BOARD OF HEALTH MEETING

November 28, 2018

SSM Community Rooms A & B

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Meeting Book - Nov 28, 2018 - Board of Health Meeting

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ALGOMA PUBLIC HEALTH
BOARD OF HEALTH MEETING
AGENDA
NOVEMBER 28, 2018 @ 5:00 PM - SSM ROOM A & B

BOARD MEMBERS

Ian Frazier - Chair
Sergio Saccucci - 1st Vice Chair
Lee Mason - 2nd Vice Chair
Dr. Patricia Avery
Dr. Lucas Castellani
Deborah Graystone
Sue Jensen
Adrienne Kappes
Dr. Heather O'Brien
Ed Pearce
Karen Raybould
Dennis Thompson

APH EXECUTIVES / MEMBERS

Dr. Marlene Spruyt - MOH/CEO
Dr. Jennifer Loo - AMOH
Justin Pino - CFO /Director, Operations
Antoniette Tomie - Director, HR
Laurie Zeppa - Director, Health Promotion /Prevention
Tania Caputo - Board Secretary

1.0 Meeting Called to Order *Ian Frazier*

a. Declaration of Conflict of Interest

2.0 Adoption of Agenda *Ian Frazier*

RESOLUTION	THAT the Agenda dated November 28, 2018 be adopted as presented.

3.0 Adoption of Minutes of Previous Meeting *Ian Frazier*

a. October 24, 2018 Minutes

RESOLUTION	THAT the Board of Health minutes for the month of October 2018 be adopted as presented.

4.0 Delegations / Presentations

a. Keynote Speaker Gil Penalosa presented at 50th Anniversary Celebration in the afternoon on this day

5.0 Business Arising from Minutes *Ian Frazier*

6.0 Reports to the Board

a. Medical Officer of Health and Chief Executive Officer Reports *Marlene Spruyt*

i. MOH Report - November 2018

RESOLUTON	THAT the report of the Medical Officer of Health and CEO for the month of November 2018 be adopted as presented.

b. Finance and Audit Committee Report

i. Finance and Audit Committee Chair Report *Sergio Saccucci*

RESOLUTION	THAT the Finance and Audit Committee Chair Report for November 14, 2018 be approved as presented

ii. Financial Statements for the period ending September 30, 2018 *Justin Pino*

RESOLUTION	THAT the Financial statements for the period ending September 30, 2018 be approved as presented

iii. **Briefing Note - 2018 Contribution to APH Reserve Fund** *Justin Pino*

RESOLUTION	THAT the Finance and Audit Committee has reviewed and put forth to the Board of Health for approval the 2018 Contribution to APH Reserve Fund.

iv. **2019 Public Health Operating and Capital Budget** *Justin Pino*

2018-60	THAT the Finance and Audit Committee has reviewed and put forth to the Board of Health for approval the 2019 Public Health Operating and Capital Budget

c. Governance Committee Report *Lee Mason*

i. Governance Committee Chair Report

RESOLUTION	THAT the Governance Committee Chair Report for November 7, 2018 be approved as presented

ii. Monthly and Yearly Evaluations

RESOLUTION	THAT the Governance Committee has reviewed and put forth to the Board of Health the revised Monthly and Yearly Board Evaluations to be adopted as presented beginning in 2019.

iii. 02-05-086 Sponsorship of Charitable Organizations

RESOLUTION	THAT the Governance Committee has reviewed and put forth to the Board of Health the 02-05-086 Sponsorship of Charitable Organizations to be adopted as presented.

iv. 02-05-025 - Board Remuneration

RESOLUTION	THAT the Governance Committee recommend the Board of Health adopt the change of renumeration for attendance at Board meetings to be $109 and; THAT staff is directed to review and bring information to the first Governance meeting in 2019 regarding travel time remuneration for geographic areas and conference attendance.

iii. 02-05-035 - Continuing Education for Board Members

RESOLUTION	THAT the Governance Committee recommend and put forth to the Board of Health the revised policy 02-05-035 Continuing Education for Board Members to be adopted as presented.

7.0 New Business/General Business *Ian Frazier*

8.0 Correspondence *Ian Frazier*

a. Letter to the Premier from HCHU re Ontario Basic Income Research Project dated Nov 8, 2018.

b. Letter to the Ministry of Attorney General from Peterborough Public Health regarding Regulatory Framework for Cannabis Storefronts in Ontario dated Nov 8, 2018

c. Letter to the Ministry of the Attorney General from Peterborough Public Health regarding Provincial Legislation for Cannabis and the amended Smoke-Free Ontario Act dated Nov 18, 2018

d. Letter to the Minister of Health from Peterborough Public Health regarding A Public Health Approach to Drug Policy Reform dated Nov 2, 2018

e. Letter to the Minister of Health from Peterborough Public Health regarding Sustainable Infrastructure and Financial Supports for local drug strategies dated Nov 5, 2018

f. Letter to the Minister of Health from Peterborough Public Health regarding Strengthening the Smoke-Free Ontario Act to address the promotion of vaping dated Nov 5, 2018

g. Letter to the Premier from Southwestern Public Health regarding Increased Actions to Opioid Crisis dated October 24, 2018

9.0 Items for Information *Ian Frazier*

10.0 Addendum: *Ian Frazier*

11.0 In-Camera *Ian Frazier*

For discussion of labour relations and employee negotiations, matters about identifiable individuals, adoption of in-camera minutes, security of the property of the board, litigation or potential litigation.

RESOLUTION	THAT the Board of Health go In-Camera

12.0 Open Meeting *Ian Frazier*

a. Resolutions resulting from in-camera meeting

13.0 Announcements / Next Committee Meetings: *Ian Frazier*

Board of Health Meeting:
January 23, 2019 @ 5:00 pm
Sault Ste. Marie, Room A

14.0 Evaluation *Ian Frazier*

15.0 Adjournment *Ian Frazier*

RESOLUTION	THAT the Board of Health meeting adjourns

ALGOMA PUBLIC HEALTH
BOARD OF HEALTH MEETING
MINUTES
OCTOBER 24, 2018 @ 5:00 PM - SSM ROOM A

PRESENT :

BOARD MEMBERS
Ian Frazier - Chair
Sergio Saccucci - 1st Vice Chair
Lee Mason - 2nd Vice Chair
Dr. Patricia Avery
Deborah Graystone
Dr. Heather O'Brien
Karen Raybould

APH EXECUTIVES / MEMBERS
Dr. Marlene Spruyt - MOH/CEO
Dr. Jennifer Loo - AMOH
Justin Pino - CFO /Director, Operations
Antoniette Tomie - Director, HR
Tania Caputo - Board Secretary

T/C : none

REGRETS : Sue Jensen, Adrienne Kappes, Lucas Castellani, Dennis Thompson, Ed Pearce

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1.0 Meeting Called to Order

a. Declaration of Conflict of Interest

I.Frazier called the meeting to order at 5:01 pm

2.0 Adoption of Agenda

2018-77

Moved: L. Mason

Seconded: H. O'Brien

THAT the Agenda items dated October 24, 2018 be adopted as presented.

CARRIED

3.0 Adoption of Minutes of Previous Meeting

a. September 26, 2018 Minutes

2018-78

Moved: L. Mason

Seconded: P. Avery

THAT the Board of Health minutes for the month of September 2018 be adopted as presented.

CARRIED

4.0 Delegations / Presentations

a. Health Equity / Poverty

Deborah Antonella presented to the board on Health Equity and Public Health Action. Her presentation covered the following topics: Social Determinants of Health, Poverty and Health in Algoma and the Bridges out of Poverty initiative.

Discussion on how the program works and the impact on people in our community. Deborah spoke about the steps for a person to build a future story and support systems through a network of partnerships with other community organizations. Discussion continued on funding, evaluations and future plans for more awareness sessions here and in the district.

5.0 Business Arising from Minutes

None

6.0 Reports to the Board

a. Medical Officer of Health and Chief Executive Officer Reports

i. MOH Report - October 2018

M. Spruyt provided an overview of the October report featuring Community Immunization and Influenza report and Rabies Prevention and Control.
A question about how we acquire immunization data from the pharmacies was posed with an explanation provided that we are able to access this through a Ministry of Health database.

2018-79

Moved: H. O'Brien

Seconded: L. Mason

THAT the report of the Medical Officer of Health and CEO for the month of October 2018 be adopted as presented.

CARRIED

b. Finance and Audit Committee Report

i. Financial Statements for the period ending August 31, 2018

J.Pino discussed the Financial statements, providing commentary on variances and surplus shown in the report. The 2019 operating budget will be presented at the November BoH meeting along with the proposed contribution to the reserve fund. Questions were asked about the amortization of the mortgage and the plan for this. Mr. Pino discussed the various options the board may wish to explore at that time.

2018-80

Moved: P. Avery

Seconded: D. Greystone

THAT the Financial statements for the period ending August 31, 2018 be approved as presented

CARRIED

ii. Finance and Audit Committee Report for October 2018

The October 10 meeting was cancelled due to lack of quorum. The agenda items will be deferred to the next meeting in November

I. Frazier reminded everyone about the next meeting and thanked all for their efforts in attending the meetings.

7.0 New Business/General Business

None

8.0 Correspondence

a. Letter to the Minister of Children, Community and Social Services from Southwestern Public Health regarding Ontario Basic Income Pilot Project dated September 25, 2018.

b. Letter to the Minister of Justice from Southwestern Public Health regarding Repeal of Section 43 of the Criminal Code of Canada dated September 25, 2018.

c. Letter to the Minister of Health and Long-Term Care and Deputy Premier from KFL&A Public Health regarding why Ontario needs a chronic disease prevention strategy dated September 27, 2018.

d. Letter to the Prime Minister of Canada from KFL&A Public Health regarding Drug Policy Reform dated September 27, 2018.

9.0 Items for Information

a. Canada's Lower-Risk Cannabis Use Guidelines (LRCUG)

A question was asked about sharing information like this with the school boards. Our school team works with school and Boards of education to provide resources as required.

b. Smoke-Free Ontario Act

J. Loo provided follow up on the SFOA. The legislation has now been enacted and licensed retailers will be able to promote but cannot display products

10.0 Addendum:

None

11.0 In-Camera - 5:58 pm

A. Tomie and J. Pino excused themselves prior to the in-camera meeting

For adoption of in-camera meeting minutes and / discussion of labour relations and employee negotiations, matters about identifiable individuals, security of the property of the board, litigation or potential litigation.

2018-81	**Moved:** L. Mason **Seconded:** S. Saccucci THAT the Board of Health go In-Camera **CARRIED**

12.0 Open Meeting - 6:16 pm

13.0 Announcements / Next Committee Meetings:

Governance Committee

November 7, 2018 @ 4:30 pm

Prince Meeting Room, 3rd Floor

Finance & Audit Committee

November 14, 2018 @ 4:30 pm

Prince Meeting Room, 3rd Floor

Board of Health Meeting:

November 28, 2018 @ 5:00 pm

Sault Ste. Marie, Room A

14.0 Evaluation

I. Frazier reminded all Board members to complete the monthly evaluation of the meeting.

15.0 Adjournment - 6:30 pm

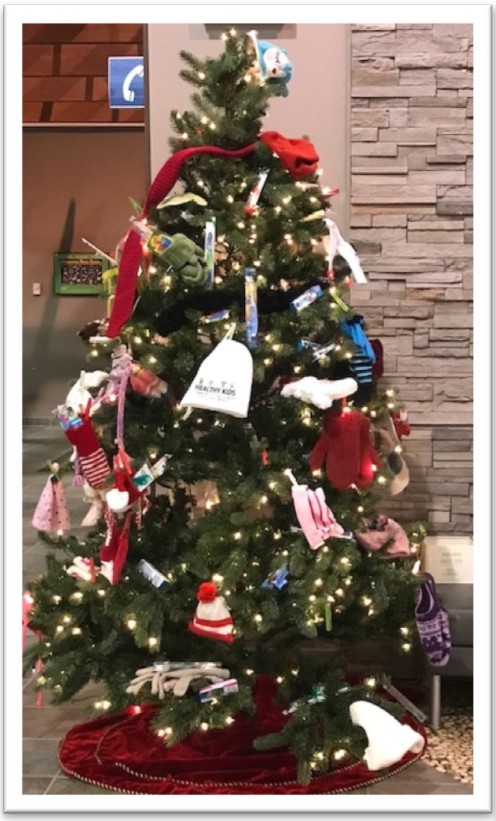
2018-82	**Moved:** P. Avery **Seconded:** S. Saccucci THAT the Board of Health meeting adjourns **CARRIED**

Ian Frazier, Chair	**Tania Caputo, Secretary**
Date	**Date**

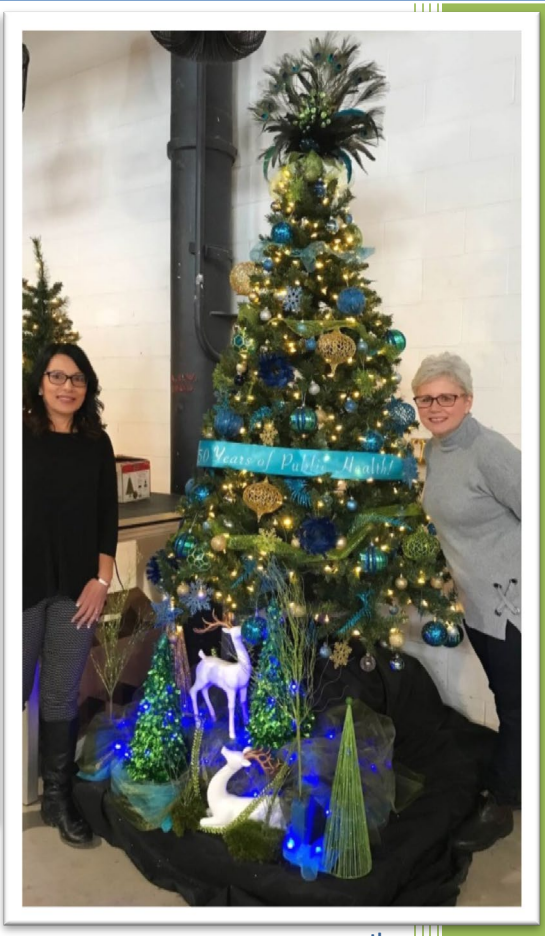
Algoma PUBLIC HEALTH
Santé publique Algoma

November 2018

Medical Officer of Health / CEO



Mitten Tree
Decorated with donated toques, scarves, mitts and socks from APH staff



Festival of Trees - APH 50th Anniversary Tree
Decorated by: Antonella Misasi, Tracey McClelland, Tania Caputo

Prepared by:
Dr. Marlene Spruyt and the Leadership Team

Presented to:
Algoma Public Health Board of Health
11/28/2018

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APH AT-A-GLANCE

The November 2018 BOH meeting marks the end of this current 4-year municipal cycle. For some of you, this may be your final year with the APH Board. I thank you for your service. New municipal councils begin their new 4-year term effective Dec 3, 2018, and we expect to hear who they have appointed in the weeks following their first meetings. Our provincial appointees have varying end dates as most of them were appointed for 3-year terms but at different times over the past few years. We anticipate that there will be some new members and have begun tentative planning for an Educational Session in mid- January 2019.

Management finalized the budget for 2019 and it was presented at the Finance and Audit Committee earlier this month before being presented to the full Board.
Our data for the 3rd quarter ending September 2018 is included for your review along with Program Reports for Tobacco Control a public health funded program and Infant, Child Development Program which is funded separately from our mandatory public health programs.
And much of the past week was spent with preparations for our 50th Anniversary celebrations. We hope that you are able to attend some of the celebrations.
Jennifer and I were able to attend the Council of Medical Officers of Health (COMOH) meeting in Toronto on October 30. We had been hoping that we might have been provided with some information from the new government regarding their vision for public health but the Minister cancelled her attendance. Additionally, you are aware that the Minister of Finance released their Economic Outlook and Fiscal review which can be found here.
https://www.fin.gov.on.ca/fallstatement/2018/fes2018-en.pdf

The message is clear that there will be no new dollars and that we should all expect to do more with less. However, details are not clear. We are hearing some suggestion that there is serious consideration of the implementation of a Low Income Seniors Dental program.

PROGRAM HIGHLIGHTS

Topic: Comprehensive Tobacco Strategy

From: Kristy Harper, Community Wellness
Chris Spooney, Environmental Health
Laurie Zeppa, Health Promotion & Prevention
Jennifer Loo, Health Protection

Public Health Goals:

- To reduce the burden of preventable injuries and substance use.
- To reduce the burden of chronic diseases of public health importance and improve well-being.

Substance Use and Injury Prevention

Requirement 2. The board of health shall develop and implement a program of public health interventions using a comprehensive health promotion approach that addresses risk and protective factors to reduce the burden of preventable injuries and substance use in the health unit population.

Requirement 3. The board of health shall enforce the *Smoke-Free Ontario Act* in accordance with the *Tobacco Protocol, 2018.*

Chronic Disease Prevention and Well-Being

Requirement 2. The board of health shall develop and implement a program of public health interventions using a comprehensive health promotion approach that addresses chronic disease risk and protective factors to reduce the burden of illness from chronic diseases in the health unit population.

Key Messages

- Algoma residents continue to bear an unacceptably high burden of preventable, tobacco-related disease.
- Algoma Public Health (APH) engages in the four pillars of comprehensive tobacco control by:

    - Voicing Board of Health (BOH) support for healthy public policies that protect Algoma youth from the marketing efforts of industry.
    - Protecting Algoma residents from the harms of tobacco and second-hand smoke through the enforcement of provincial smoke-free legislation, and the implementation of local smoke-free by-laws and policies.
    - Preventing Algoma youth from using commercial tobacco through youth-led engagement initiatives as well as supporting culture-based health promotion events with First Nation communities.
    - Delivering smoking cessation services to APH clients and leading Algoma's 5 in 5 partnerships toward improving access to smoking cessation services in Algoma.

- Comprehensive tobacco control remains a top public health priority at APH. Crucial next steps include working with municipalities in the context of updated provincial regulations, strengthening evidence-informed youth prevention strategies, and continuing to build community partnerships to intensify cessation efforts across Algoma.

Local public health and comprehensive tobacco control: the Ontario context

- Commercial tobacco smoking is the leading cause of preventable death in Canada and causes extensive, serious health harms to the entire body.[1]
- About 15,000 Ontarians die each year from diseases caused by smoking, which costs $2.2 billion in direct health care expenses.[2]
- Public health efforts to combat tobacco harms have been underway for decades in Ontario. Currently, comprehensive tobacco control in Ontario is guided by evidence-based actions aligned to four pillars[3]:

    - **Industry**: actions and interventions that most effectively counter the tobacco industry's efforts to promote and sell their products.
    - **Protection**: interventions in settings that would enhance protection for all Ontarians from physical exposure to second hand smoke and third hand smoke and from social exposure to smoking, vaping and using other tobacco products.
    - **Prevention**: primary and secondary tobacco prevention interventions that effectively target tobacco use among youth and young adults.
    - **Cessation**: interventions that motivate, encourage and support efforts to quit smoking, at both the population and individual levels.

- APH has a strong and ongoing mandate to engage in health protection, prevention and health promotion with respect to tobacco, under the requirements of the *Health Protection and Promotion Act* and the Ontario Public Health Standards, as well as the *Smoke-Free Ontario Act, 2017*.

Algoma communities still have a high burden of preventable, tobacco-related disease

Smoking continues to harm Algoma residents across the lifespan, from infants still in the womb, to children and youth, to working-age adults, to seniors.

- Algoma's smoking rate is almost twice as high as Ontario's (29.6% vs. 15.5%).[4]
- Algoma youth aged 12 to 19 are less likely to stay abstinent from smoking compared to Ontario youth (73.6% vs. 89.7%).[4]
- 20.1% of pregnant women smoke in Algoma, compared to 7.4% in Ontario.[5]
- A very high percentage of working-age adults in Algoma continue to smoke.[6]
    - 37.9% of adults aged 20-44 smoke on a daily or occasional basis
    - 39.4% of adults aged 45-64 smoke on a daily or occasional basis

Smoking-related diseases are completely preventable, but they continue to affect many Algoma residents.

- Many working-age adults die prematurely from heart disease in Algoma. An estimated 45% of heart disease deaths in adults aged 35-64 are due to smoking in Algoma.[7]
- Algoma has higher lung cancer death rates than Ontario.[4] Estimates show that over 90% of lung cancer deaths in Algoma men are due to smoking and over 80% of lung cancer deaths in Algoma women are due to smoking.[7]

Comprehensive tobacco control and APH: Industry

The BOH continues to be a strong voice for community health and well-being with respect to comprehensive tobacco control. Most recently in September 2018, the BOH for APH, along with many other public health partners, publicly called for provincial legislation to protect Ontario's youth by banning the display and promotion of vapour products.[8] This was an evidence-informed position based on studies showing that e-cigarette use among youth and young adults increases their risk of ever using combustible tobacco cigarettes.[9] In October, 2018, amendments to the *Smoke-Free Ontario Act, 2017* preserved a ban on the display of vapour products.[10]

Comprehensive tobacco control and APH: Protection

Tobacco enforcement by APH focuses on preventing the display, promotion, and sale of tobacco products to individuals under 19 years of age, and protecting the public and employees from the harmful effects of second-hand smoke through enforcement of provincial legislation. Every enforcement activity is an opportunity for public health education, which often involves ongoing collaboration with owners and operators, municipalities, other community stakeholders, and the general public. APH engages in health protection of Algoma communities through the interpretation of regulations, risk assessments, and risk communication to involved partners.

APH staff who are provincially designated as tobacco enforcement officers are responsible enforcing the *Smoke-Free Ontario Act, 2017* at all regulated premises. These premises include tobacco retailers, schools, residential care facilities, hospitals, bars and restaurants, places of entertainment, tobacconists, and multi-complex dwellings. APH has a role in following up on public complaints with regards to these premises, and conducting compliance inspections.

Algoma has about 100 tobacco vendors that APH inspects for compliance with display, marketing and product restrictions under the *Smoke-Free Ontario Act, 2017* and its regulations. APH specifically conducts access to minors or test shop inspections to verify that vendors in Algoma are not selling tobacco products to youth under the age of 19.

In 2018, APH observed 20 tobacco-related infractions which resulted in the issue of 9 warnings and 11 charges:

- 5 charges were issued for selling tobacco to a minor
- 6 charges were issued for smoking on a designated smoke-free property

At the local level, APH also supports municipalities in Algoma with respect to the development and implementation of smoke-free municipal by-laws and institutional policies. Recently, APH supported owners and managers of multi-unit housing to implement smoke-free housing policies, and facilitated

informational discussions with tenants. This past year, APH has also supported two local school boards with policy updates to further protect students and staff from exposure to secondhand smoke and vapour.

Comprehensive tobacco control and APH: Prevention

Prevention initiatives are built on a youth engagement approach, in which youth-led committees across Algoma help to develop, implement and evaluate tobacco prevention campaigns. In 2018, 34 youth leaders have been involved in this work and have gained valuable leadership skills. The youth identify acquiring an increase in knowledge and skills to stay smoke-free, prevent others from starting to smoke and help others interested in quitting. Campaign activities include the development and distribution of youth relevant resources, facilitating school and community presentations and organizing tobacco free events.

A specific focus for the youth activities is to raise awareness about onscreen tobacco use. Exposure to onscreen tobacco use has been demonstrated to increase smoking initiation among youth.[3] Smoke-free movie events and displays are organized to help youth develop critical thinking skills and media literacy when it comes to tobacco use and the imagery in films.

Youth prevention also includes collaboration with Indigenous communities to integrate culturally relevant tobacco prevention. For example, the Movers and Shakers youth program, led by Maamwesying North Shore Health Services' Aanjichigewin Health Promotion Program, is an annual culture based health promotion event hosted in partnership with APH, Cancer Care Ontario Aboriginal Program, and the Aboriginal Sports and Wellness Council of Ontario. This year, 99 youth, elders and adult allies from First Nation communities along the North Shore and the Sault Ste. Marie Indian Friendship Centre participated. Youth gained land based and cultural teachings and skills that support healthy lifestyles, including exploring the sacred use of tobacco in contrast to the commercial misuse of tobacco. Evaluations demonstrated that 74% of respondents reported this event reinforced their determination to quit and not to misuse tobacco.

Comprehensive tobacco control and APH: Cessation

APH is involved in the delivery and support of community tobacco cessation interventions in an effort to reduce the high smoking rates.

APH continues to lead a district-wide community partnership that was established to target reducing tobacco rates by 5% in 5 years. This 5 in 5 partnership includes family health teams, hospitals, long term care facilities, nurse practitioner-led clinics, pharmacies, academic institutions, addiction and mental health services, and workplaces all working together to improve tobacco cessation services throughout Algoma. At this time, the partnership is exploring trends and gaps, with the goal to coordinate and enhance tobacco cessation services for those who want to quit.

APH also provides tobacco cessation services, which include:

- Tobacco Brief Contact Intervention: all clients accessing APH services are asked about their smoking status and informed and referred to services as appropriate.

- Delivery of tobacco cessation clinic services to clients who don't have access through other health agencies. This service includes nicotine replacement therapy tailored to individual needs as appropriate.
- Integrated smoking cessation services are provided for clients involved in APH programs through Healthy Babies Healthy Children, Community Mental Health Program and Community Alcohol and Drug Addiction Program.
- Smoking cessation program/policy development consultation services to academic institutions and workplaces upon request.

To further promote tobacco cessation services, APH provides awareness and education on the health impacts of tobacco use. This includes communication campaigns, such as the recent 'this is my quit story", which focused on providing an avenue for individuals who have experienced health consequences from smoking to share their story as encouragement for others to make quit attempts. The testimonials can be viewed here: http://www.algomapublichealth.com/healthy-living/tobacco/this-is-my-quit-story/.

Comprehensive tobacco control: a public health priority in Algoma

APH continues to prioritize comprehensive tobacco control as a top public health issue of concern, in light of the ongoing widespread use of commercial tobacco in Algoma, and the significant health burden of tobacco-related disease.

In October 2018, amendments to the *Smoke-Free Ontario Act, 2017* harmonized the regulatory framework for tobacco, vapour products, and cannabis. APH has already begun work to support Algoma municipalities in exploring local opportunities to protect residents, particularly youth, from the health harms of these substances. Further by-law and organizational healthy public policy work will continue in 2019.

Internally, both the health promotion and health protection teams have newly aligned staff to smoke-free initiatives and these team members are beginning to engage in joint, interdisciplinary planning. A major priority is to advance an integrated public health approach to tobacco, with a focus on strengthening evidence-informed youth prevention strategies and continuing to build community partnerships in order to intensify cessation efforts.

References

1. Health Canada. Smoking and Your Body: Health effects of smoking. 2011. Government of Canada. Retrieved 2018-11-08 from https://www.canada.ca/en/health-canada/services/health-concerns/tobacco/smoking-your-body.html.
2. Dobrescu, Alexandru, Abhi Bhandari, Greg Sutherland, and Thy Dinh. *The Costs of Tobacco Use in Canada, 2012*. Ottawa: The Conference Board of Canada, 2017.
3. Smoke-Free Ontario Scientific Advisory Committee, Ontario Agency for Health Protection and Promotion (Public Health Ontario). Evidence to guide action: Comprehensive tobacco control in Ontario (2016). Toronto, ON: Queen's Printer for Ontario; 2017.
4. Algoma Public Health. Community Health Profile, 2018. Sault Ste. Marie, ON: Algoma Public Health; 2018.
5. Public Health Ontario. Snapshots: Maternal Health Snapshot. Smoking during pregnancy >> Overall per cent >> 2016 [Internet]. Toronto, ON: Queen's Printer for Ontario; c2018 [updated 2018 Oct 12]. Retrieved 2018-11-08 from https://www.publichealthontario.ca/en/DataAndAnalytics/Snapshots/Pages/Maternal-health.aspx.
6. Public Health Ontario. Snapshots: self-reported smoking snapshot. Self-reported adults current smoking rate (daily or occasional) >> Age-specific rate >>2015-2016 [Internet]. Toronto, ON: Queen's Printer for Ontario; c2018 [updated 2018 Jul 27]. Retrieved 2018-11-08 from https://www.publichealthontario.ca/en/DataAndAnalytics/Snapshots/Pages/Health-Behaviours---Smoking.aspx.
7. Algoma Public Health. 2018. Internal data: population-attributable fraction for smoking. Ontario Mortality Data [2008-2012], Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracted: [Sep 27, 2018]. Canadian Community Health Survey [2009-2012], Statistics Canada, Share File, Ontario MOHLTC. Methodology from Association of Public Health Epidemiologists of Ontario (APHEO): http://core.apheo.ca/index.php?pid=253
8. Board of Health for Algoma Public Health. Resolution: Protection of Algoma youth from e-cigarette industry marketing through the retention of *Smoke Free Ontario Act, 2017* provisions that ban the display and promotion of vapour products (electronic cigarettes). September 26, 2018. Retrieved 2018-11-19 from http://www.algomapublichealth.com/media/2829/sep-26-2018-board-of-health-meeting-book.pdf.
9. National Academies of Sciences, Engineering, and Medicine, Health and Medicine Division, Board on Population Health and Public Health Practice, Committee on the Review of the Health Effects of Electronic Nicotine Delivery Systems. Public Health Consequences of E-Cigarettes. Washington, DC: National Academy of Sciences; 2018.
10. *Smoke-Free Ontario Act, S.O. 2017, c. 26, Sched. 3.* Available from https://www.ontario.ca/laws/statute/17s26

Topic: Infant and Child Development Program

From: Hannele Dionisi, Child and Family Services
Antoniette Tomie, Human Resources/Corporate Services

Program Goal

The Infant and Child Development Program (ICDP) is part of a range of healthy child development programs that seek to enhance the growth and development of children, including those with a developmental disability and/ or risk of developmental delay.[1] Programs that focus on identifying and providing support early in life improve the course of a child's potential development.

Program Funder

Ministry of Children, Community and Social Services (MCCSS)

Key Messages

- ICDP is an early intervention program that supports families of children with a developmental disability and/or risk of developmental delay.
- Early intervention services are provided through home visits, clinical appointments, school transition and collaboration with community partners. In 2017-18 ICDP provided services to 720 children/families.
- Services provided are family centred, recognize the important role of parents in the development of their children, and promote working with children within their everyday routines.

Introduction

Early childhood or 'the early years' is the most important developmental phase of life in which crucial advancements in physical, social, cognitive, emotional and language domains takes place.[3]

The Infant and Child Development Program is a voluntary early intervention program that supports families of children with a developmental disability and/or risk of developmental delay. ICDP is part of a wide range of child health programs in Ontario that support early childhood development such as Healthy Babies Healthy Children Program (HBHC), Preschool Speech and Language Services (PSLS), Children's Treatment Centres (CTC) and Ontario Autism Program (OAP). Program services are available to all families across the District of Algoma.

Children from birth to 5 years of age, who have a developmental disability and/or risk of developmental delay, are eligible for this program. Prenatal exposures to alcohol or drugs, prematurity, genetic disorders, autism spectrum disorder, difficulties with self-regulation or a child who is not meeting developmental milestones are a few reasons for referral to ICDP. A diagnosis from a health care provider is not required for requesting ICDP services.

Referrals are received from various sources including parents, health care providers, and community agencies. Provincially, the top 5 referral sources are HBHC, CTC, Children's Aid Society, physicians, and parents.

Once a referral is received by APH, the family is contacted within 2-4 weeks to schedule an intake visit. This initial visit provides an opportunity to assess the needs of the child/family, process any immediate referrals and to connect the family with other community agencies as needed. The parent/caregiver is provided with initial strategies until they are transferred to active service. The intake PCA contacts the family periodically during this transition period to assess current status and any emerging needs. At this time approximately 70 families are

awaiting transfer to active service which could take between 3-6 months. Parents play a vital role in the development of their child; therefore Parent Child Advisors, focus on engaging parents/caregivers throughout the delivery of services from initial assessment to discharge.

Parent Child Advisors (PCA) provide services to both the child and family including assessments, counselling, advocacy, information about child development, parent coaching, play-based learning, assisting families with school transitions, and coordinating services with other community agencies.

A core component of this program is working in partnership with other service providers *in an effort to meet the families identified goals and provide optimal child development.

Population Health Snapshot

We can estimate that in Algoma there are approximately 96 children aged 0 to 5 years old that are diagnosed with Autism Spectrum Disorder, based on the Canadian prevalence of 1 in 66 children.

Additional factors that are reasons for a referral to our services are premature births and prenatal substance use. In 2016, 11.2% of live births in Algoma were premature, delivered before 37 weeks gestation, as compared to 8.1% in Ontario. Furthermore, 5.6% of mothers who gave birth reported substance use during their pregnancy as compared to 4.3% in Ontario.

ICDP services are available for children throughout the District of Algoma. The following table indicates the total number of children serviced in Blind River, Elliot Lake, Sault Ste. Marie and Wawa from April 1, 2017 to March 31, 2018:

	Blind River	Elliot Lake	SSM	Wawa	TOTAL
# of Clients Serviced	33	85	571	19	708

Additionally, for a number of years ICDP services have been offered to one of Algoma's First Nations communities through a service agreement. In 2017-18, there were 12 children that received services in this community.

ICDP Interventions:

Services are provided based on the following principles:

Family-Centred: The program will focus on building the capacity of the parent/caregiver to nurture and enhance the child's well-being and development.

Supportive of Function Outcomes: ICDP professionals will collaborate with families/caregivers to enhance their child's participation in family routines by embedding learning strategies into usual routines.[1]

Collaborative and coordinated: ICDP services will collaborate with other programs in the broader children's service sector to support coordinated service delivery.[1]

*Some key program partners include: Healthy Babies Healthy Children, Preschool Speech and Language Services, Licensed Child Care, THRIVE Child Development Centre, Algoma Family Services, EarlyON Centres, Waabinong Head Start Family Resource Centre, Children's Aid Society, Nog Da Win Da Min, Child and Community Resources, Community Living Algoma, First Nation Communities, Special Needs Strategy Coordinated Service Planning, Algoma District School Board, Huron Superior Catholic District School Board, Conseil Scolaire Catholique du Nouvel-Ontario and Conseil Scolaire Public du Grand-Nord de L'Ontario, Ontario Association of Infant and Child Development, Ministry of Children, Community and Social

Children that receive services early in life increase their opportunities for success in school and overall development. The following core services are provided with a framework that is family-centred, includes routine-based interventions, and collaboration with community partners;

Home Visiting Service:

Parent child advisors provide services in a variety of settings, including in the home. As the primary location of service delivery, home-based services allows the parent child advisor the opportunity to work in the child's natural environment, observe daily routines and develop the atmosphere of trust and understanding that is an integral part of any family-oriented program. Home-based intervention also includes providing services in community settings where the family is participating (i.e., therapy appointments, EarlyON Centres, etc.).

Clinical Services:

A weekly developmental clinic is available at APH in Sault Ste. Marie every Wednesday afternoon.
When a family attends the clinic, a PCA is able to screen the child's development, provide support and education about their child, and complete any referrals that may be needed to other community resources.

School Transition:

The transition into school may be critical for many children and their families and can be a complex process. If needed a PCA will support the transition of the child into the formal education system, by coordinating school transition meetings and sharing information about the child's functional abilities, goal achievement with the school transition team.

Parent child advisors invite parents and all professionals that are servicing the child/family to participate in the transition process (i.e. THRIVE, daycare staff, Child and Community Resources). This is an opportunity for the parent/caregiver to meet the school team, share any concerns related to their child starting school and address any supports the child may require upon school entry.

Community Collaborative Supports:

Parent child advisors works closely with APH programs and community partners to provide services and supports that work on building families strengths and capacities. Focusing on an interdisciplinary approach with our partners provides the greatest opportunity for optimal development of the child and family.

An example of collaboration is the Parent Coffee Break that is offered by several community agencies throughout the district. Families can connect to these sessions in person or through videoconference. Parents/caregivers are encouraged to provide suggestions on topics that would be supportive of their needs.

Next Steps

In October 2018, the Ministry of Children, Community and Social Services released the revised Infant and Child Development Program Guidelines to standardize program delivery, provide evidenced based research to support service delivery and connect the program with the wider children's services sector across Ontario.

The *new* age eligibility for referral to ICDP is birth to school entry from previous birth to 5 years of age. ICDP will be working in collaboration with community partners to implement this change in service delivery in 2019. The guidelines highlight ICDP professionals as part of the continuum of supports accessible to families. The revised guidelines also define a framework for service delivery that is family centred, recognizes the role of parents in the

identification and assessment of their children, and promotes working with children within their everyday routines.

Respectfully submitted,

Dr. Marlene Spruyt

References

1. Infant and Child Development Program Guidelines, Ministry of Children, Community and Social Services, October 2018.
2. Ontario Association for Infant and Child Development, www.oaicd.ca , 2017
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4. Centre of Excellence for Early Childhood Development, 2018
5. Prevalence reference: https://www.canada.ca/en/public-health/services/diseases/autism-spectrum-disorder-asd/surveillance-autism-spectrum-disorder-asd.html
6. Statistics Canada. 2017. The District of Algoma Health Unit, [Health region, December 2017], Ontario and Ontario [Province] (table). Census Profile. 2016 Census. Statistics Canada Catalogue no. 98-316-X2016001. Ottawa. Released November 29, 2017. https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/index.cfm?Lang=E (accessed November 22, 2018).
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8. Ontario Agency for Health Protection and Promotion (Public Health Ontario). Snapshots: Maternal health Snapshot: smoking during pregnancy–overall per cent 2015 [Internet]. Toronto, ON: Queen's Printer for Ontario; c2018 [updated 2018 Oct 12; cited 2018 Nov14]. Available from:publichealthontario.ca/en/DataAndAnalytics/Snapshots/Pages/Maternal-health.aspx

HEALTH INDICATORS

		2018 Q1 JAN - MAR	2018 Q2 APR - JUN	2018 Q3 JUL - SEP	2018 YEAR TO DATE					2017 YEAR END
HBHC POSTPARTUM		**Q1**	**Q2**	**Q3**	**WW**	**SSM**	**BR**	**EL**	**YTD**	**2017 YE**
	Phone Calls	127	118	130	10	307	36	22	375	621
	Home Visits	49	54	47	3	138	9	0	150	244
COMMUNITY MENTAL HEALTH		**Q1**	**Q2**	**Q3**					**YTD**	**2017 YE**
	CMH New Clients: Individuals receiving 1st service	61	51	48					160	209
	CMH non registered: Client Interactions	313	322	344					979	1,182
CADAP LHIN FUNDED PROGRAMS		**Q1**	**Q2**	**Q3**					**YTD**	**2017 YE**
	New Client admissions Clinics / programs	155	77	110					342	515
	Direct Client interactions / group or individual including anonymous clients AS / SRP groups included	355	265	310					930	1,143
	Back on Track Group 1 and 2 day course participants / Group Participants - every 90 days	14	17	15					46	115
SUBSTANCE MISUSE		**Q1**	**Q2**	**Q3**	**WW**	**SSM**	**BR**	**EL**	**YTD**	**2017 YE**
Needle Exchange	Needles distributed	86,066	79,107	75,070	0	231,047	63	9,133	240,243	293,382
	Needles returned - NEP (estimates)	19,625	15,247	20,288	0	52,840	0	2,320	55,160	70,649
	Needles returned - Drop Bins SSM (estimates)	59,872	63,851	68,643	0	192,366	0	0	171,103	151,440
Addictions - Overdose Prevention	Naloxone trainings completed - with at risk individuals	131	208	166	18	93	0	20	505	200
HEALTH PROTECTION		**Q1**	**Q2**	**Q3**	**WW**	**SSM**	**BR**	**EL**	**YTD**	**2017 YE**
Safe Water	Private Wells - Adverse Reports	10	47	165	7	168	40	7	222	232
	Regulated Premise - ADW (O.reg.319)	0	6	4	5	1	2	2	10	25
	Boil Water Advisory	5	8	5	3	6	6	3	18	11
	Drinking Water Advisory	1	2	0	1	1	1	0	3	3
	Beach Closures	0	0	6	0	4	2	0	6	8
Rabies	Risk investigations initiated	35	51	62	6	115	19	8	148	217

HEALTH PROTECTION (CONT'D)		Q1	Q2	Q3	WW	SSM	BR	EL	YTD	2017 YE
Food Safety	Special Event Permits issued	52	92	126	8	161	70	31	270	268
	Food Handler Training (# persons)	134	159	96	19	284	50	36	389	411
	Farmers Market Approvals	0	45	14	0	63	19	5	87	108
Health Hazard	Complaint / Investigations all types	34	51	35	0	107	11	2	120	228
Land Control - OBC	Applications / Permits - Class IV	6	57	61	2	91	22	9	124	145
Communicable Disease Control	Institutional outbreaks	17	7	0	1	19	1	3	24	26
	Outbreak days in quarter	201	75	0	5	212	17	42	268	424
	Gonorrhea	6	5	5	1	13	1	1	16	40
	Chlamydia	0	63	64	2	180	6	11	199	291
	BBI (Hep B, C, HIV)	26	32	20	0	68	0	1	69	85
	Confirmed influenza cases	135	19	0	2	134	2	15	153	87
	Other reportable diseases	42	10	18	3	60	5	2	54	124

*the SSM column is the cumulative district data

CONTRACEPTIVE PURCHASES	Q1	Q2	Q3	WW	SSM	BR	EL	YTD	2017 YE
14-19 years	55	35	34		124			124	394
20-24 years	95	79	48		222			222	631
25-29 years	171	157	141		469			469	764
30 + years	166	172	181		519			519	712
Total	487	443	404		1,334			1,334	2,501

CALLS TO THE SEXUAL HEALTH LINE	1,203	997	938					3,138	2,514

TOBACCO CESSATION	Q1	Q2	Q3	SSM	DISTR.	YTD	2017 YE
Number of APH clients assessed or reassessed for tobacco use using Brief Contact Interventions (BCI)	713	563	605	1,674	207	1,881	2,953
Number of clients referred by staff to further intensive smoking cessation supports at APH during BCI (includes district)	123	87	81	0	81	291	548
Number of clients receiving clinic or in-home intensive tobacco cessation services from APH staff	80	64	77	161	59	220	264

Shaded - Indicates data not available

Finance and Audit Committee Report

Date of Meeting: November 14, 2018

The minutes from the last finance meeting dated June 13, 2018 were approved. Then the financial statement for the period ending September 30, 2018 were discussed and reviewed with the guidance from the CFO/Director of Operations and Manager of Accounting & Budgeting. With respect to the revenue and expenses as per the statement of operations, overall there was sufficient revenue generated to cover expenses on a year to date basis. With respect to the balance sheet, the working capital position continues to trend in a satisfactory manner due to the cash and short term investments that are available. The accounts receivable and accounts payable are in line with the previous months.

The draft 2019 operating and capital budget was reviewed and prepared on the basis that there will be no increase in the 2019 provincial cost shared portion of the funding that is received. Given the 2019 financial assumptions that include the 0% increase from provincial funding, the recommendation to increase the municipal levy by .5% was recommended for approved. In addition, to assist in sustaining operations on a sound financial basis, several cost saving and revenue generating initiatives were identified in the operating and capital budget report that are to be continued.

The capital asset plan for 2018 to 2030 was then discussed. The purpose of the plan is to provide clarity to the future capital asset needs and to ensure the financing is in place to meet the expenditures. For 2019, $33,000 is estimated for capital expenditures and within our financial means.

The final item of business is in reference to the contribution to the reserve fund. The recommendation is to contribute $300,000 to the reserve fund. This contribution is not expected to impact our current funding of operations and will strengthen our long-term financial sustainability.

Sergio Saccucci,
Chair of the Finance and Audit Committee

Algoma Public Health
(Unaudited) Financial Statements September 30, 2018

Algoma Public Health
Statement of Operations
September 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	$ 2,626,635	$ 2,626,634	$ 1	$ 3,502,179	0%	100%
Provincial Grants - Cost Shared Funding	5,642,404	5,642,405	(1)	7,523,200	0%	100%
Provincial Grants - Public Health 100% Prov. Funded	2,247,288	2,247,716	(428)	2,996,950	0%	100%
Fees, other grants and recovery of expenditures	443,768	503,523	(59,755)	699,214	-12%	88%
Total Public Health Revenue	$ 10,960,095	$ 11,020,279	$ (60,184)	$ 14,721,543	-1%	99%
Expenditures						
Public Health Cost Shared	$ 8,158,263	$ 8,784,661	$ 626,398	$ 11,724,592	-7%	93%
Public Health 100% Prov. Funded Programs	2,146,839	2,253,867	107,028	2,996,951	-5%	95%
Total Public Health Programs Expenditures	$ 10,305,102	$ 11,038,528	$ 733,426	$ 14,721,543	-7%	93%
Excess of Rev. over Exp. Cost Shared Funding	$ 554,544	$ (12,098)	$ 566,642	$ 2		
Excess of Rev. over Exp. 100% Prov. Funded	100,449	(6,151)	106,600	(2)		
Total Rev. over Exp. Public Health	$ 654,993	$ (18,249)	$ 673,242	$ (0)		
Healthy Babies Healthy Children						
Provincial Grants and Recoveries	$ 803,986	803,983	(3)	1,070,986	0%	100%
Expenditures	802,183	804,634	(2,452)	1,070,986	0%	100%
Excess of Rev. over Exp.	1,803	(651)	2,454	(0)		
Public Health Programs - Fiscal 18/19						
Provincial Grants and Recoveries	$ 113,856	113,855	(1)	227,700		
Expenditures	134,298	127,000	7,298	227,700		
Excess of Rev. over Fiscal Funded	(20,442)	(13,145)	(7,297)	-		
Community Health Programs						
Calendar Programs						
Revenue						
Provincial Grants - Community Health	$ -	$ -	$ -	$ -		
Municipal, Federal, and Other Funding	255,625	249,375	6,250	332,500	3%	103%
Total Community Health Revenue	$ 255,625	$ 249,375	$ 6,250	$ 332,500	3%	103%
Expenditures						
Child Benefits Ontario Works	18,264	18,375	111	24,500	-1%	99%
Algoma CADAP programs	207,307	231,000	23,693	308,000	-10%	90%
One-Time Funding programs	0	0	-	-	#DIV/0!	#DIV/0!
Total Calendar Community Health Programs	$ 225,571	$ 249,375	$ 23,804	$ 332,500	-10%	90%
Total Rev. over Exp. Calendar Community Health	$ 30,054	$ (0)	$ 30,054	$ 0		
Fiscal Programs						
Revenue						
Provincial Grants - Community Health	$ 2,834,595	$ 2,856,706	$ (22,111)	$ 5,719,160	-1%	99%
Municipal, Federal, and Other Funding	389,238	429,172	(39,934)	724,253	-9%	91%
Other Bill for Service Programs	16,930		16,930			
Total Community Health Revenue	$ 3,240,763	$ 3,285,878	$ (45,115)	$ 6,443,413	-1%	99%
Expenditures						
Brighter Futures for Children	45,482	57,223	11,741	114,447	-21%	79%
Infant Development	312,536	320,892	8,355	643,783	-3%	97%
Preschool Speech and Languages	305,695	307,628	1,933	614,256	-1%	99%
Nurse Practitioner	71,550	73,726	2,176	145,452	-3%	97%
Genetics Counseling	225,011	183,903	(41,108)	367,806	22%	122%
Community Mental Health	1,706,822	1,788,121	81,298	3,607,762	-5%	95%
Community Alcohol and Drug Assessment	343,668	364,301	20,633	737,406	-6%	94%
Healthy Kids Community Challenge	93,255	112,500	19,245	112,500	-17%	83%
Stay on Your Feet	42,945	50,000	7,055	100,000	-14%	86%
Bill for Service Programs	16,789	-	(16,789)	-		
Misc Fiscal	-	-	-	4,000		
Total Fiscal Community Health Programs	$ 3,163,752	$ 3,258,293	$ 94,541	$ 6,447,412	-3%	97%
Total Rev. over Exp. Fiscal Community Health	$ 77,011	$ 27,584	$ 49,426	$ (3,999)		

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 Nine Months Ending September 30, 2018
(Unaudited)

	Actual YTD 2018	Budget YTD 2018	Variance Bgt. to Act. 2018	Annual Budget 2018	Variance % Act. to Bgt. 2018	YTD Actual/ Annual Budget 2018	Comparison Prior Year: YTD Actual 2017	YTD BGT 2017	Variance 2017
Levies Sault Ste Marie	1,819,323	1,819,323	0	2,425,762	0%	75%	1,817,229	1,817,229	0
Levies Vector Bourne Disease and Safe Water	44,574	44,574	0	59,433	0%	75%	44,575	44,575	(0)
Levies District	762,738	762,738	0	1,016,984	0%	75%	751,786	751,786	0
Total Levies	**2,626,635**	**2,626,636**	**0**	**3,502,179**	**0%**	**75%**	**2,613,590**	**2,613,590**	**0**
MOH Public Health Funding	5,508,681	5,508,682	(1)	7,344,900	0%	75%	5,348,176	5,348,175	1
MOH Funding Vector Borne Disease	81,523	81,523	0	108,700	0%	75%	81,523	81,525	(2)
MOH Funding Safe Water	52,200	52,200	0	69,600	0%	75%	52,200	52,200	0
Total Public Health Cost Shared Funding	**5,642,404**	**5,642,405**	**(1)**	**7,523,200**	**0%**	**75%**	**5,481,899**	**5,481,900**	**(1)**
MOH Funding Needle Exchange	48,527	48,525	2	64,700	0%	75%	38,031	38,025	6
MOH Funding Haines Food Safety	18,450	18,450	0	24,600	0%	75%	18,450	18,450	0
MOH Funding Healthy Smiles	577,424	577,425	(1)	769,900	0%	75%	577,424	577,425	(1)
MOH Funding - Social Determinants of Health	135,377	135,377	0	180,500	0%	75%	135,377	135,375	2
MOH Funding - MOH / AMOH Top Up	94,408	94,838	(430)	126,450	0%	75%	0	0	0
MOH Funding Chief Nursing Officer	91,131	91,131	0	121,500	0%	75%	91,131	91,125	6
MOH Enhanced Funding Safe Water	11,627	11,625	2	15,500	0%	75%	11,627	11,625	2
MOH Funding Unorganized	397,800	397,800	0	530,400	0%	75%	386,331	386,325	6
MOH Funding Infection Control	234,304	234,300	4	312,400	0%	75%	234,304	234,300	4
MOH Funding Diabetes	112,500	112,500	0	150,000	0%	75%	112,500	112,500	0
MOH Funding Northern Ontario Fruits & Veg.	88,036	88,045	(9)	117,400	0%	75%	88,054	88,049	5
Funding Ontario Tobacco Strategy	325,204	325,200	4	433,600	0%	75%	325,204	325,200	4
MOH Funding Harm Reduction	112,500	112,500	0	150,000	0%	75%	75,000	75,000	0
One Time Funding	0	0	0	0		0%	0	0	0
Total Public Health 100% Prov. Funded	**2,247,288**	**2,247,716**	**(428)**	**2,996,950**	**0%**	**75%**	**2,093,433**	**2,093,399**	**34**
Recoveries from Programs	38,116	24,950	13,166	27,450	53%	139%	7,499	7,546	(47)
Program Fees	160,129	178,323	(18,194)	237,764	-10%	67%	179,095	187,307	(8,213)
Land Control Fees	126,910	120,000	6,910	160,000	6%	79%	108,828	120,000	(11,172)
Program Fees Immunization	73,307	138,750	(65,443)	185,000	-47%	40%	116,899	134,625	(17,726)
HPV Vaccine Program	6,409	14,000	(7,591)	20,000	-54%	32%	8,458	4,800	3,658
Influenza Program	690	0	690	25,000	0%	3%	5,490	1,100	4,390
Meningococcal C Program	961	2,000	(1,039)	10,000	-52%	10%	1,386	1,200	186
Interest Revenue	26,175	10,500	15,675	14,000	149%	187%	11,001	8,004	2,997
Other Revenues	11,071	15,000	(3,929)	20,000	0%	55%	4,777	0	4,777
Total Fees, Other Grants and Recoveries	**443,768**	**503,523**	**(59,755)**	**699,214**	**-12%**	**63%**	**443,431**	**464,582**	**(21,151)**
Total Public Health Revenue Annual	**$ 10,960,095**	**$ 11,020,279**	**$ (60,184)**	**$ 14,721,543**	**-1%**	**74%**	**$ 10,632,353**	**$ 10,653,471**	**$ (21,118)**
Public Health Fiscal									
Panorama	0	0	0	0	0%	0%	0	0	0
Smoke Free Ontario NRT	0	0	0	0	0%	0%	0	0	0
Practicum	5,004	5,004	0	10,000	0%	50%	0	0	0
Other One Time Fiscal Funding	108,852	108,851	1	217,700	0%	50%	0	0	0
Total Provincial Grants Fiscal	**$ 113,856**	**$ 113,855**	**$ 1**	**$ 227,700**	**0%**	**50%**	**$ -**	**$ -**	**$ -**

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 Nine Months Ending September 30, 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	$ 6,214,003	$ 6,701,975	$ 487,972	$ 8,953,731	-7%	69%	$ 5,661,974	$ 6,412,549	$ 750,575
Benefits	1,534,668	1,590,320	55,652	2,126,952	-3%	72%	1,470,098	1,494,178	24,080
Travel - Mileage	55,364	90,860	35,496	120,775	-39%	46%	66,509	95,896	29,387
Travel - Other	94,760	56,250	(38,510)	75,000	68%	126%	64,787	58,457	(6,330)
Program	453,139	507,261	54,122	669,715	-11%	68%	403,203	534,766	131,563
Office	76,579	87,682	11,103	116,909	-13%	66%	88,189	101,312	13,124
Computer Services	586,804	560,411	(26,393)	782,881	5%	75%	412,987	524,639	111,652
Telecommunications	190,692	227,478	36,786	303,304	-16%	63%	256,317	264,296	7,979
Program Promotion	91,872	126,251	34,379	167,223	-27%	55%	75,275	128,098	52,823
Facilities Expenses	608,996	621,250	12,255	820,000	-2%	74%	551,589	600,262	48,674
Fees & Insurance	128,533	201,338	72,805	228,450	-36%	56%	263,630	205,322	(58,308)
Debt Management	345,674	345,675	1	460,900	0%	75%	345,674	345,675	1
Recoveries	(75,982)	(78,223)	(2,241)	(104,297)	-3%	73%	(92,635)	(51,306)	41,329
	$ 10,305,102	$ 11,038,527	$ 733,426	$ 14,721,543	-7%	70%	$9,567,597	$ 10,714,143	$1,146,546

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 – September 2018

Reporting Period

The September 2018 financial reports include nine 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 six month results from operations year ended March 31st, 2019.

Statement of Operations (see page 1)

Summary – Public Health and Non Public Health Programs

As of September 30th 2018, Public Health programs are reporting a $673k positive variance.

Total Public Health Revenues are indicating a negative $60k variance. This is a result of Fees, Other Grants & Recoveries being less than budgeted. Program Fees Immunization is the primary contributor to the negative variance. Management will adjust the Program Fees Immunization budget for 2019 to more accurately reflect actual fees received. Actual Land Control Fees are now greater than what was budgeted.

There is a positive variance of $733k related to Total Public Health expenses being less than budgeted. Salary and Wages expense is driving this positive variance. The unanticipated increase in additional base funding for 2018 is contributing to the size of the positive variance associated with Salary and Wages expense. Additionally, the recruitment of suitable candidates to fill vacant positions within the agency is contributing to the positive variance noted.

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

Brighter Futures for Children Program is indicating a positive $12k variance. This is a result of timing of expenses not yet incurred.

Genetics Counseling is showing a negative $41k variance. APH has entered into a Memorandum of Agreement with London Health Sciences for the provisions of Genetics counselling support. APH management continues to use deferred revenue associated with the program to ensure actual program costs are fairly reflected. The general administration support Public Health provides to the Genetics Program more accurately reflects actual usage.

Healthy Kids Community Challenge Program is showing a $19k positive variance. The Healthy Kids Community Challenge Program ended September 30th, 2018. This program has now come to its conclusion.

Public Health Revenue (see page 2)

Public Health funding revenues are showing a negative $60k variance.

Notes Continued...

The municipal levies are within budget.

Cost Shared and 100% Provincially Funded revenues are within budget.

Fees, Other Grants & Recoveries are showing a negative variance of $60k. Program Fees Immunization is showing a $65k negative variance. Management will adjust the Program Fees Immunization budget for 2019 to more accurately reflect actual fees received. Program Fees are indicating a negative $18k variance. This is a result of fees being less than anticipated. Land Control Fees are now showing a positive $7k variance. As forecasted, the variance has reduced month-over-month and is now positive as the bulk of the fees are collected during the summer months.

Interest Revenue is showing a positive variance of $16k. This is a result of an improved liquidity position. Management will adjust the Interest Revenue budget for 2019 to reflect this reality.

Public Health Expenses (see page 3)

Salary & Wages

The $487k positive variance associated with Salary and Wages expense is a result of the time it takes to recruit suitable candidates when a position becomes vacant within the agency. Also contributing to the positive variance associated with Salary and Wages expense is the increase in base funding APH received in 2018 which was not budgeted. The increase in base funding has allowed Management to increase the FTE complement to help meet the requirements set out in the new Standards. Relative to 2017, Salary & Wages expense has increased.

Travel - Mileage

Travel – mileage expense is indicating a positive $35k variance. Actual expenses are less than anticipated.

Travel - Other

Travel – Other expense is indicating a negative $39k variance. Relative to 2017 Year-to-Date actual expenses, Travel-Other has increased. Part of the reason for increased Travel-Other expense is the fact that APH hosted the "Bridges Out of Poverty' workshop in Sault Ste. Marie in which all staff were required to attend. This resulted in increased travel expenses as staff from the district offices attended the workshop. Aside from this event, Travel-Other expense is higher than anticipated. Management will continue to monitor this line item as the year progresses. The net impact of actual Travel – Mileage expense and Travel – Other expense is a negative $4k variance.

Program

Program expense is showing a positive $54k variance. Contributing to this positive variance is reduced spending related to supplies for Program Fees Immunization. This is a result of APH administering fewer immunizations.

Notes Continued...

Office
Office expense is indicating a positive $11k variance. This is a result of timing of expense not yet incurred.

Telecommunications
Telecommunications expense is showing a positive $37k variance. APH's contract for warranty of telephone hardware expires in 2018. At the time the 2018 budget was developed there was uncertainty as to whether further warranty was needed given the age of the assets. Management built the expense into the budget however these costs have not been realized as of September. Management is currently reviewing options with MicroAge as to the best solution related to the warranty of the hardware.

Program Promotion
Program Promotion expense is indicating a positive $34k variance. This is a result of budgeted promotional dollars not being spent. APH was able to use internal resources for some promotional activities.

Fees & Insurance
Fees & Insurance expense is indicating a positive $73k variance. APH did receive one-time funding related to legal cost incurred associated with a Public Health policy matter. This one-time funding and associated costs are now reflected in one-time Fiscal Funding as opposed to Public Health cost-shared programs. Additionally, Management budgeted for legal fees that have not been incurred.

Financial Position - Balance Sheet (see page 7)

APH's liquidity position continues to be stable and the bank has been reconciled as of September 30th 2018. Cash includes $530k in short-term investments.

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. $306k 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 Accounts Receivable collection concerns.

Note:
- Up-to-date long-term debt figures provided in Notes to Financial Statements above.
- Statement of Financial Position - Employee Future Benefit Obligations, Term Loan and Non-Financial Assets figures updated as of December 31st of previous year.

Algoma Public Health

Statement of Financial Position

(Unaudited)

Date: As of September 2018	**September 2018**	December 2017
Assets		
Current		
Cash & Investments	**$ 3,153,526**	$ 2,931,699
Accounts Receivable	**294,956**	489,631
Receivable from Municipalities	**68,318**	30,769
Receivable from Province of Ontario		
Subtotal Current Assets	**3,516,800**	3,452,099
Financial Liabilities:		
Accounts Payable & Accrued Liabilities	**1,240,073**	1,436,721
Payable to Gov't of Ont/Municipalities	**130,967**	543,083
Deferred Revenue	**436,366**	512,747
Employee Future Benefit Obligations	**2,704,275**	2,704,275
Term Loan	**5,554,992**	5,554,992
Subtotal Current Liabilities	**10,066,673**	10,751,817
Net Debt	**-6,549,873**	-7,299,718
Non-Financial Assets:		
Building	**22,732,421**	22,732,421
Furniture & Fixtures	**1,911,323**	1,911,323
Leasehold Improvements	**1,572,807**	1,572,807
IT	**3,244,030**	3,244,030
Automobile	**40,113**	40,113
Accumulated Depreciation	**-8,586,824**	-8,586,824
Subtotal Non-Financial Assets	**20,913,869**	20,913,869
Accumulated Surplus	**14,363,996**	13,614,152

Algoma PUBLIC HEALTH
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Briefing Note

www.algomapublichealth.com

To: Algoma Public Health Finance & Audit Committee

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

Date: November 28th, 2018

Re: 2018 Contribution to APH Reserve Fund

☐ For Information ☐ For Discussion ☒ For a Decision

ISSUE:

In accordance with Board of Health Policy 02-05-065, Reserve Fund,

> "the Board of Health in each year may provide in its estimates for a reasonable amount to be paid into the reserve funds provided that no amount shall be included in the estimates which is to be paid into the reserve funds when the cumulative balance of all the reserve funds in the given year exceeds 15 percent of the regular operating revenues for the Board of Health approved budget for the mandatory cost shared programs and services".

The 2017 Audited Financial Statements are complete and Management believes that there will not be any material changes from the 2017 Settlement that was submitted to the Ministry. The current amount of funds in the Reserve Fund is approximately $530,000. Any contribution decisions to the Reserve Fund must consider the cumulative balance of the Reserve Fund. Specifically, the cumulative balance of the Reserve Fund in any given year is not to exceed 15 percent of Algoma Public Health's (APH's) regular operating revenues for mandatory cost shared programs and services as mandated by the Board of Health policy 02-05-065, Reserve Fund. In 2018, total mandatory cost shared revenues derived by APH was $10,847,079, 15% of which equates to $1,627,062. The Board of Health Finance & Audit Committee has reviewed the proposed contribution to the Reserve Fund and recommends the Board of Health approve the recommended action below.

RECOMMENDED ACTION:

That the Board of Health for the District of Algoma Health Unit approves:

1) A contribution of $300,000 into the Reserve Fund from APH's operating account.

BACKGROUND:

APH's Board of Health established a Reserve Fund Policy in June of 2015. The purpose of the establishment of a Reserve Fund is to be better prepared to:

- meet any unexpected costs that may arise in the future;
- help offset one-time or capital expenditures;

- help offset any revenue shortfalls;
- minimize fluctuations in funding;
- help manage cash flows and;
- avoid application of additional levies to municipalities in the event of any cash shortfalls.

Maintaining sufficient balances in reserves is a critical component of long-term financial planning as it strengthens long-term financial sustainability. It is a financial "safety net".

In reviewing APH's cash forecasting model and factoring in APH's lowest daily liquidity position within the last year, management believes a contribution of $300,000 to the Reserve Fund will not negatively impact working capital requirements while satisfying the parameters noted in the Board of Health Policy 02-05-065, Reserve Fund.

As every provincial dollar received that is unspent by the Board of Health must be returned to the Ministry, Reserves can only be generated through municipal dollars.

As APH has transitioned from the traditional cost-shared formula of 75% provincially funded and 25% municipal funded to a cost-shared formula in which the municipalities contributed more than the minimum requirement of 25%, this financing strategy has better positioned the Board of Health to be in a financial position to make contributions to the Reserve Fund.

By continually striving to achieve efficiency within its operations, more municipal dollars become available to contribute towards the Reserve Fund.

FINANCIAL IMPLICATIONS:

The contribution of $300,000 into APH's Reserve Fund will reduce APH' working capital however management believes working capital levels are sufficient to sustain operations.

The financial implication of contributing to APH's Reserve Fund is it minimizes the risk to the agency with respect to any unexpected or unpredicted events, or extraordinary expenditures which would otherwise cause fluctuations in APH's operating and capital budgets.

A contribution of $300,000 will increase the Reserve balance to approximately $830,000. Appendix A attached is an overview of Reserve balances from December 31st, 2014 with projections for December 31st, 2018.

CONTACT:

J. Pino, Chief Financial Officer

Algoma PUBLIC HEALTH
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Algoma Public Health

2019 Public Health Operating & Capital Budget

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EXECUTIVE SUMMARY:

Issue:

The *Ontario Public Health Standards: Requirements for Programs, Services, and Accountability* (the Standards) requires boards of health to ensure administration develops a budget forecast for the fiscal year that does not project a deficit. To support municipal budget planning, Algoma Public Health (APH) attempts to advise them of their respective levies as early as possible. The Board of Health Finance & Audit Committee has reviewed the 2019 Public Health Operating and Capital Budget and recommends the Board of Health approve the enclosed budget.

Recommended Action:

"That the Board of Health for the District of Algoma Health Unit approves the 2019 Public Health Operating and Capital budget as presented".

Budget Summary:

The 2019 APH Operating & Capital Budget (the Budget) is designed to position the Board of Health for the District of Algoma Health Unit in fulfilling its mandate as per the requirements set out in the *Health Protection and Promotion Act (HPPA)*, the Standards*, the Public Health Accountability Agreement*, and APH's strategic plan. The 2019 budget reflects changes in programming consistent with the new 2018 Standards. This includes implementation of the Vision Screening Program; greater focus on using data in developing program plans; reducing involvement in services that are provided elsewhere in the community; additional enforcement activities with respect to *Smoke Free Ontario Act*, enforcing new health protection regulations, and additional disclosure requirements.

The proposed 2019 Budget for mandatory programs and services is $14,735,055 and as compared to the 2018 Board of Health approved budget, represents a 0.1% overall increase.

The recommended 0.50% increase in the municipal levy will help to offset the projected 0% increase in the provincial grant for cost-shared programs, inherent inflationary pressures and general salary increases. Cost savings measures are also reflected in the budget which is helping to manage the projected flat-lined provincial funding.

2019 Financial Assumptions:

- Cost associated with changes in service offerings are projected
- 0% increase in the 2019 provincial cost-shared portion of funding
- 0.50% ($17,511) overall increase in the 2019 municipal levy

- 0.16% overall increase in mandatory cost-shared programs budget
- Salary increases of 1.5% for both ONA and CUPE employees as of April 1st 2019, as per collective bargaining agreements
- Salary increases of 1.5% for Non-Union and Management employees as of April 1st, 2019; equivalent to that of negotiated increases with ONA and CUPE employees
- Non-salary costs are based on historical data and where possible, efficiencies introduced; adjustments for inflation have been incorporated where appropriate
- Debt repayment plans will be managed within approved (existing) resources
- Capital Asset Funding Plan developed

PUBLIC HEALTH BUDGET BACKGROUND:

Provincial Government Context

2018 marked the formation of a new Provincial government which campaigned on reducing provincial spending. With respect to this commitment, the Provincial Government obtained the services of Ernst & Young to conduct a review of Ontario Government Spending for the fifteen years ending fiscal year 2017/2018. Noted in the review was that "the Government has indicated an objective of efficiency gains in the order of four cents on the dollar"[1]. At this time, there has been no indication by the provincial government with respect to funding of the public health system.

Ministry of Health and Long-Term Care Context:

The HPPA and Accountability Agreements

Under the *HPPA*, a Board of Health has legal responsibilities for ensuring the delivery of health services and programs in accordance with the *Act* and Regulations. The Public Health Accountability Agreement, between the Ministry of Health and Long-Term Care (MOHLTC) and Boards of Health, commits Boards of Health to achieving mandatory performance and monitoring indicators.

The Standards

2018 marked the first year operating under the modernized public health Standards.

The Standards are published by the MOHLTC under the authority of section 7 of the *HPPA* to specify the mandatory health programs and services provided by boards of health. These Standards provide a framework for public health programs, services, and accountability.

[1] Managing Transformation – A Modernization Action Plan for Ontario; Line-by-line Review of Ontario Government Expenditures 2002/203-2017/2018, September 21, 2018.

Annual Service Plans

The 2018 Annual Service Plan was the first time that the MOHLTC required boards of health to demonstrate that programs align with community priorities (as identified in their population health assessment), demonstrate accountability for planning, and demonstrate the use of funding per program and service.

The Ministry has advised all public health units to plan for no growth funding with regards to cost-shared programs. The 2019 Budget reflects the Ministry's advisement.

Algoma Public Health Context

APH's Community Health Profile

In 2018 APH released its Community Health Profile which provides a snapshot of health across the District of Algoma. The Community Health Profile will serve as a guidance document in APH's Program Planning process and aid the Board of Health with the development of its strategic priorities.

APH Strategic Planning Process

The Public Health Accountability Framework section of the Standards specify that "the board of health shall have a strategic plan that establishes strategic priorities over 3 to 5 years, includes input from staff, clients and community partners, and is reviewed at least every other year". APH's current strategic plan is set to expire in 2020. The 2019 Budget includes dollars allocated for the development of a new Strategic Plan that that would be in place by 2020.

APH 2018 Grant Approval:

In May of 2018, just prior to the election, APH was notified by the Ministry that it would receive up to 3% ($214,000) in base funding and up to $227,000 in one-time funding[2]. This funding announcement was unexpected given the Ministry's recommendation to plan for no growth funding for 2018.

For context, the Board of Health for the District of Algoma Health Unit has experienced the following historical growth in provincial MOHLTC funding for mandatory cost-shared programs:

[2] $141,700 of the one-time funding total was in relation to the Northeastern Collaboration/Shared Service Project which is being shared by the five north eastern public health units.

Year	Growth (%)	
2019	*0.00%*	*projected*
2018	3.00%	
2017	0.00%	
2016	0.00%	
2015	0.00%	
2014	2.00%	
2013	1.50%	
2012	2.00%	
2011	2.52%	

2019 PUBLIC HEALTH BUDGET ANALYSIS:

As a result of the Ministry advising Public Health Units to plan for no growth funding for mandatory cost-shared programs, APH's budget is built on a 0% increase in growth funding for mandatory cost-shared programs from the MOHLTC and a recommended a 0.50% increase in the municipal levy.

Revenue Generating & Cost Savings Initiatives:

Identification of revenue generating and cost savings opportunities is necessary in order to attain a balanced budget for 2019 and in anticipation of ongoing funding pressures. Management and the Finance and Audit Committee have worked towards identifying opportunities to generate revenue and control costs. Noted below is a summary of key initiatives built into the 2019 Budget that will result in cost savings or incremental revenue generation for APH.

#	Cost Savings/Revenue Generating Initiative	Amount
1	Janitorial Services	$ 20,000
2	Security Services	$ 6,000
3	HVAC Annual Maintenance Contract	$ 8,455
4	Print Services (Xerox Contract)	$ 48,000
5	Phone Hardware Warranty (CISCO)	$ 35,000
6	Increase in Ontario Building Code Fees (Approved in 2017)	$ 6,400
TOTAL		$123,855

Action Plan to Manage Projected Flat Line Provincial Funding:

- Development of the 2019 Budget to ensure it is aligned with APH's strategic directions and MOHLTC Accountability Agreement and the Standards.
- Continue to submit one-time funding requests to the MOHLTC through the Annual Service Plan process.

- Control spending by ensuring APH is receiving "value for dollars" spent.
- Identification of process improvements and improved efficiency opportunities.
- Utilization of additional funding opportunities (i.e. through the Northern Ontario Heritage Fund).
- Continued exploration of cost-sharing opportunities with Northeast health units (Northeastern Public Health Collaboration Project).

Revenues

Cost-shared programs and services are funded by the province, municipalities and other sources of revenue, such as interest revenue, and user fees (Appendix 1).

The province also contributes funding for services to Unorganized Territories (a geographic region that is not part of a municipality or First Nation reserve).

Provincial

Pursuant to section 76 of the Health Protection & Promotion Act, the Minister may make grants for the purposes of this Act on such conditions as he or she considers appropriate.

In 2015, the Ministry of Health & Long Term Care introduced a new public health funding model for mandatory programs. The adopted public health funding model identifies an "appropriate" share for each Board of Health that reflects the needs in relation to other Boards of Health. While the model attempts to lessen the impact of a region's population to account for equity and needs of a region, the weight given to a region's population still drives the formula. The Ministry did not apply the funding model in 2018 with respect to the increase in base funding that was realized by health units across the province. The importance of the funding model will be minimal in 2019 as the Ministry has communicated to public health units to plan for no growth funding.

Municipal

Pursuant to section 72 of the Health Protection & Promotion Act, obligated municipalities in a health unit shall pay,

(a) the expenses incurred by or on behalf of the board of health of the health unit in the performance of its functions and duties under the HPPA or any other act; and
(b) the expenses incurred by or on behalf of the MOH of the board of health in the performance of his or her functions and duties under the HPPPA or any other Act.

With respect to the cost-shared programs, APH's funding ratio for 2018 was 70% provincial funding and 30% municipal funding.

The municipal share is slightly reduced compared to 2017. This is a result of the 2018 provincial increase in base funding for mandatory costs shared programs of 3% on approximately $7.3 million. In 2018, the board approved a 0.5% levy increase on approximately $3.5 million.

Other historical factors impacting the funding ratio include:

- The Ministry's decision in 2016 to fund the Healthy Smiles program at 100% provincially funded thus removing these dollars from the Municipal portion of the cost-shared formula.
- From 2015 to 2017, APH has received 0% growth with respect to Ministry cost-shared funding while receiving growth funding from the respective Municipalities within the District of Algoma in the form of levy increases.

Municipal dollars through the form of the levy have allowed the Board of Health to make contribution decisions with respect to the Board's Reserve Fund. This is within the context of the Board's risk management strategy.

APH has historically used Census data as the mechanism to apportion costs amongst the municipalities within the District of Algoma. 2016 census data is used in the 2019 Budget to apportion the levy amongst the 21 Municipalities within the District of Algoma.

Management is recommending a 0.50% overall increase in the levy from obligated municipalities. This equates to a $17,511 increase in revenues apportioned among the 21 Municipalities within the Algoma District (Appendix 2). For perspective, a 1.0% overall increase in the levy would result in an additional $35,022 of revenue compared to 2018.

For context, the Board of Health for the District of Algoma Health Unit has experienced the following historical growth with respect to the municipal levy.

Year	Levy Increase	
2019	*0.50%*	*proposed*
2018	0.50%	
2017	2.50%	
2016	4.50%	
2015	4.16%	
2014	2.00%	
2013	1.00%	
2012	2.00%	

User Fees

APH is very mindful that a strong public health system ensures access to public health programs and services for those groups of people within our population that most need them. As such, when assessing the costs and benefits of increasing user fees, APH has taken a strategic view.

In June of 2017, the Board of Health approved a nominal price increase related to the Ontario Building Code Fees. This increase has been built into the 2019 Budget. It should be noted that the Land Control program is funded only through the fees generated. As such APH must ensure that it is at least covering the cost incurred to administer the program.

Expenses

Expenses are primarily driven through staff salary and benefits, (approximately 76% of all expenses), goods and service contracts, debt financing, and inflation (Appendix 3).

Inflationary pressures will continue to place upward pressures on APH's operating costs. The Consumer Price Index percentage change from August 2017 to August 2018 increased as follows:

- Canada: 2.8%
- Ontario: 3.1%

The recommended levy increase of 0.5% is less than the increase in inflation over the past year. When assessing any potential levy increase, the rate of inflation is a factor to consider.

Salary and Wages

Salary and Wages expenses are projected to increase by 0.9% compared to 2018.

Both CUPE and ONA collective agreements were ratified in 2018 and both agreements expire in 2021. Collectively bargained salary increases are reflected within the 2019 Budget. Salary increases for Non-Union and Management staff are equivalent to that of negotiated increases with ONA and CUPE employees.

For context, a summary of Public Health Full Time Equivalent (FTE) is noted below:

Year	FTE	
2019	*123*	*budgeted*
2018	121	
2017	120	
2016	122	

Compared to budgeted 2018 FTE, the Public Health FTE count has increased by two (2) FTE in the 2019 Budget. This is a result of the Ministry announcing a 3% increase in base funding in May 2018. The 2018 increase in base funding has allowed Management to increase the FTE complement to align resources to help meet requirements set out in the new Standards.

Benefits

Benefit expenses are projected to increase by 2.7% compared to 2018.

This is a result of increased salary and wages expense as noted above as well as increasing costs associated with non-statutory benefits that the health unit is committed to.

Travel

Travel expenses are projected to decrease by 2.4% compared to 2018.

This is a result of revising the travel budget to more accurately reflect actual travel expenses incurred in 2018.

Program

Program expenses are projected to decrease by 4.0% compared to 2018.

This is a result of revising the Immunization budgeted expenses to more accurately reflect actual expenses incurred in 2018. Also, Healthy Living and Food Safety budgeted expenses have been reduced to reflect actual spending. Offsetting the reduction in spending is the inclusion of purchased services for updating the agency's strategic plan.

Equipment

Equipment expenses are projected to remain unchanged compared to 2018.

Computers typically are refreshed on a three year cycle with $25,000 budgeted annually.

Office Expenses

Office expenses are projected to decrease by 19.7% compared to 2018.

APH's Xerox lease commitments expired in 2018. Cost savings are anticipated and factored into the 2019 Budget. Co-operative Purchasing program pricing, such as the Public Sector Vendor of Record (VOR) program and the Ontario Education Collaborative Marketplace (OECM), are being explored at the time of drafting the 2019 budget. APH's centralized procurement processes continues to generate savings and improve operating efficiencies by allowing APH to capitalize on volume discounts and developing staff procurement expertise.

Computer Services

Computer Services expenses are projected to increase by 3.2% compared to 2018.

APH's Service Level Agreement with MicroAge allows APH to flex resources. In 2018, APH increased the FTE complement up to the original contract commitment of five (5) resources from four (4). As a result of this added FTE complement, APH decided not to pursue obtaining access to MicroAge's corporate resources to help with IT requests. The net impact is $27k to APH's 2019 Operating budget.

Telecommunications

Telecommunications expenses are projected to decrease by 11.7% compared to 2018.

APH's contract for warranty of telephone hardware expired in 2018. Savings of approximately $36,000 are projected for 2019 compared to 2018. Savings will be realized by moving the software component of the warranty to APH servers. This is an example of APH leveraging its investment in quality servers to support further efficiencies and generate cost savings.

Program Promotion

Program promotion expenses are projected to decrease by 4.5% compared to 2018.

Promotional activities continue to be in line with program plans. The reduction in promotional expenses is to better reflect actual spending.

Facility Leases

Facility Leases expense is projected remain unchanged in 2018.

No increases with current leased facilities in Blind River, Elliot Lake, and Wawa offices are scheduled for 2019.

Building Maintenance

Building Maintenance expenses are projected to decrease by 9.1% compared to 2018.

Since APH is projecting a surplus for 2018 with regards to mandatory cost-shared programs, Building Maintenance expenses that would have been budgeted in 2019 has been pulled forward to 2018 thus reducing budgeted Building Maintenance expenses for 2019. Furthermore, savings will be generated through the new janitorial contract that was implemented in August 2018.

Fees & Insurance

Fees & Insurance expenses are projected to increase by 6.0% as compared to 2018.

In 2018, the Board of Health made a commitment to purchase cyber insurance. This expense is factored into the 2019 Operating Budget.

Expense Recoveries

Expense Recoveries are projected to increase by 0.4% compared to 2018.

Expense Recoveries are administrative allocations from Community Health programs to Public Health programs. An example would be Public Health charging a Community Health program for administrative services related to clerical or financial reporting support. In order to more accurately reflect the work Public Health is supporting with respect to Community Health programs, Management is ensuring adequate administrative charges for non-public health programs. This is in line with the Boards strategy to ensure it is accountable for the dollars it receives and spends by not subsidizing non-public health programs. 2019 Expense Recoveries are similar to 2018 projections.

Debt Management

Debt Management expenses are projected to remain constant compared to 2017.

APH debt servicing costs will be financed through operations. The loan related to 294 Willow Avenue property continues for three (3) more years with monthly payments applied according to schedule.

Capital Expenses

In 2018 APH received a building conditions assessment that was funded through the Ministry of Community and Social Services. This document helped to facilitate a formal Building Capital Plan referred to as, Algoma Public Health 2018-2030 Capital Asset Funding Plan (Appendix 4).

Recommended Action:

"That the Board of Health for the District of Algoma Health Unit approves the 2019 Public Health Operating and Capital budget as presented".

2019 Funding Projections *Grants, Levies and Recoveries*	2018 Annual Budget	2019 Annual Budget	Ch as %
Public Health Mandatory Programs	$ 7,344,900	$ 7,344,900	0.00%
Vector-Bourne Diseases Program (75%)	108,700	108,700	0.00%
Small Drinking Water Systems (75%)	69,600	69,600	0.00%
Healthy Smiles Ontario Program (100%)	769,900	769,900	0.00%
Unorganized Territories (100%)	530,400	530,400	0.00%
Smoke-Free Ontario Strategy (100%)	433,600	433,600	0.00%
Infectious Diseases Control Initiative (100%)	222,300	222,300	0.00%
Social Determinants of Health Nurses Initiative (100%)	180,500	180,500	0.00%
Diabetes Prevention Programming (100%)	150,000	150,000	0.00%
Harm Reduction Program Enhancement (100%)	150,000	150,000	0.00%
Chief Nursing Officer Initiative (100%)	121,500	121,500	0.00%
Northern Fruit and Vegetable Program (100%)	117,400	117,400	0.00%
MOH / AMOH Compensation Initiative (100%)	126,451	126,451	0.00%
Infection Prevention and Control Nurses Initiative (100%)	90,100	90,100	0.00%
Needle Exchange Program Initiative (100%)	64,700	64,700	0.00%
Enhanced Food Safety - Haines Initiative (100%)	24,600	24,600	0.00%
Enhanced Safe Water Initiative (100%)	15,500	15,500	0.00%
Levies Sault Ste. Marie	2,425,763	2,425,763	0.00%
Levies District	1,016,983	1,016,983	0.00%
Levies VBD/Safe Water/One Time	59,433	59,433	0.00%
Recoveries	220,213	238,214	8.17%
Land Control Fees	160,000	160,000	0.00%
Program Fees	65,000	65,000	0.00%
Program Fees Immunization	185,000	160,000	-13.51%
Program Fees Influenza, HPV & Menactra	55,000	40,000	-27.27%
Interest & Other	14,000	32,000	128.57%
Total	**14,721,543**	**14,717,544**	-0.03%
Summary			
Grants	**10,520,151**	**10,520,151**	0.00%
Levies	**3,502,179**	**3,502,179**	0.00%
Recoveries	**699,213**	**695,214**	-0.57%
Total	**$ 14,721,543**	**$ 14,717,544**	-0.03%

Ont Time Funding per Accountability Agreement	**$ 227,700**

APPENDIX 2

2019 Municipal Levy	POP 2016 Census	Proposed 2019 Rate	Proposed 2019 Levy	2018 Rate	2018 Levy	Change in Net Amount	% Change in Net Amount	Apportionment of Costs
CITIES								
Sault Ste. Marie	73,368	33.80	2,479,977	33.63	2,467,639	12,338	0.50%	70.46%
Elliot Lake	10,741	33.80	363,066	33.63	361,260	1,806	0.50%	10.32%
TOWNS								
Blind River	3,472	33.80	117,360	33.63	116,776	584	0.50%	3.33%
Bruce Mines	582	33.80	19,673	33.63	19,575	98	0.50%	0.56%
Thessalon	1,286	33.80	43,469	33.63	43,253	216	0.50%	1.24%
VILLAGES/MUNICIPALITY								
Hilton Beach	171	33.80	5,780	33.63	5,751	29	0.50%	0.16%
Huron Shores	1,664	33.80	56,246	33.63	55,967	280	0.50%	1.60%
TOWNSHIPS								
Dubreuilville	613	33.80	20,721	33.63	20,617	103	0.50%	0.59%
Jocelyn	313	33.80	10,580	33.63	10,527	53	0.50%	0.30%
Johnson	751	33.80	25,385	33.63	25,259	126	0.50%	0.72%
Hilton	307	33.80	10,377	33.63	10,326	52	0.50%	0.29%
Laird	1,047	33.80	35,391	33.63	35,215	176	0.50%	1.01%
MacDonald, Meredithand Aberdeen Add'l	1,609	33.80	54,387	33.63	54,117	271	0.50%	1.55%
Wawa (formerly Michipicoten)	2,905	33.80	98,195	33.63	97,706	489	0.50%	2.79%
The North Shore	497	33.80	16,800	33.63	16,716	84	0.50%	0.48%
Plummer Add'l	660	33.80	22,309	33.63	22,198	111	0.50%	0.63%
Prince	1,010	33.80	34,140	33.63	33,970	170	0.50%	0.97%
St. Joseph	1,240	33.80	41,914	33.63	41,706	209	0.50%	1.19%
Spanish	712	33.80	24,067	33.63	23,947	120	0.50%	0.68%
Tarbutt & Tarbutt Add'l	534	33.80	18,050	33.63	17,960	90	0.50%	0.51%
White River	645	33.80	21,802	33.63	21,694	108	0.50%	0.62%
Total	104,127		3,519,690		3,502,179	17,511	0.50%	100.00%

Note:

Population from 2016 CENSUS per Stats Canada

2019 Annual Operating Budget

	2018 Annual Budget (Final Approved)	2019 Annual Budget	Inc as %
Revenues Summary			
Province Portion of Jointly Funded Programs	**$ 7,523,200**	**$ 7,523,200**	0.0%
100% Provincially Funded Programs	**2,996,951**	**2,996,951**	0.0%
Municipal Levies	**3,502,179**	**3,502,179**	0.0%
Other Recoveries and Fees	**699,213**	**695,214**	-0.6%
Total	**14,721,543**	**14,717,544**	0.0%
Expenses:			
Salaries and Wages	**8,953,731**	**9,031,429**	0.9%
Benefits	**2,126,952**	**2,185,087**	2.7%
Travel	**195,775**	**191,069**	-2.4%
Program	**657,715**	**631,433**	-4.0%
Equipment	**25,000**	**25,000**	0.0%
Office	**128,909**	**103,544**	-19.7%
Computer Services	**757,881**	**781,927**	3.2%
Telecommunications	**303,304**	**267,685**	-11.7%
Program Promotion	**167,223**	**159,632**	-4.5%
Facilities Leases	**160,000**	**160,000**	0.0%
Building Maintenance	**660,000**	**600,000**	-9.1%
Fees & Insurance	**228,450**	**242,080**	6.0%
Expense Recoveries	**(104,296)**	**(104,730)**	0.4%
Debt Management (I & P)	**460,900**	**460,900**	0.0%
Total	**14,721,543**	**14,735,055**	0.1%
Surplus/(Deficit)	**$ -**	**$ (17,511)**	

Algoma PUBLIC HEALTH
Santé publique Algoma

APPENDIX 4

Algoma Public Health

2018 - 2030 Capital Asset Funding Plan

Table of Contents

Purpose:

The Board of Health for the District of Algoma (the Board) has undertaken the development of a Capital Asset Funding Plan (the Plan). The purpose of the Plan is to provide visibility to the Board with respect to capital asset needs. The Capital Asset Plan, in conjunction with APH's Reserve Fund Policy, will allow the Board of Health to set long-term financial goals.

As part of the Ontario Public Health Standards, "the board of health shall maintain a capital funding plan, which includes policies and procedures to ensure that funding for capital projects is appropriately managed and reported". As APH owns and operates a facility in Sault Ste. Marie, there is a need to plan for and appropriately fund the cost of major ongoing repairs and maintenance associated with the facility. In addition, APH leases several facilities which may require leasehold improvements. By maintaining adequate Reserves, APH will be able to offset the need to obtain alternate sources of financing.

Operating Budget versus Capital Asset Plan:

The Operating Budget captures the projected incoming revenues and outgoing expenses that will be incurred on a daily basis for the operating year.

The Capital Asset Plan is a blueprint to identify potential capital expenditures and to develop a method in which to finance the associated expenditure. Capital expenditures are cost incurred for physical goods that will be used for more than one year.

The development of the Capital Asset Funding Plan serves as a risk management tool as it minimizes having large unforeseen budget increases in the future as a result of capital needs.

In addition, the Capital Asset Funding Plan will help the Board with contribution and withdrawal decisions to the Reserve Fund. Reserves can only be generated through unrestricted operating surpluses. As any unspent provincial dollars must be returned to the Ministry, the only mechanism to generate surplus dollars is through the Municipal levy. Maintaining adequate Reserves reduces the need for the Board of Health to further levy obligated municipalities within the district to cover unexpected expenses incurred by the board of health.

The Capital Asset Funding Plan was developed around the Building Conditions Assessment (the Assessment) that was completed on behalf of the Ministry of

Community and Social Services (the Ministry). The Assessment was conducted on November 20, 2015 with a final report received on February 20th, 2018. This Assessment report, specifically the Capital Reserve Expenditure schedule serves as the foundation of APH's Capital Asset Funding Plan over a 20 year period. In addition, the Assessment will help with Reserve Fund contribution decisions.

The Capital Asset Plan is a fluid document. The timing of planned expenditures may be moved up or pushed back depending on the situation.

Types of Capital Assets:

In addition to the specific capital building needs, APH management included items related to Computer Equipment; Furniture and Equipment; Vehicles; and Leasehold Improvements (as APH leases office space within the District). These categories mirror those referenced in APH's Financial Statements which are amortized over a period of time.

Computer Equipment/Furniture/Vehicles

Investing in Computer Equipment, Furniture, and Vehicles is required to allow APH employees to provide services within the District of Algoma. Keeping staff well-equipped improves efficiencies while improving program outcomes.

Facilities – Maintenance, Repair and Replacement

APH owns and leases space. As a result, it is necessary to make improvements to the property (capital or leasehold improvements). As the owner of the facility located at 294 Willow Avenue in Sault Ste. Marie, APH is responsible for repairs and maintenance of the facility. Anticipating what repairs or improvements may be necessary, researching and estimating the related costs, determining the target amount needed and the approximate timing of the expenditure are all part of the capital budgeting process, along with developing funding strategies.

Types of Financing Options Available to the Board of Health:

Depending of the nature and the associated cost of the expenditure, there are different financing options available to the Board of Health. Three examples include:

Operating Dollar Financing – can be used if APH is operating in a surplus position in any given year and the associated cost of the expenditure will still allow the Board to remain on target with respect to their annual operating budget. The nature of the expenditure would have to be admissible under the terms of the Ministry Accountability Agreement. Use of operating dollars for capital expenditures helps to minimize the amount of dollars that may have to be returned to the Ministry within any given year.

Reserve Financing – can be used if APH determines that the use of operating dollars is not feasible (i.e. cost of the expenditure would negatively impact the annual Operating Budget or the type of expenditure is inadmissible under the terms of the Ministry Accountability Agreement). The advantages of Reserve Financing are it minimizes the amount of debt the Board would otherwise incur and/or reduces the Levy that municipalities would have to contribute.

Debt Financing – can be used when the expenditure is large in scale such that operating dollars and Reserves would not support it.

Regardless of whether the expenditure is capital or operating in nature, APH's Procurement Policy 02-04-030 and Reserve Fund Policy 02-05-065 must be adhered to. As such, management may make capital expenditures with operating or reserve dollars provided the expenditure is within the Board approved spending limits as noted within each of the respective policies. Any debt financing would typically require Board approval.

ALGOMA PUBLIC HEALTH
CAPTIAL ASSET PLAN

Item	Anticipated Expenditure													
	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	
Computer Equipment														-
Network Servers					200,000							200,000		400,000
Telephone System	150,000								150,000					300,000
Network Infrastructure					60,000									60,000
Polycom Video Conference System			28,000					28,000						56,000
Backup Data Storage			30,000								30,000			60,000
Computers	25,000	25,000	25,000	25,000	25,000	25,000	25,000	25,000	25,000	25,000	25,000	25,000	25,000	325,000
														-
Furniture and Equipment														-
Vaccine Refrigerators			7,000				7,000				7,000			21,000
														-
Vehicle														-
Truck (land control)						50,000								50,000
														-
														-
Leasehold Improvements														-
Blind River Office	5,000													5,000
Elliot Lake Office					7,000									7,000
Wawa Office		5,000												5,000
														-
Owned Facility:														-
294 Willow Avenue Building, Sault Ste. Marie														-
Municipal/Utility Services														-
Water Supply														-
Sanitary Supply														-
Storm Sewer														-
Gas Utility														-
Hydro Utility														-
Other Municipal/Utility Services														-
Site Finishes														-
Passenger Vehicle Parking Area - Pavement and Curbing							26,600							26,600
Roadways - Pavement and Curbing							17,500							17,500
Walkways, Sidewalks and Exterior stairs														-
Exterior Light Standards														-
Soft Landscaping and Picnic Facilities														-
Signage														-
Retaining walls and other Site Improvements														-
Site Drainage														-
Parking Gates														-
Other Site Finishes														-
Structural														-
Building Substructure, including foundations and basement walls														-
Building Superstructure														-
Interior Stairs														-
Roof Construction														-
Other Structural														-
Building Exterior														-
Foundation Wall														-
Cladding System														-
Exterior Sealants and Caulking														-
Entrances and Doors														-
Windows including Frames														-
Parapets and Canopies														-
Loading Dock														-
Other Building Exterior														-
Roof														-
Roof Assembly (waterproofing membrane and roof surface)					165,000									165,000
Flashing														-
Roof Drainage (eaves troughs/downspouts, roof drains)														-
Chimneys/Boiler Stacks														-
Skylights and other Roof Openings														-
Roof venting, if any														-
Other Roof														-
Building Interior														-
Interior Partitions and Doors														-
Flooring														-
Ceiling			60,000										60,000	120,000
Wall Finishes (Paint, Trim Baseboards, etc.)			45,000										45,000	90,000
Washroom Fixtures and Accessories (Towel dispensers, hand dryers, soap dispensers, change tables, partitions, etc.)														-
Presence of Mould														-
Other Building Interior														-
Mechanical and HVAC														-
Heating, Ventilating and Air Conditioning Systems							122,000							122,000
Building, Automation Systems, if any														-
Ductwork, if any														-
Vertical Transportation Devices, if any														-
Other Mechanical and HVAC														-
Plumbing														-

ALGOMA PUBLIC HEALTH
CAPTIAL ASSET PLAN

Item	Anticipated Expenditure													
	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	
Plumbing fixtures														-
Domestic water distribution														-
Sanitary waster														-
Rainwater drainage														-
Water Fountain														-
Electric														-
Primary Feed and Main Switchgear														-
Main Transformers														-
Step-down Transformers														-
Emergency Power Source or Generator														-
Distribution Systems and Panels														-
Interior Lighting														-
Exterior Lighting (Building-Mounted)														-
Automated Lighting Control System														-
Other Electrical														-
Fire Protection and Life Safety Systems														-
Water Reservoir, if any														-
Sprinkler and/or Standpipe System, if any														-
Fire Extinguishers														-
Fire Pumps, if any														-
Fire Alarm System and Voice Communication Systems, if any														-
Smoke and Heat Detectors and Carbon Monoxide Detectors, as applicable														-
Emergency Lighting and Exit Signage														-
Security System														-
Fire/Emergency Plans														-
Fire Separations (visual inspection and inclusion of info that is readily available)														-
Automatic door closers														-
Other Fire Protection and Life Safety Systems														-
Hazardous Materials														-
Asbestos														-
PCB's														-
Other Hazardous Materials														-
Subtotal	180,000	30,000	195,000	25,000	457,000	75,000	198,100	53,000	175,000	25,000	62,000	225,000	130,000	1,830,100
Contingency (10%)	18,000	3,000	19,500	2,500	45,700	7,500	19,810	5,300	17,500	2,500	6,200	22,500	13,000	183,010
Subtotal Including Contingency	198,000	33,000	214,500	27,500	502,700	82,500	217,910	58,300	192,500	27,500	68,200	247,500	143,000	2,013,110
Escalation Allowance	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	-
Escalation Total	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Estimate Financial Projections	198,000	33,000	214,500	27,500	502,700	82,500	217,910	58,300	192,500	27,500	68,200	247,500	143,000	2,013,110

Total Net Sq. Ft. of Owned Facility	74,000
Year Built	2011
Age (yrs.)	8
Reserve Term (yrs.)	20

NOTES:

1) Contingency of 10% has been carried to cover unforeseen items & cost increases.

2) Cost in 2017 dollars with no provision for escalation.

3) HST is excluded.

Algoma Public Health - Governance Committee Report

Date of Meeting: November 7, 2018

The Committee had a good final meeting of the term and discussed several topics.

We completed a review of the APH meeting evaluations. Discussion around use of information and value of information gathered led to a revamping of some questions. Revised evaluation forms will be coming to this month's Board meeting for approval.

A brief discussion occurred regarding the possible use of a Consent Agenda process at Board and Committee meetings. There was not interest at this time to proceed, but it will be reviewed again laer next year as a way of streamlining meetings.

Other policies were reviewed for relevancy and necessary updates.

Board Member remuneration Policy was reviewed and a suggestion is being brought forth to adjust remuneration for attendance at meeting and attendance by phone to be the same amount. Equal preparation and time is given whether you are in the room or on the phone and it seems equitable to account for this at this time. As a follow up to this discussion, in the new year the policy will be reviewed to consider issues like geographic area or time considerations are part of the remuneration conditions also.

Professional Development for Board Members policy was reviewed and the process for approvals and accessing PD was clarified and wil be coming to the Board for approval.

A new policy was drafted and reviewed regarding Sponsorship and endorsement of Charitable organizations. This policy will set out how APH will be involved in or sponsor certain charitable activities. IT is a guideline when APH is approached for support or to give donations, etc.

Two suggestions were discussed regarding the Structure of Municipal Representative and Member participation in meetings. No recommendations to the Board is coming forward from these suggestion.

It was suggested that as part of the Board training sessions, a bit of time be allocated to amending, adapting or drafting policies and how to go about do it from a technical type standpoint.

Thank you to the Committee and staff who has worked hard this year on our issues. Their time and efforts are greatly appreciated.

Committee adjourned the meeting.

Lee Mason

Chair of the Governance Committee

Meeting Evaluation
Algoma Public Health Board of Health

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

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

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

Please select one response for each question in the following grid. If the question is not relevant please select "not applicable".					
	Strongly Agree 4	**Somewhat Agree 3**	**Somewhat Disagree 2**	**Strongly Disagree 1**	**Not Applicable 0**
1. The Board agenda package contained appropriate information to support the Board in carrying out its governance leadership role.					
2. The delegation/presentation was an opportunity for me to improve my knowledge and understanding of an important public health subject.					
3. The MOH/CEO report was informative, timely and relevant to my governance role.					
4. Overall, the Board meeting was conducted in an active and responsible manner.					
5. Overall, the meeting allowed me to seek clarification and provide input into issues.					

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

_____

_____

_____

Thank you for your valuable feedback.

Adapted with permission from Sudbury & District Health Unit

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

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

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

Part 1: Individual Performance **Compliance with Individual Roles and Responsibilities as a Board of Health Member.**					
	Strongly Agree 4	**Agree 3**	**Disagree 2**	**Strongly Disagree 1**	**Not Applicable 0**
1. As a BOH member, I was satisfied with my participation in meetings.					
2. As a BOH member, I understood my roles and responsibilities on the Board.					
3. As a BOH member, I understood current public health issues.					
4. As a BOH member, I was satisfied with the way that I received information through reports, dashboards, and forwarded communication.					
5. As a BOH member, I respected community perspectives during meetings.					
6. As a BOH member, I had the opportunity to provide input into policy development and decision-making.					

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

_____

_____

_____

Part 2: Board of Health Processes **Effectiveness of policy and process**					
	Strongly Agree 4	**Agree 3**	**Disagree 2**	**Strongly Disagree 1**	**Not Applicable 0**
1. The BOH ensured new members received orientation for roles and responsibilities.					
2. The BOH was adequately informed about financial management, procurement policies and practice, risk management, organizational effectiveness, and human					

Adapted with permission from Sudbury and District Health Unit

resources issues.					
3. The BOH held meetings frequently enough to ensure timely decision-making.					
4. The BOH based decision making on access to appropriate information with sufficient time for deliberations.					
5. The BOH was kept apprised of public health issues in a timely and effective manner.					

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

_____

_____

_____

Part 3: Overall Performance of the Board of Health					
	Strongly Agree 4	**Agree 3**	**Disagree 2**	**Strongly Disagree 1**	**Not Applicable 0**
1. The BOH ensured planning processes considered the strategic plan, as well as, stakeholder and community needs.					
2. The BOH had input into any change to the vision, mission and strategic direction of the organization.					
3. The BOH ensured a climate of mutual trust and respect between themselves and the Medical Officer of Health (MOH/CEO).					

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

_____

_____

_____

Adapted with permission from Sudbury and District Health Unit

APPROVED BY:	Board of Health	**REFERENCE #:**	02-05-86
DATE:	O: November 28, 2018	**SECTION:**	Board
		SUBJECT:	Sponsorship of Charitable Organizations

PURPOSE

To identify appropriate participation of APH employees with respect to charitable activities/events which the agency may support and the process by which this participation is carried out. This policy does not apply to collaborative project work for which the agency has an ongoing relationship with another organization to deliver programs or services consistent with the direction of the OPHS or to activities that employees may engage in outside of the terms of their employment.

BACKGROUND

The delivery of our mandated core public health programs may directly or indirectly support charitable organizations. Participation in community events which may include fundraising is beneficial for employee engagement, for our collaborative partnerships and for the communities that we support.

However, MOHLTC policy directs that health units may not redirect Ministry funds to charitable causes.[1] This includes direct donation of a monetary nature, supply of goods and services or human resources (employee time during work hours).

POLICY STATEMENT

APH supports community partners and other charitable organizations in their efforts to improve the health of the community through fund raising and special promotion events. Occasionally, staff at the Health Unit will become actively involved in such events or initiatives. Activities should align with effective public health practice. The appropriateness of the APH's active involvement with the event shall be determined by the senior management team when there is a potential human resource or financial commitment.

The following guidelines will assist in determining the suitability and extent of such activities:

- Activities closely align with public and population health goals.
- Activities and funds remain in Algoma or Northern Ontario.
- Use of APH infrastructure/ facilities that does not incur additional cost to the agency. (e.g. use of parking lot, meeting rooms, kitchen facilities)
- Activities do not disrupt or reduce routine APH program activities.
- Activities do not display favoritism to a group/team merely because a member of that group is an APH employee (e.g. hosting club meetings)

Any activities that involve direct sponsorship with a private/for profit corporation will be reviewed with the Board of Health.

REFERENCES

1. 2017 Program-Based Grants User Guide, Population and Public Health Division Ministry of Health and Long-Term Care January 2017, Non-Admissible Expenditures, Page 9

APPROVED BY:	Board of Health	**REFERENCE #:**	02-05-025
DATE:	O: March 20, 2002 Revised: June 17, 2014 Revised: November 25, 2015	**SECTION:**	Board
PAGE:	1 of 2	**SUBJECT:**	Board Member Remuneration/ Expenses for Attendance at Meetings and Conferences

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POLICY:

Remuneration for Attendance at Board of Health Meetings

1) Board members' attendance at meetings is verified by the attendance recorded in the minutes.

2) Payment of remuneration is issued to Board members on a monthly basis.

3) Daily remuneration as approved by the Board of Health and in accordance with *Part VI of the Health and Protection and Promotion Act, Section 49,* is paid to those Board members who are not a member of the council of a municipality, OR are a member of the council of a municipality and are not paid annual remuneration by any municipality, for the following authorized activities:
    a) Attendance at regular and/or special Board of Health meetings including teleconferenced meetings.
    b) Attendance at Standing Board Committee meetings including teleconferenced meetings.
    c) Attendance at the health unit at the request of the MOH or designate to fulfill duties related to the responsibilities of the Chair.

4) The Chair of the Board shall receive extra remuneration as described in this policy for the performance of additional duties associated with position of board chair.

Remuneration for Attendance at Board of Health Functions

Remuneration at Board of Health functions applies only to those Board members who normally receive a daily meeting rate from the Board of Health.

The categories of official Board of Health functions to which the daily remuneration rate will apply are as follows:

a) Attendance as a voting delegate to any annual or general meeting of alPHa;
b) Attendance as the official representative of the Board of Health at a local or provincial conference, briefing or orientation session, information session, or planning activity, with an expectation that a written report will be tabled with the Board.

For example:

- a briefing session with the Minister of Health or the Public Health Branch on a public health issue;
- attendance at a local workshop, information session or Task Force on a Board-related issue such as Long Term Care Reform;
- an alPHa-sponsored committee, task force, workshop, etc., at which Board attendance is specifically requested and which is not recompensed from other sources;
- others at the discretion of the Chair, subject to ratification by the Board.

c) This rate does not apply to any workshop, seminar, conference, public relation event, APH program event or celebration, which is voluntary and does not specifically require official Board representation.

The Board member remuneration as described below will be effective each January. The remuneration may be increased each year by resolution and vote of the Board and the increase will be no greater than the % change in the consumer price index for the previous year as determined by Statistics Canada.

Attendance at Board Meetings (in person or electronically)	$109	per meeting
~~Attendance at Board Meeting *(partial)*~~	~~$54~~	~~per meeting~~
Attendance at Committee Meetings	$60/ $109	$60 per meeting or $109 maximum if attending more than one meeting on the same day.
Attendance at Conferences	$181	per day
Additional duties of Board Chair	$60	per month

Expenses

1) Are recognized for attendance at Board of Health meetings and functions for which remuneration would apply.

2) Are not recognized for Board members other than the Chair who are members of the council of a municipality and are paid expenses by the municipality.

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

4) Travel Expense Claim Form is used to claim:
   a) the kilometers traveled for attendance at Board functions (conference, conventions or workshops).
   b) reasonable and actual expenses incurred respecting accommodation, food, parking and registration fees. All claims are subject to any limitations as in the General Administrative Manual. Receipts are required.

5) Once submitted, Board/MOH Expenses are to be approved as follows:
   a) The Board of Health Chair expenses: will be approved by the Chair of the Finance and Audit Committee.
   b) Board member expenses will be approved by the Board of Health Chair or delegate.
   c) MOH and/or CEO expenses will be approved by the Board of Health Chair or delegate.

Eligible expenses are reimbursed for Board members only.

APPROVED BY:	Board of Health	**REFERENCE #:**	02-05-035
DATE:	O: January 20, 2010 Reviewed: May 16, 2012 Reviewed: June 17, 2014 Revised: May 25, 2016 Revised: November 28, 2018	**SECTION:**	Board
~~**PAGE:**~~	~~1 of 1~~	**SUBJECT:**	Continuing Education for Board Members

POLICY:

Algoma Public Health encourages and supports Board Members to attend and participate in training, workshops, seminars, meetings, and conferences related to public health and governance issues.

The Medical Officer of Health/Chief Executive Officer shall bring programs, seminars or conferences relevant to the work of the Board to the attention of the Board. Board members may also identify learning and development opportunities designed to enhance their ~~professional~~ competence and knowledge throughout their mandate. These may include seminars or workshops sponsored by other community service groups or those sponsored by health associations or government departments.

Board members shall receive approval by the Chair of the Board to attend as a representative of the board and to receive financial support for expenses and remuneration. The Chair of the Board shall receive approval from First Chair. If they are not available, then the Second Chair will give approval. The member shall submit a brief written report to the Board highlighting the information/knowledge/skills presented.

Board Members, approved by the Board Chair for a professional development activity, shall be reimbursed for all expenses incurred as per policy 02-05-025 Board Member Remuneration.

HURON
COUNTY

November 8, 2018

Premier Doug Ford
Legislative Building
Queen's Park
Toronto, ON M7A 1A1

Dear Premier Ford:

Re: Ontario Basic Income Research Project

On October 4, 2018 at a regular meeting of the Board of Health for the Huron County Health Unit, the Board considered the attached correspondence from Leeds, Grenville & Lanark District Health Unit regarding the Ontario Basic Income Research Project. The following motion was passed:

MOTION:
Moved by: Member Jewitt and Seconded by: Member Rognvaldson
THAT:
The Board of Health supports correspondence received from Leeds, Grenville & Lanark District Health Unit to The Honourable Doug Ford, Premier of Ontario, The Honourable Lisa MacLeod, Minister of Children, Community and Social Services and The Honourable Christine Elliott, Minister of Health and Long-Term Care Re: Ontario Basic Income Research Project – dated August 30, 2018.

CARRIED

Sincerely,

Tyler Hessel
Chair, Huron County Board of Health

Cc: All Ontario Boards of Health
Encl.

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

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

Leeds, Grenville & Lanark District
HEALTH UNIT
Your Partner in Public Health

August 30, 2018

VIA EMAIL

The Honourable Doug Ford
Premier of Ontario
premier@ontario.ca

The Honourable Lisa MacLeod
Minister of Children, Community and Social Services
mcssinfo.css@ontario.ca

The Honourable Christine Elliott
Minister of Health and Long-Term Care
ccu.moh@ontario.ca

Dear Premier Ford and Ministers MacLeod and Elliott:

Re: Ontario Basic Income Research Project

I am writing today to express our concern about the discontinuation of the Ontario Basic Income Research Project.

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

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

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

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

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

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

We hope that you will respond favourably to our request, along with that of many health units and others, to reinstate the Ontario Basic Income Research Project.

Sincerely,

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

cc: Dr. David Williams, Ontario Chief Medical Officer of Health
Loretta Ryan, Association of Local Public Health Agencies
Pegeen Walsh, Ontario Public Health Association
Ontario Boards of Health
Leeds, Grenville and Lanark Members of Provincial Parliament
Champlain and South East Local Health Integration Network
Jamie McGarvey, President, Association of Municipalities Ontario
Brock Carlton, Chief Executive Officer, Federation of Canadian Municipalities
Leeds, Grenville and Lanark Municipalities

References

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

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

Peterborough Public Health

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

November 8, 2018

Renu Kulendran, Executive Director
Legalization of Cannabis Secretariat
Ministry of the Attorney General
McMurtry-Scott Building
720 Bay Street, 11th Floor
Toronto, ON M7A 2S9
Renu.Kulendran@ontario.ca

Dear Ms. Kulendran,

Re: Regulatory Framework for Cannabis Storefronts in Ontario

The Board of Health for Peterborough Public Health received a staff report at our October 10, 2018 board meeting outlining changes to the provincial legislation governing cannabis retailing. We understand that under the new provincial framework the Ontario Cannabis Store (OCS) will be the exclusive wholesaler and online retailer of cannabis in the province and that the Alcohol and Gaming Commission of Ontario (AGCO) will serve as the provincial regulator for private cannabis storefronts.

We further understand that the regulatory framework for cannabis storefronts is still under development. Given that the regulation of cannabis retailing is an important dimension of a public health approach to cannabis legalization, we would like to take this opportunity to submit our comments for your consideration as you develop specific regulations relating to cannabis storefront operating parameters, siting requirements, and public notice processes.

Operating Parameters

- **Limit retail hours –** Research on alcohol regulation suggests that longer retail hours increase consumption and related harms. The Centre for Addiction and Mental Health (CAMH) recommends that cannabis retail hours reflect those established by the Liquor Control Board of Ontario (LCBO).
- **Set minimum training requirements for staff –** The final report of the federal Task Force for Cannabis Legalization and Regulation recommends formal training for cannabis retail staff in order to ensure consistency of information, enforcement of minimum age restrictions, controlling overconsumption, and informing consumers of their rights and obligations. CAMH suggests that the LCBO's Challenges and Refusal program could provide a good model for this training.

Siting Requirements

- **Set minimum distances from youth-serving facilities –** Evidence from tobacco regulation suggests that greater availability of tobacco products increases consumption, normalizes use, undermines health warnings, and affects youth initiation. Examples from the U.S. suggest minimum distances of 300m between cannabis retail and youth-serving facilities (including schools, community centres, and childcare facilities) while CAMH suggests a minimum distance of 500m between cannabis storefronts and sensitive uses.

- **Regulate cannabis retail densities –** In addition to proximity to sensitive uses there is concern that high retail density can contribute to increased consumption and related harms. Examples from other Canadian cities suggest a 300m separation distance between cannabis stores to avoid clustering of retail locations. CAMH further suggests setting a cap on the number of retail locations in the province as a means to limit retail density.
- **Limit co-location of cannabis and alcohol and tobacco retail –** Evidence suggests that there are specific health and impairment risks associated with co-use of cannabis and other substances. Limiting the co-location of cannabis and alcohol and tobacco outlets could help discourage the co-use of these substances. CAMH reports that such a precautionary measure has been taken in all U.S. states that have legalized cannabis.

Public Notice Process

- **Strengthen municipal influence over store locations and density –** The *Cannabis Licence Act, 2018*, limits the authority of municipalities to pass zoning or business licensing by-laws pertaining to cannabis retail. However, municipal governments continue to have an important role in ensuring the safety and wellbeing of their residents. Strengthening the voice of municipalities within the written comment period for the AGCO would enable municipalities to better uphold this role with respect to cannabis retailing.
- **Clarify 'public interest' for written submission –** Under the *Cannabis Licence Act, 2018*, municipalities and residents will be granted a 15-day period to make written submission to the AGCO with regard to whether a retail store authorization is in the public interest. However, it remains unclear how municipalities are to operationalize this concept to make an informed determination of public interest within the 15-day comment period. Using municipal by-laws and related policies to help operationalize this concept may help to clarify the written submission parameters for municipal respondents.

Sincerely,

Original signed by

Councillor Henry Clarke
Chair, Board of Health

cc: The Hon. Doug Ford, Premier of Ontario
The Hon. Christine Elliott, Minister of Health and Long-Term Care
Local Councils
Local MPPs
Association of Local Public Health Agencies
Ontario Boards of Health

Peterborough Public Health

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

November 18, 2018

Hon. Caroline Mulroney
Ministry of the Attorney General
McMurtry-Scott Building
720 Bay Street
Toronto, ON M7A 2S9
caroline.mulroney@pc.ola.org

Dear Minister Mulroney,

The Board of Health (BOH) for Peterborough Public Health (PPH) at its October 10, 2018 meeting received and discussed a staff report regarding the provincial legislation for cannabis and the amended Smoke-Free Ontario Act, 2017.

Through the revisions to the Smoke-Free Ontario Act, 2017, boards of health have been appointed to enforce cannabis use in locations where smoking and vaping of tobacco are prohibited. Although the Ministry of Health and Long-Term Care has provided boards of health with a one-time grant opportunity to request reimbursement for costs associated with the enforcement of the use of cannabis, the BOH is very concerned about its ability to comply with the enforcement requirement within the current funding envelope and organizational constraints. We have requested $35,151 until March 31, 2019 for this additional work, with no further indication of sustained long-term funding after this date.

This suggested approach presents the BOH with several difficulties. Firstly, we understand that the funds provided to municipalities are intended for their own costs to help with the transition to recreational cannabis use being made legal in their communities. According to the Association of Municipalities of Ontario, it is likely that municipal costs would exceed the municipal share of the federal cannabis excise tax. There may not be sufficient funds to give to local public health agencies along with municipalities.

Secondly, there is no assurance that local municipalities will opt to allow retail cannabis outlets which could result in no transfer of funds from the Government of Ontario past the initial $10,000 installment.

Thirdly, as an autonomous board, there currently is no mechanism for the municipality to specifically fund enforcement activities nor share with Peterborough Public Health the proceeds from infractions.

Finally, any communication to date describes funding over the next two years only, which does not sustain needs over the long term.

This matter is of grave concern to the BOH as we experience increased demands due to implementation of modernized Ontario Public Health Standards, increased costs and no additional financial support from the Province. This is clearly unsustainable and we anticipate will result in cuts to other services. A dedicated funding stream to support cannabis education and enforcement activities is necessary for public health

interventions which can result in long-term cost savings and reduced pressures on emergency health services.

We respectfully request that you continue to engage with the BOH on this matter to ensure that public health interventions and programs continue to be delivered at a level that results in their intended impacts.

Sincerely,

Original signed by

Councillor Henry Clarke
Chair, Board of Health

cc: The Hon. Doug Ford, Premier of Ontario
The Hon. Christine Elliott, Minister of Health and Long-Term Care
Local Councils
Local MPPs
Ontario Boards of Health
The Association of Local Public Health Agencies

Peterborough Public Health

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

November 2, 2018

The Honourable Ginette Petitpas Taylor
Minister of Health
House of Commons
Ottawa, ON K1A 0A6
Ginette.PetitpasTaylor@parl.gc.ca

The Honourable Jody Wilson-Raybould
Minister of Justice and Attorney General of Canada
House of Commons
Ottawa, ON K1A 0A6
Jody.Wilson-Raybould@parl.gc.ca

Dear Honourable Ministers:

Re: A Public Health Approach to Drug Policy Reform

On September 12th, the Board of Health for Peterborough Public Health endorsed the recommendations of the Canadian Public Health Association's 2017 position statement on the decriminalization of personal use of illicit psychoactive substances. These recommendations call for a shift from addressing the use of illicit psychoactive substances as a criminal issue to that of an important public health issue. The position statement further "recognizes and supports the right of Indigenous communities to respond to psychoactive substance use according to their traditional justice and/or cultural protocols".[1]

This endorsement builds on the Board's January, 2016 resolution to apply a public health approach to psychoactive substances and their regulation to future work and resolutions. In making this endorsement, the Board also joins a growing movement across many sectors to pursue a public health approach to drug policy, one that is informed by mounting evidence of the ineffectiveness of current criminal approaches.

Evidence from other countries which have pursued a decriminalization approach demonstrate that in order to be most effective, such an approach must be accompanied with investments in harm reduction, treatment and mental health supports and services. Where this multi-tiered approach has been implemented, measurably positive outcomes have resulted, including pronounced reductions in overdose deaths, and substantial increased in entry to drug treatment.[2]

Considering the extensive evidence that criminalization perpetuates problematic drug-use and compounds its associated harms, and given the negative impacts of the current opioid crisis currently being felt in Peterborough and across Canada, we strongly urge you to consider a new approach. It is our position that decriminalizing the use of psychoactive substances together with continued commitment of resources to treatment and related services will more effectively address problematic substance use and reduce related harms in our communities.

Sincerely,

Original signed by

Councillor Henry Clarke
Chair, Board of Health

cc: Local MPs
Local Councils
Ontario Association of Police Services Board
Ontario Association of Chiefs of Police
Association of Local Public Health Agencies
Ontario Boards of Health

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[1] Canadian Public Health Association (2017) *Decriminalization of Personal Use of Psychoactive Substances*. Position Statement. Retrieved from: https://www.cpha.ca/decriminalization-personal-use-psychoactive-substances

[2] Hughes, C. and Stevens, A. (2011). Harm Reduction Digest (44) A resounding success or a disastrous failure: Re-examining the interpretation of evidence on the Portuguese decriminalization of Illicit Drugs. Drug And Alcohol Review (January 2012) 31, 101-113

Peterborough Public Health

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

November 5, 2018

The Honourable Christine Elliott
Minister of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4
christine.elliott@pc.ola.org

Dear Minister Elliott:

Re: Sustainable Infrastructure and Financial Supports for local drug strategies

The opioid crisis is a public health crisis that is devastating individuals, families and communities across the province. Tragically, thousands have lost their lives as a result of apparent opioid-related overdoses.

A strong local response is needed in order to mitigate the harms that are currently being shouldered by individuals, families, and communities. Increasing institutional and financial supports for the work of local drug strategies across the province can help support immediate collaborative action across the four pillars of prevention, treatment, harm reduction, and enforcement. The four pillar approach to drug policy is a well-established framework that ensures "a continuum of care for those suffering from substance addiction and communities impacted by those same people".[1]

The Peterborough Drug Strategy (PDS) is one of approximately 32 local drug strategies currently operating in the province of Ontario. PDS has been in operation since 2010 and represents a "shared effort to mitigate harms related to substance use in our community".[2] Since 2015, PDS has received $570,000 in project based funds and leveraged an additional $30,800 in in-kind contributions from partner agencies (including Peterborough Public Health). While PDS has received some core funding from the City of Peterborough on an annual basis, most local drug strategies operate in the absence of core funding to support ongoing administration and coordination.

With the resources it has received, PDS has shown leadership in supporting the development and implementation of a naloxone distribution program at the Peterborough Regional Health Centre Emergency Department, responding to local opioid-related harms, and developing an advisory panel of people with lived experience of substance use. With membership representing the four pillars of prevention, harm reduction, enforcement and treatment, PDS represents the leading edge of evidence-based collaborative action on substance use in our community.

We call upon your government to ensure that local drug strategies are integrated into any future planning for a provincial mental health and addiction program. These local drug strategies require both a sustainable source of funding as well as support for their coordination across the province to ensure their impact is fully

operationalized. Our board of health believes this collaborative approach to mitigating substance use harms in communities across Ontario is fundamental to our success across our various sectors.

Sincerely,

Original signed by

Councillor Henry Clarke
Chair, Board of Health

cc: Hon. Doug Ford, Premier of Ontario
Local MPPs
Local Councils
Municipal Drug Strategy Coordinators Network of Ontario
Fourcast Peterborough
Peterborough Aids Resource Network (PARN)
Peterborough Regional Health Centre
Peterborough Police Service
Ontario Boards of Health
Association of Local Public Health Agencies

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[1] MacPherson, D. (2001). *A Framework for Action: A Four-Pillar Approach to Drug Problems in Vancouver, Revised*. Retrieved from: https://www.researchgate.net/publication/242480594_A_Four-Pillar_Approach_to_Drug_Problems_in_Vancouver

[2] Peterborough Drug Strategy. 2018. *About Us*. Retrieved from: http://peterboroughdrugstrategy.com/get-to-know-us/pds-in-action/

Peterborough Public Health

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

November 5, 2018

The Honourable Christine Elliott
Minister of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4
christine.elliott@pc.ola.org

Dear Minister Elliott,

Re: Strengthening the Smoke-Free Ontario Act (2017) to address the promotion of vaping

At its meeting on October 10, 2018, the Board of Health for Peterborough Public Health passed a motion to urge the Ontario government to strengthen the Smoke-Free Ontario Act (2017) and prohibit through regulation, the promotion of vaping products.

By and large the changes in the updated Act and regulations are viewed favorably by Peterborough Public Health as it harmonizes medicinal cannabis, recreational cannabis, conventional cigarettes, and e-cigarette laws into one piece of legislation. However, health experts conclude that allowing retail vaping displays and promotion will put thousands of children and youth at risk of nicotine addiction. The legislation only bans actual vaping product displays at retail outlets and does not restrict other types of retail promotion for vaping products. It permits the widespread promotion of vaping products in convenience stores, gas bars and other retail locations across Ontario. This includes freestanding brand promotions now located inside and outside retail locations like gas bars, posters including pictures of products, video product promotion, and many other types of promotion including those featuring actual vaping products, are all allowed. Mass media promotion of vaping produces (i.e., television advertising) has already been seen in Ontario.

Public health representatives are very concerned about the outcome of nicotine exposure on the adolescent brain. There is also more evidence of respiratory health impacts among young vapers. We are sure that these serious health impacts must be of concern to you and the Government of Ontario as well. We agree with a federal commitment to reducing tobacco use to 5% in Ontario by 2035[1] and fear that current promotion of vaping will actually lead to increased tobacco use among youth. Recently released results from the Canadian Tobacco, Alcohol and Drugs Survey (CTADS) shows that current smoking rates for Canadians aged 15 years and over have actually increased to 15.1% in 2017 from 13.0% in 2015.[2] Your action is urgently needed to protect the health of youth in Ontario and avoid an epidemic of vaping and nicotine addiction. We must work collaboratively to ensure that young people do not start smoking or vaping.

In conjunction with the above actions, the Board of Health requests that the Province invest in a timely evaluation of the implementation of the Smoke-Free Ontario Act to monitor the impacts of the limited promotion of vaping products with a commitment to make the required amendments as soon as possible.

Sincerely,

Original signed by

Councillor Henry Clarke
Chair, Board of Health

cc: Hon. Doug Ford, Premier of Ontario
Local MPPs
Ontario Boards of Health
Association of Local Public Health Agencies

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[1] Health Canada (2018). Canada's Tobacco Strategy. Retrieved from https://www.canada.ca/content/dam/hc-sc/documents/services/publications/healthy-living/canada-tobacco-strategy/overview-canada-tobacco-strategy-eng.pdf

[2] Statistics Canada (2018). Canadian Tobacco, Alcohol and Drugs Survey (CTADS): Summary of results for 2017. Retrieved from https://www.canada.ca/en/health-canada/services/canadian-tobacco-alcohol-drugs-survey/2017-summary.html

SOUTHWESTERN Public Health
Oxford • Elgin • St.Thomas

St. Thomas Site
Administrative Office
1230 Talbot Street
St. Thomas, ON
N5P 1G9

Woodstock Site
410 Buller Street
Woodstock, ON
N4S 4N2

October 24, 2018

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

Dear Honourable Doug Ford,

On behalf of the Southwestern Public Health Board, I am writing to both our provincial and federal government leaders to reinforce the urgency of the opioid poisoning emergency in our country and urge both the provincial and federal governments to increase actions in response to this emergency based on the evidenced-informed four pillar approach of harm reduction, prevention, treatment and enforcement.

There is an expanding opioid crisis in Canada that is resulting in epidemic-like numbers of overdose deaths. These deaths are the result of an interaction between prescribed, diverted and illegal opioids (such as fentanyl) and the recent entry into the illegal drug market of newer, more powerful synthetic opioids. The current approaches to managing this situation – focused on changing prescribing practices and interrupting the flow of drugs – have failed to reduce the death toll and should be supplemented with an enhanced and comprehensive public health approach. Such an approach would include the meaningful involvement of people with lived experience. [1]

We call on both levels of government to support initiatives that address the causes and determinants of problematic substance use, to make all tools and resources available to support efforts to address the opioid crisis at a community level, to expand and strengthen the integration of surveillance information between provincial and federal partners, to expedite approvals for newer therapeutic modalities for medication assisted and opioid substitution treatment, to provide funding to municipalities and regional health services to establish safe consumption facilities, and to support harm reduction and health promotion services needed to mitigate the opioid crisis at a regional level.

Injection drug use is associated with many serious drug-related harms, such as the transmission of blood borne infections (HIV, Hepatitis C, Hepatitis B), and with fatal and non-fatal overdoses and injection site bacterial infections. In some parts of the world, these harms are widespread among people who inject drugs. Access to interventions such as needle and syringe exchange, opioid substitution therapies, naloxone distribution, sharps management strategies, overdose prevention sites, and supervised consumption sites are essential to reducing these harms and improving the health of the people who use drugs.[2]

We are urging both our federal and provincial Ministers of Health to continue their efforts to address this crisis in our country with a coordinated pan-Canadian action plan spanning all four pillars of the national drug strategy.

Sincerely,

Bernie Wiehle
Chair, Board of Health
Southwestern Public Health

copy:

Honourable Justin Trudeau, Prime Minister of Canada
Honourable Ginette Petitpas Taylor, Federal Minister of Health
Honourable Christine Elliott, Minister of Health and Long-Term Care, Deputy Premier
Honourable Jeff Yurek, Member of Provincial Parliament, Elgin – Middlesex – London
Honourable Ernie Hardeman, Member of Provincial Parliament, Oxford
Association of Local Public Health Agencies
Ontario Boards of Health

1 https://www.cpha.ca/opioid-crisis-canada
2 Harm reduction international www.hri.global/public-health-approaches-to-drug-related-harms