Algoma
PUBLIC HEALTH
Santé publique Algoma

June 26, 2019

BOARD OF HEALTH MEETING

SSM Community Room A & B

www.algomapublichealth.com

Jun 26, 2019 - Board of Health Meeting Book

Algoma Public Health - Board of Health Meeting Table of Contents

7. New Business

a. Collaboration of Northern Public Health Units

8. Correspondence

a. Next Board of Health Meeting - September 25, 2019

15. Evaluation

16. Adjournment

Board of Health Meeting
AGENDA
June 26, 2019 at 5:00 pm
Sault Ste. Marie - Community Room A

BOARD MEMBERS
Lee Mason - Chair
Ed Pearce - 1st Vice Chair
Deborah Graystone - 2nd Vice Chair
Dr. Patricia Avery
Louise Caicco Tett
Randi Condie
Micheline Hatfield
Adrienne Kappes
Dr. Heather O'Brien
Brent Rankin
Karen Raybould
Matthew Scott

APH EXECUTIVE
Dr. Marlene Spruyt - MOH/CEO
Dr. Jennifer Loo - AMOH & Director of Health Protection
Justin Pino - CFO /Director of Operations
Antoniette Tomie - Director of Human Resources
Laurie Zeppa - Director of Health Promotion & Prevention
Tania Caputo - Board Secretary

1.0 Meeting Called to Order *L. Mason*

a. Declaration of Conflict of Interest

2.0 Adoption of Agenda *L. Mason*

RESOLUTION

THAT the Board of Health agenda dated June 26, 2019 be approved as presented.

3.0 Adoption of Minutes of Previous Meeting *L. Mason*

RESOLUTION

THAT the Board of Health minutes dated May 22, 2019 be approved as presented.

4.0 Delegations / Presentations

a. APH Addiction and Mental Health Programs *K. Iachetta*

b. North East Public Health Transformation Update *M. Spruyt*

c. Accountability Indicators Presentation

5.0 Business Arising from Minutes *L. Mason*

6.0 Reports to the Board

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

i. MOH Report - June 2019

ii. Annual Compliance Reporting

RESOLUTION

THAT the report of the Medical Officer of Health and CEO for June 2019 be adopted as presented.

b. Finance and Audit Committee *E. Pearce*

i. Finance and Audit Committee Chair Report

RESOLUTION

THAT the Finance and Audit Committee Chair Report for June 2019 be adopted as presented.

ii. Financial Statements *E. Pearce*

RESOLUTION

THAT the Draft Financial Statements for the period ending April 30, 2019 be approved as presented.

iii Finance and Audit Committee Terms of Reference

RESOLUTION *E. Pearce*

THAT the Finance and Audit Committee has reviewed and recommend to the Board of Health that the Terms of Reference be approved as presented.

c. Governance Committee *D. Graystone*

i. Governance Committee Chair Report

RESOLUTION

THAT the Governance Committee Chair Report for May 2019 be adopted as presented.

ii Governance Committee Terms of Reference

RESOLUTION

THAT the Governance Committee has reviewed and recommend to the Board of Health that the Terms of Reference be approved as presented.

iii. 02-05-087 Board Member Terms of Office

RESOLUTION

THAT the Governance Committee recommend to the Board of Health for approval the policy for Terms for Municipal and Provincial Appointees be adopted as presented

iv. 02-04-030 Procurement Policy & Electronic Assets

RESOLUTION

THAT the Governance Committee recommend to the Board of Health for approval the Procurement Policy 02-04-030 as amended.

v. 02-05-040 Employee Retirement - Board Recognition

RESOLUTION

THAT the Governance Committee recommend to the Board of Health that policy 02-05-040 Employee Retirement - Board Recognition be archived.

7.0 New Business/General Business

L. Mason

a. Collaboration of Northern Public Health Units

RESOLUTION

WHEREAS since November 2017, the boards of health in Northeastern Ontario, namely the Boards for Algoma Public Health, Public Health Sudbury & Districts, Porcupine Health Unit, North Bay Parry Sound District Health Unit, and Timiskaming Health Unit, have proactively and strategically engaged in the Northeast Public Health Collaboration Project to identify opportunities for collaboration and potential shared services; and

WHEREAS the Northeast Public Health Collaboration Project work to date has been supported by two one-time funding grants from the Ministry of Health and Long-Term Care (MOHLTC); and

WHEREAS subsequent to the proposed transformation of public health announced in the April 11, 2019 provincial budget, the work of the Collaboration has been accelerated and reoriented as the Northeast Public Health Transformation Initiative with the vision of a healthy northeastern Ontario enabled by a coordinated, efficient, effective, and collaborative public health entity; and

WHEREAS the Board understands there will be opportunities for consultation with the MOHLTC on the regional implementation of public health transformation;
Now THEREFORE be it resolved that the Board of Health for Algoma Public Health is committed to the continued collaboration of the boards of health in Northeastern Ontario and looks forward to ongoing MOHLTC support for this work;

AND FURTHER that the Board, having engaged in this work since 2017, anticipates sharing with the MOHLTC its experiences so that other regions may benefit and further anticipates providing to the Ministry its expert advice on public health functions and structures for the North East;

AND FURTHER that this motion be shared with Members of parliament of northeastern Ontario, the leader of the official opposition, the health critic of both provincial parties, The Chief Medical Officer of Health of Ontario, the Boards of Health throughout Ontario, the councils of Algoma municipalities, and the North East LHIN CEO

8.0 Correspondence

L. Mason

a. Letter to the Prime Minister of Canada from Windsor-Essex County Health Unit regarding Smoke-Free Multi Unit Dwelling dated May 21, 2019.

b. Letter to the Minister of Health and Long-Term Card from Windsor-Essex County Health Unit regarding Alcohol Retail Sales in Ontario dated May 21, 2019.

c. Letter to the Deputy Premier and Minister of Health and Long-Term Care from North Bay Parry Sound District regarding Support for Simcoe Muskoka district Health Unit - Proposed Boundaries dated May 23, 2019.

d. Letter to the Premier of Ontario and the Deputy Premier and Minister of Health and Long-Term Care from Brant County Health Unit regarding implications of the 2019 budget dated May 27, 2019.

e. Letter to the Premier of Ontario from Sudbury Public Health regarding North East Public Health Regional Boundaries - Modernization of the Ontario Public Health System dated May 28, 2019.

f. Letter to the Premier of Ontario from Grey Bruce Health Unit regarding Modernization of alcohol sales in Ontario dated June 4, 2019.

g. Letter to the Premier of Ontario from Grey Bruce Health Unit regarding Endorsement of the Children Count Task Force Recommendations dated June 4, 2019.

h. Letter to the Premier of Ontario from Grey Bruce Health Unit regarding Minimizing Harm Alcohol Retail Sales in Ontario dated June 4, 2019.

i. Letter to the Premier of Ontario from Grey Bruce Health Unit regarding Modernization of Alcohol Sales in Ontario dated June 4, 2019.

j. Letter to the Ministry of Health and Long-Term Care from Timiskaming Health Unit regarding Northeastern Regional Public Health Boundaries dated June 4, 2019.

k. Letter to the Premier of Ontario from KFL&A Public Health regarding Retroactive Funding Cuts to Municipal funding dated June 4, 2019.

l. Letter to the Deputy Premier and Minister of Health and Long-Term Care from Algoma Public Health regarding Proposed Changes to Public Health in Ontario dated June 5, 2019.

m. Letter to the Ministry of Health and Long-Term Care from Timiskaming Health Unit regarding North East Public Health Collaboration Project dated June 6, 2019.

n. Letter to the Premier of Ontario from Hastings Prince Edward Public Health regarding concerns with announced expansion of the sale of alcohol beverage in Ontario dated June 6, 2019.

o. Letter to the Minister of Health and Long -Term Care from Sudbury and Districts Public Health regarding Public Mental Health - Parity of Esteem Position Statement dated June 7, 2019

p. Letter to the Deputy Premier and Minister of Health and Long-Term Care from the Mayor of Hamilton regarding proposed changes to Public Health in Ontario dated June 14, 2019.

q. Letter to the Deputy Premier and Minister of Health and Long-Term Care from Porcupine Health Unit regarding Support for Simcoe-Muskoka District Health Unit and Proposed Boundaries dated June 19, 2019.

r. Resolution from the Porcupine Health Unit regarding Northeast Public Health Collaboration Project dated June 19, 2019.

s. Letter to the Deputy Premier and Minister of Health and Long-Term Care from Haliburton, Kawartha, Pine Ridge District Health Unit regarding Health Promotion as a Core Function of Public Health dated June 20, 2019.

9.0 Items for Information *L. Mason*

a. Disposition of 2019 alPHa Resolutions

b. alPHa Resolution A19-9 (corrected)

10.0 Addendum *L. Mason*

11.0 In Camera *L. Mason*

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 *L. Mason*

a. Resolutions resulting from the in camera meeting.

13.0 Announcements / Next Committee Meetings: *L. Mason*

Governance Committee Meeting

September (tbd), 2019 @ 4:30 pm

Prince Meeting Room, 3rd Floor

Board of Health Meeting:

September 25, 2019 @ 5:00 pm

Sault Ste. Marie, Room A

Finance & Audit Committee Meeting

October 9, 2019 @ 4:00 pm

Prince Meeting Room, 3rd Floor

14.0 Evaluation *L. Mason*

15.0 Adjournment *L. Mason*

RESOLUTION

THAT the Board of Health meeting adjourns.

Board of Health Meeting
MINUTES
May 22, 2019 at 5:00 pm
Sault Ste. Marie - Community Room A

PRESENT :

BOARD MEMBERS
Lee Mason - Chair
Ed Pearce - 1st Vice Chair
Deborah Graystone - 2nd Vice Chair
Dr. Patricia Avery
Louise Caicco Tett
Randi Condie
Micheline Hatfield
Adrienne Kappes
Dr. Heather O'Brien
Brent Rankin
Karen Raybould
Matthew Scott

APH EXECUTIVE
Dr. Marlene Spruyt - MOH/CEO
Dr. Jennifer Loo - AMOH & Director of Health Protection
Justin Pino - CFO /Director of Operations
Antoniette Tomie - Director of Human Resources
Laurie Zeppa - Director of Health Promotion & Prevention
Tania Caputo - Board Secretary

1.0 Meeting Called to Order

a. Declaration of Conflict of Interest

None declared

2.0 Adoption of Agenda

RESOLUTION 2019-43

Moved: D. Graystone
Seconded: K. Raybould

THAT the Board of Health agenda dated May 22, 2019 be approved as presented.

CARRIED

3.0 Adoption of Minutes of Previous Meeting

RESOLUTION 2019-44

Moved: E. Pearce
Seconded: B. Rankin

THAT the Board of Health minutes dated April 24, 2019 be approved as presented.

CARRIED

4.0 Delegations / Presentations

a. Education on Strategic Planning during the in camera session of the meeting.

5.0 Business Arising from Minutes

No items brought forward

6.0 Reports to the Board

a. Medical Officer of Health and Chief Executive Officer Reports

i. MOH Report - May 2019

M.Spruyt updated the Board on the recent cyber attack and the status of operations. The BOH was informed that expenditures regarding the Cyber audit were approved outside the normal procurement procedure, the chair was informed, these costs will be covered by our insurance. Strategic planning updates followed and explanation of how the work will translate to the future state. M. Spruyt described the evolution of the NE Public Health Collaborative work and the work plan that has been developed.

RESOLUTION 2019-45

Moved: P. Avery

Seconded: A. Kappes

THAT the report of the Medical Officer of Health and CEO for May 2019 be adopted as presented.

CARRIED

b. Finance and Audit Committee

i. Financial Statements

J. Pino provided an overview of the Draft Financial Statements explaining that proposed budget changes are not reflected in the current statements. Discussion followed with questions about the anticipated change of approach going forward and the requirement of the municipalities in relation to the Levy payments.

RESOLUTION 2019-46

Moved: H. O'Brien

Seconded: L. Caicco Tett

THAT the Draft Financial Statements for the period ending March 31, 2019 be approved as presented.

CARRIED

7.0 New Business/General Business

a. Public Health Regional Boundaries

M. Spruyt provided Information on the proposed boundary and the complexity of issues around the placement of Muskoka in the northeastern Ontario region.

8.0 Correspondence

a. alPHa News Release - Ontario Budget 2019 - Reducing Investments in Public Health dated April 12, 2019.

b. Letter to the Deputy Premier, Minister of Health and Long-Term Care and the Minister of Municipal Affairs and Housing from KFL&A Public Health regarding Restructuring Ontario's Public Health System dated April 17, 2019.

c. Resolution from the Thunder Bay District Health Unit, Board of Health regarding Public Health Restructuring dated April 17, 2019.

d. Letter to the Premier of Ontario from Perth District Health Unit regarding Response to Budget and Public Health Impact dated April 18, 2019.

e. Letter to the Deputy Premier, Minister of Health and Long-Term Care from Simcoe Muskoka District Health Unit regarding The Public Health System and the 2019 Ontario Provincial Budget dated April 18, 2019.

f. Letter to the Premier of Ontario from Haliburton, Kawartha, Pine Ridge District Health Unit regarding Support for Bill 60, Establishing a Social Assistance Research Commission dated April 18, 2019.

g. Letter to the Deputy Premier of Ontario, Minister of Health and Long-Term Care and the Minister of Municipal Affairs and Housing from the Leeds, Grenville & Lanark District Health Unit regarding the Provincial / Municipal Funding Ratio dated April 23, 2019.

h. alPHa Position Statement - Impact of Reducing Investments in Public Health dated April 24, 2019.

i. Letter to the Premier of Ontario and the Deputy Premier, Minister of Health and Long-Term Care from Haliburton, Kawartha Pine Ridge District Health Unit regarding the 2019 Ontario Budget, Protecting What Matters Most dated April 24, 2019.

j. Letter to the Minister of Children, Community and Social Services from KFL&A Public Health regarding Endorsement of the Ontario Dietitians in Public Health Letter on Bill 60 dated April 25, 2019.

k. Letter to the Premier of Ontario from KFL&A Public Health regarding Minimizing Harms Associated with the Announced Expansion of the Sale of Beverage Alcohol in Ontario dated April 25, 2019.

l. Letter to the Premier of Ontario from KFL&A Public Health regarding Endorsement of the Children Count Task Force Recommendations dated April 25, 2019.

m. Letter to the Chairpersons, Boards of Health, Medical Officers of Health, Public Health Units, Chief Executive Officers, Public Health Units from the Ministry of Health and Long-Term Care regarding Public Health Modernization dated April 29, 2019.

n. Letter to the Premier of Ontario and the Deputy Premier and Minister of Health and Long-Term Care from the Renfrew County and District Health Unit regarding Proposed Changes to Local Public Health dated April 29, 2019.

o. Letter to the Premier of Ontario from Peterborough Public Health regarding the Ongoing Modernization of Alcohol Retail Sales in Ontario dated May 1, 2019.

p. Letter to the Premier of Ontario and the Deputy Premier, Minister of Health and Long-Term Care from Hastings Prince Edward Public Health regarding the 2019 Ontario Budget implications dated May 1, 2019.

q. Statement released to all Boards of Health and Medical Officers of Health from the Association of Municipalities of Ontario regarding the Increase to Ontario's Supply of Affordable Housing dated May 2, 2019.

r. Letter to the Minister of Health and Long-Term Care from Peterborough Public Health regarding Managed Opioid Programs dated May 3, 2019.

s. Letter to the Minister of Health and Long-Term Care from alPHa regarding Modernizing Ontario's Health Units dated May 3, 2019.

t. Letter to the Senate of Canada from Peterborough Public Health regarding Bill S-228, the Child Health Protection Act dated May 9, 2019.

u. Update to Board of Health Members from alPHa regarding the 2019 Ontario Budget: Public Health System Restructuring dated May 10, 2019.

v. Letter to the Deputy Premier, Minister of Health and Long-Term Care from the Windsor-Essex County Health Unit regarding Strengthening the Smoke-Free Ontario Act, 2017 to Address the Promotion of Vaping dated May 15, 2019.

9.0 Items for Information

a. alPHa Challenge results

b. Bridges Out of Poverty

These sessions being held on June 11 in Elliot Lake and June 12 in Blind River are designed to educate about the realities experienced by individuals living in poverty. For questions or additional information contact the Board Secretary.

10.0 Addendum

Not applicable

At this time a resolution was brought forward with respect to the **Agenda Item 7, Regional Boundaries** discussion.

RESOLUTION 2019-47

Moved: H. O'Brien
Seconded: D. Graystone

Be it resolved that the Board of Health for Algoma shall send a letter of support to the Deputy Premier and Minister of Health and Long-Term care for the position of Simcoe-Muskoka as stated in their letter petitioning the MOH to keep their Health Unit territory intact and merge with the York Region rather than the Northeastern Regional Public Health entity.

CARRIED

11.0 In Camera

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 2019-48

Moved: K. Raybould
Seconded: L. Caicco Tett

THAT the Board of Health go in camera.

CARRIED

12.0 Open Meeting - 7:27 pm

a. Resolutions resulting from the in camera meeting.

Not applicable

13.0 Announcements / Next Committee Meetings:

Governance Committee Meeting

May 29, 2019 @ 5:00 pm

Prince Meeting Room, 3rd Floor

Finance & Audit Committee Meeting

June 12, 2019 @ 4:00 pm

Prince Meeting Room, 3rd Floor

Board of Health Meeting:

June 26, 2019 @ 5:00 pm

Sault Ste. Marie, Room A

14.0 Evaluation

L. Mason reminded all Board members to complete the meeting evaluation.

15.0 Adjournment 7:45 pm

RESOLUTION 2019-51	**Moved:** H. O'Brien
	Seconded: D. Graystone

THAT the Board of Health meeting adjourns.

CARRIED

Lee Mason, Chair	**Tania Caputo, Secretary**
Date	**Date**

North East Public Health Transformation

Dr. Marlene Spruyt, Medical Officer of Health and CEO

Presented with credit to Public Health Sudbury & Districts

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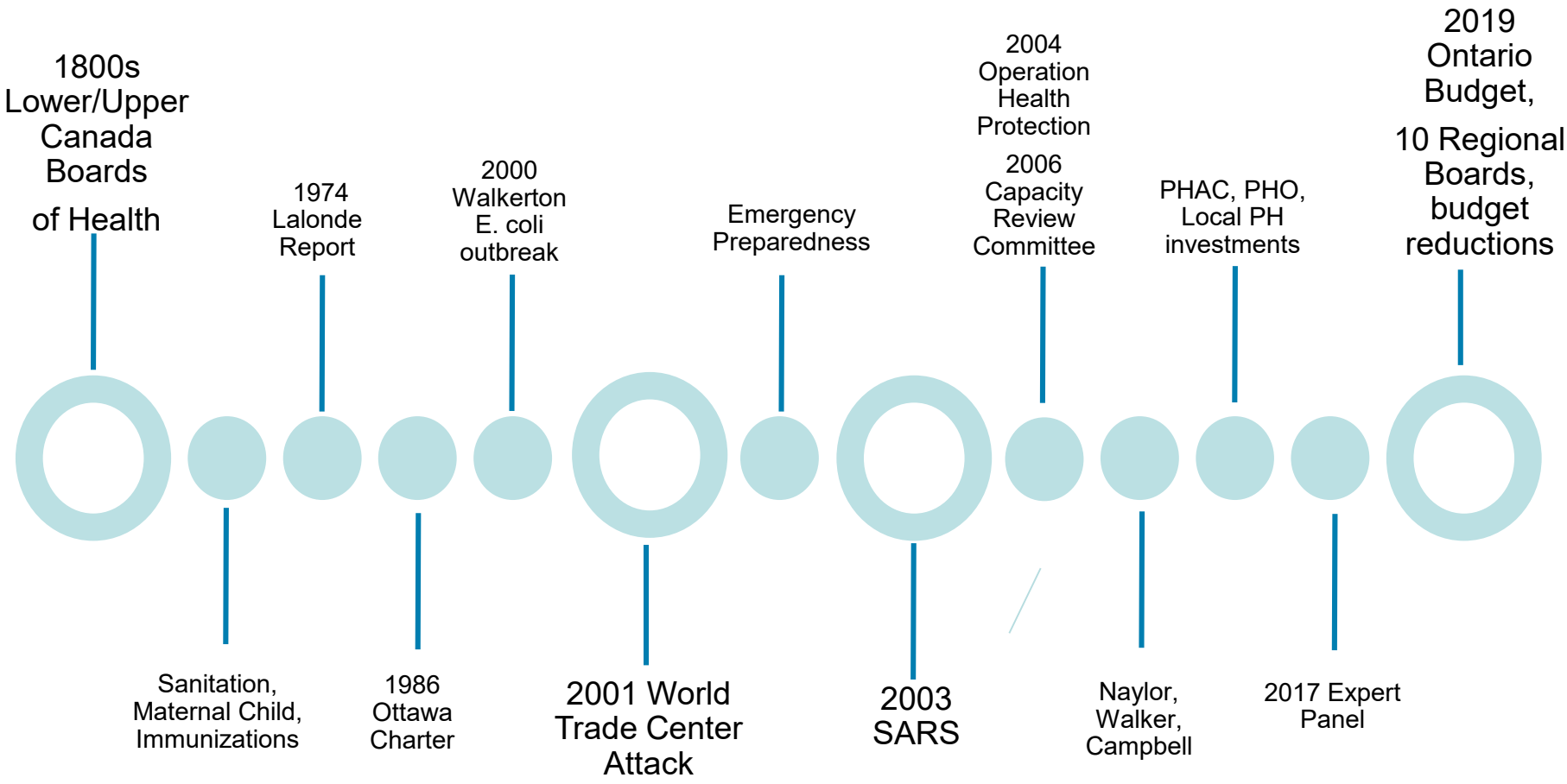
Brief Ontario-centric History of Public Health



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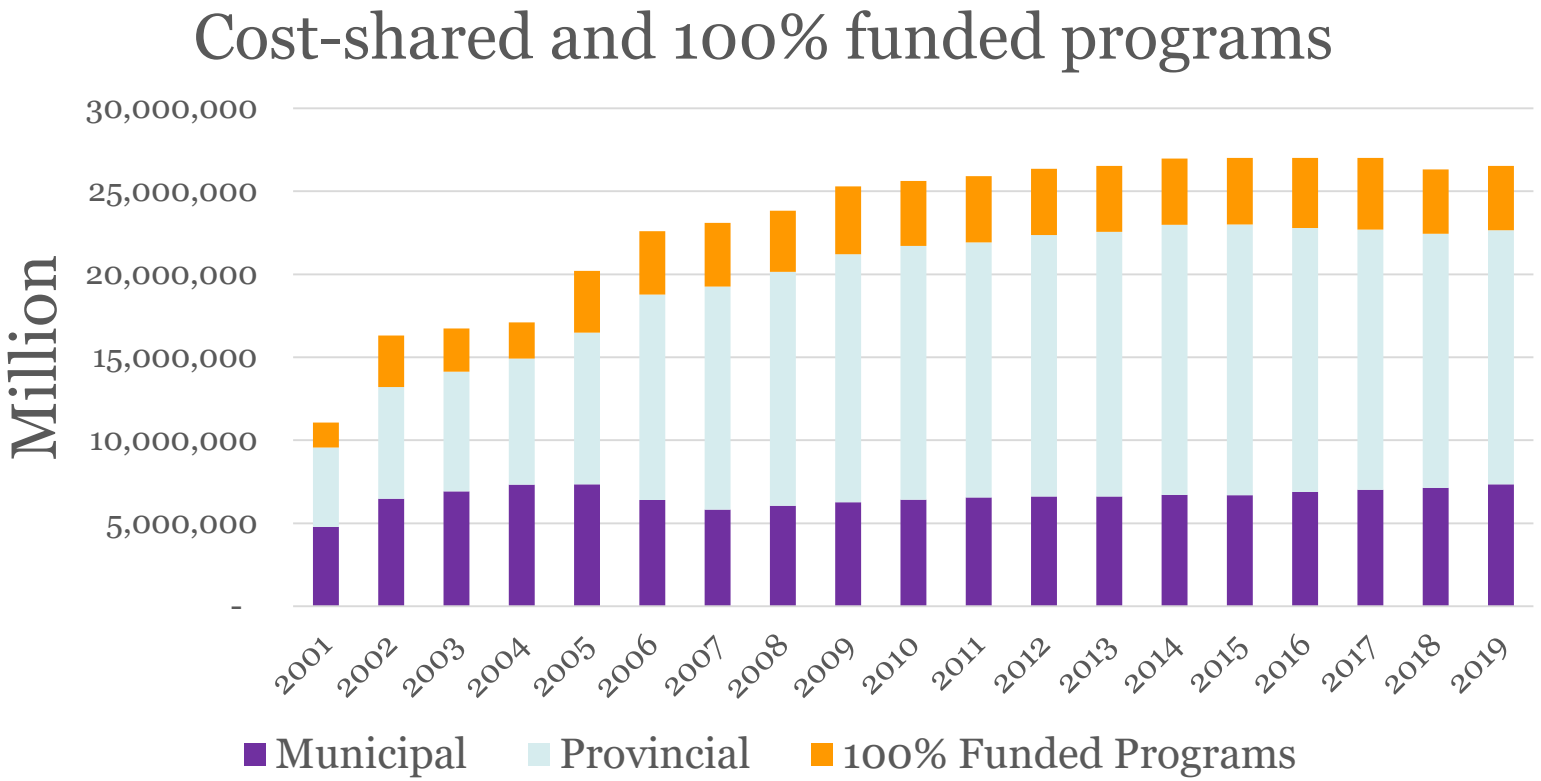
Public Health Sudbury & Districts Budget History



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Changes to the Public Health Sector

Additional Details to Date

- **Adjust municipal-provincial cost-sharing effective April 1, 2019**
  - 70:30 for Public Health Sudbury & Districts (also applies to 100% provincially-funded programs)
  - Estimated loss of $1.2M annually for Public Health Sudbury & Districts compared with 2018
  - Mitigation funds available for 2019/20
  - Annual funding letters expected in June 2019
- **Establish 10 regional public health entities/new regional boards (2020/21)**
  - Areas served currently by Boards for Public Health Sudbury & Districts, Algoma, Porcupine, North Bay Parry Sound, Timiskaming
  - Proposed to include northern part of Renfrew (Algonquin Park) and Muskoka
- **Cut of $200M annually from provincial funding (2021/22) achieved through:**
  - Funding formula change (including 100% funded programs)
  - Efficiencies realized with regionalization (~10% administrative efficiencies)
- **Limit scope of Public Health Ontario (2019/20) and reduce number of labs (2020/21)**

Implementing the Changes

- **Ministry**
  - Consultation ASAP (Association of Municipalities of Ontario, public health working groups, Association of Local Public Health Agencies, informal)
  - Legislation drafted fall 2019, finalized April 1, 2020
- **Regional**
  - North East Public Health Transformation Project
- **Local**
  - Parallel process
  - Change management
  - Financial/program management

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Current Assumptions

- Decisions are irreversible
- Governance model will be autonomous
- Significant collective budget reductions
- Structural and programming changes must achieve efficiencies
- Full scope of Ontario Public Health Standards (OPHS) and accountabilities ongoing

- Form follows function
  1. Regional functions and local service delivery functions
  2. Recommended structures to support functions
  3. Business cases based on existing assets

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Regional: Public Health in the North East

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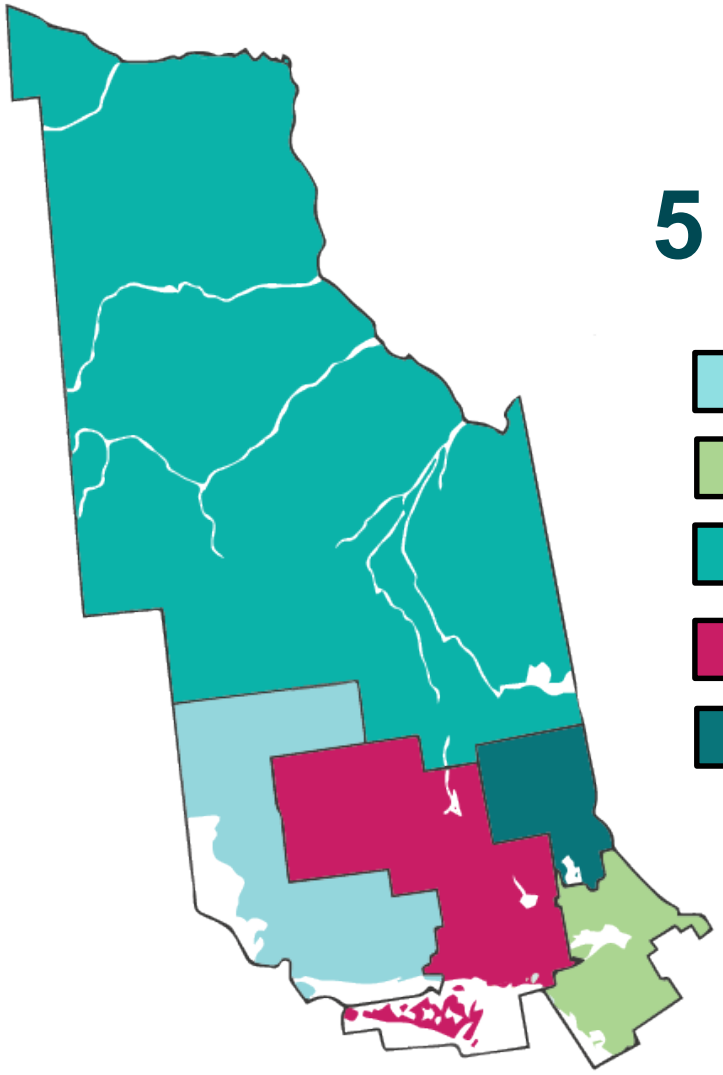

5 Boards of Health

- Algoma Public Health
- North Bay Parry Sound District Health Unit
- Porcupine Health Unit
- Public Health Sudbury & Districts
- Timiskaming Health Unit

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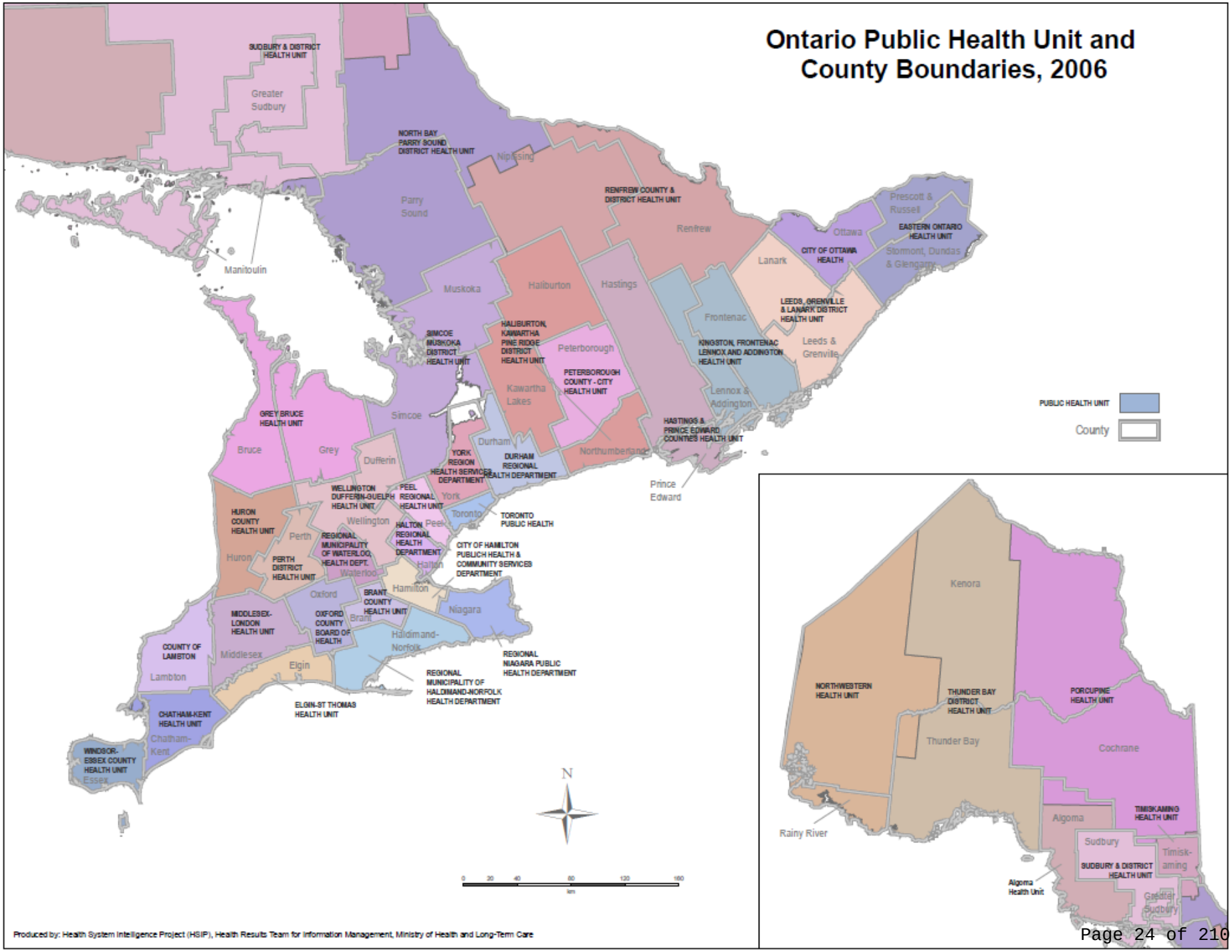
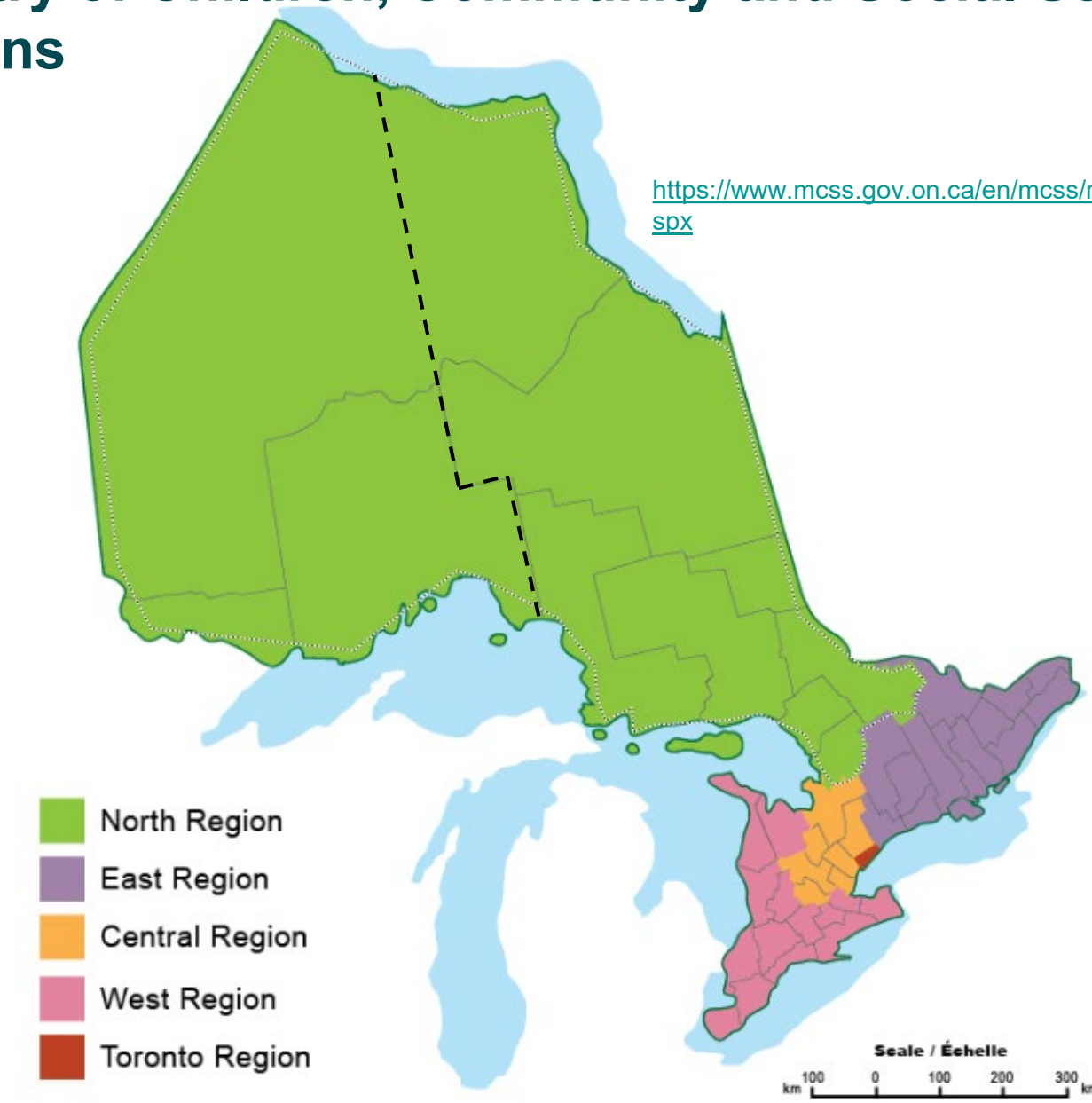

Ontario Public Health Unit and County Boundaries, 2006
SUDBURY & DISTRICT HEALTH UNIT
Greater Sudbury
NORTH BAY PARRY SOUND DISTRICT HEALTH UNIT
Nipissing
Parry Sound
Manitoulin
RENFREW COUNTY & DISTRICT HEALTH UNIT
Renfrew
Prescott & Russell
EASTERN ONTARIO HEALTH UNIT
Ottawa
CITY OF OTTAWA HEALTH
Stormont, Dundas & Glengarry
Lanark
Muskoka
Haliburton
Hastings
LEEDS, GRENVILLE & LANARK DISTRICT HEALTH UNIT
Frontenac
SIMCOE MUSKOKA DISTRICT HEALTH UNIT
HALIBURTON, KAWARTHA PINE RIDGE DISTRICT HEALTH UNIT
Peterborough
KINGSTON, FRONTENAC LENNOX AND ADDINGTON HEALTH UNIT
Leeds & Grenville
PETERBOROUGH COUNTY - CITY HEALTH UNIT
Kawartha Lakes
Lennox & Addington
GREY BRUCE HEALTH UNIT
Simcoe
HASTINGS & PRINCE EDWARD COUNTIES HEALTH UNIT
Durham
Bruce
Grey
Dufferin
YORK REGION HEALTH SERVICES DEPARTMENT
DURHAM REGIONAL HEALTH DEPARTMENT
Northumberland
Prince Edward
WELLINGTON DUFFERIN-GUELPH HEALTH UNIT
PEEL REGIONAL HEALTH UNIT
York
HURON COUNTY HEALTH UNIT
Wellington
Toronto
TORONTO PUBLIC HEALTH
Perth
Peel
REGIONAL MUNICIPALITY OF WATERLOO, HEALTH DEPT.
HALTON REGIONAL HEALTH DEPARTMENT
Huron
PERTH DISTRICT HEALTH UNIT
Halton
CITY OF HAMILTON PUBLIC HEALTH & COMMUNITY SERVICES DEPARTMENT
Waterloo
Oxford
Hamilton
BRANT COUNTY HEALTH UNIT
Niagara
MIDDLESEX-LONDON HEALTH UNIT
OXFORD COUNTY BOARD OF HEALTH
Brant
Haldimand-Norfolk
COUNTY OF LAMBTON
Middlesex
REGIONAL NIAGARA PUBLIC HEALTH DEPARTMENT
Elgin
Lambton
REGIONAL MUNICIPALITY OF HALDIMAND-NORFOLK HEALTH DEPARTMENT
CHATHAM-KENT HEALTH UNIT
ELGIN-ST THOMAS HEALTH UNIT
Chatham-Kent
WINDSOR-ESSEX COUNTY HEALTH UNIT
Essex
PUBLIC HEALTH UNIT
County
N
0 20 40 80 120 160
km
Kenora
NORTHWESTERN HEALTH UNIT
THUNDER BAY DISTRICT HEALTH UNIT
PORCUPINE HEALTH UNIT
Thunder Bay
Cochrane
Rainy River
Algoma
TIMISKAMING HEALTH UNIT
Sudbury
SUDBURY & DISTRICT HEALTH UNIT
Timiskaming
Algoma Health Unit
Greater Sudbury
Produced by: Health System Intelligence Project (HSIP), Health Results Team for Information Management, Ministry of Health and Long-Term Care

Ministry of Children, Community and Social Services Regions

https://www.mcss.gov.on.ca/en/mcss/regionalMap/regional.aspx



Catchment Area and Population, 2016

	Sudbury	Algoma	NBPS	Porcupine	Timiskaming
Total population, 2016	196,448	104,127	123,820	85,867	33,053
Area (km^2)	46,551	48,815	16,938	266,291	13,300
# Municipalities	19	21	31	14	23
# First Nations	13	8	8	7	3
Population / km^2	4.2	2.1	7.3	0.3	2.5

Data Source: Census, Statistics Canada, 2016

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Catchment Area and Population, 2016

	Muskoka District	Northern Renfrew County
Total population, 2016	60,599	1,199
Area (km^2)	3,940	7,583
# Municipalities	5	1
# First Nations	2	0
Population / km^2	15.4	0.16

Data Source: Census, Statistics Canada, 2016

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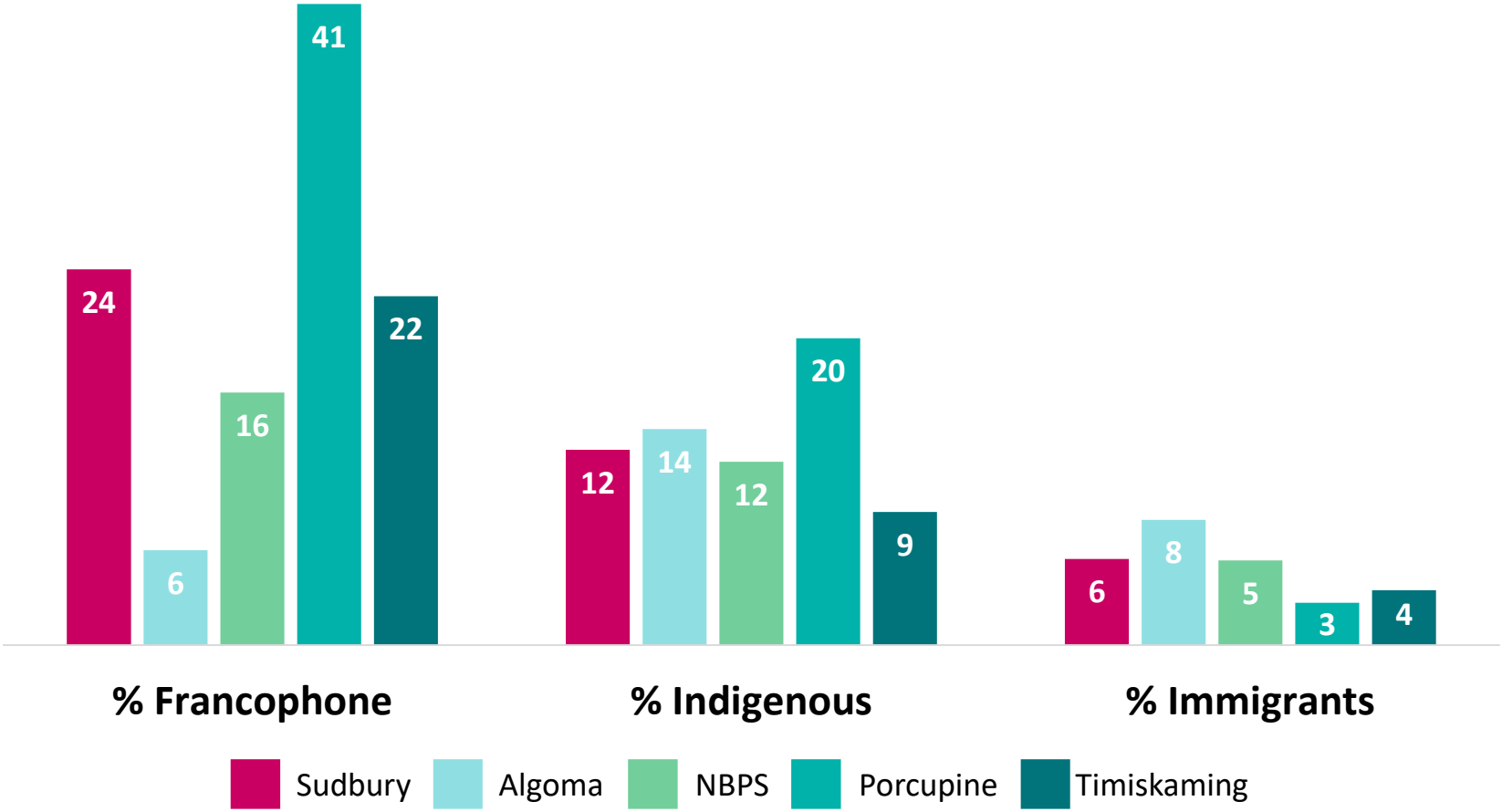
Language / Ethnicity

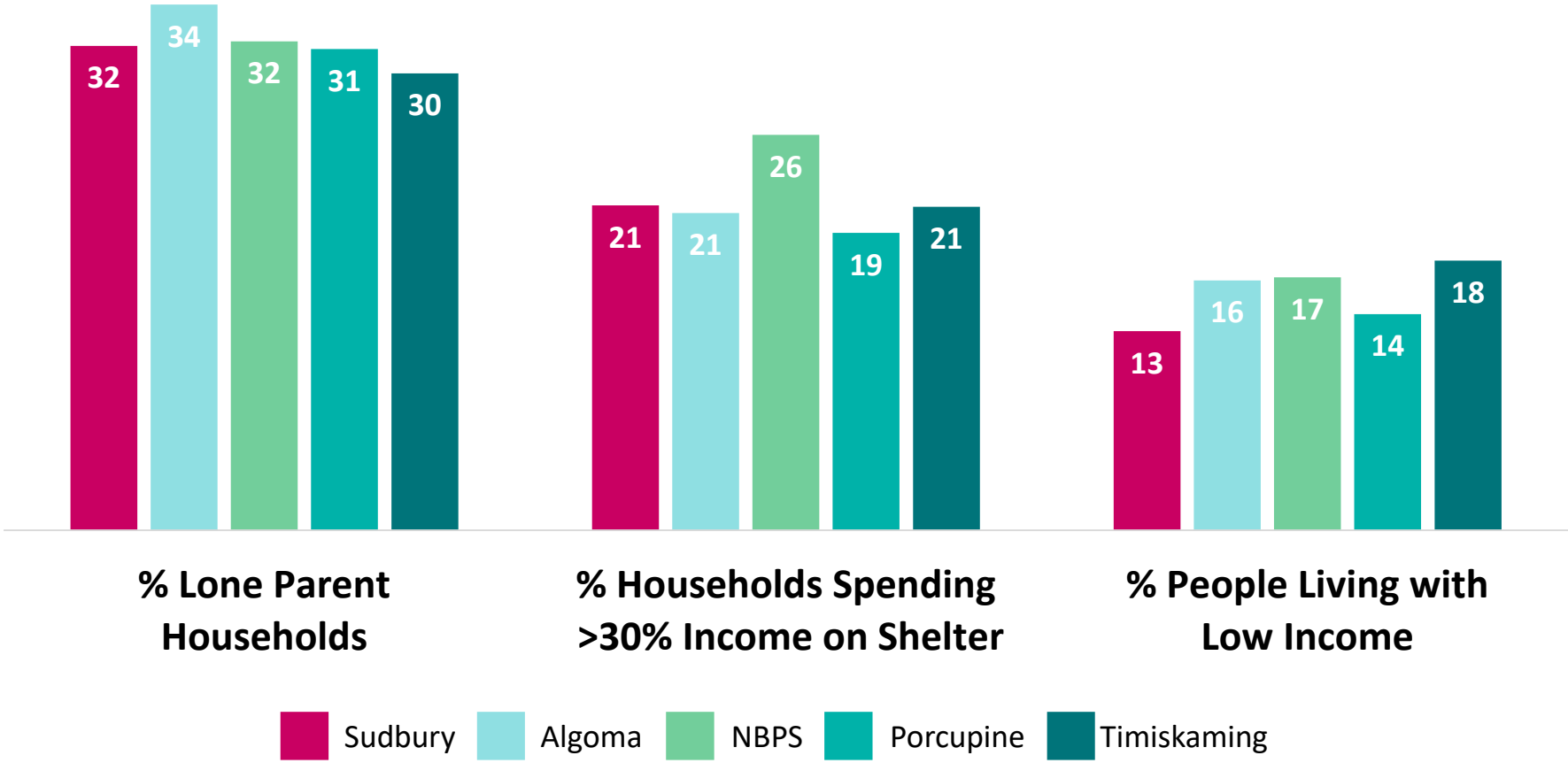
(Percentage (%) of the Population)



Data Source: Census, Statistics Canada, 2016

Socioeconomic Risk Factors

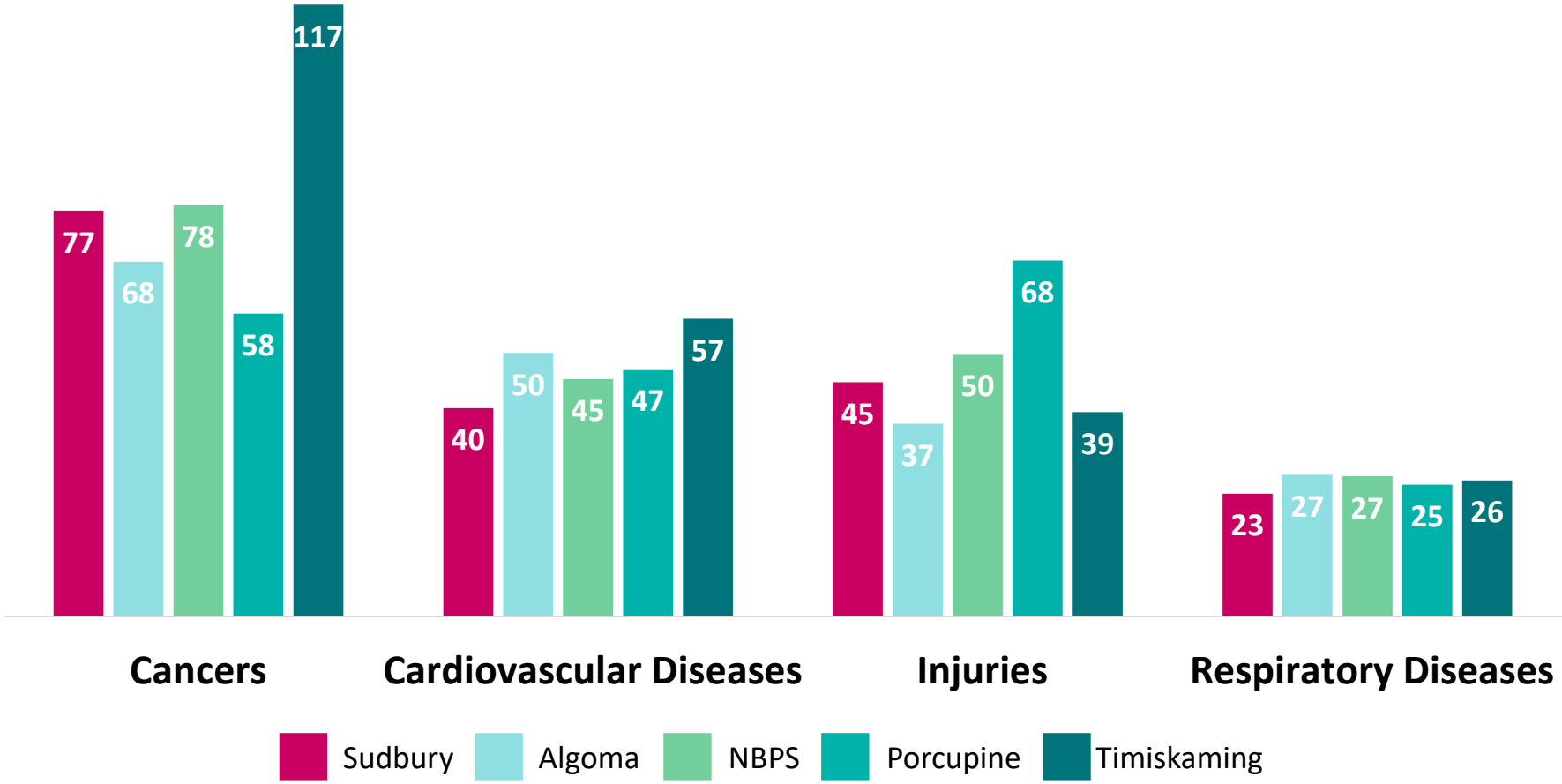
(Percentage (%) of Households / Population)



Data Source: Census, Statistics Canada, 2016

Preventable Mortality, Ages 0-74, by Cause, 2015

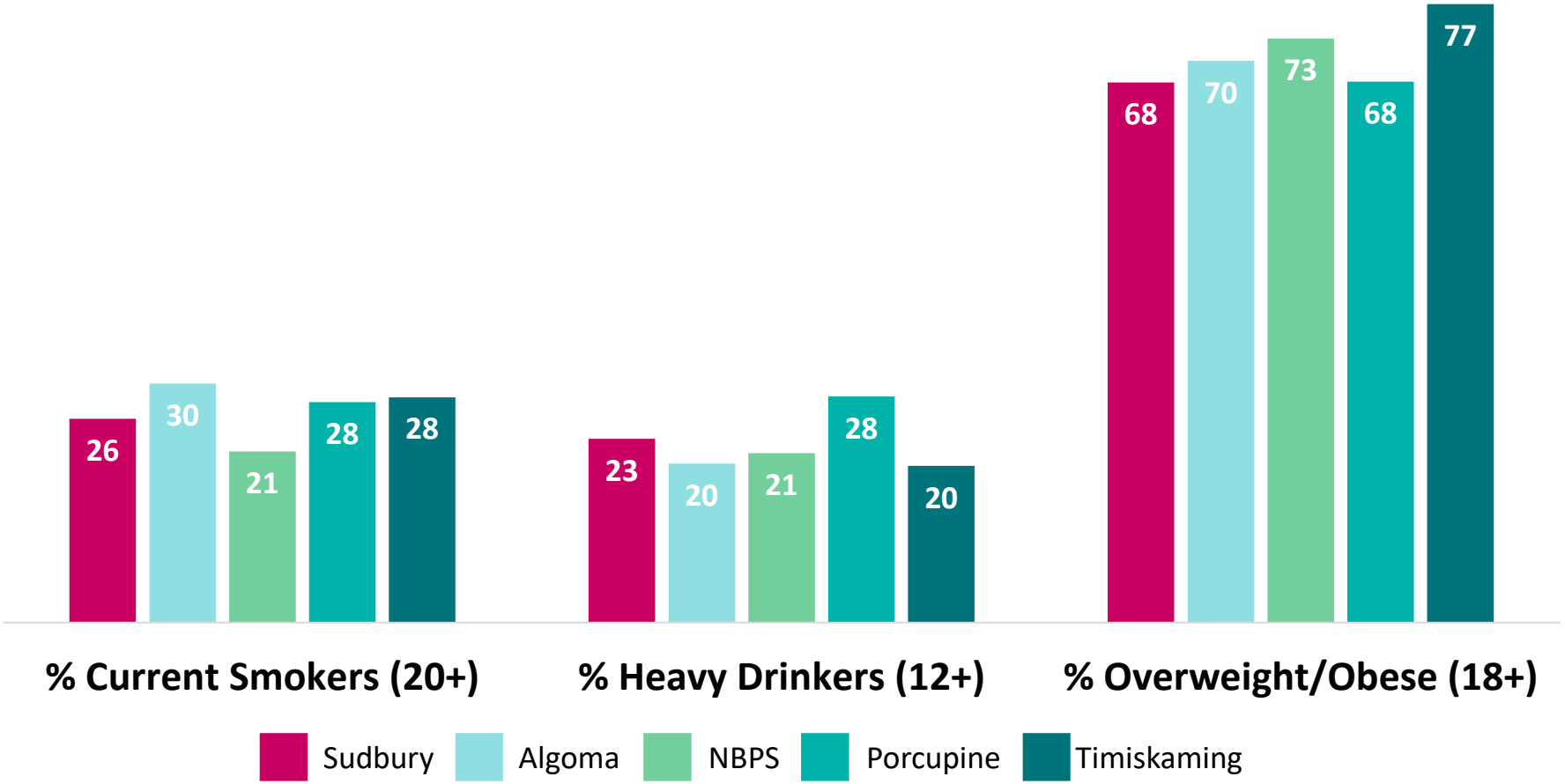
(Rates per 100,000 Population)



Data Source: Vital Statistics, Office of the Registrar General, 2015

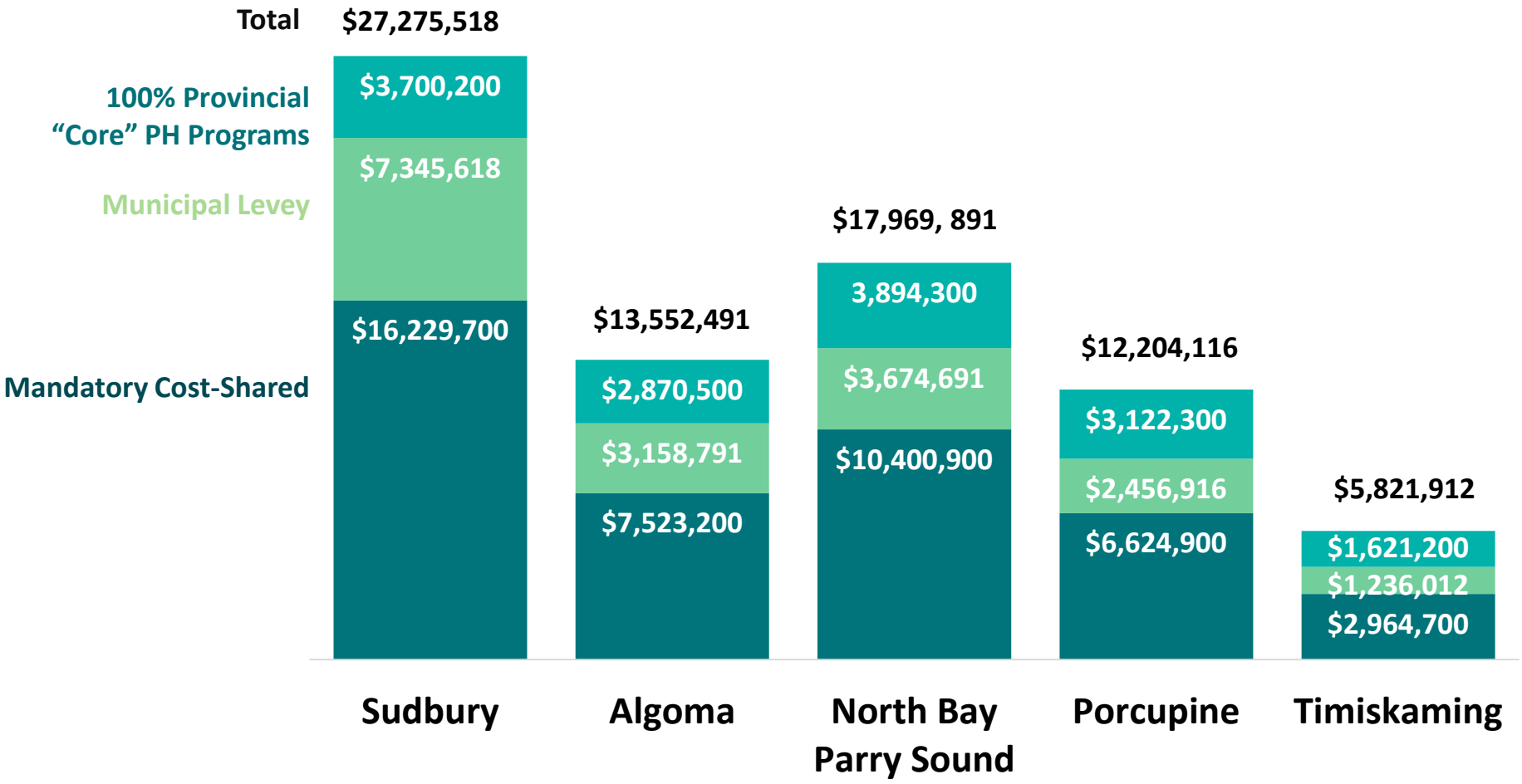
Behavioural Risk Factors, 2015-16

(Percentage (%) of Population)

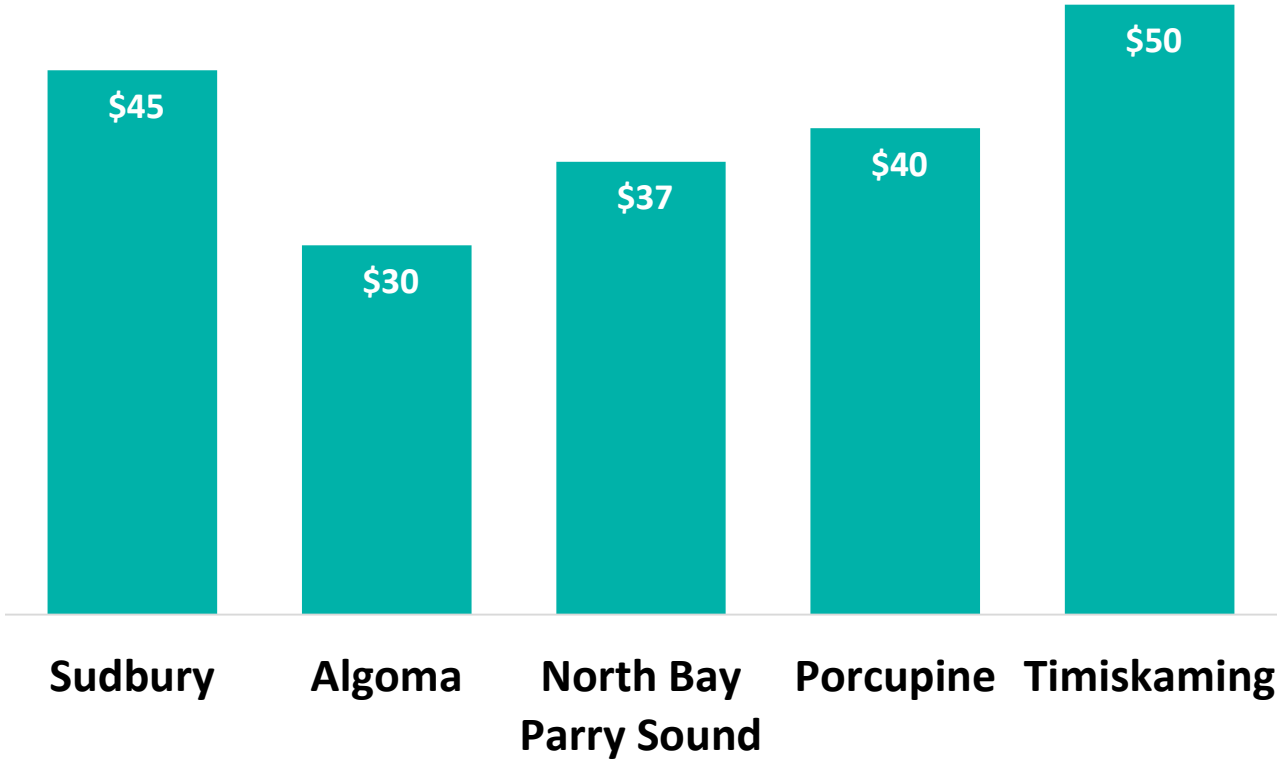


Data Source: Canadian Community Health Survey, Statistics Canada, 2015-16

Health Unit Budget Breakdown ($) – Cost Shared & 100% Funded (MOHLTC)

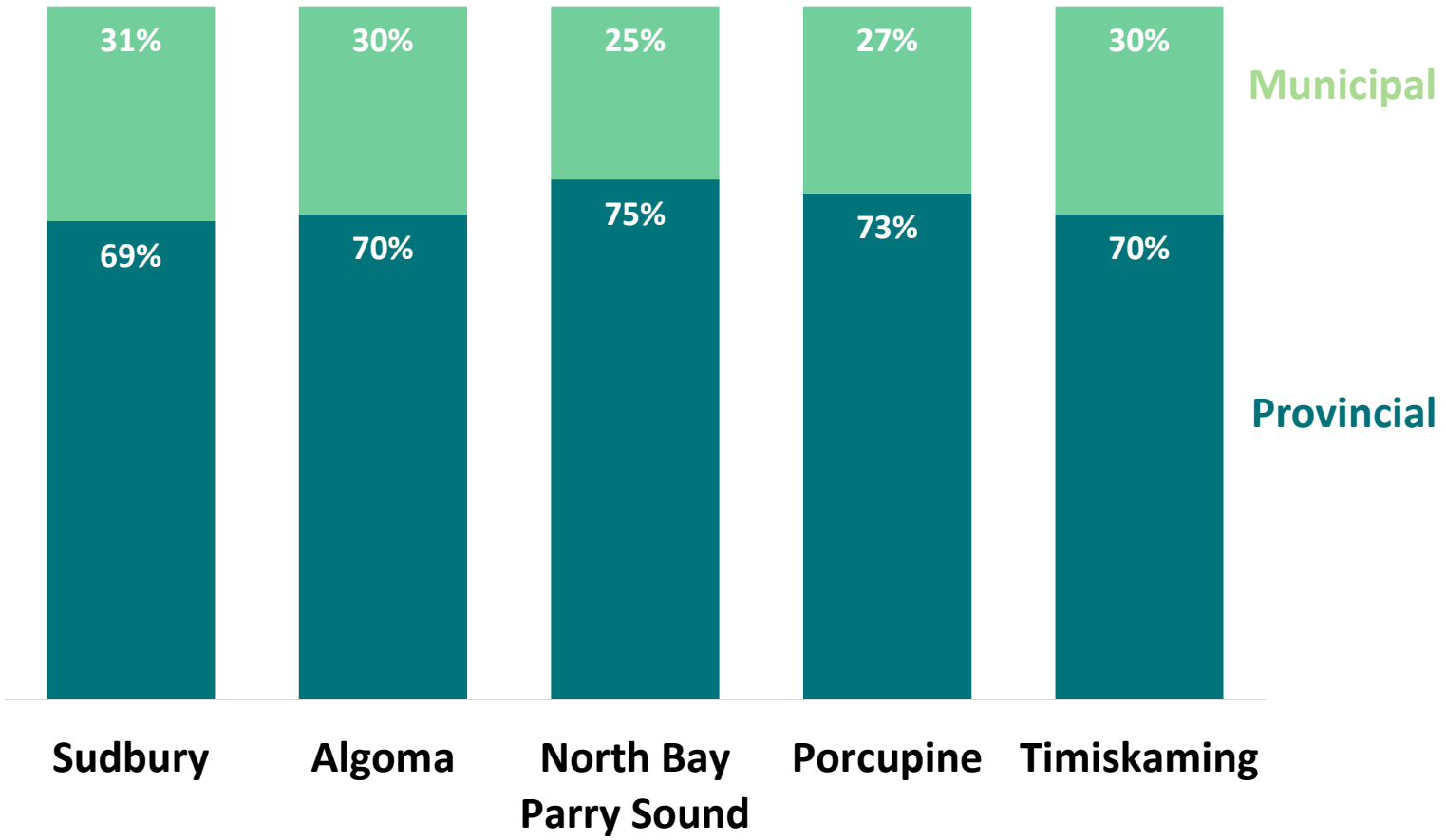


Health Unit Funding Per Capita ($)



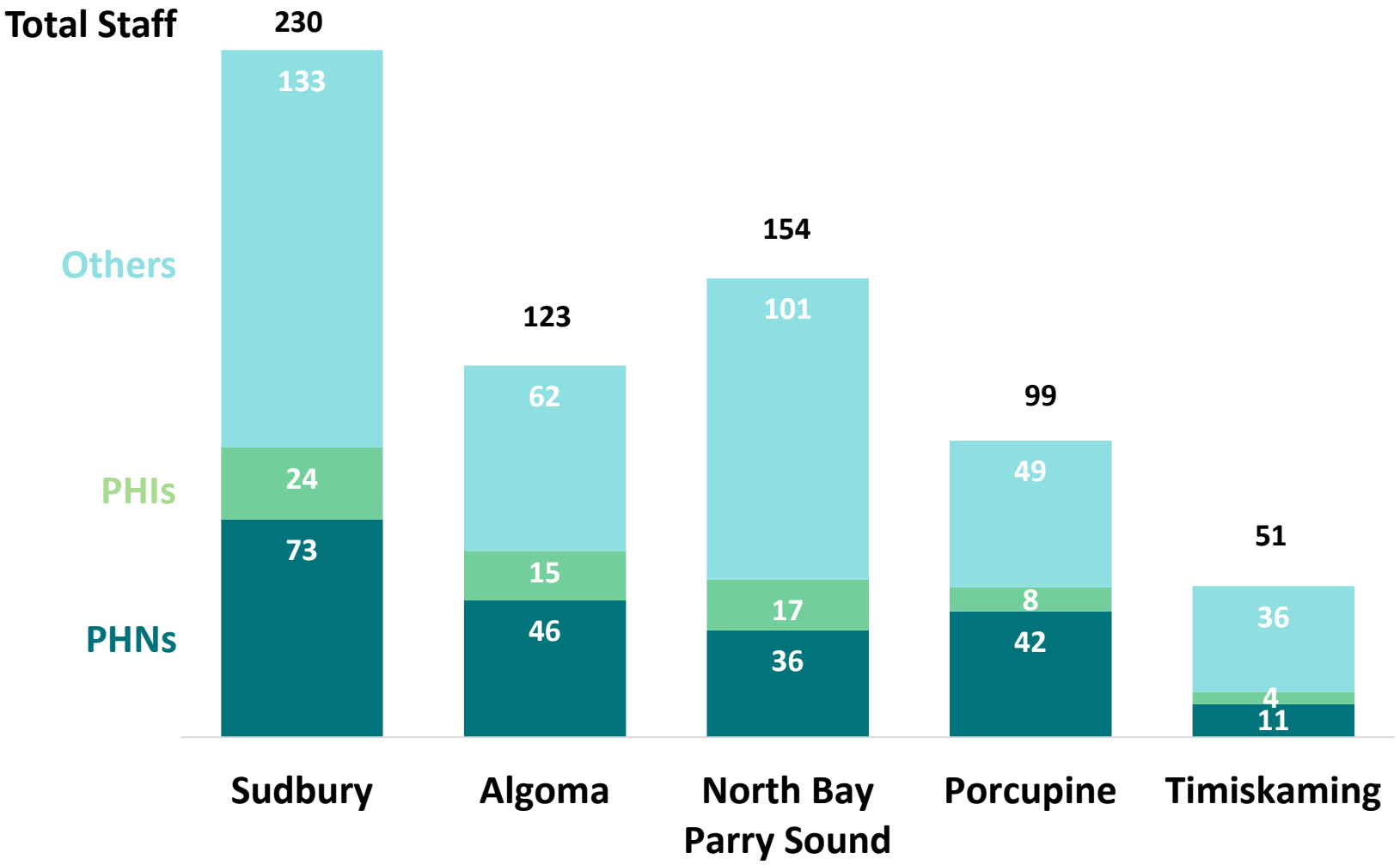
Data Source: Northeast Ontario Public Health Units, 2019

Provincial : Municipal Funding Ratio (%)



Data Source: Northeast Ontario Public Health Units, 2019

Health Unit Staffing, 2019



Data Source: Northeast Ontario Public Health Units, 2019

North East Public Health Transformation Initiative

- North East Collaborative Project
  - Began in November 2017
  - Funded by one-time dollars from the Ministry of Health and Long-Term Care
  - Dedicated project manager as of April 2019 on behalf of all North East (NE) public health units
  - *Accelerated* and *reoriented* to address current context

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North East Public Health Transformation Initiative

- Vision:
  - A healthy northeastern Ontario enabled by a coordinated, efficient, effective, and collaborative public health entity

- Goal:
  - To develop action-oriented recommendations for the implementation in the North East of a modernized public health entity as announced in Ontario's 2019 provincial budget, Protecting What Matters Most

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North East Public Health Transformation Initiative

- Values:
  1. The best interests of the health of the people of NE Ontario guide all decisions
  2. Current NE public health unit staff are valued and respected
  3. We are stronger together than apart and united in our commitment to collaboration

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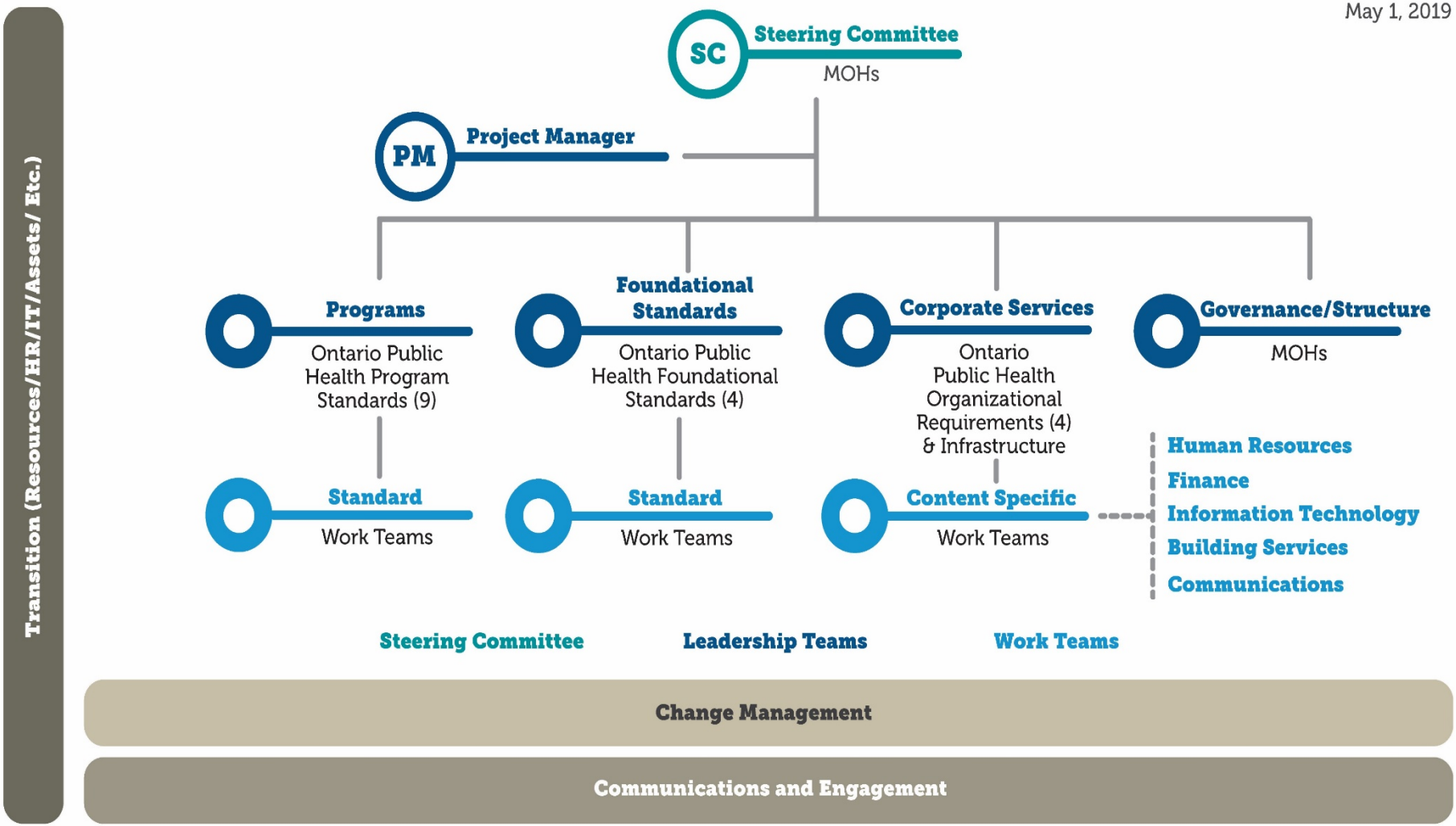
May 1, 2019


Transition (Resources/HR/IT/Assets/ Etc.)
SC
Steering Committee
MOHs
PM
Project Manager
Programs
Ontario Public Health Program Standards (9)
Standard
Work Teams
Foundational Standards
Ontario Public Health Foundational Standards (4)
Standard
Work Teams
Corporate Services
Ontario Public Health Organizational Requirements (4) & Infrastructure
Content Specific
Work Teams
Governance/Structure
MOHs
Human Resources
Finance
Information Technology
Building Services
Communications
Steering Committee
Leadership Teams
Work Teams
Change Management
Communications and Engagement

Anticipated Timelines

- Ministry consultation ASAP
- Draft legislation fall 2019
- Final legislation for 10 new boards of health April 2020

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To Be Confirmed

- Geographic regions
- Financial implications (now and into future)
- Transition timelines and processes
- Municipal funding expectations (ratio and per capita variations)
- Ability to and risk of divesting programs and services
- Intersection with Ontario Health and Ontario Health Teams

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Final Reflections:

Public Health is too important to get it wrong.

- When we get public health wrong, bad things happen.
- This is a critical opportunity to create the future of public health in the NE.
- We are the experts in understanding the implications of northern realities on public health for the NE.
- Investing time and resources **now** means getting it right tomorrow for the people and communities who depend on us.

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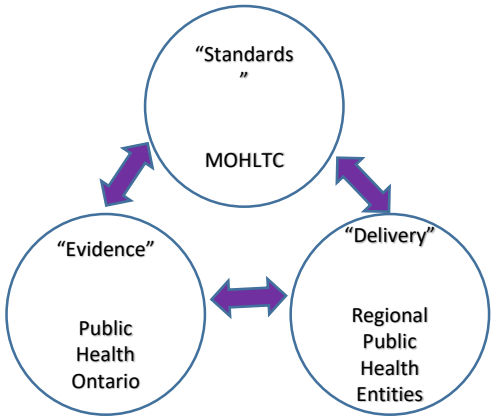
Vision: Modernized Public Health in Ontario

Purpose: The government is committed to building a connected, sustainable health care system, which includes a coordinated public health sector that is nimble, resilient, efficient, and responsive to the province's evolving health.

Increasing the health of the population by preventing communicable and non-communicable diseases and injuries, reducing health disparities, conducting surveillance and monitoring, and performing emergency management.

Principles

- ✓ Meaningful municipal engagement and sharing of perspectives
- ✓ More efficient public health system
- ✓ Stronger public health role contributing to collaboration with the health system
- ✓ Sustained focus on effective public health protection, promotion and prevention



Delivery of Key public Health Programs

- Evidence-based programs and services
- Leveraging digital technology and provincial strategies

Access to Evidence to Inform Program Design and Delivery

- Surveillance, monitoring and evaluating impact of health interventions and managing disease

Strong Public Health Laboratory Networks

- Effective and efficient network of quality diagnostic services, specialized testing

Mobilize public health

Interventions to improve health status

- Bridge between health and non-health systems, targeting vulnerable populations

Skilled and Capable Workforce

- Trained specialized public health workforce supported by communities of practice
- Critical mass required to consistently deliver core functions of public health

Effective Public Health Institutions and Emergency Response

- Clear mandate, roles, and accountabilities with strong governance, leadership and collaboration
- Preparedness and response to health emergencies

Core Elements of a Strong Public Health System

Public Health System Changes Required

It is a time of change and transformation for health in Ontario.

Why are changes required to the Public Health System

The current structure does not facilitate implementation of the core elements of a strong public health system.

Over the last few years, several reports (including from the Ontario Auditor General) have called for structural reform and greater coordination across the public health system.

Having independent entities, all with different governance structures and separate priorities/agendas, provides well-documented challenges for:

- Consistent delivery across the province.
- Recruitment/retention capacity.
- Critical mass and surge capacity.
- Lack of cohesion with the broader system.
- Lack of alignment of evidence products with delivery priorities.
- Duplication of functions.

What are the anticipated Public Health System outcomes?

Modernizing the public health sector (if passed) will result in:

- Enhanced system capacity and consistent service delivery that is responsive at the local level.
- A strengthened role for municipalities while providing an appropriate balance between their political service delivery roles.
- Greater coordination and collaboration.
- Greater oversight of the system by MOHLTC and nimbleness to adjust to identified priorities.
- Improved critical mass, consistency of service, and responsiveness.
- Strong centralized evidence functions to support health system planning.
- Better integration between laboratory surveillance, analytics, and service planning.
- Evidence-based public health intervention; improved ability to prevent infections and communicable diseases.
- Ability to coordinate seamlessly at the provincial level with the new Ontario Health Agency and at regional and local levels with the new Ontario Health Teams

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Accountability Indicators

Overview and review of 2018

Dr. Marlene Spruyt
Medical Officer of Health/CEO

Performance Measurement

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

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Accountability Agreements

- Accountability Agreements between BOH and the MOHLTC were introduced in 2011
- Initially set for a 3 year term from 2011-2013, then renewed for 2014-2016
- Set of indicators are common across all BOH in the province
- Pause in 2018 with introduction of new standards

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2018 Indicator Performance

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Common challenges for meeting targets

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

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1.0 Chronic Disease Prevention & Well-Being

Indicator 1.1

Menu labelling number and percentage of new regulated food service premises inspected in 2018

Jan - Dec 2018

- Number of newly opened/identified regulated food service premises inspected in 2018 — **3**
- Number of new regulated food service premises that have opened/been newly identified in the region during 2018 — **3**
- Percentage of new regulated food service premises inspected in 2018 — **100%**

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Indicator 1.2

Menu labelling: number and percentage of 2017 premises re-inspected in 2018

- Number of re-inspections completed during 2018 of premises that had been inspected in 2017 and had been identified as requiring a re-inspection — **4**
- Total number of regulated food service premises identified in 2017 — **76**
- Percentage of 2017 premises re-inspected in 2018 — **5.3%**

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Indicator 1.3

Menu labelling: number of inspected premises (new and re-inspected) deemed in full compliance, in partial compliance and not in compliance, charges laid

	Jan - Dec 2018
A. Number of regulated food service premises inspected in 2018 that the inspectors in the public health unit deemed in full compliance	6
B. Number of regulated food service premises inspected in 2018 that the inspectors in the public health unit deemed in partial compliance	-
C. Number of regulated food service premises inspected in 2018 that the inspectors in the public health unit deemed not in compliance	1
• Total number of inspected premises (new and re-inspected) deemed in full compliance, in partial compliance and not in compliance, charges laid (A + B + C)	7

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Indicator 1.4

Menu labelling: number and percentage of complaints that resulted in an inspection in 2018

Number of complaints resulting in an inspection received by the public health unit in 2018 for regulated food service premises' noncompliance or partial compliance with the HMCA.	1
Total number of complaints received in 2018	1
Percentage of complaints that resulted in an inspection in 2018	100%

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2.0 Food Safety

	Jan - Dec 2018
2.1 Number of year-round food premises	**608**
2.2 Number of seasonal food premises	**126**
2.3 Number of high risk food premises	**110**
2.4 Number of moderate risk food premises	**263**
2.5 Number of re-inspections for year-round food premises	**49**
2.6 Number of food safety complaints received that triggered an investigation / inspection	**37**

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Indicator 3.1

What actions are taken by the board of health to mitigate heat and cold health impacts?

- APH uses media releases and social media to disseminate health promotion messaging and mitigation strategies during heat events.

- In 2018, 2 heat advisories were issued and 4 winter warnings were issued.

4.0 Immunization

Indicator 4.1

Number of School immunization clinics held by the board of health for the grade 7 school-based program including hepatitis B (HBV), meningococcal and human papillomavirus (HPV) vaccines

90

Indicator 4.3

Number of HBV, meningococcal and HPV vaccine doses administered to students

Number of doses of HBV vaccine administered to students in grades 7 to 8 for the reporting period	1311
Number of doses of meningococcal vaccine administered to students in grades 7 to 12 for the reporting period	864
Number of doses of HPV vaccine administered to eligible female students in grades 7 to 12 for the reporting period	697
Number of doses of HPV vaccine administered to eligible male students in grades 7 to 9 for the reporting period Public Health Unit Comments (as needed)	659

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Indicator 4.4

Number and percentage of premises that store publicly funded vaccine that received their routine annual inspection as per the vaccine storage and handling requirements

Jan - Dec 2018

Number of refrigerators in operation in the public health unit jurisdiction as of Dec 31 with completed routine cold chain inspection Number of refrigerators in operation in the public health unit jurisdiction as of Dec 31

101

Percentage of premises that store publicly funded vaccine that received their routine annual inspection as per the vaccine storage and handling requirements

101

100%

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5.0 Infectious and Communicable Diseases Prevention and Control

Indicator 5.1

Number of education and awareness activities to Health Care Providers (HCPs) and the public for all Infectious Disease program areas

	Infectious & Communicable	STBBI	Vector-borne	Zoonotic	IPAC
HCP	2	1	-	-	6
Veterinarians	-	-	1	-	-
Public	28	10	7	-	2

Indicator 5.4

Percentage of reported confirmed sexually transmitted and blood borne infection (STBBI) cases in priority populations where treatment and follow up conducted according to the Infectious Diseases Protocol, 2018 (or as current), for Hepatitis C, Gonorrhea, and Syphilis

	Number of reported cases in priority populations treated according to ID Protocol	Total number of reported cases in priority populations	Percentage
Hepatitis C	72	98	73.5%
Gonorrhea	19	24	79.2%
Syphilis	8	8	100.0%
Total	99	130	76.2%

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Indicator 5.5

Number of larval mosquito surveillance activities conducted

2

- July 20, 2018: 27 vaults dipped/16 dry vaults, larvae in 1 vault
- August 17, 2018: PUC completed larvicide treatments of all underground transformer vaults
- August 29, 2018: 25 vaults dipped/10 dry, no larvae found
- 2019: request new plan from PUC to eliminate visiting dry vaults, add new vaults to surveillance that typically have water in them and are potential breeding grounds for mosquitos

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Indicator 5.6

Number of ticks for all species submitted and found

83

- Passive surveillance 23 blacklegged ticks
- Active surveillance 0 blacklegged ticks
- 1 Lone star tick, not travel related

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Indicator 5.8

Number of mosquito traps set per week 13

- A total of seventy-five (75) traps were submitted from 16 different sites during the 2018 trapping season.
- On average, 13 traps per week were submitted to Entomogen Inc. for processing.
- Trapping began the week of June 25th (week 26) and ending the week of September 3rd (week 36).
- 1 trap set in each: Wawa, White River, and Hawk Junction the week of July 15th (week 29)
- Sault Ste. Marie: 8 traps set every other week
- Blind River and Elliot Lake: 5 traps set every other week.

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Indicator 5.10

Number of individuals for whom rabies post-exposure prophylaxis (PEP) was recommended

Jan - Dec 2018

Number of cases where rabies PEP was recommended and administered	6
Number of cases where rabies PEP was recommended but not administered	-
Number of individuals for whom PEP was recommended	6

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Indicator 5.11

Number of rabies exposures investigated, broken down by species of animal and type of exposure (e.g. bite, scratch, mucous membrane, occult bat, other)

	Bite exposures	Scratch exposures	Mucous membrane exposures	Occult bat exposures	Other Exposures	Total Number of Investigations
Dog	164	-	-	-	-	164
Cat	14	5	-	-	-	19
Raccoon	-	-	-	-	-	-
Skunk	-	-	-	-	-	-
Fox	1	-	-	-	-	1
Bat	1	-	-	5	-	6
Horse		-	-	-	-	-
Cattle		-	-	-	-	-
Sheep		-	1	-	-	1
Domestic Rat	1	-	-	-	-	1
Chipmunk	1	-	-	-	-	1
Wild Weasel	2	-	-	-	-	2

Indicator 5.12

Rabies vaccination status data for all dogs, cats, ferrets, horses, cattle and sheep investigated following reported human exposures (i.e. up-to-date, overdue, never vaccinated, exempt or unknown)

	Up-to date on vaccinations	Overdue for re-vaccination	Never vaccinated	Exempt from vaccination	Unknown status	Total Number of Investigations
Dog	63	-	24	-	77	164
Cat	3	-	5	-	11	19
Ferret	-	-	-	-	-	-
Horse	-	-	-	-	-	-
Cattle	-	-	-	-	-	-
Sheep	-	-	1	-	-	1

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6.0 Safe Water

Indicator 6.1

Recreational water: number of Class A (Seasonal and year-round) pools

Seasonal	2
Year-Round	6
	8

Indicator 6.2

Recreational water: number of Class B (Seasonal and year-round) pools

Seasonal	5
Year-Round	13
	18

Indicator 6.3

Recreational water: number of Class C facilities

1

Indicator 6.4

Recreational water: number of spas (Seasonal and year-round)

Seasonal	2
Year-Round	15
	17

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Indicator 6.5

Recreational water: number of re-inspections for Class A, B, C and spas

Jan - Dec 2018

Class A	-
Class B	3
Class C	1
Spas	7
Total	11

Indicator 6.6

Recreational water: number of recreational water complaints that triggered an investigation / inspection

28

Indicator 6.9

Drinking water: percentage of adverse water quality incidents (AWQIs) that had an initial response by the public health unit within 24 hours

Number of AWQIs followed up within 24 hours	39
Total number of AWQIs	39
Percentage of AWQIs that had an initial response by the public health unit within 24 hours	100%

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Indicator 6.10

Drinking water: number of written section 13 orders under the Health Protection and Promotion Act

Jan - Dec 2018

Loss of pressure	4
Total Coliform	8
Elevated Turbidity	1
Treatment System Failure	1
E. Coli	1
Overgrown	1

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7.0 Oral Health

Indicator 7.1

Oral Health

List all clinics that were used in the reporting period for the provision of clinical service delivery to HSO clients as per the HSO Schedule of Services and Fees (i.e. service schedule)

Clinic Name	Clinic Location	Clinic Type	Types of activities/treatment provided	Clinic hours of operation
Fixed Preventive Clinic in Sault Ste. Marie Ontario and surrounding area	Sault Ste. Marie	PHU	screening, preventive and case management	2 days per week from 8:30 AM to 4:30 PM
Preventive Clinics in Blind River, Ontario and surrounding area	Blind River	Portable	screening, preventive and case management	6- 7 times per year from 8:30 AM to 4:30 PM
Preventive Clinic in Elliot Lake, Ontario and surrounding area	Elliot Lake	Portable	screening, preventive and case management	2 times per year from 8:30 AM to 4:30 PM
Preventive Clinic in Wawa, Ontario and surrounding area	Wawa	Portable	screening, preventive and case management	Once per year from 8:30 AM to 4:30 PM
School Screening in Sault Ste. Marie and Algoma District	56 schools	Portable	screening, case management, health promotion and education	All elementary and intermediate school are screened yearly
Child Care Screening and How am I Growing Clinic	38 child care centres	Portable	screening, case management, health promotion and education	All childcare centers in Sault Ste. Marie and the District of Algoma are Screening yearly

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Jun 2019

Medical Officer of Health / CEO

Team APH Runs the Great Lakes
– running for a great cause
Alicia Bouchard, Hilary Cutler, Lisa & Avery O'Brien, Lea Flynn

Home is Where the Heart is
June 18th is Infant & Child Development Day to recognize the contributions these programs make in Algoma and across the province
Brenda Laframboise, Lisa Millroy, Lori Lambert, Kelsey Dugas and Shannon Moan are APH Parent Child Advisors

Prepared by:
Dr. Marlene Spruyt and the Leadership Team

Presented to:
Algoma Public Health Board of Health
06/26/2019

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APH AT-A-GLANCE

It has been another busy month here in Algoma and across the province. It took a full 6 weeks before we fully returned to business as usual after our cyber-attack. The Recovery phase continues with our internal debriefing and evaluation as well as reporting to various other agencies and insurance discussions. We await the assessment of the external Cyber Audit to confirm that there was no intrusion into our servers. Because of the large variety of activities we engage in and the numerous databases that support our operations, this recovery operation took longer than one would expect. However, our IT team also used the opportunity to clean up servers, create a new, faster back up system, and enhance our security which included further staff education.

Jennifer and I as well as Board members Adrienne and Brent were able to travel to Kingston for the annual meeting of the Association of Local Public health Agencies (alPHa) on June 10-11. We had hoped that we might receive further information on the Ontario governments' plans for the Modernization of Public Health but details were lacking.

Shortly after our last BOH meeting the government announced that it would be placing a 'pause" on the in-year cuts to public health (and other related cuts/downloads to municipalities). We are therefore continuing to operate in a business as usual mode within our current budget.

Seniors Low Income Dental:

We received written notice June 7 that the Ministry will provide APH with $697,900 in base funding for the 2019-20 funding year to implement a new dental program for low income seniors. We were also informed that "terms and conditions governing the funding will be communicated to you when the 2019-20 funding allocations for the provision of the Ontario Public Health Standards are confirmed/approved".

North East Public Health Collaborative:

This work continues and more information will be provided in the presentation. The focus of this work is to provide the 5 MOHs of the NE a well-informed overview of the current and potential future state of NE public health to utilize when they go forward to have further consultations with the province.

Other Activities:

I was invited to speak at the Northern Ontario Service Delivers' Association (NOSDA) during their annual meeting in SSM in early June. I was part of a mental health and addictions panel discussion along with Dr Kwame McKenzie of the Wellesley Institute and Ali Juma from Algoma Family Services. We were able to share Mental Health and Addictions data from our Community Health Profile and identify the public health role in the Prevention and Harm Reduction components of the 4 pillars approach to the current opioid problem. (Other 2 pillars are Treatment and Enforcement)

We continue our cycle of presentations to our municipal councils and Justin and I travelled to St Joseph's Twp. on June 5 and Jennifer and Justin went to Thessalon on June 17 and then to Plummer Twp. on June 19. Blind River is scheduled for July 8.

PARTNERSHIPS

Ontario Health Teams:

The SSM and area health care providers group that submitted and an Expression of Interest have received notification that their application is being reviewed. We are also aware that the Ministry has also modified is timelines for the application process as it reviews the almost 180 applications it received. There were also other submissions across the district of Algoma.

PROGRAM HIGHLIGHTS

Topic: Corporate Services – Profile & Cisco
From: Christina Luukkonen – Corporate Services Supervisor
Antoniette Tomie – Human Resources Director

Key messages:

- Corporate Services provide a variety of supports to all programs at APH and contribute to efficient and effective program delivery.

- Profile is an electronic health record system that tracks appointments, documents records, and generates reports.

- Cisco is a centralized appointment booking centre and switchboard phone system that is used by all clerical at APH.

Most previous reports have focused on specific program topic areas. Foundational to all our programs and services is an effective corporate services team. Although program areas have some clerical FTE assigned to them we also have a number of employees that support multiple programs in our agency. These include our front desk reception in all offices, purchasing and stores department and our centralized appointment centre.

Electronic Health Record System - Profile

Algoma Public Health uses an electronic health record (EHR) system called Profile which was implemented in 2012, replacing our previous EHR system and giving us a more robust system that would allow us to track appointments, document client encounters and run reports and statistics. Over the last 7 years we have improved efficiencies and enhanced reporting. The majority of our programs are using Profile as our main client record including:

- Immunization
  - Immunization and Flu Clinics
  - TB Testing
  - Travel Consults

- Healthy Sexuality
  - Nurse Practitioner clinic
  - Birth Control Purchase clinic
  - Infection Control Case Management

- Mental Health & Addiction
  - Methadone Clinics, Community Alcohol Drug Assessment Program counseling sessions
  - Community Mental Health program intake

- Healthy Growth & Development
  - Healthy Babies Healthy Children

- Child & Family Services
  - Infant Child Development Program
  - Infant Hearing
  - Preschool Speech and Language

- Oral Health Clinic

- Tobacco Cessation Clinic

Benefits of Profile

Profile allows the agency to develop standardized documentation practices and share relevant client information such as client demographics and history.

In addition to being an electronic health record, other benefits of using Profile are built in functionality for:

- Integrated client appointments
- Reporting
- Record Audit

Integrated Client Appointments

Profile's appointment schedules are directly connected to the client's record; making a history of client appointments and future appointments easily accessible.

Appointment rules are created to build schedules that align with the programs' various needs, as well as provide guidelines for booking these appointments. The schedules are then used to flag clients who have arrived for their appointment and to alert staff that a client is waiting. We can monitor wait times to improve client success.

Reporting

Profile has reporting functionality built into the system, but it also allows us to extract data to create more in-depth reports. We have real-time access to program statistics that can be used for program planning and ministry reports.

With the combined functionality of tracking appointments and reporting in Profile we are able to easily provide programs with appointment statistics. This allows the program to look at trends related to "No Show" rates and or "Clients Seen" which in turn supports program planning. Figure 1 shows the total number of client in-person visits to APH's offices, for the years of 2017 and 2018. This is an example of what Profile can produce; helping staff and managers make decisions about their programs and services.

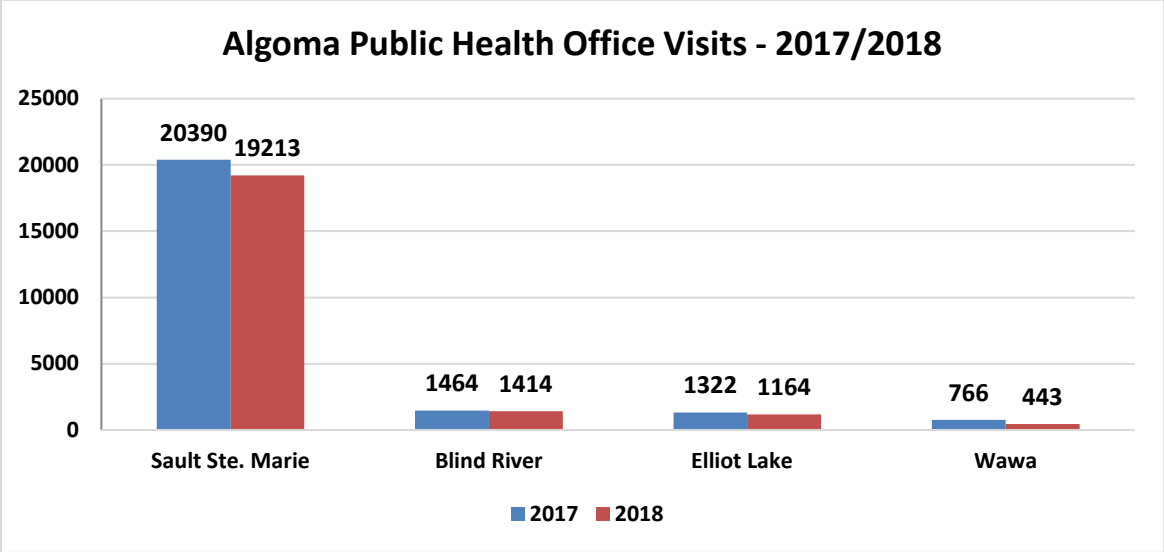

Figure 1. Total number of client in-person visits to APH offices, 2017/2018
*Wawa difference is due to staff complement

Record Audit Functionality

The record audit functionality in Profile shows employee access to each client chart. This functionality assists in meeting privacy legislation compliance. Record audits are also used to make sure Agency documentation standards and practices are followed and can identify process improvements.

Cisco Unified Communication

APH has a fully integrated phone system that allows us to have a centralized appointment centre and switchboard. Any clerical can sign into the phone system from any phone, in any office on our network. Over the last year, we have been training all clerical staff to support our centralized appointment centre. All clerical staff are scheduled to cover the line on a rotational basis. During flu season, we usually have between 4-6 clerical online answering calls Monday-Friday throughout the day. Our phone system allows for an unlimited number of users, so more support can be added as needed.

In summary

Both Profile and Cisco allow for efficient, centralized clerical work across APH offices and programs. Through Profile's report generating feature, APH can interpret factors, such as number of visits to each office annually, to help inform programmatic decisions. The Cisco phone system allows for all appointments to be centralized, minimizing challenges for clerical staff and maximizing efficiencies in the system. Both platforms contribute to an efficient, knowledge-informed corporate system at APH.

PROGRAM ACTIVITY INDICATORS

		2019 Q1 JAN - MAR	2019 YEAR END					2018 YEAR END
HBHC POSTPARTUM		**Q1**	**WW**	**SSM**	**BR**	**EL**	**2019 YE**	**2018 YE**
	Phone Calls	139	10	113	8	8	139	475
	Home Visits	47	1	41	3	2	47	173

COMMUNITY MENTAL HEALTH	**Q1**	**2019 YE**	**2018 YE**
CMH New Clients: Individuals receiving 1st service	60	60	203
CMH non registered: Client Interactions	407	407	1,325

CADAP LHIN FUNDED PROGRAMS	**Q1**	**2019 YE**	**2018 YE**
New Client admissions Clinics / programs	182	182	458
Direct Client interactions / group or individual including anonymous clients AS / SRP groups included	363	363	1,369
Back on Track Group 1 and 2 day course participants / Group Participants - every 90 days	36	36	75

SUBSTANCE MISUSE		**Q1**	**WW**	**SSM**	**BR**	**EL**	**2019 YE**	**2018 YE**
Needle Exchange	Needles distributed	35,811	35	31,155	20	4,601	35,811	312,147
	Needles returned - NEP (estimates)	9,185	0	8,400	0	785	9,185	68,021
	Needles returned - Drop Bins SSM (estimates)	82,688	0	82,688	0	0	82,688	250,457
Addictions - Overdose Prevention	Naloxone trainings completed - with at risk individuals	187	0	187	0	0	187	590

HEALTH PROTECTION		**Q1**	**WW**	**SSM**	**BR**	**EL**	**2019 YE**	**2018 YE**
Safe Water	Private Wells - Adverse Reports	8	0	8	0	0	8	282
	Regulated Premise - ADW (O.reg.319)	1	0	0	1	0	1	13
	Boil Water Advisory	3	0	3	0	0	3	21
	Drinking Water Advisory	0	0	0	0	0	0	3
	Beach Closures	0	0	0	0	0	0	6
Rabies	Risk investigations initiated	31	2	24	2	3	31	193

HEALTH PROTECTION (CONT'D)		Q1	WW	SSM	BR	EL	2019 YE	2018 YE
Food Safety	Special Event Permits issued	32	2	24	5	1	32	298
	Food Handler Training (# persons)	475	0	382	70	23	475	608
	Farmers Market Approvals	36	0	22	14	0	36	89
Health Hazard	Complaint / Investigations all types	27	0	25	1	1	27	148
Land Control - OBC	Applications / Permits - Class IV	0	0	0	0	0	0	148
Communicable Disease Control	Institutional outbreaks	12	0	9	3	0	12	26
	Outbreak days in quarter	162	0	97	65	0	162	299
	Gonorrhea	5	0	5	0	0	5	17
	Chlamydia	48	1	40	4	3	48	243
	BBI (Hep B, C, HIV)	0	0	0	0	0	0	79
	Confirmed influenza cases	72	0	68	2	2	72	154
	Other reportable diseases	4	0	4	0	0	4	62

*the SSM column is the cumulative district data

CONTRACEPTIVE PURCHASES	Q1	WW	SSM	BR	EL	2019 YE	2018 YE
14-19 years	16		16			16	155
20-24 years	52		52			52	267
25-29 years	107		107			107	606
30 + years	170		170			170	709
Total	345		345			345	1,737

CALLS TO THE SEXUAL HEALTH LINE	159	159	4,000

TOBACCO CESSATION	Q1	SSM	DISTR.	2019 YE	2018 YE
Number of APH clients assessed or reassessed for tobacco use using Brief Contact Interventions (BCI)	624	532	92	624	2,349
Number of clients referred by staff to further intensive smoking cessation supports at APH during BCI (includes district)	136	0	0	136	364
Number of clients receiving clinic or in-home intensive tobacco cessation services from APH staff	87	58	29	87	290

Shaded - Indicates data not available

ANNUAL COMPLIANCE REPORTING

	ORGANIZATIONAL REQUIREMENTS	COMPLIANCE ACTION / DOCUMENTATION	ADDITIONAL ACTION / DOCUMENTATION PLANNED OR IN PROGRESS
A	**Delivery of Programs and Services Domain**		
1	The board of health shall deliver programs and services in compliance with the Foundational and Program Standards	• Organizational Chart • Demonstrated through use of ASP and Standards Implementation Plan	
2	The board of health shall comply with programs provided for in the *Health Protection and Promotion Act*	• Prevention, protection and promotion activities of HPPA are embedded into new OPHS and into ASP and SIPs	
3	The board of health shall undertake population health assessments including identification of priority populations, social determinants of health and health inequities, and measure and report on them.	• Community Health Profile completed in September 2018	• Further reports planned • Some work done within program • Support through FASST
4	The board of health shall describe the program of public health interventions and the information used to inform them including how health inequities will be addressed.	• Standards Implementation Planning process now used by all PH programs to illustrate how each Standard is implemented	• HE integrated into annual program planning process and Annual Service Plan submitted to Ministry
5	The board of health shall publicly disclose results of all inspections or other required information in accordance with the Foundational and Program Standards.	• Results are posted on APH website as of late 2018	
6	The board of health shall prepare for emergencies to ensure 24/7 timely, integrated, safe, and effective response to, and recovery from emergencies with public health impacts, in accordance with ministry policy and guidelines.	• COOP recently updated • Emergency Response Plan updated in 2018	• Further training occurring in 2019 • IMS 100 and 200 online for all Leadership and designated front line staff. • Full day interactive EP training in May 2019
7	The board of health shall collect and analyze relevant data to monitor trends over time, emerging trends, priorities, and health inequities, and report and disseminate the data and information in accordance with the Foundational and Program Standards.	• Foundational and Strategic Support (FASS) Team established in 2017/18 • Community Health Profile completed in September 2018 • Reporting data on selected process indicators included in the BOH report quarterly • Annual Report to the Community	
8	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.	• Strategic plan (2015-2020) in place • Embedded in Board Reports	• 2020-2025 Strategic Planning process currently underway

	ORGANIZATIONAL REQUIREMENTS	COMPLIANCE ACTION / DOCUMENTATION	ADDITIONAL ACTION / DOCUMENTATION PLANNED OR IN PROGRESS
B	**Fiduciary Requirements Domain**		
1	The board of health shall comply with the terms and conditions of the Ministry-Board of Health Accountability Agreement.	• Accountability Agreement is signed by Board of Health Chair and MOH/CEO • Annual Reports • Activity reports completed when requested	
2	The board of health are required to provide costing information by program.	• Monthly Financial Statements reviewed by the Board of Health • Quarterly reports submitted to Ministry • Annual Financial Statement Audit • Annual Settlement submitted to Ministry • ASP submitted with Annual budget to identify costing by program	• ASP requires more detail into costing by program • Further work occurring here
3	The board of health shall submit budget submissions, quarterly financial reports, annual settlement reports, and other financial reports as requested.	• Submissions are signed by the MOH and either the Board Chair or CFO depending on the report • All reports submitted by deadlines and submissions are signed by the MOH and either the Board Chair or CFO depending on the report	
4	The board of health shall place the grant provided by the ministry in an interest bearing account at a Canadian financial institution and report interest earned to the ministry if the ministry provides the grant to boards of health prior to their immediate need for the grant.	• Board of Health operating account is held at a Canadian financial institution • Interest earned accounted for during Annual Audit and Settlement	
5	The board of health shall report all revenues collected by boards of health for programs or services in accordance with the direction provided in writing by the ministry.	• Quarterly reports submitted to Ministry • Annual Financial Statement Audit • Annual Settlement submitted to Ministry	
6	The board of health shall report any part of the grant that has not been used or accounted for in a manner requested by the ministry.	• Quarterly reports submitted to Ministry • Annual Financial Statement Audit • Annual Settlement submitted to Ministry	
7	The board of health shall repay amounts as requested by the ministry.	• Board of Health would repay amounts or Ministry would withhold funding	
8	The board of health shall ensure that expenditure forecasts are as accurate as possible.	• Annual Operating Budget approved by Board of Health • Quarterly reports submitted to Ministry are reviewed by Manager of Accounting and Approved by CFO and MOH/CEO • Previous Year Actual Amounts are reflected in Monthly Financial Statements and used as comparator during analysis	• We use previous years expenditures and yearly program planning information to predict budget

	ORGANIZATIONAL REQUIREMENTS	COMPLIANCE ACTION / DOCUMENTATION	ADDITIONAL ACTION / DOCUMENTATION PLANNED OR IN PROGRESS
9	The board of health shall keep a record of its financial affairs, invoices, receipts and other documents, and shall prepare annual statements of its financial affairs.	• Annual Audited Financial Statements completed which require invoices, receipts and other documents	
10	The board of health shall comply with the financial requirements of the HPPA (e.g. remuneration, informing municipalities of financial obligations, passing by-laws, etc.), and all other applicable legislation and regulations.	• Board Policy 02-05-025: Board Member Remuneration • Municipal Levy Letter Notice provided to all Municipalities once Board approves Annual Operating Budget • By-law 95-1: To Regulate the Proceedings of the Board of Health	
11	The board of health shall use the grant only for the purposes of the HPPA and to provide or ensure the provision of programs and services in accordance with the HPPA, OSPHPS, and Ministry-Board of Health Accountability Agreement.	• Program planning • Annual Service Plan (interventions tied to budget)	• Considerable attention in past 2 years to clearly separate funding streams where PH programs intersect with LHIN funded programs
12	The board of health shall spend the grant only on admissible expenditures.	• Accountability Agreements and Amending Agreements define Related Program Policies and Guidelines every year	
13	The board of health shall comply with the Municipal Act, 2001 which requires that boards of health ensure that the administration adopts policies with respect to its procurement of goods and services. All procurement of goods and services should normally be through an open and competitive process.	• BOH Procurement Policy 02-04-030	
14	The board of health shall ensure that the administration implements appropriate financial management and oversight which ensures the following are in place: a) a plan for the management of physical and financial resources; b) a process for internal financial controls which is based on generally accepted accounting principles; c) a process to ensure that areas of variance are addressed and corrected; d) a procedure to ensure the procurement policy to followed across all programs/services areas; e) a process to ensure the regular evaluation of the quality of services provided by contracted services in accordance with contract standards; a process to inform the board of health regarding resource allocation plans and decisions, both financial and workforce related, that are required to address shifts in need and capacity.	• By-law 15-1: To Provide for the Management of Property • By-law 95-2: To Provide for Banking and Finance • Board of Health approved budget • Monthly Financial reports provided to the Board of Health via the Finance & Audit Committee • Procurement Policy • Annual Board of Health approved Budget • Contractor Scorecard developed	• Annual report provided to the Finance & Audit Committee on internal review of compliance with Procurement Policy
15	The board of health shall negotiate a service level agreement for corporately provided services.	• Not applicable to APH as it is an autonomous Board of Health separate from any municipality	
16	The board of health are required to have and maintain insurance.	• Insurance reviewed annually by Finance & Audit Committee and Board of Health	

	ORGANIZATIONAL REQUIREMENTS	COMPLIANCE ACTION / DOCUMENTATION	ADDITIONAL ACTION / DOCUMENTATION PLANNED OR IN PROGRESS
17	The board of health shall maintain an inventory of all tangible capital assets developed or acquired with a value exceeding $5,000 or a value determined locally that is appropriate under the circumstances.	• IT assets are tagged and inventoried • Vaccine Fridges are tagged and inventoried	
18	The board of health shall not dispose of an asset which exceeds $100,000 without the ministry's prior written confirmation.	• Procurement policy (02-04-30) addresses disposal of assets	
19	The board of health are not permitted to carry over the grant from one year to the next, unless pre-authorized in writing by the ministry.	• Quarterly reports submitted to Ministry • Annual Financial Statement Audit • Annual Settlement submitted to Ministry	
20	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.	• By-law 15-1: To Provide for the Management of Property • Board Policy 02-05-060: Algoma Board of Health Reserve Fund • Capital Asset Plan established in 2018 and approved by Board of Health	
21	The board of health shall comply with the Community Health Capital Programs policy.	• Management has the Community Health Capital Policy and would work with the Ministry	
C	**Good Governance and Management Practices Domain**		
1	The board of health shall submit a list of board members.	• Listed on the website • Submitted with Annual Service Plan	
2	The board of health shall operate in a transparent and accountable manner, and provide accurate and complete information to the ministry.	• Board Package posted online • Inspection Results posted online • Management contact information posted online • Financial information posted online • Quarterly reporting to the ministry	• Moving to a system where all BOH and employee policies posted on line
3	The board of health shall ensure that members are aware of their roles and responsibilities and emerging issues and trends by ensuring the development and implementation of a comprehensive orientation plan for new board members and a continuing education program for board members.	• Annual Orientation and /or board training occurs • Professional Development opportunities are communicated to Board members • Code of Conduct signed • Board Policy 02-05-085 - Orientation Board Members and monthly reports to BOH on program activities	• Board members requested to identify areas where they would like further education / information in the monthly Board meeting evaluation.
4	The board of health shall carry out its obligations without a conflict of interest and shall disclose to the ministry an actual, potential, or perceived conflict of interest.	• Board Policy 02-05-015 - Conflict of Interest	

	ORGANIZATIONAL REQUIREMENTS	COMPLIANCE ACTION / DOCUMENTATION	ADDITIONAL ACTION / DOCUMENTATION PLANNED OR IN PROGRESS
5	The board of health shall comply with the governance requirements of the Health Protection and Promotion Act (e.g., number of members, election of chair, remuneration, quorum, passing by-laws, etc.) and all other applicable legislation and regulations.	• By-Law 95-1 - To Regulate Proceedings of the Board of Health • Board Policy 02-05-025 - Board Member Remuneration • Governance Committee reviews policies bi-annually	
6	The board of health shall comply with the medical officer of health appointments requirements of the Health Protection and Promotion Act, and the ministry's policy framework on medical officer of health appointments, reporting, and compensation.	• MOH and AMOH are appointed in accordance with requirements. • Board Policy 02-05-080 - Performance Evaluation for MOH CEO	
7	The board of health shall ensure that the administration establishes a human resources strategy, which considers the competencies, composition and size of the workforce, as well as community composition, and includes initiatives for the recruitment, retention, professional development, and leadership development of the public health unit workforce.	• Human Resources Operation Plan	• Time frames in plan will be reviewed and updated where necessary
8	The board of health shall ensure that the administration establishes and implements written human resource policies and procedures which are made available to staff, students, and volunteers. All policies and procedures shall be regularly reviewed and revised, and include the date of the last review/revision.	• Human Resources Employee policies in place, regularly reviewed and revised, including legislative changes	• Entire Policy Framework to be reviewed and revised in 2019 • Moving to a system of online policies to increase access and transparency
9	The board of health shall engage in community and multi-sectoral collaboration with LHIN's and other relevant stakeholders in decreasing health inequities.	• MOH is part of the Algoma Leadership Table. • NMOH group plans meeting with LHIN CEO twice annually • Partnership with the Social Services Administration boards to lead and deliver Bridges Out of Poverty awareness sessions.	
10	The board of health shall engage in relationships with Indigenous communities in a way that is meaningful for them.	• Land Acknowledgement developed for agency use • First Nations Relationship Building LDCP in partnership with NE • Explored and piloted online cultural education • Service Agreement with Garden River First Nation	• Establish an Internal Indigenous engagement work group • Enhance organizational capacity building re: cultural safety, explore current indigenous engagement activities across the agency
11	The board of health shall provide population health information, including social determinants of health and health inequities, to the public, community partners, LHINs, and health care providers in accordance with the Foundational and Program Standards.	• 2018 Community Health Profile	• Further focused reports to follow

	ORGANIZATIONAL REQUIREMENTS	COMPLIANCE ACTION / DOCUMENTATION	ADDITIONAL ACTION / DOCUMENTATION PLANNED OR IN PROGRESS
12	The board of health shall develop and implement policies or by-laws regarding the functioning of the governing body, including: a) Use and establishments of sub-committees; b) Rules of order and frequency of meetings; c) Preparation of meeting agenda, materials, minutes, and other record keeping; d) Selection of officers; e) Selection of board of health members based on skills, knowledge, competencies and representatives of the community, where boards of health are able to recommend the recruitment of members to the appointing body; f) Remuneration and allowable expenses for board members; g) Procurement of external advisors to the board such as lawyers and auditors (if applicable); h) Conflict of interest; I) Confidentiality; j) Medical officer of health and executive officers (where applicable) selection process, remuneration, and performance review; and k) Delegation of the medical officer of health duties during short absences such as during a vacation/coverage plan.	• By-law 95-1 - To Regulate the Proceedings of the Board • Board Policy 02-05-000 Composition and Accountability of the Board of Directors • Board Policy 02-05-075 - Election of Chair, Vice Chair or Committee members • Board Policy 02-05-025 - Board Member Remuneration • Board Policy 02-04-030 - Procurement Policy • Board Policy 02-05-015 - Conflict of Interest; • Employee Policy - Confidentiality, Code of Conduct • Board Policy 02-05-055 - Board of Health Self Evaluation • Delegation (Associate Medical Officer of Health) • Employee Policy - 01-04-200 Code of Conduct • Performance Review • Risk Management	
13	The board of health shall ensure that by-laws, policies and procedures are reviewed and revised as necessary, an at least every two years.	• Terms of Reference of Governance Committee states "review Board policies on a regular basis, and a minimum of every two years, and make recommendations to the Board to ensure currency and relevancy"	
14	The board of health shall provide governance direction to the administration and ensure that the board of health remains informed about the activities of the organization on the following: a) Delivery of program and services; b)Organizational effectiveness through evaluation of the organization and strategic planning; c)Stakeholder relations and partnership building; d)Research and evaluation; e)Compliance with all applicable legislation and regulations; f)Workforce issues, including recruitment of medical officer of health and any other senior executives; g)Financial management, including procurement policies and practices; and h) Risk Management.	• Governance Committee of the Board of Health • Finance Committee of the Board of Health • MOH monthly reports to BOH re program activities • Quarterly reports re program metrics • Risk management annual report reviewed and approved by the board	

	ORGANIZATIONAL REQUIREMENTS	COMPLIANCE ACTION / DOCUMENTATION	ADDITIONAL ACTION / DOCUMENTATION PLANNED OR IN PROGRESS
15	The board of health shall have a self-evaluation process of its governance practices and outcomes that is completed at least every other year. Completion includes an analysis of the results, board of health discussion, and implementation of feasible recommendations for improvement, if any.	• Board Policy 02-05-055 - Board of Health Self Evaluation • Board Policy 02-05-080 - Performance Evaluation for MOH CEO	
16	The board of health shall ensure the administration develops and implements a set of client service standards.	• Set of Agency Values which applies to both employees and clients; individual procedures have turn around times included	• Client Service standards on Work plan
17	The board of health shall ensure that the medical officer of health, as the designated health information custodian, maintains information systems and implements policies/procedures for privacy and security, data collection and records management.	• Agency Privacy Policies established • Privacy Officer and Privacy Committee in place	
D	**Public Health Practice Domain**		
1	The board of health shall ensure that the administration establishes, maintains, and implements policies and procedures related to research ethics.	• Policy refresh underway in 2019	
2	The board of health shall designate a Chief Nursing Officer.	• CNO in place • Attends monthly Executive Committee meetings	
3	The board of health shall demonstrate the use of a systematic process to plan public health programs and services to assess and report on the health of local populations describing the existence and impact of health inequities and identifying effective local strategies to decrease health inequities.	• Program planning annually now included a Standards Implementation Plan and is supported by situational assessments	• Continue to build capacity to evaluate effectiveness of program interventions on population health outcomes.
4	The board of health shall employ qualified public health professionals in accordance with the *Qualifications for Public Health Professionals Protocol, 2018* (or as current).	• PHNs, PHIs, RDs, RDHs, BA, MOH, AMOH all certified as per the requirements	
5	The board of health shall support a culture of excellence in professional practice and ensure a culture of quality and continuous organizational self-improvement. This may include: a)Measurement of client, community, and stakeholder/partner experience to inform transparency and accountability; and b)Regular review of outcome data that includes variances from performance expectations and implementation of remediation plans.	• Nursing Practice Council	• Related to work that is underway - strategic planning indicators to be developed - measurable indicators • Exploring identification of QA Co-coordinator

	ORGANIZATIONAL REQUIREMENTS	COMPLIANCE ACTION / DOCUMENTATION	ADDITIONAL ACTION / DOCUMENTATION PLANNED OR IN PROGRESS
E	**Common to All Domains**		
1	The board of health shall submit an Annual Service Plan and Budget Submission to include all programs and services delivered by boards of health and program costing for ministry-funded programs.	• Annual Service Plan and Budget is submitted to the Ministry	• New process • Finance working with program managers
2	The board of health shall submit action plans as requested to address any compliance or performance issues.	• The Board of Health would do this if required • Activity reports are submitted when requested (e.g. vector Borne)	
3	The board of health shall submit all reports as requested by the ministry.	• The Board of Health does submit all mandatory reports to the Ministry • Ministry is aware of key contact information for the agency	
4	The board of health shall have a formal risk management framework in place that identifies, assesses, and addresses risks.	• Agency Risk Management model developed - updated and approved annually by Board of Health.	
5	The board of health shall produce an annual financial and performance report to the general public.	• Annual Audited Financial Statements posted on APH website • Annual Reports or Health Profile completed • Monthly Financial reports provided to the Board of Health and are in Board Packages which are posted on APH website	

Chair's Report

Finance and Audit Committee

At the Finance and Audit Committee meeting on June 12, the Committee reviewed the draft Financial statements for the period ending April 30, 2019.

We are pleased to report that the Financial position of the APH remains strong and the liquidity remains stable.

Highlights include:

- Genetics Counselling program funding has now been fully transitioned to Health Sciences North.
- Overall revenues are within budget.
- Salaries and wages show a positive variance due to unfilled positions within the organization
- There are no collection concerns for accounts receivable.

The committee also reviewed the Terms of Reference for the Finance and Audit Committee and are recommending no changes at this time.

Algoma Public Health
(Unaudited) Financial Statements April 30, 2019

Algoma Public Health
Statement of Operations
April 2019
(Unaudited)

	Actual YTD 2019	Budget YTD 2019	Variance Act. to Bgt. 2019	Annual Budget 2019	Variance % Act. to Bgt. 2019	YTD Actual/ YTD Budget 2019
Public Health Programs						
Revenue						
Municipal Levy - Public Health	**$ 1,765,034**	$ 1,759,845	$ 5,189	$ 3,519,690	0%	100%
Provincial Grants - Cost Shared Funding	**2,507,734**	2,507,733	1	7,523,200	0%	100%
Provincial Grants - Public Health 100% Prov. Funded	**998,555**	998,983	(428)	2,996,950	0%	100%
Fees, other grants and recovery of expenditures	**148,419**	224,111	(75,693)	695,214	-34%	66%
Total Public Health Revenue	**$ 5,419,742**	$ 5,490,672	$ (70,931)	$ 14,735,054	-1%	99%
Total Public Health Programs Expenditures	**$ 4,685,091**	$ 5,032,687	$ 347,597	$ 14,735,055	-7%	93%
Total Rev. over Exp. Public Health	**$ 734,651**	$ 457,985	$ 276,666	$ (1)		
Healthy Babies Healthy Children						
Provincial Grants and Recoveries	**$ 356,011**	356,004	(7)	1,068,011	0%	100%
Expenditures	**342,631**	355,270	(12,639)	1,068,011	-4%	96%
Excess of Rev. over Exp.	**13,380**	733	12,646	-		
Public Health Programs - Fiscal 19/20						
Provincial Grants and Recoveries	**$ -**	-	-	-		
Expenditures	**525**	-	525	-		
Excess of Rev. over Fiscal Funded	**(525)**	-	(525)	-		
Community Health Programs						
Calendar Programs						
Revenue						
Provincial Grants - Community Health	**$ -**	$ -	$ -	$ -		
Municipal, Federal, and Other Funding	**109,038**	109,037	0	363,118	0%	100%
Total Community Health Revenue	**$ 109,038**	$ 109,037	$ 0	$ 363,118	0%	100%
Expenditures						
Child Benefits Ontario Works	**1,878**	8,167	6,289	24,500	-77%	23%
Algoma CADAP programs	**106,594**	119,329	12,735	338,619	-11%	89%
Total Calendar Community Health Programs	**$ 108,472**	$ 127,496	$ 19,024	$ 363,119	-15%	85%
Total Rev. over Exp. Calendar Community Health	**$ 566**	$ (18,458)	$ 19,024	$ (1)		
Fiscal Programs						
Revenue						
Provincial Grants - Community Health	**$ 468,361**	$ 468,292	$ 69	$ 5,719,507	0%	100%
Municipal, Federal, and Other Funding	**49,266**	53,866	(4,600)	253,547	-9%	91%
Other Bill for Service Programs	**1,628**		1,628			
Total Community Health Revenue	**$ 519,256**	$ 522,158	$ (2,903)	$ 5,973,054	-1%	99%
Expenditures						
Brighter Futures for Children	**6,547**	9,537	2,990	114,447	-31%	69%
Infant Development	**58,292**	53,503	(4,789)	644,031	9%	109%
Preschool Speech and Languages	**43,950**	51,021	7,072	614,256	-14%	86%
Nurse Practitioner	**12,248**	11,954	(294)	145,452	2%	102%
Genetics Counseling	**18,619**	-	(18,619)	-	0%	0%
Community Mental Health	**298,208**	301,026	2,818	3,612,862	-1%	99%
Community Alcohol and Drug Assessment	**61,647**	61,451	(196)	737,406	0%	100%
Stay on Your Feet	**8,180**	8,333	153	100,000	-2%	98%
Bill for Service Programs	**2,319**	-	(2,319)	-		
Misc Fiscal	**124**	383	259	4,600		
Total Fiscal Community Health Programs	**$ 510,133**	$ 497,209	$ (12,925)	$ 5,973,054	3%	103%
Total Rev. over Exp. Fiscal Community Health	**$ 9,122**	$ 24,950	$ (15,827)	$ 0		

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

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

Algoma Public Health
Revenue Statement
For Four Monthes Ending April 30, 2019
(Unaudited)

	Actual YTD 2019	Budget YTD 2019	Variance Bgt. to Act. 2019	Annual Budget 2019	Variance % Act. to Bgt. 2019	YTD Actual/ Annual Budget 2019	*Comparison Prior Year:* *YTD Actual 2018*	*YTD BGT 2018*	*Variance 2018*
Levies Sault Ste Marie	1,219,050	1,219,050	0	2,438,100	0%	50%	1,212,882	1,212,882	0
Levies Vector Bourne Disease and Safe Water	29,716	29,716	0	59,433	0%	50%	29,716	29,716	0
Levies District	516,268	511,079	5,189	1,022,157	1%	51%	508,492	508,492	0
Total Levies	**1,765,034**	**1,759,845**	**5,189**	**3,519,690**	**0%**	**50%**	**1,751,090**	**1,751,090**	**0**
MOH Public Health Funding	2,448,301	2,448,300	1	7,344,900	0%	33%	2,376,967	2,376,967	0
MOH Funding Vector Borne Disease	36,233	36,233	(0)	108,700	0%	33%	36,233	36,233	0
MOH Funding Safe Water	23,200	23,200	0	69,600	0%	33%	23,200	23,200	0
Total Public Health Cost Shared Funding	**2,507,734**	**2,507,733**	**1**	**7,523,200**	**0%**	**33%**	**2,436,400**	**2,436,400**	**0**
MOH Funding Needle Exchange	21,567	21,567	0	64,700	0%	33%	21,567	21,567	0
MOH Funding Haines Food Safety	8,200	8,200	0	24,600	0%	33%	8,200	8,200	0
MOH Funding Healthy Smiles	256,633	256,633	(0)	769,900	0%	33%	256,633	256,633	0
MOH Funding - Social Determinants of Health	60,167	60,167	0	180,500	0%	33%	60,167	60,167	0
MOH Funding - MOH / AMOH Top Up	41,718	42,150	(432)	126,450	-1%	33%	41,718	42,150	(432)
MOH Funding Chief Nursing Officer	40,501	40,500	1	121,500	0%	33%	40,501	40,500	1
MOH Enhanced Funding Safe Water	5,167	5,167	0	15,500	0%	33%	5,167	5,167	0
MOH Funding Unorganized	176,800	176,800	0	530,400	0%	33%	176,800	176,800	0
MOH Funding Infection Control	104,134	104,133	1	312,400	0%	33%	104,134	104,133	1
MOH Funding Diabetes	50,000	50,000	0	150,000	0%	33%	50,000	50,000	0
MOH Funding Northern Ontario Fruits & Veg.	39,134	39,133	1	117,400	0%	33%	39,126	39,133	(7)
Funding Ontario Tobacco Strategy	144,534	144,533	1	433,600	0%	33%	144,534	144,534	0
MOH Funding Harm Reduction	50,000	50,000	0	150,000	0%	33%	50,000	50,000	0
One Time Funding	0	0	0	0		0%	0	0	0
Total Public Health 100% Prov. Funded	**998,555**	**998,983**	**(428)**	**2,996,950**	**0%**	**33%**	**998,547**	**998,984**	**(437)**
Recoveries from Programs	13,414	20,914	(7,499)	27,621	-36%	49%	33,924	20,783	13,141
Program Fees	70,743	79,531	(8,788)	238,593	-11%	30%	73,584	79,255	(5,671)
Land Control Fees	12,115	45,000	(32,885)	160,000	-73%	8%	14,350	53,333	(38,983)
Program Fees Immunization	32,788	51,667	(18,878)	155,000	-37%	21%	35,903	61,667	(25,764)
HPV Vaccine Program	442	4,000	(3,558)	12,000	0%	4%	298	7,000	(6,703)
Influenza Program	885	0	885	25,000	0%	4%	0	0	0
Meningococcal C Program	349	0	349	8,000	0%	4%	77	1,000	(924)
Interest Revenue	15,064	10,667	4,397	32,000	41%	47%	11,084	4,667	6,417
Other Revenues	2,618	12,333	(9,715)	37,000	0%	7%	0	6,667	(6,667)
Total Fees, Other Grants and Recoveries	**148,419**	**224,111**	**(75,693)**	**695,214**	**-34%**	**21%**	**169,219**	**234,372**	**(65,153)**
Total Public Health Revenue Annual	**$ 5,419,742**	**$ 5,490,673**	**$ (70,931)**	**$ 14,735,054**	**-1%**	**37%**	**$ 5,355,256**	**$ 5,420,846**	**$ (65,590)**

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 Four Monthes Ending April 30, 2019

(Unaudited)

	Actual YTD 2019	Budget YTD 2019	Variance Act. to Bgt. 2019	Annual Budget 2019	Variance % Act. to Bgt. 2019	YTD Actual/ YTD Budget 2019	*Comparison Prior Year:* *YTD Actual 2018*	*YTD BGT 2018*	*Variance 2018*
Salaries & Wages	$ 2,801,794	$ 3,010,474	$ 208,680	$ 9,031,427	-7%	31%	$ 2,716,444	$ 2,953,346	$ 236,902
Benefits	732,837	728,363	(4,474)	2,185,088	1%	34%	704,753	701,726	(3,027)
Travel	60,040	63,690	3,650	191,069	-6%	31%	52,696	65,166	12,469
Program	154,134	210,478	56,344	631,433	-27%	24%	132,406	217,047	84,641
Office	29,141	34,515	5,374	103,544	-16%	28%	34,566	38,970	4,404
Computer Services	249,010	301,646	52,636	806,927	-17%	31%	229,951	225,294	(4,657)
Telecommunications	97,663	115,895	18,232	267,685	-16%	36%	81,435	101,101	19,667
Program Promotion	6,579	20,977	14,398	62,930	-69%	10%	7,235	29,249	22,014
Professional Development	38,093	32,234	(5,859)	96,702	18%	39%	35,860	25,714	(10,146)
Facilities Expenses	247,285	253,333	6,048	760,000	-2%	33%	256,588	265,000	8,412
Fees & Insurance	149,253	142,360	(6,893)	242,080	5%	62%	124,259	131,150	6,891
Debt Management	153,633	153,633	0	460,900	0%	33%	153,633	153,633	0
Recoveries	(34,372)	(34,910)	(538)	(104,730)	-2%	33%	(33,747)	(34,766)	(1,018)
	$ 4,685,090	$ 5,032,688	$ 347,598	$ 14,735,055	**-7%**	**32%**	$ 4,496,079	$ 4,872,631	$ 376,552

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

Notes to Financial Statements – April 2019

Reporting Period

The April 2019 financial reports include four months of financial results for Public Health and the following calendar programs; Healthy Babies & Children, Child Benefits Ontario Works, and Algoma CADAP programs. All other programs are reporting one month result from operations year ended March 31st, 2020.

Statement of Operations (see page 1)

Summary – Public Health and Non Public Health Programs

The Provincial Government has publically announced changes in the funding model associated with Public Health programs and services however individual health units have not received written notices. As a result, it is anticipated that the cost sharing split between municipalities and the province will change. Specifically for APH, the traditional 75% provincially funded, 25% municipally funded ratio would transition to a 70% provincially funded and 30% municipally funded ratio. Initially the funding changes were to be retroactive to the 2019 budget year however on May 27th the government announced that the funding changes would not be implemented this fiscal year. The financial statements as of April 30th, 2019 do not reflect these proposed changes and will not reflect the proposed changes in light of the fact that changes are not taking effect in 2019.

As of April 30th, 2019, Public Health programs are reporting a $277k positive variance.

Total Public Health Revenues are indicating a negative $71k variance. This is a result of Fees, Other Grants and Recoveries being less than budgeted. APH typically captures the bulk of its fees between the spring and fall months.

There is a positive variance of $348k related to Total Public Health expenses being less than budgeted. Salary and Wages expense is driving this positive variance.

Community Health Calendar programs are showing a positive $19k variance.

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

Genetics Counseling program funding has now been fully transitioned to Health Sciences North. Operationally, APH continues to help with the transition in terms of client services. APH is utilizing deferred revenue associated with the program until the operational transition is completed. It is anticipated that by June 30th, transition cost should end.

Notes Continued…

Public Health Revenue (see page 2)

Overall, Public Health funding revenues are within budget.

The municipal levies are showing a positive $5k variance. This is a result of timing of receipts of the municipal levy as some smaller municipalities have paid their portion of the levy in full.

Cost Shared Funding is within budget.

100% Provincially Funded Grants are within budget.

Fees, Other Grants & Recoveries are showing a negative variance of $76k. Land Control Fees are showing a negative $33k variance. In addition, Program Fees Immunization is showing a $19k negative variance. APH typically captures the bulk of its fees between the spring and fall months.

Public Health Expenses (see page 3)

Salary & Wages
The $209k 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. A Public Health supervisor position was budgeted for the full calendar year. The successful candidate started in late February. Currently, there are some vacant positions within the agency that have been budgeted but yet to be filled.

Program
Program expense is indicating a positive $56k variance. As Public Health programs are only four month's into the budget year, this variance is a result of timing of expenses not yet incurred. Additionally, Program Fees Immunization is $19k under budget which directly impacts the costs of associated Program expenses.

Computer Services
Computer Services expense is indicating a positive $52k variance. This is primarily a result of Microsoft licenses that have been budgeted but have yet to be paid. Additionally, Management budgeted $56k per month for computer support services however actual expenses have resulted in a $14k year-to-date savings.

Telecommunications
Telecommunications expense is indicating a positive $18k variance. This is a result of year-to-date expenses being less than budgeted.

Notes Continued…

Program Promotion
Program Promotion expense is indicating a positive $14k variance. This is a result of timing of expenses not yet incurred.

Financial Position - Balance Sheet (see page 7)

APH's liquidity position continues to be stable and the bank has been reconciled as of April 30th, 2019. Cash includes $838k in short-term investments.

Long-term debt of $5.02 million is held by TD Bank @ 1.95% for a 60 month term (amortization period of 180 months) and matures on September 1, 2021. $293k 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 collection concerns for accounts receivable.

Algoma Public Health

Statement of Financial Position

(Unaudited)

Date: As of April 2019		**April 2019**	December 2018
Assets			
Current			
Cash & Investments	**$**	**3,407,883**	$ 3,095,904
Accounts Receivable		**250,414**	513,364
Receivable from Municipalities		**275,983**	75,726
Receivable from Province of Ontario			
Subtotal Current Assets		**3,934,279**	3,684,994
Financial Liabilities:			
Accounts Payable & Accrued Liabilities		**1,143,929**	1,345,384
Payable to Gov't of Ont/Municipalities		**97,520**	344,305
Deferred Revenue		**431,689**	428,341
Employee Future Benefit Obligations		**2,811,714**	2,811,714
Term Loan		**5,199,815**	5,199,815
Subtotal Current Liabilities		**9,684,666**	10,129,560
Net Debt		**(5,750,387)**	(6,444,566)
Non-Financial Assets:			
Building		**22,732,421**	22,732,421
Furniture & Fixtures		**1,936,985**	1,936,985
Leasehold Improvements		**1,572,807**	1,572,807
IT		**3,244,030**	3,244,030
Automobile		**40,113**	40,113
Accumulated Depreciation		**(9,476,105)**	(9,476,105)
Subtotal Non-Financial Assets		**20,050,250**	20,050,250
Accumulated Surplus		**14,299,863**	13,605,684

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

O: May 22, 2015

R: September 28, 2016

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

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

	• Monitor the effectiveness of internal controls to ensure compliance with Board policies and standard accounting principles; • Review and ensure that all risk management is complete with respect to all insurance coverage for the Board; • Review and make recommendations to the Board regarding long-term financial goals and long-term revenue and expense projections; • Review and make recommendation to the Board concerning any material asset acquisitions; • Review and make recommendations to the Board regarding financial, Investing and banking transactions, providers and signing officers; and • Review other projects or developments as directed by the Board. • Complete tasks as stated in the Board's Annual Activity Plan
Chair:	The Chair of the Committee shall be elected annually by the Board and shall serve no longer than three terms. The Chair of the Finance and Audit Committee will also serve as the 1st Vice-Chair of the Board of Health. The Committee chair in consultation with the MOH/CEO/CAO is responsible for: establishing Committee agendas; conducting the meetings; liaison with the Board Chair, the Board and the MOH/CEO/CAO; reporting to the Board on the activities of the Committee and presenting Committee recommendations to the Board. The Committee may elect a vice-chair on an annual basis.
Recorder:	The secretary to the Board will act as recorder for the Finance and Audit Committee.
Reporting and Accountability to the Board:	The Committee will keep brief decision minutes of its meetings in which shall be recorded all matters considered at each meeting. These minutes will be circulated to the full Board once approved by the Committee. The Committee chair will report to the Board on recommendations from the Committee, including a brief outline of the issue, the options considered, the conclusions and recommendations arrived at and the implications and risks associated with the recommendations. In the absence of the Committee chair, this responsibility may be delegated to the Vice-Chair or another Director member of the Committee or to staff.
Committee Performance:	The performance and effectiveness of the Committee shall be assessed annually as part of the Board's evaluation process. The evaluation will be based on the Committee fulfilling its Mandate.
Membership:	The Finance and Audit Committee shall be comprised of: • Up to six (6) members of the Board of Health plus the Board Chair and no less than three (3) voting members; • MOH/CEO/CAO of Algoma Public Health, resource • CFO or designate of Algoma Public Health, resource
Frequency:	A minimum of four (4) meetings will be held annually as outlined in the Board's annual activity plan. Additional meetings can be held at the call of the Chair or at the request of the Board. The location of the meetings will be at APH's main office unless otherwise

	agreed upon by the Committee.
Term:	The Committee shall be appointed annually by the Board.
Committee Operations:	Quorum for Committee meetings is a majority of the voting members of the Committee. The Committee shall operate in accordance with the procedures for Board meetings as set out in By-Law No. 95-1 The Committee may, with the approval of the Board, establish sub-committees.
Amendments:	The Committee will review the Terms of Reference on an annual basis and make recommendations for any amendments to the Board for its review and decision re: approval.
Distribution of Minutes:	Minutes shall be provided to the committee members and the Board of Health.

Signature of Board of Health Chair Date

Governance Committee Meeting

May 29, 2019

Attendees:

Deborah Graystone - Chair
Adrienne Kappes
Heather O'Brien
Louise Caicco Tett

Regrets: Karen Raybould
Lee Mason - Board Chair

APH Executive

Marlene Spruyt - MOH/CEO
Tania Caputo - Board Secretary

A draft policy for Board membership Term Limits was approved with amendments by the Governance Committee. It was agreed to include in this policy that a letter of recommendation from the Board Chair be sent to the appropriate contact prior to end of the term of each board member.

Board Membership Skill Mix/Matrix was deferred to next meeting.

The Travel Policy for Employees and Board Members were reviewed. Discussion regarding increasing meal expenses and possibly mileage costs. Marlene Spruyt will review and bring a recommended combined policy to the next Governance Committee meeting.

The Board Remuneration policy will be reviewed by Tania Caputo and Marlene Spruyt after consultation with other similar boards. Recommendations will be presented at the September Governance meeting.

A motion to archive The Board Employee Retirement Recognition Policy was passed. The rationale was that this was an operational issue. This will be presented to the Board for approval.

The Procurement Policy was discussed. The Finance Committee made one recommended amendment. This Policy was approved by the Governance Committee to be brought to the Board for review and approval.

A chart with all board members and their dates of appointment and term limits was developed. This will be shared with the entire Board.

Terms of Reference for the Finance and Governance Committees were reviewed with minor amendments. The Finance Committee Terms of Reference will be sent back to the Finance Committee for their review and recommendations prior to sending to the Board for final approval.

NAME	TERM END	APPOINTED BY
Dr. Heather O'Brien	End of Term 2020	• City of Sault Ste. Marie
Matt Scott	End of Term 2020	• City of Sault Ste. Marie
Louise Caicco Tett	End of Term 2022	• City of Sault Ste. Marie
Dr. Patricia Avery	3-Aug-19	• Province of Ontario
Deborah Graystone	3-Aug-19	• Province of Ontario
Adrienne Kappes	10-May-20	• Province of Ontario
Karen Raybould	10-May-20	• Province of Ontario
Lee Mason	End of Term 2022	• Town of Bruce Mines • Village of Hilton Beach • Townships of Hilton • Jocelyn • Johnson • Laird • MacDonald, Meredith & Aberdeen Additional • Plummer Additional • Prince • St. Joseph • Tarbutt Township
Randi Condie	End of Term 2022	• Town of Blind River • Town of Spanish • Township of the North Shore
Micheline Hatfield	End of Term 2022	• Municipality of Wawa • Township of White River • Township of Dubreuilville
Ed Pearce	End of Term 2022	• Elliot lake
Brent Rankin	End of Term 2022	• Town of Thessalon • Municipality of Huron Shores

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

Original: September 22, 2015
Reviewed: September 28, 2016
Revised: June 26, 2019

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

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

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

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

Signature of Board of Health Chair

Date

APPROVED BY:	Board of Health	**REFERENCE #:**	02-05-087
DATE: May 29, 2019		**SECTION:**	Board
		SUBJECT:	Board Member Membership and Terms

The Algoma Public Health Board believes that its members, to be effective should be appointed according to skills and attributes. Terms of Members should comply with Municipal and Provincial legislative requirements.

Purpose:

To ensure skill and experience is maintained with staggering of appropriate terms of office and regular turnover while maintaining experience and expertise.

Board Membership:

The Algoma Public Board of Health may have a maximum of 15 members to represent the various jurisdictions with the Algoma catchment area. A skills and attributes matrix will facilitate a qualified and effective Board Membership.

All Boards of Health have a legislative duty to comply with the Health Protection and Promotion Act (HPPA) as per below articles:

The Lieutenant Governor in Council may appoint one or more persons as members of a board of health, but the number of members so appointed shall be less than the number of municipal members of the board of health. R.S.O. 1990, c. H.7, s. 49 (3).

The term of office of a municipal member of a board of health continues during the pleasure of the council that appointed the municipal member but, unless ended sooner, ends with the ending of the term of office of the council. R.S.O. 1990, c. H.7, s. 49 (7).

The Algoma Public Board of Health Policy #02-05-000 describes the geographic jurisdiction and subsequent representation required for the Algoma Public Health Unit.

Provincial Board Members shall:

1) apply through the appropriate provincial process for Provincial Appointees; skills and attributes required by the Algoma Board of Health will ensure the best quality of Board Membership

2) according to the Policy #02-05-000 Provincial appointees are appointed for a three year term and may be renewed for one additional term not to exceed 6 years.

Municipal Board Members shall:

1) be appointed by each appropriate Municipality with consideration of APHU's skills and attributes matrix at the beginning of each term of office of the Municipal council.

2) the term of office of appointed Municipal members should extend for the duration of their 4 year term with an option of one additional term not to exceed 8 years.

Prior to municipal or provincial appointments the chair of APH Board of Health will recommend reappointment of members.

APPROVED BY:	Board of Health	**REFERENCE #:**	02-04-030
DATE:	O: February 13, 1996 Revised: May 28, 2015 Revised: October 28, 2015 Revised : March 28 2018 Revised : June 26, 2019	**SECTION:**	Board Policy
PAGE:	1 of 14	**SUBJECT:**	Procurement Policy

1.0 PURPOSE

The purpose of this policy is:

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

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

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

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

2.0 POLICY ACCOUNTABILITY AND RESPONSIBILITIES

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

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

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

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

c) Ensures changes to the Procurement Policy are implemented

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

The Leadership Team

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

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

c) Considers the total acquisition cost

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

3.0 SCOPE OF APH PROCUREMENT POLICY

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

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

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

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

d) Professional and Special Services

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

e) Utilities/Communication Infrastructure

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

g) Bailiff or collection agencies

h) Software licensing renewals

i) Ongoing maintenance agreements

j) Vaccine purchases

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

l) Real Property Interests
   i. All real estate transactions

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

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

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

4.0 FORM OF COMMITTEMENT BY ROLE/SIGNING AUTHORITY

4.1 Signing Authority to Make Purchases

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

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

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

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

4.2 General Guidelines

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

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

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

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

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

5.0 QUOTATION PROCEDURE

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

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

- $1 – $5,000: single quote (Purchase Order) **is required**. Multiple quotes **are recommended.**
- $5,000 – $15,000: Two (2) written bids, quotations, and/or proposals **are required**.
- $15,000 to $55,000: Three (3) written bids, quotations, and/or proposals **are required**.

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

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

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

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

5.2 Confidentiality of Bids/Quotations/Proposals

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

5.3 Late Bids/Quotations/Proposals

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

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

5.4 Errors in Bids/Quotations/Proposals

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

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

5.5 Sole Source Procurement and Justification

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

a) where there is only one known source

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

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

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

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

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

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

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

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

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

6.0 VENDOR SELECTION

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

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

6.1 Vendor of Record

The use of a Vendor of Record (VOR) from the Ministry of Government Services website precludes the need to go to a public bid solicitation process since this process was already done by that Ministry. Examination of the pricing should be done against local/current

suppliers of the same product or service to ensure that the Health Unit is obtaining the best price, quality, availability and suitability before engaging a VOR.

6.2 Co-operative Purchasing

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

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

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

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

7.0 SPECIAL PROCUREMENT POLICIES

7.1 CONTRACTS/LEASES

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

The Board must approve contracts where:

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

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

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

7.2 Consulting Services

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

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

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

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

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

7.3 Approvals for Construction and Alterations to Physical Space

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

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

7.4 Equipment and Equipment Screening

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

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

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

8.0 PROHIBITIONS

8.1 Conflicts of Interest

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

8.2 Gifts, Gratuities, and Kickbacks

Algoma Public Health policy prohibits all employees from accepting gifts, gratuities or kickbacks of any value from vendors or service providers. Items of a very minimal value which are of an advertising nature only, and available to other customers may be accepted (e.g. pens, hats, coffee cups, etc.). Any questions an APH employee may have as the appropriateness of the value of the item must be communicated to the employee's Manager/ Director/ MOH/CEO/Board of Health (as may be appropriate).

8.3 Personal Purchases

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

8.4 Division of Contracts

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

8.5 Local Preference

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

8.6 Prohibited Classes of Vendor

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

a) Board of Health Members;

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

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

9.0 General Information

9.1 The Accessibility for Ontarians with Disabilities Act (AODA)

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

9.2 Environmental Considerations

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

The Board of Health will endeavor, whenever possible, to purchase and utilize products that support environmentally sound practices from the manufacturing process through to final delivery and disposal. Priority consideration will be given to products that espouse environmentally friendly sound practices.

9.3 Disposal of Surplus Goods

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

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

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

No disposition of such Good(s) shall be made to employees, elected officials, or their family members with the exception of of electronic assets that have been fully depreciated. **The disposition of electronic assets would be at the discretion of the CFO in conjunction with the MOH/CEO and the Manager of IT.**

9.4 Purchase of Surplus Goods

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

9.5 Consulting Services Requirements

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

All consultants or service providers working on behalf of APH who will interact with children, youth or vulnerable persons as per the terms of their contract are required to provide a current police vulnerable sector check (PV5C). If the service provider is required to provide a criminal

reference check to their Regulatory College as part of the annual licensure process, an attestation from the service provider along with the copy of their current licensure will be accepted.

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

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

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

10.0 Review and Evaluation

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

11.0 PROCUREMENT PROCEDURES

The purchasing cycle includes the following steps:

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

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

c) Quotation procedure and vendor selection

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

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

f) Payment made to vendor

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

11.1 Purchase Requisition/Purchase Order.

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

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

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

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

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

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

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

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

11.2 Change Order – Cancellation or Modification of a Purchase Order

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

11.3 Blanket Purchase Orders

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

Request to enter into a blanket Purchase Order must be approved by the CFO or Manager of Accounting and Budgeting. A Blanket Purchase Order generally should not exceed 1 year. The associated Program Manager and their reporting Director must approve the Blanket Purchase Order.

11.4 Cheque Requisition

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

11.5 Petty Cash

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

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

11.6 Use of Corporate Credit Card

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

specific expenditure exceeds their signing authority, an approved purchase order signed by the appropriate signing authority is required for each purchase.

11.7 Custody of Documents

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

Glossary of Roles Noted within Algoma Public Health Procurement Policy

Administration – consists of any position within APH including and above the role of Supervisor in the following Departments: Finance & Accounting, Human Resource, Payroll, Corporate Services, Communications, and Operations.

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

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

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

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

Leadership Team – consists of any position within APH including and above the role of Supervisor.

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

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

Original: February 13, 1996
Revised: March 2006

Revised: February 24, 2009
Revised: March 18, 2015
Revised: May 28, 2015
Revised: October 28, 2015
Revised: March 28, 2017
Revised: June 26,2018

APPROVED BY:	Board of Health	**REFERENCE #:**	02-05-040
DATE:	O: April 18, 1990 Revised: March 18, 2009 Reviewed: May 16, 2012 Revised: June 17, 2014 Revised: May 25, 2016	**SECTION:**	Board
PAGE:	1 of 1	**SUBJECT:**	Employee Retirement – Board Recognition

POLICY:

Assuming availability of funds, the Board will recognize the length of service, if 10 years or greater, of the employee by the presentation of a gift upon retirement.

The value of the gift to be presented will be:

Length of Continuous Service	Value
10 – 14 Years	$250.00
15 – 19 Years	$350.00
20 – 24 Years	$425.00
25 Years +	$500.00

PROCEDURES:

Retiree: Receive gift from the Board on their last day of work.

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

519-258-2146 | www.wechu.org

Windsor 1005 Ouellette Avenue, Windsor, ON N9A 4J8
Essex 360 Fairview Avenue West, Suite 215, Essex, ON N8M 3G4
Leamington 33 Princess Street, Leamington, ON N8H 5C5

May 21, 2019

The Right Honorable Justin Trudeau
Prime Minister of Canada
House of Commons
Ottawa, ON K1A 0A6
Justin.trudeau@parl.gc.ca

Dear Prime Minister Trudeau:

On May 16, 2019, the Windsor-Essex County Board of Health passed the following Resolution regarding **Smoke-Free Multi-Unit Dwellings** to reduce the exposure of second-hand smoke in multi-unit housing:

Whereas, the federal government has passed the Cannabis Act, 2017 to legalize non-medical cannabis, coming into effect on October 17th, 2018, and

Whereas, cannabis smoke contains many of the same carcinogens, toxins, and irritants found in tobacco smoke with the added psychoactive properties of cannabinoids like THC, and

Whereas, Ontarians spend most of their time at home, and it is in this environment where exposure continues to be reported, and

Whereas, indoor air studies show that, depending on the age and construction of a building, up to 65% of the air in a private residence can come from elsewhere in the building and no one should be unwillingly exposed or forced to move due to unwanted second-hand smoke exposure,

Now therefore be it resolved that the Windsor-Essex County Board of Health endorse the following actions and policies to reduce the exposure of second-hand smoke in multi-unit housing:

1. Encourage all landlords and property owners of multi-unit housing to voluntarily adopt no-smoking policies in their rental units or properties and explicitly include cannabis smoke and vaping of any substance in the definition of smoking;

2. All future private sector rental properties and buildings developed in Ontario should be vape and smoke-free from the onset;

3. Encourage public/social housing providers to voluntarily adopt no-smoking and/or vaping policies in their units and/or properties;

4. All future public/social housing developments in Ontario should be smoke and vape-free from the onset.

5. Encourage the Ontario Ministry of Housing to develop government policy and programs to facilitate the provision of smoke-free housing.

AND FURTHER that this resolution be shared with the Honorable Prime Minister of Canada, local Members of Parliament, the Premier of Ontario, local Members of Provincial Parliament, Minister of Health and Long-term Care, Federal Minister of Health, the Attorney General, Chief Medical Officer of Health, Association of Local Public Health Agencies, Ontario Boards of Health, Ontario Public Health Association, the Centre for Addiction and Mental Health, and local community partners.

We would be pleased to discuss this resolution with you and thank you for your consideration.

Sincerely,

Gary McNamara
Chair, Board of Health

Theresa Marentette
Chief Executive Officer

c: Hon. Doug Ford, Premier of Ontario
Hon. Christine Elliott, Minister of Health & Long-Term Care
Hon. Ginette Petitpas Taylor, Minister of Health
Hon. David Lametti, Minister of Justice and Attorney General of Canada
Dr. David Williams, Chief Medical Officer of Health, Ministry of Health & Long Term Care
Pegeen Walsh, Executive Director, Ontario Public Health Association
Centre for Addiction and Mental Health
Association of Local Public Health Agencies – Loretta Ryan
Ontario Boards of Health
WECHU Board of Health
Corporation of the City of Windsor – Clerk's office
Corporation of the County of Essex – Clerk's office
Local MPP's – Percy Hatfield, Lisa Gretzky, Taras Natyshak, Rick Nicholls
Local MP's – Brian Masse, Cheryl Hardcastle, Tracy Ramsey

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

519-258-2146 | www.wechu.org

Windsor 1005 Ouellette Avenue, Windsor, ON N9A 4J8
Essex 360 Fairview Avenue West, Suite 215, Essex, ON N8M 3G4
Leamington 33 Princess Street, Leamington, ON N8H 5C5

May 21, 2019

The Honorable Christine Elliott
Minister of Health and Long-Term Care
Hepburn Block 10th Floor
80 Grosvenor Street
Toronto, ON M7A 1E9

Dear Minister Elliott:

Urgent provincial action needed to address the potential health and social harms from the ongoing modernization of alcohol retail sales in Ontario

On behalf of the Windsor-Essex County Board of Health we are writing to you in support of Simcoe Muskoka District Health Unit's request to the Government of Ontario to develop a comprehensive provincial alcohol strategy to mitigate harms and monitor the health impacts of the increasing access and availability of alcohol in Ontario.

Annual costs directly attributed to alcohol-related harms in the form of health care, law enforcement, lost productivity, premature mortality and other alcohol-related problems, are estimated at $5.3 billion, contributing to a significant burden on Ontario's health care system. Research evidence shows that policy tools designed to influence drinking levels and patterns can reduce disease, disability, death and social disruption from alcohol.

It is well established that increased alcohol availability leads to increased consumption and alcohol–related harms. We agree with the SMDHU's belief that a comprehensive, provincially led alcohol strategy can help mitigate the potential harms of alcohol use, and thereby encourage the government to develop a provincial strategy to include education and awareness campaigns, enforcement of alcohol marketing regulations and improved monitoring systems to track alcohol-related harms.

The Windsor-Essex County Health Unit thanks you for your consideration.

Sincerely,

Gary McNamara, Chair
Chair, Board of Health

Theresa Marentette
Chief Executive Officer

Encl: SMDHU Letter to Christine Elliott, MOHLTC
c: Premier Doug Ford
Ontario Boards of Health
Loretta Ryan, Association of Local Public Health Units
Dr. David Williams, Chief Medical Officer of Health, MOHLTC
Hon. Vic Fedeli, Minister of Finance
Ken Hughes, Special Advisor for the Beverage Alcohol Review
WECHU Board of Health
Local MPP's – Percy Hatfield, Lisa Gretzky, Taras Natyshak, Rick Nicholls

April 17, 2019

The Honourable Christine Elliott
Deputy Premier and Minister of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, Ontario M7A 2C4

Dear Minister Elliott:

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

On behalf of the Simcoe Muskoka District Health Unit (SMDHU) Board of Health, I am writing to urge the Government of Ontario to develop a comprehensive provincial alcohol strategy to mitigate harms and monitor the health impacts of increasing access and availability of alcohol in Ontario.

Alcohol costs to the individual and society are significant. In 2014, Ontario spent $5.34 billion on alcohol-related harms, including $1.5 billion for healthcare and $1.3 billion for criminal justice.[1] Since 2015, alcohol use has contributed to more than 43,000 emergency room visits and 66 hospitalizations per day, a significant and avoidable burden on Ontario's healthcare system.[2]

It is well established that increased alcohol availability leads to increased consumption and alcohol-related harms. A comprehensive, provincially led alcohol strategy can help mitigate the potential harms of alcohol use as the government liberalizes access. Such a strategy should include:

- Strong policies to minimize the potential health and social harms of alcohol consumption;
- An improved monitoring system to track alcohol-related harms;
- Rigorous enforcement of alcohol marketing regulations, and;
- Public education and awareness campaigns aimed at changing attitudes and social norms around consumption.

The Ontario Government has committed to ensure the health and safety of our communities as it increases the availability of alcohol; however, recent changes in the way alcohol is sold and the 2019 Ontario Budget 'Protecting What Matters Most' [3] released on April 11, 2019 suggest that economic interests are superseding the health and well-being of Ontarians and further diminishes the likelihood of meeting the goal of ending hallway medicine. Recent changes that raise the potential for increased alcohol-related harms include reducing the minimum retail price of beer to $1.00, halting the annual inflation-indexed increase in the beer tax, and extending the hours of sale for alcohol retail outlets. This is in conjunction with the anticipated changes of legislation permitting municipalities to designate public areas for consumption of alcohol, advertising happy hour and creating a tailgating permit for eligible sporting events including post-secondary events.

The SMDHU Board of Health has on numerous occasions sent advocacy letters to the provincial government to support healthy alcohol policy, most recently in 2017, calling on the government to

prioritize the health and well-being of Ontarians by enacting a comprehensive, evidence-based alcohol strategy.

We believe it is possible to create a healthy alcohol culture in Ontario that balances interests in public health, government revenue, economic development, and consumer preferences without sacrificing the health of Ontarians. We support both the Council of Ontario Medical Officers of Health and Association of Local Public Health Agencies' request to ensure such a balance, and we thereby encourage the government to develop a provincial alcohol strategy that incorporates health goals.[4, 5] This would include a monitoring and evaluation plan to measure intended and unintended impacts of policy change. Now is the time for Ontario to take leadership and address the harms of alcohol use in our province.

Thank you for your consideration.

Sincerely,

ORIGINAL Signed By:

Anita Dubeau
Chair, Board of Health

cc. Hon. Vic Fedeli, Minister of Finance
Ken Hughes, Special Advisor for the Beverage Alcohol Review
Doug Downey, MPP Barrie-Springwater-Oro-Medonte
Jill Dunlop, MPP Simcoe North
Andrea Khanjin, MPP Barrie-Innisfil
Norman Miller, MPP Parry Sound-Muskoka
Hon. Caroline Mulroney, MPP York-Simcoe
Jim Wilson, MPP Simcoe-Grey
Dr. David Williams, Chief Medical Officer of Health for Ontario
Loretta Ryan, alPHa Executive Director
Ontario Boards of Health

References

1. The Canadian Centre on Substance Use and Addiction. (2018) Canadian Substance Use Costs and Harms in the Provinces and Territories (2007–2014)
2. Ontario Public Health Association. (2018) The Facts: Alcohol Harms and Costs in Ontario.
3. Ministry of Finance of the Ontario Government, 2019 Ontario Budget Protecting What Matters Most, April 11, 2019 , Honourable Victor Fedeli
4. Council of Ontario Medical Officers of Health, Re: Alcohol Choice & Convenience Roundtable Discussions [Letter written March 14, 2019 to Honorable Vic Fedeli].
5. Association of Local Public Health Agencies, Re: Alcohol Choice & Convenience Roundtable Discussions [Letter written March 8, 2019 to Honorable Vic Fedeli].

North Bay Parry Sound District Health Unit
Bureau de santé du district de North Bay-Parry Sound
Your lifetime partner in healthy living.
345 Oak Street West, North Bay, ON P1B 2T2 TEL 705-474-1400 FAX 705-474-8252 | myhealthunit.ca
70 Joseph Street, Unit 302, Parry Sound, ON P2A 2G5 TEL 705-746-5801 FAX 705-746-2711 | 1-800-563-2808

May 23, 2019 **SENT ELECTRONICALLY**

The Honourable Christine Elliott
Deputy Premier and Minister of Health and Long-Term Care
College Park, 5th Floor
777 Bay Street
Toronto, ON M7A 2J3
christine.elliott@ontario.ca

Dear Minister Elliott:

Re: Letter of Support for Simcoe Muskoka District Health Unit – Proposed Boundaries

It is our understanding that the provincial government is willing to consider feedback on the proposed boundary changes for public health units. With this in mind, the Board of Health for the North Bay Parry Sound District Health Unit is fully supportive of the May 15, 2019, letter from the Simcoe Muskoka District Health Unit's Board of Health recommending that the full territory of the Simcoe Muskoka District Health Unit remain intact and join with York Region Public Health to form a new regional public health entity on April 1, 2020.

The North Bay Parry Sound District Health Unit, having merged with Parry Sound in 2005, is well aware of the complexities, disruptions in program service delivery, time and effort, cultural change issues, and especially involved costs associated with such an undertaking. It will be difficult enough merging five health units with intact boundaries, let alone splitting up Simcoe Muskoka, and especially in such a short time frame.

Creating a single health unit entity with such a massive area of over 400,000 Km^2 will make it extremely challenging to respond, in a timely manner, to the local public health needs of the communities we would be required to serve.

For these many reasons, the North Bay Parry Sound District Health Unit Board of Health strongly urges the government to reconsider the proposed boundary change and keep the Simcoe Muskoka District Health Unit intact and join as a whole with York Region Public Health.

Sincerely yours,

Nancy Jacko
Chairperson, North Bay Parry Sound District Health Unit Board of Health

/sb

…/2

Enclosure

Copy to: North Bay Parry Sound District Health Unit Member Municipalities
Boards of Health for, Algoma, North Bay Parry Sound, Porcupine, Renfrew, Simcoe Muskoka, Sudbury, Timiskaming, and York
Medical Officers of Health for Algoma, North Bay Parry Sound, Porcupine, Renfrew, Simcoe Muskoka, Sudbury, Timiskaming, and York
Helen Angus, Deputy Minister, Ministry of Health and Long-Term Care
Elizabeth Walker, Director, Accountability and Liaison Branch, Ministry of Health and Long-Term Care
Loretta Ryan, Executive Director, Association of Local Public Health Agencies
Dr. David Williams, Chief Medical Officer of Health
Vic Fedeli, MPP, Nipissing
John Vanthof, MPP, Timiskaming Cochrane
Norm Miller, MPP, Parry Sound-Muskoka

simcoe muskoka
DISTRICT HEALTH UNIT

May 15, 2019

The Honourable Christine Elliott
Deputy Premier and Minister of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4

Dear Minister Elliott:

I am writing on behalf of the Board of Health for the Simcoe Muskoka District Health Unit (SMDHU) to recommend that the full territory of SMDHU remain intact and join with York Region to form a new regional public health entity on April 1, 2020. This is in response to information provided verbally to Dr. Charles Gardner, Medical Officer of Health for SMDHU by staff from the Ministry of Health and Long - Term Care on May 7th, 2019 indicating that public health services in the District of Muskoka will be provided by a regional public health entity that will also serve Sudbury, North Bay, Parry Sound, Algoma, Porcupine, Timiskaming and part of Renfrew; he also was informed that Simcoe County will be served by a public health entity that will also serve York Region. From this communication it is also Dr. Gardner's understanding that the provincial government is willing to consider feedback on these boundary changes. The Board appreciates having the opportunity to recommend that all of the territory served by SMDHU be combined with that of York Region in a new regional public health entity.

The Board and staff have worked very hard since the inception of SMDHU (the result of a merger prompted by the province in 2005) in order to create a cohesive public health agency that is highly successful in fulfilling its mandate. The District of Muskoka benefits from public health services provided in partnership with Simcoe County. The division of our Muskoka and Simcoe operations would disrupt and undermine program delivery.

The geographic area of the proposed *northeastern regional public health entity* is extremely large (over 400,000 kilometers, extending to James Bay). Providing public health services over such a large and low density area will be very challenging, and it will be very difficult for the governance and management of such a regional public health entity to provide attention to local service provision. The provision of public health services in the District of Muskoka would be more challenging within this very large public health entity than they would be if Muskoka were to join Simcoe County in a regional public health entity with York Region. The provision of public health services for the remaining communities in the proposed *northeastern regional public health entity* would also be further challenged with the addition of Muskoka to their territory.

The inclusion of the District of Muskoka with Simcoe County and York Region in a single public health entity would also be consistent with the observation that in general, the community and health care service referral patterns in Muskoka are directed to facilities in Simcoe County (Barrie and Orillia), and to communities further south (including in York Region).

Finally, of great concern to the Board is the reality that the division of Muskoka from Simcoe would greatly increase the complexity, cost and duration of time required for the creation of the new public health entities, compared with having Muskoka and Simcoe join together with the public health services in York Region. A merger between SMDHU and York Region would be complex on its own, however the splitting of our operations between Simcoe and Muskoka at the same time as mergers both with York, and with six other health units to the north would be overwhelming in its complexity.

Given the inherent and substantial disadvantages of dividing Simcoe and Muskoka, the Board recommends that SMDHU join in its entirety with York Region in the modernization of public health.

Thank you for considering our recommendation.

Sincerely,

ORIGINAL Signed By:

Anita Dubeau
Chair, Board of Health

CG:cm

cc. Mayor and Council of Simcoe and Muskoka
Members of Provincial Parliament for Simcoe and Muskoka
Boards of Health for York Region, Sudbury, North Bay, Parry Sound, Algoma, Porcupine, Timiskaming, and Renfrew
Loretta Ryan, Executive Director, Association of Local Public Health Agencies
Dr. David Williams, Chief Medical Officer of Health
Central Local Health Integration Network
North Simcoe Muskoka Local Health Integration Network

BRANT COUNTY
HEALTH UNIT

194 Terrace Hill Street
Brantford, ON N3R 1G7
519-753-4937

www.bchu.org

May 27, 2019

The Honourable Doug Ford
Premier of Ontario
Legislative Building, Queen's Park
Toronto, ON M7A 1A1
(sent via email to: premier@ontario.ca)

The Honourable Christine Elliott
Deputy Premier and Minister of Health and Long-Term Care
Hepburn Block, 10th Floor
80 Grosvenor Street
Toronto, ON M7A 1E9
(sent via email to: Christine.elliott@ola.org)

Dear Premier Ford and Minister Elliott,

On behalf of the Brant County Health Unit (BCHU) Board of Health, we are writing to express our concerns regarding the implications of the 2019 budget. Ontario's local public health system is an essential part of keeping communities safe and healthy. Public health delivers an excellent return on investment and works on the front line to protect communities from illness, and promote health and wellbeing. The services provided by public health, outlined in the Ontario Public Health Standards, ensure that the population stays out of the health care system and remains healthy.

While we recognize the need for a sustainable public health system in Ontario, it is difficult to comprehend how a $200 million provincial reduction in preventative services will contribute to lowering future overall health care costs. The Public Health budget represents approximately 2% of the Province's total health care expenditures and every dollar spent on public health services saves an average of $14 in the acute care system. For every $1 invested in:

- immunizing children with the measles-mumps-rubella vaccine $16 are saved in health care costs;
- early childhood development and health care saves up to $9 in future spending on health, social and justice services;
- car and booster seat education and use saves $40 in avoided medical costs;
- fluoridated drinking water results in $38 saved in dental care;
- tobacco prevention programs saves up to $20 in future health care costs; and
- mental health and addictions saves $7 in health costs and $30 in lost productivity and social costs.

The proposed provincial reduction in funding for public health services represents a significant strain on the ability of local public health units, like the Brant County Health Unit, to continue to deliver on its mandate. A reduction in funding that represents 26% of the budget cannot occur without cutting services. These cuts will

impact on our ability to deliver the front-line public health services that keep people out of hospitals and primary care offices and will ultimately mean greater costs to the health care system.

Before the new directions for public health units are fully implemented, the BCHU Board of Health recommends that any changes to the funding ratio be done in consultation with municipalities rather than unilaterally by the Province and deferred to the municipal 2020 funding year. The 2019 municipal levy has already been established and municipalities are already almost 50% through their budget year.

Additionally, the BCHU Board of Health recommends that the following be considered when the development of the new regional public health entities and regional governance structure occurs to maintain a strong public health presence and impact in our community:

1. No loss of service to our community – All current programs and services under the Foundational and Program Standards continue to be funded by the Regional Public Health Entity to provide services in Brant.
2. Meaningful input into program planning – The needs of Brantford and Brant County are considered in the planning of programs and services for our community.
3. Integrity of the Health Unit – The Health Unit continues to function as a unit and services continue to be provided locally.
4. Appropriate municipal role in governance – The public expects that their municipal tax dollars are overseen by municipal politicians. For the municipal investment, representatives of the obligated municipalities will continue in this oversight role.
5. Effective administrative support – All administrative services provided by the Regional Public Health Entity will be at the same level or better than currently exists in the Health Unit.

Ontario local public health units play a crucial role in ensuring the safety, health and well-being of Ontario communities and their populations. This crucial role is played out daily as Public Health Units work diligently and professionally to protect their communities from illnesses and promote health and well-being. These services outlined in the Ontario Public Health Standards and Related Programs ensure that our population remains healthy and does not end up requiring costly care and treatment in hospital emergency rooms and wards. The Board of Health for the Brant County Health Unit implores your government to leave the current public health structure as it is, delivering excellent and local preventative care to our community.

Sincerely,

Greg Anderson,
Chair, Brant County Board of Health

JAT/lmj
Copied: Dr. David Williams, Chief Medical Officer of Health
The Honourable Willem Bouma, MPP—Brantford-Brant
Association of Local Public Health Agencies
Monika Turner, Association of Municipalities of Ontario
Ontario Boards of Health
City of Brantford
County of Brant
The Expositor

Public Health
Santé publique
SUDBURY & DISTRICTS

May 28, 2019

VIA ELECTRONIC MAIL

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

Dear Premier:

Re: North East Public Health Regional Boundaries – Modernization of the Ontario Public Health System

At its meeting on May 16, 2019, the Board of Health for Public Health Sudbury & Districts carried the following resolution #17-19:

WHEREAS the Health Protection and Promotion Act amendment effective April 1, 2005, enabled the merger of the Muskoka-Parry Sound Health Unit with the Simcoe County District Health Unit and with the North Bay & District Health Unit; and

WHEREAS North Bay Parry Sound District Health Unit and Simcoe Muskoka District Health Unit (SMDHU) have invested greatly since that time to successfully transition to their respective new agencies; and

WHEREAS the new public health entity for northeastern Ontario is proposed to include the existing public health units in the region (Algoma Public Health, Public Health Sudbury & Districts, Porcupine Health Unit, North Bay Parry Sound District Health Unit, Timiskaming Health Unit) along with Muskoka District and a part of Renfrew; and

Sudbury
1300 rue Paris Street
Sudbury ON P3E 3A3
t: 705.522.9200
f: 705.522.5182

Rainbow Centre
10 rue Elm Street
Unit / Unité 130
Sudbury ON P3C 5N3
t: 705.522.9200
f: 705.677.9611

Sudbury East / Sudbury-Est
1 rue King Street
Box / Boîte 58
St.-Charles ON P0M 2W0
t: 705.222.9201
f: 705.867.0474

Espanola
800 rue Centre Street
Unit / Unité 100 C
Espanola ON P5E 1J3
t: 705.222.9202
f: 705.869.5583

Île Manitoulin Island
6163 Highway / Route 542
Box / Boîte 87
Mindemoya ON P0P 1S0
t: 705.370.9200
f: 705.377.5580

Chapleau
101 rue Pine Street E
Box / Boîte 485
Chapleau ON P0M 1K0
t: 705.860.9200
f: 705.864.0820

Toll-free / Sans frais
1.866.522.9200

phsd.ca

WHEREAS the northeast public health entity is the only one of ten proposed regional entities that would not respect existing health unit boundaries and would require the costly dissolution of existing health units; and

WHEREAS the demographics, socioeconomic status, health status, and important health care referral patterns of the Muskoka District are all distinct from those of the northeast; and

WHEREAS the proposed northeast public health entity is a massive area (402,489 km^2) with significant administrative and geographic complexities, for which the incorporation of an additional distinct area would tax the region's ability to respond appropriately to diverse public health needs; and

WHEREAS the Board of Health for SMDHU having expressed similar observations, is requesting the support of northeast boards of health for their position that SMDHU remain intact as they transition to a new regional entity;

THEREFORE be it resolved that the Board of Health for Public Health Sudbury & Districts endorse the position of the Board of Health for SMDHU that the organization of their public health services remains intact as they transition to the new regional public health entity.

Thank you very much for your attention to this important matter. The Board of Health is working hard with regional counterparts to be able to engage constructively with the anticipated Ministry of Health and Long-Term Care consultation process over the next number of months.

Sincerely,

René Lapierre
Chair, Board of Health

cc: Honorable C. Elliott, Deputy Premier and Minister of Health and Long-Term Care
Dr. D. Williams, Chief Medical Officer of Health, Ministry of Health and Long-Term Care
L. Ryan, Executive Director, Association of Local Public Health Agencies
J. McGarvey, President, Association of Municipalities Ontario
F. Gélinas, MPP Nickel Belt
M. Mantha, MPP Algoma-Manitoulin
J. West, MPP Sudbury
J. Vanthof, MPP Timiskaming, Cochrane
Ontario Boards of Health

June 4, 2019

The Honourable Doug Ford
Premier of Ontario
Premier's Office
Room 281
Legislative Buidling, Queen's Park
Toronto, ON M7A 1A1

Re: Modernization of alcohol retail sales in Ontario

On May 24, 2019 at a regular meeting of the Board for the Grey Bruce Health Unit, the Board considered the attached motion from Peterborough Public Health urging the Government of Ontario to develop a comprehensive, province-wide strategy to minimize alcohol-related harm and support for safer consumption of alcohol in the province. The following motion was passed:

GBHU BOH Motion 2019-33

Moved by: Anne Eadie Seconded by: Selwyn Hicks
"THAT, the Board of Health support the correspondence from Peterborough Public Health with respect to developing a provincial strategy to minimize alcohol-related harm and safer consumption of alcohol in Ontario."

Carried

Sincerely,

Mitch Twolan
Chair, Board of Health
Grey Bruce Health Unit

Encl.

Cc: The Honourable Christine Elliot, Minister of Health and Long-Term Care, Deputy Premier
Larry Miller, MP Bruce-Grey-Owen Sound

Kellie Leitch, MP Simcoe-Grey
Ben Lobb, MP Huron-Bruce
Bill Walker, MPP Bruce-Grey-Owen Sound
Lisa Thompson, MPP Huron-Bruce
Jim Wilson, MPP Simcoe-Grey
Association of Local Public Health Agencies
Ontario Health Units

Peterborough Public Health
1889-2019 LOCAL & STRONG

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

May 1, 2019

The Honourable Doug Ford
Premier of Ontario
Legislative Building, Queen's Park
Toronto, ON M7A 1A1
Sent via e-mail: doug.ford@pc.ola.org

Dear Premier Ford:

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

On behalf of the Peterborough Public Health (PPH) Board of Health, I am writing to call on the Government of Ontario to develop a comprehensive, province-wide strategy to minimize alcohol-related harm and support safer consumption of alcohol in the province.

Alcohol is a legal psychoactive substance, not a regular commodity. As with other psychoactive substances, alcohol causes changes in perception and behaviour and its use exists on a spectrum from beneficial, to problematic, to chronic dependence. Recent statistics show that approximately 21% of Ontarians who drink exceed the low-risk alcohol drinking guidelines[1], a key modifiable risk factor of chronic diseases and injuries and their associated health care costs.

The costs of alcohol are significant. In 2014, Ontario spent $5.3 billion on alcohol-related harms; more than any other substance including tobacco, cannabis and opioids.[2] In the same year net revenue from alcohol amounted to only $3.9 billion, representing a net annual loss of over $1.4 billion.[3] Since 2015, alcohol use has contributed to more than 43,000 emergency room visits and 66 hospitalizations per day, a significant and avoidable burden on Ontario's healthcare system.[4]

It is well established that increasing access to alcohol is related to a subsequent increase in alcohol use[5], which in turn increases the potential for rising harms and costs. A comprehensive provincial alcohol strategy can help support a culture of moderation and mitigate the potential harms and costs of alcohol use. Such a strategy should include:

- Strong policies to minimize the potential health and social harms of alcohol consumption;
- Strategies to enhance alcohol treatment and harm-reduction programs;
- An improved monitoring system to track alcohol-related harms;
- Rigorous enforcement of alcohol marketing regulations, and;
- Public education and awareness campaigns aimed at changing attitudes and social norms around consumption.

The Ontario Government has committed to putting more money in people's pockets, and cutting hospital wait times and ending hallway healthcare as part of the 2019 Ontario Budget.[6] Given the significant costs associated with alcohol consumption, which are shouldered by both individual taxpayers and government systems, these commitments risk being undermined by recent and anticipated changes to provincial alcohol policy, including: reducing the minimum retail price of beer to $1.00, halting the annual inflation-indexed increase in the beer tax, extending the hours of sale for alcohol retail outlets, permitting municipalities to designate public areas for consumption of alcohol, advertising happy hour, and creating a tailgating permit for eligible sporting events including post-secondary events.

We echo the call from the Canadian Centre for Substance Use Research which, in the 2019 review of alcohol policies across Canada, identified that "in light of the on-going expansion of alcohol availability in Ontario the development and implementation of an alcohol-specific government-endorsed strategy should be given high priority".[7] In doing so, Ontario would join Alberta, Nova Scotia, and Nunavut as leaders in this important domain of alcohol policy.[8]

We believe it is possible to create a healthy alcohol culture in Ontario that balances interests in public health, government revenue, economic development, and consumer preferences without sacrificing the health of Ontarians. We support both the Council of Ontario Medical Officers of Health and Association of Local Public Health Agencies' request to ensure such a balance, and we thereby encourage the government to develop a provincial alcohol strategy that incorporates health goals. Now is the time for Ontario to take leadership and address the harms of alcohol use in our province.

Thank you for your consideration.

Sincerely,

Original signed by

Councillor Kathryn Wilson
Chair, Board of Health

/ag

cc: Hon. Christine Elliott, Deputy Premier and Minister of Health and Long-Term Care
Hon. Vic Fedeli, Minister of Finance
Ken Hughes, Special Advisor for the Beverage Alcohol Review
Dr. David Williams, Chief Medical Officer of Health for Ontario
Local MPPs
Association of Local Public Health Agencies
Ontario Boards of Health

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[1] Canadian Tobacco, Alcohol and Drugs Survey. (2017). Table 18 Alcohol Indicators by province 2017. Accessed from: https://www.canada.ca/en/health-canada/services/canadian-tobacco-alcohol-drugs-survey/2017-summary/2017-detailed-tables.html#t18
[2] Canadian Centre for Substance Use and Addiction. (2019). Canadian substance Use Costs and Harms. Accessed from: https://csuch.ca/
[3] Canadian Institute for Substance Use Research. (2019). Reducing Alcohol-Related Harms and Costs in Ontario: A Policy Review.
[4] Ontario Public Health Association. (2018) The Facts: Alcohol Harms and Costs in Ontario.

[5] Popova, S., Giesbrecht, N., Bekmuradov, D. & Petra, J. (2009) Hours and days of sale and density of alcohol outlets: Impacts of alcohol consumption and damage: A systematic review. Alcohol and Alcoholism, 44(5), 500-516.
[6] Province of Ontario. (2019). 2019 Ontario Budget: Protecting What Matters Most. Accessed from: http://budget.ontario.ca/2019/foreword.html#section-0
[7] Canadian Institute for Substance Use Research. (2019). Reducing Alcohol-Related Harms and Costs in Ontario: A Policy Review.
[8] Canadian Institute for Substance Use Research. (2019). Canadian Alcohol Policy Evaluation (CAPE). Accessed from: https://www.uvic.ca/research/centres/cisur/projects/active/projects/canadian-alcohol-policy-evaluation.php

June 4, 2019

The Honourable Doug Ford
Premier of Ontario
Premier's Office
Room 281
Legislative Buidling, Queen's Park
Toronto, ON M7A 1A1

Re: Endorsement of the Children Count Task Force Recommendations

On May 24, 2019 at a regular meeting of the Board for the Grey Bruce Health Unit, the Board considered the attached motion from Kingston, Frontenac and Lennox & Addington Board of Health endorsing the Children Count Task Force Recommendations. The following motion was passed:

GBHU BOH Motion 2019-32

Moved by: Laurie Laporte Seconded by: Brian Milne
"THAT, the Board of Health support the correspondence from Kingston, Frontenac and Lennox & Addington Public Health endorsing the Children Count Task Force Recommendations."

Carried

Sincerely,

Mitch Twolan
Chair, Board of Health
Grey Bruce Health Unit

Encl.

Cc: The Honourable Christine Elliot, Minister of Health and Long-Term Care, Deputy Premier
The Honourable Lisa Thompson, Minister of Education, MPP Huron-Bruce

The Honourable Lisa MacLeod, Minister of Children, Community and Social Services and Minister Responsbile for Women's Issues
Larry Miller, MP Bruce-Grey-Owen Sound
Kellie Leitch, MP Simcoe-Grey
Ben Lobb, MP Huron-Bruce
Bill Walker, MPP Bruce-Grey-Owen Sound
Jim Wilson, MPP Simcoe-Grey
Association of Local Public Health Agencies
Ontario Health Units

KFL&A Public Health

April 25, 2019

VIA: Electronic Mail (doug.ford@pc.ola.org)

Honourable Doug Ford
Premier of Ontario
Premier's Office
Room 281
Legislative Building, Queen's Park
Toronto, ON M7A 1A1

Dear Premier Ford:

RE: Endorsement of the Children Count Task Force Recommendations

The Kingston, Frontenac and Lennox & Addington (KFL&A) Board of Health passed the following motion at its April 24, 2019 meeting:

That the KFL&A Board of Health endorse the Children Count Task Force Recommendations and send correspondence to:

1) **The Honourable Doug Ford, Premier of Ontario**
2) **The Honourable Christine Elliott, Minister of Health and Long-Term Care, Deputy Premier**
3) **The Honourable Lisa Thompson, Minister of Education**
4) **The Honourable Lisa MacLeod, Minister of Children, Community and Social Services and Minister Responsible for Women's Issues**
5) **Ian Arthur, MPP Kingston and the Islands**
6) **Randy Hillier, MPP Lanark-Frontenac-Kingston**
7) **Daryl Kramp, MPP Hastings-Lennox and Addington**
8) **Loretta Ryan, Association of Local Public Health Agencies**
9) **Ontario Boards of Health**

At present, there are approximately 50 federal programs collecting health data on the Canadian population, many of which include school age children and youth. Notwithstanding the number of sources, data collected from these surveys are not always collected in a way that provides representative results at the regional and local levels. As such, Ontario needs a coordinated and cost-effective system for measuring the health and well-being of children and youth to inform local, regional and provincial programming. Such a system will enable stakeholders at all levels (local, regional and provincial) to effectively measure the health and well-being of our kids, and in turn, the return on investment in relevant programs.

To address this gap, the Children Count Task Force has made one overarching recommendation, which is to create a secretariat responsible for overseeing the implementation of the systems, tools, and resources required to improve the surveillance of child and youth health and well-being in Ontario. To further support this secretariat, the task force made an additional five recommendations:

- **Recommendation 1**: Create an interactive web-based registry of database profiles resulting from child and youth health and well-being data collection in Ontario schools.
- **Recommendation 2**: Mandate the use of a standardized School Climate Survey template in Ontario schools and a coordinated survey implementation process across Ontario.
- **Recommendation 3**: Develop and formalize knowledge exchange practice through the use of centrally coordinated data sharing agreements.
- **Recommendation 4**: Develop and implement a centralized research ethics review process to support research activities in Ontario school boards.
- **Recommendation 5**: Work with the Information and Privacy Commissioner (IPC) of Ontario to develop a guideline for the interpretation of privacy legislation related to student health and well-being data collection in schools.

The KFL&A Board of Health urges the Government of Ontario to act on the recommendations from the Children Count Task Force.

Yours truly,

Denis Doyle, Chair
KFL&A Board of Health

Copy to: The Honourable Christine Elliott, Minister of Health and Long-Term Care, Deputy Premier
The Honourable Lisa Thompson, Minister of Education
The Honourable Lisa MacLeod, Minister of Children, Community and Social Services and Minister Responsible for Women's Issues
Ian Arthur, MPP Kingston and the Islands
Randy Hillier, MPP Lanark-Frontenac-Kingston
Daryl Kramp, MPP Hastings-Lennox and Addington
Loretta Ryan, Association of Local Public Health Agencies
Ontario Boards of Health

June 4, 2019

The Honourable Doug Ford
Premier of Ontario
Premier's Office
Room 281
Legislative Buidling, Queen's Park
Toronto, ON M7A 1A1

Re: Minimizing harms associated with the announced expansion of the sale of beverage alcohol in Ontario

On May 24, 2019 at a regular meeting of the Board for the Grey Bruce Health Unit, the Board considered the attached motion from Kingston, Frontenac and Lennox & Addington Board of Health urging the Government of Ontario to outline the actions they will take to implement their commitment to safe and responsible sale and consumption of alcohol in Ontario. The following motion was passed:

GBHU BOH Motion 2019-31

Moved by: Anne Eadie Seconded by: Selwyn Hicks
"THAT, the Board of Health support the correspondence from Kingston, Frontenac and Lennox & Addington Public Health urging the provincial government to ensure a plan to address safe and responsible sale and consumption of alcohol in Ontario."

Carried

Sincerely,

Mitch Twolan
Chair, Board of Health
Grey Bruce Health Unit

Encl.

Cc: The Honourable Christine Elliot, Minister of Health and Long-Term Care, Deputy Premier
The Honourable Lisa Thompson, Minister of Education, MPP Huron-Bruce
The Honourable Lisa MacLeod, Minister of Children, Community and Social Services and Minister Responsbile for Women's Issues
Larry Miller, MP Bruce-Grey-Owen Sound
Kellie Leitch, MP Simcoe-Grey
Ben Lobb, MP Huron-Bruce
Bill Walker, MPP Bruce-Grey-Owen Sound
Jim Wilson, MPP Simcoe-Grey
Association of Local Public Health Agencies
Ontario Health Units

KFL&A Public Health

April 25, 2019

VIA: Electronic Mail (doug.ford@pc.ola.org)

Honourable Doug Ford
Premier of Ontario
Premier's Office
Room 281
Legislative Building, Queen's Park
Toronto, ON M7A 1A1

Dear Premier Ford:

RE: Minimizing harms associated with the announced expansion of the sale of beverage alcohol in Ontario

The Kingston, Frontenac and Lennox & Addington (KFL&A) Board of Health passed the following motion at its April 24, 2019 meeting:

THAT the KFL&A Board of Health ask the Government of Ontario to outline the actions that they will take to implement their commitment to the safe and responsible sale and consumption of alcohol in Ontario as noted in the 2019 provincial budget; and

THAT the KFL&A Board of Health strongly urge the provincial government to ensure that any plan to address the safe and responsible sale and consumption of beverage alcohol include a wide range of evidence-based policies including: implementing alcohol pricing policies, controlling physical and legal availability, curtailing alcohol marketing, regulating and monitoring alcohol control systems, countering drinking and driving, educating and promoting behaviour change, increasing access to screening and brief interventions, and surveillance, research and knowledge exchange, and that this plan be funded, and monitored for effectiveness; and

THAT the KFL&A Board of Health ask the Government of Ontario to indicate how much alcohol consumption will increase with the proposed expansion over the next five years, how much this increased consumption will cost the justice, social and health care systems over the next five years, and the fiscal plan to pay for these anticipated costs;

AND FURTHER THAT correspondence be sent to:

1) **Honourable Doug Ford, Premier of Ontario**
2) **Honourable Vic Fedeli, Minister of Finance, Chair of Cabinet**
3) **Honourable Christine Elliot, Provincial Minister of Health and Long-term Care, Deputy Premier**
4) **Ian Arthur, MPP Kingston and the Islands**
5) **Randy Hillier, MPP Lanark-Frontenac-Kingston**
6) **Daryl Kramp, MPP Hastings-Lennox and Addington**

Kingston, Frontenac and Lennox & Addington Public Health www.kflaph.ca

Main Office 221 Portsmouth Avenue
Kingston, Ontario K7M 1V5
613-549-1232 | 1-800-267-7875
Fax: 613-549-7896

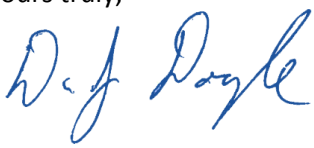
Branch Offices
Cloyne 613-336-8989 Fax: 613-336-0522
Napanee 613-354-3357 Fax: 613-354-6267
Sharbot Lake 613-279-2151 Fax: 613-279-3997

7) **Loretta Ryan, Association of Local Public Health Agencies**
8) **Dr. David Williams, Chief Medical Officer of Health, Ministry of Health and Long-term Care**
9) **Ontario Boards of Health**

The recent release of the 2019 Ontario budget includes a number of changes to increase the choice and convenience of beverage alcohol for consumers. However, this same document, while assuring Ontarians that safe and responsible sale and consumption of alcohol in Ontario is, and will continue to be, a top priority, the document does not include any specific action by the Government of Ontario to realize this goal. The KFL&A Board of Health would be pleased to hear the government's plans for safe and responsible sale and consumption of alcohol. Furthermore, there are many evidence-based strategies that protect and promote health that KFL&A Public Health would encourage the government to include in this plan.

In addition, evidence from other provinces have demonstrated that increases to the availability of alcohol had negative social and health outcomes, including increased alcohol-related traffic incidents and suicides. These are the short-term impacts of the over-consumption of alcohol. Longer term effects will result in increased chronic diseases such as cancers and heart disease both of which are costly to manage and treat. There is no reason to believe that the expansion of beverage alcohol sales in Ontario will not have the same result – an increase in alcohol consumption with the concomitant increase in health, social and justice services use, and hence, costs. The KFL&A Board of Health would also be pleased to hear from the provincial government regarding how much the increase in alcohol availability is anticipated to impact consumption and the use of health, social and justice services. Furthermore, the KFL&A Board of Health would ask that the government provide a plan for how these anticipated expenses will be funded.

Yours truly,



Denis Doyle, Chair
KFL&A Board of Health

Copy to: The Honourable Christine Elliott, Minister of Health and Long-Term Care, Deputy Premier
The Honourable Lisa Thompson, Minister of Education
The Honourable Lisa MacLeod, Minister of Children, Community and Social Services and Minister Responsible for Women's Issues
Ian Arthur, MPP Kingston and the Islands
Randy Hillier, MPP Lanark-Frontenac-Kingston
Daryl Kramp, MPP Hastings-Lennox and Addington
Loretta Ryan, Association of Local Public Health Agencies
Ontario Boards of Health

June 4, 2019

The Honourable Christine Elliott
Deputy Premier and Minister of Health and Long-Term Care
College Park, 5th Floor
777 Bay Street
Toronto ON M7A2J3

Re: Modernization of Alcohol Sales in Ontario

On May 24, 2019 at a regular meeting of the Board for the Grey Bruce Health Unit, the Board considered the attached motion from Simcoe Muskoka District Health Unit regarding their support for provincial action needed to address the potential health and social harms from the ongoing modernization of alcohol retail sales in Ontario. The following motion was passed:

GBHU BOH Motion 2019-30

Moved by: Anne Eadie Seconded by: Selwyn Hicks
"THAT, the Board of Health support the correspondence from Simcoe Muskoka District Health unit with respect to the need for a comprehensive provincial alcohol strategy."

Carried

Sincerely,

Mitch Twolan
Chair, Board of Health
Grey Bruce Health Unit

Encl.

Cc: Local MP's and MPP's
Association of Local Public Health Agencies
Ontario Health Units

simcoe muskoka
DISTRICT HEALTH UNIT

April 17, 2019

The Honourable Christine Elliott
Deputy Premier and Minister of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, Ontario M7A 2C4

Dear Minister Elliott:

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

On behalf of the Simcoe Muskoka District Health Unit (SMDHU) Board of Health, I am writing to urge the Government of Ontario to develop a comprehensive provincial alcohol strategy to mitigate harms and monitor the health impacts of increasing access and availability of alcohol in Ontario.

Alcohol costs to the individual and society are significant. In 2014, Ontario spent $5.34 billion on alcohol-related harms, including $1.5 billion for healthcare and $1.3 billion for criminal justice.[1] Since 2015, alcohol use has contributed to more than 43,000 emergency room visits and 66 hospitalizations per day, a significant and avoidable burden on Ontario's healthcare system.[2]

It is well established that increased alcohol availability leads to increased consumption and alcohol-related harms. A comprehensive, provincially led alcohol strategy can help mitigate the potential harms of alcohol use as the government liberalizes access. Such a strategy should include:

- Strong policies to minimize the potential health and social harms of alcohol consumption;
- An improved monitoring system to track alcohol-related harms;
- Rigorous enforcement of alcohol marketing regulations, and;
- Public education and awareness campaigns aimed at changing attitudes and social norms around consumption.

The Ontario Government has committed to ensure the health and safety of our communities as it increases the availability of alcohol; however, recent changes in the way alcohol is sold and the 2019 Ontario Budget 'Protecting What Matters Most' [3] released on April 11, 2019 suggest that economic interests are superseding the health and well-being of Ontarians and further diminishes the likelihood of meeting the goal of ending hallway medicine. Recent changes that raise the potential for increased alcohol-related harms include reducing the minimum retail price of beer to $1.00, halting the annual inflation-indexed increase in the beer tax, and extending the hours of sale for alcohol retail outlets. This is in conjunction with the anticipated changes of legislation permitting municipalities to designate public areas for consumption of alcohol, advertising happy hour and creating a tailgating permit for eligible sporting events including post-secondary events.

The SMDHU Board of Health has on numerous occasions sent advocacy letters to the provincial government to support healthy alcohol policy, most recently in 2017, calling on the government to

prioritize the health and well-being of Ontarians by enacting a comprehensive, evidence-based alcohol strategy.

We believe it is possible to create a healthy alcohol culture in Ontario that balances interests in public health, government revenue, economic development, and consumer preferences without sacrificing the health of Ontarians. We support both the Council of Ontario Medical Officers of Health and Association of Local Public Health Agencies' request to ensure such a balance, and we thereby encourage the government to develop a provincial alcohol strategy that incorporates health goals.[4, 5] This would include a monitoring and evaluation plan to measure intended and unintended impacts of policy change. Now is the time for Ontario to take leadership and address the harms of alcohol use in our province.

Thank you for your consideration.

Sincerely,

ORIGINAL Signed By:

Anita Dubeau
Chair, Board of Health

cc. Hon. Vic Fedeli, Minister of Finance
Ken Hughes, Special Advisor for the Beverage Alcohol Review
Doug Downey, MPP Barrie-Springwater-Oro-Medonte
Jill Dunlop, MPP Simcoe North
Andrea Khanjin, MPP Barrie-Innisfil
Norman Miller, MPP Parry Sound-Muskoka
Hon. Caroline Mulroney, MPP York-Simcoe
Jim Wilson, MPP Simcoe-Grey
Dr. David Williams, Chief Medical Officer of Health for Ontario
Loretta Ryan, alPHa Executive Director
Ontario Boards of Health

References

1. The Canadian Centre on Substance Use and Addiction. (2018) Canadian Substance Use Costs and Harms in the Provinces and Territories (2007–2014)
2. Ontario Public Health Association. (2018) The Facts: Alcohol Harms and Costs in Ontario.
3. Ministry of Finance of the Ontario Government, 2019 Ontario Budget Protecting What Matters Most, April 11, 2019 , Honourable Victor Fedeli
4. Council of Ontario Medical Officers of Health, Re: Alcohol Choice & Convenience Roundtable Discussions [Letter written March 14, 2019 to Honorable Vic Fedeli].
5. Association of Local Public Health Agencies, Re: Alcohol Choice & Convenience Roundtable Discussions [Letter written March 8, 2019 to Honorable Vic Fedeli].

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PO Box 1090
New Liskeard, ON P0J 1P0
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Branch Offices:
Englehart Tel.: 705-544-2221 Fax: 705-544-8698
Kirkland Lake Tel.: 705-567-9355 Fax: 705-567-5476

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June 4, 2019

The Honourable Christine Elliott
Ministry of Health & Long-Term Care
Hepburn Block, 10th Floor
80 Grosvenor Street
Toronto ON M7A 2C4

Dear Minister Elliott:

Re: Northeastern Regional Public Health Regional Boundaries

On May 29, 2019, at a regular meeting of the Board for the Timiskaming Health Unit, the Board passed the following motion:

Motion 35R-2019
Moved by: Sue Cote
Seconded by: Mike McArthur

That the BOH for Timiskaming send a letter to the Ontario Minister of Health to support the motion passed by the Sudbury and Districts Health Unit which endorses the position of the Board of Health for the Simcoe Muskoka District Health Unit that the organization of their public health services remains intact as they transition to the new regional public health entity. Further, the BOH for Timiskaming asks that this letter be copied to the local MPP, Chief Medical Officer of Health for Ontario, the Premier of Ontario, the Association of Local Public Health Agencies and all Ontario Boards of Health.

Carried

Sincerely,

Chair Carman Kidd
Timiskaming Board of Health

cc. Honorable Doug Ford, Premier of Ontario
Mr. John Vanthof, MPP, Timiskaming-Cochrane
Mrs. Linda Stewart, Association of Local Public Health Agencies
Ontario Boards of Health
Dr. David Williams, Chief Medical Officer of Health

Public Health
Santé publique
SUDBURY & DISTRICTS

May 28, 2019

VIA ELECTRONIC MAIL

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

Dear Premier:

Re: North East Public Health Regional Boundaries – Modernization of the Ontario Public Health System

At its meeting on May 16, 2019, the Board of Health for Public Health Sudbury & Districts carried the following resolution #17-19:

WHEREAS the Health Protection and Promotion Act amendment effective April 1, 2005, enabled the merger of the Muskoka-Parry Sound Health Unit with the Simcoe County District Health Unit and with the North Bay & District Health Unit; and

WHEREAS North Bay Parry Sound District Health Unit and Simcoe Muskoka District Health Unit (SMDHU) have invested greatly since that time to successfully transition to their respective new agencies; and

WHEREAS the new public health entity for northeastern Ontario is proposed to include the existing public health units in the region (Algoma Public Health, Public Health Sudbury & Districts, Porcupine Health Unit, North Bay Parry Sound District Health Unit, Timiskaming Health Unit) along with Muskoka District and a part of Renfrew; and

Sudbury
1300 rue Paris Street
Sudbury ON P3E 3A3
t: 705.522.9200
f: 705.522.5182

Rainbow Centre
10 rue Elm Street
Unit / Unité 130
Sudbury ON P3C 5N3
t: 705.522.9200
f: 705.677.9611

Sudbury East / Sudbury-Est
1 rue King Street
Box / Boîte 58
St.-Charles ON P0M 2W0
t: 705.222.9201
f: 705.867.0474

Espanola
800 rue Centre Street
Unit / Unité 100 C
Espanola ON P5E 1J3
t: 705.222.9202
f: 705.869.5583

Île Manitoulin Island
6163 Highway / Route 542
Box / Boîte 87
Mindemoya ON P0P 1S0
t: 705.370.9200
f: 705.377.5580

Chapleau
101 rue Pine Street E
Box / Boîte 485
Chapleau ON P0M 1K0
t: 705.860.9200
f: 705.864.0820

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1.866.522.9200

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WHEREAS the northeast public health entity is the only one of ten proposed regional entities that would not respect existing health unit boundaries and would require the costly dissolution of existing health units; and

WHEREAS the demographics, socioeconomic status, health status, and important health care referral patterns of the Muskoka District are all distinct from those of the northeast; and

WHEREAS the proposed northeast public health entity is a massive area (402,489 km^2) with significant administrative and geographic complexities, for which the incorporation of an additional distinct area would tax the region's ability to respond appropriately to diverse public health needs; and

WHEREAS the Board of Health for SMDHU having expressed similar observations, is requesting the support of northeast boards of health for their position that SMDHU remain intact as they transition to a new regional entity;

THEREFORE be it resolved that the Board of Health for Public Health Sudbury & Districts endorse the position of the Board of Health for SMDHU that the organization of their public health services remains intact as they transition to the new regional public health entity.

Thank you very much for your attention to this important matter. The Board of Health is working hard with regional counterparts to be able to engage constructively with the anticipated Ministry of Health and Long-Term Care consultation process over the next number of months.

Sincerely,

René Lapierre
Chair, Board of Health

cc: Honorable C. Elliott, Deputy Premier and Minister of Health and Long-Term Care
Dr. D. Williams, Chief Medical Officer of Health, Ministry of Health and Long-Term Care
L. Ryan, Executive Director, Association of Local Public Health Agencies
J. McGarvey, President, Association of Municipalities Ontario
F. Gélinas, MPP Nickel Belt
M. Mantha, MPP Algoma-Manitoulin
J. West, MPP Sudbury
J. Vanthof, MPP Timiskaming, Cochrane
Ontario Boards of Health

simcoe muskoka
DISTRICT HEALTH UNIT

May 15, 2019

The Honourable Christine Elliott
Deputy Premier and Minister of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4

Dear Minister Elliott:

I am writing on behalf of the Board of Health for the Simcoe Muskoka District Health Unit (SMDHU) to recommend that the full territory of SMDHU remain intact and join with York Region to form a new regional public health entity on April 1, 2020. This is in response to information provided verbally to Dr. Charles Gardner, Medical Officer of Health for SMDHU by staff from the Ministry of Health and Long - Term Care on May 7th, 2019 indicating that public health services in the District of Muskoka will be provided by a regional public health entity that will also serve Sudbury, North Bay, Parry Sound, Algoma, Porcupine, Timiskaming and part of Renfrew; he also was informed that Simcoe County will be served by a public health entity that will also serve York Region. From this communication it is also Dr. Gardner's understanding that the provincial government is willing to consider feedback on these boundary changes. The Board appreciates having the opportunity to recommend that all of the territory served by SMDHU be combined with that of York Region in a new regional public health entity.

The Board and staff have worked very hard since the inception of SMDHU (the result of a merger prompted by the province in 2005) in order to create a cohesive public health agency that is highly successful in fulfilling its mandate. The District of Muskoka benefits from public health services provided in partnership with Simcoe County. The division of our Muskoka and Simcoe operations would disrupt and undermine program delivery.

The geographic area of the proposed *northeastern regional public health entity* is extremely large (over 400,000 kilometers, extending to James Bay). Providing public health services over such a large and low density area will be very challenging, and it will be very difficult for the governance and management of such a regional public health entity to provide attention to local service provision. The provision of public health services in the District of Muskoka would be more challenging within this very large public health entity than they would be if Muskoka were to join Simcoe County in a regional public health entity with York Region. The provision of public health services for the remaining communities in the proposed *northeastern regional public health entity* would also be further challenged with the addition of Muskoka to their territory.

The inclusion of the District of Muskoka with Simcoe County and York Region in a single public health entity would also be consistent with the observation that in general, the community and health care service referral patterns in Muskoka are directed to facilities in Simcoe County (Barrie and Orillia), and to communities further south (including in York Region).

Finally, of great concern to the Board is the reality that the division of Muskoka from Simcoe would greatly increase the complexity, cost and duration of time required for the creation of the new public health entities, compared with having Muskoka and Simcoe join together with the public health services in York Region. A merger between SMDHU and York Region would be complex on its own, however the splitting of our operations between Simcoe and Muskoka at the same time as mergers both with York, and with six other health units to the north would be overwhelming in its complexity.

Given the inherent and substantial disadvantages of dividing Simcoe and Muskoka, the Board recommends that SMDHU join in its entirety with York Region in the modernization of public health.

Thank you for considering our recommendation.

Sincerely,

ORIGINAL Signed By:

Anita Dubeau
Chair, Board of Health

CG:cm

cc. Mayor and Council of Simcoe and Muskoka
Members of Provincial Parliament for Simcoe and Muskoka
Boards of Health for York Region, Sudbury, North Bay, Parry Sound, Algoma, Porcupine, Timiskaming, and Renfrew
Loretta Ryan, Executive Director, Association of Local Public Health Agencies
Dr. David Williams, Chief Medical Officer of Health
Central Local Health Integration Network
North Simcoe Muskoka Local Health Integration Network

KFL&A Public Health

June 4, 2019

VIA: Electronic Mail (doug.ford@pc.ola.org)

Honourable Doug Ford
Premier of Ontario
Premier's Office
Room 281
Legislative Building, Queen's Park
Toronto, ON M7A 1A1

Dear Premier Ford:

RE: Announcement re: Reversing Retroactive Funding Cuts to Municipal Funding

The Kingston, Frontenac and Lennox & Addington (KFL&A) Board of Health is extremely pleased with the provincial government's decision to reverse retroactive funding changes to municipalities, and commitment to working with municipalities and Boards of Health to find ways to reduce spending.

The Board is cognizant that there is a deficit at the provincial level and a need to work collaboratively and creatively with the provincial government to find efficiencies in multiple areas, including public health. In so doing, KFL&A Public Health commits to continued work with the government in this regard.

KFL&A Public Health looks forward to the opportunity to work collaboratively with the Province of Ontario, ensuring the core public health functions will be preserved and leveraged to help reorient the health system, creating efficiencies in health care through protection from disease and promotion of health, to reduce hallway medicine and keep the people of Ontario healthy.

Yours truly,

Denis Doyle, Chair
KFL&A Board of Health

Copy to: The Honourable Christine Elliott, Minister of Health and Long-Term Care, Deputy Premier
The Honourable Steve Clark, Minister of Municipal Affairs and Housing
Ian Arthur, MPP Kingston and the Islands
Randy Hillier, MPP Lanark-Frontenac-Kingston
Daryl Kramp, MPP Hastings-Lennox and Addington
Todd Smith, MPP Bay of Quinte
Loretta Ryan, Association of Local Public Health Agencies
Ontario Boards of Health

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June 5, 2019

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

Dear Minister Elliott,

RE: Proposed changes to Public Health in Ontario

Public Health is a key function in the lives of people in Ontario. The work done by local Public Health agencies is cornerstone support to keeping people healthy and helping to reduce the load and expense incurred in the regular primary care system. Education and information dissemination are vital components for preventing disease transmission and promoting the overall healthy lifestyle that Ontarians need to maintain a good quality of life. As you are aware, public health programs and services are focused primarily in four domains: Social Determinants of Health; Healthy Behaviours; Healthy Communities; and Population Health Assessment.

The Board of Algoma Public Health would like to voice its concern over the recent changes that have been suggested and implemented to public health in Ontario. The Board is asking the Ministry to seriously look at how funding cuts and regionalization if they must occur, will be implemented based on historical and current health needs/concerns and common socio-economic factors which are extremely important determinants to public health goals and directives.

Public health has been stretched thin and underfunded for many years and has been able to efficiently meet the goals and standards given to it by the Province. Any reduction would have a serious consequence and jeopardize the health of all citizens in our area. Front line staff are vital. Funding cuts or redistribution of funds across a larger region would have an immediate impact upon access programs and goals that are vital to support our communities in the North. While there are similarities in population needs, there are also great differences in access and importance. "The work is diverse, including individual clinical service delivery, education, inspection, surveillance, and policy development, among other activities." (Minister of Health and Long-Term Care, pursuant to Section 7 of the Health Protection and Promotion Act. Revised: July 1, 2018) How is this to be settled with fewer funds and a larger area?

The board considers these specific issues of significant importance during a potential restructuring process:
• Guarantee that service levels in Algoma will be maintained, with no service losses nor reduction to quality of care.

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

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

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

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

• Ensure meaningful involvement by the communities, municipalities, First Nations and networked organizations throughout Algoma if a change happens.
• Improve the effectiveness of collaboration by grouping health unit populations together that make sense. Take into account geography and whether the necessary the socioeconomic and health issues of areas are compatible over the long term.
• Ensure any regional Public Health Agency would maintain proper administrative ”back office” positions to meet the needs of employees and public welfare in a timely fashion and are of equal quality to the standards currently in place.
• Ensure that Algoma District has a strong voice in whatever governance structure is put in place should a regionalization come about.

Algoma Public Health has worked diligently to develop local partnerships with Municipalities and stakeholders so that a web of support can be created for all citizens, whether urban, rural or remote parts of the district. “No wrong number to call for assistance” is a pledge that was mentioned at a recent Board meeting when discussing access to resources from our catchment area and a commitment that each stakeholder shares. Regionalization must be able to maintain or enhance this standard to allow for all people in Algoma and the newly created area or it will have failed to live up to the basic purpose of public health: The work is diverse, including individual clinical service delivery, education, inspection, surveillance, and policy development, among other activities..

Reductions, efficiencies and regionalization all have pros and cons. We would ask that the Ministry of Health and Long-term Care and the Provincial Government take more time to consult with all stakeholders in an in-depth way to make sure the changes that may follow are done with careful thought and planning for each area of the province. One model applied based on numbers or geography is not the answer.

On behalf of the Board for Algoma Public Health, I look forward to hearing from you and working together to move public health in Ontario forward to meet the needs of people in Algoma and all across the province.

Sincerely,

Lee Mason
Board of Health Chair for the
District of Algoma Health Unit

Cc (via email): Minister of Health – Ginette Petitpas Taylor
R. Romano, MPP Sault Ste. Marie
M. Mantha, MPP Algoma-Manitoulin
J. West, MPP Sudbury
J. Vanthof, MPP Timiskaming, Cochrane
A. Horwath, Leader, Official Opposition
F. Gélinas, MPP Nickel Belt
Dr. D. Williams, Chief Medical Officer of Health, Ministry of Health and Long-Term Care
J. Stevenson, NE LHIN CEO
Ontario Boards of Health
Councils of Algoma municipalities

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Board of Health

DATE: April 24, 2019	**RESOLUTION NO.: 2019 - 41**
MOVED: K. Raybould	**SECONDED: A. Kappes**
SUBJECT: Board of Health letter regarding changes to Public Health	

Resolution:

That the Board of Health of Algoma send a notice of concern related to the proposed changes to Public Health.

Whereas the role of public health is to promote health, prevent and control chronic diseases and injuries, prevent and control infectious diseases, prepare for and respond to public health emergencies.

Whereas public health is primarily focused on the social determinants of health, healthy behaviors, healthy communities and population health assessment.

Whereas section 5 of the Health Protection and Promotion Act gives boards of health power to ensure community sanitation and the prevention or elimination of health hazards; provision of safe drinking water systems, control of infectious and diseases of public health significance including immunization; health promotion, health protection, and disease and injury prevention; family health; collection and analysis of epidemiological data, and such additional health programs such as mental health and opioid prevention programs.

Whereas the work of public health is best done in the local urban and rural settings in partnership with government, nongovernment, community, Indigenous communities (inclusive of First Nations [Status and Non-Status], Métis, Inuit, and those who self-identify as Indigenous) to work together to address their public health needs.

Whereas the 12 great achievements of public health are acting on the social determinants of health, control of infectious diseases, decline in deaths from coronary heart disease and stroke, family planning, healthier environments, healthier mothers and babies, motor-vehicle safety, recognition of tobaccos use as a health hazard, safer and healthier foods, safer workplaces, universal policies, and vaccination. (Canadian Public Health Association)

Whereas the province of Ontario is in the midst of an opioid crisis, where the underlying issues include social determinants of health, upon which public health focuses.

Whereas the current provincial government proposes to amalgamate 35 health units into 10 provincial entities.

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

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

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

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

Whereas the health of Ontarians may be put at risk.

Now therefore be it resolved that the Board of Health for Algoma Public Health Board write to the Minister of Health and Long-Term Care and to local Members of Provincial Parliament in Algoma to voice their concern over the amalgamation of health units and how it will impact the health of Ontarians, and;

Be it further resolved correspondence of this resolution be copied to the Federal Minister of Health, Members of parliament of northeastern Ontario, the leader of the official opposition, the health critic of both provincial parties, The Chief Medical Officer of Health of Ontario, the Boards of Health throughout Ontario, the councils of Algoma municipalities, and the North East LHIN CEO.

CARRIED: Chair's Signature: Lee Mason

☐ **Patricia Avery**	☐ **Micheline Hatfield**	☐ **Ed Pearce**
☐ **Louise Caicco Tett**	☐ **Adrienne Kappes**	☐ **Brent Rankin**
☐ **Randi Condie**	☐ **Lee Mason**	☐ **Karen Raybould**
☐ **Deborah Graystone**	☐ **Heather O'Brien**	☐ **Mathew Scott**

Algoma PUBLIC HEALTH
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Board of Health

DATE: May 22, 2019	**RESOLUTION NO.: 2019 - 47**
MOVED: H. O'Brien	**SECONDED: D. Graystone**
SUBJECT: Supporting Simcoe-Muskoka regarding proposed regional boundary	

Resolution:

Be it resolved that the Board of Health for Algoma shall send a letter of support to the Deputy Premier and Minister of Health and Long-Term care for the position of Simcoe-Muskoka as stated in their letter petitioning the MOH to keep their Health Unit territory intact and merge with the York Region rather than the Northeastern Regional Public Health entity.

CARRIED: Chair's Signature: Lee Mason

☐ **Patricia Avery**	☐ **Micheline Hatfield**	☐ **Ed Pearce**
☐ **Louise Caicco Tett**	☐ **Adrienne Kappes**	☐ **Brent Rankin**
☐ **Randi Condie**	☐ **Lee Mason**	☐ **Karen Raybould**
☐ **Deborah Graystone**	☐ **Heather O'Brien**	☐ **Mathew Scott**

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Kirkland Lake Tel.: 705-567-9355 Fax: 705-567-5476

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June 6, 2019

VIA ELECTRONIC MAIL

The Honourable Christine Elliott
Ministry of Health & Long-Term Care
Hepburn Block, 10th Floor
80 Grosvenor Street
Toronto ON M7A 2C4

Dr. David Williams
Chief Medical Officer of Health
5775 Yonge Street - 16th Floor
Toronto, ON M7A 2E5

Dear Minister Elliott and Dr. Williams:

Re: North East Public Health Collaboration Project

At its May 29, 2019 meeting, the Timiskaming Board of Health carried the following motion 34R-2019 to support the following resolution:

WHEREAS since November 2017, the boards of health in Northeastern Ontario, namely the Boards for Algoma Public Health, Public Health Sudbury & Districts, Porcupine Health Unit, North Bay Parry Sound District Health Unit, and Timiskaming Health Unit, have proactively and strategically engaged in the *Northeast Public Health Collaboration Project* to identify opportunities for collaboration and potential shared services; and

WHEREAS the *Northeast Public Health Collaboration Project* work to date has been supported by two one-time funding grants from the Ministry of Health and Long-Term Care (MOHLTC); and

WHEREAS subsequent to the proposed transformation of public health announced in the April 11, 2019 provincial budget, the work of the Collaboration has been accelerated and reoriented as the *Northeast Public Health Transformation Initiative* with the vision of a healthy northeastern Ontario enabled by a coordinated, efficient, effective, and collaborative public health entity; and

WHEREAS the Board understands there will be opportunities for consultation with the MOHLTC on the regional implementation of public health transformation;

THEREFORE be it resolved that the Board of Health for Timiskaming is committed to the continued collaboration of the boards of health in Northeastern Ontario and looks forward to ongoing MOHLTC support for this work;

AND FURTHER that the Board, having engaged in this work since 2017, anticipates sharing with the MOHLTC its experiences so that other regions may benefit and further anticipates providing to the Ministry its expert advice on public health functions and structures for the North East.

AND FURTHER that this motion be shared with the Ministry of Health and Long-Term Care, the Chief Medical Officer of Health, the MPP, Timiskaming-Cochrane and the NE Board of Health Chairs.

Sincerely,

Carman Kidd
Chair - Board of Health

HASTINGS PRINCE EDWARD
Public Health

Main Office – Belleville
179 North Park Street, Belleville, ON K8P 4P1
T: 613-966-5500 |1-800-267-2803 | **F:** 613-966-9418
TTY: 711 or 1-800-267-6511
www.hpePublicHealth.ca

June 06, 2019

The Honourable Doug Ford
Premier of Ontario
Legislative Building, Room 281 Queen's Park
Toronto, ON M7A 1A1

Dear Premier Ford:

Re: Concerns with announced expansion of the sale of alcohol beverage in Ontario

At our May 1, 2019 Board of Health meeting for Hastings Prince Edward, our members expressed concern regarding the announced expansion of the sale of beverage alcohol in Ontario. This letter highlights the basis for our concerns and expresses recommendations to address them.

It is well known that increased alcohol consumption is related to numerous health and social consequences that can be broadly categorized into acute or short-term harms such as violence, alcohol-related motor vehicle collisions, injuries and suicides, as well as chronic long-term health effects such as cancers, heart and liver disease. The provincial government's announced changes to Ontario's beverage alcohol policy will increase alcohol availability, lower prices, and increase exposure to alcohol promotion. Research has proven that with increased physical availability, pricing and alcohol advertising comes increased harms, adding to the burden on Ontario's healthcare, social and justice systems.

Hastings and Prince Edward County (HPEC) residents are not immune to these alcohol harms. Our latest data shows that in 2014, 44.4% of Hastings Prince Edward (HPE) adults (age 19+) exceeded the Low-Risk Alcohol Drinking Guidelines. In Ontario, the proportion of adults who are binge drinkers (exceeded Guideline 2 on at least one occasion in the previous year) is also increasing over time. In HPE, 41.6% of adults are binge drinkers. HPEC has higher overall rates of injury-related hospitalizations attributable to alcohol which include self-inflicted harm, falls and motor vehicle collisions when compared to Ontario and peer public health units as defined by Statistics Canada.

We are particularly concerned about our vulnerable residents, including youth, individuals living on low income and those with substance use concerns. The harms of

increasing financial and physical access to alcohol tend to concentrate within these specific populations. It is well known that alcohol is the most commonly used substance among grade 7-12 students in Ontario. Research demonstrates that alcohol consumption by youth and other vulnerable populations is strongly influenced by the density of alcohol outlets. Higher availability also facilitates alcohol becoming a normative commodity and experience. There is evidence that exposing young people to alcohol marketing can encourage some to start drinking at an earlier age and increase consumption in those individuals who already drink.

Canadian and international case studies demonstrate that an absence of, or government decision to loosen alcohol policies has significant, measurable impacts on alcohol consumption and related harms. Full and partial privatization of alcohol sales in Alberta and British Columbia (respectively) has been followed by significant increases in alcohol-related traffic incidents, suicides, deaths and lower compliance with age of sale policies. The World Health Organization (WHO) European Region lacked a coordinated alcohol strategy until 2011. As of 2018, the European Region still has the highest alcohol consumption and burden of numerous alcohol-related harms, including alcohol-attributable deaths, alcohol use disorders, injuries, and cancers compared to all other regions.

Alcohol policy that aims to increase choice and convenience relies heavily on the assumption that individuals will make decisions about their alcohol consumption based on their knowledge of its health and social harms. Interventions involving individual education and awareness-raising strategies have limited effectiveness without supportive policy level interventions. Policy measures that raise minimum pricing, limit privatization, and control alcohol availability are some of the most effective policies for preventing alcohol-related harms at a population level. Such policies help to create environments that support individuals to make low-risk decisions for alcohol consumption.

The evidence is clear. Increased access to alcohol results in increased harms. As part of your government’s commitment to make evidence-informed decisions to improve the lives of Ontarians and end hallway medicine, we ask you to reconsider the extensive expansion of beverage alcohol sale.

We do note that the report, “Increasing Choice and Expanding Opportunity in Ontario’s Alcohol Sector”, released May 27 2019, states that your government will be working with public health experts to ensure that any changes do not lead to increased social costs. We also note that, as stated in Bill 100, “Protecting What Matters Most Act (Budget Measures), 2019”, municipalities will be empowered to maintain their role in local policy-making which can assist in addressing alcohol-related harms. While the details of these plans currently remain to be determined, we are encouraged by these

statements. We support your commitment to safe and responsible consumption of alcohol and urge your government that any actions undertaken to achieve this use evidence-based policies and are funded and monitored for effectiveness.

We look forward to working with you on this important issue.

Sincerely,

Dr. Piotr Oglaza MD, CPHI(C), CCFP, MPH, FRCPC
Medical Officer of Health

Jo-Anne Albert
Chair, Board of Health

Copied to:
The Honourable Christine Elliot, Minister of Health and Long-Term Care, Deputy Premier
The Honourable Lisa Thompson, Minister of Education
The Honourable Vic Fedeli, Minister of Finance, Chair of Cabinet
Todd Smith, MPP (Bay of Quinte)
Daryl Kramp, MPP (Hastings-Lennox and Addington)
Loretta Ryan, Executive Director, Association of Local Public Health Agencies
Dr. David Williams, Chief Medical Officer of Health, Ministry of Health and Long-Term Care
Ontario Boards of Health
Andrea Horwath, Leader, Official Opposition MPP Hamilton- Centre
John Fraser, MPP Ottawa South

Public Health
Santé publique
SUDBURY & DISTRICTS

June 7, 2019

VIA EMAIL

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

Dear Minister Elliott:

Re: Public Mental Health – Parity of Esteem Position Statement

I am very pleased to highlight for you the recent decision of the Board of Health for Public Health Sudbury & Districts to formally adopt the Parity of Esteem Position Statement. The Position Statement asserts that public health equally values mental and physical health.

The Parity of Esteem Position Statement is in direct alignment with Bill 116 in its recognition that mental health is an essential element of health. We are very enthusiastic about the provisions within Bill 116 to establish a Mental Health and Addictions Centre of Excellence and to implement a mental health and addictions strategy with sustained commitment from all sectors and levels of government. Please be assured that the Board of Health for Public Health Sudbury & Districts is a committed local partner in this important work.

At its meeting on May 16, 2019, the Board of Health carried the following resolution #15-19:

> *WHEREAS* the Board of Health for Public Health Sudbury & Districts recognizes that there is no health without mental health; and
>
> *WHEREAS* Public Health Sudbury & Districts intentionally adopts the term, public mental health, to redress the widespread misunderstanding that public health means public physical health;

Sudbury
1300 rue Paris Street
Sudbury ON P3E 3A3
t: 705.522.9200
f: 705.522.5182

Rainbow Centre
10 rue Elm Street
Unit / Unité 130
Sudbury ON P3C 5N3
t: 705.522.9200
f: 705.677.9611

Sudbury East / Sudbury-Est
1 rue King Street
Box / Boîte 58
St.-Charles ON P0M 2W0
t: 705.222.9201
f: 705.867.0474

Espanola
800 rue Centre Street
Unit / Unité 100 C
Espanola ON P5E 1J3
t: 705.222.9202
f: 705.869.5583

Île Manitoulin Island
6163 Highway / Route 542
Box / Boîte 87
Mindemoya ON P0P 1S0
t: 705.370.9200
f: 705.377.5580

Chapleau
101 rue Pine Street E
Box / Boîte 485
Chapleau ON P0M 1K0
t: 705.860.9200
f: 705.864.0820

Toll-free / Sans frais
1.866.522.9200

phsd.ca

THEREFORE BE IT RESOLVED THAT the Board of Health for Public Health Sudbury & Districts endorse the Public Mental Health - Parity of Esteem Position Statement, May 16, 2019; and

FURTHER THAT copies of this motion and position statement be forwarded to local and provincial partners including all Ontario boards of health, Chief Medical Officer of Health, local MPPs, Ontario Public Health Association (OPHA), Association of Local Public Health Agencies (alPHa), local municipalities and Federation of Northern Ontario Municipalities (FONOM).

Officially adopting parity of esteem reinforces new, current and ongoing work which has been identified in our Public Mental Health Action Framework. The Framework is action-oriented and provides the roadmap for interventions, articulating our commitment to concepts and investments to improve mental health opportunities for all throughout the Public Health Sudbury & Districts service area.

Our local public health work in mental health will be more sustainable and effective if it is supported by organizational and provincial policies and structures that acknowledge mental health as an explicit goal along with physical health.

Yours sincerely,

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

Enclosure (1)

cc: All Ontario Boards of Health
Dr. David Williams, Chief Medical Officer of Health, Ministry of Health and Long-Term Care
Mr. Jamie West, MPP, Sudbury
Ms. France Gelinas, MPP, Nickel Belt
Mr. Michael Mantha, MPP, Algoma-Manitoulin
Ms. Pageen Walsh, Executive Director, Ontario Public Health Association
Ms. Loretta Ryan, Executive Director, Association of Local Public Health Agencies
Constituent Municipalities within Public Health Sudbury & Districts
Ms. Alison Stanley, Executive Director, Federation of Northern Ontario Municipalities

OFFICE OF THE MAYOR
CITY OF HAMILTON

June 14, 2019

The Honourable Christine Elliott, Deputy Premier and
Minister of Health and Long-Term Care
Hepburn Block, 10th Floor
80 Grosvenor Street
Toronto, ON M7A 1E9

Dear Minister Elliot,

At its May 22, 2019 meeting, Hamilton City Council discussed the changes being proposed for public health in Ontario and their potential effects. Before I convey the recommendations that arose from that discussion, I would like to commend you and your colleagues for your announcement on June 3rd that any changes to the provincial funding of public health will not affect the current fiscal year.

Hamilton's City Council recommends that any restructuring or modernization of local Public Health take into account the following principles:

- That its unique mandate to keep people and our communities healthy, prevent disease and reduce health inequities be maintained;
- That its focus on the core functions of public health, including population health assessment and surveillance, promotion of health and wellness, disease prevention, health protection and emergency management and response be continued;
- That sufficient funding and human resources to fulfill its unique mandate are ensured.
- That the focus for public health services be maintained at the community level to best serve residents and lead strategic community partnerships with municipalities, school boards, health care organizations, community agencies and residents;
- That there be local public health senior and medical leadership to provide advice on public health issues to municipal councils and participate in strategic community partnerships. The importance of this has been highlighted by the recent cluster of HIV among those using intravenous drugs in Hamilton;

.../2

71 MAIN STREET WEST, 2ND FLOOR, HAMILTON, ONTARIO L8P 4Y5 PHONE 905.546.4200 FAX: 905.546.2340

- That local public health services be responsive and tailored to the health needs and priorities of each local community, including those of vulnerable groups or those with specific needs such as the indigenous community;

- That representation of municipalities on any board of health be proportionate to both their population and to the size of the financial contribution of that municipality to the Regional Public Health Entity;

- That any transition be carried out with attention to good change management, and while ensuring ongoing service delivery.

For decades Hamilton has enjoyed and benefited from the knowledge, skills and implementation of 'preventive maintenance' that our public health staff have provided which we know has resulted in our community avoiding many costly health 'breakdowns' that would have arisen otherwise! As we move forward we also look forward to working directly with you and collaborating with our provincial colleagues through the relevant partnerships, such as the Association of Municipalities of Ontario (AMO), the Association of Local Public Health Agencies (alPHa).

In closing, we believe consultation directly with local public health agencies, such as ours, is critical to developing the best local public health system as we move forward.

Sincerely,

Fred Eisenberger
Mayor

CC: Dr. Elizabeth Richardson, Medical Officer of Health, City of Hamilton

June 19, 2019

The Honourable Christine Elliott
Minister of Health and Long-Term Care
Deputy Premier
777 Bay Street, 5th Floor
College Park
Toronto, Ontario M7A 1E9
christine.elliott@ontario.ca

Dear Minister Elliott:

Re: Letter of Support for Simcoe-Muskoka District Health Unit and Proposed Northeastern Boundaries

The Board of Health for the Porcupine Health Unit (PHU) is supportive of Simcoe Muskoka District Health Unit's (SMDHU) letter dated May 15, 2019, to remain intact and join with York Region Public Health to form a new regional Public Health entity on April 1, 2020.

As the largest geographical public health unit in the Province, the Porcupine Health Unit (PHU) is aware of the challenges inherent to ensuring strong and nimble public health coverage while maintaining a local voice and connections.

With the proposed Northeast regional public health entity including the existing five public health units (Public Health Sudbury and Districts, North Bay Parry Sound District Health Unit, Algoma Public Health, Timiskaming Health Unit and Porcupine Health Unit), it will be challenging to ensure the local voice and priorities are represented at the regional level. Increasing this area to over 400,000km^2 to include Muskoka District will create even further challenges to respond to local public health needs. In addition to concerns with capacity and greater geography, there is a risk of increasing health inequities as the Northeast is unique in terms of socioeconomic status, health status, and health care referral patterns compared to Muskoka District.

The Porcupine Health Unit urges the government to reconsider the proposed boundary for the Northeast regional public health entity and keep Simcoe-Muskoka District Health Unit intact to join York Region Public Health. We remain committed to ensuring a strong, nimble and locally informed public health system in the Northeast and firmly believe this would contribute to those goals.

Sincerely,

Sue Perras
Chairperson, Board of Health for the Porcupine Health Unit

cc Dr. David Williams, Chief Medical Officer of Health
Ontario Boards of Health
Association of Local Public Health Agencies
Gilles Bission, MMP Timmins-James Bay
John Vanthof, MPP Temiskaming-Cochrane
Guy Bourgouin, MPP Mushkegowuk-James Bay
Porcupine Health Unit Member Municipalities

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Head Office:
169 Pine Street South
Postal Bag 2012
Timmins, ON P4N 8B7

Phone: 705 267 1181
Fax: 705 264 3980
Toll Free: 800 461 1818

E-mail: info4you@porcupinehu.on.ca
Web site: www.porcupinehu.on.ca

Branch Offices: Cochrane, Hearst, Hornepayne, Iroquois Falls, Kapuskasing, Matheson, Moosonee, Smooth Rock Falls

Date: 19 / 06 / 19
y m d

R-2019 - 44

MOVED BY: Kristin Murray

SECONDED BY: Sebastien Lessard

WHEREAS since November 2017, the boards of health in Northeastern Ontario, namely the Boards for Algoma Public Health, Public Health Sudbury & Districts, Porcupine Health Unit, North Bay Parry Sound District Health Unit, and Timiskaming Health Unit, have proactively and strategically engaged in the *Northeast Public Health Collaboration Project* to identify opportunities for collaboration and potential shared services; and

WHEREAS the *Northeast Public Health Collaboration Project* work to date has been supported by two one-time funding grants from the Ministry of Health and Long-Term Care (MOHLTC); and

WHEREAS subsequent to the proposed transformation of public health announced in the April 11, 2019 provincial budget, the work of the Collaboration has been accelerated and reoriented as the *Northeast Public Health Transformation Initiative* with the vision of a healthy northeastern Ontario enabled by a coordinated, efficient, effective, and collaborative public health entity; and

WHEREAS the Board understands there will be opportunities for consultation with the MOHLTC on the regional implementation of public health transformation;

THEREFORE, be it resolved that the Board of Health for the Porcupine Health Unit supports the continued collaboration of the boards of health in Northeastern Ontario and looks forward to ongoing MOHLTC support for this work;

AND FURTHER that the Board, having engaged in this work since 2017, anticipates sharing with the MOHLTC its experiences so that other regions may benefit and further anticipates providing to the Ministry its expert advice on public health functions and structures for the North East;

AND FURTHER that this motion be shared with the Premier of Ontario, the Minister of Health and Long-Term Care, the Chief Medical Officer of Health, the Association of Local Public Health Agencies, all Ontario Boards of Health and Porcupine Health Unit member municipalities.

(circle as appropriate)

CARRIED **DEFEATED**

Chair - Board of Health

75 Years of Public Health

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1944-2019

Head Office:
169 Pine Street South
Postal Bag 2012
Timmins, ON P4N 8B7

Phone: 705 267 1181
Fax: 705 264 3980
Toll Free: 800 461 1818

E-mail: info4you@porcupinehu.on.ca
Web site: www.porcupinehu.on.ca

Branch Offices: Cochrane, Hearst, Hornepayne, Iroquois Falls, Kapuskasing, Matheson, Moosonee, Smooth Rock Falls

HALIBURTON, KAWARTHA, PINE RIDGE DISTRICT HEALTH UNIT
1-866-888-4577 • www.hkpr.on.ca • info@hkpr.on.ca

June 20, 2019

Honourable Christine Elliott
Minister of Health and Long-Term Care and Deputy Premier of Ontario
Hepburn Block
10th Floor
80 Grosvenor Street
Toronto, ON M7A 1E9
Sent via email: christine.elliott@pc.ola.org

Dear Minister Elliott:

RE: Health Promotion as a Core Function of Public Health

At its meeting held on June 20, 2019, the Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit discussed correspondence from The Kingston, Frontenac and Lennox & Addington Public Health Unit regarding health promotion as a core function of public health.

The core functions of public health, as outlined in the Ontario Public Health Standards: Requirements for Programs, Services, and Accountability, include assessment and surveillance, health promotion and policy development, health protection, disease prevention, and emergency management. Boards of health are responsible for programs and services within these core functions.

Programs supported through the core function of health promotion and policy development have recently been publicly highlighted by the Government as areas where public health should not be investing its resources. These examples have included studies on energy drinks and bike lane development.

Health promotion is the process of enabling people to increase control over and improve their health (World Health Organization). The components of health promotion include strengthening community action, developing personal skills, creating supportive environments, building healthy public policy and re-orienting health services. Health promotion within public health has played a significant role in improving health outcomes among Ontarians over many years, an example of this is the *Smoke-Free Ontario Act, 2017*. Policy development, advocacy, and community action were all health promotion tools used in the development of the Act. The same tools are used in addressing the dietary factors leading to the consumption of energy drinks and developing local active transportation initiatives.

Health promotion and policy development are as equally important as health protection and disease prevention within the public health system.

…/2

At its June 20, 2019 meeting, the Board of Health endorsed the recommendations made by Kingston, Frontenac, and Lennox & Addington Public Health (attached) and supported the mandate/function of health promotion and policy development as stated in the Ontario Public Health Standards: Requirements for Programs, Services, and Accountability.

We appreciate your support of this important public health issue.

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

Cammie Jaquays, Chair, Board of Health

CJ/aa

Cc (via email) : Honourable Doug Ford, Premier
Dr. David Williams, Chief Medical Officer of Health
Dr. Paul Roumeliotis, Chair, Council of Medical Officers of Health
Ontario Boards of Health
Association of Local Public Health Agencies (alPHa)
Health Promotion Ontario (HPO)
Association of Municipalities of Ontario (AMO)

Attachment

May 23, 2019

VIA: Electronic Mail (christine.elliott@pc.ola.org)

Honourable Christine Elliott
Minister of Health and Long-Term Care and Deputy Premier of Ontario
Hepburn Block
10th Floor
80 Grosvenor Street
Toronto, ON M7A 1E9

Dear Minister Elliott:

RE: Health Promotion as a Core Function of Public Health

The Kingston, Frontenac and Lennox & Addington (KFL&A) Board of Health passed the following motion at its May 22, 2019 meeting:

THAT the KFL&A Board of Health strongly urge the Government of Ontario to maintain the current health promotion mandate of local public health units; and

THAT the KFL&A Board of Health ask the Government of Ontario to consult with Medical Officers of Health across Ontario should they consider any changes to the health promotion mandate and/or functions of local public health units or future public health entities.

There has been a recent flurry of media attention on public health in Ontario in response to announced changes to the public health system including decreased funding, a change in how public health units are funded, and the transition of 35 public health units to ten regional public health entities. In this media maelstrom, there has been recognition of the importance of public health and the programs and services it provides; however, the current media rhetoric regarding the benefits of public health is almost exclusively focused on the health protection and disease prevention mandates of public health agencies (e.g., preventing and mitigating infectious diseases such as measles and SARS). While these are critical aspects of the work public health provides to our communities, the Provincial Government has been silent on the importance of health promotion as a core function of public health. Furthermore, when health promotion work is mentioned, the Government of Ontario has noted that the Ministry of Health and Long-Term Care will assume centralized lifestyle messages or has noted that the work (e.g., a study of energy drinks or bike lanes) is not where public health should invest its resources. This is worrisome.

. . . / 2

Kingston, Frontenac and Lennox & Addington Public Health www.kflaph.ca

Main Office 221 Portsmouth Avenue
Kingston, Ontario K7M 1V5
613-549-1232 | 1-800-267-7875
Fax: 613-549-7896

Branch Offices
Cloyne 613-336-8989 Fax: 613-336-0522
Napanee 613-354-3357 Fax: 613-354-6267
Sharbot Lake 613-279-2151 Fax: 613-279-3997

Health promotion is more than just crafting messages and making posters. It is the methodical and scientific application of a comprehensive approach to address health issues. Components of health promotion include strengthening community action, developing personal skills, creating supportive environments, building healthy public policy, and re-orienting the health care system. Health promotion, when used with fidelity, has demonstrated great success. Tobacco is a great example of a health promotion success story. While most people would agree that the policy and taxation levers used by the federal and provincial governments are responsible for the dramatic and sustained drop in smoking rates, it is the work of health promotion that enabled those tools to be created and enacted. It was through successful knowledge translation activities informing the general public of the evidence that smoking causes lung cancer, the evaluation of prevention and cessation programs, and community action and advocacy from non-smokers—all the result of health promotion—that put tobacco on the public's agenda. Once tobacco was on the public's agenda, and recognized as a health hazard, policies were implemented, and continue to be implemented to this day, to protect the public from the harms of tobacco use. Clearly, health promotion is an effective tool to improve the health of the population.

Furthermore, effective health promotion is needed now more than ever as communities across Ontario grapple with the epidemic of chronic diseases. In Ontario, chronic diseases are the leading cause of disability and death and account for nearly 80% of all deaths. With a rapidly aging population, the prevalence of chronic diseases is expected to rise along with a significant associated financial toll on the provincial health care budget. Health care costs in Ontario are projected to account for 70 percent of the provincial budget by 2022 and 80 percent by 2030, making the prevention of chronic diseases a health and financial priority.

Medical Officers of Health -- highly trained and trusted professionals with the expertise to address health threats in their communities -- are well-positioned to determine effective strategies to address common risk factors for chronic disease (i.e., tobacco use, alcohol use, unhealthy eating and physical inactivity) and other factors that impact health such as early childhood development, mental health and the social determinants of health. Medical Officers of Health must be afforded the full slate of public health tools to protect and promote the health of their communities.

. . . / 3

Kingston, Frontenac and Lennox & Addington Public Health www.kflaph.ca

Main Office 221 Portsmouth Avenue
Kingston, Ontario K7M 1V5
613-549-1232 | 1-800-267-7875
Fax: 613-549-7896

Branch Offices
Cloyne 613-336-8989 Fax: 613-336-0522
Napanee 613-354-3357 Fax: 613-354-6267
Sharbot Lake 613-279-2151 Fax: 613-279-3997

Health protection, disease prevention and health promotion are equally important and core functions of public health. Having a well-resourced public health system with the tools required to address both acute and chronic health threats is the best chance that Ontario has to make our health care system sustainable, to end hallway medicine, and to protect what matters most – health.

Yours truly,

Denis Doyle, Chair
KFL&A Board of Health

Copy to: The Honourable Doug Ford, Premier
Ian Arthur, MPP Kingston and the Islands
Randy Hillier, MPP Lanark-Frontenac-Kingston
Daryl Kramp, MPP Hastings-Lennox and Addington
Loretta Ryan, Association of Local Public Health Agencies
Dr. David Williams, Chief Medical Officer of Canada
Dr. Chris Mackie, Chair, Council of Medical Officers of Health
Susan Stewart, Chair, Ontario Chronic Disease Prevention Managers in Public Health
Monika Turner, Director of Policy, Association of Municipalities of Ontario
Ontario Boards of Health

DISPOSITION OF 2019 RESOLUTIONS

2019 Annual General Meeting
Monday, June 10, 2019
Ballroom, Four Points by Sheraton
285 King Street East
Kingston, Ontario

alPHa
Association of Local PUBLIC HEALTH Agencies

RESOLUTIONS CONSIDERED
at June 2019 alPHa Annual General Meeting

Resolution Number	Title	Sponsor	Page
A19-1	Climate Change and Health in Ontario: Adaptation and Mitigation	Council of Ontario Medical Officers of Health	1-3
A19-2	Affirming the Impact of Climate Change on Health	Kingston, Frontenac, and Lennox & Addington Public Health	4-5
A19-3	Public Health Approach to Drug Policy	Toronto Public Health	6
A19-4	Asbestos-Free Canada	Peterborough Public Health	7
A19-5	Public Health Support for including Hepatitis A Vaccine in the School Immunization Program	Peterborough Public Health	8-10
A19-6	No-Fault Compensation for Adverse Effects Following Immunization (AEFI)	Kingston, Frontenac, and Lennox & Addington Public Health	11-12
A19-7	Considering the Evidence for Recalling Long-Acting Hydromorphone	Kingston, Frontenac, and Lennox & Addington Public Health	13-14
A19-8	Promoting Resilience through Early Childhood Development Programming	Northwestern Health Unit, Thunder Bay District Health Unit, and Middlesex-London Health Unit	15-16
A19-9	Public Health Support for Accessible, Affordable, Quality Licensed Child Care	Simcoe Muskoka District Health Unit	17-18
A19-10	Children Count Task Force Recommendations	Windsor-Essex County Board of Health	19
A19-11	Public Health Funding to Support Healthy Weights and Prevention of Childhood Obesity	Chatham-Kent Public Health Unit	20
A19-12	Public Health Modernization: Getting it Right!	Peterborough Public Health	21-22

alPHa
Association of Local PUBLIC HEALTH Agencies

alPHa RESOLUTION A19-1

TITLE: **Climate Change and Health in Ontario: Adaptation and Mitigation**

SPONSOR: **Council of Ontario Medical Officers of Health**

WHEREAS the "*Lancet Countdown: Tracking Progress on Health and Climate Change*", a global, interdisciplinary research collaboration between 27 academic institutions and inter-governmental organizations, describes climate change as the biggest global health threat of the 21st century and tackling climate change is described as potentially the greatest health opportunity[1]; and

WHEREAS there is clear evidence that, like the rest of Canada, Ontario's climate has experienced warming, as well as more frequent events of extreme temperature, wind and precipitation[2-4]; and

WHEREAS the current environmental health harms borne by the people of Ontario are significant, and include

- Four excess deaths per day for each 5°C change in daily temperature in warm seasons[5]
- 560 cancer cases per year attributable exposure to fine particulate matter air pollution[6]
- Vector borne disease including 138 cases of West Nile virus disease and 612 cases of Lyme disease in 2018[7]
- 67 deaths, 6,600 hospitalizations, and 41,000 emergency department visits per year related to foodborne illness[8]
- 73 deaths, 2,000 hospitalizations, and 11,000 emergency department visits per year related to waterborne disease[9]
- Community evacuations as a result of flooding or forest fires, with First Nation and northern Ontario communities particularly affected[10-12];
- Findings of established population of exotic mosquitoes (i.e., *Aedes albopictus* and *Aedes aegypti*) posing new disease threats (i.e., Zika virus, Dengue); and

WHEREAS national and provincial projections indicate that ongoing climate change will lead to increased health harms from extreme weather, floods, drought, forest fires, heat waves, air pollution, and changing patterns of infectious disease[3,13-17]; and

WHEREAS just as all sectors of the economy are facing increasing impacts and financial costs due to climate change[4], the increasing health harms to the people of Ontario may be associated with increased health care utilization and health care costs; and

WHEREAS the health harms and costs of climate change will continue to have a disproportionately worse impact on certain groups and regions of Ontario, including people who are elderly, infants and young children, people with chronic diseases,

people who are socially disadvantaged, Indigenous people, and residents of northern Ontario and rural Ontario[4,13]; and

WHEREAS climate change adaptation and mitigation actions, such as increasing active transport and reducing greenhouse gas emissions, can have powerful health benefits which include improved cardiovascular and mental health, and decreasing air pollution-related deaths, respectively[1]; and

WHEREAS there is broad support among Canadian physicians and public health professionals for specific, evidence-informed actions on climate change and health, as demonstrated by the seven recommendations of the "*Lancet Countdown 2018 Report: Briefing for Canadian Policymakers*" co- developed by the Canadian Medical Association and the Canadian Public Health Association[1]

WHEREAS the Ontario Public Health Standards articulate a general goal to improve and protect the health and well-being of the population of Ontario and reduce health inequities, and a specific goal to reduce exposure to health hazards and promote the development of healthy built and natural environments that support health and mitigate existing and emerging risks, including the impacts of a changing climate[18]; and

WHEREAS as part of a made-in-Ontario environment plan, the Government of Ontario has committed to undertake a provincial impact assessment to identify where and how climate change is likely to impact Ontario's communities, critical infrastructure, economies and natural environment, as well as impact and vulnerability assessments for key sectors, such as transportation, water, agriculture and energy distribution[4];

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies write to the provincial Minister of the Environment, Conservation and Parks and the Minister of Health and Long-Term Care to support the Ontario government's commitment to undertake provincial level climate change impact and vulnerability assessments;

AND FURTHER that the Association of Local Public Health Agencies recommend that health and health sector impacts borne by the full diversity of Ontario communities be included in provincial climate change impact and vulnerability assessments;

AND FURTHER that the Association of Local Public Health Agencies recommend that the provincial government's approaches to the health impacts of climate change be aligned with the recommendations of the *Lancet Countdown 2018 Report: Briefing for Canadian Policymakers*;

AND FURTHER that copies be sent to the Chief Medical Officer of Health of Ontario.

ACTION FROM CONFERENCE: Carried as amended

References – Resolution A19-1

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16. Ogden N, Gachon P. Climate change and infectious diseases: What can we expect? *Canadian Communicable Disease Report.* 2019;45:76-80.
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alPHa RESOLUTION A19-2

TITLE: **Affirming the Impact of Climate Change on Health**

SPONSOR: **Kingston, Frontenac, and Lennox & Addington Public Health**

WHEREAS climate change is defined as a shift in long-term worldwide climate phenomena associated with changes in the composition of the global atmosphere[1]; and

WHEREAS the World Health Organization states climate change to be the greatest global health threat of the 21st century[2]; and

WHEREAS the United Nations Intergovernmental Panel on Climate Change concludes that human influence on climate change is clear and is extremely likely that human influence is the dominant cause[3]; and

WHEREAS climate change impacts the health of all people through temperature-related morbidity and mortality, extreme weather events, poor air quality, food and water contamination, altered exposure to ultraviolet rays, increasing risk of vector-borne infectious diseases, food security and indirectly impacts people by affecting labour capacity and population migration and displacement[4–6]; and

WHEREAS climate change disproportionately affects vulnerable populations such as children, seniors, low income and homeless people, those who are chronically ill, Indigenous peoples, and rural and remote residents[7,8]; and

WHEREAS the City of Kingston, the City of Hamilton, and the City of Ottawa declared a climate emergency for the purposes of naming, framing, and deepening commitment to protecting the economy, the ecosystem, and the community from climate change; and

WHEREAS tackling climate change requires political commitment by international, federal, provincial, and municipal stakeholders in acknowledging climate change as a public health issue

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) affirm the anthropogenic cause of climate change and its adverse impact on health in all people;

AND FURTHER will call upon strategic and provincial partners including the Ontario Ministry of Health and Long-Term Care, Ministry of Environment, Conservation and Parks, Ministry of Labour, Association of Municipalities of Ontario, Ontario Public Health Association, etc. to support climate change mitigation and adaptation measures in local communities.

ACTION FROM CONFERENCE: Carried

References – Resolution A19-2

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alPHa
Association of Local PUBLIC HEALTH Agencies

alPHa RESOLUTION A19-3

TITLE: **Public Health Approach to Drug Policy**

SPONSOR: **Toronto Public Health**

WHEREAS governments around the world are considering different approaches to drugs, including the decriminalization of drug use and possession and legal regulation, including here in Canada for non-medical cannabis; and

WHEREAS a growing number of health officials and boards of health are calling for changes to our approach to drugs, especially in the midst of the opioid poisoning crisis in which the contaminated, unregulated supply of illegal drugs is the main contributor to the crisis; and

WHEREAS laws that criminalize people simply for using and possessing drugs have resulted in serious health and social harms, including forcing people into unsafe spaces and high-risk behaviours leading to HIV and HCV infection, resulting in criminal records that make it difficult to obtain employment and housing, and reinforcing negative stereotypes and judgements about people who use drugs; and

WHEREAS some groups are more impacted by our drug laws than others, including people who are homeless and/or living in poverty, people with mental health and substance use issues, people from racialized groups, Indigenous people, women and youth; and

WHEREAS a public health approach to drugs would be based on principles and strategies that have been shown to support healthy individuals, families and communities; and

WHEREAS countries that have decriminalized personal drug use and possession and invested in public health interventions have seen results, including decreases in HIV and overdose, decreases in costs to the criminal justice system, and improved police/community relationships; and

WHEREAS the evidence on the health and social harms of our current criminalization approach to illegal drugs as well as that of alternative approaches such as decriminalization and legal regulation strongly support the need to shift to a public health approach to drugs in Canada;

NOW THEREFORE BE IT RESOLVED that the federal government be urged to decriminalize the possession of all drugs for personal use, and scale up prevention, harm reduction and treatment services;

AND FURTHER that the federal government convene a task force, comprised of people who use drugs, family members, and policy, research and program experts in the areas of public health, human rights, substance use, mental health, and criminal justice, to explore options for the legal regulation of all drugs in Canada, based on a public health approach.

ACTION FROM CONFERENCE: Carried as amended

alPHa RESOLUTION A19-4

TITLE: **Asbestos-Free Canada**

SPONSOR: **Peterborough Public Health**

WHEREAS the adverse health effects associated with exposure to asbestos exposure have been well established: Epidemiological, clinical, and laboratory studies have shown that asbestos is capable of causing lung cancer, mesothelioma, and a range of asbestos-related diseases (International Agency for Research on Cancer [IARC], 1987); and

WHEREAS asbestos is one of the most important occupational carcinogens causing about half of all deaths from occupational cancer. Currently, about 125 million people in the world are exposed to asbestos in the workplace, and at least 90,000 people die each year from lung cancer, mesothelioma, and asbestosis resulting from occupational exposures (Driscoll et al., 2005); and

WHEREAS it is believed that thousands of deaths each year can be attributed to other asbestos-related diseases as well as to non-occupational exposures, and the global burden of disease is still rising (World Health Organization [WHO], 2006); and

WHEREAS Canada was the fourth largest producer of chrysotile asbestos, exporting to more than 70 countries, even after introducing strict restrictions on its use in 1985, 1999 and 2004. In 2001, the World Trade Organization ruled against Canada's challenge to national asbestos bans. Canada went on to oppose the addition of chrysotile asbestos to the Rotterdam Convention, an international treaty regulating the environmentally-sound use of hazardous materials, in 2004 and 2006. In 2008, Canada abstained; and

WHEREAS Canada reached a historic milestone on December 30, 2018. On that date, after 130 years as a leading exporter of asbestos, Canada finally banned its use, import and export; and

WHEREAS we can take inspiration from other countries' experiences in eliminating the impact of asbestos on people and the environment. The most successful efforts have taken place in countries with comprehensive strategies, coordinated by a transparent and accountable institutional framework. The European Union has a lot to teach us, but the most impressive example is the Australian Agency for Asbestos Safety and Eradication (ASEA). https://www.asbestossafety.gov.au/;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) call on the federal government to make Canada "asbestos free" by establishing a federal asbestos agency based on the Australian model. The agency, in cooperation with Indigenous peoples, the provinces, territories and municipalities, would be mandated to develop a comprehensive Canadian asbestos strategy (see appendix A) and an implementation plan, while respecting the jurisdictions of each level of government;

AND FURTHER that the Chief Public Health Officer of Canada and the Ontario Public Health Association, be so advised.

ACTION FROM CONFERENCE: Carried

alPHa
Association of Local PUBLIC HEALTH Agencies

alPHa RESOLUTION A19-5

TITLE: **Public Health Support for including Hepatitis A Vaccine in the School Immunization Program**

SPONSOR: **Peterborough Public Health**

WHEREAS hepatitis A is a viral liver disease that can cause mild to severe illness, and according to the World Health Organization (2018), epidemics that can be difficult to control and cause substantial economic loss; and

WHEREAS recent hepatitis A outbreaks have been reported in Ontario and through-out North America, related to infected food handlers and to food products (strawberries, scallops, pomegranate seeds, organic berries) ; amongst men who have sex with men; people who use illicit drugs, and people experiencing homelessness[2]; and

WHEREAS hepatitis A is one of the most common vaccine preventable diseases in travellers. Protection against hepatitis A is recommended for all travellers to hepatitis A endemic countries; and

WHEREAS recovery from hepatitis A infection may take months, with about 25% of adult cases requiring hospitalization, resulting, in Ontario (2016/2017) with potential hospital stays costing is over $5300 per person; and

WHEREAS in 2018, 12 million Canadians reported travel to overseas countries; and

WHEREAS studies estimate that 44% to 55% of reported HA cases in Canada are linked to travel with low-budget travellers, volunteer humanitarian workers, and Canadian-born children of new Canadians returning to their country of origin to visit friends and relatives being at highest risk[6]; and

WHEREAS immunization is a cost-effective health intervention that reduces the burden on the health care system and offsets the high costs of doctor visits, trips to the emergency room, hospitalizations, medication therapy and outbreak management; and

WHEREAS pre-exposure hepatitis A immunization is at least 90% to 97% effective with protective concentrations of hepatitis A antibody likely persisting for at least 20 years, possibly for life, following immunization with 2 doses of hepatitis A-containing vaccine; and

WHEREAS increasing access to publicly funded vaccinations such as those offered in school clinics improves health equity and reduces disparities in immunization coverage across communities; and

WHEREAS combined vaccines result in fewer injections, fewer office visits, more convenience for clients, simplified logistics and increased compliance; and

WHEREAS a combined hepatitis A/B vaccine could easily be implemented in the existing school-based clinic schedule provided in conjunction with the human papillomavirus (HPV) vaccine at 0 and 6 months; and

WHEREAS there is no increase in adverse events with the combined hepatitis A/B vaccine when compared with the hepatitis A vaccine given alone or concomitantly with the hepatitis B vaccine; and

WHEREAS the logistics and the related costs to adding a combined vaccine would be nil or minimal for the current Ontario school-based vaccine program and would further be reduced through bulk purchasing; and

WHEREAS the process of obtaining consent for the combined hepatitis A/B vaccine may be easy to update given that information on hepatitis is already included in the current package and thus, would require minimal modification; and

WHEREAS a goal of the Ministry of Health and Long-Term Care's Immunization 2020 – Modernizing Ontario Publicly Funded Immunization Program (2015), is to improve access to immunizations by offering additional vaccines and catch-up immunizations for school-aged children and adolescents through school-based immunization clinics[9];

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) endorse the replacement of the hepatitis B vaccine in the school-based program with the combined hepatitis A/B vaccine;

AND FURTHER that alPHa request that the provincial Government include the combined hepatitis A/B vaccine in the provincially funded immunization program as a way to reduce vaccine-preventable diseases and promote the health of all Ontarians;

AND FURTHER that the Premier of Ontario, the Chief Medical Officer of Health for Ontario, the Ontario Public Health Association and the Ministry of Health and Long-Term Care be so advised.

ACTION FROM CONFERENCE: Carried

References – Resolution A19-5

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[10] Canadian Immunization Guide. Part 4 active vaccines: Hepatitis B vaccine https://www.canada.ca/en/public-health/services/publications/healthy-living/canadian-immunization-guide-part-4-active-vaccines/page-7-hepatitis-b-vaccine.html#a10

[11] Centres for Disease Control and Prevention (2019). Recommendations of the Advisory Committee on Immunization Practices for Use of Hepatitis A Vaccine for Persons Experiencing Homelessness. Available from: https://www.cdc.gov/mmwr/volumes/68/wr/mm6806a6.htm

[12] Public Health Ontario (2019). Public health responses to recent hepatitis A outbreaks: Spotlight on San Diego County, California and Middlesex-London, Ontario: Introduction. Available from: https://www.publichealthontario.ca/-/media/documents/presentations/grand-rounds-january-15-2019.pdf?la=fr

[13] Quebec Immunisation Program: https://www.quebec.ca/en/health/advice-and-prevention/vaccination/hepatitis-a-and-b-vaccine/

alPHa RESOLUTION A19-6

TITLE: **No-Fault Compensation for Adverse Effects Following Immunization (AEFI)**

SPONSOR: **Kingston, Frontenac, and Lennox & Addington Public Health**

WHEREAS routine immunization programmes are a significant part of public health practice and an important tool to protect the health of the public from the incidence and severity of vaccine-preventable diseases; and

WHEREAS serious adverse events following immunizations are much less likely to occur than similar adverse events following infection with vaccine preventable diseases, but will rarely occur after approximately 1 in 1,000,000 immunizations; and

WHEREAS in Canada, few individuals will bear the burden of serious adverse events for the communal benefit of the population; and

WHEREAS serious adverse events occur in spite of best practices being followed by health care providers and vaccine manufacturers; and

WHEREAS the Canadian legal system lacks an appropriate mechanism to provide individuals with compensation and this does not meet the ethical principle of reciprocity; and

WHEREAS no-fault compensation programs are increasingly regarded as a component of a successful vaccination program as an expression of community solidarity in which members of a community do not bear the risks of vaccination alone; and

WHEREAS Canada stands alone among the G7 countries as the only jurisdiction without a national publicly administered no-fault vaccine compensation program; and

WHEREAS Quebec is the only province or territory in Canada that has no-fault compensation for AEFIs; and

WHEREAS providing access to a fair reasonable process for compensation of serious adverse events weakens the argument against vaccination; and

WHEREAS no-fault compensation programs can quickly, effectively, and consistently make awards that are proportional to the serious adverse event;

NOW THEREFORE BE IT RESOLVED THAT the Association of Local Public Health Agencies (alPHa) call upon the Chief Medical Officer of Health of Ontario and the Minister of Health and Long-Term Care to institute a program of no-fault compensation for adverse outcomes following immunization;

AND FURTHER that the Association of Local Public Health Agencies (alPHa) call upon the Chief

Medical Officer of Health of Ontario and the Minister of Health and Long-Term Care to call upon their counterparts across Canada as well as their Federal counterparts to institute a National system of no-fault compensation for adverse outcomes following immunization;

AND FURTHER that the Minister of Health and Long-Term Care, and the Chief Medical Officer of Health for Ontario, as well as the provincial, territorial, and federal Ministers of Health and Chief Medical Officers of Health be so advised.

ACTION FROM CONFERENCE: Carried

alPHa RESOLUTION A19-7

TITLE: **Considering the Evidence for Recalling Long-Acting Hydromorphone**

SPONSOR: **Kingston, Frontenac, and Lennox & Addington Public Health**

WHEREAS data from 2017 estimates 1,250 Ontarians died from opioid-related causes, representing a 246% increase in mortality from 2003 (Public Health Ontario, 2019); and

WHEREAS one in three people who died from an opioid-related cause had an active prescription for an opioid (Gomes, 2018); and

WHEREAS the harms associated with long-acting and high-dose formulations of opioids are well- characterized and include accidental overdose, cognitive impairment, falls, depression, and physical dependence (Bohnert, et al., 2011) (Juurlink, 2017); and

WHEREAS there is emerging evidence that long-acting hydromorphone is able to sustain HIV infectiousness due to the microcrystalline cellulose component of the drug and can infect people who inject drugs as a result of sharing equipment (Ball, et al., 2019); and

WHEREAS there is evidence that HIV persisted in long-acting hydromorphone residuals which may be used in "serial washes", where the non-solubilized drug from an initial preparation for injection is reused; and

WHEREAS there is additional evidence that long-acting hydromorphone prescribing patterns are associated with an increased incidence of infective endocarditis among people who inject drugs (Weir, et al., 2019); and

WHEREAS the federal Minister of Health has the power under the Food and Drug Act to recall drugs that pose serious or imminent risk to health (Government of Canada, 1985); and

WHEREAS the known harms of opioids coupled with new evidence of additional risk of infectious disease uniquely associated with long-acting hydromorphone meet the threshold for action from the federal Minister of Health;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) petition the federal Minister of Health and Health Canada to review the scientific literature and other available data regarding potential harms associated with long-acting hydromorphone, particularly with respect to the risk it poses for the spread of infectious diseases among people who inject drugs;

AND FURTHER that if evidence of serious or imminent risk to health is found, that the federal Minister of Health and Health Canada consider recalling or restricting prescribing of long-acting hydromorphone;

AND FURTHER that the Federal Minister of Health, the Minister of Health and Long-Term Care, the Chief Medical Officer of Health for Ontario, the Chief Coroner for Ontario, the CEO of Public Health Ontario, the Chief Medical Officer of Health for Canada, and all Chief Medical Officers of Health across all Provinces and Territories be so advised.

ACTION FROM CONFERENCE: Carried

References – Resolution A19-7

Ball, L. et al., 2019. Heating injection drug preparation equipment used for opioid injection may reduce HIV transmission associated with sharing equipment.

Bohnert, A. B., Valenstein, M. & Bair, M. J., 2011. Association between opioid prescribing patterns and opioid overdose-related deaths. *JAMA,* Volume 305, pp. 1315-21.

Gomes, T., 2018. Contributions of prescribed and non-prescribed opioids to opioid-related deaths: A population-based cohort study in Ontario, Canada. *BMJ.*

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Herder, M. & Juurlink, D., 2018. High-strength opioid formulations: the case for a ministerial recall. *CMAJ,* Volume 190, pp. 1404-5.

Juurlink, D. N., 2017. Rethinking "doing well" on chronic opioid therapy. *CMAJ,* Volume 189, pp. 1222-

3. Public Health Ontario, 2019. *Interactive Opioid Tool.* [Online]
Available at: https://www.publichealthontario.ca/en/data-and-analysis/substance-use/interactive-opioid-tool#/dTrends

Weir, M. A. et al., 2019. The risk of infective endocarditis among people who inject drugs: a retrospective, population-based time series analysis. *CMAJ,* Volume 191, pp. 93-9.

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Association of Local PUBLIC HEALTH Agencies

alPHa RESOLUTION A19-8

TITLE: **Promoting Resilience through Early Childhood Development Programming**

SPONSORS: **Northwestern Health Unit**
Thunder Bay District Health Unit
Middlesex-London Health Unit

WHEREAS one in five Canadians are affected by mental illness or an addiction issue every year, and the burden of illness is more than 1.5 times the burden of all cancers and 7 times the burden of all infectious diseases; and

WHEREAS suicide is the second leading cause of mortality among young Canadians aged 10-24 and suicide accounted for 24% of all deaths among youth 15 to 24 years old from 2009-2013; and

WHEREAS there were more than 9,000 deaths in Canada from 2016 to 2018 and more than 1,250 deaths in Ontario in 2017 related to opioids; and

WHEREAS the annual economic burden of mental illness is approximately 51 billion in Canada with a substantial impact on emergency room departments and hospitals; and

WHEREAS 70% of mental health and substance use problems begin in childhood; and adverse childhood experiences, such as poor attachment to parents, child abuse, family conflict and neglect, have been clearly linked to risk for mental illness and addiction later in life; and

WHEREAS programming that enhances the early childhood experience has proven benefits in IQ levels, educational achievements, income levels, interactions with the criminal justice system and utilization of social services; and

WHEREAS every $1 invested in early childhood development can save $9 in future spending on health, social and justice services; and

WHEREAS the Healthy Babies Healthy Children (HBHC) program is a prevention/early intervention initiative designed to ensure that all Ontario families with children (prenatal to the child's transition to school) who are at risk of physical, cognitive, communicative, and/or psychosocial problems have access to effective, consistent, early intervention services; and

WHEREAS the HBHC program provides home visiting services and home visiting programs have demonstrated effectiveness in enhancing parenting skills and promoting healthy child development in ways that prevent child maltreatment; and

WHEREAS the HBHC program supports the early childhood experience and development of resiliency by enhancing the parent-child attachment, parenting style, family

relationships, and financial instability and addressing parental mental illness and substance misuse, child abuse or neglect thereby reducing the risk of subsequent mental illness and addictions; and

WHEREAS in 1997 the province committed to funding the Healthy Babies Healthy Children program at 100% and the HBHC budget has been flat-lined since 2008 with the exception of increased base funding in 2012 for an increase in public health nursing positions for Healthy Babies Healthy Children program as part of the 9,000 Nurses Commitment; and

WHEREAS fixed costs such as salaries and benefits, travel, supplies, equipment and other operational costs have increased the costs of operating the HBHC program, and

WHEREAS operating the HBHC program with the existing funding has become increasingly more challenging and will result in reduced services for high-risk families if increased funding is not provided;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) actively engage with the Ministry of Children, Community and Social Services, the Ministry of Health and Long term Care, and the Premier's Council on Improving Health Care and Ending Hallway Medicine to support investments in early childhood development as a strategy to enable health and resiliency throughout life, promote mental health and reduce mental illness and addictions;

AND FURTHER that alPHa engage with the Ministry of Children, Community and Social Services, the Ministry of Health and Long term Care, and the Premier's Council on Improving Health Care and Ending Hallway Medicine to urgently support adequate funding (including staffing and operational costs) of the Healthy Babies Healthy Children program as a strategic immediate action to enhance the early childhood experience and address mental illness and addictions in Ontario;

AND FURTHER that the Chief Medical Officer of Health of Ontario, Ontario Public Health Association, Centre for Addictions and Mental Health and other relevant partner agencies be so advised.

ACTION FROM CONFERENCE: Carried as amended

alPHa RESOLUTION A19-9 (Corrected)

TITLE: **Public Health Support for Accessible, Affordable, Quality Licensed Child Care**

SPONSOR: **Simcoe Muskoka District Health Unit**

WHEREAS the Ontario Public Health Standards indicate the child care sector is an important setting for Public Health interventions, related to the Standards for Health Equity, Healthy Growth and Development, Immunization, Institutional Outbreak Management, Infection Prevention, Food Safety and others; and

WHEREAS supporting families and healthy early childhood development is a core part of the mandate of public health; and

WHEREAS early childhood experiences and socioeconomic status (SES) are important social determinants of health, and are supported by affordable, accessible, quality child care; and

WHEREAS the positive effects of high quality child care and early learning programs can last a lifetime and are associated with immediate and long-term positive outcomes for children, particularly for children from lower socioeconomic backgrounds; and

WHEREAS the current number of licensed child care spaces across Ontario can accommodate less than 1 in 4 (23%) children from ages 0-4; and

WHEREAS Ontario has the highest child care costs provincially, with parents spending $750-$1700 per month for licensed child care, totalling between $9,000-$20,000+ per year for each child; and

WHEREAS public investment in child care demonstrates positive economic benefits; in Ontario, the return on investment is $2.27 for every dollar invested; and

WHEREAS the Ontario government's plan for a refundable tax credit for child care costs will not improve access to quality licensed child care spaces, requires initial out of pocket expenses by families, and may thereby increase health inequities; and

WHEREAS Ontario has the lowest rate of women's workforce participation nationally; recognizing income is a key social determinant of health for Canadian families; and

WHEREAS no provincial standard or definition for quality of child care exists; most of Ontario's municipalities have a quality assurance coordinator, however only half are using a measurement tool to assess quality of child care; and

WHEREAS there is a shortage of Registered Early Childhood Educators in Ontario, in part due to the low compensation they receive and burdensome workplace conditions;

NOW THEREFORE BE IT RESOLVED that alPHa will endorse the importance of an accessible, affordable, quality child care and early learning system, for improved health equity for families and enhanced child development outcomes;

AND FURTHER that alPHa will advocate to the provincial and federal governments to maintain their commitment to ensuring a more affordable child care system, and to expand access to quality, licensed child care services for all Ontario families, including access for families with diverse needs (eg. 24 hour care, weekend care, part time care);

AND FURTHER that alPHa will advocate to the province to maintain its commitment towards creating a provincial definition of quality, including establishing an early years and child care workforce strategy, to ensure child care professionals are adequately qualified and compensated;

AND FURTHER that alPHa will support local public health agencies to:

- enhance their knowledge and transfer knowledge to decision-makers and the general public about the health impacts of the current state of the child care system and the importance of progressing towards an increasingly accessible, affordable, quality child care system; this could be initiated at an upcoming alPHa forum.
- build capacity to support the child care sector, by sharing examples of best practices for public health programming in child care environments and useful approaches for creating and enhancing partnerships with child care providers; this could be initiated through professional development opportunities in collaboration with partner organizations, in particular the College of Early Childhood Educators.

ACTION FROM CONFERENCE: Carried as amended

alPHa RESOLUTION A19-10

TITLE: **Children Count Task Force Recommendations**

SPONSOR: **Windsor-Essex County Board of Health**

WHEREAS boards of health are required under the Ontario Public Health Standards (OPHS) to collect and analyze health data for children and youth to monitor trends overtime; and

WHEREAS boards of health require local population health data for planning evidence-informed, culturally and locally appropriate health services and programs; and

WHEREAS addressing child and youth health and well-being is a priority across multiple sectors, including education and health; and

WHEREAS Ontario lacks a single coordinated system for the monitoring and assessment of child and youth health and well-being; and

WHEREAS there is insufficient data on child and youth health and well-being at the local, regional and provincial level; and

WHEREAS the Children Count Task Force recommendations build upon years of previous work and recommendations, identifying gaps and priorities for improving data on child and youth health and wellbeing;

NOW THERFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) endorse the recommendations of the Children Count Task Force;

AND FURTHER that alPHa request the provincial government establish a mechanism to oversee the implementation of the systems, tools, and resources required to improve the monitoring and assessment of child and youth health and well-being and ensure:

1. The implementation of the five recommendations of the task force.
2. A process is developed so that assessment and monitoring systems remain effective and relevant over time by addressing emerging issues and data gaps;

AND FURTHER that the Premier of Ontario, the Deputy Premier of Ontario and Minister of Health, the Minister of Children, Community and Social Services, the Minister of Education, the Chief Medical Officer of Health for Ontario, the Association of Municipalities of Ontario, the Council of Directors of Education for Ontario be so advised.

ACTION FROM CONFERENCE: Carried

alPHa RESOLUTION A19-11

TITLE: **Public Health Funding to Support Healthy Weights and Prevention of Childhood Obesity**

SPONSOR: **Chatham-Kent Public Health Unit**

WHEREAS almost 30% of Ontario Children are overweight or obese; and

WHEREAS children and youth who are overweight or obese are more likely to become obese adults; and

WHEREAS children who are obese also have a higher risk of chronic disease and premature death as adults; and

WHEREAS previous funding through the Healthy Kids Community Challenge provided 45 communities with the ability to hire a local project manager as part of an evidence-based EPODE model and best practice in childhood overweight and obesity prevention; and

WHEREAS local project managers can enhance community capacity to plan, implement and evaluate sustainable local health interventions; and

WHEREAS the function of local project managers works to assist in facilitating community collaboration and coordination of community programming through multi-sectoral partnerships; and

WHEREAS the Healthy Kids Community Challenge has concluded and the subsequent role and funding of local project managers no longer exists;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) call upon the Ministry of Health and Long-Term Care to ensure a sustained financial commitment to the Healthy Kids Panel's recommendations involving all Ontario health units to support childhood overweight and obesity prevention efforts in all Ontario communities.

ACTION FROM CONFERENCE: Carried as amended

alPHa RESOLUTION A19-12

TITLE: **Public Health Modernization: Getting it Right!**

SPONSOR: **Peterborough Public Health**

WHEREAS the services provided by local boards of public health are critical to supporting and improving the health and quality of life of all residents of the Province; and

WHEREAS public health interventions are an important strategy in the prevention of hallway medicine and have been found to produce significant cost-saving with estimates that every dollar invested will save or avert at least $14 in future costs; and

WHEREAS boards of health are accountable to both the province and their "obligated municipalities" to maximize their financial resources; and

WHEREAS meaningful municipal participation on boards of health ensures that public health agencies understand and respond to local and specific municipal needs; and

WHEREAS revenue opportunities for municipalities are constrained by both the ability to pay and provincial regulation; and

WHEREAS the current proposal for reorganizing the public health sector in Ontario was developed without meaningful consultation with either boards of health or their obligated municipalities;

NOW THEREFORE BE IT RESOLVED that the Ontario public health mandate as currently outlined in the Ontario Public Health Standards not be altered or diminished in an effort to achieve budget reduction targets and that the Province continues to financially support public health units to adequately implement the Standards;

AND FURTHER that the Association of Local Public Health Agencies (alPHa) calls upon the Ontario government to delay the implementation of any organizational and financial changes to local public health until April 1, 2021 with a commitment to engage in meaningful consultation over the next eighteen (18) months;

AND FURTHER that any changes in the cost-shared formula be phased in over five (5) years commencing in fiscal 2021-22;

AND FURTHER that in ongoing consultations with the province, that alPHa propose the establishment of a joint task force made up of both political representatives and professional staff from existing public health agencies, alPHa, the Association of Municipalities of Ontario (AMO) and the City of Toronto to undertake the following activities:

- Establish a set of principles to guide the reorganization of public health in Ontario that include:
    - Assurance that the enhancement of health promotion and disease prevention is the primary priority of any changes undertaken
    - Undertaking the consolidation of health units around a community of interests which include distinguishing between rural and urban challenges, and the meaningful participation of First Nations
    - Taking into account the ability of municipalities to pay, considerations for the broad range of proposed changes in funding arrangements between the province and municipalities
    - Developing a governance structure that provides accountability to local councils required to fund local public health agencies; and
- Conduct public outreach to municipal, public health and other stakeholders to validate both the principles and the resulting plans for future re-organization; and
- Ensure that the municipal and public health perspectives on any proposed changes, including the outcomes of consultation, are incorporated.

ACTION FROM CONFERENCE: Carried as amended

alPHa RESOLUTION A19-9 (Corrected)

TITLE: **Public Health Support for Accessible, Affordable, Quality Licensed Child Care**

SPONSOR: **Simcoe Muskoka District Health Unit**

WHEREAS the Ontario Public Health Standards indicate the child care sector is an important setting for Public Health interventions, related to the Standards for Health Equity, Healthy Growth and Development, Immunization, Institutional Outbreak Management, Infection Prevention, Food Safety and others; and

WHEREAS supporting families and healthy early childhood development is a core part of the mandate of public health; and

WHEREAS early childhood experiences and socioeconomic status (SES) are important social determinants of health, and are supported by affordable, accessible, quality child care; and

WHEREAS the positive effects of high quality child care and early learning programs can last a lifetime and are associated with immediate and long-term positive outcomes for children, particularly for children from lower socioeconomic backgrounds; and

WHEREAS the current number of licensed child care spaces across Ontario can accommodate less than 1 in 4 (23%) children from ages 0-4; and

WHEREAS Ontario has the highest child care costs provincially, with parents spending $750-$1700 per month for licensed child care, totalling between $9,000-$20,000+ per year for each child; and

WHEREAS public investment in child care demonstrates positive economic benefits; in Ontario, the return on investment is $2.27 for every dollar invested; and

WHEREAS the Ontario government's plan for a refundable tax credit for child care costs will not improve access to quality licensed child care spaces, requires initial out of pocket expenses by families, and may thereby increase health inequities; and

WHEREAS Ontario has the lowest rate of women's workforce participation nationally; recognizing income is a key social determinant of health for Canadian families; and

WHEREAS no provincial standard or definition for quality of child care exists; most of Ontario's municipalities have a quality assurance coordinator, however only half are using a measurement tool to assess quality of child care; and

WHEREAS there is a shortage of Registered Early Childhood Educators in Ontario, in part due to the low compensation they receive and burdensome workplace conditions;

NOW THEREFORE BE IT RESOLVED that alPHa will endorse the importance of an accessible, affordable, quality child care and early learning system, for improved health equity for families and enhanced child development outcomes;

AND FURTHER that alPHa will advocate to the provincial and federal governments to maintain their commitment to ensuring a more affordable child care system, and to expand access to quality, licensed child care services for all Ontario families, including access for families with diverse needs (eg. 24 hour care, weekend care, part time care);

AND FURTHER that alPHa will advocate to the province to maintain its commitment towards creating a provincial definition of quality, including establishing an early years and child care workforce strategy, to ensure child care professionals are adequately qualified and compensated;

AND FURTHER that alPHa will support local public health agencies to:

- enhance their knowledge and transfer knowledge to decision-makers and the general public about the health impacts of the current state of the child care system and the importance of progressing towards an increasingly accessible, affordable, quality child care system; this could be initiated at an upcoming alPHa forum.
- build capacity to support the child care sector, by sharing examples of best practices for public health programming in child care environments and useful approaches for creating and enhancing partnerships with child care providers; this could be initiated through professional development opportunities in collaboration with partner organizations, in particular the College of Early Childhood Educators.

ACTION FROM CONFERENCE: Carried as amended