoma Public Health - Governance Committee Report

February 15, 2018

It was the first meeting of the new committee. Committee Board members are Lee Mason, Ian Frazier, Heather O'Brien, Connie Nykyforak, Karen Raybould and Lucas Castellani.

A review of the system for numbering and labeling the policies and by-laws of the Board was mentioned and will be looked at re-examined at a future meeting this year.

The Committee reviewed and discussed the draft Code of Conduct policy update that had gone for legal review with the Conflict of Interest Policy in the Fall. There were no recommendations to alter any parts, so the Committee is recommending adoption of the updated policy.

We continued the review and creation of the MOH/CEO Evaluation policy. Antoinette gave a general review of the process and the background used to develop the policy using parts of existing policies from other Boards. A robust discussion occurred related to the policy and the evaluation form that accompanies the policy. A final version was determined and it is going to be recommended to the Board for approval.

Christina updated the Committee on the progress of integrating Policies 02-05-010 Board Minutes and 02-05-070 In-Committee Materials Posting – Circulating-Retention that was brought forward in the fall. It was decided that a combined updated policy 02-05-010 would be out for and the former policy 02-05-070 would be archived. This is the recommendation that will be brought to the Board.

Policy 02-05-060 Meetings and Access to Information was discussed and reviewed. Some changes were suggested and its update will be recommended for approval by the Board.

A discussion regarding the monthly and yearly evaluations occurred. A review and update of the wording to ensure that the Board is getting useful and necessary information will occur at the next meeting. Some of the wording has not been modified since the inception of the evaluations.

Ian Frazier presented a draft plan to create a policy that would be used to ensure that new Board members have an orientation in a timely fashion after being appointed. The plan would include initial welcoming, technical instruction, and priority of materials reviewed. Discussion as to the extent and timelines of training were debated. The Committee is recommending the approval of the new policy.

A proposed schedule for staggering the Committee meetings was put forth for discussion at the next meeting. It will be sent to the Finance and Audit Committee also to get this input. It was requested that a review of staggering the meetings to possibly fall on alternating months and the schedule would make sure meetings are held when most needed.

A review of the Procurement policy 02-04-030 was undertaken at the Finance and Audit Committee and changes were suggested to be reviewed by the Governance Committee. The committee reviewed the changes and discussed the impact of the changes. It is recommended by the Committee that the Policy is updated and an Ad-hoc Committee of the Chairs be set to further study and clarify the section on Exemptions with a report and further recommendations back to the September 2018 Board meeting.

Committee adjourned the meeting.

Lee Mason

Chair of the Governance Committee

APPROVED BY:	Board of Health	**REFERENCE #:**	02-05-030
DATE:	O: June 20, 2007 Reviewed; June 17, 2014 Revised October 28, 2015 Revised: February 28, 2018	**SECTION:**	Board
PAGE:	1 of 2	**SUBJECT:**	Board Member Code of Conduct

The Algoma Public Health Board believes that its members must adhere to a high standard of ethical behavior in all aspects of their conduct at all times and that all members shall fulfill their duties in a manner that maintains and enhances public confidence in the APH Board.

POLICY:

Each member of the Board of Health shall comply with the Code of Conduct for the District of Algoma Health Unit (operating as Algoma Public Health).

CODE OF CONDUCT:

Board Members shall:

1) Adhere to all Board of Health bylaws, policies, and rules of procedure and perform their duties with integrity, transparency and accountability.

2) Represent the best interests of public and community health and the respective programs and services of Algoma Public Health.

3) Comply with conflict of interest policy and declare conflicts either perceived or actual on agenda matters as appropriate.

4) Keep in confidence any confidential information acquired by virtue of their position as a board member.

5) Attend both board and committee meetings as scheduled as it is an important accountability for all members. The expectation is that all members attend a minimum of 2/3 of all meetings within the year unless approved by the chair of the board or affected committee.

6) Preserve a state of neutrality by supporting and endorsing board and committee decisions regardless of the level of prior personal disagreement. Public inquiries regarding APH services shall be directed to the board chair or MOH/CEO or delegate

7) Review board package materials in advance of the meeting and participate productively in meetings.

8) Recognize that only the Board of Health Chair speaks for the board on public disclosures unless the chair delegates that responsibility on a specific topic.

9) Not publish or post on social media, a statement that could impair the public's confidence in the Algoma Public Health Unit and its ability to make transparent, objective, impartial and fair decisions that are in the public interest.

10) Interact with each other, staff and members of the public with respect, diplomacy and dignity. Respect the boundaries between the roles of staff and the roles of board and committee members.

11) Support one another and the MOH/CEO.

PROCEDURE

If a board member has a performance concern that violates the Code of Conduct, and is unable to resolve with informal communication with the member or regarding the MOH/CEO, the concern shall be brought to the Chair of the board or Vice Chair (*if issue is with Chair*).

The Board Chair in collaboration with the two Vice-Chairs *(if issue is with a Vice-Chair the remaining Vice Chair and Board Chair will be involved)* will mediate any disputes between Board members and/or the MOH/CEO in situations where the parties were unable to resolve the issue.

Where a Board or Committee member believes that another board or committee member has violated the Code of Conduct with respect to confidentiality or a conflict of interest that has not been declared despite any appropriate informal communications, the board or committee member shall advise an appropriate person such as the Chair of the Board or Chair of the affected committee. The Board Chair will in collaboration with the two Vice-Chairs investigate and try to resolve the issue informally.

Where there has been a failure on the part of a Chair and Vice-Chairs to resolve informally, the issue will be brought back to the entire Board for review. The Board may request that the Chair:

i) Issue a verbal reprimand; or
ii) Issue a written reprimand; or
iii) Request that the Board member resign or
iv) Seek dismissal of the Board member based on regulations relevant as to how the board member \ was appointed.

APPROVED BY:	Board of Health	**REFERENCE #:**	02-05-080
DATE:	O: February 28, 2018 R:	**SECTION:**	Board
PAGE:	**1** of **2**	**SUBJECT:**	Performance Evaluation for Medical Officer Of Health/Chief Executive Officer (MOH/CEO)

POLICY:

A written performance evaluation system will be used to provide an objective and uniform way to evaluate the Medical Officer of Health/Chief Executive Officer MOH/CEO's performance. It is a constructive process to build on strengths, correct weaknesses, and maximize performance.

The MOH/CEO's performance is to be evaluated before the end of the probationary period, in order to recommend to the Board of Health (BOH) appointment to regular appointment status, extension of probationary period, or termination of employment.

At the beginning of each year, the Board Chair (Chair) will meet with the MOH/CEO to set and review an annual work plan which includes professional development goals.

A standing committee of the BOH named the MOH/CEO Performance Evaluation Committee (MOHPEC) will conduct the performance evaluation of the MOH/CEO. MOHPEC is made up of the current Chair and Vice Chairs. The Director of Human Resources will assist with the evaluation process. The performance evaluation will be conducted by MOHPEC chaired by the Chair annually for two (2) years and every two (2) years thereafter. MOHPEC will incorporate feedback from internal stakeholders such as board of health members, staff and where appropriate external stakeholders as part of the 360° component of the evaluation.

As part of the performance evaluation, the MOH/CEO is responsible for completing a self-appraisal.

Formal performance evaluations do not take the place of ongoing evaluation and feedback. If the MOH/CEO's work is not adequate, the matter is to be dealt with while details and facts are fresh and will not wait for the formal review. The MOH/CEO's performance must return to the required standard within a specified time period or further action may be taken by the Board.

PROCEDURES

1. Annually, the Chair of the BOH will meet with the MOH/CEO to review the annual work plan, which includes the setting of professional development goals.

2. The Chair will schedule the performance evaluation before the end of the probationary period and then annually for two (2) years and every two (2) years thereafter.

3. The Director of Human Resources will send out the evaluation form to MOHPEC and they will complete and return to the Director of Human Resources for collation. MOHPEC can consult with any other persons they feel could provide relevant input to the performance evaluation, review the job description, operational plans, significant events and any other pertinent items from the period under review.

4. The Director of Human Resources will send the MOH/CEO a self-evaluation form to be completed before the meeting with the Chair. The self-evaluation is not to be submitted.

5. The Chair will work with the Director of Human Resources to organize the 360^0 component of the evaluation. This would include a list of staff and external stakeholders, when warranted, who could be approached for potential feedback.

6. The Director of Human Resources will schedule a meeting with the Chair and Vice Chairs to review responses obtained and prepares the draft form. The information collected from the various sources will be used to grade each factor to complete the evaluation form, using the definitions included in the performance evaluation form and support the decision with comments and examples wherever possible. The evaluation should also include an assessment of performance relative to any learning or performance objectives set in the previous performance evaluation. In the BOH's comments, clearly indicate whether the overall performance is satisfactory or not. For probationary MOH/CEOs indicate if probation has been completed satisfactorily.

7. The Chair will present the performance evaluation to the BOH at the next BOH meeting in-camera session. The MOH/CEO is not present for this part of the meeting. BOH members may alter the draft evaluation.

8. The Director of Human Resources schedules a meeting(s) with the Chair and the MOH/CEO to discuss the evaluation. This part may require more than one meeting. When weighing all of the feedback, consideration should be given to the MOH/CEO's input and make changes/additions to the factor comments, examples and even grading where warranted.

9. The Chair will forward the draft evaluation form to the Director of Human Resources to update the form with changes. The Director of Human Resources will send the final copy to the Chair.

10. The Chair and MOH/CEO meet to sign and date the performance evaluation form. The MOH/CEO's signature means that they have read and understood the review.

11. The Chair will provide the MOH/CEO a copy of the completed performance evaluation form. The Director of Human Resources is to retain the original in the MOH/CEO's personnel file.

12. A follow up meeting(s) may be scheduled should the Chair deem it necessary.

Algoma Public Health- Medical Officer of Health/Chief Executive Officer (MOH/CEO)

Performance Evaluation Form

Name:

This performance evaluation is due on:

It reviews the performance for the period from: to:

And sets objectives for the period from: to:

The following rating scale is used in this performance evaluation:

Exceeds Expectations	Performance consistently exceeds all expectations/standards
Meets Expectations	Accomplishments are clearly obvious. Solid reliable performance that substantially meets expectations. In some instances, expectations are exceeded. In some instances, expectations are still being developed.
Progressing	Fulfilled some requirements of expectations/standards however expectation/standard is not fully or consistently met.
Requires Improvement	Fulfillment of requirements of expectations/standards was less than adequate and must improve.
Not applicable (n/a)	The Board of Health is not able to rate this area at this time.

Append additional sheets / documentation where required/appropriate.
Once completed, discussed and all signatures obtained, the original of this form is to be retained in the MOH/CEO's personnel file.

Program Excellence- *This area reflects on how the MOH/CEO has influenced the impact APH has on: population health measures; the use of health status data; evidence-informed program decision making; delivery of mandated and locally needed community and public health services*	**Exceeds Expectations**	**Meets Expectations**	**Progressing**	**Requires Improvement**	**n/a**
• Responds effectively to health hazards and provides effective control of communicable diseases under the Health Protection and Promotion Act.					
• Champions coordinated approaches and engagement of clients and community partners in planning and evaluation of programs and services.					
• Maintains statutory obligations through the delivery of mandated and locally needed community and public health services.					
• Anticipates and plans for major trends in needs and services.					
• Uses evidence-informed decision making in developing programs and services to meet community needs.					
• Considers Health Equity in all program work.					
• Ensures processes in place to regularly evaluate public health programs and services, seeking ways to improve efficiency and effectiveness.					
Comments: (include major strengths in this area of focus and any areas that may need future development)					

Client and Community Impact – *This area reflects on the MOH/CEO's representation of APH in the community*	**Exceeds Expectations**	**Meets Expectations**	**Progressing**	**Requires Improvement**	**n/a**
• Contributes to increasing community awareness about public health.					
• Promotes productive relationships with the media and acts as a resource to the media regarding public health issues.					
• Promotes productive relationships, maintains regular communication and strong working partnerships with external stakeholders including Boards of Education, labour, government and media, health care providers, community organizations, citizen groups and the Ministry of Health.					
• Seeks new and innovative ways to work with partners to advance mutual goals in the community.					
• Promotes excellence in customer service within APH. Responds quickly and efficiently to enquiries/ complaints/issues from citizens/community groups. Exhibits tact and diplomacy in dealing with citizen/group complaints. Resolves complaints to					

citizen/ groups' satisfaction whenever feasible. Provides helpful explanation where legislatively or otherwise constrained. Researches/facilitates appropriate contact when referral is necessary.					
Comments: (include major strengths in this area of focus and any areas that may need future development)					
Employee Engagement and Learning – *This area reflects on how the MOH/CEO has influenced APH's organizational capacity, climate and culture and the contribution made to enabling engaged and empowered staff; thoughtful and responsive leadership and organizational structures that support decision-making, innovation and learning*	**Exceeds Expectations**	**Meets Expectations**	**Progressing**	**Requires Improvement**	**n/a**
• Promotes a positive working environment. Advocates integrity, empowerment, collaboration and striving for excellence among staff. Sets a professional example for staff.					
• Allocates resources to maximize departmental and program effectiveness. Proposes revision to staff structure and numbers as necessary. Collaborates with the executive team on opportunities for sharing/reallocating existing staff/resources wherever possible. Explores alternatives such as cost-sharing/joint services with other agencies and/or contract services.					
• Provides adequate supervision and direction of direct-reporting staff. Includes working with them to identify and prioritize short					

and longer-term goals. Conducts meaningful performance evaluations in a timely manner, and identifies their strengths and areas for development. Identifies and takes actions necessary to obtain improved performance where necessary. Recognizes and commends staff for outstanding work. Identifies and deals with performance concerns quickly and effectively by dealing with performance / communication / disciplinary issues in an appropriate manner.					
• Maintains effective communication with staff. Fosters a workplace climate conducive to open communication. Holds regular executive and leadership team meetings. Institutes feedback mechanisms to gauge leadership effectiveness.					
• Identifies areas where staff training and development would be of benefit to the leadership team and/or agency as a whole. Encourages staff commitment and ownership to upgrading and maintaining job related effectiveness. Promotes the view of training as a shared responsibility between staff and the organization. Supports planning of short and long term departmental training and development initiatives.					
• Regularly evaluates corporate operations, seeking ways to improve efficiency and effectiveness.					
• Exhibits excellent time					

management skills. Systematically organizes own time. Commits to and meets deadlines. Respects others' time. Is punctual for meetings.					
• Sets and achieves personal and professional development objectives.					
Comments: (include major strengths in this area of focus and any areas that may need future development)					

Governance- *This area reflects on how the MOH/CEO has influenced the alignment of management methods and systems to ensure appropriate structures and resources are in place to achieve APH's mission and vision. This area also reflects on the MOH/CEO's responsibility for actions, decision and policies that impact APH's ability to achieve the requirements as set out under the strategic plan, the Ontario Public Health Standards (OPHS), other funder requirements and direction provided by the Board of Health*	**Exceeds Expectations**	**Meets Expectations**	**Progressing**	**Requires Improvement**	**n/a**
• Monitors overall APH financial situation demonstrating effective management of financial resources. Ensures transparency and understanding of financial processes and procedures.					
• Develops innovative approaches to financing and revenue generation. Devises strategies to protect APH assets.					
• Ensures agency compliance with the Ontario Public Health Standards.					
• Abides by employment and other relevant legislation including Employment Standards Act, Labour Relations Act, Occupational					

Health and Safety Act, Accessibility for Ontarians with Disabilities Act and the Human Rights Code. Adheres to terms of union and other contracts.					
• Develops and maintains APH bylaws, policies and procedures and ensures adherence within the organization. Advises and consults with the BOH on significant matters.					
• Communicates regularly with the Chair of the Board and provides support in identifying agenda items for the BOH and Committee meetings.					
• Ensures adequate orientation and on-going education of BOH members.					
• Informs BOH of important developments affecting public health and APH (e.g. legislative changes, public health emergencies, organizational issues, system development, and environmental trends.) Makes recommendations as appropriate and includes financial analysis for recommendations.					
• Provides appropriate and timely written reports to the BOH. Writes and speaks clearly. Reports are easily understood by the BOH members.					
Comments: (include major strengths in this area of focus and any areas that may need future development)					

SUMMARY OF OVERALL PERFORMANCE

Area of Focus	Exceeds Expectations	Meets Expectations	Progressing	Requires Improvement	n/a
Program Excellence					
Community and Client Impact					
Employee Engagement and Learning					
Governance					
Comments – (Including comments with respect to the major strengths of the MOH/CEO and areas for future development.)					

GOALS FOR THE NEXT PERIOD – BY AREA OF FOCUS

Program Excellence	Possible Key Performance Indicator(s)

Community and Client Impact	Possible Key Performance Indicator(s)

Employee Engagement and Learning	Possible Key Performance Indicator(s)

Governance	Possible Key Performance Indicator(s)

SIGNATURES

Medical Officer of Health/CEO

I discussed this performance evaluation with the Chair of the Board of Health.

I have participated in the setting of goals and targets for the next performance period, have reviewed my job responsibilities with the Chair of the Board of Health, and agree to the goals, targets and measurement standards noted above for the next performance period.

Comments

_____ _____

Medical Officer of Health/CEO Date

For the Board of Health

I have discussed the performance evaluation with the Medical Officer of Health/CEO. We have reviewed the past period's work performance and goals and objectives, and have discussed goals and objectives for the coming performance period. We have also discussed professional development and training needs. The goals and objectives for the coming year have been established, including job responsibilities and measurement methods.

_____ _____

Chair, Board of Health Date

APPROVED BY:	Board of Health	**REFERENCE #:**	02-05-010
DATE:	O: February 12, 1996 Revised: September 22, 2015 Revised: November 25, 2015 Revised: March 28, 2018	**SECTION:**	Board
PAGE:	1 of 1	**SUBJECT:**	Board Minutes/Packages – Posting/Circulation/Retention

POLICY:

Algoma Public Health utilizes electronic board management software for access to agenda packages for board members. Agenda packages will be posted to the platform 1 week prior to the board meetings. The agenda package is also posted to the APH website for public access with the exception of unapproved minutes. Once the meeting minutes have been approved by the Algoma Public Health Board, the approved minutes will then be posted on the website.

Algoma Public Health Board "In Camera" documentation will be posted to the platform along with the Board Meeting Package to allow Board Members time to become familiarized with information prior to meetings. Board members should not make copies, save to desktop, photograph, or download in any format any version of the in-committee documentation to save. Minutes of "In Camera" sessions will be passed while in the next "In Camera" session. Once the meeting is complete the "In Camera" package will be removed from the platform.

Addendum packages will be posted to the platform and the APH website as soon as it is available.

Access, storage and retrieval of this information will be in accordance with general standards of APH and the Municipal Act section 239.2 and Section 239.3.

PROCEDURES:

Secretary to the Board of Health:

1) Will upload the Board package and In Camera package to the electronic board management platform one week prior to the Board meeting.

2) Will post the Board package to the Algoma Public Health Website and email the link to municipalities one week prior to the Board meeting. In Camera documentation will not be included.

Board:

3) Will access the meeting package(s) on an electronic board management platform prior to the board meeting.

Secretary to the Board of Health:

4) Maintain a binder of the original signed approved Board minutes plus signed resolutions by the Board Chair for each Board meeting on a yearly basis.

5) Allow onsite access to Board of Health members to review the "In Camera" binder as required with reasonable notice.

APPROVED BY:	Board of Health	**REFERENCE #:**	02-05-010
DATE:	O: February 12, 1996 Revised: June 17, 2014 Revised: September 22, 2015 Revised: November 25, 2015	**SECTION:**	Board
PAGE:	1 of 1	**SUBJECT:**	Board Minutes/Packages – Posting/Circulation/Retention

POLICY:

Algoma Public Health Board meeting packages will be posted to the APH website. Once the meeting minutes have been approved by the Algoma Public Health Board, the approved minutes will be posted on the website. Access, storage and retrieval of this information will be in accordance with general standards of APH and the Municipal Act.

PROCEDURES:

Secretary to the Board of Health:

1) Will post the Board package to the Algoma Public Health Website and the email the link to municipalities one week prior to the Board meeting. In-committee documentation will not be included.(See Policy 02-05-060)

2) Maintain a binder of original signed approved Board minutes plus signed resolutions by the Board Chair for each Board meeting on a yearly basis.

APPROVED BY:	Board of Health	**REFERENCE #:**	02-05-070
DATE:	O: September 22, 2015 R:	**SECTION:**	Board
PAGE:	1 of 1	**SUBJECT:**	"In Committee" material – Posting/Circulation/Retention

POLICY:

Algoma Public Health Board "In Committee" documentation will be posted to the APH Secure Board website along with the Board Meeting Package to allow Board Members time to become familiarized with information prior to meetings. Minutes will be marked as **Confidential**. Access, storage and retrieval of this information will be in accordance with general standards of APH and the Municipal Act section 239.2 and Section 239.3.

PROCEDURES:

Board:

1) Has access to "In Committee" documentation through the APH Secure Board Webpage when the Board Meeting package is posted.

2) The "In Committee" documentation will be posted as a separate hyperlink after the Board Meeting package hyperlink.

3) "In Committee" documentation will be available to the Board Members until the close of the meeting, and then will be removed from the Secure Board Webpage.

4) Board members may review the "In Committee" documentation online, but should not make copies, save to desktop, photograph, or download in any format any version of the documentation to save.

5) Minutes of "In Committee" sessions will be passed while in the next "In Committee" session

6) Paper copies of the "In Committee" documentation (with the confidential watermark) will be made available for the Board members during the meeting and collected after the session is over.

Secretary to the Board of Health:

7) Maintain a binder of agenda and minutes of the "In Committee" sessions including motion to enter, people present during "In Committee" session, directives given to Staff, reports referenced and motion to exit.

8) Allow onsite access to Board of Health members to review the "In Committee" binder as required with reasonable notice.

APPROVED BY:	Board of Health	**REFERENCE #:**	02-05-060
DATE:	O: October 28, 2015 Revised: March 28, 2018	**SECTION:**	Board of Health
PAGE:	1 of 2	**SUBJECT:**	Meetings and Access to Information

PREAMBLE:

As reflected in the Algoma Public Health Strategic Plan the Board of Health strongly supports the principles of accountability and transparency. This policy regarding Meetings and Access to Information instructs the Board and informs the public as to:

i) how meetings of the Board will be held
ii) how the public can access information from Board meetings
iii) how information from Board meetings will be disseminated
iv) the terms under which a meeting or part of a meeting may be closed to the public in accordance with Section 239 of the *Municipal Act.*

POLICY:

Board of Health meetings are open to the public and the Board will conduct its meetings subject to Section 239 of the Municipal Act.

Minutes of Board of Health, Finance Committee and Governance Committee meetings will be posted on Algoma Public Health's Website and emailed to each municipal clerk in Algoma Public Health's catchment area with the exception of the in-committee minutes.

Copies of Board records in the possession or under the control of the Secretary to the Board may also be made available to members of the public and shall be processed in accordance with the General Administrative Manual (GAM) policy for information requests. Payment of the costs of photocopying shall be in accordance with the Algoma Public Health fee schedule.

Municipal Freedom of Information and Protection of Privacy Act does not apply to a record of a meeting closed under subsection (3.1). 2006, c. 32, Sched. A, s. 103 (3) of the *Municipal Act*.

In the event that the APH receives a complaint relating to a closed Board of Health meeting, ~~the~~ APH will utilize the services of the Ombudsman Ontario as the investigator when required in accordance with s.239 of the *Municipal Act*. (reference 03-08).

The Secretary to the Board of Health will ensure that members of the media covering Board meetings have access to relevant information.

In accordance with Section 239 of the *Municipal Act,* which also applies to local boards or committees of local boards, a meeting or part of a meeting may be **closed** to the public if the subject matter being considered is:

- * the security of the property of the municipality or local board;
- * personal matters about an identifiable individual, including municipal or local board employees;
- * a proposed or pending acquisition or disposition of land by the municipality or local board;
- * labour relations or employee negotiations;

- * litigation or potential litigation, including matters before administrative tribunals, affecting the municipality or local board;
- * advice that is subject to solicitor-client privilege, including communications necessary for that purpose;
- * a matter in respect of which a Council, board, committee or other body may hold a closed meeting under another Act;
- * information explicitly supplied in confidence to the municipality or local board by Canada, a province or territory or a Crown agency of any of them;
- * a trade secret or scientific, technical, commercial, financial or labour relations information, supplied in confidence to the municipality or local board, which, if disclosed, could reasonably be expected to prejudice significantly the competitive position or interfere significantly with the contractual or other negotiations of a person, group of persons, or organization;
- * a trade secret or scientific, technical, commercial or financial information that belongs to the municipal local board and has monetary value or potential monetary value; or
- * a position, plan, procedure, criteria or instruction to be applied to any negotiations carried on or to be carried on by or on behalf of the municipality or local board. 2001, c. 25, s. 239 (2); 2017, c. 10, Sched. 1, s. 26.
- * A meeting is held for the purpose of educating or training the members and at the meeting, no member discusses or otherwise deals with any matter in a way that materially advances the business or decision-making of the council, local board or committee. 2006, c. 32, Sched. A, s. 103 (1). ~~the security of the property of the Algoma Public Health (APH);~~

- ~~personal matters involving one or more identifiable individuals, including employees or prospective employees;~~
- ~~proposed or pending acquisition, rent or disposition of land or realty;~~
- ~~reports on charges which have been laid for contravention of by-laws or regulations, but which have not yet been dealt with in court;~~
- ~~labour relations or employee negotiations;~~
- ~~litigation or potential litigation, including matters before administrative tribunals, affecting the board;~~
- ~~advice that is subject to solicitor-client privilege, including communications necessary for that purpose;~~
- ~~a matter in respect of which a council, board, committee or other body may hold a closed meeting under another Act; and~~
- ~~for the purpose of educating or training the members (reference section 239, Subsection 3.1 of the *Municipal Act.)*~~

A meeting shall be closed to the public if the subject matter relates to the consideration of a request under the *Municipal Freedom of Information and Protection of Privacy Act* if the council, board, commission or other body is the head of an institution for the purposes of that Act.
(1990, c. 25, s. 239 (3))

Before holding a meeting or part of a meeting that is to be closed to the public, a municipality or local board or committee of either of them shall state by resolution,

(a) the fact of the holding of the closed meeting and the general nature of the matter to be considered at the closed meeting; or

(b) in the case of education or training sessions, the fact of the holding of the closed meeting, the general nature of its subject-matter and that it is to be closed under article 239 subsection 3.1 of the *Municipal Act.*

APPROVED BY:	Board of Health	**REFERENCE #:**	02-05-085
DATE:	O: February 28, 2018	**SECTION:**	Board
PAGE:	**1** of **2**	**SUBJECT:**	Orientation – Board Members

POLICY:

The Board of Health (BOH) for Algoma Public Health (APH) shall ensure that BOH members are aware of their roles and responsibilities and emerging public health issues and trends by ensuring the development and annual implementation of a comprehensive orientation plan for new BOH members and a continuing education for continuing BOH members.

Orientation and continuing education activities shall occur on an on-going basis and shall include information on the following topics:

- The structure, vision, mission goals and objectives of the public health unit;
- Overview of the strategic plan, the planning process, its relationship to the operational plan, and performance monitoring;
- Community demographics overview, including information on social and cultural diversity;
- Program and service overview, including organizational emergency preparedness planning;
- Provincial government structure and the funding streams of the three ministries;
- The duties and responsibilities of board members, including requirement to attend board meetings, advanced review of meeting materials, understanding of board of health policies and procedures, and understanding of public health issues;
- Board members' fiduciary responsibilities in terms of trusteeship, due diligence, avoiding conflict of interest, maintaining confidentiality, strategic oversight, ethical and compliance oversight, stakeholder engagement, MOH (and executive officers, where applicable) compensation, risk management oversight and succession planning; and
- Opportunities for board members to participate in conferences or seminars that are sponsored or hosted by other organizations.

New members of the BOH for APH will be provided with an orientation process and access to the orientation materials (either an orientation binder or available electronically) when they become a member of the BOH. The purpose of the orientation process is to provide all BOH members with information relating to public health standards, finance, Legislation governing health units, BOH roles, responsibilities, by-laws, structure, relevant policies and procedures. The orientation process will take place as a separate in-person meeting apart from regularly scheduled BOH meetings and will include review of the orientation materials.

The orientation material is created by the office of the MOH/CEO and will be revised at a minimum once a year or as changes occur. BOH members will be provided with updated information for their orientation material as changes occur in order to ensure current information is available to all BOH members. BOH members are encouraged to attend alPHa seminars, workshops, and meetings as they arise.

SCOPE

This policy applies to new and continuing members of the BOH.

RESPONSIBILITIES

MOH/CEO and/or BOH Chair (or appropriate designate(s)) will:

- Set up an orientation meeting with each new BOH member prior to the first BOH meeting;
- Within three months of appointment review the orientation material with the BOH member to provide a clear understanding of relevant BOH and APH information;
- Provide ongoing orientation to all BOH members during their tenure on the BOH;
- Provide each BOH member with current and complete orientation material: and
- Ensure the orientation material is kept up to date and revised information is provided to each BOH member.

BOH Members will:

- Attend an initial orientation meeting with the BOH Chair and/or MOH/CEO upon becoming a member of the BOH;
- Ensure they have a working understanding of their role as a BOH member and all information as outline in the orientation material;
- Attend/participate in continuing education activities; and
- Use the orientation material as a BOH resource.

APPROVED BY:	Board of Health	**REFERENCE #:**	02-04-030
DATE:	O: February 13, 1996 Revised: May 28, 2015 Revised: October 28, 2015 Revised : February 28 2018	**SECTION:**	Board Policy
PAGE:	1 of 14	**SUBJECT:**	Procurement Policy

1.0 PURPOSE

The purpose of this policy is:

a) To ensure that Algoma Public Health (APH) utilizes fair, reasonable and efficient methods to procure quality goods and services required to execute the Board of Heath for the District of Algoma Health Unit's (the Board's) programs and services.

b) To ensure APH aims to be accountable and transparent when procuring goods and services while safeguarding the assets of the agency.

c) To protect the financial interest of APH while meeting the needs of its programs and services it offers within the District of Algoma.

d) To promote and ensure the integrity of the procurement process and to ensure the necessary controls are present for a public institution.

2.0 POLICY ACCOUNTABILITY AND RESPONSIBILITIES

The Board is accountable to ensure that Algoma Public Health uses fair, reasonable and efficient methods to procure quality goods and services required to execute the Board's programs and services. The Board delegates responsibility to Algoma Public Health employees as outlined below:

<u>Medical Officer of Health (MOH)/Chief Executive Officer (MOH/CEO)</u>

a) Ensures the Leadership Team is aware of and follows the Procurement policy

b) Ensures that an adequate system of internal controls is in place related to APH's Procurement policy

c) Ensures changes to the Procurement Policy are implemented

d) Reports to the Board on any liability incurred as a result of the policy not being followed

The Leadership Team

a) Ensures all staff know and follow policy directions for procurement of goods and services

b) Considers price, quality and timely delivery of the product or service being procured rather than only the lowest invoice price

c) Considers the total acquisition cost

d) Monitors expenses on a regular basis to ensure that they are within the approved budget

3.0 SCOPE OF APH PROCUREMENT POLICY

This policy applies to the procurement of goods and services for APH. Exemptions of this policy include:

a) Training and Education
   i. Registration for conferences, conventions, courses, workshops and seminars
   ii. Magazines, subscriptions, books and periodicals
   iii. Memberships and association fees
   iv. Guest speakers for employee development

b) Refundable Employee Expenses
   i. Meal allowances
   ii. Travel expenses
   iii. Kilometer and other incidental expense reimbursement

c) Employer's General Expenses
   i. Payroll and honoraria remittances
   ii. Government license fees
   iii. Insurance Premiums
   iv. Employee benefits
   v. Damage and insurance deductible claims
   vi. Petty cash replenishment
   vii. Tax remittances
   viii. Loan payments
   ix. Bank fees and charges
   x. Grants to agencies and partners
   xi. Payments pursuant to agreements approved by the Board

d) Professional and Special Services
   i. Special tax, accounting, actuarial and audit services and advice from the Board-approved auditor

ii. Legal fees and other professional services related to litigation, potential litigation or legal matters
iii. Clinical Service that are required to meet a community need and for which there are a limited number of professionals willing to provide these services
iv. Confidential items (i.e. investigations, forensic audits)
v. Honoraria
vi. Warranty work resulting from contractual obligations
vii. Group Benefits and Employee Assistance Programs
viii. Agency Insurance

e) Utilities/Communication Infrastructure

f) Advertising services required by APH on or in but not limited to radio, television, online, newspaper and magazines

g) Bailiff or collection agencies

h) Software licensing renewals

i) Ongoing maintenance agreements

j) Vaccine purchases

k) A situation where APH staff are incurring the cost of a service (i.e. exercise class on APH premises)

l) Real Property Interests
i. All real estate transactions

m) A situation where a competitive process could interfere with APH's ability to maintain security or order or to protect human, animal or plant life or health

n) Emergency Goods & Services where an unforeseen situation or urgency exists, and the goods or services cannot be obtained through a competitive process. Purchase of these emergency items must be authorized by the CFO or the MOH/CEO. The Chair of the Board or designate must be notified. An unforeseen situation of emergency does not occur where APH has failed to allow sufficient time to conduct a competitive process.

o) Goods & services where there is only one supplier available and no alternative or substitute exists

4.0 FORM OF COMMITTEMENT BY ROLE/SIGNING AUTHORITY

4.1 Signing Authority to Make Purchases

The delegation of signing authority to make purchases on behalf of the agency is based on dollar amount of the expenditure and the role in which the employee occupies within the agency.

Expenditure $ Amount	Required Approval
0-$500	Executive Assistant to MOH/CEO and Board Secretary or Executive Assistants to Executive Team
0- $4,000	Program or Administration Supervisors and Managers
$0 - $15,000	Any Director or Associate MOH or Manager of Accounting & Budgeting
$0 - $55,000	CEO/MOH or CFO
Greater than $55,000	Board of Health

The delegation of signing authority for the Execution of Documents is defined by Algoma Public Health By-Law 95-1 – To Regulate the Proceedings of the Board of Health, Clause 34 and 35, Execution of Documents.

Note: When the Associate MOH is functioning in the capacity of the MOH, signing authority will reflect that of the MOH noted above.

4.2 General Guidelines

When assessing what dollar value the purchase falls within, the following conditions are considered:

a) The spending authorization limits noted above and throughout this policy are before applicable taxes

b) The goods or services purchased must be taken in their entirety and not broken down into component parts in an attempt to circumvent this policy.

c) The cumulative value of those goods or services over a calendar year

d) The total value of the contract that will be awarded to the same individual/company over the term of that contract whether for a single or multiple years.

5.0 QUOTATION PROCEDURE

5.1 Requests for Bids/Quotations/Proposals/Tenders and Dollar Thresholds

Requests for bids, quotations and proposals are **mandated** for the purchase of all goods and services according to the following guidelines:

- $1 – $5,000: Bids, quotations and/or proposals are **recommended but not required**.
- $5,000 – $15,000: Two (2) written bids, quotations, and/or proposals **are required**.

- $15,000 to $55,000: Three (3) written bids, quotations, and/or proposals **are required**.
- For purchases greater than $55,000 a formal Request for Quotation (Tender) must be adhered to. Board approval is required once the successful bidder is chosen.
- The time frames for soliciting this information are generally between ten (10) to fifteen (15) business days depending on the complexity and value of the request.

The submission of split requisitions in an attempt to circumvent the bidding policy is not allowed.

Written bids, quotations and/or proposals must go through APH Administration.

Administration may, at their discretion, secure other competitive bids regardless of the dollar thresholds listed at any time. Furthermore, Administration may, at their discretion, conduct negotiations with more than the apparent low bidder when it is deemed to be in APH's best interest to do so.

5.2 Confidentiality of Bids/Quotations/Proposals

In accordance with fair and best business practice, all information supplied by vendors in their bid, quotation or proposal must be held in strict confidence by the employee(s) evaluating the bid, quotation or proposal and may not be revealed to any other vendor or unauthorized individual. Failure to do so may result in termination.

5.3 Late Bids/Quotations/Proposals

a) All bids, quotations and proposals are to be date and time stamped to assure that they are received prior to the deadline for submission. It is the responsibility of the vendor to ensure that their bids are received by the responsible person no later than the appointed hour of the bid opening date as specified on the request for bid.

b) **Late submissions will not be considered**.

5.4 Errors in Bids/Quotations/Proposals

a) Vendors are responsible for the accuracy of their quoted prices. In the event of an error between a unit price and its extension, the unit price will govern. Quotations may be amended or withdrawn by the bidder up to the bid opening date and time, after which, in the event of an error, bids may not be amended but may be withdrawn prior to the acceptance of the bid.

b) After an order has been issued, no bid may be withdrawn or amended unless the Administration considers the change to be in APH's best interests.

5.5 Sole Source Procurement and Justification

The Director, in consultation with the applicable Manager, shall initiate sole source purchases provided that any of the following conditions apply:

a) where there is only one known source

b) where the compatibility of a purchase with existing equipment, facilities, or services is a paramount consideration

c) when competition is precluded because of the existence of patent rights, copyrights, trade secrets

d) where the procurement is for electric power or energy, gas, water or other utility services

e) where it would not be practical to allow a contractor other than the utility company itself to work upon the system

f) where a good is purchased for testing or trial use

g) where it is most cost effective or beneficial to APH

h) when the procurement is for technical services in connection with the assembly, installation or servicing of equipment of a highly technical or specialized nature

i) when the procurement is for parts or components to be used as replacements in support of equipment specifically designed by the manufacturer

j) the extension or reinstatement of an existing contract would be more cost-effective or beneficial to APH

6.0 VENDOR SELECTION

As APH strives to provide the best quality of program offerings and services, the lowest price received in the bid and RFQ process may not always be accepted. In such cases, justification for choosing an alternative bid or RFQ must accompany the package of bids or RFQs. In some cases, the required number of formal bids may not be possible (i.e. potential vendors decide not to bid). In such cases, evidence of solicitation of the required number of bids as outlined in this policy must be maintained. Administration reserves the right to exclude an RFQ/RFP if there is evidence to support the vendor is not in good standing with APH.

Purchasing decisions are based on price, quality, availability and suitability.

6.1 Vendor of Record

The use of a Vendor of Record (VOR) from the Ministry of Government Services website precludes the need to go to a public bid solicitation process since this process was already done by that Ministry. Examination of the pricing should be done against local/current suppliers of the same product or service to ensure that the Health Unit is obtaining the best price, quality, availability and suitability before engaging a VOR.

6.2 Co-operative Purchasing

The Health Unit shall participate with other government agencies or public authorities in Cooperative Purchasing where it is in the best interests of the Health Unit to do so.

The CFO, in conjunction with the MOH/CEO, has the authority to participate in arrangements with on a co-operative or joint basis for purchases of goods and/or services where there are economic advantages to do so, purchases comply with the principles of this Policy, and the annual expenditures are expected to be less than $55,000.

If the annual expenditure is expected to be greater than $55,000, Board of Health approval for the purchase will be required.

The policies of the government agencies or public authorities calling the cooperative tender are to be the accepted policy for that particular tender.

7.0 SPECIAL PROCUREMENT POLICIES

7.1 CONTRACTS/LEASES

Signing authority to enter into a contract/lease will follow the limits as set out in section 4.1 of this policy. In addition;

The Board must approve contracts where:

a) Irregularities preclude the award of a contract to the lowest bidder in the Tending and Request for Quotation process **and** the 'total acquisition cost' exceeds $55,000,

b) A bid solicitation has been restricted to a single source supply and the 'total acquisition cost' of such goods or services exceeds $55,000

c) The contract/lease is for multiple years and exceeds $55,000 per year

7.2 Consulting Services

Consulting Services are provided by an individual or company with expertise or strategic advice. The individual is working under a contract relationship rather than an employee relationship.

The acquisition of consulting services **must** be sought through a competitive process when the total expenditure for the service is greater than $10,000. The limits for the competitive process for consulting services are as follows:

- $0 - $10,000: negotiation with the prospective consultant to acquire consulting services
- $10,000 – $55,000: Three (3) written bids, quotations, and/or proposals **are required**.
- For purchases greater than $55,000 a formal Request for Proposal must be adhered.

All contractual agreements with consultants up to $55,000 must be approved by the MOH/CEO **and** CFO. Consulting Contracts for more than $55,000 requires the approval of the MOH/CEO **and** the Board of Health.

Consulting Services do not include services in which the physical component of an activity would be prevailing. For example, services for the operation and maintenance of a facility or plant;

7.3 Approvals for Construction and Alterations to Physical Space

a) All requisitions for construction, renovation, or alteration to physical space at Algoma Public Health under $55,000 require the review and prior written approval of the CFO **and** the Medical Officer of Health/CEO**.** All requisitions for construction, renovation, or alteration to physical space at Algoma Public Health over $55,000, require authorization of the Board of Health.

b) Detailed specifications, drawings, and/or blue prints, if appropriate, should accompany the Purchase Requisition. Requisitions submitted to Accounts Payable without the prior written approval will not be processed.

7.4 Equipment and Equipment Screening

a) Algoma Public Health has established a policy governing the acquisition, control, and disposition of Algoma Public Health equipment.

b) It is the policy of Algoma Public Health to ensure that every effort is made to avoid the purchase of unnecessary or duplicate equipment.

c) The purchasing authorization levels by role defined in the policy will govern equipment purchases.

8.0 PROHIBITIONS

8.1 Conflicts of Interest

a) Employee shall not place themselves into positions where they could be tempted to prefer their own interests or the interest of another, over the interest of the public that they are employed to serve. Whenever employees, during the discharge of their duties, become exposed to or involved in actual/or potential Conflicts of Interest, they must disclose the situation to their Manager/Director/MOH/CEO/Board of Health (as may be appropriate) and shall abide by the advice given.

8.2 Gifts, Gratuities, and Kickbacks

Algoma Public Health policy prohibits all employees from accepting gifts, gratuities or kickbacks of any value from vendors or service providers. Items of a very minimal value which

are of an advertising nature only, and available to other customers may be accepted (e.g. pens, hats, coffee cups, etc.). Any questions an APH employee may have as the appropriateness of the value of the item must be communicated to the employee's Manager/ Director/ MOH/CEO/Board of Health (as may be appropriate).

8.3 Personal Purchases

The purchase of any goods or services for personal use by or on behalf of any APH employee, for purposes other than the bona fide requirements of APH is strictly prohibited.

8.4 Division of Contracts

The division of a contract to avoid the requirements of this policy is prohibited.

8.5 Local Preference

No local preference shall be shown or taken into account in acquiring goods and services on behalf of APH. Consideration will be given to local/regional products and services which are considered equal in quality and price and have a level of performance acceptable to the Board of Health.

8.6 Prohibited Classes of Vendor

APH shall not acquire goods and/or services from any of the following:

a) Board of Health Members;

b) Employees of the Health Unit at or above the level of Supervisor;

c) Businesses in which the individuals in (a) or (b) above hold a controlling interest.

9.0 General Information

9.1 The Accessibility for Ontarians with Disabilities Act (AODA)

In deciding to purchase goods or services through the procurement process for the use of itself, its employees or the public, APH, to the extent possible, shall have regard to the accessibility for persons with disabilities to the goods or services.

9.2 Environmental Considerations

Consideration will be given to recycled and other environmentally responsible products which are considered equal in quality and price and have a level of performance acceptable to the Board of Health.

The Board of Health will endeavor, whenever possible, to purchase and utilize products that support environmentally sound practices from the manufacturing process through to final

delivery and disposal. Priority consideration will be given to products that espouse environmentally friendly sound practices.

9.3 Disposal of Surplus Goods

The Disposal of surplus and obsolete equipment shall be evaluated on a case by case basis.

The CFO in conjunction with the MOH/CEO shall have the authority to sell, exchange, or otherwise dispose of Goods declared as surplus needs of APH, and where it is cost effective and in the best interest of APH to do so. Items or groups of items may:

a) Be offered for sale to other Health Units, affiliates or other government agencies or public authorities; or
b) Be sold by external advertisement, formal request, auction or public sale (where it is deemed appropriate, a reserve price may be established); or
c) Be donated to a not-for-profit agency; or
d) Be recycled; or
e) In the event all efforts to dispose of Goods by sale are unsuccessful, these items may be scrapped or destroyed if recycling is unavailable

No disposition of such Good(s) shall be made to employees, elected officials, or their family members.

9.4 Purchase of Surplus Goods

As appropriate, the Manager of Accounting and Budgeting and/or the CFO shall record the disposition of Tangible Capital Assets.

9.5 Consulting Services Requirements

All consultants working on behalf of APH who will have direct access to APH financial records, bank accounts, or employee records as per the terms of their contract are required to provide a current police information check (PIC). This includes but is not limited to any consultant or licensed professional who will serve in the capacity of APH's Chief Financial Officer/Business Administrator, Manager of Accounting and Budgeting, Director of Human Resources, Manager of Human Resources, Supervisor of Payroll Administrator, or Information Technology support.

All consultants or service providers working on behalf of APH who will interact with children, youth or vulnerable persons as per the terms of their contract are required to provide a current police vulnerable sector check (PV5C). If the service provider is required to provide a criminal reference check to their Regulatory College as part of the annual licensure process, an attestation from the service provider along with the copy of their current licensure will be accepted.

Provision of the required criminal record search is required prior to commencement of any consulting work with APH. All offers for consulting services are conditional on receipt of satisfactory criminal reference checks.

All consultants are required to provide the names and contact information of at least two (2) references for which similar services were recently provided. This includes, but is not limited to any consultant or licensed service provider who is a nurse.

Positive references are required prior to commencement of any consulting work with APH. All offers for consulting services are conditional on receipt of satisfactory reference checks.

10.0 Review and Evaluation

The effectiveness of this policy will be evaluated and reviewed every two (2) years by the Board of Health, or more frequently as required. This review will include both legislative requirements and best practices.

11.0 PROCUREMENT PROCEDURES

The purchasing cycle includes the following steps:

a) Authority to purchase goods and services through budget approval and delegation of duties by the Board to the MOH/CEO

b) The MOH/CEO delegates authority to purchase goods and services to other employees based on roles defined within the agency

c) Quotation procedure and vendor selection

d) A purchase requisition/purchase order approval or executed service contract

e) Receipt of goods/services (Bill of Lading) and invoice

f) Payment made to vendor

All goods and services necessary to support APH programs and services must be authorized and follow the appropriate purchasing procedures. Note: any purchase that is noted as an exception in this policy does not require a purchase order (i.e. utility expense).

11.1 Purchase Requisition/Purchase Order.

For the purposes of this Policy, an APH Purchase Order will serve as the request to purchase a good or service (purchase requisition) by staff. Requisitions may be initiated at any level, but only the above named positions can bind a Purchase Order through the authorization levels as defined by the dollar amounts noted above. A Purchase Order serves as the legal offer to buy products or services from a vendor. Once a vendor accepts a Purchase Order from APH, a contract now exists to purchase the goods or services.

a) The Purchase Requisition/Purchase Order is used to request a vendor or administration to acquire materials, parts, supplies, equipment, or services.

b) The Purchase Requisition/Purchase Order is a three (3) part form with a pre-printed number. The white copy is to be forwarded to the vendor via mail or electronic means, the yellow copy is to be forwarded to APH Accounts Payable. APH Accounts Payable will use the Purchase Order number to match with the vendor invoice in addition to the receipt documentation such as a packing slip in order to execute payment. Once payment is completed, documentation is filed by APH Accounts Payable department. The pink copy along with copies of all documentation should be retained by the requisitioning department for future inquiry,

c) The requisitioning program is responsible for providing the complete account number, and appropriate signature(s) as indicated by Signing Authority established in this policy.

d) All quotations and correspondence from the vendor and supporting documentation (e.g., written bids, letters of justification and/or Sole Source Justification) must be attached by the requisitioning department to the Purchase Order when submitted to APH Accounts Payable.

e) Administration reserves the right to seek additional bids from other qualified sources as it deems appropriate.

f) Departments should anticipate their requirements to allow adequate lead time for order processing and product delivery. Item descriptions should be complete and accurate to allow buyers to bid the requirements expeditiously.

g) Petty Cash purchases are not required to provide a Purchase Order.

11.2 Change Order – Cancellation or Modification of a Purchase Order

Only Administration is authorized to change a Purchase Order. Changes in a previously issued purchase order can be made only by a new Purchase Order marked “Change Order”. The changes may refer to price, quantities ordered, terms and conditions, delivery point, etc. Please contact Administration for assistance with Change Orders.

11.3 Blanket Purchase Orders

A Blanket Purchase Order is a is any contract for the purchase of goods or services which will be required frequently or repetitively but where the exact quantity of goods or services required may not be precisely known or the time period during which the goods or serves are to be delivered may not be precisely determined. A Blanket Purchase Order is often negotiated to take advantage of predetermined pricing. It is normally used when there is a recurring need for expendable goods (i.e. birth control pills, vaccines, etc.). Blanket Purchase Orders are often used when APH buys large quantities of a particular good and has obtained special discounts as a result of bulk purchasing.

Request to enter into a blanket Purchase Order must be approved by the CFO or Manager of Accounting and Budgeting. A Blanket Purchase Order generally should not exceed 1

year. The associated Program Manager and their reporting Director must approve the Blanket Purchase Order.

11.4 Cheque Requisition

For miscellaneous or non-competitive purchases, payment for goods and services may be initiated by completing a Cheque Requisition. A Cheque Requisition is completed by the department making the request and is authorized and signed by the employee's Manager. Cheque Requisitions require the approval of the appropriate signing authority.

11.5 Petty Cash

Petty cash **may be used for immediate needs such as** stationery, or miscellaneous program material supply purchases of $200 and under. Petty cash **may not be used** for travel expenses, business meetings, personal loans, consultant fees or any other type of personal service payments, salary advances or the cashing of personal cheques.

Disbursements from the Petty Cash Fund must be properly documented with original itemized receipts approved by the employees Manager or a Director and include the appropriate cost center as to where the charges should be expensed to. Receipts should include a description of the business purpose of the transaction, goods, or services purchased and the date. (See petty cash policy).

11.6 Use of Corporate Credit Card

The Board of Health has authorized the use of corporate credit cards to carry out approved business transactions. The MOH/CEO or designate will approve employees who require a corporate credit card to execute needs of the Health Unit. Purchases made via a corporate credit card must follow the guidelines as set out in this policy and the Health Unit's Corporate Credit Card Policy. Specifically, the delegation of signing authority noted above will govern individual credit card purchases. In situations where a credit card has been issued to an employee who has not been designated signing authority, an approved purchase order signed by the appropriate signing authority is required for each purchase. In situations where an employee has been issued a corporate credit card and where the specific expenditure exceeds their signing authority, an approved purchase order signed by the appropriate signing authority is required for each purchase.

11.7 Custody of Documents

The CFO, or designate shall be responsible for the safeguarding of original purchasing and contract documentation for the contracting of goods, services or construction and will retain documentation in accordance to the records retention policy.

Glossary of Roles Noted within Algoma Public Health Procurement Policy

Administration – consist of the Medical Officer of Health/CEO, the Executive Team, the Manager of Accounting & Budgeting, the Manager of Operations, the Manager of Communications, and the Supervisor of Payroll.

Board of Health for the District of Algoma Health Unit - is the governing body of Algoma Public Health and is established by the provincial public health legislation, the Health Protection and Promotion Act, RSO 1990, (HPPA) and regulations.

Chair of the Board – is the highest officer of Algoma Public Health. The individual holding this position is elected by members of the Board of Health for the District of Algoma Health Unit.

Consultant – is an individual or company that provides expertise or strategic advice to Algoma Public Health. The individual is working under a contract relationship rather than an employee relationship and is paid through submission of invoices.

Executive Team – consists of the Medical Officer of Health/CEO, the Associate Medical Officer of Health, the Chief Financial Officer, Director of Human Resources, Program Directors.

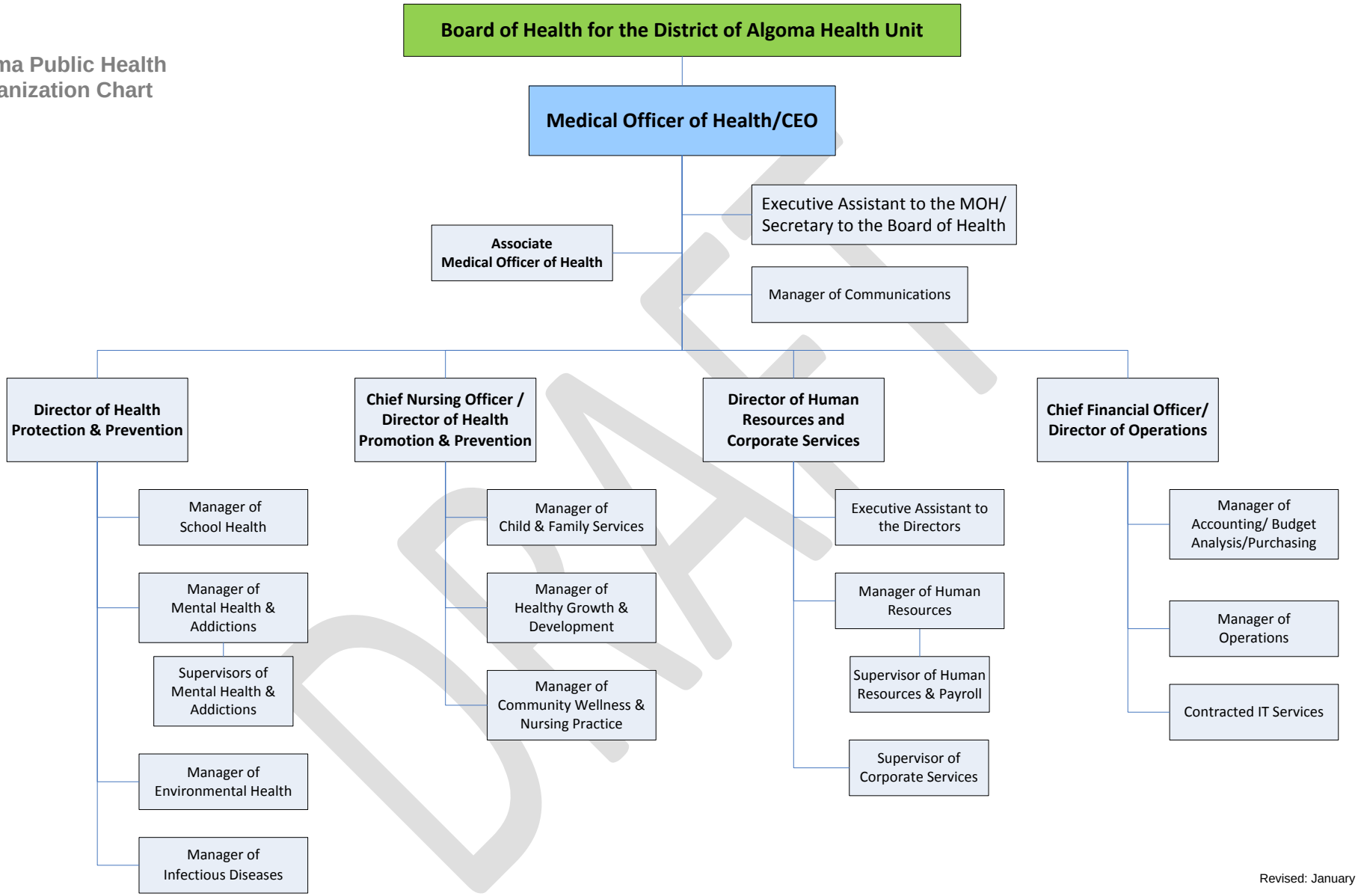
Leadership Team – consists of the Executive Team plus Program Managers, the Manager of Accounting and Budgeting and the Manager of Operations, the Manager of Communications, Supervisor of Payroll and Supervisor of CADAP/CMH and any other Program or Administrative Supervisor or Manager.

Staff/Employee – a person who is hired to provide services to a company on a regular basis in exchange for compensation and who does not provide these services as part of an independent business.

Vendor – the party in the supply chain that makes the goods or services available or sells something to Algoma Public Health.

Original: February 13, 1996
Revised: March 2006
Revised: February 24, 2009
Revised: March 18, 2015
Revised: May 28, 2015
Revised: October 28, 2015
Revised: February 28, 2017

Algoma Public Health
Organization Chart



Revised: January 31, 2018

ALGOMA PUBLIC HEALTH
GOVERNANCE STANDING COMMITTEE MEETING
OCTOBER 30, 2017 @ 5:30PM
PRINCE MEETINGROOM, 3RD FLOOR, SSM
MINUTES

COMMITTEE MEMBERS PRESENT: Ian Frazier Deborah Graystone Lee Mason Heather O'Brien

APH STAFF PRESENT:		
	Dr. Marlene Spruyt	Medical Officer of Health
	Dr. Jennifer Loo	Associate Medical Officer of Health
	Antoniette Tomie	Director of HR and Corporate Services
	Christina Luukkonen	Recording Secretary

1) CALL TO ORDER:
Ms. Graystone called the meeting to order at 5:02 pm.

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

3) ADOPTION OF AGENDA ITEMS
Approved with the addition of 6e) Amendments to the Annual Activity Plan.

GC2017-18 Moved: I. Frazier
Seconded: L. Mason

THAT the agenda items for the Governance Standing Committee dated October 30, 2017 be adopted as amended.
CARRIED.

4) ADOPTION OF MINUTES

GC2017-19 Moved: H. O'Brien
Seconded: L. Mason

THAT the minutes for the Governance Standing Committee dated September 13, 2017 be adopted as circulated.
CARRIED.

5) BUSINESS ARISING FROM MINUTES

a. 02-05-015 – Conflict of Interest Policy
Committee discussed changes.

GC2017-20 Moved: H. O'Brien
Seconded: I. Frazier

THAT the Governance Standing Committee recommends the changes to policy 02-05-015 – Conflict of Interest with amendments and puts for to the Board of Health for approval.
CARRIED.

b. 02-05-030 – Code of Conduct Policy
Committee discussed proposed changes. Ms. Graystone will make recommended changes to policy and bring back to the next committee meeting on February 14, 2018.

c. Performance Evaluation for MOH CEO
Committee members discussed the new policy and evaluation tool presented. A 6 month evaluation to be completed from the date of hire followed by a larger more in depth evaluation 12 months from date of hire. Subsequent evaluations to be completed every 12 months or as needed. Mr. Mason and Mrs. Tomie will make the suggested changes to the policy and evaluation tool and bring back to the February 14, 2018 meeting.

d. New Board Member Orientation Checklist
Mr. Frazier to bring forward an orientation plan for new board members to the February 14, 2018 meeting.

6) NEW BUSINESS/GENERAL BUSINESS

a. 02-05-010 – Board Minutes – Posting - Circulation
b. 02-05-070 – In-Committee Material Posting – Circulating - Retention
c. 02-05-060 – Meetings and Access to Information
Three policies coming forward for review. Dr. Spruyt suggested combining the three policies into one as they all pertain to access of Board material. Dr. Spruyt and Mrs. Luukkonen will work on combining and bring forth to the February 14, 2018 meeting.
d. Evaluations
Discussed content and purpose of the evaluations. Changes were suggested to the policy. Policy and evaluations to be brought back to the February 14, 2018 meeting for further discussion.
e. Amendments to Annual Activity Plan
Mr. Frazier and Mr. Mason brought forth an amendment to the Annual Activity Plan. They would like the draft financial statements provided to the Finance and Audit Committee electronically on the off months that the committee does not meet keeping with the same time lines of two weeks prior to the Board meeting and monthly during summer months and December when the Board does not meeting.

Committee agreed and the amendment to be made.

7) ADDENDUM

8) IN COMMITTEE - Deferred

9) OPEN MEETING – N/A

10) NEXT MEETING: Wednesday, February 14, 2017 @ 5:30 pm.

11) THAT THE MEETING ADJOURN:

GC2017-21 Moved: L. Mason
Seconded:
THAT the Governance Standing Committee meeting adjourns at 7:31 pm.
CARRIED.

February 15, 2018

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

Dear Minister Hoskins:

Re: Alcohol Retail Sales

On November 24, 2017 at a regular meeting of the Board for the Grey Bruce Health Unit, the Board considered the attached correspondence items from Northwestern Health Unit, Algoma Public Health and Thunder Bay District Health Unit regarding alcohol retail sales. The following motion was passed:

Moved by: Mitch Twolan Seconded by: Mike Smith

"THAT the Board of Health endorse correspondence items 8.5, 8.6 and 8.11 from Northwestern Health Unit, Algoma Public Health and Thunder Bay District Health Unit regarding provincial action to address the potential health harms from the modernization of alcohol retail sales."

Carried

Sincerely,

Hazel Lynn, MD, FCFP, MHSc
Acting Medical Officer of Health
Grey Bruce Health Unit

Cc: All Ontario Boards of Health

Encl.

Northwestern Health Unit
www.nwhu.on.ca

210 First Street North
Kenora, ON P9N 2K4

October 31, 2017

DELIVERED VIA E-MAIL

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

Attention: The Honourable Eric Hoskins

Dear Hon. Hoskins:

Re: Urgent provincial action needed to address the potential health harms from the modernization of alcohol retail sales in Ontario

On behalf of Northwestern Health Unit Board of Health, I am writing to call on the Government of Ontario to fulfil its commitment (as announced in December 2015) to develop a comprehensive, province wide strategy to minimize harm and support the safe consumption of alcohol, in light of the expansion of alcohol sales in Ontario. Alcohol remains the most harmful drug in society, impacting tens of thousands of Ontarians every year.

Alcohol is no ordinary commodity; alcohol causes injury, addiction, disease, and social disruption and is one of the leading risk factors for disability and death in Canada. Alcohol has significant costs to the individual and society from both a health and financial perspective. These costs include health care, law enforcement, prevention, lost productivity and premature mortality. As such, a comprehensive, evidence-based approach is critical to limit these harms.

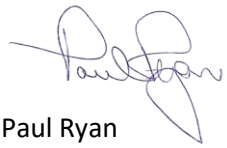
The Ontario Government has committed to social responsibility as it increases the availability of alcohol; however, actions by government since 2014 indicate that economic interests are superseding the health and well-being of Ontarians. Such developments include the increased availability of alcohol at up to 450 grocery stores, wine and cider in farmers' markets, online sales of alcohol through the LCBO and the expansion of bars, restaurants and retail outlets permitted at alcohol manufacturing sites.

It is well established that increased alcohol availability leads to increased consumption and alcohol-related harms. A comprehensive, provincially led alcohol strategy can help mitigate the harms of alcohol. Effective policy interventions include socially responsible alcohol pricing, limits on the number of retail outlets and hours of sale, and restrictions on alcohol marketing. Strong evidence shows that these three policy levers are among the most effective interventions especially when paired with

targeted interventions such as drinking and driving countermeasures, enforcement of the minimum legal drinking age as well as screening, brief intervention and referral activities.

In order to address the health and social harms of alcohol, and the impact of increased access, a comprehensive strategy is needed We are calling on the government to both fulfil its promise and prioritize the health and wellbeing of Ontarians by enacting a comprehensive, evidence-based alcohol strategy as soon as possible.

Sincerely,



Paul Ryan
Board Chair

C: The Honourable Charles Sousa
Premier Kathleen Wynne
Office of the Minister

Algoma
PUBLIC HEALTH
Santé publique Algoma

www.algomapublichealth.com

October 30, 2017

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

Dear Minister Hoskins:

Re: Urgent provincial action needed to address the potential health harms from the modernization of alcohol retail sales in Ontario

On behalf of the Board of Health of Algoma, I am writing to call on the Government of Ontario to fulfil its commitment (as announced in December 2015) to develop a comprehensive, province wide strategy to minimize harm and support the safe consumption of alcohol, in light of the expansion of alcohol sales in Ontario. Alcohol remains the most harmful drug in society, impacting tens of thousands of Ontarians every year.

Alcohol is no ordinary commodity; alcohol causes injury, addiction, disease, and social disruption and is one of the leading risk factors for disability and death in Canada. Alcohol has significant costs to the individual and society from both a health and financial perspective. These costs include health care, law enforcement, prevention, lost productivity and premature mortality. As such, a comprehensive, evidence-based approach is critical to limit these harms.

The Ontario Government has committed to social responsibility as it increases the availability of alcohol; however, actions by the government since 2014 indicate that economic interests are superseding the health and well-being of Ontarians. Such developments include the increased availability of alcohol at up to 450 grocery stores, wine and cider in farmers' markets, online sales of alcohol through the LCBO and the expansion of bars, restaurants and retail outlets permitted at alcohol manufacturing sites.

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

Elliot Lake
ELNOS Building
302-31 Nova Scotia Walk
Elliot Lake, ON P5A 1Y9
Tel: 705-848-2314
TF: 1 (877) 748-2314
Fax: 705-848-1911

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

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

It is well established that increased alcohol availability leads to increased consumption and alcohol-related harms. A comprehensive, provincially led alcohol strategy can help mitigate the harms of alcohol. Effective policy interventions include socially responsible alcohol pricing, limits on the number of retail outlets and hours of sale, and restrictions on alcohol marketing. Strong evidence shows that these three policy levers are among the most effective interventions especially when paired with targeted interventions such as drinking and driving countermeasures, enforcement of the minimum legal drinking age as well as screening, brief intervention and referral activities.

In order to address the health and social harms of alcohol, and the impact of increased access, a comprehensive strategy is needed. We are calling on the government to both fulfil its promise and prioritize the health and wellbeing of Ontarians by enacting a comprehensive, evidence-based alcohol strategy as soon as possible.

Sincerely,

Lee Mason

Mr. Lee Mason
Board Chair

cc: The Honourable Charles Sousa
Premier Kathleen Wynne
Boards of Health

Thunder Bay District Health Unit

Board of Health Resolution

MOVED BY: C. Bryson **SECONDED BY:** J. Daiter

SOURCE: TBDHU Board of Health **DATE:** October 18, 2017 **Page 1 of 1**

RESOLUTION NO.: 85-2017

ITEM NO.: 8.1

X	CARRIED		AMENDED		LOST		DEFERRED/ REFERRED

J. Virdiramo
CHAIR

RE: Provincial Alcohol Strategy Endorsement

THAT with respect to Report No. 49 – 2017 (Injury and Substance Misuse Prevention) we recommend that:

- The Thunder Bay District Board of Health supports the Ontario Public Health Association Advocacy package; and
- A letter be sent requesting that the Government of Ontario fulfils its commitment to develop a provincial strategy to minimize harm and support the safe consumption of alcohol, copied to Ontario Public Health Units.

FOR OFFICE USE ONLY --- RESOLUTION DISTRIBUTION

	TO:	*INSTRUCTIONS:*	*TO:*	*INSTRUCTIONS:*
1.	L. Roberts		S. Oleksuk	
2	J. Piper			
3				
4				
5				
6				File Copy

Thunder Bay District
Health Unit

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

GERALDTON
P.O. Box 1360
510 Hogarth Avenue, W.
Geraldton, ON P0T 1M0
Tel: (807) 854-0454
Fax: (807) 854-1871

MANITOUWADGE
P.O. Box 1194
Manitouwadge Health
Care Centre
1 Health Care Crescent
Manitouwadge, ON P0T 2C0
Tel: (807) 826-4061
Fax: (807) 826-4993

MARATHON
P.O. Box 384
Marathon Library Building
Lower Level,
24 Peninsula Road
Marathon, ON P0T 2E0
Tel: (807) 229-1820
Fax: (807) 229-3356

NIPIGON
P.O. Box 15
Nipigon District
Memorial Hospital
125 Hogan Road
Nipigon, ON P0T 2J0
Tel: (807) 887-3031
Fax: (807) 887-3489

TERRACE BAY
P.O. Box 1030
McCausland Hospital
20B Cartier Road
Terrace Bay, ON P0T 2W0
Tel. (807) 825-7770
Fax: (807) 825-7774

TBDHU.COM

October 18, 2017

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

Dear Minister Hoskins:

Re: Urgent provincial action needed to address the potential health harms from the modernization of alcohol retail sales in Ontario

On behalf of the Thunder Bay District Board of Health, I am writing to call on the Government of Ontario to fulfil its commitment (as outlined in its 2015 Budget) to develop a comprehensive, province wide strategy to develop initiatives to support safe consumption of alcohol, in light of the expansion of alcohol sales in Ontario. Alcohol remains the most harmful drug in society, impacting tens of thousands of Ontarians every year.

Alcohol is no ordinary commodity; alcohol causes addiction, disease, and social disruption and is one of the leading risk factors for disability and death in Canada. Alcohol has significant costs to the individual and society from both a health and financial perspective. These costs include health care, law enforcement, prevention, lost productivity and premature mortality. As such, a comprehensive, evidence-based approach is critical to limit these harms.

The Ontario Government has committed to social responsibility as it increases the availability of alcohol; however, actions by government since 2014 indicate that economic interests are superseding the health and well-being of Ontarians. Such developments include the increased availability of alcohol at 450 grocery stores, wine and cider in farmers markets, online sales of alcohol through LCBO and the expansion of bars and restaurants permitted at alcohol manufacturing sites.

It is well established that increased alcohol availability leads to increased alcohol-related harms. A provincially led alcohol policy can help mitigate the harms of alcohol. Effective interventions to reduce alcohol-related problems include socially responsible pricing of alcohol, limits on the number of retail outlets and hours of sale and alcohol marketing controls. These three policy levers have strong evidence to show that they are among the most effective interventions especially when paired with targeted interventions such as drinking and driving counter measures, enforcement of minimum drinking age as well as screening and brief intervention and referral activities.

.../2

In order to address the health and social harms of alcohol a strategy is necessary, particularly in light of the expanded sales in grocery stores, farmers markets and online. We are calling on the government to both fulfil its promise and prioritize the health and wellbeing of residents by enacting a comprehensive, evidence-based alcohol strategy as soon as possible.

Thank you for your consideration of this matter.

Sincerely,

Joe Virdiramo, Chair
Thunder Bay District Board of Health

cc: The Honourable Charles Sousa
Premier Kathleen Wynne
Ontario Boards of Health

HALIBURTON, KAWARTHA, PINE RIDGE DISTRICT HEALTH UNIT

www.hkpr.on.ca • info@hkpr.on.ca

1-866-888-4577

March 13, 2018

Honourable Helena Jaczek
Minister of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, Ontario M7A 2C4

Dear Minister Jaczek:

Re: 2018 Annual Service Plan including the 2018 Budget for the Haliburton, Kawartha, Pine Ridge District Health Unit

At its meeting on February 15, 2018, the Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit approved its 2018 Annual Service Plan (Plan) including the 2018 Budget. As the Board discussed the Plan and Budget, it expressed its concerns that the Ministry of Health and Long-Term Care (MOHLTC) had frozen base funding at 2014 levels for our Health Unit and others. Of course, the Board recognizes that there have been additions to base funding for targeted purposes such as the recent Harm Reduction Program Enhancement funding. Boards of health continue to face significant financial pressures as costs increase with no corresponding increase in base funding going into this fourth-year post-budget freeze. Locally, our obligated municipalities have increased their share of the Board's base funding every year to the point that now the ratio of cost-shared base funding is 29% municipal to the MOHLTC's 71%. We understand that the majority of Ontario boards of health are in a similar position.

As you know, the past couple of years have been a period of significant transformation for Ontario boards of health with the release of the new Ontario Public Health Standards (OPHS), amended and new protocols and guidelines to support the new OPHS and amendments to the *Health Protection and Promotion Act, 1990* and many of its Regulations. The Board is most appreciative of the Harm Reduction Program Enhancement funding, and other minor adjustments to base funding. However, the Board is concerned about the MOHLTC's increasing expectations regarding the new/amended OPHS, protocols and guidelines including those pertaining to Infection Prevention and Control Lapse investigations, engagement with the Local Health Integration Networks, the new School Health Program Standard, the Healthy Environments Program Standard requirement for health impact assessment related to climate change, and follow-up of hepatitis C cases to name a few, as well as the role of public health regarding opioids and the new cannabis legislation. Doing more with less is causing strain on staff and the Board is concerned about the psychological and physical well-being of Health Unit employees in light of ever-increasing requirements and our ability to deliver programs and services.

The Board has implemented many initiatives over the past four years to address the provincial funding shortfall including closing branch offices and renegotiating leases as well as utilizing technological solutions where feasible to address telephone and fax as well as organizational meetings. The Board recognizes its important role in community-based health promotion, disease prevention and health protection over a large geographic area with a low population density. The Board values its relationships with the broader health sector as well as its many community partners and stakeholders including local municipalities, school boards, children's aid societies, law enforcement, non-governmental

.../2

agencies and community coalitions and wishes to build on these relationships to implement the new OPHS. The Board is concerned that if the provincial share of the base budget remains frozen, decisions will need to be made regarding delivery of essential programs and services and the remaining programs may erode making them harder to re-build when not maintained at optimal levels.

The Board has again approved a 2% municipal increase for the Health Unit this year and has requested a 2% increase in its base funding from the MOHLTC in addition to some one-time requests to facilitate addressing new program requirements. Municipalities are also facing increasing cost pressures and may be challenged to continue to offset provincial funding with enhanced municipal support in the future. The Board respectfully requests that the MOHLTC approve its 2018 Annual Service Plan including the 2018 Budget. Lastly, with this request to approve the proposed budget, the Board would greatly appreciate earlier budget approval than the historic September to November timeline so that the Health Unit can effectively plan and implement one-time funding approvals.

Sincerely

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

Mark Lovshin
Chair, Board of Health

ML/ALN/MCM:ed

Copy: Laurie Scott, MPP, Haliburton-Kawartha Lakes-Brock
Lou Rinaldi, MPP, Northumberland-Quinte West
Dr. David Williams, Chief Medical Officer of Health
Roselle Martino, Assistant Deputy Minister, Population and Public Health Division, MOHLTC
City of Kawartha Lakes
Haliburton County
Northumberland County
Association of Municipalities of Ontario
Association of Local Public Health Agencies
Ontario Boards of Health
Eastern Ontario Wardens' Caucus

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www.algomapublichealth.com

February 15, 2018

Mayor Christian Provenzano
City of Sault Ste. Marie
99 Foster Drive
Civic Centre – Level 4
Sault Ste. Marie, ON P6A 5X6

Dear Mayor Provenzano:

Thank you for coming to our recent Board of Health Education session and sharing the City of Sault Ste. Marie vision for community development. Many of the goals presented align with those of population health and improving health equity. At the January 24, 2018 Board meeting for Algoma Public Health I was directed to communicate to you our support for this initiative.

As you are no doubt aware the Algoma Leadership Table has agreed to focus on topics within the Social Equity domain of the plan and I will continue to represent APH at that table. As well Algoma Public Health will continue to promote issues of health equity and poverty reduction throughout the district as part of our ongoing work. Currently we are utilizing the Bridges Out of Poverty framework to increase community awareness of the difficulties that individuals living in poverty face particularly as it relates to their health.

One of our BOH members Deborah Graystone, who has worked as a NP for many years in the city has volunteered to be a member of the Health Sector table. She can be reached at dgraystone@algomapublichealth.com.

I look forward to continuing to partner in all aspects of community development as it is well documented that vibrant and engaged communities provide a nourishing environment for health throughout the lives of its residents.

Sincerely,

Marlene Spruyt, BSc., MD, CCFP, FCFP, MSc-PH
Medical Officer of Health/CEO
Algoma Public Health

/tc

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

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Elliot Lake, ON P5A 1Y9
Tel: 705-848-2314
TF: 1 (877) 748-2314
Fax: 705-848-1911

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

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

TOWN OF
VILLE DE BLIND RIVER

OFFICE OF THE CLERK ADMINISTRATOR

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

BUREAU DU COMMIS ADMINISTRATEUR

January 18, 2018

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

Please find attached Council Resolution #18-014 regarding the Expert Panel on Public Health: "Public Health within an Integrated Health System.

I trust this is satisfactory to your needs, please do not hesitate to contact the undersigned if you have any questions or concerns.

Yours truly,

Kathryn Scott

Kathryn Scott
Clerk Administrator

KS/pw

Encl.

cc: AMO

Tel./Tél. 705-356-2251

Fax/Télécopieur 705-356-7343

RESOLUTION NO. 18-014:

MOVED BY: S. WELLS
SECONDED BY: P. SUMMERS

"**WHEREAS,** the Town of Blind River received the report of the Minister's Expert Panel on Public Health: "Public Health within an Integrated Health System"; and
WHEREAS, the Council for the Town of Blind River has significant concerns regarding the recommendations of the Expert Panel to integrate a population health approach into local planning and service delivery; and
WHEREAS, there is an apparent lack of empirical evidence base upon which the recommendations are founded; and
WHEREAS, the current mandate of public health to prevent disease, protect, and promote health should remain unchanged; and
WHEREAS, public health must remain distinct from acute care health services and Local Health Integration Networks (LHINs) in terms of role, funding, governance, and accountability in order for public health to focus on a more upstream approach, the causes of poor health or the social determinants of health; and
WHEREAS, the important linkages with local communities for programming, understanding local needs, and leveraging these partnerships will be undermined; and
WHEREAS, regionalization of public health units with centralized decision-making will have significant negative consequences for local public health and municipalities:

- Less municipal representation (400 Board of Health members reduced to approximately 180) and loss of local voice in governing and directing public health programs and services to understand and meet the needs of our communities;
- Substantial delays in responding to local program and service needs especially during emergencies;
- Adding another layer of bureaucracy resulting in increased costs and inefficiencies;
- Governance structure will not be flexible enough to meet/adjust/respond to local needs and negatively impact vulnerable priority populations;
- Potential loss of important local services fundamental to day-to-day public health unit operations and efficiencies (i.e., corporate services, finance, planning and evaluation, communications, information technology, etc.);
- Key positions (chair, vice-chair, finance, etc.) on regional boards of health should not be appointed Orders in Council to avoid political influence/interference; and

WHEREAS, the current cost-shared provincial/municipal funding formula (75%-25%) will not support the implementation of the proposed recommendations; and
WHEREAS, LHIN boundaries should be reconfigured to align with municipal, local public health, education, and social service boundaries to support their relationships with local public health and population health and health care system planning; and
WHEREAS public health can be integrated into the health care system without the significant system disruption, enormous cost, and risk of eroding community valued Public Health programs and services that would result with implementation of the Expert Panel's recommendations;
NOW THEREFORE BE IT RESOLVED, that the Town of Blind River does not support the recommendations of the Expert Panel and is in agreement with the Association of

Municipalities of Ontario (AMO) urging the Minister of Health and Long-Term Care, Dr. Eric Hoskins, not to adopt them." CARRIED

SUE JENSEN
MAYOR

CERTIFICATION BY THE CLERK:

I, Kathryn Scott, Clerk Administrator of the Corporation of the Town of Blind River, do hereby certify that the above is a true copy of Resolution No. 18-014 which was passed in Open Meeting of the 8th Day of January, 2018.

Kathryn Scott

February 1st, 2018

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

Dear Minister Hoskins:

The Middlesex-London Board of Health commends the Ministry of Health and Long-Term Care for its review and modernization of the Ontario Public Health Standards: Requirements for Programs, Services, and Accountability (2017), and looks forward to working with you and our partners at the Ministry to support their implementation.

At the November 16th, 2017 meeting of the Middlesex-London Board of Health, report No. 060-017 (attached) was reviewed and it was recommended that the Board of Health:

1. ***Write to the Minister of Health and Long-Term Care supporting maintaining local surveillance and monitoring of food costing by public health units within the modernized Standards for Public Health Programs and Services (SPHPS);***
2. ***Submit a letter to the Associate Deputy Minister of Health System Information Management and CIO of the Ministry of Health and Long-Term Care, and the Director General of the Office of Nutrition Policy and Promotion at Health Canada, advocating for the Household Food Security Survey Module to be made a core module of the Canadian Community Health Survey; and,***
3. ***Forward Report No. 060-17 re: "2017 Nutritious Food Basket Survey Results and Implications for Government Public Policy" and Appendix A to Ontario Boards of Health, the City of London, Middlesex County, and appropriate community agencies.***

Although the requirement to monitor the cost of healthy eating may remain in the Population Health Assessment and Surveillance Protocol (2016), there is no longer a requirement for Nutritious Food Basket (NFB) survey information to be systematically and consistently gathered by public health units across the province. The results of the NFB survey are used annually by local public health units to monitor food affordability by comparing the local cost of basic healthy eating (the nutritious food basket) and rental costs to various individual and family income scenarios. Routine monitoring of food affordability across Ontario helps to generate evidence-based recommendations for collective public health action to address income inadequacy and food insecurity.

…./////1

The importance of determining local food costs has also been identified in Bill 6, Ministry of Community and Social Services Amendment Act, 2016 and *Income Security: A Roadmap for Change* as one factor to include when determining social assistance rates and the cost of basic living. A consistent data collection and analysis protocol for monitoring food affordability, like the NFB, supports these priorities and should be used for gathering food costs data in different regions of the province.

The Middlesex-London Board of Health urges you to ensure the continuation of the consistent local surveillance and monitoring of food costing by public health units through an updated Nutritious Food Basket Protocol and Guidance Document. Consistent and reliable food costing data makes an impact on equity-focused public health practice and the goals of the Ministry of Health and Long-Term Care through the updated Ontario Public Health Standards, and the goals of Ontario's Poverty Reduction Strategy and income security reform. Thank you for your consideration.

Sincerely,

Jesse Helmer, Chair
Middlesex-London Board of Health

cc: Hon. Deborah Matthews, Deputy Premier and MPP London North Centre
Hon. Helena Jaczek, Minister of Community and Social Services
Hon, Peter Milczyn, Minister of Housing and Minister Responsible for the Poverty Reduction Strategy
Ms. Teresa Armstrong, MPP London—Fanshawe
Mr. Monte McNaughton, MPP Lambton-Kent-Middlesex
Ms. Peggy Sattler, MPP London West
Mr. Jeff Yurek, MPP Elgin-Middlesex-London
Ontario Boards of Health

February 1st, 2018

Ms. Lorelle Taylor
Associate Deputy Minister
Health System Information Management and CIO
Ontario Ministry of Health and Long-Term Care

Dear Ms. Taylor:

The Middlesex-London Board of Health is writing to express its support for regular and consistent monitoring of household food insecurity (HFI) because it is a serious and prevalent public health problem that requires routine surveillance.

At the November 16th, 2017 meeting of the Middlesex-London Board of Health, report No. 060-017 (attached) was reviewed and it was recommended that the Board of Health:

1. ***Write to the Minister of Health and Long-Term Care supporting maintaining local surveillance and monitoring of food costing by public health units within the modernized Standards for Public Health Programs and Services (SPHPS);***
2. ***Submit a letter to the Associate Deputy Minister of Health System Information Management and CIO of the Ministry of Health and Long-Term Care, and the Director General of the Office of Nutrition Policy and Promotion at Health Canada, advocating for the Household Food Security Survey Module to be made a core module of the Canadian Community Health Survey; and,***
3. ***Forward Report No. 060-17 re: "2017 Nutritious Food Basket Survey Results and Implications for Government Public Policy" and Appendix A to Ontario Boards of Health, the City of London, Middlesex County, and appropriate community agencies***.

The Household Food Security Survey Module (HFSSM) of Canada's Canadian Community Health Survey (CCHS) has facilitated monitoring of HFI in Canada since 2005. The Board of Health was disappointed to learn that Ontario was one of three provinces/territories that did not measure HFI in the 2015/2016 cycle of the CCHS because HFSSM is only mandatory every second cycle. This was the first time since the HFSSM was added to the CCHS in 2005 that Ontario has not measured HFI. As a result, local HFI data will not be available nor will it be possible to accurately estimate the prevalence of HFI provincially or nationally for those years. This gap in data impedes research on trends in food insecurity and the impact of public policies on the problem. It also has ramifications for the assessment of the Ontario Food Security Strategy and Ontario Basic Income Pilot.

…../////1

Regular and consistent monitoring of HFI is fundamental to population health research and evidence-based policy decision-making at all levels of government. Ontario's decision to opt out of measurement also has serious consequences for analyses of trends in food insecurity, limiting our ability to see the impact of policy changes over this period. It is critical that provinces and territories participate in all cycles of HFI measurement and by mandating that the HFSSM become a core module of the CCHS, then provinces and territories would not have the option of opting out.

Thank you for your consideration.

Sincerely,

Jesse Helmer, Chair
Middlesex-London Board of Health

cc: Dr. Michael Hillmer, Executive Director, Information Management, Data and Analytics Office, Ontario Ministry of Health and Long-Term Care
Dr. William Yan, Director of Nutritional Sciences, Food Directorate, Health Canada
Ontario Boards of Health

February 1st, 2018

Dr. Hassan Hutchison
Director General
Office of Nutrition Policy and Promotion, Health Canada
Laboratory Centre for Disease Control (LCDC) Building # 6
Tunney's Pasture
Ottawa, Ontario
K1A 0L2

Dear Dr. Hutchison:

The Middlesex-London Board of Health is writing to express its support for regular and consistent monitoring of household food insecurity (HFI) because it is a serious and prevalent public health problem that requires routine surveillance.

At the November 16th, 2017 meeting of the Middlesex-London Board of Health, report No. 060-017 (attached) was reviewed and it was recommended that the Board of Health:

1. ***Write to the Minister of Health and Long-Term Care supporting maintaining local surveillance and monitoring of food costing by public health units within the modernized Standards for Public Health Programs and Services (SPHPS);***
2. ***Submit a letter to the Associate Deputy Minister of Health System Information Management and CIO of the Ministry of Health and Long-Term Care, and the Director General of the Office of Nutrition Policy and Promotion at Health Canada, advocating for the Household Food Security Survey Module to be made a core module of the Canadian Community Health Survey; and,***
3. ***Forward Report No. 060-17 re: "2017 Nutritious Food Basket Survey Results and Implications for Government Public Policy" and Appendix A to Ontario Boards of Health, the City of London, Middlesex County, and appropriate community agencies***.

The Household Food Security Survey Module (HFSSM) of Canada's Canadian Community Health Survey (CCHS) has facilitated monitoring of HFI in Canada since 2005. The Board of Health was disappointed to learn that Ontario was one of three provinces/territories that did not measure HFI in the 2015/2016 cycle of the CCHS because HFSSM is only mandatory every second cycle. This was the first time since the HFSSM was added to the CCHS in 2005 that Ontario has not measured HFI. As a result, local HFI data will not be available nor will it be possible to accurately estimate the prevalence of HFI provincially or nationally for those years. This gap in data impedes research on trends in food insecurity and the impact of public policies on the problem. It also has ramifications for the assessment of the Ontario Food Security Strategy and Ontario Basic Income Pilot.

…../////1

Regular and consistent monitoring of HFI is fundamental to population health research and evidence-based policy decision-making at all levels of government. Ontario's decision to opt out of measurement also has serious consequences for analyses of trends in food insecurity, limiting our ability to see the impact of policy changes over this period. It is critical that provinces and territories participate in all cycles of HFI measurement and by mandating that the HFSSM become a core module of the CCHS, then provinces and territories would not have the option of opting out.

Thank you for your consideration.

Sincerely,

Jesse Helmer, Chair
Middlesex-London Board of Health

cc: Dr. William Yan, Director of Nutritional Sciences, Food Directorate, Health Canada
Ms. Lorelle Taylor, Associate Deputy Minister, Health System Information Management and CIO, Ontario Ministry of Health and Long-Term Care
Dr. Michael Hillmer, Executive Director, Information Management, Data and Analytics Office, Ontario Ministry of Health and Long-Term Care
Ontario Boards of Health

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 060-17

TO: Chair and Members of the Board of Health

FROM: Dr. Christopher Mackie, Medical Officer of Health and CEO

DATE: 2017 November 16

2017 NUTRITIOUS FOOD BASKET SURVEY RESULTS AND IMPLICATIONS FOR GOVERNMENT PUBLIC POLICY

Recommendations

It is recommended that the Board of Health:

1. ***Write to the Minister of Health and Long-Term Care supporting maintaining local surveillance and monitoring of food costing by public health units within the modernized Standards for Public Health Programs and Services (SPHPS);***
2. ***Submit a letter to the Associate Deputy Minister of Health System Information Management and CIO of the Ministry of Health and Long-Term Care, and the Director General of the Office of Nutrition Policy and Promotion at Health Canada, advocating for the Household Food Security Survey Module to be made a core module of the Canadian Community Health Survey; and***
3. ***Forward Report No. 060-17 re: "2017 Nutritious Food Basket Survey Results and Implications for Government Public Policy" and Appendix A to Ontario Boards of Health, the City of London, Middlesex County, and appropriate community agencies***.

Key Points

- The Nutritious Food Basket survey results for 2017 demonstrate that the incomes of many Middlesex-London residents are not adequate to afford basic needs.
- Food insecurity has a pervasive impact upon health, and there is a need for income-based solutions.
- Routine monitoring of food affordability across Ontario helps to generate evidence-based recommendations for addressing income inadequacy and food insecurity, and should remain a core requirement under modernized public health standards.
- Consistent monitoring of household food security is fundamental to evidence-based policy decision-making; therefore, the Household Food Security Survey Module should be made a core module of the Canadian Community Health Survey.

Background

Each year in May, in accordance with the Ontario Public Health Standards, public health units conduct the Nutritious Food Basket (NFB) survey. The survey provides a measure of the cost of basic healthy eating and food affordability by comparing the local cost of the food basket and rental costs to various individual and family income scenarios. Poor nutrition increases the risk of chronic and infectious diseases, and negatively impacts the growth and development of children.

Survey Results

In May 2017, the estimated local monthly cost to feed a family of four was $843.01. Estimated food costs are a snapshot of the prices at the time of data collection. Any increase or decrease year-to-year may or may not represent a significant change, especially in the context of other changes (e.g., utilities and housing costs, incomes). In general, food is affordable for Middlesex-London residents with adequate incomes; a family of four with average income spends only about 11% of its after-tax income on food.

Individuals and families with low incomes would need to spend up to 36% of their income to achieve a healthy diet, which leaves inadequate income for other basic necessities. Table 1 highlights scenarios for Middlesex-London residents, using 2017 income rates, rental costs, and food costs, demonstrating again that people with low incomes cannot afford to eat healthy after meeting other essential needs for basic living. Appendix A, "Food Security in Middlesex-London (2017)," provides an overview of local food insecurity, income inadequacy, and opportunities for community action.

Table 1: Monthly Income and Cost-of-Living Scenarios, 2017

	Single Man Ontario Works	Single Man ODSP	Single Woman over 70 OAS/ GIS	Family of 4 Ontario Works	Family of 4, Minimum Wage Earner	Family of 4 Average Income (after tax)
Income (Inc. Benefits & Credits)	$794	$1,226	$1,663	$2,549	$3,268	$7,896
Estimated Rent**	$621	$802	$802	$1,166	$1,166	$1,166
Food (Nutritious Food Basket)	$283.60	$283.60	$205.14	$843.01	$843.01	$843.01
WHAT'S LEFT?*	**-$110.60**	**$140.40**	**$655.86**	**$539.99**	**$1,258.99**	**$5,886.99**

* People still need funds for utilities, phone, transportation, cleaning supplies, personal care items, clothing, gifts, entertainment, Internet, school supplies, medical and dental costs, and other expenses.

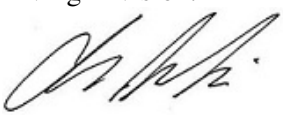
**Rental estimates are from *Canadian Mortgage and Housing Corporation Rental Market Statistics*, fall 2016. Utility costs may or may not be included in the rental estimates.

Opportunities for Action

Routine monitoring of food affordability across Ontario helps to generate evidence-based recommendations for collective public health action to address income inadequacy and food insecurity. In 2016, the Board of Health sent a letter to the Minister of Health and Long-Term Care supporting the inclusion of the Nutritious Food Basket (NFB) standard in the modernized SPHPS (Report 063-16). The SPHPS Consultation Document includes no explicit requirement that public health units continue annual, systematic collection and analysis of the NFB survey information. Local food-cost monitoring data is critical for policy and program development as it relates to healthy eating and health equity. It is recommended that the Board of Health write to the Minister of Health and Long-Term Care supporting the continuation of local surveillance and monitoring of food costing by public health units through a standardized protocol or guidance document under the modernized SPHPS.

The Household Food Security Survey Module (HFSSM), included on annual cycles of Statistics Canada's Canadian Community Health Survey (CCHS), has facilitated monitoring Household Food Insecurity (HFI) since 2005. Consistent monitoring of HFI is fundamental to population health research and evidence-based policy decision-making at all levels of government. HFI is especially important to help inform public health program delivery for food insecurity, food literacy, and health equity. Ontario is one of three provinces/territories that did not include this module in the 2015–16 cycle, and the lack of data will have ramifications for the assessment of the Ontario Food Security Strategy and the Ontario Basic Income Pilot. It is recommended that the Board of Health send a letter to Health Canada and the Ontario Ministry of Health and Long-Term Care advocating for the HFSSM to be made a core module of the Canadian Community Health Survey.

This report was prepared by the Chronic Disease Prevention and Tobacco Control Team of the Healthy Living Division.

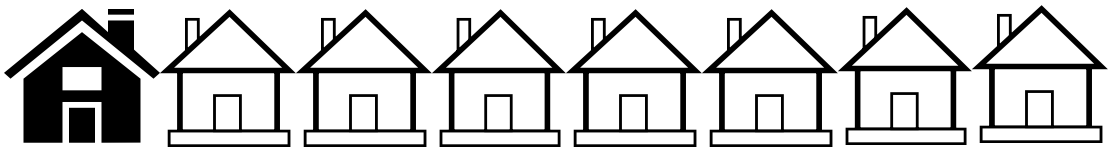


Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

Food Insecurity in Middlesex-London

2017

All residents should have access to a nutritious, adequate and culturally acceptable diet.



About 1 in 8 Middlesex-London households struggle to put food on the table.

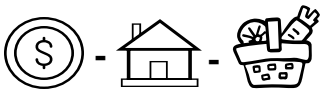
When money is tight, people cut food budgets to pay for other expenses.

They buy cheaper, less nutritious foods or skip meals.

Poor diets increase risk of infections & chronic diseases (e.g. diabetes, heart disease, cancer).

Social assistance rates are NOT ENOUGH

Single people receiving social assistance do not have enough money for adequate housing and healthy food.



Many incomes are NOT ENOUGH

3 out of 5 households who struggle to put food on the table have paid employment.

What can you do?

- Advocate for basic income, living wage, increased social assistance.
- Get involved during elections, your vote matters!
- Find out what type of community organizer you are at www.ifyouknew.ca.
- Read " London for All: A Roadmap to End Poverty".
- Volunteer as an ally, child minder or meal provider at Bridges Out of Poverty / Circles.
  - sclarke@goodwillindustries.ca (London)
- Volunteer as a gardener or meal provider.
  - info@wrrcsa.org (Strathroy)
- Donate time, skills or money to support local organizations.

www.healthunit.com/cost-of-healthy-eating

February 15, 2018

Honourable Katheen Wynne
Premier, Minister of Intergovernmental Affairs
Room 281
Main Legislative Building
Queen's Park
Toronto ON M7A 1A1

Dear Premier Wynne:

Re: Food Insecurity/Nutritious Food Basket Costing

On December 15, 2017 at a regular meeting of the Board for the Grey Bruce Health Unit, the Board considered the attached correspondence from Sudbury and District Health Unit regarding food insecurity and nutritious food basket costing. The following motion was passed:

Moved by: Stewart Halliday Seconded by: David Shearman

"THAT, the Board of Health support item 8.3, Sudbury and District Board of Health resolution regarding food insecurity and nutritious food basket costing."

Carried

Sincerely,

Hazel Lynn, MD, FCFP, MHSc
Acting Medical Officer of Health
Grey Bruce Health Unit

Cc: All Ontario Boards of Health

Encl.

Working together for a healthier future for all.
101 17th Street East, Owen Sound, Ontario N4K 0A5 www.publichealthgreybruce.on.ca
519-376-9420 1-800-263-3456 Fax 519-376-0605

Sudbury & District Health Unit
Service de santé publique

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🖷 : 705.677.9611

Chapleau
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Box / Boîte 485
Chapleau ON P0M 1K0
☎ : 705.860.9200
🖷 : 705.864.0820

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

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

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1.866.522.9200

www.sdhu.com

December 5, 2017

VIA EMAIL

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

Dear Premier Wynne:

Re: Food Insecurity/Nutritious Food Basket Costing

I am very pleased to write to you on behalf of the Board of Health for the Sudbury & District Health Unit to share our sincere appreciation for two recent provincial policy decisions in support of food security, a serious public health concern. The basic income pilot, which includes a commitment to work with First Nations communities, and the commitment to increase the minimum wage rate are two key policy initiatives that are expected to significantly support food security for Ontarians.

The Board of Health for the Sudbury & District Health Unit has a keen interest in food security. We recently reviewed our 2017 data from the annual Nutritious Food Basket Survey and concurred that to further support food security, additional income policies and standardized approaches to monitoring food costs are needed at both the provincial and federal levels.

At its meeting on November 23, 2017, the Sudbury & District Board of Health carried the following resolution #48-17:

> ***WHEREAS the Sudbury & District Board of Health has monitored the cost of healthy eating on an annual basis in accordance with the Nutritious Food Basket Protocol and the Population Health Assessment and Surveillance Protocol per the Ontario Public Health Standards 2008; and***
>
> ***WHEREAS the draft Standards for Public Health Programs and Services, 2017 do not include the Nutritious Food Basket Protocol which is a concern because food costing data gathered by public health units each year is important for policy and program development; and***
>
> ***WHEREAS the Canadian Community Health Survey's Household Food Security Survey Module (HFSSM) is a measure of food security but is not always a mandatory core module; and***

WHEREAS regular and consistent monitoring of household food insecurity is essential for evidence-informed policy decision making;

THEREFORE BE IT RESOLVED that the Sudbury & District Board of Health request that social assistance rates be increased immediately to reflect the cost of the Nutritious Food Basket and local housing costs; and

THAT the Sudbury & District Board of Health advocate to the Province to ensure continued consistent local surveillance and monitoring of food costing by public health units through the continuation of a Nutritious Food Basket Protocol and Guidance document; and

THAT the Sudbury & District Board of Health advocate to Statistics Canada for the HFSSM to become a core module of the Canadian Community Health Survey; and

FURTHER THAT the Sudbury & District Board of Health share this motion and supporting materials with community agencies, boards, municipalities, elected representatives and others as appropriate throughout the SDHU catchment area.

Thank you for your attention to the important public health matters raised in this motion.

Sincerely,

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

Encl.

cc: The Honorable Navdeep Bains, Minister of Innovation, Science and Economic Development
Ms. Roselle Martino, Assistant Deputy Minister, Population and Public Health Division
Dr. David Williams, Chief Medical Officer of Health
Mr. Marc Serré, MP, Nickel Belt
Mr. Paul Lefebvre, MP, Sudbury
Ms. Carol Hughes, MP, Algoma-Manitoulin-Kapuskasing
Mr. Glenn Thibeault, MPP, Sudbury
Ms. France Gélinas, MPP, Nickel Belt
Mr. Michael Mantha, MPP, Algoma-Manitoulin
Dr. P. Sutcliffe, Medical Officer of Health and Chief Executive Officer
All Ontario Boards of Health
Constituent Municipalities within the SDHU catchment area
First Nations within the SDHU catchment area

2017 NUTRITIOUS FOOD BASKET SCENARIOS

	Households with children				Single person households		
	Scenario **1**	Scenario **2**	Scenario **3**	Scenario **4**	Scenario **5**	Scenario **6**	Scenario **7**
Scenarios[a]	 Ontario Works	 Minimum Wage Earner	 Median Ontario Income	 Ontario Works	 Ontario Works	 ODSP*	 Senior OAS / GIS**
	Income						
Total Monthly Income (after tax)	$2,568	$3,287	$7,896	$2,353	$806	$1,238	$1,675
	Expenses						
	3 Bedroom			**2** Bedroom	Bachelor	**1** Bedroom	
Monthly Rent (may include heat/hydro)[b]	$1,111	$1,111	$1,111	$990	$600	$776	$776
Food[c]	$884	$884	$884	$668	$297	$297	$216
	Funds remaining for other basic needs						
	$573	**$1,292**	**$5,901**	**$695**	**($91)**	**$165**	**$683**
% of Income Required for Rent	43%	34%	14%	42%	74%	63%	46%
% of Income Required to Purchase Healthy Food	34%	27%	11%	28%	37%	24%	13%

a - As applicable, all scenarios are based on the following:
1 male adult, 1 female adult, 1 girl, 1 boy, 1 female older adult.

b - Rental costs calculations are from the Rental Market Report: Ontario Highlights. Canada Mortgage and Housing Corporation, Fall 2017.

https://www03.cmhc-schl.gc.ca/catalog/productDetail.cfm?lang=en&cat=102&itm=1&fr=1472132413287

c - Reference: Nutritious Food Basket Data Results 2017 for the Sudbury & District Health Unit – Includes Household Size Adjustment Factors.

For more information, please call 705.522.9200, ext. 257.

* Ontario Disability Support Program
** Old Age Security / Guaranteed Income Supplement

Ce document est disponible en français.

Sudbury & District Health Unit
Service de santé publique

March 8, 2018

For Immediate Release

United Way Sault Ste. Marie & Algoma District is pleased to announce the establishment of a Food Security Division. This Division, under the leadership of Director of Operations Mike Delfre, will establish and operate a Food Security Resource Centre in our community. The Centre will include a food warehouse, commercial kitchen, community garden and will provide Outreach & Education Programs. The Centre will also have sufficient space to accommodate the Christmas Cheer program in the future and for an on-site Social Enterprise. Initial funding of the project is provided by the Sault Ste. Marie District Social Services Administration Board and United Way.

United Way Sault Ste. Marie & Algoma District has worked for the past two years with Co-Chairs from Algoma Public Health & Algoma University along with twenty-five local organizations to develop and implement a community plan to reduce the impact of low income on the health and well-being of families and individuals in Sault Ste. Marie Ontario. The community plan, which includes five priorities, (Food Security, Housing , Essential Services, Workforce Entry and Engagement & Communication) has been endorsed by City Council and is being implemented by the Sault Ste. Marie Poverty Round Table. The United Way Food Security Resource Centre addresses the priority issue of Food Security and has consequently been endorsed by the Sault Ste. Marie Poverty Round Table.

The Food Security Resource Centre will coordinate food collection in the community and distribute food to the public through existing channels as well as through new channels as required. The Centre will establish a sustainable supply of food for the Sault Ste. Marie region and will strive to reduce dependency of vulnerable members of the community on food assistance through education and advocacy.

-30-

For additional Information please contact:

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Mike Delfre, Director Operations
Food Security Division
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January 5, 2018

Sent via email to: incomesecurity@ontario.ca; mcssinfo.css@ontario.ca

Ministry of Community and Social Services
80 Grosvenor St - Hepburn Block - 6th Floor
Toronto ON M7A 1E9

Dear Minister Jaczek,

I am writing as the Medical Officer of Health of Northwestern Health Unit to provide feedback on the recently released report called “Income Security: A Roadmap for Change”. As the Medical Officer of Health, I lead the local public health agency in Northwestern Ontario that covers part of the Kenora District and the Rainy River District, and includes 19 municipalities and 40 First Nation communities[1]. Local public health agencies implement programs and services that promote health, prevent illness and protect from disease.

Research has established the strong relationship between income and health. With increasing income, there are improvements in a wide scope of health outcomes including life expectancy, mortality and morbidity of cancers, heart disease, lung disease, mental health, addictions and substance misuse, and infectious diseases[2]. For the population of Northwestern Ontario, there are high rates of mental health, addictions, chronic diseases such as cancer and lung disease, and life threatening infectious diseases such as hepatitis C and invasive group A streptococcus[3]. Poverty/low income is a significant contributor to the high rates of these diseases.

Poverty and low-income intersect and impact other social determinants of health including housing, education, early childhood development, access to affordable and healthy foods (food security) and social inclusion[2]. Inequities in health brought about by these social factors can be challenging to change. Poverty/low-income is a core issue that must be addressed in order to improve food insecurity, early childhood vulnerability, housing inadequacy and overall health.

I applaud the work that has been carried out in to produce “Roadmap for Change”. The recommendations of the report can have substantial population health improvements for the individual, the family, the community, and future generations.

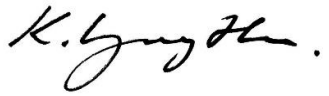
1. Northwestern Health Unit 2. The Canadian Facts 3. Health Statistics - Northwestern Health Unit 4. Cost of Eating in Northwestern Ontario

In particular, I stress the importance of the following:

1. ***Income adequacy*** to ensure affordable housing and food security. Northwestern Health Unit often has the highest cost of food in Ontario with remote First Nation communities being particularly affected. Northwestern Ontario statistics indicate that current social assistance rates are distressingly inadequate considering the cost of food and housing[4].
2. Income as it relates to ***early childhood development***. Early childhood experiences are affected by family income[2]. Poverty/low-income contributes to family stress, food insecurity, social exclusion, and decreased opportunities which can have detrimental effects on the critical period of the early years. Early childhood development has lifelong impacts on health outcomes, high school completion rates, educational attainment, employment success and subsequent demands on the social service and criminal justice system. I strongly support the recommendations under *Income Supports for Children*
3. Income as it relates to ***housing***. Safe, stable and affordable housing is necessary for addressing health concerns and maintaining good health[2]. Northwestern Ontario is plagued with high rates of mental health and addictions. Recovery from such illnesses would be challenging for anyone and is particularly difficult without stable housing. I strongly support the recommendations under *Ontario Housing Benefit.*

As a public health and preventive medicine specialist and a Medical Officer of Health, I fully support the recommendations of “Roadmap to Change”. Moving forward with the recommendations of this report will be **investing in human health and wellbeing**, will lead to the improvements in population health, and will decrease future demands on the health care system, social service system and justice/enforcement system.

Sincerely,



Dr. Kit Young Hoon, Medical Officer of Health
Northwestern Health Unit

Copy: Hon. Kathleen Wynne, Premier of Ontario
Hon. Peter Milczyn, Minister Responsible for the Poverty Reduction Strategy
Hon. Eric Hoskins, Minister of Health and Long-term Care
Hon. Michael Coteau, Minister of Child and Youth Services
Sarah Campbell, MPP, Kenora – Rainy River
Dr. David Williams, Chief Medical Officer of Health, Ontario
Board of Health, Northwestern Health Unit

Northwestern Health Unit
www.nwhu.on.ca

NORTHWESTERN HEALTH UNIT

BOARD OF HEALTH

MOTION/RESOLUTION

No. 10-2018

Moved by Alan Smith

Seconded by Enid Board

THAT WHEREAS, the Northwestern Health Unit Board of Health has a mandate to decrease health inequities such that everyone has equal opportunities for health and can attain their full health potential without disadvantage due to social position or other socially determined circumstances; and

WHEREAS, it is well documented that household income influences housing, food security, education, early childhood development and the ability to participate in society; and

WHEREAS, evidence confirms that people with lower incomes have inadequate nutrition, poorer physical and mental health and higher rates of mortality, and;

WHEREAS, low-income individuals and families are more likely to be challenged with covering basic needs and social factors such as low education, precarious employment, inadequate housing, and social exclusion; and

WHEREAS, the costs of food, housing, child care and transportation make it increasingly difficult for those experiencing poverty/low income to make ends meet; and

WHEREAS, over 1 in 10 people in the NWHU catchment area (11.1%) are in low-income households, and nearly 1 in 5 children (19.4%) live in low-income houses compared with 18.1% provincially; and

WHEREAS, for the population of Northwestern Ontario, poverty/low income is a significant contributor to the high rates of mental illness, addictions, chronic diseases such as cancer and lung disease, and life threatening infectious diseases such as hepatitis C and invasive group A streptococcus; and

WHEREAS, the NWHU region has a higher proportion of the population considered to have lower socioeconomic status when compared with the rest of the province, and this population is at risk of experiencing health inequities, both in terms of health outcomes and access to care; and

WHEREAS, proceeding with the recommendations of *Income Security: A Roadmap for Change*, will lead to substantial population health improvements for individuals, families, communities and future generations; and

Northwestern Health Unit
www.nwhu.on.ca

NORTHWESTERN HEALTH UNIT

BOARD OF HEALTH

MOTION/RESOLUTION

WHEREAS, the Roadmap will decrease future demands on the health care system, social service system and justice/enforcement system;

THEREFORE BE IT RESOLVED that the Northwestern Health Unit Board of Health commend the work done in producing the "Roadmap for Change", as an effort to make a better life for those experiencing poverty/low income; and

FURTHER BE IT RESOLVED THAT the Board of Health fully support the recommendations made in this report as an investment in human health and wellbeing; and that the Northwestern Board of Health share this motion and supporting materials with community agencies, municipalities and elected representatives, and the Association of Local Public Health Agencies (alPHa), Ontario Boards of Health and others as appropriate.

	Yea	Nay	Abstained	Disclosure of Interest
C. Baron				
D. Brown				
Y. Kirlew				
L. MacDonald				
J. Ruete				
P. Ryan				
T. Sachowski				
S. Smith				
D. Squires				
B. Thompson				

CARRIED ✓ Date: January 19, 2018

Chair Paul Ryan

Backgrounder: "Income Security: A Roadmap for Change"

A new report written by three working groups was released by the provincial government on November 2, 2017**.** The report is called "Income Security: A Roadmap for Change".

This is the first report in 30 years that recommends major investments in and improvements to programs that affect the lives of low-income people in Ontario. It reflects a fundamentally different approach to supports and services that puts people – and their needs and rights – at the centre of the system, with a recognition that social and economic inclusion, and not just getting a job, should be the goal. The recommendations in the Roadmap also recognize and reflect the realities of life on a low income in Ontario, whether in work or on social assistance, and respond to the differential impact that poverty has on different groups in Ontario society – particularly Indigenous peoples, but also people with disabilities, racialized communities, and other marginalized groups.

The Roadmap makes recommendations on:

- What an adequate standard of living should be for people who get income supports from benefit programs in Ontario
- How to change the social assistance system so it supports people and responds quickly and appropriately to their needs and goals
- How to make social assistance programs work better for Indigenous people in Ontario
- Improving benefits and supports that go to all low-income people in Ontario, whether they're on social assistance or not
- How to ensure the rights of First Nations to create and administer their own social programs, and the importance of providing appropriate levels of funding
- The investments that government should make immediately to help those in deepest poverty.

This backgrounder gives an overview of the report and highlights many key recommendations. Page numbers in this backgrounder refer to the pages in the Roadmap where recommendations appear.

The Roadmap is online here: https://www.ontario.ca/page/income-security-reform.

The government is looking for public feedback on the Roadmap between now and January 5, 2018. They intend to release an "income security strategy for Ontario" early in the new year, using the Roadmap as a guide.

It is very important for people who are interested in improving the income security and social assistance systems in Ontario to engage with the report and provide feedback on what they feel is positive about the report, what's missing, and the actions that government should take immediately. Information about the feedback process is below.

Who wrote this report?

About a year ago, the Minister of Community and Social Services asked three different working groups to give her recommendations on how to improve the income security system in Ontario.

One was made up of people with lived experience, policy experts, advocates from various community-based agencies that work with people from disadvantaged communities, social assistance administrators, and people from business. ISAC's Director of Advocacy & Legal Services was a member of this working group. A second working group represented First Nations

in Ontario, including the Chiefs of Ontario, representatives of a range of First Nations communities, and First Nations welfare and social service administrators. A third represented urban Indigenous peoples, including the Ontario Federation of Indigenous Friendship Centres (OFIFC), the Ontario Native Women's Association (ONWA), and the Métis Nation of Ontario. The three working groups worked separately. The Roadmap brings together all of their recommendations in one document.

Why is this report important?

The Roadmap recommends transformative change that could have positive impacts for low-income people in Ontario. It not only recommends increasing the amount, quality and kind of benefits and services that low-income people receive, but also transforming the vision for the income security system, the principles behind the provision of programs and services, and the goals and outcomes that the system should be structured to help people achieve.

The Roadmap also invites people who will be impacted into the process of change so that the new vision can actually be achieved, through co-design of programs for people with disabilities and through recognition of the inherent right of First Nations to design and deliver the programs that serve their communities. These recommendations, among others, reflects the human-rights based equity approach that the Roadmap recommends be used as the basis for change, to recognize and appropriately respond to the reality that different groups are both more likely to live in poverty and experience poverty and its effects differently.

The Roadmap rejects the framework of the current income security system in important ways. It recommends that the provincial government:

- Make a commitment that income security programs should aim to lift people out of poverty
- Create supports for low-wage workers to help them deal with the high cost of housing and extended health care coverage, like dental services and pharmacare
- Transform social assistance programs, moving them from punishment and coercion to client-centred and supportive
- Recognize the unique needs of people with disabilities through the provision of services that are based on their rights under international conventions
- Recognize the inherent jurisdiction of First Nations over the social programs that they need
- Make immediate investments in improving benefits for those who are in deepest poverty.

These recommendations provide a new, positive direction for the programs that low-income people in Ontario have struggled with for many years. The social assistance system, for example, was designed in the late 1990s to be deliberately inadequate, punitive and coercive. Ontario Works presumes that everyone is employment ready, and doesn't recognize barriers to employment such as caregiving, racism, trauma, violence and the many other factors that leave people economically and socially isolated. ODSP is very difficult to access, and makes it so hard to prove that you have a disability that getting into or back into a job becomes nearly impossible. Neither program adequately supports the individual ambitions and goals of people, whether those goals are related to work or to other kinds of activities.

The Roadmap recommends that government adopt six guiding principles as basis for change: adequacy, human rights, reconciliation, access to services, economic and social inclusion, and equity and fairness (p.62-63). It also sets out a phased ten-year plan for how change should happen, and the investments that government should make in the first three years.

What changes does the report recommend?

The Roadmap recommends a new vision for Ontario's income security system, in which:

> "All individuals are treated with respect and dignity and are inspired and equipped to reach their full potential. People have equitable access to a comprehensive and accountable system of income and in-kind support that provides an adequate level of financial assistance and promotes economic and social inclusion, with particular attention to the needs and experience of Indigenous peoples" (p.69).

To achieve the new vision, the report recommends changes in five key areas:

- Making a commitment to income adequacy
- Improving the broader income security system
- Transforming the social assistance system, including a First Nations-based approach
- Providing immediate help to those in deepest poverty
- Respecting First Nations jurisdiction and ensuring adequate funding

Many of the recommendations in the Roadmap reflect demands that advocates have made over the years to fix existing programs.

a) Making a Commitment to Income Adequacy

The Roadmap recommends that government make a commitment to providing low-income people in Ontario with incomes that are adequate, by adopting a Minimum Income Standard (p.69-72). The Minimum Income Standard sets a target for the minimum amount of income that it is acceptable for people to live on.

Making a commitment to adequacy is important. Currently there is no standard for the amount of income that people should receive from income support programs, and so government has no plan for increasing benefits in any meaningful way.

The Roadmap sets the Minimum Income Standard initially at the Low Income Measure (LIM) used in the provincial government's Poverty Reduction Strategy, with 30% more for people with disabilities. The LIM is a tool that the government uses to measure whether or not people are living in "straightened circumstances" relative to other people. It is not quite the same as a "poverty line". If your income is below the LIM number, it means your income is not adequate.

The LIM is currently about $22,000 for a single person. For a single person with a disability, the LIM is about $28,500. The recommendation means that the government would commit to making investments into both social assistance rates and other benefits, in order to bring everyone up at least to these amounts.

Current incomes from OW and ODSP are far below this standard. The benefit amounts given to people in the province's Basic Income Pilot Project are also below this standard. The Roadmap recommends achieving the Minimum Income Standard over ten years, through a combination of benefits and other income sources. The Minimum Income Standard would have to be adjusted for inflation over time.

The Roadmap also recommends that government create an Ontario Market Basket Measure (p.69-72). A Market Basket Measure is a tool that essentially lists and counts up the real costs of regular expenses like food, housing, clothing, transportation, communications and other items. It is then compared against people's real incomes to see whether or not incomes are enough to

pay for regular costs of living. An Ontario Market Basket Measure, particularly one that increases as costs rise, would be a more transparent way to track progress towards adequacy. The Roadmap says it could eventually replace the LIM as the Minimum Income Standard.

In other parts of the report, the Roadmap outlines changes to parts of Ontario's income security system that would help achieve income adequacy:

- A flat rate within social assistance (p.112-115)
- Increases to social assistance rates (p.124-128)
- Letting people on social assistance keep at least part of CPP-D, EI, or WSIB benefits (p.121)
- Improving income supports and benefits for children (p.79-83)
- A housing benefit that would go to all low-income people (p.74-78)
- Increases to the federal Working Income Tax Benefit (p.84-85).

Some of these recommendations are discussed further on in this backgrounder.

The Roadmap also makes recommendations for the investments that government needs to make immediately to move toward income adequacy. We discuss these recommendations below.

b) Improving the Income Security System

The Roadmap makes a number of recommendations for creating or improving benefits outside of social assistance. These benefits would help all low-income people in Ontario.

- Core health benefits (p. 86-87)
- A portable housing benefit (p.74-78)
- An assured income program for people with disabilities (p.89 – see the discussion of this recommendation later in this backgrounder)
- Benefits for children outside social assistance (p.79-81)
- An improved Working Income Tax Benefit (p.84).

It also recommends improving access to justice in tax-delivered benefit programs (p.87-88). Some key recommendations are:

i. Health benefits: Enormous changes in the labour market have meant that too many jobs are now not only precarious, with uncertain hours, low pay, and poor working conditions, but also can't be relied on to provide extended medical benefits like dental, drug and vision care. This means that many workers in Ontario don't have and can't afford to pay for these critically important health care services.

The Roadmap makes recommendations to ensure that all low-income adults receive Pharmacare, dental, vision, hearing, and medical transportation benefits, phased in over the next ten years starting with prescription drug coverage for all low-income adults (p.86-87).

ii. Portable housing benefit: The Roadmap recommends creating a new Ontario Housing Benefit to help all low-income people with the high cost of rental housing, no matter where their income comes from (social assistance, work, other benefits, etc.). This benefit would pay for a portion of the "affordability gap" between their actual rent and what an affordable rent would be relative to their income (p.74-79).

Housing is usually defined as "affordable" if it costs no more than 30% of an individual's or family's income. If rent is more than 30% of income, there is an "affordability gap" (p.77). The Roadmap recommends creating a housing benefit in the next two years that would initially cover

25% of the gap. It recommends increasing investments over time so that 35% of the gap would be covered by 2020-21 and 75% of the gap by or before 2027-28. Everyone would be eligible for a different amount, depending on their actual income and rent.

Some housing advocates have expressed concerns about housing benefits, due to the risk that it would be used as a substitute for building new or repairing existing affordable housing stock. The Roadmap stresses that a housing benefit is only one tool that government should use to help with housing affordability, and says that affordability is such an urgent issue that a housing benefit must be taken seriously (p.74). Some advocates also express concern about the impact that a housing benefit could have on the broader rental market in terms of whether or not it would drive rental costs higher and act as a subsidy to bad landlords. And the impact of a housing benefit on rent supplements and shelter allowances has not been examined. Government must take these important considerations into account when and if they move to design a housing benefit.

The Roadmap also stresses that people in First Nations communities should be eligible for the benefit, or for a similar program created by them if an alternate approach better meets their needs. It also recognizes that some low-income people own their own homes, particularly in rural areas, and recommends that government create a separate benefit that responds appropriately to their needs.

iii. Access to justice: A growing number of benefit programs outside of social assistance are delivered through the income tax system. A good example is the Canada Child Benefit, which people can get if they file their tax returns and if their income is low enough.

But delivering benefits through the tax system creates issues when a person's eligibility for a benefit is challenged by the Canada Revenue Agency (CRA), which oversees the income tax system. The CRA has a very cumbersome appeal process that is difficult to understand and not easy to access, and doesn't provide interim benefits while appeals are being heard.

The Roadmap recommends that a fair, transparent and efficient appeal process be created for any future benefits, like a housing benefit (p.87-88), and that the government seek advice on ways to improve the current appeal processes for tax-delivered benefits (p.88).

c) Transforming the Social Assistance System, including a First Nations-based approach

A large part of the Roadmap focuses on making the kinds of changes that would transform Ontario Works (OW) and the Ontario Disability Support Program (ODSP). The Roadmap says that the objective is to make these programs "simpler and eliminate coercive rules and policies" and to "create an explicit focus on helping people overcome barriers to moving out of poverty and fully participating in society" (p.90). The changes include:

- Rewriting the legislation that governs the programs (p.90-92)
- Building a culture of trust, collaboration and problem solving, including fundamentally changing the role of the caseworker (p.93-102)
- Creating a flat rate structure in OW and ODSP (p.112-116)
- Keeping and improving ODSP as a separate program, while ensuring that both OW and ODSP can better support people with disabilities (p.103-108)
- Moving toward an "assured income" program for people with disabilities and away from the welfare model (108-111)
- Eliminating punitive rules and redesigning benefits to support individual employment goals (p.117-119)

- Improving income and asset rules (p.120-121)
- Keeping all targeted benefits, at least until income adequacy is achieved (p.121-123).

A separate section talks about how to change the social assistance system so that it works better for First Nations peoples (p.136-140). A number of important changes are being recommended in these sections, and we urge everyone interested in improving social assistance to review them in detail. Some key recommendations are:

i. Legislative change: Transformation of OW and ODSP can't be accomplished without rewriting the laws that govern the programs. The culture of the programs – which is currently focused on coercion, surveillance, control, and punishment – is written into the rules, and those rules are contained in laws, regulations and policies. The Roadmap clearly states that if the rules are going to change in ways that promote a culture of "respect, collaboration, support and autonomy" (p.91), then the laws, regulations and policies have to change.

The Roadmap also states that the new laws would have to explicitly recognize the authority of First Nations to opt out of rules that do not work well in their communities and to create their own models that would work better for them.

ii. Changing the culture of social assistance and improving the role of the caseworker: The Roadmap makes a number of recommendations that would fundamentally change the focus of OW and ODSP and promote a culture of "trust, collaboration and problem-solving" (p.93-102). Recommendations include:

- Changing the system so that caseworkers don't have to be "welfare police" and instead can act as "case collaborators" to support people to solve problems and to help them navigate various systems of support (e.g., income supports, health care services, mental health treatment, childcare, etc.)
- Creating a new comprehensive assessment tool and a "triage" system that would identify people's needs right away, and connect them with the supports and services that would help them on the road toward greater economic and social inclusion – and that this tool would be based on an equity and trauma-informed approach
- Moving to a holistic, wraparound structure of person-centred supports
- Eliminating the coercive rules that punish people by reducing their benefits or kicking them off the programs when they don't or can't meet employment-related requirements
- Providing mandatory professional development and learning opportunities for caseworkers, including anti-racism and anti-oppressive practice training
- Creating provincial service quality standards and controls
- Conduct continuous service reviews and quality assessments, including culture- and gender-based analyses of programs, and provide ongoing professional development.

The recommendations in this section that would better support Indigenous peoples are:

- Requiring OW and ODSP caseworkers to spend time working in Indigenous service delivery offices to increase cultural awareness and improve ties between Indigenous and non-Indigenous delivery providers
- Making sure Indigenous people have the right to choose where their services are delivered, including in First Nations communities on reserve.

iii. Flat rate in OW and ODSP: Currently, people on OW or ODSP who rent, lease or own their own homes get two basic monthly benefits: "basic needs" and "shelter". The "basic needs" benefit is intended for basic costs of living and the "shelter" benefit is for housing-related costs.

Currently, for example, single people on OW get $337 in basic needs and $384 as the maximum amount for shelter, for a total of $721 per month. If a person's real housing costs are lower than the maximum, the benefit they get is only equal to their real costs, which means some people get less than $721. And people on OW or ODSP who live in public housing pay a very low housing charge based on a separate "social assistance rent scale".

While it's widely recognized that these amounts are dangerously insufficient, it's not as well known that there are many people on OW and ODSP who get even less. People who are homeless, people who live in shelters and people who live in long-term care homes or certain kinds of institutions get less. For example, a single person in a "board and lodge" living situation (where they get shelter and food from the same provider) on OW gets only $594. A person with a disability who, because of that disability, lives in a situation where meals are prepared for them gets $881. A single person who is homeless gets only $337 from OW. It is extremely difficult to pay for regular costs of living and impossible to find decent housing with these amounts.

The Roadmap recommends collapsing the basic needs and maximum shelter amounts in OW and ODSP into one flat rate for each program (p.112-116), so that everyone on that program would get the same amount no matter what their living situation is. Doing this would have a number of benefits. A flat rate would mean an immediate increase for everyone who now receives a lower benefit amount due to where they live, and for those whose housing costs are below the maximum monthly shelter benefit. It would also eliminate the requirement for people to report on where they live, how much their rent is, whether or not they have a roommate, and whether someone else prepares their food. This would reduce the amount of time caseworkers have to spend policing benefits and allow them to spend more time providing help and support. It could also allow people to get financial benefits from sharing accommodation, which doesn't happen now. And it would go a long way toward reducing the surveillance and intrusion that's currently built into the social assistance system.

A flat rate would also benefit other parts of the income security system. People on OW or ODSP who live in "rent-geared-to-income" housing would pay 30% of their total income instead of the reduced social assistance rate, so the social housing system would get more money from the provincial government. More funding would result in better quality housing. And people wouldn't lose out, because the other 70% of their income would be more than they get now. And this would eliminate the extremely negative impacts that people on OW or ODSP currently face when they live in social housing and have more income from work than the social assistance rent scale allows – which is that their rent goes up precipitously, from the low social assistance rent scale rate to 30% of their income. This can and does cause people to lose their housing and prevents people from working as much as they might want to.

The Roadmap recommends that couples get a rate equal to 1.5 times the Standard Flat Rate in each program, and that adult children who live with parents who are on social assistance would get an additional amount equal to 75% of the Standard Flat Rate. The Roadmap doesn't explain how these rates were decided. These rates should be examined in the context of the Roadmap's guiding principles.

iv. Improving supports for people with disabilities: The Roadmap is clear that people with disabilities must have a distinct program that supports their needs and is guided by the UN Convention on the Rights of Persons with Disabilities.

Recommendations to improve ODSP (p.103-111) include:

- Keeping the current definition of disability
- Improving and streamlining the application and adjudication process
- Giving people supports they need to complete the applications
- Improving the decision-making processes within the Ministry about who qualifies as a person with a disability.

The Roadmap also recognizes that Ontario Works must be improved to better serve people with disabilities, since many people with disabilities either enter the system through OW first while trying to get onto ODSP or remain on OW for many years if they are not able to get ODSP. Many of the recommendations in the social assistance transformation sections would help to improve OW in this way.

The Roadmap also recommends that First Nations be given the ability to administer and deliver ODSP, so that people with disabilities who live in First Nations communities can get better access to the supports that ODSP provides.

v. "Assured Income" for people with disabilities: The Roadmap recommends that a new program be created over the next ten years that would move ODSP away from the current welfare-based model (p.108-111). A new "assured income" model would provide supports to people with disabilities based primarily on their incomes and not on their assets. It would be designed in ways that would make it easy to move in and out of the workforce, which would be much more responsive to the needs of people with disabilities, especially those with episodic disabilities. It would also come with a suite of caseworker services and supports.

The Roadmap doesn't give recommendations for exactly how this program would work, but instead recommends that the government enter into a co-design process with people with disabilities to design and build the program together over time. That process would include reviewing what the impact would be of moving to a system in which eligibility would not depend on the incomes of other family members; in other words, whether to change the benefit unit to the individual instead of the family.

vi. A First Nations-based approach: One of the most important parts of the Roadmap is the recommendation to ensure that social inclusion and community engagement become stated goals of social assistance programs, which reflects the traditional approach of First Nations communities (p.136). This would broaden the focus of OW and ODSP so that these goals become just as important and valued as finding a job, and so that the system provides supports to achieve these goals.

The Roadmap makes a number of recommendations that also speak to a much more holistic approach to service provision that focuses on ensuring physical, spiritual, mental and emotional well-being (p.137-140). A whole range of services are recommended that address the real needs that people have for training and supports (e.g., literacy services, mental health referrals, life stabilization, self-employment, etc.) and that focus on the well-being of the family and the community as well as the individual.

Reshaping social assistance programs in this way is an ongoing theme of the Roadmap. The specific recommendations in this section give that theme life and structure, and a concrete vision for how social inclusion and community engagement can be supported and achieved.

vii. Other specific issues:

The Roadmap makes important recommendations about specific issues that are long-standing concerns of people on OW and ODSP. These include:

a. Targeted benefits: The Roadmap recommends that, at least until it can be demonstrated that monthly benefits cover people's real expenses (as measured using the Minimum Income Standard), no special-purpose benefits in social assistance should be eliminated (p.122-123). This would mean, for example, that those parts of the Special Diet Allowance that are intended for people who have health conditions that require a balanced and nutritious diet (like hypertension, etc.) would remain at least until such time as everyone has enough money to pay for a healthy diet. Some Special Diet Allowance amounts would remain even after adequacy is reached, because some people have other, more expensive nutritional costs related to addressing the impact of their disabilities.

The Roadmap also recommends that eligibility for the Remote Communities Allowance be expanded to better serve the needs of people in northern and remote areas, many of which are First Nations communities (p.123). The Roadmap also says funeral and burial costs should be made mandatory, and that Ontario Works discretionary benefits, which are now administered by municipalities should be redesigned and provided to the broader low-income community (p.123).

b. The definition of "spouse": OW and ODSP currently define someone as a "spouse" after only three months of living together. This means that people can lose eligibility for OW or ODSP after only three months of living with someone else, because that person's income can be included in their eligibility calculation. This rule prevents people from forming relationships given the risks involved in losing benefits and additional supports. The Roadmap recommends that the definition of "spouse" be changed to align with the *Family Law Act*, which would require three years of living together before financial obligations start (p.116). This would mean that low-income people in Ontario would live by the same support obligations as everyone else.

c. Treatment of employment-related benefits: Benefits from EI, CPP-D and WSIB, which people only receive if they have worked and paid into those programs in the past, are currently deducted dollar-for-dollar from OW and ODSP. This lack of benefit "stacking" means that people's incomes are effectively capped at the very low rates provided by OW and ODSP. The Roadmap recommends that, to help achieve income adequacy and as an initial measure, people should be allowed to keep 25% of benefits from CPP-D, EI and WSIB. It says that that amount should increase over the next five years so that people can keep the same amount of those benefits as they are able to keep when they get income from work (p.121).

The Roadmap is silent on, however, on whether or not the current earned income exemption amount should continue or be increased. Currently people are able to keep the first $200 in a month, and 50% of any earnings thereafter. Advocates have long been calling on government to increase this amount. As part of moving toward the goal of income adequacy, government must examine how to increase the amount of income that people can keep when they work.

d. Exemption of funds intended for retirement: The Roadmap recommends that assets held in all forms of Registered Retirements Savings Plans (RRSPs) and in Tax-Free Savings Accounts (TFSAs) should be fully exempt (p.121). Right now, people must spend down these amounts to a certain level before they become eligible for support from OW or ODSP. Exempting these investments would mean that people would have a much better financial cushion for retirement.

e. Health benefits: The Roadmap makes a recommendation to improve existing health benefits within the social assistance system (p.86-87). People who are on social assistance have some health benefits, but access to and the quality of these benefits should be improved. The Roadmap states that all of the current mandatory health benefits (like dental care for adults) should be provided to everyone on both OW and ODSP, and that dentures should be included. The Roadmap doesn't, however, give direction to government to address the problems that people have actually accessing dental care from dentists in some regions of Ontario.

d) Immediate help for those in deepest poverty

The Roadmap makes compelling arguments about the need for urgent action to address the deep poverty that people on social assistance live with every day (p.124-125 and p.35-49). It talks about the nearly 22% rate cut of the late 1990's and the erosion in incomes that followed as inflation outpaced rate increases. According to the Roadmap, the purchasing power of people on social assistance has fallen precipitously in the last 22 years – single people on OW have $315 per month and singles on ODSP have $302 less per month, taking inflation into account, than they did in 1995 (p.125).

Comparing social assistance incomes to the minimum wage clearly demonstrates the urgency. The Roadmap states that the income of a single person on OW has dropped from 70% of the minimum wage in 1990 to 38% today (p.125). When the minimum wage increases to $15 per hour, the ratio will drop again to 30%.

The Roadmap also documents the health impact of that deep poverty. The poorest 20% of the population have double the rate of diabetes and heart disease as the richest 20% (p.46). The death rate is 67% higher for men and 42% higher for women who are poor versus those who are wealthy. These impacts are greater and more disproportionately felt by Indigenous peoples, people from racialized communities, people with disabilities, and other marginalized groups.

In response, the Roadmap recommends an immediate, significant increase to social assistance rates, because doing so is the simplest and most immediate way to make progress towards adequacy. The recommended increases are:

- Create a flat rate structure immediately to improve the incomes of those receiving less than the base benefit rates (see above)
- Set the OW Standard Flat Rate at $794 / month (a 10% increase) and the ODSP Standard Flat Rate at $1,209 / month (a 5% increase) starting in Fall 2017
- Increase the OW flat rate by 7% and the ODSP flat rate by 5% in 2018
- Increase the OW flat rate by 5% and the ODSP flat rate by 5% in 2019.

These recommendations fall short of real progress towards meeting the essential costs of living of people on social assistance. The Roadmap argues that these numbers were chosen because of the expectation that they could be implemented by the government. But even these modest increases are facing pushback, in the media and elsewhere, because of the cost. The Roadmap estimates the cost of implementing its year one recommendations (most of which would address social assistance poverty) at $810 million (p.162). By year three, costs would be $3.2 billion annually.

But the Roadmap also clearly outlines the costs of inaction, which are staggeringly large and have a huge toll on real people and their families, and the impacts of action, which would not only help those living in poverty but would benefit us all (p.157-163).

Everyone who cares about ending the deep poverty caused by social assistance programs will need to work together to build a broad-based movement to get the government to make the investments that need to be made. We must not only communicate the urgency of making real progress on increasing the incomes of those in deepest poverty, we must create the political will to make the needed investments.

e) Respecting First Nations jurisdiction and ensuring adequate funding

The needs of Indigenous peoples are expressed throughout the Roadmap, but a separate section of the report outlines specific issues around jurisdiction and funding.

The United Nations Declaration on the Rights of Indigenous Peoples recognizes that Indigenous peoples have inherent rights that must be respected. The Declaration recognizes that, as the original nations on these lands, Indigenous peoples have the right to self-determination over their territories and their lives. Given the context of colonization in Canada and the systematic exclusion of Indigenous peoples from social and economic life and opportunity, the recognition and implementation of Indigenous rights is key to creating harmonious and just relationships between Ontario and Indigenous peoples.

This section of the Roadmap states clearly that First Nations communities must be full participants in designing and administering programs and services, which is also key to making services meaningful and effective. The recommendations in this section are to:

- Take steps to ensure that social services for First Nations people are ultimately controlled and determined by First Nations themselves (p.132-136)
- Provide funding for benefits and administration of programs in amounts that recognize the particular needs, realities and issues of First Nations communities (p.141-143).

Other Issues

Other sections of the Roadmap provide other important recommendations, including:

- Calling on the federal government to do more, especially around universal pharmacare, improving access to the Canada Child Benefit for people who don't have regular immigration status in Canada or don't regularly file their tax returns (which includes many Indigenous peoples), improving eligibility for and benefit amounts in CPP-D, EI, and OAS/GIS, and creating a national program for people with disabilities and a national housing strategy (p.144-147).
- Creating a "change management plan" to make sure that, as change happens in the social assistance system and new benefit programs are implemented, unintended negative consequences can be avoided (p.148)
- Ensuring transparency and accountability through annual reporting on outcomes and meaningful indicators, using disaggregated data and data collection methods that are respectful of First Nations peoples, with third-party review and accountability to the Ontario Legislature (p.151).

What has the government said about the Roadmap?

The government has not yet made any commitments to implement the Roadmap's recommendations. But they have said that "the government agrees with the need to fundamentally reform the income security system, including the transformation of social assistance, to ensure all individuals are treated with respect and dignity and are inspired to reach their full potential, with

particular attention to the needs and experience of Indigenous peoples" (https://news.ontario.ca/mcss/en/2017/11/working-groups-deliver-roadmap-for-income-security-reform.html).

They have also said that they want public feedback on the Roadmap, and that they will be releasing their own Income Security plan in early 2018.

What's next?

The Roadmap is very different from past reports on how to improve income security in Ontario. It's important that people who are interested in improving social assistance and ensuring better income security in Ontario take the time to understand the report and its recommendations.

But the Roadmap is only a report. The only way for change to happen is for people to engage with the report, talk about it in their communities, and push decision-makers to act.

1. Provide your feedback on the Roadmap

The government wants feedback on:

- the vision, recommendations and timeframe
- the recommendations that are most important to you
- your overall thoughts.

We have created a Feedback Kit that individuals and organizations can use to respond.

The Feedback Tool, including where your feedback should be sent, is available here: http://incomesecurity.org/policy-advocacy/a-roadmap-for-change-tools-you-can-use-to-have-your-voice-heard/.

Remember that the deadline for feedback is January 5, 2018

2. Talk about the Roadmap in your community

Even if you aren't able to provide feedback before January 5, we encourage everyone to continue talking about the Roadmap in your communities.

This is because the Roadmap can be used as a tool to advocate for change in both the short and long term. It can be used to push for investments in the upcoming provincial budget. It can also be used to talk about the importance of transforming Ontario's income security system in the upcoming provincial election and beyond, including getting commitments from local candidates and provincial political parties to act to make change.

If you are someone on low income, please read the Roadmap and talk about it with other people who might be in similar situations. Connect with groups or organizations in your community, like your local legal clinic, to see if they can support you in having your voice heard. Or if you work for an organization that regularly works with or supports low-income people in Ontario, set up a meeting or series of meetings with them to talk about the Roadmap. Write down their ideas for change, and send them to the Minister of Finance before the Budget or to all the political parties before the election, including your local candidates.

We will be providing more tools in the new year to help with these processes. But please get the conversation started sooner rather than later.

RESOLUTION #2017-03

Board of Health, Haliburton, Kawartha, Pine Ridge District Health Unit

December 7, 2017

Repeal of Section 43 of the Criminal Code Refresh 2017

WHEREAS, research indicates that physical punishment is harmful to children and youth and is ineffective as discipline; and

WHEREAS, the goal of the Ontario Public Health Standards (OPHS) Child Health Program (2008) is to enable all children to attain and sustain optimal health and developmental potential and of the draft Ontario Standards for Public Health Programs and Services (2017) Healthy Growth and Development Standard is to achieve optimal maternal, newborn, child, youth, and family health; and

WHEREAS, Section 43 of the Criminal Code of Canada justifies the use of physical punishment of children between the ages of 2 and 12; and

WHEREAS, the Ontario Public Health Association (OPHA) supports the repeal of Section 43 of the Criminal Code of Canada, as repeal would provide children the same protection from physical assault as that given to adults; and

WHEREAS, over 550 organizations in Canada, including the Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit (in 2006) and the City of Kawartha Lakes, have endorsed the *Joint Statement on Physical Punishment of Children and Youth;* and

WHEREAS, calls for the repeal of Section 43 of the Criminal Code of Canada have been made repeatedly for almost 40 years; and

WHEREAS, Prime Minister Justin Trudeau stated the Calls to Action of the Truth and Reconciliation Commission, which includes the repeal of Section 43, would be fully implemented;

THEREFORE BE IT RESOLVED that the Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit support the repeal of Section 43 of the Criminal Code of Canada and write to the Minister of Justice indicating the Board's position and urging swift action on this matter;

BE IT FURTHER RESOLVED that copies of this resolution be sent to the Prime Minister, all local Members of Parliament, all local Members of Provincial Parliament, all Member Municipalities, all local Boards of Education, all Ontario Boards of Health, and all local children's planning tables for support.

February 15, 2018

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

Dear Minister Hoskins:

Re: Smoke-Free Modernization

On November 24, 2017 at a regular meeting of the Board for the Grey Bruce Health Unit, the Board considered the attached correspondence from Simcoe Muskoka District Health Unit regarding Smoke-Free Ontario Modernization. The following motion was passed:

Moved by: Mitch Twolan Seconded by: Mike Smith

"THAT the Board of Health endorse Simcoe Muskoka District Health Unit's recommendation's to the province regarding the Smoke-Free Ontario Modernization strategy and commitment to the Tobacco Endgame for Canada."

Carried

Sincerely,

Hazel Lynn, MD, FCFP, MHSc
Acting Medical Officer of Health
Grey Bruce Health Unit

Cc: All Ontario Boards of Health

Encl.

simcoe muskoka
DISTRICT HEALTH UNIT

October 25, 2017

Dr. Eric Hoskins
Minister – Minister's office
Minister of Health and Long-Term Care
Hepburn Block, 10th Floor
80 Grosvenor St.
Toronto, ON M7A 2C4

Dear Minister Hoskins,

On March 15, 2017, the Board of Health for the Simcoe Muskoka District Health Unit passed a motion to write to the federal government in supporting the approaches identified at the 2016 summit, A Tobacco Endgame for Canada and its target of reducing tobacco use to less than five per cent by 2035. Accordingly, we communicated with the Ministry of Health and Long-Term care in recommending that modernization of the Smoke-Free Ontario Strategy include the recommendations identified in the tobacco endgame. In supporting these recommendations, the Province and its partners can successfully address and minimize the preventable death and disease caused by tobacco product use and reduce the unmaintainable drain it places on our health care system.

The Board of Health is therefore pleased to review the recently released "Smoke-Free Ontario Modernization" Report of the Executive Steering Committee. In particular, the Board of Health is encouraged by the report's evidence-based recommendations, supports and strategies which identify actionable and achievable outcomes for future action that are in keeping with the resolutions by the Association of Local Public Health Agencies that identified the need for intensified and targeted tobacco controls to protect and promote the health of Ontario residents. Further, the Board of Health commends the Executive Steering Committee in recognizing that Ontario is closer to ending the tobacco epidemic despite on-going efforts by the tobacco industry who demonstrate a profound, self-serving disinterest in its customers' health and a calculating, sophisticated determination to resist any regulation. Thus, The Board of Health recommends that the province proceed with developing a renewed Smoke-Free Ontario strategy committing to the endgame target with a smoking prevalence of less than 5% by 2035, by employing the bold strategies recommended in the Smoke Free Ontario Modernization report.

Ontario's success in alleviating this tobacco epidemic requires strong leadership and action by your Ministry to strengthen and create legislation and supports that will diminish addiction to products that are the single greatest threat to the health of Ontarians. We look forward to working with the province as it updates the Smoke-Free Ontario strategy.

Sincerely,

ORIGINAL SIGNED BY

Scott Warnock,
Chair, Board of Health

c. Simcoe Muskoka Municipal Councils
Ontario Boards of Health
Central Local Health Integration Network
North Simcoe Muskoka Local Health Integration Network
Association of Local Public Health Agencies

Public Health
Santé publique
SUDBURY & DISTRICTS

February 27, 2018

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Dr. Pierre Zundel, Interim President and Vice-Chancellor
Laurentian University
Email: president@laurentian.ca

Mr. Daniel Giroux, President
Collège Boréal
Email: daniel.giroux@collegeboreal.ca

Mr. William Best, President
Cambrian College
Email: william.best@cambriancollege.ca

Dear Dr. Zundel, Mr. Giroux and Mr. Best:

Re: Tobacco and Smoke-Free Campuses

Post-secondary institutions have an important and unique opportunity to positively impact on the health and wellness of young people. By creating smoke and tobacco-free campuses, post-secondary institutions proactively put students' health first and significantly reduce harms from the use of tobacco and other substances.

At its meeting on February 15, 2018, the Board of Health for Public Health Sudbury & Districts considered the health effects and epidemiology of smoking and the leadership on this issue of McMaster University. The Board carried the following resolution #07-18:

> ***WHEREAS on January 1, 2018, McMaster University became the first post-secondary institution in Ontario to establish a 100% tobacco and smoke-free campus; and***

WHEREAS the presence of tobacco use on campus further normalizes tobacco use, undermining provincial and local tobacco prevention and cessation efforts; and

WHEREAS an Environmental Scan of Ontario College and University Tobacco Control Policies 2016-2017, indicates that while the three post-secondary campuses in Sudbury have policies exceeding the current Smoke-Free Ontario Act (SFOA), they maintain on-campus Designated Smoking Areas (DSA's);

THEREFORE BE IT RESOLVED THAT the Board of Health for Public Health Sudbury & Districts congratulate area post-secondary institutions for their tobacco-related health protective policies surpassing current provincial legislation; and

FURTHER that the Board strongly urge and support area post-secondary institutions to enhance existing policies to achieve 100% tobacco and smoke-free campuses within an accelerated timeframe; and

FURTHERMORE that the Board share this motion with area post-secondary leadership, alPHa, the Chief Medical Officer of Health, Minister of Health and Long-Term Care, Ministry of Advanced Education and Skills Development, and local MPPs.

Post-secondary campuses offer a unique opportunity to intervene and support large numbers of young adults to not start – or quit – smoking, and to protect them, as well as staff, faculty, administration, and visitors, from exposure to second-hand smoke through a tobacco and smoke-free campus policy. The presence of tobacco use on campus encourages and facilitates further tobacco use, undermining tobacco prevention and cessation efforts.

Tobacco and smoke-free policies, which include tobacco, cannabis, shisha, the use of an electronic cigarettes, and other emerging products, eliminate exposure to the harmful effects of tobacco and other smoking products and work to denormalize smoking.

We are committed to creating opportunities for health for all in our communities and look to your continued leadership to protect and promote the health of those who learn, live, work and play on post-secondary campuses.

We would be pleased to work with you as you investigate opportunities on your campus. Public Health Sudbury & Districts staff will be in contact shortly to explore how we might best support your work.

Sincerely,

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

cc: The Honourable Helena Jaczek, Minister of Health and Long-Term Care
The Honourable Mitzie Hunter, Ministry of Advanced Education and Skills Development
Dr. David Williams, Chief Medical Officer of Health
Mr. Glenn Thibeault, MPP, Sudbury
Ms. France Gélinas, MPP, Nickel Belt
Mr. Michael Mantha, MPP, Algoma-Manitoulin
Ms. Loretta Ryan, Executive Director, Association of Local Public Health Agencies
All Ontario Boards of Health
Mr. David Lindsay, President and Chief Executive Officer, Council of Ontario Universities
Ms. Linda Franklin, President and Chief Executive Officer, Colleges Ontario

February 15, 2018

Honourable Katheen Wynne
Premier, Minister of Intergovernmental Affairs
Room 281
Main Legislative Building
Queen's Park
Toronto ON M7A 1A1

Dear Premier Wynne:

Re: Vaccine Recommendations for Childcare Workers

On October 27, 2017 at a regular meeting of the Board for the Grey Bruce Health Unit, the Board considered the attached correspondence from Durham Region Public Health and the Council of Ontario Medical Officers of Health regarding vaccine recommendations for childcare workers. The following motion was passed:

Moved by: Alan Barfoot Seconded by: Arlene Wright

"WHEREAS, it is the position of the Grey Bruce Health Unit to support vaccines for high risk groups and those working with high risk groups, which would include child care workers, and

WHEREAS, it is the position of the Health Unit that access to services should not be restricted due to financial hardship,

THEREFORE BE IT RESOLVED THAT, the Board of Health supports the recommendations of the Council of Ontario Medical Officers of Health with respect to providing publically funded vaccines for child care workers."

Carried

Sincerely,

Hazel Lynn, MD, FCFP, MHSc
Acting Medical Officer of Health
Grey Bruce Health Unit

Cc: All Ontario Boards of Health

Encl.

OCT 16 2017

DURHAM REGION

The Regional Municipality of Durham

Corporate Services
Department
Legislative Services

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Don Beaton, B.A.S., M.P.A.
Commissioner of
Corporate Services

October 12, 2017

The Honourable Kathleen Wynne
Premier
Minister of Intergovernmental Affairs
Room 281
Main Legislative Building
Queen's Park
Toronto ON M7A 1A1

COPY

RE: Memorandum from Dr. R. Kyle, Commissioner and Medical Officer of Health – re: Vaccine Recommendations for Child Care Workers
Our File: P00

Please be advised that Committee of the Whole of Regional Council considered the above matter and at a meeting held on October 11, 2017, Council adopted the following recommendations of the Committee:

"A) That the correspondence from the Council of Ontario Medical Officers of Health (COMOH) requesting the Government of Ontario to amend the Publicly Funded Immunization Schedule such that vaccinations recommended for child care workers by Medical Officers of Health would be publicly funded for those workers, be endorsed; and

B) That the Premier of Ontario, Ministers of Finance and Health and Long-Term Care, Durham's MPPs, Chief Medical Officer of Health and all Ontario boards of health be so advised."

Attached for your reference is a copy of the Memorandum from Dr. Kyle, Commissioner and Medical Officer of Health, dated October 4, 2017.

Ralph Walton
Regional Clerk/Director of Legislative Services

RW/np

Attach.

If this information is required in an accessible format, please contact 1-800-372-1102 ext. 2009.

"Service Excellence for our Communities"

c. The Honourable Charles Sousa, Minister of Finance
The Honourable Eric Hoskins, Minister of Health and Long-Term Care
Joe Dickson, MPP (Ajax/Pickering)
Lorne Coe, MPP (Whitby/Oshawa)
The Honourable Tracy MacCharles, MPP, (Pickering/Scarborough East)
Granville Anderson, MPP (Durham)
Jennifer French, MPP (Oshawa)
Laurie Scott, MPP, (Haliburton/Kawartha Lakes/Brock)
Dr. David Williams, Chief Medical Officer of Health
Ontario Boards of Health
Dr. R.J. Kyle, Commissioner and Medical Officer of Health

DURHAM REGION

The Regional Municipality of Durham

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An Accredited Public Health Agency

MEMORANDUM

To: Committee of the Whole

From: Dr. Robert Kyle

Date: October 4, 2017

Re: Vaccine Recommendations for Child Care Workers

On July 18, 2017, the Council of Ontario Medical Officers of Health (COMOH) sent the attached correspondence to the Chief Medical Officer of Health of Ontario and the Assistant Deputy Minister, Population and Public Health Division, Ministry of Health and Long-Term Care. The correspondence outlines COMOH's recommendations regarding public health requirements in the *Immunization of School Pupils Act* and the *Child Care and Early Years Act, 2014* (CCEYA).

One of the recommendations requests the Government of Ontario to amend the Publicly Funded Immunization Schedule such that vaccinations recommended for child care workers by Medical Officers of Health (MOHs) would be publicly funded for those workers.

As articulated in *Ontario Regulation* 137/15 of the CCEYA, child care operators are required to ensure that employees have immunizations as recommended by the local MOH. COMOH has agreed that all MOHs will, at a minimum, recommend that all child care workers receive vaccines recommended by the National Advisory Committee on Immunization (NACI). NACI recommends two immunizations for child care workers which are not currently publicly funded for adults (unless they meet high-risk eligibility criteria). These include immunization against varicella (i.e., chickenpox) and hepatitis B.

Given the low wages of child care workers and the high cost of these vaccines, I recommend that the Committee of the Whole recommends to Regional Council that:

a) The correspondence from COMOH as regards vaccine recommendations for child care workers is endorsed; and

b) The Premier of Ontario, Ministers of Finance and Health and Long-Term Care, Durham's MPPs, Chief Medical Officer of Health and all Ontario boards of health are so advised.

Respectfully submitted,

Original signed by

R.J. Kyle, BSc, MD, MHSc, CCFP, FRCPC, FACPM
Commissioner & Medical Officer of Health

alPHa
Association of Local
PUBLIC HEALTH
Agencies

2 Carlton Street, Suite 1306
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July 18 2017

Dr. David Williams
Chief Medical Officer of Health
393 University Ave 21st Flr
Toronto, ON M5G 2M2

Ms. Roselle Martino
Assistant Deputy Minister, Health and Long-Term Care
777 Bay St #1903
Toronto, ON M7A 1S5

Dear Dr. Williams and Ms. Martino,

Re: COMOH Recommendations – ISPA and CCEYA

On behalf of members of the Council of Ontario Medical Officers of Health (COMOH), I am writing to inform you of the Council's adoption of recommendations for local medical officers of health (MOHs) to follow regarding public health requirements for the Child Care and Early Years Act and the Immunization of School Pupils Act.

The recommendations are meant to encourage coordinated practice across all 36 health units, and prevent discrepancies, especially as children and adults move between health units.

1. The Child Care and Early Years Act – Vaccine Recommendations for Child Care Workers:

Under section 57, any vaccinations recommended by MOHs for child care workers become mandatory under the Act. COMOH has agreed that all MOHs will at minimum recommend that all child care workers receive vaccines that the National Advisory Committee on Immunization (NACI) recommends* for this group, excluding influenza vaccine.

Some of these vaccinations are not publicly-funded, and the costs of purchase and clinician's fees must be borne by individual. Unfortunately, child care workers are identified in the Ontario Poverty Reduction Strategy as in need of income supplementation given their low wages and we want to ensure that financial barriers are not an obstacle to protecting these individuals and the children in their care.

- **COMOH therefore requests that the Publicly Funded Immunization Schedule be amended such that vaccination recommended for child care workers by MOHs (per NACI recommendation) would be publicly funded for those workers.**

Currently the gaps are varicella and hepatitis B vaccinations, however, as hepatitis B is included in the school vaccination program and many adults have pre-existing natural immunity for varicella, the financial impact is expected to be relatively small. This also supports the Ministry's Immunization 2020 Action #18, to develop targeted health equity approaches for vulnerable communities.

2. The Immunization of School Pupils Act (ISPA):

I) Period of Grace for Vaccination Given up to 4 Days before the Required Date:

COMOH has received for information the recommendation that MOHs consider a 4-day grace period when using the discretionary provision to decide whether to suspend a student under the ISPA. This grace period is meant to strike a balance between the goal of ISPA (to ensure that children are properly vaccinated) and its inflexible timing requirements that are in some cases an impediment to reaching it.

It is up to each MOH to decide, based on his/her discretionary provision, how to implement this in their health unit. Currently, the administrative exemption is the only tool in Panorama for a health unit to use for this purpose and is being recommended for health units to utilize when accepting a vaccine that was administered before the required date.

- **COMOH therefore requests that the Ministry consider a new tool for health units to utilize when implementing a period of grace.**

In particular, the following features should be considered:

- The early dose should be accepted as valid meaning no exemption is required, similar to the estimated vaccination date. There should be no increase to the number of exemptions in the database and no need to analyze these numbers in local/provincial coverage reports.

- There are no impacts to the forecaster and the client will proceed through screening activities without any follow up required.

- These clients will not appear on at-risk reports during an outbreak. If an administrative exemption is used, these clients will appear on 'at risk' reports during an outbreak and staff involved with outbreak management need to asses these records individually prior to contact/case management.

- There is less risk for errors in forecasting and/or screening practices if a separate Panorama function is created.

II) Communication Campaign for Health Care Providers by Ministry

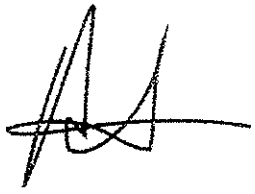
As part of Immunization 2020 Action #8, the Ministry has agreed to launch a coordinated immunization communication strategy. COMOH is requesting the Ministry to work closely with health care partners to share important immunization information to make informed immunization decisions.

- **COMOH therefore requests that the Ministry provide clear guidance to all physicians in Ontario to vaccinate children according to Ontario's Publicly Funded Immunization Schedule, especially adhering to provide vaccinations on or after the specified age (with particular attention to MMR and Meningococcal C vaccinations given on or after the 1st birthday and Tdap-IPV vaccine given on or after the 4th birthday).**

COMOH is fully supportive of ensuring high vaccination rates and preventing disease outbreaks in child care centres and schools. We would be pleased to share further background from the COMOH ISPA

Working Group that developed these recommendations should you require it, and we look forward to working with you to implement the above recommendations.

Sincerely,



Dr. Penny Sutcliffe
Chair, Council of Ontario Medical Officers of Health

COPY: Dr. Jessica Hopkins, Chair, COMOH ISPA Working Group

*https://www.canada.ca/en/public-health/services/publications/healthy-living/canadian-immunization-guide-part-3-vaccination-specific-populations/page-11-immunization-workers.html#p3c10t3