Algoma
PUBLIC HEALTH
Santé publique Algoma

September 23, 2020

BOARD OF HEALTH MEETING

SSM Algoma Community Room - Video/Teleconference

www.algomapublichealth.com

Meeting Book - September 23, 2020 Board of Health Meeting

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Board of Health Meeting
AGENDA
September 23, 2020 at 5:00 pm
Video/Teleconference | Algoma Community Room
**** Meeting held during the provincially declared emergency***

BOARD MEMBERS	**APH EXECUTIVE**
Lee Mason - BOH Chair	Dr. Marlene Spruyt - Medical Officer of Health/CEO
Ed Pearce - F&AC Chair	Dr. Jennifer Loo - AMOH & Director of Health Protection
Deborah Graystone - Gov. Chair	Justin Pino - CFO /Director of Operations
Dr. Patricia Avery	Antoniette Tomie - Director of Human Resources
Louise Caicco Tett	Laurie Zeppa - Director of Health Promotion & Prevention
Sally Hagman	Tania Caputo - Board Secretary
Micheline Hatfield	
Dr. Heather O'Brien	
Brent Rankin	
Matthew Scott	

* ***Proceedings are being recorded via Webex and will be available for public viewing.*** *L. Mason*

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 September 23, 2020** be approved as presented.

3.0 Delegations / Presentations

a. Health Equity - Basic Income Guarantee *L. Zeppa*

b. Basic Income resolution

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

RESOLUTION

THAT the **June 24, 2020 Board of Health Minutes, August 18, 2020 Special Meeting Minutes and September 2, 2020 Special Meeting Minutes** be approved as presented.

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, September 2020

ii. Public Health System Evaluation - *for information only*

RESOLUTION

THAT the **report of the Medical Officer of Health and CEO for September 2020** be adopted as presented.

b. Finance and Audit

i. Financial Statements *E. Pearce*

ii. COVID Costs

RESOLUTION

THAT the **unaudited Financial Statements for the period ending July 31, 2020** be approved as presented.

ii. Infant Development Annual Reconciliation *J. Pino*

RESOLUTION

THAT the Board of Health receives and approves the Transfer Payment Annual Reconciliation for the Infant Development program as presented.

iii Levy Reimbursement Briefing Note *J. Pino*

RESOLUTION

c. Governance

i. Governance Committee Chair Report *D. Graystone*

ii. **02-05-015 Conflict of Interest - Policy**

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

iii. 02-05-080 Performance Evaluation for MOH CEO - Policy

v. 02-05-086 Sponsorship of Charitable Organizations

RESOLUTION

THAT the **Governance Committee Chair report** for September 2020 be accepted as presented.

THAT the Board of Health has reviewed and approves **Policy 02-05-015 Conflict of Interest** as presented, and;

THAT the Board of Health has reviewed and approves **Policy 02-05-035 Continuing Education for Board Members** as presented, and;

THAT the Board of Health has reviewed and approves **Policy 02-05-080 Performance Evaluation for MOH CEO** as presented, and;

THAT the Governance Committee has reviewed and approves **Policy 02-05-086 Sponsorship of Charitable Organizations** as presented.

7.0 New Business/General Business *L. Mason*

8.0 Correspondence *L. Mason*

a. Emails addressed to the Board of Health regarding the direction to mask in indoor public places.

b. Letter to the Prime Minister of Canada, The Deputy Prime Minister and the Minister of Finance from Peterborough Public Health regarding **Basic Income for Income Security during Covid-19 Pandemic and Beyond** dated June 25, 2020.

c. Letter to the Prime Minister of Canada, The Deputy Prime Minister and the Minister of Finance from Porcupine Health Unit regarding **Basic Income for Income Security during Covid-19 Pandemic and Beyond** dated June 29, 2020.

d. Letter to the Prime Minister of Canada, The Deputy Prime Minister and the Minister of Finance from Renfrew County and District Health Unit regarding **Basic Income for Income Security during Covid-19 Pandemic and Beyond** dated July 16, 2020.

e. Letter to the Prime Minister of Canada, The Deputy Prime Minister and the Minister of Finance from Chatham-Kent Public Health regarding **Basic Income for Income Security during Covid-19 Pandemic and Beyond** dated July 27, 2020.

f. Letter to the Minister of Health and Minister of Justice and Attorney General of Canada from Chatham-Kent Public Health regarding **The Decriminalization of Personal Possession of Illicit Drugs** dated July 30, 2020.

g. Letter to the Deputy Premier, Minister of Health and Long-Term Care from Simcoe Muskoka District Health Unit regarding **Health Unit Funding During COVID-19,** dated August 19, 2020.

9.0 Items for Information *L. Mason*

a. Letter to the Minister of the Association of Local Public Health Agencies regarding **Protecting Children and Youth from Dangers of Vaping** dated July 9 2020.

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.

12.0 Open Meeting *L. Mason*

Resolutions resulting from in-camera meeting.

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

Finance & Audit Committee Meeting
October 14, 2020 @ 5:00 pm
Webex Audio / Video Conference |SSM Algoma Community Room

Board of Health Meeting
October 28, 2020 @ 5:00 pm
Webex Audio / Video Conference |SSM Algoma Community Room

Governance Committee Meeting
November 18, 2020 @ 5:00 pm
Webex Audio / Video Conference |SSM Algoma Community Room

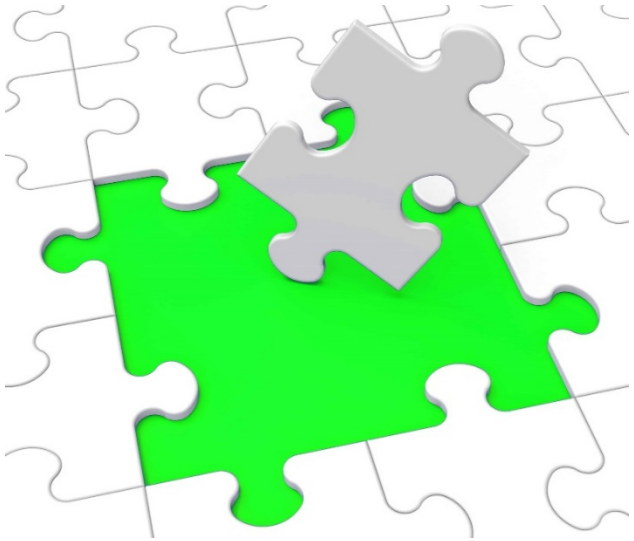
14.0 Evaluation *L. Mason*

15.0 Adjournment *L. Mason*

RESOLUTION

THAT the Board of Health meeting adjourns.

Build Back Better: The case for basic income



Deborah Antonello, Health Equity Public Health Nurse
Lisa O’Brien, Public Health Dietitian

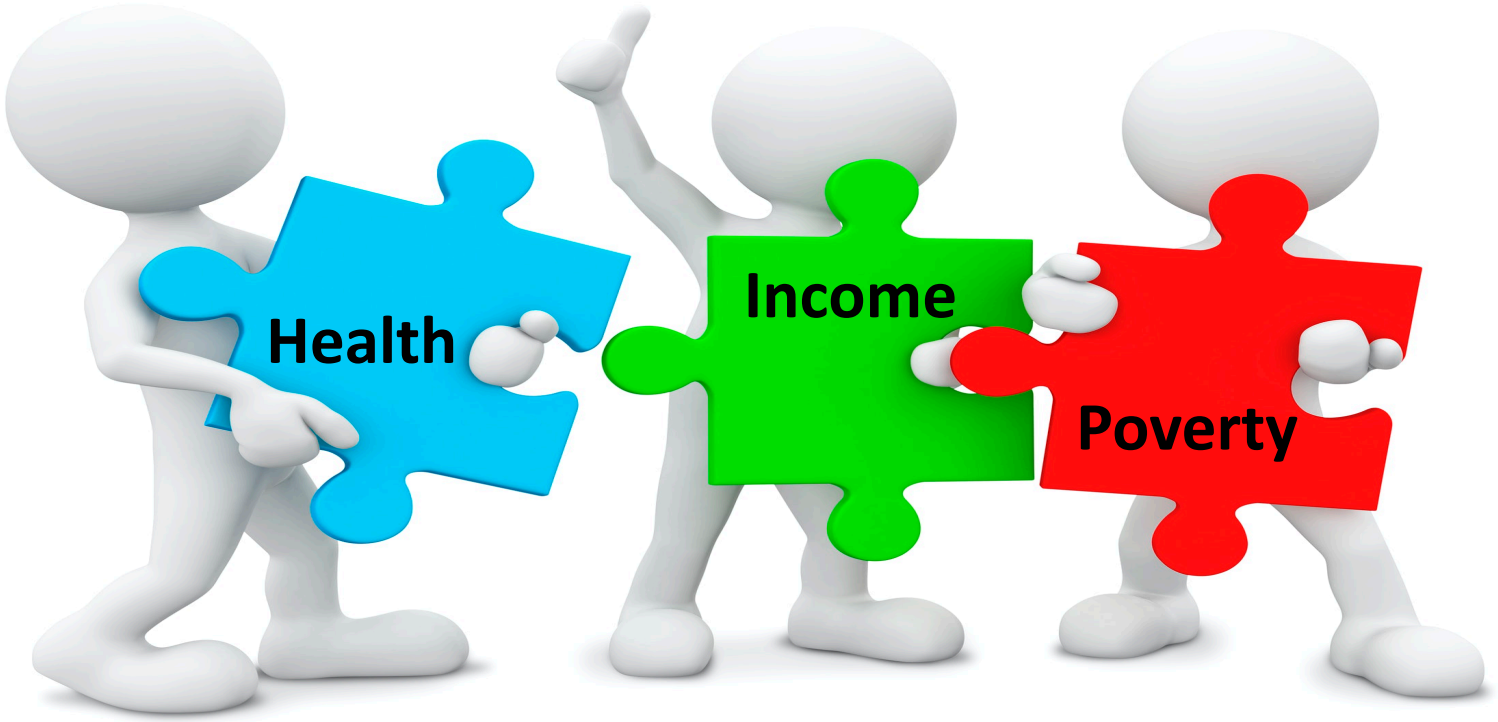
September 23, 2020

What is basic or guaranteed income?

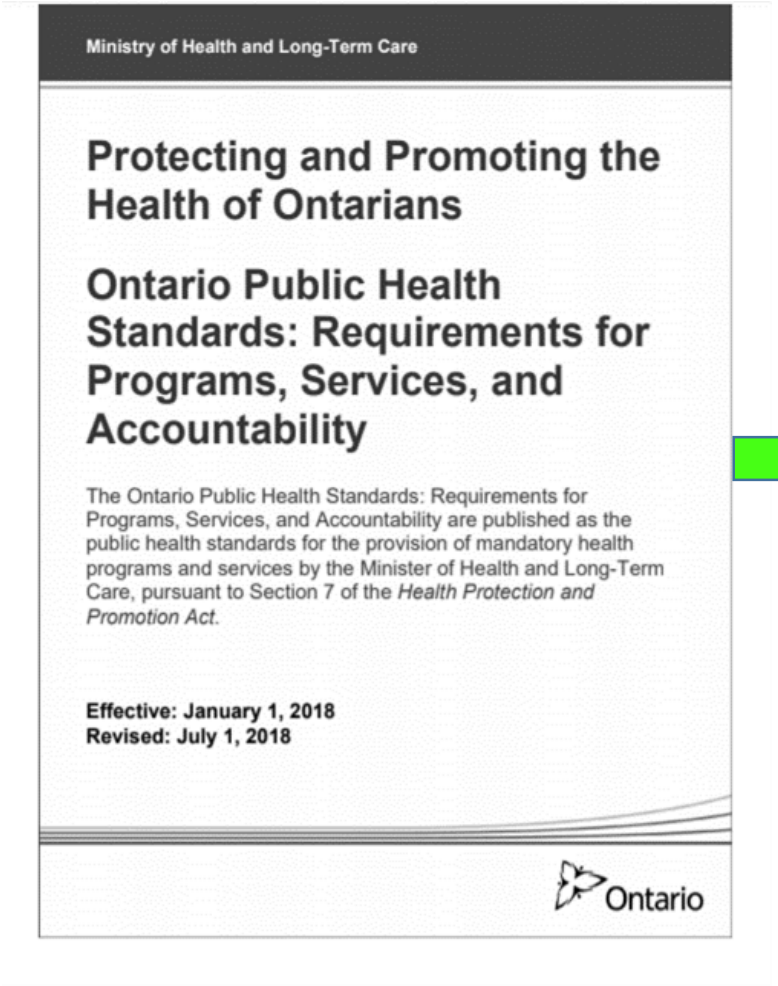
Basic or Guaranteed Income is a regular, reliable distribution of money to individuals or families to help ensure everyone has an income sufficient to meet their basic needs.

Pasma, C., and Mulvale, J. Income Security for All Canadians: Understanding Guaranteed Income. Ottawa: Basic Income Earth Network Canada, 2009.

Why is basic income a public health issue?



Public health has a mandate for health equity


Ministry of Health and Long-Term Care

Protecting and Promoting the Health of Ontarians

Ontario Public Health Standards: Requirements for Programs, Services, and Accountability

The Ontario Public Health Standards: Requirements for Programs, Services, and Accountability are published as the public health standards for the provision of mandatory health programs and services by the Minister of Health and Long-Term Care, pursuant to Section 7 of the *Health Protection and Promotion Act*.

Effective: January 1, 2018
Revised: July 1, 2018

Ontario

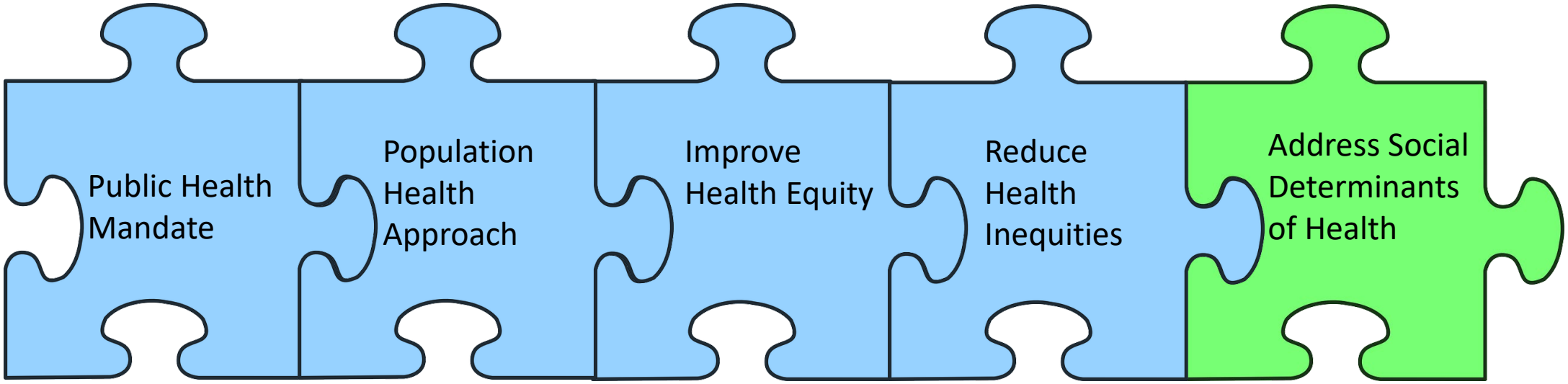
2018: Revised Ontario Public Health Standards

Foundational and Program Standards:

- Population Health Assessment
- **Health Equity**
- Effective Public Health Practice,
- Emergency Management

Goal:
"Public health practice results in **decreased health inequities** such that everyone has **equal opportunities for optimal health** and can attain their full health potential **without disadvantage due to social position or other socially determined circumstances**"

The Public Health Picture



Social determinants of health (SDOH)

- Access to health services
- Culture, race, and ethnicity
- Disability
- Early childhood development
- Education, literacy, and skills
- Employment, job security, and working conditions
- Food insecurity
- Housing
- **Income and income distribution**
- Indigenous status
- Personal health practices and resiliency
- Physical environments
- Sexual orientation and attraction
- Social inclusion/exclusion
- Social support networks

Income is a primary driver of health outcomes

- Low income is linked to poor health outcomes
  - **People in Northern Ontario have poorer health outcomes**, compared to Southern Ontario, due to limitations to social and economic opportunities

- Low income increases the risk for preventable conditions, including chronic diseases, injuries, suicide and mental illness

- **Income determines the quality of other social determinants of health,** such as food security, housing, and other basic necessities of life

Braveman & Gottlieb (2014) .The social determinants of health: it's time to consider the causes of the causes.
Health Quality Ontario (2018). Northern Ontario Health Equity Strategy.
Public Health Agency of Canada (PHAC) Pan-Canadian Public Health Network; Ottawa, Canada: 2018. Key Health Inequalities in Canada: A National Portrait; p. 437
Raphael, D. (2009). The Social Determinants of Health: Canadian Perspectives, p.12

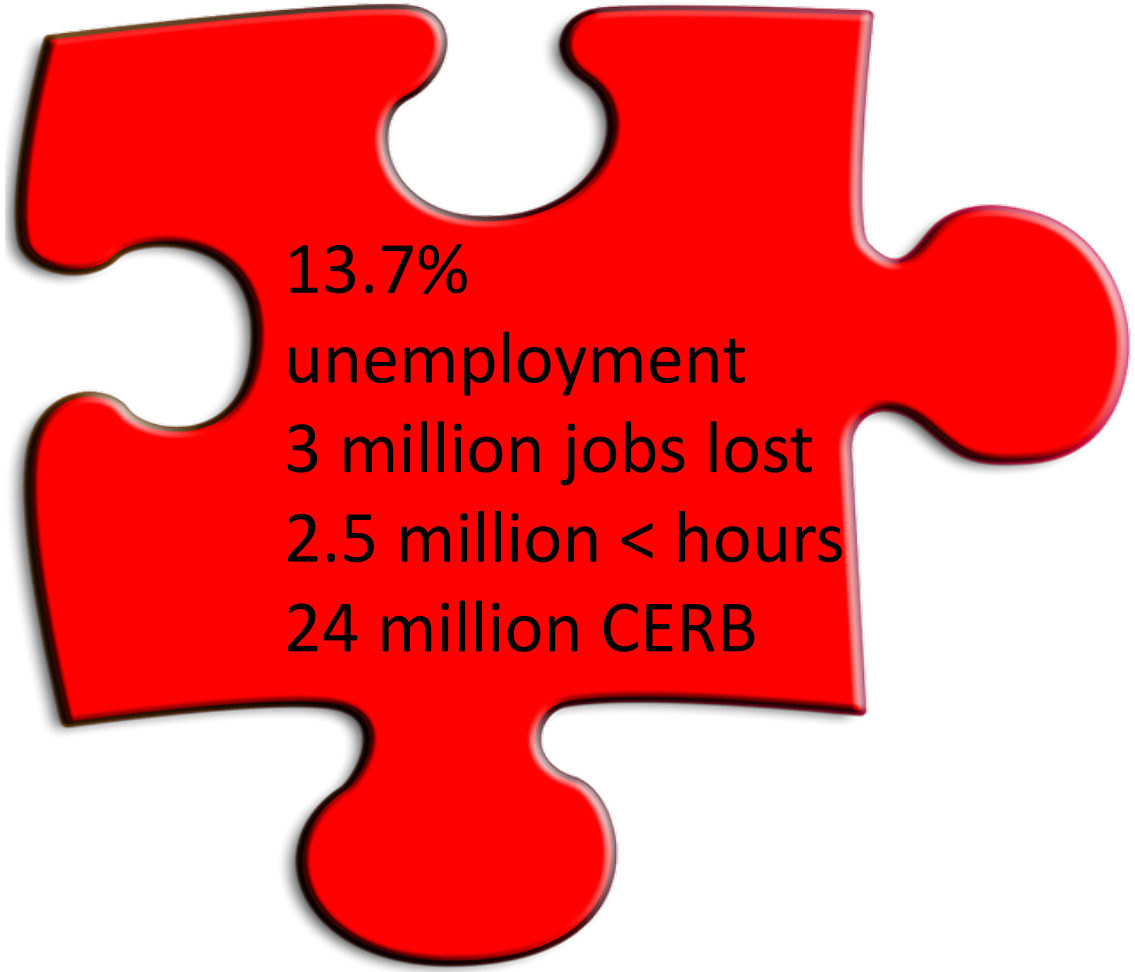
Poverty in Canada and Algoma

Pre-COVID-19 Poverty Rates

- 14.2% of Canadians,
- 13.7 % of Ontarians and

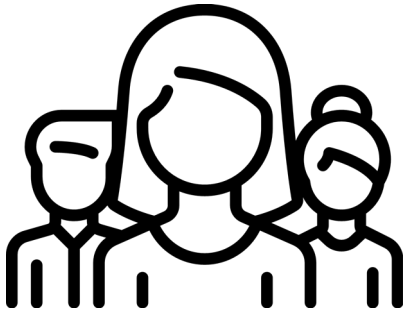
16.1% of Algoma residents live in low income

Canada's COVID-19 stats (summer 2020)



https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/index.cfm?Lang=E (accessed September 2, 2020)
https://globalnews.ca/news/7029601/canada-may-unemployment-rate/
https://www.canada.ca/en/services/benefits/ei/claims-report.html

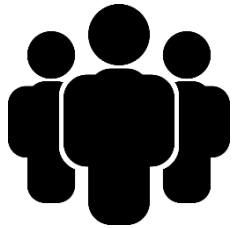
Snapshot of low income in Algoma, Pre-COVID-19



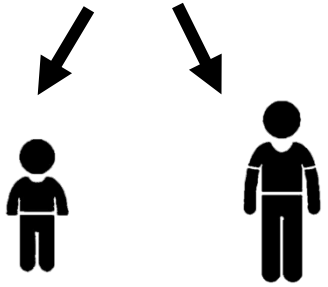
18,500 people

10,000 households

12.4% of households



13.8% Indigenous

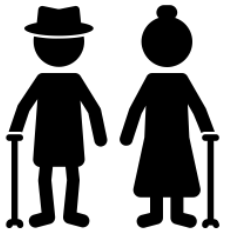


25% children under 6

22% youth under 18

17.6% lone parent families

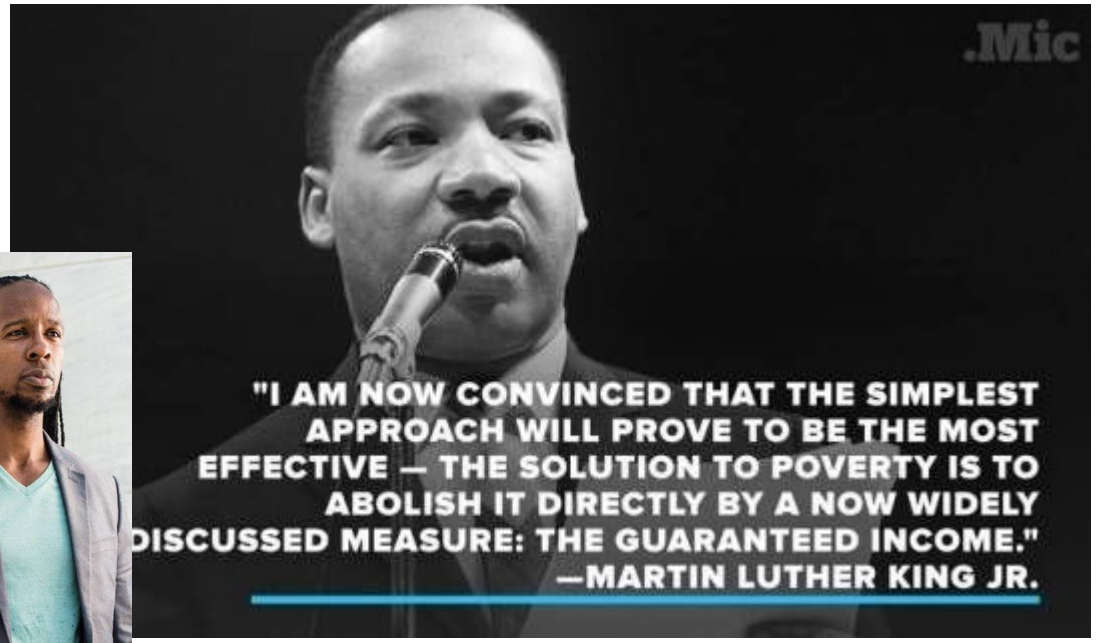
40.2% have not completed post-secondary

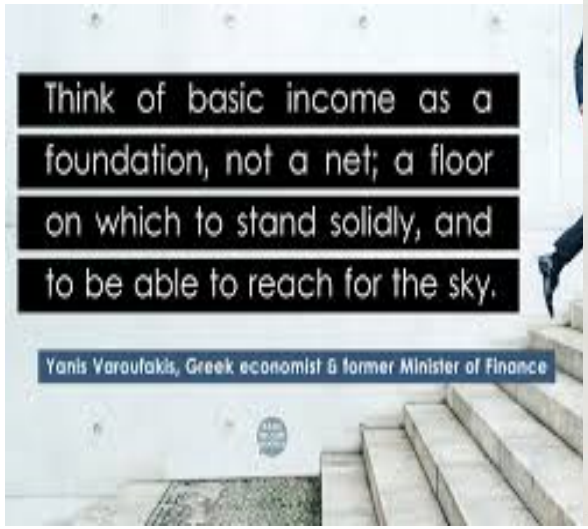


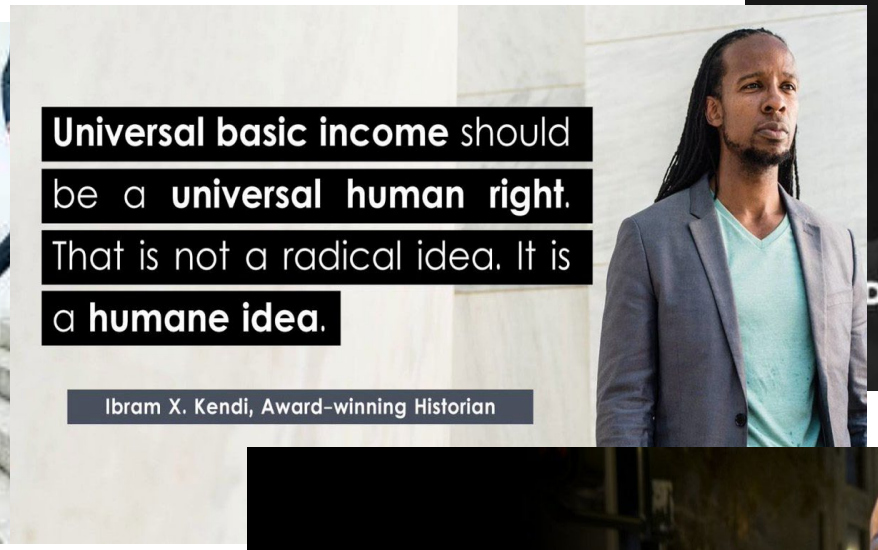
23.7% aged 65+

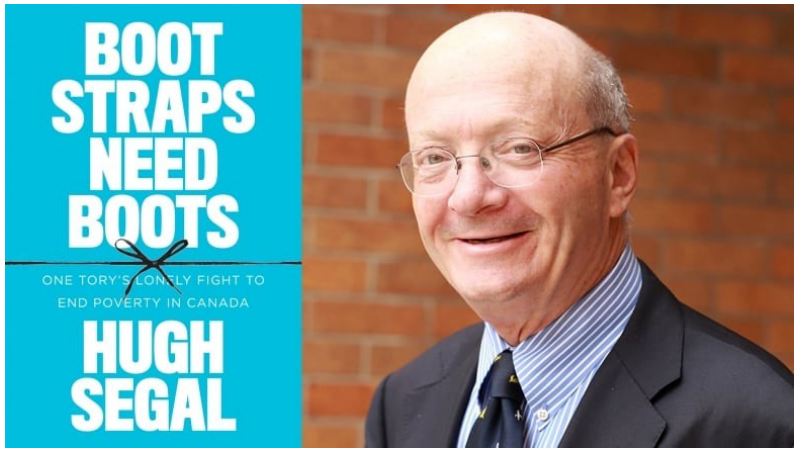
Census Profile. 2016 Census of Canada Statistics Canada. Canadian Community Health Survey [2015-2016])
Buajitti E, Chiodo S, Watson T, Kornas K, Bornbaum C, Henry D, Rosella LC. Ontario atlas of adult mortality, 1992-2015, Version 2.0: Trends in Public Health Units. Toronto, ON: Population Health Analytics Lab; 2018.
Algoma Public Health. Community Health Profile, 2018. Sault Ste. Marie (ON): Algoma Public Health; 2018.

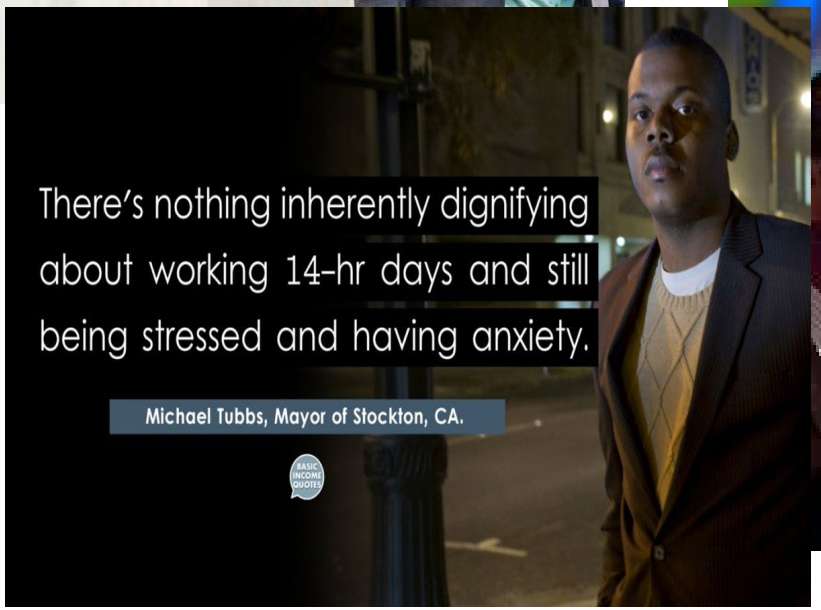
Basic Income: It's not a new idea!











The Town with No Poverty: The Health Effects of a Canadian Guaranteed Annual Income Field Experiment

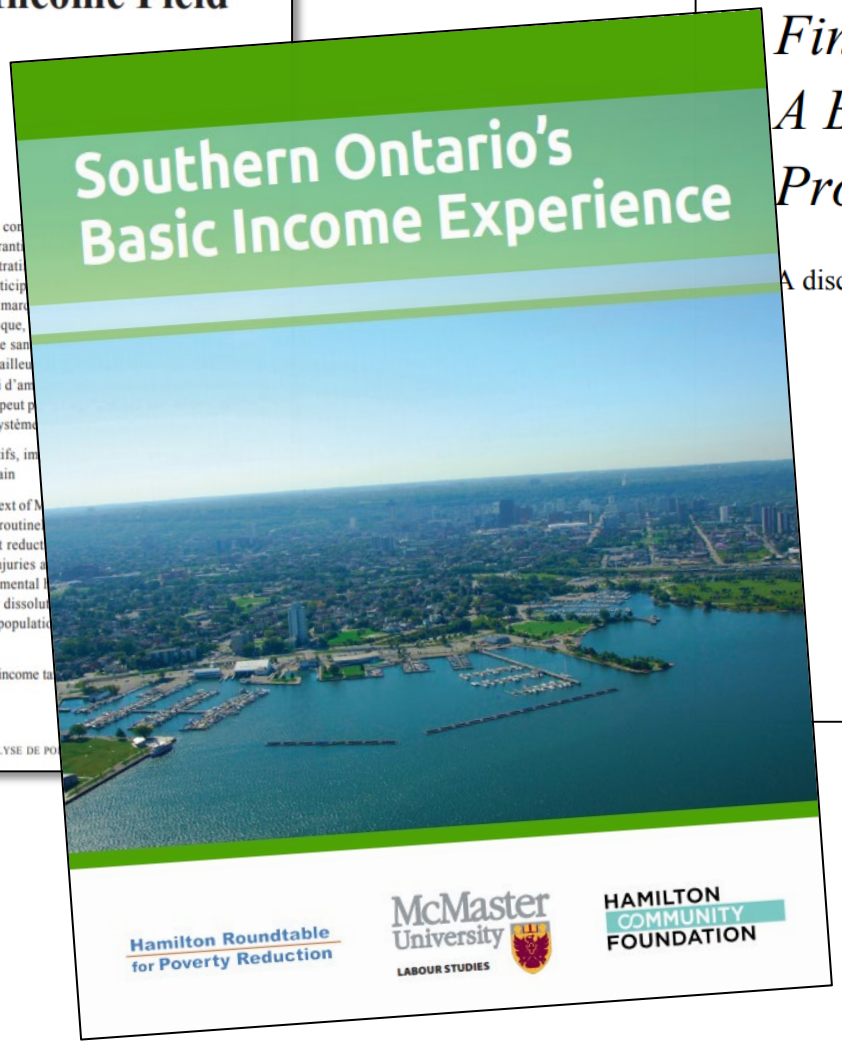
Evelyn L. Forget
Community Health Sciences
University of Manitoba, Winnipeg

L'objet de cet article est double. Premièrement, il documente le cor
expérience canadienne en matière de revenu annuel minimum garanti
ment, grâce à des données provenant de dossiers de santé administrati
expérimental, il indique que le taux d'hospitalisations chez les particip
inférieur à celui d'un groupe témoin, et que cette différence était mar
et blessures et de maladies mentales. Les résultats montrent aussi que,
participants chez le médecin, en particulier pour des questions de san
d'adolescents ont poursuivi leurs études après la 12e année. Par ailleu
hausse du taux de natalité et du taux d'éclatement des familles, ni d'an
grossesse. Je conclus qu'un revenu annuel garanti même modeste peut p
population, entraînant ainsi des économies importantes pour le système

Mots clés : revenu annuel minimum garanti, dossiers administratifs, im
pour la santé, revenu de base, MINCOME, expérience sur le terrain

This paper has two purposes. First, it documents the historical context of M
annual income field experiment (1974 to 1979). Second, it uses routine
data and a quasi-experimental design to document an 8.5 percent reduct
participants relative to controls, particularly for accidents and injuries a
that participant contacts with physicians declined, especially for mental h
continued into grade 12. We found no increase in fertility, family dissolut
comes. We conclude that a relatively modest GAI can improve populatio
health system savings.

Keywords: guaranteed annual income, administrative data, negative income ta
MINCOME, field experiment



Finding a Better Way: A Basic Income Pilot Project for Ontario

A discussion paper by Hugh D Segal

alPHa
Association of Local Public Health Agencies

alPHa RESOLUTION A15-4

TITLE: **Public Health Support for a Basic Income Guarantee**

SPONSOR: **Simcoe Muskoka District Health Unit**

WHEREAS low income, and high income inequality, have well-established, strong relationships with a range of adverse health outcomes; and

WHEREAS 1,745,900 Ontarians, or 13.9% of the population, live in low income according to the 2011 National Household Survey after-tax low-income measure; and

WHEREAS income inequality continues to increase in Ontario and Canada; and

WHEREAS current income security programs by provincial and federal governments have not proved sufficient to ensure adequate, secure income for all; and

WHEREAS a basic income guarantee – a cash transfer from government to citizens not tied to labour market participation - ensures everyone an income sufficient to meet basic needs and live with dignity, regardless of work status; and

WHEREAS basic income resembles income guarantees currently provided in Canada for seniors and children, which have contributed to health improvements in those age groups; and

WHEREAS there was an encouraging pilot project of basic income for working age adults conducted jointly by the Government of Manitoba and the Government of Canada in Dauphin, Manitoba in the 1970s, which demonstrated several improved health and educational outcomes; and

WHEREAS a basic income guarantee can reduce poverty and income insecurity, and enable people to pursue educational, occupational, social and health opportunities relevant to them and their family; and

WHEREAS the idea of a basic income guarantee has garnered expressions of support from the Canadian Medical Association and the Alberta Public Health Association as a means of improving health and food security for low income Canadians; and

WHEREAS there is momentum growing across Canada from various sectors and political backgrounds for a basic income guarantee;

NOW THEREFORE BE IT RESOLVED THAT the Association of Local Public Health Agencies (alPHa) endorse the concept of a basic income guarantee;

Why basic income?

- Despite Canada's poverty reduction strategy, **14.2% of Canadians still live in poverty** (pre-COVID-19)
  - Income security is a foundational element to any poverty reduction strategy

- **Basic income increases health status, resulting in less strain on the health care system**
  - Participants in Ontario's 2017 pilot study reported less-frequent visits to health care providers and hospital emergency rooms

- Global health crises (e.g. SARS,COVID-19, future pandemics) cause **significant economic, social, and political disruption, especially for priority populations**:
  - Immigrants, refugees, and other newcomers account for nearly 44% of all COVID-19 cases in Ontario

https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/index.cfm?Lang=E (accessed September 2, 2020)
Madhav N, Oppenheim B, Gallivan M, et al. Pandemics: Risks, Impacts, and Mitigatione. Disease Control Priorities: Improving Health and Reducing Poverty. 3rd edition.
Ferdosi et al. (March 2020). Southern Ontario's Basic Income Experience. Available from https://labourstudies.mcmaster.ca/news/access-southern-ontario2019s-basic-income-experience-report#:~:text=The%20self%2Dreported%20outcomes%20of,in%20today's%20precarious%20labour%20market.
Guttmann et al. COVID-19 in Immigrants, Refugees and Other Newcomers in Ontario: Characteristics of Those Tested and Those Confirmed Positive, as of June 13, 2020. Toronto, ON: ICES; 2020.

Does basic income make a difference?

- Canada already has forms of guaranteed income -- cash transfers from government – *Canada Child Benefit*, *Old Age Security* and the *Guaranteed Income Supplement*
- Guaranteed annual income programs have been shown to have positive impacts on physical and mental health

"For a significant number of participants, basic income purportedly proved to be transformational, fundamentally reshaping their living standards as well as their sense of self-worth and hope for a better future" (Southern Ontario's Basic Income Experience Report, 2020)

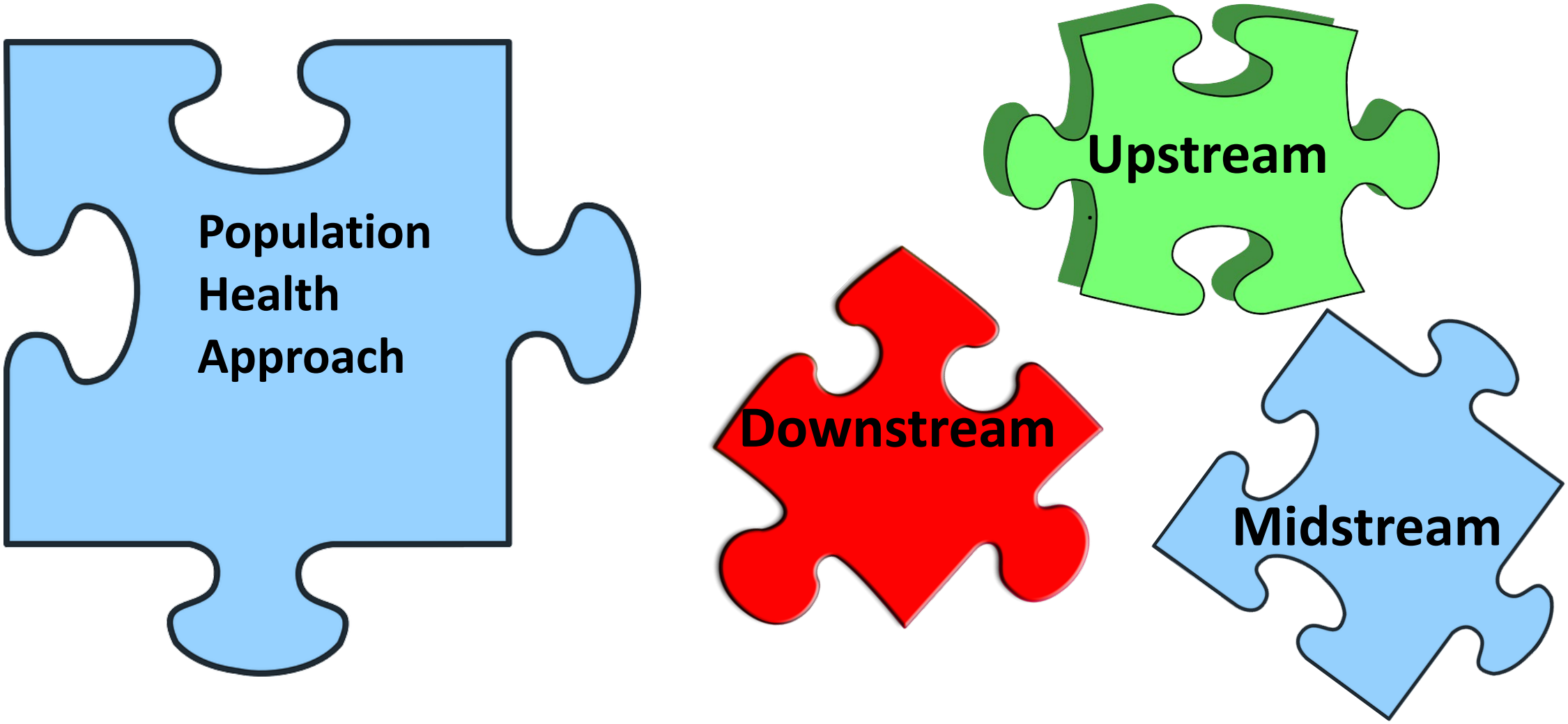
McIntyre et al. (2016). Impact of a guaranteed annual income program on Canadian seniors' physical, mental and functional health. *Can J Public Health*. 2016;107(2)
Cheng et al. The Health Implications of Social Pensions: Evidence from China's New Rural Pension Scheme. IZA Discussion Paper No. 9621,
Brown E.M. & Tarasuk, V. Money speaks: Reductions in severe food insecurity follow the Canada Child Benefit. Preventive Medicine. 2019; 129.
Chen et al. (2019). Does money relieve depression? Evidence from social pension expansions in China. *Soc Sci Med*.
Ferdosi et al. (March 2020). Southern Ontario's Basic Income Experience.

The Canada Emergency Response Benefit (CERB)

- A crisis-driven support program, CERB provides temporary income support to workers who have stopped working because of COVID-19

- **CERB represents a healthy public policy opportunity**
  - Evolving CERB into a basic income program for Canadians would improve the health of all Canadians

Public health's role



Moving Upstream

About changing the effects of the causes.

Ensure that public health programs are accessible to low income people

About changing the causes.

Link low-income clients with social assistance or back-to-work programs, completing income tax forms

About diminishing the causes of the causes.

Advocate for living wage policies, wage capping, progressive taxation, **Basic income**

Moving Upstream …
The example of food insecurity

No More

Shift the focus from food charity to income

Food Charity (soup kitchen, food bank)	Adequate Income
Temporary hunger relief (food insecurity does not go away)	Addresses the root cause of food insecurity (not enough money)
Limited reach (only about 20% use food banks)	Household can choose how, when and what food to buy.
Limited operating hours Restrict number of visits and amount of food	
Cannot meet daily needs for nutritious food	
Undermines people's dignity	Preserves dignity when people have enough money to buy food.
Excuses decision makers from ensuring the basic right to food.	Ensures the basic right to food.

Ontario Dietitians in Public Health (ODPH). Position Statement and Recommendations on Responses to Food Insecurity. 2020
PROOF (Food Insecurity Policy Research). Relationship between food banks and food insecurity in Canada. Toronto, ON; 2019.
Daily Bread Food Bank. Hunger Lives Here: Risks and Challenges Faced by Food Bank Clients During COVID-19, 2020. Toronto, ON.

Food should be a basic human right … yet many struggle

Food Insecure Households in Canada

Pre- COVID-19	During COVID-19 (May 2020)
10.5%	14.6%

People more vulnerable to food insecurity:

- Female lone parent households (children under 18)
- Low wage earners
- Employed in part-time, short-term, 'precarious' work
- Main income from social assistance or employment insurance
- Renters
- People who identify as Indigenous or Black

Statistics Canada. Food insecurity during the COVID-19 pandemic, May 2020. Ottawa, ON: Statistics Canada; 2020.
PROOF (Food Insecurity Policy Research). Household food insecurity in Canada [webpage online]. Toronto, ON: Food Insecurity Policy Research (PROOF) [updated 2018 Feb 22].
Ontario Dietitians in Public Health (ODPH). Position Statement and Recommendations on Responses to Food Insecurity. 2020

It’s not about food

- Food-insecure households experience material deprivation
- It is a struggle to afford the basic costs of living (food, housing, utilities, medication, child care, transportation, etc.)

Nutritious Food Basket (NFB), Income Scenarios - 2019

	Monthly Income (after tax)	Monthly Rent	Monthly Food (NFB)	Money Leftover
Family of Four receiving OW	$2,643	$929 (35% of income)	$975.85 (37% of income)	$738.15
Single Male receiving OW	$838	$603 (72% of income)	$328.23 (39% of income)	-$93.23

✘ More food will NOT solve the problem. ✓ More money can.

Algoma Public Health. 2019 NFB Income Scenarios Spreadsheet.

Build back better: A policy opportunity for improving population health

- Write to the Prime Minister of Canada recommending the revision of CERB into a basic income for all Canadians, during the COVID-19 pandemic and beyond.

- Strategically include the following stakeholders and partners, for the purpose of starting and maintaining a conversation about basic income in Algoma:
  - Premier of Ontario, Algoma District MPs and MPPs and municipal councils, the Sault Ste. Marie Poverty Round Table, the North Shore Poverty Network, the Association of Local Public Health Agencies, the Ontario Public Health Association, and the Boards of Health in Ontario


BASIC INCOME
FOR CANADA

Algoma Public Health in support of basic income

Whereas addressing the determinants of health and reducing health inequities are fundamental to the work of public health; and

Whereas effective public health programs and services consider the impact of the determinants of health on health outcomes; and

Whereas income is the single largest determinant of health and low income has a well-established link to adverse health outcomes and is associated with shorter life expectancy; and

Whereas income or lack thereof determines the *quality* of other social determinants of health, such as food insecurity, housing and basic necessities of life; and

Whereas currently, 14.2% of Canadians, 13.7 % of Ontarians and **16.1% of Algoma residents** live in low income circumstances; and

Whereas income inequality continues to increase in Ontario and Canada while current income security programs by provincial and federal governments are not sufficient to ensure adequate, secure income for all; and

Whereas the current economic disruption of COVID-19 has exacerbated income inequality to unprecedented levels, with certain priority populations (e.g. immigrants, refugees, low income workers, having been disproportionately impacted: and

Whereas the Canadian Emergency Response Benefit (CERB) was created as a temporary measure to respond to the immediate economic crisis associated with COVID-19; and

Whereas this is an opportunity to build healthy public policy by restructuring CERB into a basic income program for all Canadians; and

Whereas a basic income program will reduce persistent poverty and improve Canadians' health, and their ability to manage future and existing income challenges; and

Whereas the concept of a basic income has been endorsed by many, including, Association of Local Public Health Agencies (Ontario), Canadian Medical Association, Canadian Public Health Association, Ontario Public Health Association, and the Ontario Dietitians in Public Health, as part of multipronged approach to reducing poverty; and

Whereas there is growing public and political sector support for a national basic income.

Now Therefore Be It Resolved That the Board of Health of Algoma Public Health write to the Prime Minister of Canada recommending the revision of the Canada Emergency Response

Benefit (CERB) into a basic income for all Canadians, during the COVID-19 pandemic and beyond.

And furthermore That the Premier of Ontario, Algoma District MPs and MPPs and municipal councils, the Sault Ste. Marie Poverty Round Table, the North Shore Poverty Network, the Association of Local Public Health Agencies, the Ontario Public Health Association, and the Boards of Health in Ontario receive a copy of the Board's letter to the Prime Minister.

Board of Health Meeting
MINUTES
June 24, 2020 at 5:00 pm
Video/Teleconference | Algoma Community Room
**** Meeting held during the provincially declared emergency***

PRESENT :	**BOARD MEMBERS** Dr. Heather O'Brien	**APH EXECUTIVE** Tania Caputo - Board Secretary
VC/TC :	Lee Mason - BOH Chair Ed Pearce - F&AC Chair Deborah Graystone - Gov. Chair Dr. Patricia Avery Louise Caicco Tett Sally Hagman Micheline Hatfield Brent Rankin Matthew Scott	Dr. Marlene Spruyt - Medical Officer of Health/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

* ***Proceedings are being recorded via Webex and will be available for public viewing.***

1.0 Meeting Called to Order

a. Declaration of Conflict of Interest

No conflicts were declared.

2.0 Adoption of Agenda

RESOLUTION 2020-51

Moved: D. Graystone
Seconded: P. Avery

THAT the **Board of Health agenda dated June 24, 2020** be approved as amended.

CARRIED

3.0 Delegations / Presentations

4.0 Adoption of Minutes of Previous Meeting

In regards to the June 3, 2020 Special Meeting Minutes, **Item 3. Reporting Concerns,** it was noted by B. Rankin that the minutes should capture that existing policies were followed by APH Staff and Senior Administration and that there was thought to be room for change and accommodation and review.

RESOLUTION 2020-52

Moved: M. Hatfield
Seconded: P. Avery

THAT the May 27, 2020 **Board of Health Meeting Minutes and and June 3, 2020 Board of Health Special Meeting Minutes** be approved as presented.

CARRIED

5.0 Business Arising from Minutes

Not Applicable

6.0 Reports to the Board

a. Medical Officer of Health and Chief Executive Officer Reports

i. MOH Report, June 2020

M. Spruyt spoke about resuming the regular work of Public Health while still responding to COVID-19 and upscaling those activities if there is a surge. A link is included in the MOH/CEO report to an article about the risk of not returning to Public Health work and makes the point that a number of other health issues still exist and require continued attention.

M. Spruyt provided expamples of programs that have found efficiencies as a result of COVID induced changes - an example is the Pre-natal nutrition program which supports pregnant women living in poverty. They would travel in, meet with a Dietician or Public Health Nurse and receive educational supports and a package with food and milk coupons. The virtual program cuts out the transportation and they are given vouchers to use at any grocery store and have reported that they have better choice now without an increased cost to the program. The clientele has increased by 30%. Other agencies have also had positive responses from clientele involved in virtual programs.

ii. More to Public Health than Covid-19 - *for information only*

iii. APH Covid-19 Response - the slide deck will be posted in the Addendum

J. Loo delivered this presentation explaining the goals of pandemic response; to minimize serious illness and death and to minimize societal disruption requiring a "whole of society" response. She explained the structure of IMS along with the role of each area. J.Loo walked us through a timeline of the APH Covid-19 Response including an overview of the Communications Team media initiatives throughout. There was discussion about mask wearing recommendations and messaging, as well as effectiveness of various face coverings. Communicating Provincial directives and implementation was discussed, as well as redeploying nurses to COVID-19 work, and preparedness for future waves. Concerns remain about minimizing risk to communities when travellers are arriving from outside of our district. APH will work closely with places of business to ensure measures are in place for protection. School plans for fall are in the works and we expect to receive direction from the Province as they lay the groundwork for these plans.

RESOLUTION 2020-53

Moved: S. Hagman

Seconded: D. Graystone

THAT the **report of the Medical Officer of Health and CEO for June 2020** be adopted as presented.

CARRIED

b. Finance and Audit

i. Finance and Audit Committee Chair Report

E. Pearce provided an overview of the June 11, 2020 Finance and Audit Committee meeting.

ii. Financial Statements

J. Pino provided an overview and of the April 30, 2020 financial statements.

RESOLUTION 2020-54

Moved: E. Pearce

Seconded: P. Avery

THAT the **unaudited Financial Statements for the period ending April 30, 2020** and the **Finance and Audit Committee Chair Report for June 11, 2020** be approved as presented.

CARRIED

ii. Summary of Covid Costs as of April 2020 - *for information only*

iii. Terms of Reference - Finance and Audit Committee

RESOLUTION 2020-55	**Moved:** E. Pearce **Seconded:** B. Rankin

THAT the **Terms of Reference for the Finance and Audit Committee** be approved as presented.

CARRIED

c. Governance

i. Governance Committee Chair Report

ii. 02-05-060 Meetings and Access to Information - Policy

iii. 02-05-085 Orientation Board Members - Policy

iv. 02-05-015 Conflict of Interest - Policy

v. 02-05-045 Attendance at Meetings Using Electronic Means - Policy

vi. 06-02 Ontario Building Code Appointments - Bylaw

vii. 15-01 To Provide for the Management of Property - Bylaw

viii. Terms of Reference for the Governance Committee

D. Graystone provided an overview of the Jun 17, 2020 Governance Committee Meeting with discussion about the Conflict of Interest policy that is being revisited at the September 2020 meeting.

RESOLUTION 2020-56	**Moved:** S. Hagman **Seconded:** L. Caicco Tett

THAT the **Governance Committee Chair report for June 2020** be accepted as presented and;

THAT the Board of Health has reviewed and approves **Policy 02-05-060 Meetings and Access to Information** as presented, and;

THAT the Board of Health has reviewed and approves **Policy 02-05-085 Orientation Board Members** as presented, and;

THAT the Board of Health has reviewed and approves **Policy 02-05-015 Conflict of Interest** as presented, and;

THAT the Board of Health has reviewed and approves **Policy 02-05-045 Attendance at Meetings Using Electronic Means** as presented, and;

THAT the Board of Health has reviewed and approves **Bylaw 06-02 Ontario Building Code Appointments** as presented, and;

THAT the Board of Health has reviewed and approves **Bylaw 15-01 To Provide for the Management of Property** as presented, and;

THAT the Board of Health has reviewed and approves **the Terms of Reference for the Governance Committee** as presented.

CARRIED

7.0 New Business/General Business

Not applicable.

8.0 Correspondence

a. Memo from the Ministry of Health regarding **Pandemic Pay Eligibility** dated May 27, 2020.

b. Letter to the Transitional Regional Lead West, Ontario Health from Grey Bruce Health Unit regarding **Reporting Inaccuracy COVID-19 Enhanced Surveillance of Long-Term Care,** dated June 8, 2020.

c. Letter to the Prime Minister of Canada, The Deputy Prime Minister and the Minister of Finance from The Timiskaming Board of Health regarding **Basic Income for Income Security during Covid-19 Pandemic and Beyond** dated June 9, 2020.

9.0 Items for Information

Not applicable.

10.0 Addendum

a. APH Covid-19 Response Item 6. a) iii.

b. Letter to municipalities on communication to clarify procedures and processes and welcoming feedback.

11.0 In-Camera 6:29 pm

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 2020-57	**Moved:**	D. Graystone
	Seconded:	P. Avery

THAT the Board of Health go in-camera.

CARRIED

12.0 Open Meeting - 6:45 pm

No resolutions resulting from the in-camera meeting.

13.0 Announcements / Next Committee Meetings:

Governance Committee Meeting
September 9, 2020 @ 5:00 pm
Webex Audio / Video Conference │SSM Algoma Community Room

Board of Health Meeting
September 23, 2020 @ 5:00 pm
Webex Audio / Video Conference │SSM Algoma Community Room

Finance & Audit Committee Meeting
October 14, 2020 @ 5:00 pm
Webex Audio / Video Conference │SSM Algoma Community Room

14.0 Evaluation

L. Mason requested that board members complete the yearly evaluation

15.0 Adjournment - 6:47 pm

RESOLUTION 2020-59	**Moved:** E. Pearce
	Seconded: D. Graystone

THAT the Board of Health meeting adjourns.

CARRIED

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

Board of Health Special Meeting
MINUTES
August 18, 2020 at 4:00 pm
Video/Teleconference | Algoma Community Room
**** Meeting held during the provincially declared emergency***

	BOARD MEMBERS	APH EXECUTIVE
PRESENT :	Lee Mason - BOH Chair Ed Pearce - F&AC Chair Deborah Graystone - Gov. Chair	Antoniette Tomie - Director of Human Resources Tania Caputo - Board Secretary
VC/TC :	Dr. Patricia Avery Louise Caicco Tett Sally Hagman Micheline Hatfield Dr. Heather O'Brien Brent Rankin Matthew Scott	Dr. Marlene Spruyt - Medical Officer of Health/CEO

1.0 Meeting Called to Order

a. Declaration of Conflict of Interest

No conflicts were declared

2.0 Adoption of Agenda

RESOLUTION 2020-60

Moved: E. Pearce
Seconded: D. Graystone

THAT the Board of Health Special Meeting agenda dated August 18, 2020 be approved as presented.

CARRIED

3.0 In-Camera - 4:05 pm

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 2020-61

Moved: D. Graystone
Seconded: L. Caicco Tett

THAT the Board of Health go in-camera.

CARRIED

4.0 Open Meeting - 6:15 pm

Resolutions resulting from in-camera meeting.

RESOLUTION 2020-63

Moved: L. Caicco Tett
Seconded: S. Hagman

THAT the Board of Health accepts the recommendation of the Recruitment Committee for the position of the MOH/CEO.

CARRIED

NOTE: M. Hatfield left the meeting at 5:30 pm

5.0 Announcements / Next Committee Meetings:

Governance Committee Meeting
September 9, 2020 @ 5:00 pm
Webex Audio / Video Conference │SSM Algoma Community Room

Board of Health Meeting
September 23, 2020 @ 5:00 pm
Webex Audio / Video Conference │SSM Algoma Community Room

Finance & Audit Committee Meeting
October 14, 2020 @ 5:00 pm
Webex Audio / Video Conference │SSM Algoma Community Room

6.0 Adjournment at 6:18 pm

RESOLUTION 2020-64	**Moved:** E. Pearce **Seconded:** H. O'Brien

THAT the Board of Health meeting adjourns.

Board of Health Special Meeting
MINUTES
September 2, 2020 at 5:00 pm
Video/Teleconference | SSM Algoma Community Room

	BOARD MEMBERS	APH EXECUTIVE
PRESENT :	Lee Mason - BOH Chair	Antoniette Tomie - Director of Human Resources
	Ed Pearce - F&AC Chair	Tania Caputo - Board Secretary
	Deborah Graystone - Gov. Chair	
VC/TC :	Dr. Patricia Avery	Dr. Marlene Spruyt - Medical Officer of Health/CEO
	Louise Caicco Tett	
	Sally Hagman	
	Micheline Hatfield	
	Dr. Heather O'Brien	
	Brent Rankin	
	Matthew Scott	

1.0 Meeting Called to Order - 5:04 PM

a. Declaration of Conflict of Interest

No conflicts declared.

2.0 Adoption of Agenda

RESOLUTION 2020-65	**Moved:**	E. Pearce
	Seconded:	L. Caicco Tett

THAT the Board of Health Special Meeting agenda dated September 2, 2020 be approved as presented.

CARRIED

3.0 In-Camera - 5:05 PM

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 2020-66	**Moved:**	E. Pearce
	Seconded:	L. Caicco Tett

THAT the Board of Health go in-camera.

CARRIED

4.0 Open Meeting - 5:45 pm

There were no resolutions resulting from in-camera meeting.

5.0 Announcements / Next Committee Meetings:

Governance Committee Meeting
September 9, 2020 @ 5:00 pm
Webex Audio / Video Conference |SSM Algoma Community Room

Board of Health Meeting
September 23, 2020 @ 5:00 pm
Webex Audio / Video Conference │SSM Algoma Community Room

Finance & Audit Committee Meeting
October 14, 2020 @ 5:00 pm
Webex Audio / Video Conference │SSM Algoma Community Room

6.0 Adjournment 5:50 pm

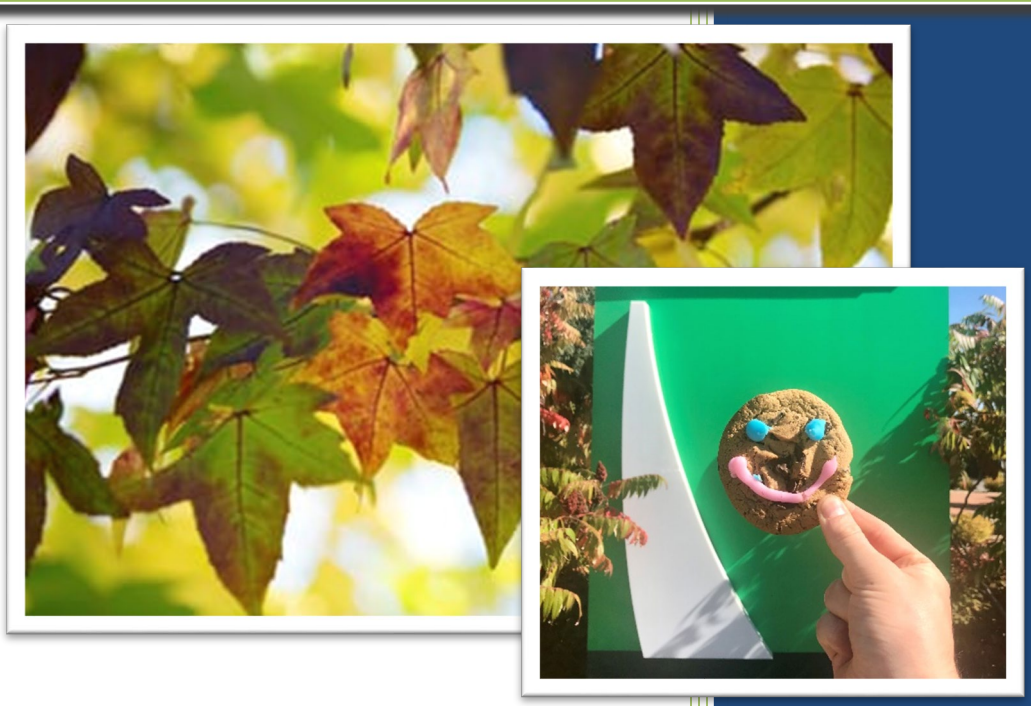
RESOLUTION 2020-69	**Moved:**	D. Graystone
	Seconded:	H. O'Brien

THAT the Board of Health meeting adjourns.

Algoma
PUBLIC HEALTH
Santé publique Algoma

September 2020

Medical Officer of Health / CEO



Prepared by:
Dr. Marlene Spruyt and the
Leadership Team

Presented to:
Algoma Public Health Board of Health
23/9/2020

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APH AT-A-GLANCE

APH 6 months into the COVID-19 Pandemic.

In my last writing in June, we experienced steady numbers of less than 200 positive cases per day. Over the summer, the numbers continued to fall and stayed in the 100 to 150 range. This, combined with the eventual movement of all regions in the province to Stage 3, may have created some complacency among the community. Many people began to think that life was back to normal. Some felt wearing masks meant they did not have to maintain a physical distance. Larger groups celebrated summer weekends without masks. Unfortunately, as most of you are aware, this behaviour is resulting in an increase in positive cases across the province, which has resulted in a reduction of the size of allowable social gatherings in the three areas of the province seeing the highest numbers. Other regions may follow.

Evaluation of the effectiveness of our interventions is a common element of public health practice. A package developed by the Council of Medical Officers of Health (COMOH), which examines the collective actions of public health units across the province, is attached to my section of the report.

During the initial days after the Emergency Order was invoked, we scrambled to build teams that could;

1. Respond and support individuals exposed and/or affected by the virus by expanding our case management and contact tracing capacity.
2. Respond to community concerns and provide advice on how to stay safe.
3. Support agencies and employers and organizations on how to integrate infection prevention and control measures into the work of essential workers (this eventually involved other businesses as the economy opened up).
4. Support municipalities in their local Emergency response efforts.
5. Communicate to all the different sectors of our community about a situation that most had never imagined.

This occurred while we transitioned most of our staff to work from home and implemented internal controls to minimize risk to our own employees. Lower priority work was paused. Almost everyone had to learn new skills and perform different work. Our employees have been amazingly resilient during this process.

Change has been a constant companion during the past six months. Every few weeks, new directives, guidance documents, or regulations would be announced, and our activities would shift again. During the summer, more and more businesses were allowed to open with school and post-secondary institution re-openings being the most recent transition.

At the six month mark, some of this activity has begun to feel normal and sustainable. And now, we begin to examine how we can return to some of our previous work.

Schools: As schools were closed, our entire school team of PHNs was directed to COVID-19 response work. Fortunately, additional funding has been provided specifically for the return to school support as otherwise, we might not have been able to redeploy this group of experienced staff back to their previous area of focus. Their work will be different, but they can leverage the partnerships they had with individual school communities to support those schools in navigating the complexity of providing quality education and social interaction in the safest way possible. The new hires will fill the vacancies left in COVID response and help us to resume other important public health activities such as immunization.

Dental Services: Seniors dental services have resumed, and children's services are poised to resume, although school dental screening remains on hold.

Harm Reduction Programs: Needle exchange and naloxone distribution have continued throughout.

Immunization: Catchup clinics for school immunizations that were paused in the spring are underway, and planning for this years' influenza season is almost complete. Many feel that the demand for vaccine will be increased, and we are working with community partners via the recently approved Algoma Ontario Health Team to increase uptake among healthcare providers and the community at large. Low demand has paused the travel health program.

Environmental Health Programs: Food Safety and Safe Water activities have continued throughout with modifications, including reduced inspections as food premises were closed. Now inspections include responding to increased complaints from community members regarding businesses that they feel might not be following public health measures. Food safety courses have resumed in a virtual format.

Communications: Supporting all the changes above and connecting our program staff with the public has been our amazing Communications team. They are continually updating our website, monitoring media content, creating fact sheets to simplify complex guidance documents, creating new social media content to make our messaging interesting, circulating updates to our partners and answering media enquiries.

PARTNERSHIPS

Partnerships have been integral to all our work. As we have been saying, we are all in this together.

PUBLIC HEALTH SYSTEM EVALUATION AND LESSONS FROM THE FIRST PEAK OF COVID-19:
A Report on Behalf of the Council of Ontario Medical Officers of Health
Sept.1, 2020

INTRODUCTORY COMMENTS

I am pleased to share the attached report undertaken on behalf of the Council of Ontario Medical Officers of Health (COMOH) evaluating Ontario's local public health system response to the first peak of COVID-19.

Thanks to a colossal and unprecedented multisectoral effort led by the provincial government on advice from the Office of Chief Medical Officer of Health/Public Health and Public Health Ontario, our province was able to flatten the COVID-19 curve. The quick, province-wide implementation of public health measures, closures and emergency regulations all played an important collective role in preventing potentially devastating consequences including thousands more deaths and overwhelming hospital/ICU-use surges seen in other countries, even to this day. Recognizing the co-operation and sacrifices made by individual Ontarians and their families, and business/service sectors across provincial, local, and municipal levels we are now poised for the next phase of the COVID-19 pandemic.

It is the intent of this report to clearly describe the role of the local public health system during the 1st COVID-19 peak and provide lessons learned and identified opportunities that collectively form foundations to build upon in preparation for the next phase as we wait for an effective vaccine. This includes supporting a safe return to school, preparing for the upcoming flu season while we continue our timely contact tracing and surveillance activities to identify and contain new COVID-19 infections/outbreaks as rapidly as possible, and maintain our pandemic-related collaborations, partnerships and communications activities.

The report captures the vast array of work in response to the pandemic lead by local Medical Officers of Health (MOH) and their highly devoted, professional, and nimble public health staff working along side their local boards of health. The identified components of the local public health response include several key cornerstones: A collaborative approach, supportive community leadership, strategic partnerships, health equity and a vital communications role. Additionally, unique public health expertise in infectious disease control and outbreak management, contact tracing, epidemiology/surveillance, and working collaboratively with Ontario Health all contributed to protection of the community as well as preventing our acute healthcare system from being overwhelmed.

The key words here are collaboration, public health expertise, partnerships and trust, all hallmarks of public health. Due to their local presence and familiarity with area politicians, healthcare partners, stakeholders and the community, that public health units can effectively and efficiently tailor, deliver and/or implement provincial directives and policies locally.

In closing, I would like to gratefully acknowledge the group of MOHs that created this report and the tireless work and dedication of all my MOH and Associate MOH colleagues and their incredible public health staff.

Thank you for taking the time to review our report.

Dr. Paul Roumeliotis, MD.CM.,MPH, FRCP(C), CCPE
Chair, Council of Ontario Medical Officers of Health

Public health system evaluation and lessons from the first peak of COVID-19

A report on behalf of the Council of Ontario Medical Officers of Health

August 2020

The **Council of Ontario Medical Officers of Health,** a section of the Association of Local Public Health Agencies, is committed to improving the health of Ontarians and increasing health equity by strengthening Ontario's public health system. This report and supporting appendix are presented on behalf of the Council in an effort to achieve its mission through system leadership and coordination in collaboration with the provincial government and other organizations, and through evidence-informed advocacy on public health policy.

Context

- Local public health units have spent months **leading the response to the COVID-19 pandemic across sectors** in their communities
- Public health is evaluating its actions and **sharing lessons learned** from the first peak and resurgences
- These findings can be used to protect Ontario's communities by:
  - Building on aspects of the public health system response that should continue or be enhanced during resurgence and future peaks
  - Informing health system planning and preparedness for resurgence of COVID-19 and the upcoming influenza season
  - Leveraging the strengths of the local public health system connections with community to ensure cross sector interventions
  - Enhancing collaborative efforts with the public health system and health system partners in the Ministry of Health, Ontario Health, Ministry of Long-Term Care, and Primary Care

Impact of public health

- Contained COVID-19 and **prevented our health system from being overwhelmed,** despite seeing jurisdictions that demonstrated early control now facing significant resurgence[1,2]
- Implemented widespread and timely public health measures and local public health responses that **prevented an estimated 220,000 cases and 4,400 deaths**[3]
- Local public health units kept **cases contained** by tackling **challenges faced with re-opening and by tracing growing numbers of contacts** for every case

1. Public Health Agency of Canada. Update on COVID-19 in Canada: Epidemiology and Modelling (August 14, 2020).
2. Government of Ontario. COVID-19 case data (August 14, 2020).
3. Office of the Premier of Ontario. Ontario provides full transparency by releasing COVID-19 modelling [press release] (2020 April 3).

Methods

- The Council of Ontario Medical Officers of Health (COMOH) initiated a sector-wide evaluation to:
    1. Capture what happened during public health's prevention, preparedness, and response efforts in the first six months of the COVID-19 pandemic
    2. Identify and learn from aspects of the public health system response that should continue or be enhanced during resurgences and future peaks
    3. Apply lessons learned to prepare for resurgences of COVID-19, the upcoming influenza season, and future pandemics
- Evaluations and continuous quality improvement processes have been carried out by local public health units through reviews, surveys, and interviews with their teams, the public, community partners, and stakeholders across sectors, which have been incorporated into this report.

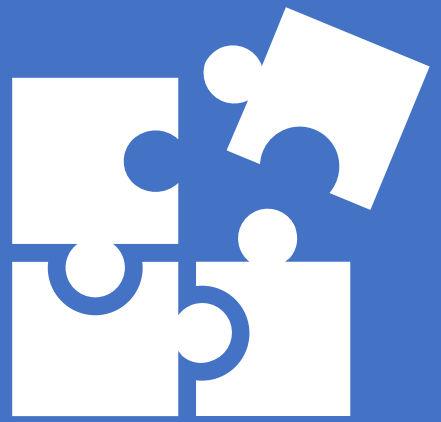
Methods

- All Medical Officers of Health invited to participate in the evaluation via email from COMOH on July 24, 2020
- 17/34 (50%) local public health units participated (60% rural, 40% urban), sharing insights on >100 local initiatives
- Working group members collated responses and used qualitative methods (thematic analysis) to synthesize findings
- Further input received from all COMOH membership at two meetings
- Appendix outlining local public health initiatives, partner feedback, and collaborative efforts accompanies this report

Key questions:

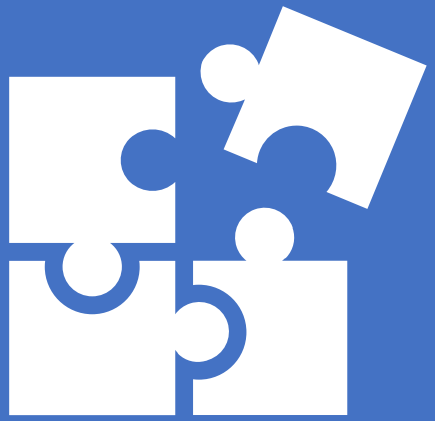
1. What **worked well during** the first peak?
2. What could be **improved**?
3. What should **continue** or **be enhanced**?
4. What else should we consider for **future COVID-19 planning** and **influenza** in the coming months?

Key components of local public health response



- **Protecting our communities** using public health measures to protect people from the virus, by minimizing transmission and deaths
- **Supporting sustainability of our health care system** by preventing cases and transmission
- **Protecting and supporting** those most adversely impacted by the pandemic due to poverty, social circumstance, or other discrimination
- **Leading and supporting recovery across our communities** to mitigate against the health, social, and economic harms of the virus, isolation, and restrictive measures
- **Partnering and collaborating to support** municipal, education, social service, health care, business, and community sectors
- **Communicating timely evidence-based information and data** to the public and partners

Key components of local public health response



- Using **surveillance and epidemiological analysis** to target public health action and inform local health partners
- **Synthesizing new scientific evidence, research and evaluation** to apply the most effective and up-to-date public health interventions locally
- Conducting **intensive and meticulous case management and contact tracing** while supporting isolation requirements
- **Preventing and rapidly responding to outbreaks** in community, workplace, congregate, and institutional settings
- Identifying key priorities and populations for **focused testing strategies**
- **Preparing for safe re-opening** of local schools, workplaces, daycares, personal service settings, restaurants, and other spaces
- **Planning and preparing** our health system and communities for resurgences, future peaks, and influenza

Sustaining the local public health response

- **Local public health leadership** has been critical to protecting health and **tailoring responses** to meet the needs of our communities during the first peak
- **Experience** and **technical training** in public health emergencies and health protection prepared local public health to respond and built on existing pandemic preparedness and business continuity plans
- **Public health measures** prevented illnesses and deaths that would have **overwhelmed our health care system** and continue to threaten to do so as seen in other jurisdictions
- Public health leadership **brought communities together** to flatten the epidemic curve using preventive measures that continue to be a mainstay of the response
- The most effective system in a public health emergency relies on **independent local public health authorities** that can leverage strong partnerships and community knowledge to adapt direction that is coordinated at the provincial level

- Public health holds a unique, **established, and trusted position that allows collaboration** with municipalities, schools, childcare settings, businesses, social services including congregate settings, health care and institutions, media, and community organizations **to effectively shape local response**
- **Provincial and regional coordination** is critical to supporting the strong leadership and response undertaken by local public health units and boards of health
- Pandemic response required rapid mobilization and scaling up of a **skilled public health workforce that will need ongoing investment** to respond to resurgence and increasing complexity of case management and contact tracing
- Public health innovation and adoption of new **digital solutions** to improve effectiveness and efficiency have been vital to enhancing widespread detection and containment efforts

Themes identified in the public health system evaluation

Public health's effective response relied on

- Early upstream interventions to **prevent** illness and **prepare** our communities
- An approach to improving health of the whole population with a focus on **health equity**
- **Leveraging local partnerships** to translate provincial direction into effective local action
- Provincial and regional **coordination** to support local implementation
- A highly skilled and agile **workforce** that will require ongoing investment
- **Digital solutions** to optimize efficiency and support data sharing

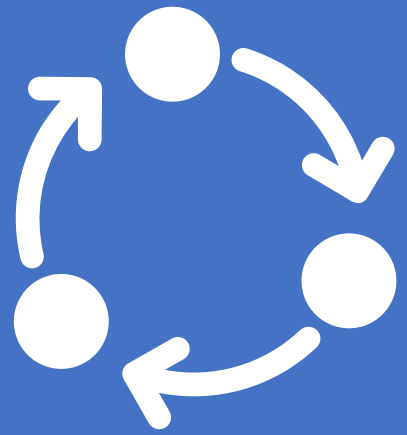
Prevention and preparedness

> *"Keep up the good work! We depend on you to keep us safe by keeping an eye on the important things that may affect our health while we do what we need to do."*
>
> - Community partner feedback

Local public health expertise focused on **community-wide pandemic preparedness** and **upstream prevention of illness and death**

- Worked with local partners to ensure health system capacity was not overwhelmed
- Rapidly moved to enhanced operations and IMS structures due to pandemic preparedness and continuity of operations planning
- Advocated for early interventions to address **personal protective equipment (PPE)** needs across sectors, **implementing testing** of all staff and residents within outbreak facilities, and for **universal masking** in hospitals, long term care and retirement homes, and community and primary care settings
- Conducted **proactive infection prevention and control (IPAC) assessments** with partners to prevent local outbreaks in congregate settings, essential workplaces, and institutional settings
- Shared **modelling projections** for transmission with the public and partners while tailoring surveillance and epidemiological analyses to support communication about local situation

Prevention and preparedness



Highlights from the field

- Due to concerns of community transmission, **Peel Public Health** along with other local health units across the province pre-emptively closed nightclubs, concert venues, theatres, and dine-in services at restaurants ahead of provincial direction.
- **Halton Region Public Health** worked closely with local hospitals and LHINs to lead a congregate setting strategy, which took a pro-active approach with all congregate and institutional settings in doing in-person IPAC visits and assisted these priority settings in ensuring appropriate IPAC measures were in place to reduce their risk level for COVID-19.
- **Simcoe Muskoka District Health Unit,** in partnership with primary care and hospitals, proactively established local assessment centres prior to provincial direction.
- **Hamilton Public Health Services** conducted proactive pre-opening inspections of all licensed childcare programs in the city, working with the Child System Services Manager to ensure the safe re-opening of all child care spaces.

Health Equity

> *"Our shelters have had relatively low numbers, and we expected to have numbers like long term care facilities. We should think about what we are doing right."*
>
> - Community partner feedback

- Public health applied **population-level interventions** that addressed **health equity** by considering the needs of settings that may be more vulnerable to COVID-19 and populations that would disproportionately experience the negative unintended consequences of public health measures
    - Identified and addressed needs of **people who may be more susceptible** to COVID-19 by providing IPAC and testing support to congregate settings such as **shelters and long term care homes**
    - Partnered to develop **isolation centres** for people experiencing homelessness, distributed non-medical masks to those with limited means, and mobilized volunteers to provide supports like **grocery or prescription delivery** to people in isolation or quarantine
    - Monitored and mitigated the **unintended consequences** of public health measures by providing PPE to **community agencies** serving priority populations, continued to distribute **naloxone kits** and other essential public health services, and partnered with local agencies to address rising **mental health and substance use** concerns
    - Developed new methods for engaging and collaborating with communities on the collection of local raced-based and socioeconomic data

Health Equity

Highlights from the field

- **Timiskaming Health Unit** convened a Community Support Collaborative to identify priority population needs arising from COVID-19, and partnered to access funds for cleaning supplies, PPE, and Plexiglas partitions for private transportation providers in rural communities without public transit.
- **York Region Public Health,** in collaboration with shelters, identified an increase in domestic violence rates and developed resources to support this population with guidance for individuals experiencing abuse during heightened times of isolation.
- **Public Health Sudbury & Districts** ensured local partners working with priority populations were trained in IPAC measures to continue to safely deliver services, supported the implementation of isolation shelter for people experiencing homelessness, and mobilized volunteers to provide supports to people in isolation.
- **North Bay Parry Sound District Health Unit** enhanced their community harm reduction work through promotion of new harm reduction messages within the context of COVID-19, redirecting clients when service disruptions occurred, and collaborated on a community alert when surges in adverse events related to drugs were detected in the community.

Partnerships

- Public health acted as a **bridge across health and social systems** to enhance **collective community action** for a strong and effective response
- **Leveraged existing local partnerships** with health care sector, municipalities, schools, and community organizations to facilitate:
  - Collaborative planning tables to ensure coordinated local responses and resources for **First Nations, Inuit, and Métis** community members
  - Provision of IPAC support to **hospitals, long term care and retirement homes, child care centres, and congregate settings like shelters, group homes, and detention centres**
  - Direct support for local implementation of public health measures including development of regulations and by-laws and **tailored guidance for schools, businesses, child care centres, and community organizations** in order to protect the health of **workers and their clients**

> *We as an organization depend on public health webpages, news releases, and phone calls for the advice we need to give the people we support a better quality of life.*
>
> - Community partner feedback

Partnerships

Highlights from the field

- **Public Health Sudbury & Districts** has a First Nations Community Partners Table to discuss community needs during the pandemic, share resources, and help make connections with other sectors (e.g., to support re-opening plans, surveillance testing, and community pandemic response plans).
- **Simcoe Muskoka District Health Unit's** past pandemic planning enabled a strong, collaborative relationship with municipalities when responding to COVID-19. Weekly teleconferences enabled a coordinated response to a number of challenges, including public crowding on beaches and use of face coverings in indoor public spaces.
- **North Bay Parry Sound District Health Unit** partnered with a local construction company to develop COVID-19 safety protocols well in advance of these being asked by the Ministry.
- **Hamilton Public Health Services** worked with local Indigenous service providers to launch an Indigenous peer-to-peer COVID-19 phone line to access public health information on COVID-19.
- **Ottawa Public Health**'s relationship with the City of Ottawa enabled success in countless initiatives from redeploying city staff and infrastructure to the response, working rapidly to implement a bylaw for indoor masking, proactively building a safer approach for public transit and emergency child care centres, and working as a member of the city's Human Needs Task Force to plan for food security, housing, transportation, volunteer services, fundraising, and psychosocial supports.

Coordination

> *From the hospital perspective, most decisions made by health service partners have an impact on our operations. The coordination by [a local public health unit] to many, if not all, players at the same table at the same time, hearing the same message, enhanced our understanding and response*
>
> - Hospital partner feedback

- **Coordination** between local public health units helped strengthen the **pandemic response, improve efficiency, and share work loads:**
  - Public health units **shared human and digital resources, technical expertise and new methods, and collaborated** to promote regional consistency during times of uncertainty from the earliest phases of the pandemic
  - Increasing proportion of public health workforce **working remotely** while **embracing new technological platforms** for engagement has allowed greater coordination and collaboration across jurisdictions
  - Public health **implemented provincial strategies**, while allowing for local variation and adaptation due to different **local contexts** on issues such as community transmission, cross-border travel, masking, testing, and laboratory capacity
- **Provincial and regional information sharing** through channels such as Ministry Emergency Operations Committee calls, updates from Public Health Ontario, calls with Medical Officers of Health, and Ontario Health regional planning tables

Coordination

Highlights from the field

- **Eastern Ontario Health Unit, Leeds, Grenville and Lanark District Health Unit, Renfrew County and District Health, and Ottawa Public Health** coordinated to develop a mandatory masking policy to ensure consistency across the region and avoid duplication of efforts, with each public health unit then moving forward to adapt within their own local context.
- Since January 2020, the **Ontario Public Health Emergency Managers Network** shared updates, resources, consultations, and professional development information amongst its members to support local responses.
- Medical Officers of Health in the **Greater Toronto and Hamilton area** worked together during the pandemic to share information and where possible, coordinate their responses given the mobility of individuals within their geographic area.
- **Porcupine Health Unit** and **Timiskaming Health Unit** formed a working group to provide timely and consistent responses and support to School Boards that span their districts. The group also aims to reduce duplication of effort related to ongoing COVID-19 supports for schools.

Workforce

> *The ability of the IMS structure to be flexible and responsive to the emerging needs was extremely helpful. Training by the Rapid Response Team helped to ready people. I think we did amazing work, and I am very proud to have been part of it.*
>
> - Local public health unit staff

- **Local public health leadership** rapidly responded to COVID-19 by applying **years of experience in public health emergencies** and working with community partners on IPAC and outbreak management
- When redeployed to the COVID-19 response, public health's highly skilled workforce has **adapted quickly to new roles and technologies, demonstrating resilience**
- **Key public health skills and roles** highlighted in the response include epidemiology, emergency preparedness, IPAC, case management and contact tracing, health communications, community engagement, and focus on health equity implications of pandemic
- **Critical core services that protect the health of our communities**, such as public health inspections and responding to other infectious diseases, continued to be offered during the pandemic and must continue in order to prevent increased pressures on the health care system

Workforce

Highlights from the field

- *"From the time I received the call that I was positive to COVID-19, I ALWAYS felt like I had the support of **Algoma Public Health**… Having gone through the experience, the community should have complete faith in the process - I have never answered so many questions in my life and to say that your case management was thorough is an understatement. The nurses on your front line were remarkable… I truly felt like they cared about my physical and mental wellbeing."* – Community member feedback
- While many health system partners were scaling back and experiencing lower volumes, **Huron Perth Public Health and Brant County Health Unit** rapidly scaled up from a Monday to Friday 8:30 - 4:30 and 24/7 on-call operation to Monday to Friday two shifts with evenings, weekend shifts, and 24/7 on-call in order to respond to the need for support to the public, partners, and stakeholders.
- *"They received a call, they responded immediately. They gave accurate information and they followed up on each situation that I was involved in."*– Community partner feedback to **Public Health Sudbury & Districts**

Digital solutions

Excellent media and social media presence with clear, succinct, and recent evidence-based principles.

- Community partner feedback

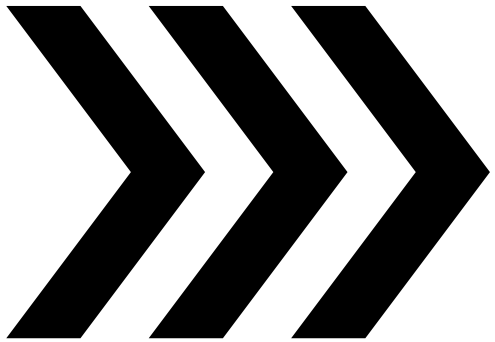
- Local public health units adopted new **digital solutions** that were critical to **optimize the function, efficiency, and effectiveness** of case management, contact tracing, and outbreak investigation and management
- Dashboards were developed to **visualize data** while allowing for **real-time transparency** of public health efforts and health system pressures, including indicators for local monitoring and informing re-opening decisions
- Public health workforce rapidly adapted to new platforms for working remotely and continued supporting case and contact management efforts virtually

Digital solutions

Highlights from the field

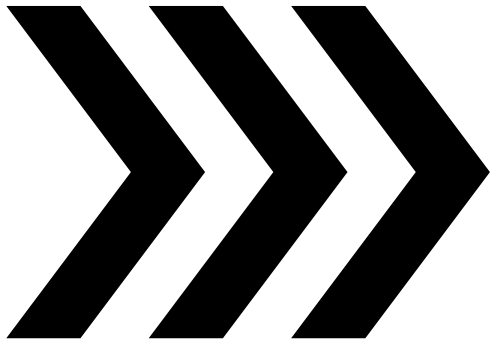
- **Ottawa Public Health** developed a dynamic disease reporting system. The COVID-19 Ottawa Database (known as "The COD"), adapted from a system used in Newfoundland and Labrador, supports local case management and contact tracing. Building from this database has led to development of novel epidemiological methods and technology to detect potential clusters earlier and mobilize resources to investigate.
- **KFL&A Public Health**, working with the Office of the CMOH, enabled the real-time capture of suspected COVID-19 emergency department visits across the province in the Acute Care Enhanced Surveillance (ACES) system and built the Pandemic Tracker as a public tool (https://www.kflaphi.ca/aces-pandemic-tracker/).
- Machine learning was developed by **York Region Public Health** to optimize the utility and interpretation of OLIS lab results data to support the automation of reporting and timely case follow up.
- **Hamilton Public Health Services** adapted existing technology used for routine inspections of food premises. Inspectors record COVID-19 IPAC observations and education data into the existing Hedgehog Inspection System to ensure all information is stored together.
- **Middlesex-London Health Unit** developed Azure software and several other local public health units were able to use this platform to facilitate the COVID-19 response.

Opportunities to sustain the public health response



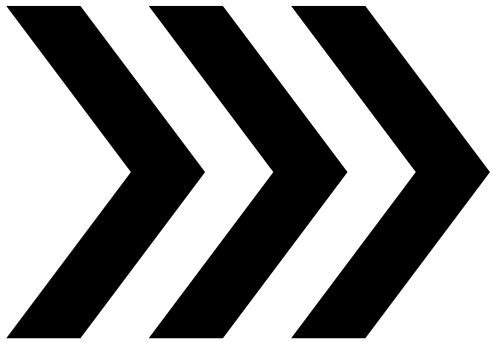
- Local public health must provide ongoing **leadership and guidance in all essential public health functions** to support sectors and tailor responses that meet the needs and strengths of our communities
    - Continue to lead planning and preparedness efforts in our communities using data-driven projections and evidence-informed interventions founded in public health expertise
    - Lead clear, concise, and engaging public health communications across traditional and social media platforms that enable the public to reduce their risk
- Local public health must build on **partnerships and collaboration** across sectors to **address new and complex community challenges** such as return to school, increased demand for health services, increase in visitors to long term care homes, re-opening of businesses, and larger social gatherings
    - Build well-resourced school health teams led by local public health to prepare and respond to new cases while supporting students and families with mental health and other health concerns

Opportunities to sustain the public health response



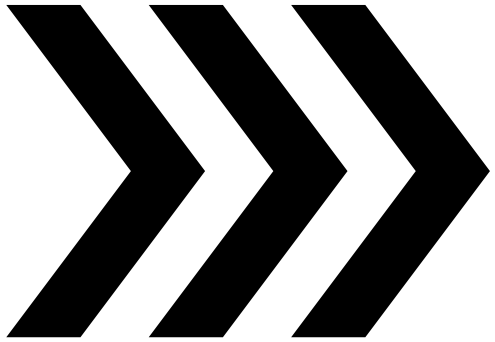
- There must be investment in **local public health workforce** to allow for surge capacity needed for increasing complexity of pandemic response and maintaining critical core public health services
  - Support collaboration between local public health units through new or existing public health "hubs" where resources can be shared and broader actions coordinated without reducing workforce
  - Enhance surge capacity for contact tracing and outbreak management by enabling rapid movement of workforce from one jurisdiction to another, based on local epidemiology
  - Enhance sharing of expert technical guidance, standards of practice, communications products, data analysis
  - Explore strategies to ensure and promote workforce resilience, while protecting mental and physical health

Opportunities to sustain the public health response



- There must be **increased resources for IPAC and outbreak management** in higher-risk settings and priority populations to minimize severe illness that would strain the health care system
  - Health system support and ongoing collaboration with Ontario Health for targeted and mobile testing strategies as part of early community cluster response
  - Proactive IPAC through audits and consultation with higher risk congregate and institutional settings in partnership with the broader health system
  - Review effective strategies to increase population uptake of influenza vaccine as added protection during resurgence and reduce potential strain of respiratory illness on the healthcare system

Opportunities to sustain the public health response



- **Local public health expertise and connections with community** must be capitalized on at regional and provincial tables
- Roles of **key health system players** must be clarified and mutually respected for maximum health gains
    - Clarify and align roles across Ontario pandemic response structure for public health and health system partners including local public health, Ministry of Health, Chief Medical Officer of Health, Public Health Ontario, Ontario Health, and Ministry of Long-Term Care
    - Ensure public health and acute care expertise are informing each other's separate but complimentary actions through partnerships at the five regional Ontario Health pandemic response tables, with clear lines of communication with local and provincial planning tables
    - Streamline reporting and coordination on pandemic response for medical officers of health with Chief Medical Officer of Health while maintaining local independence and accountability to boards of health
- **New technologies** must be developed and adapted to support case management, contact tracing, and outbreak investigations so local public health units can enhance effectiveness despite growing complexity
- Innovative technologies must be explored to help with **advanced planning, forecasting, and operational response** in dealing with resurgence and other respiratory illnesses

Community partner feedback

Thank you for the long hours and tireless work to try to get us through the pandemic. I know we have smart and innovative people who work for us to come up with solutions for us to live during this pandemic. We can get through this together.

Public health system evaluation and lessons from the first peak of COVID-19

Appendix of local public health initiatives and feedback

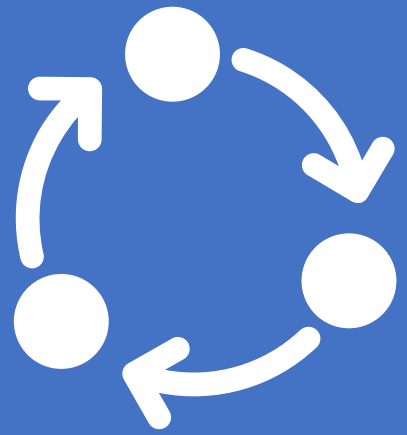
A report on behalf of the Council of Ontario Medical Officers of Health

August 2020

Public health's effective response relied on

This document is provided as an Appendix to the ***'Public health system evaluation and lessons from the first peak of COVID-19'*** report and captures feedback provided by members of the Council of Ontario Medical Officers of Health on local public health unit initiatives, partner perspectives, and collaborative efforts across the public health system. The highlights received from the field are categorized across the six themes identified in the evaluation, though in many cases are cross-cutting.

Prevention and preparedness



Halton Region Public Health worked closely with local hospitals and LHINs to lead a congregate setting strategy, which took a pro-active approach with all congregate and institutional settings in doing in-person IPAC visits and assisted these priority settings in ensuring appropriate IPAC measures were in place to reduce their risk level for COVID-19.

Hamilton Public Health Services conducted proactive pre-opening inspections of all licensed childcare programs in the city, working with the Child System Services Manager to ensure the safe re-opening of all child care spaces.

KFL&A Public Health has worked to complete an After-Action Review using key informant interviews, focus groups, and a survey, to identify strengths and enhance agency's response moving forward.

KFL&A Public Health piloted mass testing surveillance activities.

Hospital partners highlighted they valued the "visibility, accessibility, and expertise" of **Ottawa Public Health** and its "outstanding" support for their organizations. Relayed they appreciated the team "daily huddles" and an approach to infection prevention and control that recognized their own expertise as well. - Hospital partner feedback

Ottawa Public Health's skilled team of epidemiologists collaborated with hospital and university partners to use modelling to project the impact of public health interventions on the local epidemic curve. This supported the health care system in planning for hospital admissions and use of intensive care unit resources like ventilators.

Due to concerns of community transmission, **Peel Public Health** along with other local health units across the province pre-emptively closed nightclubs, concert venues, theatres, and dine-in services at restaurants ahead of provincial direction.

Public Health Sudbury & Districts supported hospitals, schools, daycares, and local businesses to help with informed decisions and safe practices:

- *"Public health proved very helpful!" "Keep up the good work! We depend on you to keep us safe by keeping an eye on the important things that may affect our health while we do what we need to do."* - Community partner feedback

Simcoe Muskoka District Health Unit, in partnership with primary care and hospitals, proactively established local assessment centres prior to provincial direction.

York Region Public Health provided direct support to long term care and congregate living settings through onsite infection prevention and control (IPAC) preparedness and outbreak assessment visits, IPAC educational support to staff in these settings, and the provision of emergency personal protective kits for interim supply while additional resources were acquired.

Health Equity

Halton Region Public Health partnered with paramedics to set up a community paramedic team for the purpose of testing people in the community who were unable to attend a community COVID-19 assessment centre due to physical mobility challenges.

Halton Region Public Health continued to deliver critical services to families and individuals throughout the pandemic (e.g. harm reduction services, Healthy Babies Healthy Children, telephone parenting supports).

Hamilton Public Health Services developed enhanced surveillance indicators for priority populations to monitor the societal impacts of COVID-19 and the response. Through a partnership with local hospitals and police, indicators are provided in as close to real-time as possible, and jointly monitored by the Public Health Emergency Control Group and Hamilton's EOC to enable a timely and collaborative response.

Huron Perth Public Health accessed United Way and private donor funding pots to provide grocery store cards to families at increased risk and those self-isolating, as well as computer access to those living with low incomes in rural areas.

KFL&A Public Health maintained key programming (e.g., HBHC and Child and BabyTalk) to support families during the COVID-19 crisis and worked with municipalities, health, and social service partners to establish a self-isolation centre for individuals experiencing homelessness.

KFL&A Public Health coordinated IPAC activities with local partners working with priority populations (shelters) and higher-risk settings (correctional institutions).

KFL&A Public Health worked with Frontenac Paramedics to implement an outreach COVID-19 swabbing program to support rural populations, people with mobility issues and populations at higher risk.

Ottawa Public Health used their relationships with community organizations to support the work of collecting, analyzing and reporting on race-based COVID-19 data, recognizing the critical importance of understanding how the health of certain communities has been disproportionately affected by the pandemic.

"Our shelters have had relatively low numbers, and we expected to have numbers like long term care facilities. We should think about what we are doing right." - Community partner feedback to **Ottawa Public Health**

Public Health Sudbury & Districts provided guidance to agencies working with priority populations on safe best practices, access to harm reduction equipment, and daily visits to support homeless populations.

Public Health Sudbury & Districts ensured local partners working with priority populations were trained in IPAC measures to continue to safely deliver services, supported the implementation of an isolation shelter for people experiencing homelessness, and mobilized volunteers to provide supports to people in isolation.

Health Equity

North Bay Parry Sound District Health Unit enhanced their community harm reduction work through promotion of new harm reduction messages within the context of COVID-19, redirecting clients when service disruptions occurred, and collaborated on a community alert when surges in adverse events related to drugs were detected in the community.

Simcoe Muskoka District Health Unit (SMDHU) employed locally specific strategies for engaging or staying in touch with priority populations. Communications were distributed to different priority population groups (e.g. guidance to shelters, congregate settings). SMDHU worked with social services, priority population planning committees, and individuals on a one-on-one basis to ensure:

- Mandatory requirements were met re: case and contact management
- Heat planning for priority populations and assessment of existing infrastructure
- Established testing options for priority populations (e.g. lower income), assessment centre outreach options, and worked with District of Muskoka to help with promotion of testing
- Communication strategy for priority population notification system
- Funeral homes included in listserv
- Worked with primary care and hospitals to establish local assessment centres prior to provincial direction and the Central Region Ontario Health

Timiskaming Health Unit convened a Community Support Collaborative for the purpose of identifying priority population needs arising from COVID-19, and partnered to access funds that provided cleaning supplies, PPE, and Plexiglas partitions for private transportation providers in rural communities without public transit.

Facilitated by **Timiskaming Health Unit**, the Community Support Collaborative meets weekly to identify and address priority population needs arising from COVID-19 and related public health measures. Initiatives linked to this collaborative include:

- Timiskaming Connections Initiative, including a phone line to link volunteers with those in need of support related to COVID-19 and public health measures.
- Partnered to access funds and provide masks/face coverings to those with barriers to access. Includes a wide range of community partners serving as depots across the district including small, rural areas.
- Sourced funding and coordinated masks/face coverings for distribution to passengers with all transportation providers.
- Partnered to access funds to address the digital divide; a pre-existing equity issue exacerbated by COVID-19. This initiative will provide technology, Internet, and digital health literacy skills to individuals in need.

York Region Public Health, in collaboration with shelters, identified an increase of domestic violence rates and developed resources to support this population with guidance for individuals experiencing abuse during heightened times of isolation.

York Region Public Health supported local shelters via the provision of 6600 surgical masks as well as provided guidance and recommendations for the establishment of both transitional housing and an isolation shelter for priority populations along with emergency personal protective equipment kits

Partnerships

Hamilton Public Health Services worked with local Indigenous service providers to support the safe opening of various community-based supports; including a Friendship Centre, licensed child care and health care centre, as well as launch an Indigenous peer-to-peer COVID-19 phone line to access public health information on COVID.

Hamilton's Health Sector Emergency Management Committee is responsible for a collaborative multi-agency response and is chaired by **Hamilton Public Health's** MOH. This group developed a novel approach to assessment centres in the city – the collaborative model is a partnership between hospitals, primary care, public health and the City of Hamilton.

"Planning moved quickly, and there was a high level of trust between [organizations] despite uncertain times and at times uncertain funding resources. We just made it happen."- **Hamilton Health Sector Emergency Management Committee/Hamilton Health Team** debrief

Hamilton Public Health Services collaborated with partner hospitals to complete virtual COVID-19 IPAC audits with all long term care facilities and retirement homes in the city. This work assessed COVID-19 preparedness in these facilities and prepared partner hospitals for rapid response should outbreak assistance be needed.

Hamilton Public Health Services provided extensive IPAC support to community partners, including staff educational webinars and IPAC assessments for the Ministry of Children, Community and Social Services, bi-weekly calls with Hamilton-Wentworth Detention Centre, consultation and IPAC assessments for the housing and shelter sector and congregate settings, proactive inspections of all licensed childcare settings, and consultations with workplaces for safe re-opening.

KFL&A Public Health initiated and coordinated the emergency response to ensure access to COVID-19 testing with health sector and municipal partners (e.g., primary care, paramedics, acute care and municipalities)

City partners have shared a strong support of the way public health has been working with the municipality and encouraged **Ottawa Public Health** to "keep doing great things" with in local collaboration with city partners-–this has been highlighted as a key theme of the "successes achieved together." – City of Ottawa feedback

Ottawa Public Health's relationship with the City of Ottawa has enabled success in countless initiatives with its municipal partners, from redeploying city staff and infrastructure to the response, working rapidly to implement a bylaw for indoor masking, proactively building a safer approach for public transit and emergency child care centres, and working as a member of the city's Human Needs Task Force to plan for food security, housing, transportation, volunteer services, fundraising, and psychosocial supports.

Partnerships

Public Health Sudbury & Districts provided reliable information that local businesses, community organizations, and partners used to make best decisions for staff and the community:

- *"We as an organization depend on public health webpages, news releases and phone calls for the advice we need to give the people we support a better quality of life."*
- *"Collaboration with senior leaders to help make informed decisions related to staffing, procedure, etc."*

North Bay Parry Sound District Health Unit partnered with a local construction company to develop COVID-19 safety protocols well in advance of these being asked for by the Ministry.

North Bay Parry Sound District Health Unit provided enhanced surveillance data to local hospital partners, who were provided with weekly, customized syndromic surveillance reports that alerted hospitals when surges in specific syndromes were detected through the Emergency Department. Reports also included testing rates, outbreaks, and cases for their specific catchment area.

North Bay Parry Sound District Health Unit Public Health Inspectors offered training, education, and recommendations for infection prevention and control to management at Nipissing Mental Health Housing and Support Services, and others supporting the local temporary homeless shelter.

Peel Public Health, in bringing public health expertise to a Regional integrated response table, was able to quickly initiate surveillance screening in Long-Term Care (LTC) homes and complete screening of all residents and staff at 28 LTCs one week ahead of the provincially mandated deadline. This response table was then able to quickly pivot into directing expanded community testing in workplaces and areas of high incidence.

Public Health Sudbury & Districts has a First Nations Community Partners Table to discuss community needs during the pandemic, share resources, and help make connections with other sectors (e.g., to support re-opening plans, surveillance testing, and community pandemic response plans).

Simcoe Muskoka District Health Unit's past pandemic planning enabled a strong, collaborative relationship with municipalities when responding to COVID-19. Weekly teleconferences enabled a coordinated response to a number of challenges, including public crowding on beaches and use of face coverings in indoor public spaces.

Simcoe Muskoka District Health Unit documented many examples of strong working relationships with community partners (e.g. hospitals, City of Barrie, Indigenous groups) including teleconferences with local municipal and health care system partners, partnerships with assessment centres, homeless shelter operations in hotels, local PPE donation management strategy, and strong relationships developed with Family Health Teams.

Simcoe Muskoka District Health Unit's MOH acted as co-chair with the Central Region of Ontario Health to liaise with the MOHs of the public health units in the region in order to inform the Region and its health care leader of local public health responses, and to help coordinate actions among the players.

Partnerships

Simcoe Muskoka District Health Unit's MOH sat at the provincial Public Health Measures Table and liaised between the CMOH office and local MOHs in Central East Region on the changes in the provincially lead control measures.

Southwestern Public Health Units collaborated together with local Ontario Health partners to create epidemiology summaries for the region to inform local Health Care System Planning.

A Testing Policy Advisory Council was established early in the pandemic in the Southwest. Made of partners from **Southwestern Public Health Units and Ontario Health,** the Council developed testing guidance to ensure that testing was implemented in a fair and consistent manner across the southwest, taking into consideration local/regional capacity.

Timiskaming Health Unit convened health system partners weekly to provide situation updates and provide clarification on guidance and directives:

- *"From the Hospital perspective, most decisions made by health service partners have an impact on our operations. The coordination by THU to many, if not all, players at the same table at the same time, hearing the same message, enhanced our understanding and response"* – Health system partner

As part of the structure of the Regional Municipality of York, **York Region Public Health** (YRPH) has been able to leverage many partnerships embedded within the regional structure like social services, paramedic, and seniors' services; enabling a collaborative and coordinated approach to the response from all service delivery areas. Pre- existing relationships with key partners in each municipality (i.e. Community Emergency Management Coordinators) allowed for close collaboration. YRPH collaborated rapidly with Ontario Health/LHIN and local hospitals to support the IPAC extender program to provide timely assessments and education. Partnership was also in place between YRPH, LHIN and the Ministry of Children, Community and Social Services to establish a coordinated approach to personal protective requirements.

Coordination

Algoma Public Health coordinated weekly teleconferences with the Community Emergency Management Coordinators of Algoma's 21 municipalities. Partners identified major sources of community health risk and worked together to communicate and mitigate risk. Early groundwork in emergency preparedness meant that days before Canada issued mandatory quarantine orders, Algoma returning travellers were already receiving and following local public health advice to stay home for 14 days, and they were well-supported to do this thanks to delivery services of groceries and essentials which were rapidly set up by Algoma municipalities.

Eastern Ontario Health Unit, Leeds, Grenville and Lanark District Health Unit, Renfrew County and District Health, and Ottawa Public Health coordinated to develop a mandatory masking policy to ensure consistency across the region and avoid duplication of efforts, with each public health unit then moving forward to adapt within their own local context.

Medical Officers of Health in the **Greater Toronto and Hamilton area** have worked together during the pandemic to share information and where possible, coordinate their responses given the mobility of individuals within their geographic area.

KFL&A Public Health has coordinated many initiatives over the course of the pandemic:

- Held weekly meetings with Medical Directors of all LTC and RH as well as weekly meetings with municipal partners.
- Ran an educational session for all area primary care physicians and conducted two continuing professional development webinars for area physicians.
- Coordinated enforcement activities in their region by bringing together Kingston Police, OPP and City of Kingston Bylaw Officers to reduce duplication of enforcement activities.
- Planned to conduct table top exercises with large institutions in their region: Queen's University, municipalities and other community services.

KFL&A Public Health worked with municipal partners, including mayors, wardens and CAOs to implement and enforce the Section 22 mask order.

Since January 2020, the **Ontario Public Health Emergency Managers Network** shared updates, resources, consultations, and professional development information amongst its members to support local responses.

The community and partners relied on public health statistics to keep them informed on the status of cases. Also, public health provided consistent messaging coordinated across the **North East**:

- *"The epidemiological statistics were very helpful. The collaboration between APH, PPH and PHSD so that we may have a consistent message in our schools is also helpful."* – Northeastern community partner speaking of the coordination between **Algoma Public Health, Porcupine Health Unit, and Public Health Sudbury & Districts.**

Coordination

Public Health Units in the North East worked together to share frameworks and templates for detailed epidemiological reports.

Simcoe Muskoka District Health Unit coordinated and supported other public health units in conducting rapid reviews of literature regarding the harms to physical, mental, and social wellbeing resulting from public health measures, both population-wide and from a health equity perspective. Findings will be used to inform enhanced efforts to help mitigate these harms, where possible, for the remainder of the pandemic.

Simcoe Muskoka District Health Unit played a lead role in planning coordination, liaison work and collaborative work with assessment centres, homeless shelters, Ontario Health Teams, and hospitals.

York Region Public Health (YRPH) provided ongoing infection prevention and control support to congregate settings in partnerships with York Region Social Services, Ministry of Health, and other stakeholders. YRPH has also coordinated with private sector businesses such as corporate food operators to relay messaging, ensure policy compliance, and garner support in preventing further spread. In addition, ongoing coordination between the Regional Environmental Services Department and external stakeholders was led by YRPH to participate in pilot research and testing for COVID-19 in wastewater.

York Region Public Health (YRPH) partnered with local community partners (i.e. municipality), paramedic services and Ontario Health to host a mobile testing day in Georgina. In addition, YRPH coordinated a Customer Experience journey mapping with local assessment centre which has ensured open communication channels with hospitals and public health and allowed for quick implementation of changes in practice such as changing screening criteria. YRPH and the hospitals continue to work together to improve the customer experience of accessing testing to ensure York Region residents access testing when and where needed.

York Region Public Health (YRPH) coordinated weekly joint meetings with the Public and Catholic School Boards to support school reopening strategies. Similarly, YRPH and Social Services partnered with childcare settings to ensure preparedness support is provided to these stakeholders to assist in the safe reopening of these facilities.

In addition to resource sharing and coordination, **York Region Public Health,** along with other public health units, combined efforts to implement a coordinated approach to responding to workplace-related investigations to identify effective public health measures for these unique investigations and to enable timely information sharing for impacted public health units.

Workforce

"I've been meaning to reach out to you and say a big thanks and tell you how wonderful your staff are at APH. The support for reopening [child care centre location] as a whole and previous to that for emergency child care was beyond excellent! A special shout out to [APH employees] who are our Inspectors and have answered all of our many, many questions!" – Child care centre operator feedback to **Algoma Public Health.**

*"From the time I received the call that I was positive for COVID-19, I ALWAYS felt like I had the support of **Algoma Public Health**...Having gone through the experience, the community should have complete faith in the process - I have never answered so many questions in my life and to say that your case management was thorough is an understatement. The nurses on your front line were remarkable...I truly felt like they cared about my physical and mental wellbeing."* – Feedback from community member

While many health system partners were scaling back and experiencing lower volumes, **Huron Perth Public Health and Brantford County Public Health** rapidly scaled up from a Monday to Friday 8:30 - 4:30 and 24/7 on-call operation to Monday to Friday two shifts with evenings, weekend shifts, and 24/7 on-call in order to respond to the need for support to the public, partners, and stakeholders.

"Camaraderie - in these trying times, [Public Health Nurses] have come together, problem solved, encouraged, and helped one another. It's been very inspiring and makes me proud to be a part of the COVID-19 response" - **Hamilton Public Health** employee

KFL&A Public Health staff were cross-trained and deployed to implement work of the newly established COVID-19 functional units, including an Assessment Centre, Call Centre, Case and Contact Management, IPAC, and Enforcement.

KFL&A Public Health created nurse and public health inspector teams to provide sector specific IPAC guidance to high risk congregate settings, e.g., LTC/RH, childcare, and correctional institutions.

KFL&A Public Health has implemented CCM using a combination of nurse and non-nurse staff.

Ottawa Public Health has been in enhanced operations since January 28, 2020. By early June, >75% of staff were deployed to the response and many new team members were hired to address the pandemic. The team responded to >2000 cases, traced >7000 contacts, managed >30 outbreaks, collaborated on testing >20,000 individuals in long term care homes and congregate settings, fielded >24,000 inquiries from the community, and had >250,000 likes, comments, and shares on social media.

"The ability of the IMS structure to be flexible and responsive to the emerging needs was extremely helpful. Training by the Rapid Response Team helped to ready people. I think we did amazing work, and I am very proud to have been part of it."
- Ottawa Public Health employee

Ottawa Public Health recruited nurses via a Registered Nurses Association of Ontario call-out, hired 4th year Nursing Students, and retired Public Health Nurses.

Workforce

The ability to adjust and scale the call centre processes, tools, and workforce, along with the various modes on media interaction highlighted the flexibility of the **North Bay Parry Sound District Health Unit**. This was necessary when comparing the challenges and addressing gaps of decisions made provincially vs. local interpretation and implementation. For example, 99% of staff members have been consistently using Microsoft Teams, which has enabled the workforce to work remotely, efficiently communicate and share information, and collaborate internally and externally with health care services in their district.

For the **North Bay Parry Sound District Health Unit,** a local connection to the communities helped inform the COVID-19 topics that resulted in the most inquiries, which directly informed the work of the Communications Department. Having locally informed data allowed for strategic messaging in specific pockets of the district.

At **Public Health Sudbury & Districts,** over ¾ of staff members have been redeployed to support the pandemic response. Public health nurses, inspectors, dietitians, nutritionists, dental hygienists, health promoters, and support staff refocused their efforts to pandemic response or adapted essential public health programs and services.

Community partner feedback about the professionalism of **Public Health Sudbury & Districts** staff, their immediate responses, provision of accurate information, and following-up on each situation:

- *"Public health Sudbury comes with professional staff who have many resources for organizations and people alike."*
- *"I have been really impressed with how helpful, thorough, and friendly every member of the public health team has been!"*
- *"Thank you for the long hours and tireless work to try to get us through the pandemic. I know we have smart and innovative people who work for us to come up with solutions for us to live during this pandemic. We can get through this together."*
- *"Great job!! Each and every one is to be commended!! Keep up the great work…and thank you all for your service to our community."*
- *"Personally, their response team. They received a call, they responded immediately. They gave accurate information and they followed up on each situation that I was involved in."*
  - Community partner feedback

Simcoe Muskoka District Health Unit formally activated the agency's Incidence Management System on January 24, 2020, and the agency began to implement the Infectious Diseases Emergency Response Plan. With the changes in the agency's operations and modifications in work, staff were redeployed to the Infectious Disease (ID) and Health Connection programs along with the provision of training, support, working at home, and staff recruitment.

Simcoe Muskoka District Health Unit developed a COVID-19 Business Continuity Plan (BCP) to manage the redeployment, recruitment, training, and repatriation (of staff back to their base programs). The BCP was not designed for the scope and scale of the COVID-19 pandemic, and thus had to be remade during the pandemic for this application. The BCP informed the subsequent development of a modified 2020 budget.

Workforce

Timiskaming Health Unit's diverse workforce was able to tap into affiliate networks for timely sharing of information, tools, and processes. This supported agile response and reduced duplication of effort during peak response time. OPHEN, ODPH, APHEO, Business Administrators. This included assisting in areas to which they were redeployed.

York Region Public Health (YRPH) created a workgroup focusing on children and youth to ensure parents, caregivers, schools, and health care professionals had information and resources focused on the health and wellbeing of this population. In addition, YRPH has invested in developing a highly skilled infection prevention and control team. This has proved to be extremely valuable in quickly mobilizing these resources in providing rapid support to many stakeholders during the COVID-19 pandemic response. YRPH provided support to their workforce via the activation of the Public Health Emergency Support Group providing peer to peer support for mental health support.

Operating within an Incident Management Structure (IMS), **York Region Public Health** has been in active response structure since January 23, 2020 with enhanced monitoring and surveillance in place prior. Throughout the duration of the response, YRPH has gradually redeployed public health staff to meet the operational requirements of the response with over 70% of staff redeployed at the peak. Efforts were made to ensure continuity of critical core services while balancing the response.

York Region Public Health has also greatly benefited from their position within the Regional Municipality of York, where an additional 67 staff were redeployed to directly support the response (many with unique skill sets such as Data Analytics and Visualization Services) as well as additional non-direct support from other areas (i.e. Human Resources, Property Services, Information Technology Services, Access York).

Digital solutions

Halton Region Public Health worked with other departments at Halton Region to look for technology to support case and contact management for COVID-19 so that staff could begin working from home. Selection and the first phase of implementation of a new electronic record had occurred when the province began to review different systems. The province chose the same platform that Halton staff had already vetted and Halton staff have provided much support to the province on the planning and implementation of the provincial CCM tool that has been launched this summer.

Hamilton Public Health Services adapted existing technology used for routine inspections of food premises. Inspectors record COVID-19 IPAC observations and education data into the existing Hedgehog Inspection System to ensure all information is stored together.

KFL&A Public Health created a public facing dashboard to communicate COVID-19 case identification, assessment and testing updates to the community.

KFL&A Public Health has worked to create an internal capacity prediction dashboard to inform staff allocation during surge response.

KFL&A Public Health, with other health units, has contributed toward the development and implementation of the provincial CCM tool

KFL&A Public Health, working with the Office of the CMOH, enabled the real-time capture of suspected COVID-19 emergency department visits across the province in the Acute Care Enhanced Surveillance (ACES) system and built the Pandemic Tracker as a public tool (https://www.kflaphi.ca/aces-pandemic-tracker/).

KFL&A Public Health's community COVID-19 dashboard (https://www.kflaph.ca/en/healthy-living/status-of-cases-in-kfla.aspx), has received an average of 6000 hits per day, and provides timely data on the status of cases, assessment, and testing.

Middlesex-London Health Unit developed Azure software and several other local public health units were able to use this platform to facilitate the COVID response.

Ottawa Public Health developed a dynamic disease reporting system (the COVID-19 Ottawa Database known as "The COD"), adapted from a system used in Newfoundland and Labrador that supports local case management and contact tracing Building from this database has led to development of novel epidemiological methods and technology to detect potential clusters earlier and mobilize resources to investigate.

Ottawa Public Health's information technology team built a digital platform for daily screening of symptoms of COVID-19 in employees to help protect the health and safety of their workforce.

"Evidence based information, great graphics, informative without being preachy, and a wicked sense of humour. It's everything a public health organization should be!" - Community member feedback on **Ottawa Public Health's** social media presence

Digital solutions

Public Health Sudbury & Districts has been proactive, active, and responsive on social media. Video and evidence based information is valued and trusted:

- *"Appreciate the health unit's presence on social media and the quick communication re: new cases in our area."*
- *"Excellent media and social media presence with clear, succinct, and recent evidence-based principles."*

Simcoe Muskoka District Health Unit was well prepared with a pre-existing database to capture contact management and for surveillance reporting. IT already had technology for virtual conferencing (Skype for Business) to enable staff working from home; moved to VPN for all staff.

Simcoe Muskoka District Health Unit's website supported the distribution of information, guidance, and direction to communities, as well as received communication from community members (in addition to the community Health Connection line).

Simcoe Muskoka District Health Unit had frequent media events (5 times weekly in April), where the MOH held press conferences via Facebook Live from his home office, then posted content on YouTube.

York Region Public Health adopted many digital solutions to allow for the automation of data visualization where various datasets (i.e. iPHIS, OLIS, assessment centre data) are linked to provide the final publicly accessible dashboards.

York Region Public Health (YRPH) implemented an outbreak investigation system to better navigate the complexities of outbreak investigations and allow for linkages amongst cases. This has allowed for the provision of evidence based public health measures to settings in active outbreak. YRPH has collaborated with a local company specialized in big data analysis to support in evidence based local forecasting for anticipated spread/transmission of COVID-19.

York Region Public Health adopted a crowdsourcing approach through the implementation of an online client survey linked to an educational video on contact tracing. The aim of this approach was support local health unit in conducting a timely and efficient investigation for individuals testing positive.

Machine learning was developed by **York Region Public Health** to optimize the utility and interpretation of OLIS lab results data to support the automation of reporting and timely case follow up.

Public health system evaluation and lessons from the first peak of COVID-19

A report on behalf of the Council of Ontario Medical Officers of Health | August 2020

SUMMARY OF KEY FINDINGS

Local public health units have spent months leading the response to the COVID-19 pandemic across sectors in their communities

Findings from this evaluation can be used to **protect Ontario's communities** by:

- Building on public health system response that should continue or be enhanced during resurgence and future peaks
- Informing health system planning and preparedness for resurgence of COVID-19 and the upcoming influenza season
- Leveraging the strengths of the local public health system connections with community to ensure cross sector interventions

METHODS

- All Medical Officers of Health were invited to participate in the evaluation via email
- Further input received from all COMOH membership at two meetings

Key questions:
What **worked well during** the first peak?
What could be **improved**?
What should **continue** or **be enhanced**?
What else should we consider for **future COVID-19 planning** and **influenza** in the coming months?

- 17/34 (50%) local public health units participated (60% rural, 40% urban), sharing insights on >100 local initiatives
- Evaluations and continuous quality improvement processes carried out by local public health units through reviews, surveys, and interviews with their teams, the public, community partners, and stakeholders across sectors were been incorporated into this report

SUSTAINING THE PUBLIC HEALTH RESPONSE

Local public health leadership has been critical to protecting health and tailoring responses to meet the needs of our communities during the first peak

SIX THEMES IDENTIFIED

- **Public health measures** prevented illnesses and deaths that would have **overwhelmed our health care system** and remain a threat as seen in other jurisdictions
- Public health leadership **brought communities together** to flatten the epidemic curve using preventive measures that continue to be a mainstay of the response
- **Experience** and **technical training** in public health emergencies and health protection prepared local public health to respond and built on existing pandemic preparedness plans
- The most effective system in a public health emergency relies on **independent local public health authorities** that can leverage strong partnerships and community knowledge to adapt direction coordinated at the provincial level
- Public health holds a unique, **established, and trusted position that allows collaboration** with municipalities, schools, childcare settings, businesses, social services including congregate settings, health care and institutions, media, and community organizations **to effectively shape local response**
- **Provincial and regional coordination** is critical to supporting the strong leadership and response undertaken by local public health units and boards of health
- Pandemic response required rapid mobilization and scaling up of a **skilled public health workforce that will need ongoing investment** to respond to resurgence and increasing complexity of case management and contact tracing
- Public health innovation and adoption of new **digital solutions** to improve effectiveness and efficiency have been vital to enhancing widespread detection and containment efforts

> *Thank you for the long hours and tireless work to try to get us through the pandemic. I know we have smart and innovative people who work for us to come up with solutions for us to live during this pandemic. We can get through this together.*
> - Community partner feedback

OPPORTUNITIES

Local public health must provide ongoing leadership and guidance in all essential public health functions

- Local public health must build on **partnerships and collaboration** across sectors to **address new and complex community challenges** such as return to school, increased demand for health services, increase in visitors to long term care homes, re-opening of businesses, and larger social gatherings
- There must be investment in **local public health workforce** to allow for surge capacity needed for increasing complexity of pandemic response and maintaining critical core public health services
- There must be **increased resources for IPAC and outbreak management in higher-risk settings and priority populations** to minimize severe illness that would strain the health care system
- **Local public health expertise and connections with community** must be capitalized on at regional and provincial tables
- Roles of **key health system players** must be clarified and mutually respected for maximum health gains
- **New technologies** must be developed and adapted to support case management, contact tracing, and outbreak investigations so local public health units can enhance effectiveness despite growing complexity
- Innovative technologies must be explored to help with **advanced planning, forecasting, and operational response** in dealing with resurgence and other respiratory illnesses

Algoma Public Health
(Unaudited) Financial Statements July 31, 2020

Algoma Public Health
Statement of Operations
July 2020
(Unaudited)

	Actual YTD 2020	Budget YTD 2020	Variance Act. to Bgt. 2020	Annual Budget 2020	Variance % Act. to Bgt. 2020	YTD Actual/ YTD Budget 2020
Public Health Programs						
Revenue						
Municipal Levy - Public Health	$ **2,841,373**	$ 2,841,373	$ 0	$ 3,788,497	0%	100%
Provincial Grants - Cost Shared Funding	**5,828,723**	5,200,259	628,464	8,949,681	12%	112%
Provincial Grants - Public Health 100% Prov. Funded	**850,042**	873,708	(23,666)	1,497,786	-3%	97%
Provincial Grants - Mitigation Funding	**0**	471,645	(471,645)	1,037,800	-100%	0%
Fees, other grants and recovery of expenditures	**254,581**	328,517	(73,935)	620,814	-23%	77%
Total Public Health Revenue	$ **9,774,720**	$ 9,715,502	$ 59,218	$ 15,894,578	1%	101%
Expenditures						
Public Health Cost Shared	$ **8,161,546**	$ 8,154,938	$ (6,608)	$ 14,396,793	0%	100%
Public Health 100% Prov. Funded Programs	**765,290**	873,156	107,866	1,497,786	-12%	88%
Total Public Health Programs Expenditures	$ **8,926,836**	$ 9,028,094	$ 101,259	$ 15,894,578	-1%	99%
Total Rev. over Exp. Public Health	$ **847,884**	$ 687,408	$ 160,476	$ 0		
Healthy Babies Healthy Children						
Provincial Grants and Recoveries	$ **356,011**	356,004	(7)	1,068,011	0%	100%
Expenditures	**405,533**	355,337	50,196	1,068,011	14%	114%
Excess of Rev. over Exp.	**(49,522)**	667	(50,189)	-		
Public Health Programs - Fiscal 19/20						
Provincial Grants and Recoveries	$ **66,000**	-	(66,000)	-		
Expenditures	**1,799**	-	1,799	-		
Excess of Rev. over Fiscal Funded	**64,201**	-	64,201	-		
Community Health Programs (Non Public Health)						
Calendar Programs						
Revenue						
Provincial Grants - Community Health	$ -	$ -	$ -	$ -		
Municipal, Federal, and Other Funding	**173,676**	179,919	(6,243)	311,933	-3%	97%
Total Community Health Revenue	$ **173,676**	$ 179,919	$ (6,243)	$ 311,933	-3%	97%
Expenditures						
Child Benefits Ontario Works	**5,865**	14,292	8,427	24,500	-59%	41%
Algoma CADAP programs	**164,754**	168,494	3,741	287,433	-2%	98%
Total Calendar Community Health Programs	$ **170,618**	$ 182,786	$ 12,168	$ 311,933	-7%	93%
Total Rev. over Exp. Calendar Community Health	$ **3,058**	$ (2,867)	$ 5,925	$ (1)		
Fiscal Programs						
Revenue						
Provincial Grants - Community Health	$ **1,836,090**	$ 1,945,375	$ (109,285)	$ 5,813,257	-6%	94%
Municipal, Federal, and Other Funding	**52,484**	52,484	-	119,247	0%	100%
Other Bill for Service Programs	**4,896**		4,896			
Total Community Health Revenue	$ **1,893,470**	$ 1,997,859	$ (104,389)	$ 5,932,504	-5%	95%
Expenditures						
Brighter Futures for Children	**36,898**	38,149	1,251	114,447	-3%	97%
Infant Development	**158,950**	214,106	55,156	644,317	-26%	74%
Preschool Speech and Languages	**179,477**	204,019	24,541	614,256	-12%	88%
Nurse Practitioner	**53,604**	53,384	(220)	162,153	0%	100%
Community Mental Health	**1,118,170**	1,153,742	35,572	3,551,560	-3%	97%
Community Alcohol and Drug Assessment	**203,718**	236,929	33,210	710,786	-14%	86%
Stay on Your Feet	**27,630**	33,333	5,703	100,000	-17%	83%
Bill for Service Programs	**2,084**	-	(2,084)	-		
Misc Fiscal	**2,476**	3,000	524	4,800	-17%	83%
Total Fiscal Community Health Programs	$ **1,783,009**	$ 1,936,661	$ 153,653	$ 5,902,320	-8%	92%
Total Rev. over Exp. Fiscal Community Health	$ **110,462**	$ 61,198	$ 49,264	$ 30,184		

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 Seven Months Ending July 31, 2020
(Unaudited)

	Actual YTD 2020	Budget YTD 2020	Variance Bgt. to Act. 2020	Annual Budget 2020	Variance % Act. to Bgt. 2020	YTD Actual/ Annual Budget 2020	*Comparison Prior Year:* YTD Actual 2019	YTD BGT 2019	Variance 2019
Levies Sault Ste Marie	2,002,033	2,002,033	0	2,669,377	0%	75%	1,828,575	1,828,575	0
Levies Vector Bourne Disease and Safe Water							44,574	44,574	0
Levies District	839,340	839,340	0	1,119,120	0%	75%	774,452	766,617	7,835
Total Levies	**2,841,373**	**2,841,373**	**0**	**3,788,497**	**0%**	**75%**	**2,647,601**	**2,639,766**	**7,835**
MOH Public Health Funding	4,343,961	3,656,078	687,883	6,985,802	19%	62%	4,284,529	4,284,525	4
MOH Funding Needle Exchange	37,743	37,742	1	45,290	0%	83%	37,743	37,742	1
MOH Funding Haines Food Safety	14,350	14,350	0	17,220	0%	83%	14,350	14,350	0
MOH Funding Healthy Smiles	449,107	449,108	(1)	538,930	0%	83%	449,107	449,108	(1)
MOH Funding - Social Determinants of Health	175,829	105,280	70,549	126,350	67%	139%	105,293	105,292	1
MOH Funding Chief Nursing Officer	30,375	70,882	(40,507)	85,050	-57%	36%	70,879	70,875	4
MOH Enhanced Funding Safe Water	9,043	9,042	1	10,850	0%	83%	9,043	9,042	1
MOH Funding Infection Control	152,204	182,238	(30,034)	218,680	-16%	70%	182,236	182,233	3
MOH Funding Diabetes	87,500	87,500	0	105,000	0%	83%	87,500	87,500	0
Funding Ontario Tobacco Strategy	252,936	252,933	3	303,520	0%	83%	252,936	252,933	3
MOH Funding Harm Reduction	87,500	87,500	0	105,000	0%	83%	87,500	87,500	0
MOH Funding Vector Borne Disease	27,175	63,406	(36,231)	101,448	-57%	27%	63,407	63,408	(1)
MOH Funding Small Drinking Water Systems	17,400	40,600	(23,200)	64,960	-57%	27%	40,600	40,600	0
Total Public Health Cost Shared Funding	**5,685,123**	**5,056,659**	**628,464**	**8,708,100**	**12%**	**65%**	**5,685,123**	**5,685,108**	**15**
MOH Funding - MOH / AMOH Top Up	91,429	88,717	2,713	152,086	3%	60%	73,332	73,763	(431)
MOH Funding Northern Ontario Fruits & Veg.	68,486	68,483	3	117,400	0%	58%	68,486	68,483	3
MOH Funding Unorganized	309,400	309,400	0	530,400	0%	58%	309,400	309,400	0
MOH Senior Dental	380,727	407,108	(26,381)	697,900	-6%	55%	0	0	0
MOH Funding Indigenous Communities	0	0	0	98,000	#DIV/0!	0%	0	0	0
One Time Funding (Pandemic Pay)	143,600	143,600	0	143,600	0%	100%	0	0	0
Total Public Health 100% Prov. Funded	**993,642**	**1,017,308**	**(23,666)**	**1,739,386**	**-2%**	**57%**	**451,218**	**451,646**	**(428)**
Total Public Health Mitigation Funding	**0**	**471,645**	**(471,645)**	**1,037,800**	**-100%**	**0%**	**0**	**0**	**0**
Recoveries from Programs	23,773	16,059	7,714	27,511	48%	86%	23,065	23,429	(364)
Program Fees	109,407	117,416	(8,009)	201,284	-7%	54%	123,027	139,179	(16,152)
Land Control Fees	74,971	75,000	(29)	160,000	0%	47%	84,760	97,500	(12,740)
Program Fees Immunization	29,875	67,083	(37,208)	115,000	-55%	26%	68,903	90,417	(21,513)
HPV Vaccine Program	0	3,000	(3,000)	12,500	0%	0%	442	4,000	(3,558)
Influenza Program	0	1,500	(1,500)	25,000	0%	0%	885	0	885
Meningococcal C Program	0	625	(625)	7,500	0%	0%	349	0	349
Interest Revenue	14,925	23,333	(8,408)	40,000	-36%	37%	26,688	18,667	8,021
Other Revenues	1,630	24,500	(22,870)	32,000	-93%	5%	37,316	21,583	15,733
Total Fees, Other Grants and Recoveries	**254,581**	**328,517**	**(73,935)**	**620,795**	**-23%**	**41%**	**365,435**	**394,775**	**(29,340)**
Total Public Health Revenue Annual	**$ 9,774,719**	**$ 9,715,502**	**$ 59,217**	**$ 15,894,578**	**1%**	**61%**	**$ 9,149,377**	**$ 9,171,296**	**$ (21,919)**

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 Seven Months Ending July 31, 2020
(Unaudited)

	Actual YTD 2020	Budget YTD 2020	Variance Act. to Bgt. 2020	Annual Budget 2020	Variance % Act. to Bgt. 2020	YTD Actual/ Budget 2020	*Comparison Prior Year:* *YTD Actual 2019*	*YTD BGT 2019*	*Variance 2019*
Salaries & Wages	$ 5,440,515	$ 5,509,108	$ 68,593	$ 9,926,606	-1%	55%	$ 5,067,242	$ 5,268,331	$ 201,089
Benefits	1,352,654	1,336,582	(16,072)	2,264,828	1%	60%	1,324,133	1,274,635	(49,498)
Travel	64,360	111,417	47,057	191,000	-42%	34%	121,837	111,457	(10,380)
Program	381,524	399,874	18,350	681,660	-5%	56%	278,679	368,336	89,657
Office	30,094	39,492	9,397	71,200	-24%	42%	53,886	60,401	6,515
Computer Services	495,950	483,121	(12,829)	853,146	3%	58%	484,269	491,126	6,857
Telecommunications	183,241	151,110	(32,131)	267,615	21%	68%	155,364	172,816	17,453
Program Promotion	25,387	54,351	28,964	96,173	-53%	26%	11,486	36,709	25,223
Professional Development	8,482	79,042	70,560	135,500	-89%	6%	52,570	56,410	3,840
Facilities Expenses	518,678	451,743	(66,935)	774,417	15%	67%	455,956	443,333	(12,623)
Fees & Insurance	216,879	191,430	(25,449)	253,880	13%	85%	188,680	182,880	(5,800)
Debt Management	268,858	268,858	1	460,900	0%	58%	268,858	268,858	1
Recoveries	(59,786)	(48,033)	11,752	(82,343)	24%	73%	(56,758)	(61,092)	(4,334)
	$ 8,926,836	$ 9,028,094	$ 101,258	$ 15,894,582	-1%	56%	$ 8,406,201	$ 8,674,200	$ 267,998

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 – July 2020

Reporting Period

The July 2020 financial reports include seven-months of financial results for Public Health and the following calendar programs: Child Benefits Ontario Works, and Algoma CADAP programs. All other programs are reporting four-month result from operations year ended March 31 2020.

Statement of Operations (see page 1)

Summary – Public Health and Non Public Health Programs

Note: On August 21st 2020, Algoma Public Health received the 2020-2021 Public Health funding approval letters from the Ministry of Health and Long-Term Care. APH will receive up to $115,300 in additional base funding, $1,109,900 in one-time funding for the 2020-21 funding year and up to $1,037,800 in one-time funding for the 2021-222 funding year.

One-time funding requests and approvals are summarized below:

One-Time Request	Amount BoH Requested ($)	2020 Approved Allocation ($)
Public Health Inspector Practicum Program (2) (100%)	13,000	10,000
New Purpose-Built Vaccine Refrigerators (100%)	7,330	7,400
MOH/AMOH Compensation Initiative	-	22,700
Ontario Seniors Dental Care Program Capital: Dental Clinic Upgrades - Sault Ste. Marie	-	To be communicated at later date
Temporary Pandemic Pay Initiative	-	143,600
Indigenous Engagement Specialist Support*	98,000	98,000
Northern Communities Environment & Health Specialist Support	103,000	-
Smoking Prevention and Cessation Mass Media Campaign	60,000	-
Total One Time Funding	**$281,330**	**$281,700**

Notes Continued...

Mitigation funding associated with cost-sharing changes has been approved in the amount of $1,037,800 for the period January 1, 2020 to December 31, 2020 and for the period January 1, 2021 to December 31, 2021 and is summarized below:

	Amount BoH Budgeted ($)	2020 Approved Allocation ($)
Mitigation**	808,535	1,037,800

	Amount BoH Budgeted ($)	2021 Approved Allocation ($)
Mitigation**	-	1,037,800

NOTES:
** APH received $98,000 in Unorganized Territories/Indigenous Communities as part of 100% Provincial Base Funding.*

*** Mitigation funding is meant to ensure that municipalities do not experience any increase as a result of cost-sharing change*

The July 2020 statements and corresponding analysis have been adjusted to reflect these funding changes.

As of July 31st, 2020, Public Health programs are reporting a $160k positive variance.

Total Public Health Revenues are indicating a $59k positive variance. This is primarily a result of the Ministry continuing to flow funds similar to 2019 cost-sharing ratios in spite of their announcement to change the cost-sharing funding formula from 75% provincial funding to 70% provincial funding for 2020. Management budgeted according to the Ministry's 2019 announcement.

Technically, Public Health Mitigation funding has yet-to-flow to health units, however the negative $472k variance associated with mitigation funding is being offset with the positive $628k variance associated with Provincial Cost-Shared Funding.

100% Provincially Funded programs are showing a negative $24k variance. This negative variance is associated with timing of receipts related to the Ontario Seniors Dental program.

The negative variance associated with Fees, Other Grants and Recoveries is a result of less fees received than budgeted as a result of the COVID-19 pandemic.

There is a positive variance of $101k related to Total Public Health expenses being less than budgeted however this positive variance is being driven by 100% Provincially Funded Senior Dental program. A

Notes Continued...

vacant position within the program is driving this variance. Cost-shared programs are aligned with budget.

APH's Community Health (Non-Public Health) Fiscal Programs are four-months into the fiscal year.

Infant Development, Preschool Speech and Language and Community Alcohol and Drug Assessment Programs are all indicating positive variances associated with expenses as a result of inherent staff gapping.

Notes Continued...

Public Health Revenue (see page 2)

Overall, Public Health funding revenues are within budget.

The municipal levies are within budget.

Provincial Cost-Shared funding is reflecting a $628k positive variance. As a result of the Ministry announcement in 2019 to change the cost-sharing funding formula from 75% provincial funding to 70% provincial funding, management budgeted accordingly. As of July 31 2020, Provincial Cost-Shared funding is flowing similar to 2019 ratios. Management is anticipating that the difference between actual and budgeted cost-shared dollars can be interpreted as mitigation funding.

Offsetting the positive variance noted with Cost-Shared Funding is the negative variances associated with 100% Provincially Funded programs, Public Health Provincial mitigation funding, and Fees Other Grants and Recoveries.

100% Provincially Funded programs are showing a negative $24k variance. This variance is associated with the timing of receipts associated with the Ontario Seniors Dental program.

Management has adjusted the budgeted Public Health Mitigation funding to reflect the most recent funding announcement. Technically, mitigation funding has yet-to-flow with regards changes to the cost-sharing formula however the negative $472k variance associated with mitigation funding is being offset with the positive $628k variance associated with Provincial Cost-Shared Funding.

Fees, Other Grants & Recoveries are showing a negative variance of $74k. This is primarily a result of the impact the COVID-19 pandemic is having on revenue generating services such as travel vaccine fees and pill sales. A lower bank interest rate is also impacting the actual interest earned on APH accounts.

Public Health Expenses (see page 3)

Salary & Wages
There is a $69k positive variance associated with Salary and Wages. This is primarily associated with the Ontario Seniors Dental program. The 2020 Operating Budget included a Data Analyst position to support these programs and other agency needs. This position has now been filled. Overall, Salary and Wages is operating within 1% of budget.

Travel
There is a $47k positive variance associated with Travel expenses. This is a result of APH employees working virtually as opposed to travelling within the District of Algoma. Management is anticipating Travel expenses to be less than budgeted for 2020 as a result of the impact of COVID-19 pandemic.

Telecommunications
Telecommunications is indicating a negative $32k variance. This is a result of APH processing its annual phone support payment in the month of June. Also contributing to this negative variance is the incremental costs associated with providing employees with the telecommunication tools needed to function in a virtual work environment.

Notes Continued...

Program Promotion
Program Promotion expense is indicating a positive $29k variance. This is a result of budgeted promotional dollars being spent primarily on COVID-19 messaging with less budgeted dollars being spent on other program initiatives. For example, the 2020 APH budget included approximately $60k for a Smoking Cessation campaign that has been put on-hold.

Professional Development
There is a $71k positive variance associated with Professional Development. This is a result of APH employees participating in less Professional Development opportunities to-date as a result of the COVID-19 pandemic. Specially, the Ontario Public Health Convention (TOPHC), one of the major provincial Public Health conferences, which some APH staff typically attend, was cancelled in March.

Facilities Expenses
Facilities expense is reflecting a negative $67k variance. This is a result of the cost incurred with improving the sound quality of the Algoma room in addition to needed safety improvements made throughout APH facilities as a result of managing COVID-19.

Fees and Insurance
Fees and Insurance is showing a negative $25k variance. Insurance expense is $21k over budget due to unanticipated increases in insurance premiums not budgeted. Additionally legal fees are currently $4k over budget.

Note: The Ministry has established a process for Boards of Health to submit for one-time COVID-19 Extraordinary expenses which APH has recently submitted.

Financial Position - Balance Sheet (see page 7)

APH's liquidity position continues to be stable and the bank has been reconciled as of July 31 2020. Cash includes $1.15M in short-term investments.

Long-term debt of $4.56 million is held by TD Bank @ 1.95% for a 60-month term (amortization period of 180 months) and matures on September 1, 2021. $266k of the loan relates to the financing of the Elliot Lake office renovations which occurred in 2015 with the balance related to the financing of the 294 Willow Avenue facility located in Sault Ste. Marie.

There are no material accounts receivable collection concerns.

NOTE:

1. Management is tracking COVID-19 associated costs. Costs will be reported in the time-period in which they are incurred.

Algoma Public Health

Statement of Financial Position

(Unaudited)

Date: As of July 2020	**July 2020**	December 2019
Assets		
Current		
Cash & Investments	**$ 4,248,520**	$ 3,456,984
Accounts Receivable	**298,788**	433,414
Receivable from Municipalities	**286,907**	74,976
Receivable from Province of Ontario		
Subtotal Current Assets	**4,834,215**	3,965,374
Financial Liabilities:		
Accounts Payable & Accrued Liabilities	**1,454,213**	1,579,444
Payable to Gov't of Ont/Municipalities	**396,014**	514,362
Deferred Revenue	**296,674**	281,252
Employee Future Benefit Obligations	**2,910,195**	2,910,195
Term Loan	**4,836,784**	4,836,784
Subtotal Current Liabilities	**9,893,879**	10,122,037
Net Debt	**(5,059,664)**	(6,156,664)
Non-Financial Assets:		
Building	**22,867,230**	22,867,230
Furniture & Fixtures	**1,998,117**	1,998,117
Leasehold Improvements	**1,572,807**	1,572,807
IT	**3,252,107**	3,252,107
Automobile	**40,113**	40,113
Accumulated Depreciation	**(10,429,282)**	(10,429,282)
Subtotal Non-Financial Assets	**19,301,092**	19,301,092
Accumulated Surplus	**14,241,427**	13,144,428

Algoma Public Health
COVID 19 - 402
July 31, 2020

Account Name	*Curr YTD*	*BGT YTD*	*Variance*	*Annual BGT*	*Funds Remaining*
Revenue					
Expenses					
Management Salaries and Wages	598,183	0	-598,183	0	-598,183
Non-Union Salaries and Wages	138,467	0	-138,467	0	-138,467
CUPE Salaries and Wages	384,810	0	-384,810	0	-384,810
ONA Salaries and Wages	1,054,070	0	-1,054,070	0	-1,054,070
Travel Food/Lodging/Other	190	0	-190	0	-190
Program Materials and Supplies	25,077	0	-25,077	0	-25,077
Computer Equipment Purchased	17,463	0	-17,463	0	-17,463
Telecommunications	13,171	0	-13,171	0	-13,171
Media	17,487	0	-17,487	0	-17,487
Janitorial	27,057	0	-27,057	0	-27,057
Security	1,514	0	-1,514	0	-1,514
	2,277,488	0	-2,277,488	0	-2,277,488
Surplus/(Deficit)	**-2,277,488**	**0**	**2,277,488**	**0**	**2,277,488**

TRANSFER PAYMENT ANNUAL RECONCILIATION

SECTION I: SUMMARY, CERTIFICATION and VERIFICATION

SERVICE PRO Board of Health for the Algoma Health Unit

Mar. 31, 2019 (e.g. Mar. 31, 2020)

SERVICE CONTRACT/CFSA APPR Oct. 24, 2019

PART A: SUMMARY

LINE	SERVICES					
100	Service (Detail Code) Name	Service (Detail Code) Name	Executive and Allotment Control	Total Eligible Expenditures (pending final Ministry review and approval)	Total Approved Ministry Funding	Summary of Revised Ministry Funding after Financial Flexibility (pending final Ministry review and approval)
101	F134	Infant Development	0	$ 590,160	$ 624,935	$ 590,160
102	0			$ -	$ -	$ -
103	0			$ -	$ -	$ -
104	0			$ -	$ -	$ -
105	0			$ -	$ -	$ -
106	0			$ -	$ -	$ -
107	0			$ -	$ -	$ -
108	0			$ -	$ -	$ -
109	0			$ -	$ -	$ -
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195	0			$ -	$ -	$ -
196	0			$ -	$ -	$ -
197	0			$ -	$ -	$ -

198	0			$ -	$ -	$ -
199	0			$ -	$ -	$ -
200	0			$ -	$ -	$ -
TOTAL				$ 590,160	$ 624,935	$ 590,160

PART B: CERTIFICATION BY SERVICE PROVIDER / DELIVERY AGENT AUTHORITY

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

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

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

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

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

PART C: VERIFICATION BY THE BOARD OF DIRECTORS

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

the B _____ day of _____ . _____ . (LINE 160)

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

Signature

Name of Chairperson or Designate

Title

Section I

Basis of Accounting

Without modifying our conclusion we draw attention to Note 1 to the Statement which describes the basis of accounting. The Statement is prepared to provide information to the Members of the Entity and the Ministry of Children, Community and Social Services North Region. As a result, the Statement may not be suitable for another purpose.

Restriction on Use

Our report is intended solely for the Members of the Board of the Entity and the Ministry of Children, Community and Social Services North Region and should not be used by parties other than the Members of the Board of the Entity and the Ministry of Children, Community and Social Services North Region.

KPMG LLP

Chartered Professional Accountants, Licensed Public Accountants

Sault Ste. Marie, Canada

August 12, 2020

ALGOMA PUBLIC HEALTH

Infant Development Program

Statement of Revenue and Expenditures
(Unaudited)

Year ended March 31, 2020, with comparative information for 2019

	Budget	2020	2019
Revenue:			
Provincial grants	$ 624,935	$ 624,935	$ 624,935
Expenditures:			
Salaries and benefits	537,924	502,007	511,794
Occupancy	50,354	50,855	50,771
Travel and training	22,000	20,771	21,569
Administration	16,000	16,120	16,040
Program materials and supplies	7,952	7,167	12,786
Telephone	5,400	7,972	7,662
Professional development	2,400	2,400	4,446
Professional fees	2,000	2,035	2,035
Janitorial	–	–	131
Subscriptions/memberships	–	–	495
Expenses recovered	(19,095)	(19,167)	(18,884)
	624,935	590,160	608,845
Excess of revenue over expenditures	$ –	$ 34,775	$ 16,090

See accompanying notes to financial information.

ALGOMA PUBLIC HEALTH

Infant Development Program

Notes to Financial Information
(Unaudited)

Year ended March 31, 2020

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1. Basis of accounting:

The Statement of Revenue and Expenditures of the Entity has been prepared in accordance with the recognition and measurement principles of Canadian public sector accounting standards of the CPA Canada Handbook – Accounting (PSAB) and not the presentation principles or the presentation of all financial statements and related note disclosures required for a complete set of financial statements.

The statement is prepared to provide information to the Members of the Board of the Entity, and to the Ministry of Children, Community and Social Services North Region. As a result, the Statement may not be suitable for another purpose.

2. Significant accounting policies:

(a) Revenue and expenses are reported on the accrual basis of accounting.

(b) Capital expenditures are recorded as expenses rather than being capitalized.

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

INDEPENDENT PRACTITIONERS' REVIEW ENGAGEMENT REPORT

To the Members of the Board of the Algoma Public Health and the Ministry of Children, Community and Social Services North Region

We have reviewed the Statement of Revenue and Expenditures of the Infant Development Program of the Algoma Public Health (the Entity) for the year ended March 31, 2020 and notes, comprising summary of significant accounting policies (the Statement). The Statement has been prepared by management in accordance with the basis of accounting described in Note 1 to the Statement.

Management's Responsibility for the Statement

Management is responsible for the preparation of the Statement in accordance with the basis of accounting described in Note 1 to the Statement, and for such internal control as management determines is necessary to enable the preparation of the Statement that is free from material misstatement, whether due to fraud or error.

Practitioners' Responsibility

Our responsibility is to express a conclusion on the accompanying Statement based on our review. We conducted our review in accordance with Canadian generally accepted standards for review engagements, which require us to comply with relevant ethical requirements.

A review in accordance with Canadian generally accepted standards for review engagements is a limited assurance engagement. The practitioner performs procedures, primarily consisting of making inquiries of management and others within the entity, as appropriate, and applying analytical procedures, and evaluates the evidence obtained.

The procedures performed in a review are substantially less in extent than, and vary in nature from, those performed in an audit conducted in accordance with Canadian generally accepted auditing standards. Accordingly, we do not express an audit opinion on this Statement.

Conclusion

Based on our review, nothing has come to our attention that causes us to believe that the Statement of Revenue and Expenditures for the Entity for the year ended March 31, 2020 is not prepared, in all material respects, in accordance with the basis of accounting described in Note 1 to the Statement.

Financial Information of

ALGOMA PUBLIC HEALTH

Infant Development Program

And Independent Practitioners' Review Engagement Report thereon

Year ended March 31, 2020
(Unaudited)

Algoma PUBLIC HEALTH Santé publique Algoma

Briefing Note

www.algomapublichealth.com

To: Algoma Public Health Finance and Audit Committee

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

Date: September 23, 2020

Re: 2020 Levy Increase Reimbursement

☐ For Information ☐ For Discussion ☒ For a Decision

ISSUE:

On August 21st, 2020, APH received its 2020-2021 Public Health funding approval letters from the Ministry of Health and Long-Term Care. The letter indicated that APH would receive one-time mitigation funding in the amount $1,037,800 for both the 2020 and 2021 funding years. This funding is designed to ensure that municipalities do not experience any increase as a result of the previously announced cost-sharing changes. APH's 2020 levy increase to contributing municipalities was a direct result of the previously announced cost-sharing changes the Ministry announced in 2019. Management is seeking Board of Health direction as to how to implement the Province's intent on minimizing the financial impact to municipalities.

BACKGROUND:

In April 2019 the Provincial Government announced that as of January 1st, 2020 the provincial funding share would be reduced from 75% to 70% while municipalities will contribute 30% from 25%. Additionally, the majority of programs that were previously 100% provincially funded would be cost-shared at the new ratios. To help provide additional stability as municipalities began to adapt to shifting funding models, the Government announced they would provide one-time mitigation funding in 2020 to assist all public health units and municipalities to manage this increase. Municipalities were protected from any cost increases resulting from this new cost-sharing formula by capping the increase at no more than 10% of existing municipal costs (based on 2018 expenditures). As a result, APH management budgeted approximately $808,535 in expected provincial one-time mitigation funding.

The levy increase associated with APH's 2020 Operating and Capital Budget was a direct result of the changes in the funding formula. There was no portion of the levy increase

associated with inflationary pressures (which some health units may have included in their respective levy increases).

RECOMMENDED ACTION:

1) That the Board of Health understands and respects that any levy increase in the year's 2020 and 2021 are not to be associated with transitioning to achieving a cost-shared funding formula of 70% provincially funded and 30% municipally funded and
2) That, as a result of the 2020 levy increase being a direct result of the previously announced cost-sharing changes, the Board of Health for the District of Algoma reimburse contributing municipalities a total $229,265 to be apportioned based on 2016 Census data.

FINANCIAL IMPLICATIONS:

There is no financial impact to the Board of Health.

The incremental increase in the levy associated with adjusting the cost-sharing allocation will now be funded by the province through additional mitigation funding. This essentially reverses the Ministry's previously communicated plan of adjusting the cost-sharing split to 70% provincially funded and 30% municipal funded to the traditional 75% - 25% ratios.

APH had budgeted $808,535 in expected provincial one-time mitigation for 2020 but will receive $1,037,800 in provincial mitigation funding. The increase in provincial funding of $229,265 is designed to offset the increase in the municipal levy that was associated with transitioning towards a new cost-sharing formula. Essentially, instead of the Board of Health receiving these from contributing municipalities, the Board will now be receiving these dollars from the province with no change in the 2020 funding figures (only the source of the funding has changed).

CONTACT:

J. Pino, Chief Financial Officer/Director of Operations

Governance Committee Meeting

September 9, 2020

Attendees:

Deborah Graystone - Chair
Heather O'Brien
Louise Caicco Tett
Lee Mason
Brent Rankin

APHU Executive

Marlene Spruyt - MOH/CEO
Jennifer Loo - AMOH
Tania Caputo - Board Secretary

The following Board Policies were discussed amended and approved by the Governance Committee:

Policy #02-05-015 - Conflict of Interest

There was a robust discussion regarding the inclusion of some of the criteria from the *Municipal Conflict of Interest Act*. Some of the details of that legislation were integrated into the document but some of it was deemed not as appropriate for this organization. It was decided to keep the actual and perceived conflict wording as is. Minor wordsmithing was made and the policy was approved by the committee.

Policy #02-05-080 - Performance Evaluation for MOH/CEO

Questions regarding the organizational "work plan" that had been integrated into this policy was removed as it was confusing and it was thought the focus should be the MOH's personal professional development goals and objectives. Discussion around the work plan brought our attention to the need for an annual review with the board regarding this plan. Elements of the work plan are currently brought to the board through the MOH/CEO reports however it was thought that an annual overall review shared with the board would be helpful.
There was also debate about the presence of the Director of Human Resources being involved in the performance evaluation of a colleague. However it was thought that the expertise regarding human resource best practice issues were important to ensure compliance.

Policy #02-05-086 - Sponsorship of Charitable Organizations

Some discussion regarding this policy but no substantive changes made.

Policy #02-05-035 - Continuing Education for Board Members

The committee had a discussion regarding selection of members for education. Although there has never been an issue with too many people wanting to attend an education session there was a question on participant selection.
There was discussion regarding not sending a novice member who may not have clear insight into the needs of the organization as yet or members who are in their last months of their term of office. Although not mentioned in the policy these factors and the needs of the board member are considered in participant selection.

APPROVED BY:	Board of Health	**REFERENCE #:**	02-05-015
DATE:	Original: Jan 18, 1995 Revised: Oct 28, 2015 Revised: Jan 24, 2018 Revised: Jun 24, 2020 Revised: Sep 23, 2020	**SECTION:**	Policies
		SUBJECT:	Conflict of Interest

POLICY:

Each member of the Board of Health has an obligation to avoid ethical, legal, financial or other conflicts of interest and to ensure that their activities and interests do not conflict with their obligations to the Board of Health of the Algoma District Health Unit (operating as Algoma Public Health) or its welfare.

It is the responsibility of the individual to disclose any conflicts of interest to the meeting.

If there is any doubt as to a perception of conflict, the member shall discuss with the Chair and/or Board of Health for direction.

A Board member should not use information that is not public knowledge, obtained as a result of their appointment, for personal benefit.

No Board member should divulge confidential information obtained as a result of their appointment unless legally required to do so.

A Board member shall remove oneself from the Board of Health if employment at APH is being sought.

The purpose of the Conflict of Interest Policy is to:

i) Assist individual Board members in determining when their participation in a Board decision/discussion has the potential to be used for personal or private benefit, financial or otherwise;

ii) Protect the integrity of the Board as a whole and its members by following the conflict of Interest Policy and Procedures.

Definitions:

A conflict of interest situation arises where a member either on their own behalf or while acting for, by, with or through another, has any direct or indirect non-pecuniary or pecuniary interest in any contract or transaction with the Board or in any contract or transaction that is reasonably likely to be affected by a decision of the Board. Where the Board member or their close relative or friend or affiliated entity uses the Board member's position with APH to advance their personal or financial interests.

Actual conflict of interest: A situation where a Board member has a private or personal interest that is sufficiently connected to their duties and responsibilities as a Board member that it influences the exercise of these duties and responsibilities.

Perceived conflict of interest: A situation where reasonably well-informed persons could have a reasonable belief that a Board member may have an actual conflict even where that is not the case, in fact.

Indirect pecuniary interest: A member has an indirect pecuniary interest in any matter in which the council or local Board, as the case may be, is concerned, if;

(a) the member or their nominee,

(i) is a shareholder in, or a director or senior officer of, a corporation that does not offer its securities to the public,

(ii) has a controlling interest in or is a director or senior officer of, a corporation that offers its securities to the public, or

(iii) is a member of a body, that has a pecuniary interest in the matter; or

(b) the member is a partner of a person or is in the employment of a person or body that has a pecuniary interest in the matter.

PROCEDURE:

1) At the beginning of every Board/Committee meeting, the Chair shall ask and have recorded in the minutes whether any Board member has a conflict to declare in respect to any agenda item.

2) If a Board member believes that they have an actual or perceived conflict of interest in a particular matter, they shall;

a) disclose the interest and the general nature thereof, prior to any consideration of the matter at the meeting.

b) not take part in the discussion of, or vote on any question in respect of the matter.

c) not attempt in any way to influence the voting or do anything which might be reasonably perceived as an attempt to influence other councillors or committee members or the decision relating to that matter.

d) leave the meeting or the part of the meeting during which the matter is under consideration if the meeting is not open to the public.

3) Where the interest of a member has not been disclosed as required by subsection (2) by reason of the member's absence from the meeting referred to therein, the member shall disclose the interest and otherwise comply with subsection (2) at the first meeting of the Board attended by the member after the meeting referred to in subsection (2).

4) At a meeting at which a member discloses an interest under section (2) or as soon as possible afterwards, the member shall file a written statement of the interest and its general nature to the Chair of the Board or affected committee.

5) Where a member, either on their own behalf or while acting for, by, with or through another, has any pecuniary interest, direct or indirect, in any matter that is being considered by the Board, shall not use their position in any way to attempt to influence any decision or recommendation that results from consideration of the matter.

6) Where a Board or committee member believes that another member has a conflict of interest that has not been declared despite any appropriate informal communications, the first member shall advise an appropriate person such as the Chair of the Board or affected committee.

7) Where a Board or committee member believes that another Board or committee member has acted in or is in an ongoing conflict of interest, they shall advise in writing an appropriate person such as Chair of the Board or affected committee.

8) In situations where a Board member declares **a perceived conflict of interest,** the Board will determine by majority vote whether the member(s) participate in the discussion and vote on the item. The minutes should reflect the discussion and the Board decision on the matter. Alternately the Board member may decide on their own accord to not participate in the discussion and to not vote on the agenda item in question.

9) Prior to seeking employment with programs administered by the Board, the member shall provide a letter of resignation; however, the member may seek re-appointment if not successful in the job competition.

10) Where a conflict of interest is discovered during or after consideration of a matter, it is to be declared to the Board at the earliest opportunity and recorded in the minutes.

11) If the Board determines that the involvement of the member declaring the conflict influenced the decision on the matter, the Board shall re-examine the matter and may rescind, vary, or confirm its decision. Any action taken by the Board shall be recorded in the minutes.

12) Where there has been a failure on the part of a Board member to comply with this policy unless the failure is the result of a bona fide error in judgement as determined by the Board; the Board shall request that the Chair;

    i) issue a verbal reprimand; or
    ii) issue a written reprimand; or
    iii) request that the Board member resign or seek dismissal of the Board member based on regulations relevant as to how the Board member was appointed.

APPROVED BY:	Board of Health	**REFERENCE #:**	02-05-035
DATE:	Original: Jan 20, 2010 Reviewed: Jun 17, 2014 Revised: May 25, 2016 Revised: Nov 28, 2018 Reviewed: Sep 23, 2020	**SECTION:**	Policies
		SUBJECT:	Continuing Education for Board Members

POLICY:

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

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

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

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

APPROVED BY:	Board of Health	**REFERENCE #:**	02-05-080
DATE:	Original: Mar 28, 2018 Revised: Sep 23, 2020	**SECTION:**	Policies
		SUBJECT:	Performance Evaluation for Medical Officer Of Health/Chief Executive Officer (MOH/CEO)

POLICY:

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

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

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

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

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

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

PROCEDURES

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

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

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

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

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

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

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

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

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

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

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

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

APPROVED BY:	Board of Health	**REFERENCE #:**	02-05-086
DATE:	Original: Nov 28, 2018 Revised: Sep 23, 2020	**SECTION:**	Policies
		SUBJECT:	Sponsorship of Charitable Organizations

PURPOSE

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

BACKGROUND

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

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

POLICY STATEMENT

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

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

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

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

REFERENCES

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

Peterborough Public Health

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June 25, 2020

The Right Honourable Justin Trudeau, P.C., MP
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The Honourable Chrystia Freeland, P.C., M.P.
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The Honourable Bill Morneau, P.C., M.P.
Minister of Finance
90 Elgin Street, 17th Floor
Ottawa, ON K1A 0G5
bill.morneau@parl.gc.ca

Dear Prime Minister, Deputy Prime Minister and Minister Morneau:

Subject: Endorsement of the letter from Simcoe Muskoka District Health Unit, *Basic Income for Income Security during COVID-19 Pandemic and Beyond*

I am writing on behalf of the Board of Health for Peterborough Public Health to express support for recommendations from the Simcoe Muskoka District Health Unit (SMDHU) Board of Health, for the "evolution of the Canada Emergency Response Benefit (CERB) into a basic income for all Canadians, during the COVID-19 pandemic and beyond."

As mentioned in the letter endorsed by SMDHU, from the Ontario Dietitians in Public Health, there is a lack of evidence that charitable food distribution systems can lower household food insecurity rates. Basic income is an evidence-based strategy to address poverty and household food insecurity in Canada.

Poverty and household food insecurity are severe problems in Peterborough. For example, half of single mothers in Peterborough are food insecure, worrying about running out of money for food.[1] Also, many residents have little income left over after paying rent: Peterborough has the highest percentage of renting households with unaffordable shelter costs in Canada, and over half of local renters are housing insecure.[2] There are also significant income challenges faced by rural communities, including those in the Peterborough County. Of note, net farm incomes in Ontario were almost 50% lower in 2019 when compared to 2017, highlighting risk of poverty for farmers.[3]

During the COVID-19 pandemic and beyond, local residents and all Canadians require adequate incomes to meet basic needs and live with dignity. Basic income is a strategy that has been shown to facilitate critical outcomes including housing stability, household food security, and improved physical and mental health. Basic income would also allow for flexibility of Canadians to meet needs in ways that are reflective of their cultures and traditions. A basic income is what our country needs to address impacts of COVID-19 and other adversity we will face, to allow for an equitable, healthy, and resilient future.

Sincerely,

Original signed by

Mayor Andy Mitchell
Chair, Board of Health

/ag
Encl.

cc: Local MPs
Opposition Critics
The Association of Local Public Health Agencies
The Ontario Public Health Association
Ontario Boards of Health

---

[1] Peterborough Public Health. (2019). Limited Incomes Report: No Money for Food is Cent$less. Retrieved from: https://www.peterboroughpublichealth.ca/reports-and-data/

[2] United Way Peterborough and District. (2019). Housing is Fundamental. Retrieved from https://www.uwpeterborough.ca/housing-is-fundamental/

[3] Statistics Canada. (2020). Net Farm Income (x1000). Retrieved from https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=3210005201

Porcupine
Health Unit • Bureau de santé

June 29, 2020

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

Phone: 705 267 1181
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Toll Free: 800 461 1818

The Right Honourable Justin Trudeau, P.C., M.P.
Prime Minister of Canada
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80 Wellington Street
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The Honourable Chrystia Freeland, P.C., M.P.
Deputy Prime Minister
Privy Council Office
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80 Sparks Street
Ottawa, ON K1A 0A3

The Honourable Bill Morneau, P.C., M.P.
Minister of Finance
90 Elgin Street, 17th Floor
Ottawa, ON K1A 0G5

Dear Prime Minister Trudeau, Deputy Prime Minister Freeland and Minister Morneau:

Subject: Basic Income for Income Security during COVID-19 Pandemic and Beyond

The Board of Health for the Porcupine Health Unit strongly supports a basic income for all Canadians to ensure everyone has a sufficient income to meet their basic needs. As such, the Board of Health endorses the enclosed correspondence to the federal government from Simcoe Muskoka District Health Unit, dated May 20, 2020, Timiskaming Health Unit, dated June 9, 2020, the Ontario Dietitians in Public Health, dated May 9, 2020 and Canada's Senate, dated April 21, 2020. These letters request that the federal government change the Canada Emergency Response Benefit (CERB) into a basic income for all Canadians, during the COVID-19 pandemic and beyond.

The measures taken during COVID-19 to support Canadians are an important opportunity to address the economic disparities that impact health. Income insecurity impacts the health of the population. This includes housing instability, food security, poorer physical and mental health outcomes as well as chronic health conditions. Food insecurity is an important public health issue in the Porcupine Health Unit (PHU) area. The PHU is located in Northeastern Ontario and serves communities in the Cochrane District as well as Hornepayne, in Algoma District. Geographically, the PHU is the largest of the 34 health units in Ontario. As the most sparsely populated of all the health units, about one-third of the PHU area is rural. There are many demographic and socioeconomic factors that make the PHU district unique in the province, including a higher Francophone and Indigenous population in addition to a higher unemployment rate, a higher percentage of those not completing high school and lower life expectancy.(1)

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

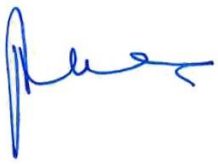
Branch Offices: Cochrane, Hearst, Hornepayne, Iroquois Falls, Kapuskasing, Matheson, Moosonee, Smooth Rock Falls

Furthermore, access to affordable, nutritious foods is a challenge, especially in the smaller communities in the region. Many of the communities only have one grocery store and some do not have a grocery store and must travel to other communities to purchase food. The PHU has experienced a 10% increase in the cost of healthy food since 2015. In 2019, the cost of the Nutritious Food Basket was approximately $25 higher per week than the Ontario provincial average. When the cost of healthy eating is added to local rent rates and various income scenarios are compared, year after year this survey demonstrates that many residents in the PHU area living on a low income are unlikely to have sufficient income to purchase a basic healthy diet for themselves and their families.

Food-insecure Canadians are much more likely than others to have serious physical and mental health problems[4], and they are less able to manage these conditions. Research shows that severe food insecurity can reduce a person's life expectancy by 9 years, as well as pose a significant cost to our health care system.

We strongly recommend your government take immediate action on developing the Canada Emergency Response Benefit into legislation for a basic income as an effective long-term response to the problems of income insecurity, poverty and household food insecurity, as well as a response to the economic impact of the COVID-19 pandemic.

Sincerely,



Sue Perras
Board Chair, Porcupine Health Unit

cc: *Hon., Doug Ford, The Premier of Ontario*
Mr. Charlie Angus, MP – Timmins – James Bay
Ms. Carol Hughes, MP – Algoma – Manitoulin – Kapuskasing
Mr. Gilles Bisson, MPP – Timmins – James Bay
Mr. Guy Bourgouin, MPP – Mushkegowuk - James Bay
Municipal Councils
Association of Local Public Health Agencies (alPHa)
Ontario Boards of Health
Ontario Public Health Association

1. Porcupine Health Unit. Health Status Report 2020 (Draft); 2020 [cited 2020 May 29].

2. Tarasuk V, Mitchell A. (2020). Household food insecurity in Canada, 2017-18. Toronto: Research to identify policy options to reduce food insecurity (PROOF). Retrieved from https://proof.utoronto.ca/.

3. Mohammad Ferdosi, Tom McDowell, Wayne Lewchuk, Stephanie Ross. Southern Ontario's Basic Income Experience [Internet]. 2020 [cited 2020 May 25]. Available from: https://labourstudies.mcmaster.ca/documents/southern-ontarios-basic-income-experience.pdf

4. Nutritious Food Basket [Internet]. [cited 2019 Mar 1]. Available from: http://www.porcupinehu.on.ca/en/your-family/nutrition-food-basket/

July 16, 2020

The Right Honourable Justin Trudeau, P.C., M.P.
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The Honourable Bill Morneau, P.C., M.P.
Minister of Finance
90 Elgin Street, 17th Floor
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bill.morneau@parl.gc.ca

Dear Prime Minister Trudeau, Deputy Prime Minister Freeland and Minister Morneau:

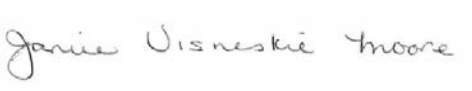
Re: Basic Income for Income Security during Covid-19 Pandemic and Beyond

On June 30, 2020, at the Regular Board meeting for the Renfrew County and District Health Unit, the Board of Health approved a motion to endorse Timiskaming Health Unit's letter of support for the attached correspondence of Simcoe Muskoka District Health Unit, dated May 20, 2020.

Simcoe Muskoka District Health Unit (SMDHU) called for the federal government to *take*

swift and immediate action on the evolution of the CERB Benefit into legislation for a basic income as an effective long-term response to the problems of income insecurity, persistent poverty and household food insecurity, as well as a response to the economic impact of the COVID-19 pandemic.

Sincerely,



Janice Visneskie Moore
Chair, Board of Health

Attachments

c. Honourable Doug Ford, Premier of Ontario
Dr. David Williams, Chief Medical Officer of Health
Pegeen Walsh, Executive Director, Ontario Public Health Association
Association of Local Public Health Agencies—Loretta Ryan
Ontario Boards of Health
Honourable John Yakabuski, M.P.P.—Renfrew-Nipissing-Pembroke
Honourable Chery Gallant, M.P.—Renfrew-Nipissing-Pembroke
Local Municipalities
AMO/ROMA

Services de santé du TIMISKAMING Health Unit
Enhancing your health in so many ways.

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June 9, 2020

The Right Honourable Justin Trudeau, P.C., MP
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The Honourable Chrystia Freeland, P.C., M.P.
Deputy Prime Minister
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The Honourable Bill Morneau, P.C., M.P.
Minister of Finance
90 Elgin Street, 17th Floor
Ottawa, ON K1A 0G5

Dear Prime Minister Trudeau, Deputy Prime Minister Freeland and Minister Morneau:

Re: Basic Income for Income Security during Covid-19 Pandemic and Beyond

On June 3, 2020, at a regular meeting of the Board for the Timiskaming Health Unit, the Board supported the enclosed correspondence of Simcoe Muskoka District Health Unit, dated May 20, 2020 and passed the following motion:

MOTION #26R-2020
Moved by: Kim Gauthier
Seconded by: Patrick Kiely

BE IT RESOLVED that the Board of Health endorses the Simcoe Muskoka District Health Unit (SMDHU) call for the federal government to 'take swift and immediate action on the evolution of the CERB Benefit into legislation for a basic income as an effective long-term response to the problems of income insecurity, persistent poverty and household food insecurity, as well as a response to the economic impact of the COVID-19 pandemic'; AND
FURTHER THAT Prime Minister Trudeau, Deputy Prime Minister Freeland and Minister Morneau, Timiskaming's MPs, MPPs and Chief Medical Officer of Health, and all Ontario boards of health are so advised.

CARRIED

Sincerely,

Carman Kidd, Board of Health Chair

Enclosure

cc Mr. John Vanthof, MPP - Timiskaming-Cochrane
Mr. Anthony Rota, MP – Timiskaming-Nipissing
Dr. David Williams, Chief Medical Officer of Health
Mrs. Loretta Ryan, Association of Local Public Health Agencies
Ontario Boards of Health
Ms. Pegeen Walsh, Executive Director, Ontario Public Health Association
Mr. Doug Jelly, Chairman of District of Timiskaming Social Services Administration Board

simcoe muskoka
DISTRICT HEALTH UNIT

May 20, 2020

The Right Honourable Justin Trudeau, P.C., MP
Prime Minister of Canada
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80 Wellington Street
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The Honourable Chrystia Freeland, P.C., M.P.
Deputy Prime Minister
Privy Council Office
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The Honourable Bill Morneau, P.C., M.P.
Minister of Finance
90 Elgin Street, 17th Floor
Ottawa, ON K1A 0G5

Dear Prime Minister Trudeau, Deputy Prime Minister Freeland and Minister Morneau:

Re: Basic Income for Income Security during Covid-19 Pandemic and Beyond

On behalf of the Simcoe Muskoka District Health Unit (SMDHU) Board of Health, I am writing to convey our strong support for the evolution of the Canada Emergency Response Benefit (CERB) into a basic income for all Canadians, during the COVID-19 pandemic and beyond.

While we commend the federal government for the economic measures that have been put into place to support Canadians during this unprecedented time of the COVID-19 pandemic, we also know that many are falling through the cracks. Measures such as the CERB, the Canada Emergency Student Benefit (CESB) and the Canada Emergency Wage Subsidy (CEWS), though necessary and very important, have left many Canadians, who do not qualify for or not able to access these programs, vulnerable to household food insecurity and the negative consequences of income insecurity and poverty such as inadequate or unstable housing, and poorer mental and physical health, including chronic diseases. A basic income would address these gaps, offering support to the most vulnerable Canadians.

Before the COVID-19 pandemic, many Canadians were already experiencing household food insecurity. In 2017-18 approximately 4.4-million (1 in 8) Canadians reported being food insecure, including 1.2 million children under the age of 18.[i] As a result of COVID-19, this number is predicted to increase as many individuals are facing precarious employment, have had their hours reduced or have lost their jobs altogether. Many are relying on food banks and other charitable programs, however, this only meets the need on a temporary basis and is not a long term solution.

Examples of key Canadian initiatives that demonstrate the positive impact of basic income-like programs on health and well-being include the Old Age Security and Guaranteed Income Supplement through Canada's public pension system, the Canada Child Benefit, and the Newfoundland Poverty Reduction Strategy.

Basic income pilots for working-age adults in Canada have also led to promising findings, including the Mincome pilot in Manitoba and the recent Ontario Basic Income Pilot. The research study, *Southern Ontario's Basic Income Experience* released in March 2020, is based on Ontario's pilot. This pilot was implemented in three Ontario cities in 2018 by the provincial government, and the project was terminated in 2019 following a change in government. While the formal pilot evaluation was cancelled, this research study made use of surveys of individuals from Hamilton, Brantford and Brant County who had been enrolled in the pilot (217 individuals participated out of 1000 enrolled households), and interviews with 40 participants. Some of the key findings cited by participants in this report include improvements in physical and mental health; increased labour market participation; moving to higher paying and more secure jobs; reduced household food insecurity; housing stability; improved financial status and social relationships; less frequent visits to health practitioners and hospital emergency rooms; improved living standards; and an improved sense of self-worth and hope for a better future.

Additional evidence supporting the potential of a basic income for reducing the prevalence and severity of household food insecurity is presented in: *Implications of a Basic Income Guarantee for Household Food Insecurity*, a research paper prepared for the Northern Policy Institute based on the Ontario Basic Income Pilot.

Moving forward during and following the COVID-19 pandemic is an opportune time for the federal government to take action to evolve the CERB into a basic income. This would provide income security to all Canadians during the economic challenges of the pandemic itself, the post-pandemic recovery, and into the future. This is particularly pertinent given the dramatic shifts in the labour market in recent decades, such that full-time permanent employment is no longer the norm. The current CERB has helped demonstrate the logistical feasibility of delivering a basic income, and it could be readily evolved into an ongoing basic income for anyone who falls below a certain income floor. There is evidence of growing support for this concept, as outlined in Appendix A. The Basic Income Canada Network has outlined key features of basic income design for Canada, which we support.

The SMDHU has been a strong proponent of basic income repeatedly since 2015. This includes having sponsored a resolution at the Association of Local Public Health Agencies (alPHa) general meeting endorsing the concept of basic income and requesting the federal and provincial governments jointly consider and investigate a basic income policy option for reducing poverty and income insecurity (2015), and expressing support and input into the Ontario Basic Income Pilot (2017). SMDHU has also been encouraging advocacy for income solutions to household food insecurity through our No Money for Food is Cent$less initiative since 2017.

In keeping with this, we strongly recommend your government take swift and immediate action on the evolution of the CERB Benefit into legislation for a basic income as an effective long-term

response to the problems of income insecurity, persistent poverty and household food insecurity, as well as a response to the economic impact of the COVID-19 pandemic.

Sincerely,

ORIGINAL Signed By:

Anita Dubeau
Chair, Board of Health

AD:CS:cm

Encl. (1)

cc. Hon. Doug Ford, Premier of Ontario
Simcoe and Muskoka MPs and MPPs
Simcoe Muskoka Municipal Councils
Association of Local Public Health Agencies
Ontario Public Health Association
Ontario Boards of Health

Appendix A: Examples of Support for Basic Income in Response to COVID-19 and Beyond

On April 21, 2020, 50 members of Canada's Senate wrote a letter to the federal government calling for a restructuring of the CERB into a minimum basic income to "ensure greater social and economic equity", especially for those who are most vulnerable. In support of this letter, Senator McPhedran's Youth Advisory Council, the Canadian Council of Young Feminists, in collaboration with the Basic Income Canada Youth Network, sent their own letter to the federal government.

In our region, Simcoe North MP Bruce Stanton has expressed agreement that it's time to consider basic income. He is quoted as saying "Based on my reading of this, like Senator Boniface, I am persuaded that it could be very good public policy" (News Story).

The Ontario Dietitians' of Public Health (ODPH) have also written a letter to the federal government stating "We ask that you take immediate action to enact legislation for a basic income guarantee as an effective long-term response to the problem of persistent poverty and household food insecurity as well as shorter-term consequences of the economic fallout of the COVID-19 pandemic".

The Board of Health of the Kingston, Frontenac, Lennox and Addington Health Unit in Ontario also passed a motion requesting the federal government to provide a basic income support to all Canadians (News Story).

Municipality of Chatham-Kent
CK Public Health
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Email ckpublichealth@chatham-kent.ca

July 27, 2020

The Right Honourable Justin Trudeau, P.C., MP
Prime Minister of Canada
Office of the Prime Minister
80 Wellington Street Ottawa, ON K1A 0A2
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The Honourable Chrystia Freeland, P.C., M.P.
Deputy Prime Minister
Privy Council Office
Room 1000
80 Sparks Street Ottawa, ON K1A 0A3
Sent via email: chrystia.freeland@parl.gc.ca

The Honourable Bill Morneau, P.C., M.P.
Minister of Finance
90 Elgin Street, 17th Floor
Ottawa, ON K1A 0G5
Sent via email: bill.morneau@parl.gc.ca

Dear Prime Minister Trudeau, Deputy Prime Minister Freeland, and Minister Morneau:

RE: Basic Income for Income Security during COVID-19 Pandemic and Beyond

At its meeting held on June 17, 2020, the Chatham-Kent Board of Health received correspondence to the federal government from Simcoe Muskoka District Health Unit, dated May 20, 2020, Timiskaming Health Unit, dated June 9, 2020, Haliburton, Kawartha, Pine Ridge District Health Unit, dated June 19, 2020. These letters request that the federal government transition the Canada Emergency Response Benefit (CERB) into a basic income for all Canadians during the COVID-19 response and beyond. The Board also endorses the May 11, 2020 resolution by the City of Kitchener to establish a universal basic income.

Income is one of the strongest predictors of health, and it makes sense that focusing on population health interventions to address socioeconomic factors will impact health outcomes far greater than individual focused interventions.

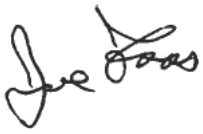
…/2

Previous to COVID-19, Chatham-Kent residents have experienced lower median household incomes, higher rates of poverty (with more than one in four children living in low income), lower rates of post-secondary education, higher proportions of the population working in lower wage manufacturing, retail, and service occupations, as well as higher rates of lone-parent families, seniors, and people living alone. Socio-economic factors vary across the Municipality with some communities and neighbourhoods facing a higher degree of material deprivation than others. An examination of local chronic disease health inequities has shown significantly higher rates of chronic disease-related health care utilization and death in the most materially deprived areas compared to the least deprived areas of Chatham-Kent. Annual analysis of the local cost of a nutritious food basket has continued to illustrate how little money a family of four on a social assistance budget would have left to cover the costs of childcare, rural transportation, and other basic needs, after paying for shelter and healthy food. Furthermore, the most recent calculation of Chatham-Kent's living wage well exceeded $16 per hour, and local costs of living have increased since that time.

As a result of the COVID-19 pandemic, we can anticipate the exacerbation of existing disparities, creating an even wider gap between those with opportunity and those without. Local concerns around homelessness, poverty, food insecurity, transportation, mental health and addictions, child and partner violence, and the needs of Indigenous people have been amplified.

The Board strongly recommends your government take immediate action to evolve CERB into legislation for a basic income as an effective long-term response to the issues of income security, poverty, food insecurity, and overall community health and well-being.

Sincerely,



Joe Faas
Chair, Chatham-Kent Board of Health

C: Honourable Doug Ford, Premier of Ontario
Dr. David Williams, Chief Medical Officer of Health
Pegeen Walsh, Executive Director, Ontario Public Health Association
Association of Local Public Health Agencies
Ontario Boards of Health
Honourable Dave Epp, MP, Chatham-Kent-Leamington
Honourable Rick Nicholls, MPP, Chatham-Kent-Leamington
Honourable Monte McNaughton, MPP, Lambton-Kent-Middlesex
Chatham-Kent Municipal Council

Municipality of Chatham-Kent
CK Public Health
PO Box 1136, 435 Grand Avenue West, Chatham, ON N7M 5L8
Tel: 519.352.7270 Fax: 519.352.2166
Email ckpublichealth@chatham-kent.ca

July 30, 2020

The Honourable Patty Hajdu. P.C., M.P.
Minister of Health
House of Commons
Ottawa, ON K1A 0A6
Sent via email: Patty.Hajdu@parl.gc.ca

The Honourable David Lametti
Minister of Justice and Attorney General of Canada
Department of Justice Canada
284 Wellington Street
Ottawa, ON K1A 0H8
Sent via email: David.Lametti@parl.gc.ca

Dear Minister Hajdu and Minister Lametti:

RE: The Decriminalization of Personal Possession of Illicit Drugs

This builds on the Board's September 2018 endorsement of a similar motion from Toronto Public Health. In making this endorsement, the Board joins a growing movement to pursue a public health approach to drug policy.

Opioid use and its related harms is a growing problem here in Chatham-Kent. From 2003 to 2017 the rate of emergency room visits for opioid poisoning among Chatham-Kent residents increased 225% and the rate of hospitalizations increased by 45%. Since the declaration of the COVID-19 pandemic, there have been an increasing number of calls to local EMS and emergency department visits related to opioid overdoses.

Evidence from other countries that have pursued decriminalization, demonstrate, that in order for it to be effective, this approach must be accompanied by investments in harm reduction, treatment, and mental health supports and services. [1]

The Board strongly supports the decriminalization of personal possession of illicit drugs together with comminuted commitment of resources to effectively address problematic substance use and reduce related harms in our community and calls on the federal government to create a national task force to research drug policy reform.

Sincerely,

Joe Faas
Chair, Chatham-Kent Board of Health

C: Association of Local Public Health Agencies
Ontario Association of Chiefs of Police
Honourable Dave Epp, MP, Chatham-Kent-Leamington
Honourable Rick Nicholls, MPP, Chatham-Kent-Leamington
Honourable Monte McNaughton, MPP, Lambton-Kent-Middlesex
Chatham-Kent Municipal Council

[1] Hughes, C. and Stevens, A. (2011). Harm Reduction Digest (44) A resounding success or a disastrous failure: Re-examining the interpretation of evidence on the Portuguese decriminalization of illicit drugs. Drug And Alcohol

simcoe muskoka
DISTRICT HEALTH UNIT

August 19, 2020

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

Dear Minister Elliott:

On behalf of the Board of Health for the Simcoe Muskoka District Health Unit I commend the provincial government for its leadership in bringing COVID-19 under control throughout Ontario. Through the definitive leadership of the provincial government, and with the concerted action of local public health units, Ontario has achieved a cumulative incidence of disease that is less than half of our neighbouring states, and a daily incidence at present that is less than 10% of theirs. The rapid action of the province putting in place public health measures in March, and their careful withdrawal since that time have been essential to our success. Also essential has been the redirection of almost all the resources within local health units to enable the timely identification of cases and their contacts for home isolation, management of outbreaks in workplaces, Long Term-Care facilities and retirement homes, and the provision of guidance and direction to municipalities, businesses, organizations and the general public supporting physical distancing, hand hygiene, and face coverings. All of these actions have enabled our communities to flatten the curve without which we would have had the same experience as our neighbouring jurisdictions to the south.

Local public health units, with the leadership of their boards of health, are completely dedicated to the successful control of COVID-19 moving forward until our provision of mass vaccination and with it the hoped-for end to the pandemic. If necessary, we will continue this struggle for years.

In order to continue to be successful, additional resources are needed, and the promise of additional resources by the province has been very much appreciated. This includes the $100 million to public health communicated earlier in the year (the *COVID-19 Extraordinary Expenses*), and recently the $50 million (500 nurses) for the public health support to the recommencement of the schools (the *School-Focused Nurses*).

This additional funding will be essential to enable the success of the local public health response to the pandemic; however, its timely provision is also critical to our success. Through communication with Ministry of Health staff we have learned that the *COVID-19 Extraordinary Expenses* will be provided late in 2020 as reimbursement for extraordinary expenditures related to the pandemic response. This approach requires boards of health to take on these expenditures throughout the year without certainty as to the actual amount that they will be reimbursed. Some boards do not have reserve funds, and others have depleted their reserves

already in their response (including our Board of Health). Without the provision of the funds at this time, these boards will not be able to maintain the level of their response needed to fully control COVID-19. In addition, the boards have been instructed to proceed with hiring the additional *School-Focused Nurses* without having the additional funding at this time required to do so; those boards that do not have remaining reserve funds will not be in a position to do so until they receive these additional funds.

Local public health has performed extraordinary work with the province to flatten the curve, and to enable the opening of the economy and soon the school system. This is a critical time for us all as we strive to maintain these achievements while avoiding a resurgence of cases that would threaten these gains. Therefore, the Board of Health urges the immediate provision of the funding allocations to local boards of health regarding the *COVID-19 Extraordinary Expenses* and for the *School-Focused Nurses* in order to enable a response by local public health units that is unobstructed by local financial shortfalls.

Thank you for your consideration of this request, and for your exemplary leadership.

Sincerely,

ORIGINAL Signed By:

Anita Dubeau, Chair
Simcoe Muskoka District Health Unit Board of Health

AD:CG:cm

cc. Dr. David Williams, Chief Medical Officer of Health
Loretta Ryan, Executive Director, Association of Local Public Health Agencies
Ontario Boards of Health
Mayor and Council of Simcoe and Muskoka
Members of Provincial Parliament for Simcoe and Muskoka

alPHa
Association of Local PUBLIC HEALTH Agencies

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Toronto, Ontario M5G 1V2
Tel: (416) 595-0006
E-mail: info@alphaweb.org

Hon. Patty Hajdu
Minister of Health
House of Commons
Ottawa, Ontario, K1A 0A6

July 9, 2020

Dear Minister Hajdu,

Re: Protecting Children and Youth from Dangers of Vaping

On behalf of the Association of Local Public Health Agencies (alPHa) and its member Medical Officers of Health, Boards of Health and Affiliate organizations, I am writing today to congratulate you for introducing further regulatory restrictions on the promotion of vapour products and to encourage you to move forward on the further regulatory measures under consideration.

As you noted in your announcement, the evidence demonstrates that the increase in the rate of vaping in Canada has been driven almost entirely by youth and young adults, and it is reasonable to conclude that the aggressive promotion of and easy access to these devices in the absence of strong regulations were contributing factors.

We are pleased that the Government of Canada has recognized that swift action on promotion and display are key interventions to stem the alarming uptake of vaping by young Canadians and we wholeheartedly support the new measures that ban advertising of vaping products in any situation where it can be seen or heard by young people.

We are also pleased to learn that Health Canada is considering additional regulatory measures that would further restrict the nicotine content and available flavours of vaping liquids as well as require manufacturers to disclose more information about their products. Each of these measures was recommended in the January 22, 2020 Statement on Nicotine Vaping in Canada by Canada's Council of Chief Medical Officers of Health, which concluded that it would be reasonable from a health protection and promotion perspective to regulate vaping devices as analogous to tobacco products. alPHa has endorsed this Statement in full and we strongly encourage you to follow through on each of the recommendations directed at the federal level.

Once again, we are grateful for the regulatory amendments that will be taking effect in the coming months and we look forward to working with you as further steps to protect Canada's young people from the harms of vapour products are considered. We would be pleased to discuss this with you further. To schedule a meeting, please have your staff contact Loretta Ryan, Executive Director, alPHa, at loretta@alphaweb.org or 416-595-0006 x 222.

Yours sincerely,

Carmen McGregor
alPHa President

COPY: Hon. Christine Elliott, Minister of Health (Ontario)
Dr. David Williams, Chief Medical Officer of Health
Dianne Alexander, Director, Health Promotion and Prevention Policy and Programs Branch, Ministry of Health

The Association of Local Public Health Agencies (alPHa) is a not-for-profit organization that provides leadership to the boards of health and public health units in Ontario. alPHa advises and lends expertise to members on the governance, administration and management of health units. The Association also collaborates with governments and other health organizations, advocating for a strong, effective and efficient public health system in the province. Through policy analysis, discussion, collaboration, and advocacy, alPHa's members and staff act to promote public health policies that form a strong foundation for the improvement of health promotion and protection, disease prevention and surveillance services in all of Ontario's communities.