Algoma
PUBLIC HEALTH
Santé publique Algoma

September 22, 2021

BOARD OF HEALTH MEETING

Algoma Community Room

www.algomapublichealth.com

Meeting Book - September 22, 2021 - Board of Health Meeting

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Board of Health Meeting
AGENDA
September 22, 2021 at 5:00 pm
Video/Teleconference | Algoma Community Room

BOARD MEMBERS
Sally Hagman - Board Chair
Ed Pearce - 1st Vice Chair
Deborah Graystone - 2nd Vice Chair
Lee Mason
Micheline Hatfield
Musa Onyuna
Brent Rankin
Matthew Scott
Louise Caicco Tett

APH EXECUTIVE
Dr. Jennifer Loo - Acting Medical Officer of Health / CEO
John Tuinema - Acting Associate Medical Officer of Health
Antoniette Tomie - Director of Corporate Services
Laurie Zeppa - Director of Health Promotion/ Health Protection
Joel Merrylees - Controller
Tania Caputo - Board Secretary

GUESTS: Hilary Cutler, Manager of Child and Family Services - presenting
Corina Artuso, Youth Advisor, Public Health Programs, currently serving as Indigenous Liaison

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

1.0 Meeting Called to Order *S. Hagman*

a. Land Acknowledgement

b. Declaration of Conflict of Interest

2.0 Adoption of Agenda *S. Hagman*

RESOLUTION

THAT the Board of Health agenda dated September 22, 2021 be approved as presented.

3.0 Delegations / Presentations

Seniors Oral Health Presentation *H. Cutler*

4.0 Adoption of Minutes of Previous Meeting *S. Hagman*

RESOLUTION

THAT the Board of Health meeting minutes dated June 23, 2021 and August 30, 2021 be approved as presented.

5.0 Business Arising from Minutes

a. Land Acknowledgement Briefing Note *C. Artuso*

RESOLUTION

Whereas the Truth and Reconciliation Commission (TRC) of Canada released a report documenting the voices of survivors of Indian Residential Schools; and

Whereas the Ontario Public Health Standards recognize the requirement for boards of health to engage with Indigenous communities in ways that are meaningful for them; and

Whereas the research project titled Talking Together To Improve Health identified four principles of Indigenous engagement, including respect, trust, self-determination, and commitment; and

Whereas the literature indicates that saying a Land Acknowledgement, when appropriate, can be a small but important step in continuing to build and sustain meaningful relationships with Indigenous communities and people;

Be it resolved that APH acknowledge the harm that colonization and the residential school system caused and continues to cause to Indigenous people in Canada;

6.0 Reports to the Board

a. Medical Officer of Health and Chief Executive Officer Reports *J. Loo*

i. MOH Report -September 2021

RESOLUTION

THAT the report of the Medical Officer of Health/CEO for September 2021 be accepted as presented.

b. Finance and Audit

i. Unaudited Financial Statements for the period ending July 31, 2021. *J. Merrylees*

RESOLUTION

THAT the Board of Health approves the Unaudited Financial Statements for the period ending July 31, 2021, as presented.

c. Governance Committee

i. Governance Committee Chair Report *D. Graystone*

RESOLUTION

THAT the Governance Committee Chair Report for September 2021 be accepted as presented.

ii. 02-05-025 Board Member Remuneration

RESOLUTION

THAT the Board of Health has reviewed and approves policy **02-05-025 Board Member Remuneration**, as presented.

iii. 02-05-055 Board of Health Self-Evaluation

RESOLUTION

THAT the Board of Health has reviewed and approves policy **02-05-055 Board of Health Self-Evaluation**, as presented.

iv. 06-01 Sewage System Part 8 of Ontario Building Code Act

RESOLUTION

THAT the Board of Health has reviewed and approves policy **06-01 Sewage System Part 8 of Ontario Building Code Act** as presented.

v. 95-1 To Regulate Proceedings of the Board

RESOLUTION

THAT the Board of Health has reviewed and approves policy **95-1 To Regulate Proceedings of the Board** as presented.

7.0 New Business/General Business

a. Chair of Boards of Health Meeting *S. Hagman*

b. Algoma Vaccination Council Update *L. Caicco Tett*

8.0 Correspondence *S.Hagman*

a. Letter to the Minister of Health, and the Long-Term Care, from The City of Hamilton regarding Support for a Local Board of Health dated September 15, 2021.

b. Letter to the Deputy Premier and Minister of Health, from Haliburton, Kawartha, Pine Ridge District Health Unit regarding Public Health Funding dated September 16, 2021.

c. Letter to the Deputy Premier and Minister of Health, from Northwestern Health Unit regarding Public Health Mitigation Funding dated August 27, 2021.

d. Letter to the Deputy Premier and Minister of Health, from Northwestern Health Unit regarding IPAC Hub Funding dated August 27, 2021.

9.0 Items for Information *S. Hagman*

a. August 2021 Issue of alPHa's Information Break

10.0 Addendum *S. Hagman*

11.0 In-Camera *S. Hagman*

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

RESOLUTION

THAT the Board of Health go in-camera.

12.0 Open Meeting *S. Hagman*

Resolutions resulting from in camera meeting.

13.0 Announcements / Next Committee Meetings: *S. Hagman*

Finance & Audit Committee
Wednesday, October 13, 2021 @ 5:00 pm
Video Conference │SSM Algoma Community Room

Board of Health Meeting
Wednesday, October 27, 2021 @ 5:00 p
Video Conference │SSM Algoma Community Room

Finance & Audit Committee
Wednesday, November 10, 2021 @ 5:00 pm
Video Conference │SSM Algoma Community Room

Governance Committee Meeting
Wednesday, November 17, 2021 @ 5:00 pm
Video Conference │SSM Algoma Community Room

14.0 Evaluation *S. Hagman*

15.0 Adjournment *S. Hagman*

RESOLUTION

THAT the Board of Health meeting adjourns.

Ontario Seniors Dental Care Program

Hilary Cutler

Manager, Child & Family Services

September 22, 2021

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Overview

- Oral health services as a lever for reducing health inequities
- The role of public health in senior's oral health
- The Ontario Seniors Dental Care Program (OSDCP)
- OSDCP in Algoma – year in review
- Next steps

Oral Health Services as a Lever for Reducing Health Inequities

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How can oral health services reduce health inequities?

- Oral health is an important component of overall health
- Poor oral health:
  - Impacts children's speech development, ability to thrive, and readiness to learn
  - Compromises the quality of life for older adults
  - Increases preventable costs to the health system (e.g. ER visits, hospitalizations)
- **Financial barriers** prevent those living in low-income from accessing dental care

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- Association of Local Public Health Agencies (2010). alPHA resolution A10-10- dental health for low-income Ontarians.
- Ontario Dental Hygienists' Association (2016). Dental hygiene facts- Oral care for seniors.

Why is there a need for public health in oral health services?

- There is growing evidence linking gum disease to a variety of serious health conditions (e.g. heart disease, stroke, respiratory disorders)
- Gum disease may worsen diabetes or increase complications associated with diabetes
- Dental care is part of **health promotion** and **protection** for healthy aging
    - Public health uniquely prioritizes **health equity** at the forefront of planning and service delivery

- Canadian Dental Association (2021). Oral health- Good for life. Retrieved from http://www.cda-adc.ca/en/oral_health/cfyt/good_for_life/
- Ontario Dental Hygienists' Association (2016). Dental hygiene facts- Oral care for seniors. Retrieved from https://odha.on.ca/wp-content/uploads/2016/08/ODHA-Facts-seniors.v2.pdf

Speaking of health promotion and protection…

alPHa
Association of Local PUBLIC HEALTH Agencies

alPHa RESOLUTION A17-1

TITLE: **Access to Publicly Funded Oral Health Programs for Low-Income Adults and Seniors**

SPONSOR: **Chatham-Kent Public Health Unit & Porcupine Health Unit**

WHEREAS the relationship between poor oral health and poor overall health and social well-being is well established; and

WHEREAS dental care is excluded from the Ontario Health Insurance Program; and

WHEREAS one-third of Ontario workers do not have employee health benefits; and

WHEREAS 13.9% of the Ontario population, live in low income; and

WHEREAS the burden of poor oral health is greater in marginalized populations; and

WHEREAS financial barriers prevent many marginalized and low-income adults from accessing preventive and acute dental care; and

WHEREAS Over 60,000 visits to emergency departments across Ontario in 2015 were due to oral health concerns (Ontario Oral Health Alliance, 2017), as acute health care services are often the only remaining option for treatment of complications from lack of dental care; and

WHEREAS an estimated $38M is spent in the acute care medical system for these complications without addressing their underlying causes; and

WHEREAS the majority of these acute dental complications are avoidable with timely preventive care such as cleanings and fluoride treatments by dental hygienists, as well as fillings and extractions; and

WHEREAS the Ontario Liberals made provision of oral health services to low-income Ontarians a key plank in its 2007 election platform; and

WHEREAS the 2014 Ontario Budget included the provision of dental benefits to all low-income workers by 2025 as part of its 10-year economic plan; and

WHEREAS alPHa believes that the ongoing exclusion of low-income adults from publicly-funded oral health treatment and prevention services creates health inequities and is contrary to the original intent of the Government's 2007 promise;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) call upon the Ministry of Health and Long-Term Care (MOHLTC) to immediately begin the process to develop standards for preventative and restorative oral health care and implement a provincially funded oral health program for low-income adults and seniors in Ontario well before the proposed 2025 timeline.

ACTION FROM CONFERENCE: **Resolution CARRIED**

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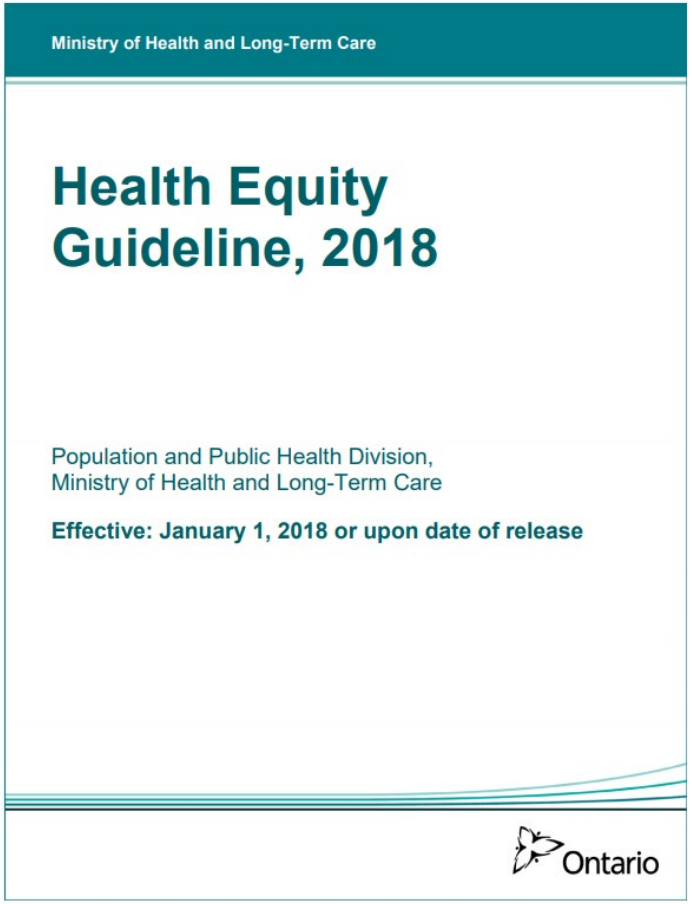
- Association of Local Public Health Agencies (2010). alPHA resolution A10-10- dental health for low-income Ontarians.
- World Health Organization (1986). Ottawa Charter for Health Promotion

Ontario Public Health Standards

Foundational Standard:

Health Equity

"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."



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- Ministry of Health and Long-Term Care. (2018). Ontario public health standards: Requirements for programs, services, and accountability.

Oral health is embedded in the public health approach…

School Health

Goal

To achieve optimal health of school-aged children and youth through partnership and collaboration with school boards and schools.

Program Outcomes

- The board of health is aware of and uses data to influence and inform the development of local healthy public policy and its programs and services related to the health of school-aged children and youth.
- Board of health programs and services are designed to address the identified needs of the community, including priority populations, associated with the health of school-aged children and youth.
- There is a decrease in health inequities related to the health of school-aged children and youth.
- School boards and schools are aware of relevant and current population health needs impacting students in their schools.
- School boards and schools are meaningfully engaged in the planning, development, implementation, and evaluation of public health programs and services relevant to school-aged children and youth.
- School boards and schools have the knowledge, skills, and capacity needed to act on the factors associated with the health of school-aged children and youth.
- School-based initiatives relevant to healthy living behaviours and healthy environments are informed by effective partnerships between boards of health, school boards, and schools.
- School-aged children, youth, and their families are aware of factors for healthy growth and development.
- There is an increased adoption of healthy living behaviours among school-aged children and youth.
- The board of health achieves timely and effective detection and identification of children and youth at risk of poor oral health outcomes, their associated risk factors, and emerging trends.
- Children and youth from low-income families have improved access to oral health care.
- The oral health of children and youth is improved.
- The board of health and parents/guardians are aware of the visual health needs

Chronic Disease Prevention and Well-Being

Goal

To reduce the burden of chronic diseases of public health importance[6] and improve well-being.

Program Outcomes

- The board of health is aware of and uses data to influence and inform the development of local healthy public policy and its programs and services for the prevention of chronic diseases.
- Board of health programs and services are designed to address the identified needs of the community, including priority populations, associated with the prevention of chronic diseases.
- Priority populations and health inequities related to chronic diseases have been identified and relevant data have been communicated to community partners.
- There is a reduction in population health inequities related to chronic diseases.
- Community partners are aware of healthy behaviours associated with the prevention of chronic diseases.
- Community partners have knowledge of and increased capacity to act on the factors associated with the prevention of chronic diseases and promotion of well-being, including healthy living behaviours, healthy public policy, and creating supportive environments.
- Community partners, policy-makers, and the public, including priority populations, are meaningfully engaged in the planning, implementation, development and evaluation of programs and services for the prevention of chronic diseases.

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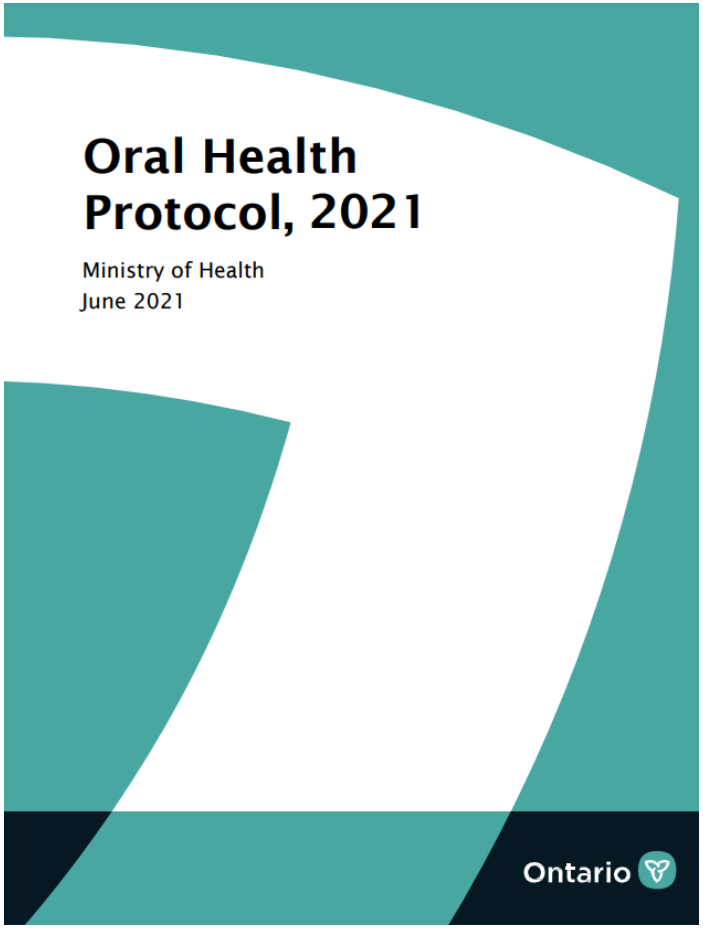
Oral Health Protocol, 2021

- Updated in 2021 to reflect the **OSDCP** and requirements to:
  - Conduct health promotion
  - Provide service navigation
  - Establish a dental home
  - Increase awareness of oral health services in the community
  - Encourage community uptake



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- Ministry of Health. (2021). Oral health protocol, 2021.

Publically Funded Oral Health Programs

OSDCP is **one of many** publicly funded oral health programs

- School screenings and follow-ups
- Healthy Smiles Ontario (HSO) APH Clinic
- Children's Oral Health Initiative (COHI) with Garden River First Nation
- Fluoride varnish for high-risk preschool children

The Ontario Seniors Dental Care Program (OSDCP)

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About the OSDCP

- Launched in November, 2019
- 100% funded by the provincial government
- **Purpose:**
  - Provide free, routine dental services for low-income seniors aged 65+
  - Reduce unnecessary trips to the hospital, prevent chronic disease, and increase quality of life for seniors in Ontario

- Ontario Association of Public Health Dentistry, Alliance for Healthier Communities, and Ontario Oral Health Alliance (2019). Ontario Seniors Dental Care Program: Recommendations to Ensure Program Effectiveness.
- Ontario Ministry of Health (2021). Dental care for low-income seniors.

OSDCP Eligibility

- 65 years of age or older
- Resident of Ontario
- Meet the income requirements of:
  - An annual net income of $22,200 or less for a single senior
  - A combined annual net income of $37,100 or less for a couple
- Have no other form of dental benefits, including private insurance or coverage under another government program

In Algoma, an estimated **3,792 people are eligible** for the program. Roughly 1,500 people are expected to utilize the program annually.

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- Algoma Population 2021: Population Projections [2018-2031], Ontario Ministry of Health and Long-Term Care, IntelliHealth Ontario.
- Ministry of Health (2021). Dental care for low-income seniors.
- Ministry of Health and Long-Term Care (Spring, 2019). Overview of Ontario Seniors Dental Care Program - capital process [Confidential PowerPoint].

OSDCP Coverage

- Check-ups, including scaling, fluoride and polishing
- Repairing broken teeth and cavities
- X-rays
- Removing teeth or abnormal tissue
- Anesthesia
- Treating infection and pain
- Treating gum conditions and diseases
- Dental prosthetics, including dentures – *partial coverage*

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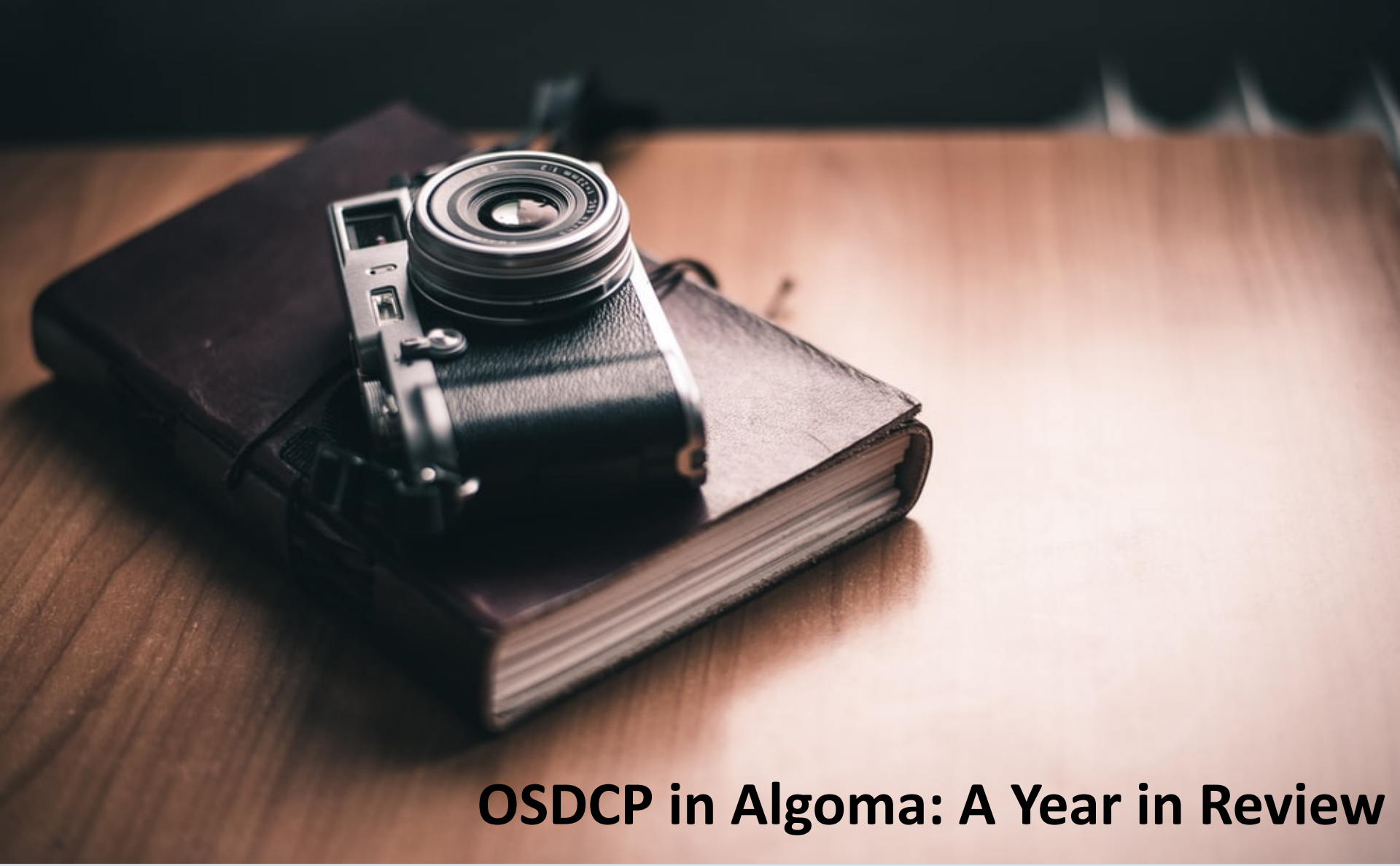
- Ontario Ministry of Health (2021). Dental care for low-income seniors.



OSDCP in Algoma: A Year in Review

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OSDCP: A True Community Effort

- 5 Contract Dentists: APH clinic and community settings
- 4 Denturists: Community settings
- Registered Dental Hygienists
- Dental Health Educators
- 1 Summer Student
- Clerical Support
- Program Manager

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Elliot Lake Dental Centre

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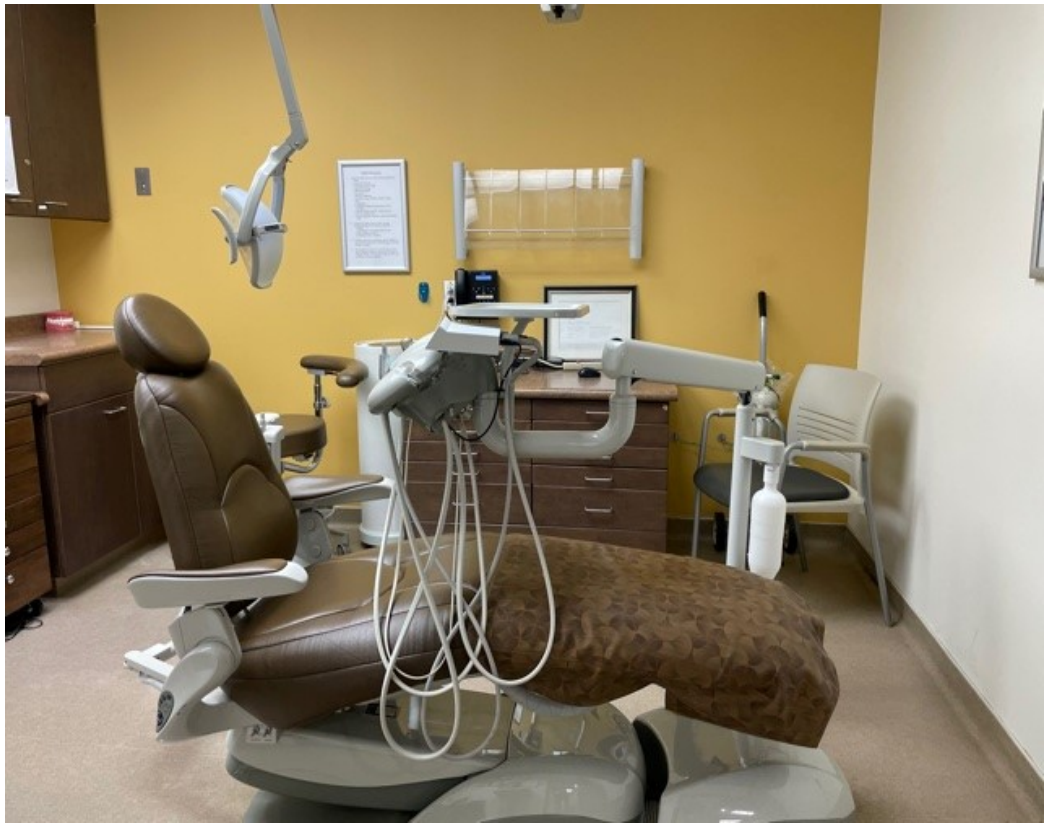
Wawa Dental Centre

Sault Ste. Marie
APH Clinic



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Sault Ste. Marie
APH Clinic

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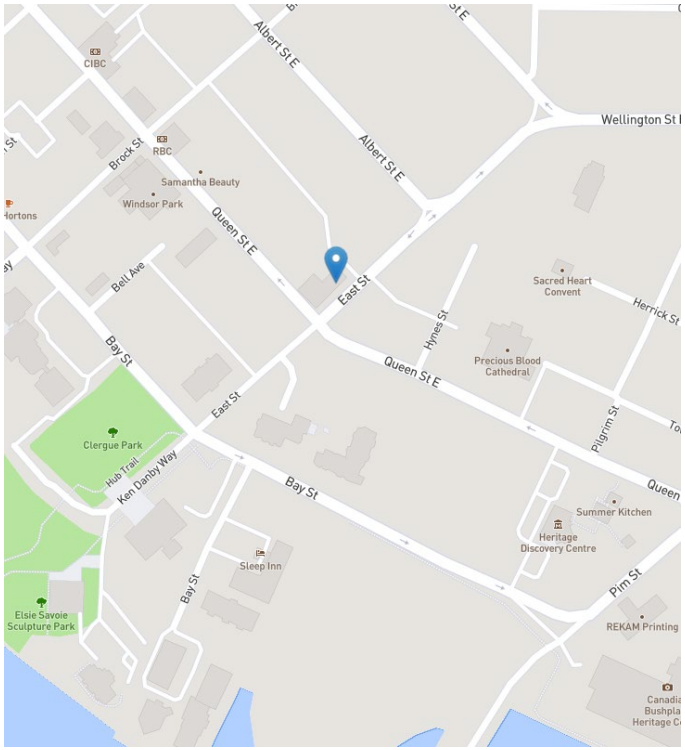
Berkenbosch Denture Clinic
Sault Ste. Marie



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OSDCP 2020-2021

- An estimated **700 people will receive services** in Algoma
- Roughly **140 people will receive dentures**
  - 20% of client base

- APH Hygiene clinics are offered 2 days/week
- APH Treatment clinics are offered 1 day/week
- Installation of a panoramic x-ray machine is in progress, which will contribute to diagnostic imaging for clients

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Program Pressures

- **Cost of dentures**
- High OSDCP demand
  - Exceeds APH resources during the pandemic with staff deployed to COVID-19 Response
- Natural learning curve with a new program
  - Assess demand
  - Situate the OSDCP within other mandated oral health programs

Next Steps

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Next Steps

- Performance management system
  - Program indicators
  - $$ invested in prevention saves $$ in hospital visits
- Service model for 2022
  - Communicate with service providers to inform planning
- Advocacy
  - Operational budgets
  - Program evaluation

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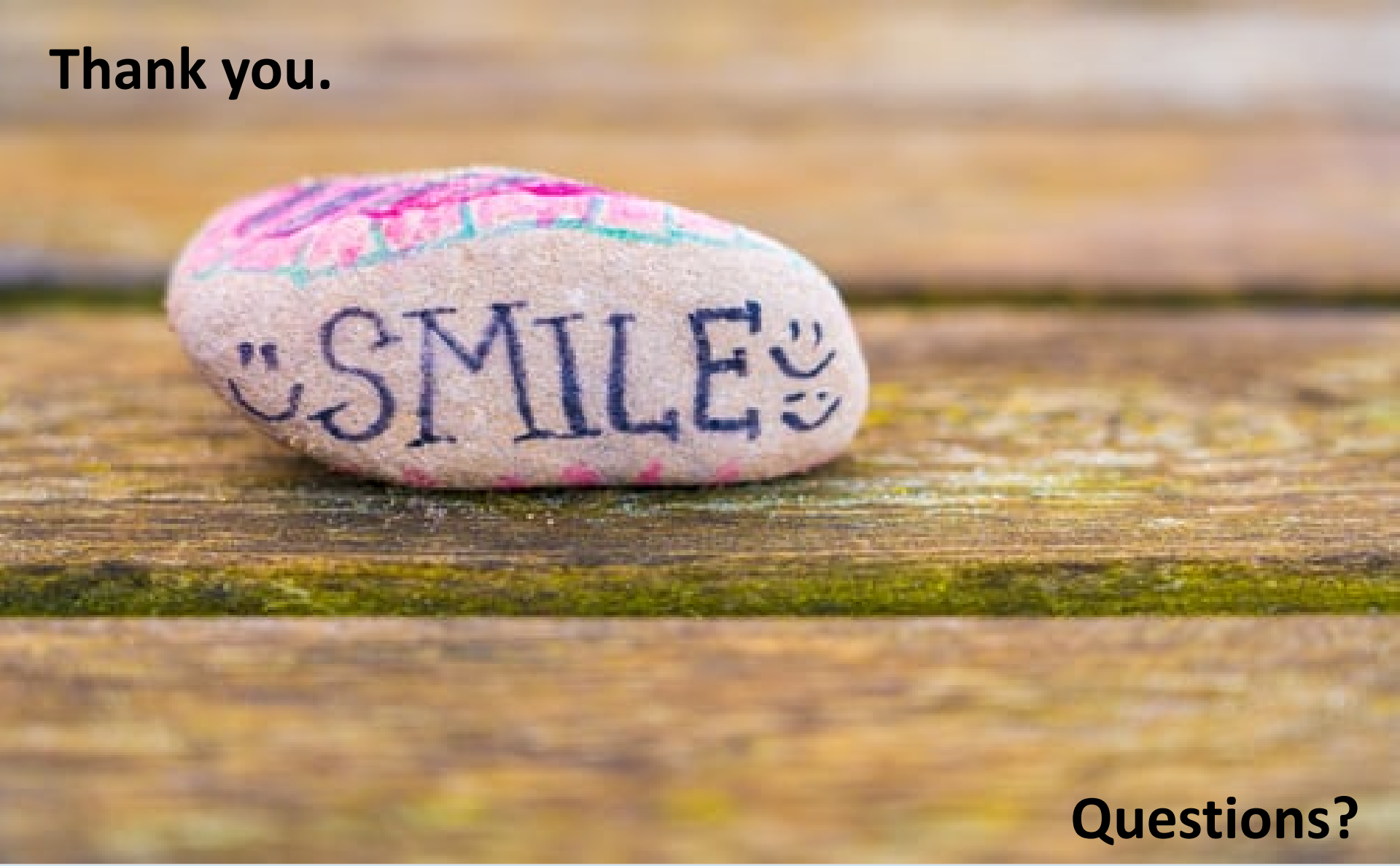
Thank you.



Questions?

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Background Note

To: **The Board of Health**
From: **Dr. Jennifer Loo, Medical Officer of Health / CEO**
Date: **September 22, 2021**
Re: **Relationship building with First Nation and Métis Communities in Algoma: An Updated Land Acknowledgment as a Next Step**

Key Messages

- Relationships are the foundation of successful collaboration between public health and Indigenous communities to achieve and maintain good health for all in Algoma.
- The Truth and Reconciliation Commission (TRC) of Canada's final report, along with public health-specific guidance documents, provide an evidence-base from which Algoma Public Health (APH) can continue to maintain and build meaningful relationships with Indigenous communities in Algoma.
- APH staff consulted with First Nations and Métis partners to create an Algoma district-wide Land Acknowledgement that recognized the diverse lands on which board of health and staff members live, work, and play, as well as the interconnectedness of communities across the Algoma district.
- Indigenous partners who were consulted viewed the Land Acknowledgement as a positive gesture that needs to be followed up with action that demonstrates APH's commitment to the shared goal of Reconciliation.
- The resolution to support the voluntary reading of the district-wide Land Acknowledgement at APH-led meetings and events, if approved, will help to continue building agency-wide awareness of Indigenous history, presence, and rights. It will also serve as a re-commitment to public health action, in partnership with Indigenous communities, towards the shared goal of Reconciliation.

Ontario Public Health Standards Addressed in this Report

- **Health Equity, Foundational Standard:** 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.[1]
- **Standard Requirement(s) Addressed: Requirement #3:** The board of health shall engage in multi-sectoral collaboration, including engagement with communities and organizations, such as Indigenous communities.[1] The *Relationship with Indigenous Communities Guideline, 2018* emphasizes the importance of engaging with Indigenous communities to foster and create meaningful relationships and collaborative partnerships to work towards decreasing health inequities.[1,2]

Relationships and the Role of Land Acknowledgements in Public Health

Relationships are the foundation of successful collaboration between public health and Indigenous communities to achieve and maintain good health for all.[3] The Truth and Reconciliation Commission (TRC) of Canada defines reconciliation as "…an ongoing process of establishing and maintaining respectful relationships."[4, p.16]

Several key documents have influenced the development of the resolution and updated Algoma district-wide Land Acknowledgement, as outlined below.

- The findings and calls to action from the Truth and Reconciliation Commission's final report prompted agencies, such as the Ontario Public Health Association (OPHA), to encourage boards of health and public health staff to form a deeper understanding of Indigenous history and culture, as well as prioritize cultural competency training for both staff and board members.[5]
- The *Relationship with Indigenous Communities Guideline, 2018* has provided the fundamentals for boards of health to form meaningful relationships with Indigenous communities that come from a place of trust, mutual respect, understanding, and reciprocity.[2]

- An Ontario-based research project titled *Talking Together to Improve Health*[6] has identified four principles of Indigenous engagement, all of which APH can reference when building and sustaining meaningful relationships with Indigenous communities in Algoma. The four principles from the research project are respect, trust, self-determination, and commitment.[6]

A Land Acknowledgement is an important way to help build awareness of Indigenous history, presence, and rights in everyday life, and reignites the traditional territory of the Indigenous people who called the land home before the arrival of settlers, and still call it home today.[7,8]

Background on Algoma Public Health's (APH) Land Acknowledgement
In 2019, APH staff collaborated with Indigenous partners to create Land Acknowledgements for Sault Ste. Marie & Area, East Algoma, and Wawa & Area. The intention of the Land Acknowledgements was to show respect for and build meaningful relationships with Indigenous communities, with the hopes of achieving the shared goal of improved health and wellbeing for all that live in Algoma.

The APH Board of Health (BOH) passed a resolution that acknowledged the harm that colonialization and the residential school system caused and continues to Canada's Indigenous people; and that the Land Acknowledgements written for communities in the Algoma district were approved for use by the board of health and staff, when saying a Land Acknowledgement was deemed meaningful to do so.[9]

Since the 2019 resolution, the BOH has included a Land Acknowledgement at the first meeting of each year, and some staff have included a statement during meetings with external and internal partners as deemed meaningful.

In June 2021, a need was identified by the BOH and APH staff to (a) increase the frequency of saying the Land Acknowledgement to each BOH meeting, and (b) re-shape the Land Acknowledgements to establish a comprehensive, district-wide acknowledgement in consultation with Indigenous partners.

Four considerations for the revised Land Acknowledgment included:

1. An Understanding of Treaty Territories

APH operates within three treaty territories (*see Table 1*), including the Robinson-Huron Treaty, Robinson-Superior Treaty, and Treaty 9 territories. These Treaties encompass vast territories that extend far beyond the Algoma district.

Table 1.0: Treaty Territories in which the Algoma District is Situated At-a-Glance:

Treaty	First Nations Communities	APH Sub-Region Located within the First Nation Treaty Territory
Robinson-Superior	Michipicoten FN	North Algoma
Treaty 9	Missanabie-Cree FN*	North Algoma
Robinson-Huron***	Batchewana FN Garden River FN	Sault Ste. Marie & Area
	Thessalon FN Mississauga FN	Central & East Algoma
	Serpent River FN Sagamok Anishnawbek**	Elliot Lake & Area

*Missanabie Cree First Nation also intersects with Porcupine Health Unit. **Sagamok First Nation also intersects with Public Health Sudbury & Districts. ***Robinson-Huron Treaty educational webpage.

Of note, Treaty 9 was brokered in 1906. Since the BOH approved the initial Land Acknowledgements in 2019, Missanabie Cree First Nation settled a 114 year old land claim in October 2020. Missanabie Cree community members do not live on their reserve lands at this time, and instead live within different hubs in Ontario. In the Algoma district, there is a Hub in Wawa and a Hub in SSM.

2. An Understanding of Métis Communities

In previous Land Acknowledgements, recognition of Métis partners included: "as well as Métis people." This statement did not acknowledge the history, identity, and existence of regional Métis communities.

Algoma is home to the Huron-Superior Métis Community as part of the Métis Nation of Ontario (MNO) represented by the Historic Sault Ste. Marie Métis Council and the North Channel Métis Council. MNO is one of five governing members of the Métis National Council.

The term Métis does not include all people of mixed ancestry, but rather is the proper name of a unique Indigenous People, with a distinct history, culture, way of life and territory. Métis communities emerged from the Upper Great Lakes in the late 18th century. After centuries of denial and ignorance from colonial governments, the Métis won legal recognition of their distinct history and rights in 2003, when the Supreme Court of Canada ruled in favour of the Powley family – a Métis family from the Historic Sault Ste. Marie Métis community.

In 2019, MNO signed a *Métis Government Recognition and Self-Government Agreement*[10] that provides full recognition of MNO as the Government of the Métis people and communities in Ontario, including those in Algoma. The agreement provides legal protection to the MNO in areas of citizenship, fiscal relations, leadership selection, and internal government operations.

While there are increasing numbers of people identifying as Métis due to an ancestral connection to a First Nations ancestor – the Métis Nation has specific criteria for identifying those who belong to the Métis community. MNO maintains the only legitimate, recognized registry of Métis citizens in Ontario.

Table 2.0: Traditional Métis Communities in Algoma At-a-Glance

Métis Communities	APH Sub-Region Alignment
Huron-Superior Regional Métis Community as part of the Métis Nation of Ontario is represented by:	
Historic Sault Ste. Marie Métis Council	Sault Ste. Marie & Area
North Channel Métis Council	Central & East Algoma Elliot Lake & Area

3. A Commitment Towards Learning, Evolving and Working Towards Reconciliation

APH continues to provide services in partnership with First Nations and Métis leaders for Indigenous community members living in urban and rural communities, and acknowledges the importance of Indigenous ways of knowing, doing, and being. To reflect APH's strengthened commitment to the shared goal of Reconciliation, a statement of commitment was to remain in the Land Acknowledgement.

4. An Algoma-Wide Lens

APH's service boundary covers over 41,000 square kilometers and contains numerous Indigenous communities.[11] In addition, BOH members and APH staff reside and work virtually from all areas of the district, not solely the lands in which APH's buildings are located.

Land Acknowledgements should remain part of all gatherings, including virtual meetings taking place across the district.[12] As such, it was important that the Land Acknowledgement be inclusive of the many lands and traditional territories in which we live and work.

2021 Consultations with First Nations and Métis Partners

APH staff conducted consultations on the draft Algoma district-wide Land Acknowledgement via email and phone with First Nations Health Directors and staff, as well as the Provisional Council of the Métis Nation of Ontario Region 4 Councilor, from April-September 2021. The purpose of consultation was to continue identifying respectful and meaningful approaches to integrate First Nations and Métis perspectives into the Land Acknowledgement.

Responses were received from Missanabie-Cree First Nation, Batchewana First Nation, Garden River First Nation, Thessalon First Nation, Mississauga First Nation, the Sault Ste. Marie Indigenous Friendship Centre, and the Métis Nation of Ontario. At the time of this report, feedback was not yet received by Michipicoten First Nation, Serpent River First Nation, and Sagamok Anishnawbek.

Feedback received was integrated into the Land Acknowledgement, as presented below, and circulated for continued review. The value of a comprehensive Land Acknowledgement was affirmed by First Nation and Métis partners as a necessary part of Reconciliation and healing. The Land Acknowledgement also supports relationship building between Indigenous partners and public health.

In addition to feedback on the Land Acknowledgement content and value, partners indicated that it was critical for APH to follow-up to ensure meaningful actions are taken towards the shared goal of Reconciliation. One of such recommendations included the potential for Indigenous representation on the Board of Health.

Algoma District Land Acknowledgement for Algoma Public Health Events (September 2021)

We begin by acknowledging the land on which we are gathered is in the traditional territories of the Anishnaabeg (*aw-nish-naw-bek*).

Algoma Public Health delivers services and programs within some of the Robinson-Huron Treaty, Robinson-Superior Treaty, and Treaty 9 territories, specifically within the traditional territories of the Michipicoten, Missanabie-Cree, Batchewana, Garden River, Thessalon, Mississauga, Serpent River, and Sagamok First Nations.

Algoma Public Health also delivers services and programs within the traditional territory of the Huron-Superior Regional Métis Community, represented by the Historic Sault Ste. Marie Métis Council and the North Channel Métis Council as part of the Métis Nation of Ontario.

We say miigwech to thank Indigenous Peoples for taking care of this land from time immemorial. We are all called to treat this sacred land, its plants, animals, stories and its Peoples with honour and respect.

We commit to the shared goal of Reconciliation.

Next Steps

A Land Acknowledgement is one of many steps needed to engage with Indigenous communities and create meaningful relationships that come from a place of trust, mutual respect, understanding, and reciprocity, as mandated for Boards of Health by the Foundational Standard of Health Equity within the Ontario Public Health Standards.[1] Updating the Land Acknowledgement serves as a step forward on the shared path of Reconciliation, and affirms the need to respect and support the inherent rights of Indigenous peoples set out in treaties, agreements, and other constructive arrangements.[13]

A Land Acknowledgement as a practice is fluid and likely to evolve over time as our relationship with Indigenous partners and work towards Reconciliation grows.[14] As need arises, APH staff will work to revise the Land Acknowledgement and bring any significant new learnings to the attention of the BOH.

Moving forward, as per the strong recommendation of First Nation and Métis partners, and mandate within the Ontario Public Health Standards, staff will continue to follow-up and engage with First Nation and Métis partners to explore opportunities for meaningful action by public health towards Reconciliation. Insight shared by partners will help to inform Health Equity standard implementation planning and the work of public health with Indigenous communities in Algoma.

Finally, internal work will continue to support cultural safety education for all staff through virtual learning webinars, lived experience sharing, ongoing reflection, and the integration of learning and reflection into public health practice.

Strengthening partnerships with First Nations and Métis Peoples to support Indigenous health and wellbeing and reduce health inequities will remain a priority within the work of Algoma Public Health.

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RESOLUTION

Whereas the Truth and Reconciliation Commission (TRC) of Canada released a report documenting the voices of survivors of Indian Residential Schools; and

Whereas the Ontario Public Health Standards recognize the requirement for boards of health to engage with Indigenous communities in ways that are meaningful for them; and

Whereas the research project titled *Talking Together To Improve Health* identified four principles of Indigenous engagement, including respect, trust, self-determination, and commitment; and

Whereas the literature indicates that saying a Land Acknowledgement, when appropriate, can be a small but important step in continuing to build and sustain meaningful relationships with Indigenous communities and people;[3,4]

Be it resolved that APH acknowledge the harm that colonization and the residential school system caused and continues to cause to Indigenous people in Canada;

Be it further resolved that the Algoma district-wide Land Acknowledgement is approved for use by the board of health and staff, when saying the Land Acknowledgement is deemed meaningful to do so.

LAND ACKNOWLEDGEMENT FAQs AND SUPPORTING RESOURCES

The frequently asked questions (FAQs) and associated information is being provided to support the understanding and meaningful, voluntary delivery of Algoma Public Health's Land Acknowledgement by the board of health and staff at APH-led meetings and events.

1. What is a Land Acknowledgement?

- A Territorial or Land Acknowledgement involves making a statement that recognizes the traditional territory of the Indigenous Peoples who called the land home before the arrival of settlers, and still call it home today.

2. Why are Land Acknowledgements provided?

- A Land Acknowledgement is a way to help build awareness of Indigenous history, presence, and rights in everyday life.
- Algoma Public Health's Land Acknowledgement is part of the long-term journey we are taking, as individuals and an organization, towards Reconciliation with Indigenous partners and communities across Algoma.[1]
- Many consider Land Acknowledgements to be a small, yet essential step towards Reconciliation and building meaningful relationships with Indigenous Peoples and communities.[2]
- It is critical that we work towards understanding the longstanding history that has brought us to live, work, and play on the land, and our place within that history. Recognizing that colonialism is a current and ongoing process, we must be mindful of our present participation in colonialism and how we will work towards meaningful Reconciliation.[3]

- A Land Acknowledgement is rooted in history, and linked to identity and a sense of wellbeing.

  "When we talk about land, land is part of who we are. It's a mixture of our blood, our past, our current, and our future. We carry our ancestors in us, and they're around us. As you all do."

  – Mary Lyons[3]

- A Land Acknowledgement must take place within the broader context of genuine, ongoing work towards Reconciliation to forge true understanding and to challenge the legacies of colonialism.[4]

3. When and how might a Land Acknowledgement be provided?

- Land Acknowledgement statements may be delivered verbally at the beginning of APH-led:
  - public meetings and consultations,
  - formal meetings for large groups (e.g., 20 people), workshops, and training sessions,
  - meetings/consultations/events with Indigenous partners and clients, and
  - special events or gatherings.
- Land Acknowledgements may also be provided at any event if there is a specific request that one be provided from staff or by a community member.
- The Land Acknowledgement will also be located on the APH website in the 'About Us' section.
- When sharing a Land Acknowledgement at the start of an APH-led meeting or event, it is important **not to shorten and/or rush through the statements**. You should never say a Land Acknowledgement as an "obligatory statement before getting to business," or "just because." It is an honour and privilege to share a Land Acknowledgement, and it should be said with respect.
- As you share a Land Acknowledgement, it is important to critically think and reflect on why you are saying the statements and how they relate to your public health practice.[5] Consider what it means to acknowledge the impact of colonialism and how this reflects your individual and our organizational actions towards Reconciliation.

4. Who can provide a Land Acknowledgement?

- A Land Acknowledgement can be provided by any APH staff or board of health member. You do not have to identify as Indigenous to provide a Land Acknowledgement.
- Indigenous staff, partners, or community members may wish to offer a Land Acknowledgement, but should never be expected to do so unless it is their preference. It is often most meaningful when shared by people who identify as settlers, as a sign of understanding and mutual respect.
- If your meeting or event is with Indigenous partners, out of respect, you may wish to ask someone from the Indigenous community ahead of time if they would like to provide an opening or blessing. (Note that there are certain protocols for reaching out to an Elder or Knowledge Keeper; be aware prior to the event.)

5. Pronunciation Guide

Proper pronunciation of the Traditional Territories, First Nations, and Métis communities within the Land Acknowledgement is a sign of respect. Practicing before the meeting or event can help build confidence and provide time for reflection on the Land Acknowledgement. The guide below can help with pronunciation.

Anishnaabeg	Aw-nish-naw-bek [Note: "g" and "k" make a similar sound in anishinaabe-mowen]
Michipicoten	Mich-ih-pih-cot-en
Missanabie-Cree	Miss-anaw-bee Cree
Batchewana	Batch-a-wana
Thessalon	Thess-a-lon
Mississauga	Miss-a-saw-ga
Sagamok	Sag-a-mok
Métis	May-tee

If you would like further support or resources, or would like to practice saying the Land Acknowledgement, please connect with Corina Artuso, Youth Engagement Coordinator (CArtuso@algomapublichealth.com).

References:

1. Indigenous Advisory Committee. (2021). A guide to acknowledge First Peoples and traditional lands: Land acknowledgements for staff and volunteers. Retrieved from https://engineerscanada.ca/sites/default/files/diversity/land-acknowledgements-guide.pdf
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Algoma PUBLIC HEALTH
Santé publique Algoma

Board of Health

RESOLUTION

Date: September 22, 2021	**Resolution No:** 2021-75
Moved:	**Seconded:**

Subject: Land Acknowledgement

Whereas the Truth and Reconciliation Commission (TRC) of Canada released a report documenting the voices of survivors of Indian Residential Schools; and

Whereas the Ontario Public Health Standards recognize the requirement for boards of health to engage with Indigenous communities in ways that are meaningful for them; and

Whereas the research project titled Talking Together To Improve Health identified four principles of Indigenous engagement, including respect, trust, self-determination, and commitment; and

Whereas the literature indicates that saying a Land Acknowledgement, when appropriate, can be a small but important step in continuing to build and sustain meaningful relationships with Indigenous communities and people;

Be it resolved that APH acknowledge the harm that colonization and the residential school system caused and continues to cause to Indigenous people in Canada;

Be it further resolved that the Algoma district-wide Land Acknowledgement is approved for use by the board of health and staff, when saying the Land Acknowledgement is deemed meaningful to do so.

CARRIED: Chair's Signature _____

☐ **Louise Caicco Tett**	☐ **Micheline Hatfield**	☐ **Musa Onyuna**	☐ **Brent Rankin**
☐ **Deborah Graystone**	☐ **Lee Mason**	☐ **Ed Pearce**	☐ **Matthew Scott**
☐ **Sally Hagman**			

Algoma
PUBLIC HEALTH
Santé publique Algoma

September 22, 2021

Report of the

Medical Officer of Health / CEO

Prepared by:
Dr. Jennifer Loo and the
Leadership Team

Presented to:
Algoma Public Health Board of Health

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APH AT-A-GLANCE

COVID-19 Pandemic Response in Algoma

Over the summer months of 2021, Ontario progressed through the three steps of reopening as COVID-19 case counts, hospitalizations, and deaths declined, while immunization coverage rose steadily. During the first two weeks of July, Algoma communities experienced a two-week period without any active cases of COVID-19. However, with the emergence and rise of the more transmissible and severe Delta variant, both Algoma and the broader province saw cases rise again, and on August 17, 2021, the provincial government paused the exit from the Roadmap to Reopen, and intensified efforts to increase vaccine coverage in Ontario. Currently, the aspiration is to achieve immunization coverage of over 90% in all those who are eligible. Modelling from Ontario's science advisory table suggests that this high coverage, in addition to the maintenance of public health measures, are necessary to stop the fourth wave of COVID-19 from overwhelming provincial hospital and ICU capacity.

During the week of September 7 to 13, Algoma's 7-day incidence was 14.0 new cases per 100,000 people per week, with a weekly percent positivity of 1.4%. Since mid July and the beginning of the fourth wave in Algoma, approximately 80% of new COVID-19 cases have been among people who are not fully immunized. Due to the majority of sectors now being open, there are a large number of high risk close contacts associated with each new case, all of whom require public health follow up. During the period of September 8 to 14, there were 181 high risk close contacts being followed by APH.

COVID-19 Immunization Update

As of September 14, 2021, of all eligible Algoma residents born in 2009 or later, just over 85% have received at least one dose of a COVID-19 vaccine, and over 78% have received two doses. This means that, 70% of the total population in Algoma, or about 80,000 residents, are fully immunized. Just over 27,000 Algoma residents remain unimmunized with any dose of COVID-19 vaccine, of which about 15,000 are currently eligible for immunization based on age.

Immunization progress in Algoma has been made possible by the intensification of outreach efforts, through no-appointment necessary pop-up clinics district wide, many of which are hosted in collaboration with community partners, such as schools, post-secondary institutions, and community service agencies. Pharmacy and primary care partners have also offered significant points of access for COVID-19 vaccine, even as large-scale mass immunization clinics were ramped down at the end of summer.

The powerful lever of healthy public policy has also greatly supported the strong uptake of COVID-19 immunization. At the provincial level, this includes Ontario's requirement of proof of vaccination in select discretionary public settings, and making COVID-19 vaccination policies mandatory in high risk

settings. At the local level, in addition to developing an internal COVID-19 immunization policy in accordance with the instructions of the Chief Medical Officer of Health, APH has strongly recommended local employers to implement workplace vaccine policies, and provided implementation support to local businesses and organizations via a workplace vaccine policy toolkit. Within the first 24 hours of the toolkit's launch, about 700 users navigated to the webpage, and APH's e-blast advertising the toolkit to local employers was opened by over 1,000 recipients.

Developing an Approach Towards Recovery

Despite ongoing demands of the pandemic response, which have increased as a result of the fourth wave, APH continues to maintain critical public health functions and essential programs and services. As COVID-19 immunization rates rise, APH will be in a better position to shift attention to assessing the impacts of the COVID-19 pandemic, lessons learned, and what this means for our collective recovery as employees, an organization, and a community.

The recovery planning processes started in June 2021, with the design of an APH Framework for Recovery and establishment of a Recovery Steering Committee. The Framework for Recovery focuses on:

- Renewing the public heath workplace through employee engagement and excellence, focusing on employees' lived experience, lessons learned, employee wellness (including mental health), communication, and organizational capacity development;

- Routinizing COVID-19 work for sustainable prevention, mitigation, preparedness, and response to COVID-19;

- Restoring public health programs and services to pre-pandemic levels (i.e., clearing the backlog of mandatory public health work), while responding to new, post-pandemic priorities with consideration of lessons learned and the Ontario Public Health Standards; and

- Rebuilding public health, with a focus on strategic policy and change at local, provincial and federal levels.

While sustaining the public health response to COVID-19 and balancing program needs, the Continuity of Operations Planning team and Recovery Steering Committee continue to meet to strategize for an effective recovery from COVID-19, using a collaborative, evidence-informed approach.

PARTNERSHIPS

Advancing Public Health and Health Equity with Partners

In addition to, and throughout the pandemic response, much core public health work has continued. This month we note two particular items for celebration and commemoration.

- **Working with Algoma University for a Smoke Free Campus**
  - As of September 1st, Algoma University's campus in Sault Ste. Marie is 100% Smoke Free. Algoma Public Health has supported Algoma University in their journey to a Smoke Free campus by providing public health consultation and evidence informed resources. A comprehensive Smoke Free policy supports a healthier learning environment for everyone including students, faculty, staff and visitors. Congratulations Algoma University!

- **Commemorating the National Day for Truth and Reconciliation**
  - As highlighted in this board report's Land Acknowledgement resolution and accompanying backgrounder, APH continues to seek meaningful ways to engage with our Indigenous partners.

  - During August and September, and following the heartbreaking recovery of children's remains at unmarked graves at residential schools, a series of Indigenous-led education and reflective practice sessions were offered to all APH staff, to support each other during a difficult and emotional time for many.

  - APH's Indigenous Engagement Working Group has collated a series of in-person and virtual opportunities for staff, who wish to commemorate Orange Shirt Day on September 30th, designated as the National Day for Truth and Reconciliation.

Algoma Public Health
(Unaudited) Financial Statements July 31, 2021

Algoma Public Health
Statement of Operations
July 2021
(Unaudited)

	Actual YTD 2021	Budget YTD 2021	Variance Act. to Bgt. 2021	Annual Budget 2021	Variance % Act. to Bgt. 2021	YTD Actual/ YTD Budget 2021
Public Health Programs (Calendar)						
Revenue						
Municipal Levy - Public Health	**$ 2,856,284**	$ 2,856,284	$ 1	$ 3,808,378	0%	100%
Provincial Grants - Cost Shared Funding	**5,079,732**	5,079,732	(0)	8,708,100	0%	100%
Provincial Grants - Public Health 100% Prov. Funded	**1,042,940**	999,016	43,925	3,650,186	4%	104%
Provincial Grants - Mitigation Funding	**605,386**	605,388	(2)	1,037,800	0%	100%
Fees, other grants and recovery of expenditures	**255,756**	228,365	27,391	418,330	12%	112%
Total Public Health Revenue	**$ 9,840,098**	$ 9,768,784	$ 71,314	$ 17,622,794	1%	101%
Expenditures						
Public Health Cost Shared	**$ 9,551,739**	$ 9,237,656	$ (314,082)	$ 16,027,008	3%	103%
Public Health 100% Prov. Funded Programs	**946,452**	931,596	(14,856)	1,595,786	2%	102%
Total Public Health Programs Expenditures	**$ 10,498,191**	$ 10,169,252	$ (328,939)	$ 17,622,794	3%	103%
Total Rev. over Exp. Public Health	**$ (658,093)**	$ (400,468)	$ (257,625)	$ 1		
Healthy Babies Healthy Children (Fiscal)						
Provincial Grants and Recoveries	**$ 356,011**	356,011	-	1,068,011	0%	100%
Expenditures	**320,435**	355,270	(34,835)	1,068,011	-10%	90%
Excess of Rev. over Exp.	**35,576**	741	34,835	-		
Public Health Programs (Fiscal)						
Provincial Grants and Recoveries	**$ 231,000**	231,000	-	693,000		
Expenditures	**151,455**	231,000	(79,545)	693,000		
Excess of Rev. over Fiscal Funded	**79,545**	-	79,545	-		
Community Health Programs (Non Public Health)						
Calendar Programs						
Revenue						
Provincial Grants - Community Health	**$ -**	$ -	$ -	$ -		
Municipal, Federal, and Other Funding	**71,858**	71,858	-	71,858	0%	100%
Total Community Health Revenue	**$ 71,858**	$ 71,858	$ -	$ 71,858	0%	100%
Expenditures						
Child Benefits Ontario Works	**0**	-	-	-	#DIV/0!	#DIV/0!
Algoma CADAP programs	**71,858**	71,858	-	71,858	0%	100%
Total Calendar Community Health Programs	**$ 71,858**	$ 71,858	$ -	$ 71,858	0%	100%
Total Rev. over Exp. Calendar Community Health	**$ -**	$ -	$ -	$ -		
Fiscal Programs						
Revenue						
Provincial Grants - Community Health	**$ 638,367**	$ 638,343	$ 24	$ 2,059,744	0%	100%
Municipal, Federal, and Other Funding	**47,687**	38,149	9,538	114,447	25%	125%
Other Bill for Service Programs	**0**	0	-	-		
Total Community Health Revenue	**$ 686,054**	$ 676,492	$ 9,562	$ 2,174,191	1%	101%
Expenditures						
Brighter Futures for Children	**42,767**	38,149	(4,618)	114,447	12%	112%
Infant Development	**204,455**	214,072	9,617	644,317	-4%	96%
Preschool Speech and Languages	**197,693**	217,477	19,785	733,971	-9%	91%
Nurse Practitioner	**53,623**	53,384	(238)	162,153	0%	100%
Stay on Your Feet	**30,207**	33,333	3,126	100,000	-9%	91%
Rent Supplements CMH	**110,080**	139,768	29,688	419,303	-21%	79%
Bill for Service Programs	**8,093**	0	(8,093)	(0)		
Misc Fiscal	**-**	-	-	-	#DIV/0!	#DIV/0!
Total Fiscal Community Health Programs	**$ 646,919**	$ 696,184	$ 49,265	$ 2,174,191	-7%	93%
Total Rev. over Exp. Fiscal Community Health	**$ 39,135**	$ (19,692)	$ 58,827	$ -		

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, 2021
(Unaudited)

	Actual YTD 2021	Budget YTD 2021	Variance Bgt. to Act. 2021	Annual Budget 2021	Variance % Act. to Bgt. 2021	YTD Actual/ Annual Budget 2021	*Comparison Prior Year:* *YTD Actual 2020*	*YTD BGT 2020*	*Variance 2020*
Levies Sault Ste Marie	2,012,541	2,012,541	0	2,683,388	0%	75%	2,002,033	2,002,033	0
Levies District	843,744	843,744	0	1,124,992	0%	75%	839,340	839,340	0
Total Levies	**2,856,285**	**2,856,285**	**0**	**3,808,380**	**0%**	**75%**	**2,841,373**	**2,841,373**	**0**
MOH Public Health Funding	5,079,732	5,079,732	0	8,708,100	0%	58%	4,343,961	3,656,078	687,883
MOH Funding Needle Exchange	0	0	0	0	0%	0%	37,743	37,742	1
MOH Funding Haines Food Safety	0	0	0	0	0%	0%	14,350	14,350	0
MOH Funding Healthy Smiles	0	0	0	0	0%	0%	449,107	449,108	(1)
MOH Funding - Social Determinants of Health	0	0	0	0	0%	0%	175,829	105,280	70,549
MOH Funding Chief Nursing Officer	0	0	0	0	0%	0%	30,375	70,882	(40,507)
MOH Enhanced Funding Safe Water	0	0	0	0	0%	0%	9,043	9,042	1
MOH Funding Infection Control	0	0	0	0	0%	0%	152,204	182,238	(30,034)
MOH Funding Diabetes	0	0	0	0	0%	0%	87,500	87,500	0
Funding Ontario Tobacco Strategy	0	0	0	0	0%	0%	252,936	252,933	3
MOH Funding Harm Reduction	0	0	0	0	0%	0%	87,500	87,500	0
MOH Funding Vector Borne Disease	0	0	0	0	0%	0%	27,175	63,406	(36,231)
MOH Funding Small Drinking Water Systems	0	0	0	0	0%	0%	17,400	40,600	(23,200)
Total Public Health Cost Shared Funding	**5,079,732**	**5,079,732**	**0**	**8,708,100**	**0%**	**58%**	**5,685,123**	**5,056,659**	**628,464**
MOH Funding - MOH / AMOH Top Up	132,637	88,716	43,921	152,086	50%	87%	91,429	88,717	2,713
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	407,107	407,108	(1)	697,900	0%	58%	380,727	407,108	0
MOH Funding Indigenous Communities	57,164	57,162	2	98,000	0%	58%	0	0	0
OTF COVID-19 extraordinary costs mass imms	68,145	68,145	0	2,054,400	0%	3%	993,642	1,017,308	
Total Public Health 100% Prov. Funded	**1,042,939**	**999,015**	**43,925**	**3,650,186**	**4%**	**29%**	**850,042**	**873,708**	**2,715**
Total Public Health Mitigation Funding	**605,386**	**605,386**	**0**	**1,037,800**	**0%**	**58%**	**0**	**0**	**0**
Recoveries from Programs	6,160	23,330	(17,170)	28,010	-74%	22%	0	0	0
Program Fees	72,784	79,323	(6,539)	105,320	-8%	69%	23,773	16,059	7,714
Land Control Fees	159,765	75,000	84,765	160,000	113%	100%	109,407	117,416	(8,009)
Program Fees Immunization	2,162	29,162	(27,000)	45,000	-93%	5%	74,971	75,000	(29)
HPV Vaccine Program	0	0	0	12,500	0%	0%	29,875	67,083	(37,208)
Influenza Program	0	0	0	25,000	0%	0%	0	3,000	(3,000)
Meningococcal C Program	0	0	0	7,500	0%	0%	0	1,500	(1,500)
Interest Revenue	7,885	11,550	(3,665)	20,000	-32%	39%	0	625	(625)
Other Revenues	7,000	10,000	(3,000)	15,000	0%	47%	14,925	23,333	(8,408)
Total Fees and Recoveries	**255,756**	**228,365**	**27,391**	**418,330**	**12%**	**61%**	**252,951**	**304,017**	**(51,065)**
Total Public Health Revenue Annual	**9,840,098**	**9,768,783**	**71,315**	**17,622,796**	**1%**	**56%**	**9,629,489**	**9,075,756**	**580,114**
Public Health Fiscal April 2021 - March 2022									
Vaccine Refrigerators	0	0	0	0	0%	0%			
Infection Prevention and Control Hub	0	0	0	320,000	0%	0%			
Practicum	0	0	0	0	0%	0%			
School Nurses Initiative	231,000	231,000	0	700,000	0%	33%			
Sr Dental Capital Upgrades	0	0	0	0	0%	0%			
Total Provincial Grants Fiscal	**231,000**	**231,000**	**0**	**1,020,000**	**0%**	**23%**	**0**	**0**	**0**

Algoma Public Health

Expense Statement- Public Health

For Seven Months Ending July 31, 2021

(Unaudited)

	Actual YTD 2021	Budget YTD 2021	Variance Act. to Bgt. 2021	Annual Budget 2021	Variance % Act. to Bgt. 2021	YTD Actual/ Budget 2021	*Comparison Prior Year:* *YTD Actual 2020*	*YTD BGT 2020*	*Variance 2020*
Salaries & Wages	$ 6,079,710	$ 6,047,208	$ (32,502)	$ 10,756,870	1%	57%	$ 5,440,515	$ 5,509,108	$ 68,593
Benefits	1,502,194	1,391,465	(110,729)	2,366,268	8%	63%	1,352,654	1,336,582	(16,072)
Travel	74,510	100,864	26,354	172,909	-26%	43%	64,360	111,417	47,057
Program	823,238	674,501	(148,737)	1,112,190	22%	74%	381,524	399,874	18,350
Office	34,712	33,274	(1,438)	57,040	4%	61%	30,094	39,492	9,397
Computer Services	511,237	557,936	46,699	929,676	-8%	55%	495,950	483,121	(12,829)
Telecommunications	227,560	216,533	(11,027)	371,200	5%	61%	183,241	151,110	(32,131)
Program Promotion	40,321	48,284	7,963	83,035	-16%	49%	25,387	54,351	28,964
Professional Development	15,591	44,042	28,451	75,500	-65%	21%	8,482	79,042	70,560
Facilities Expenses	733,037	610,380	(122,657)	1,046,365	20%	70%	518,678	451,743	(66,935)
Fees & Insurance	256,511	233,925	(22,586)	290,300	10%	88%	216,879	191,430	(25,449)
Debt Management	269,682	268,858	(824)	460,900	0%	59%	268,858	268,858	1
Recoveries	(70,113)	(58,018)	12,095	(99,459)	21%	70%	(59,786)	(48,033)	11,752
	$ 10,498,191	$ 10,169,252	$ (328,939)	$ 17,622,794	**3%**	**60%**	$ 8,926,836	$ 9,028,094	$ 101,258

Notes to Financial Statements – July 2021

Reporting Period

The July 2021 financial reports include seven months of financial results for Public Health. All other non-funded public health programs are reporting four-month results from operations year ending March 31, 2022.

Statement of Operations (see page 1)

Summary – Public Health and Non Public Health Programs

APH received the 2021 Amending Agreement from the province identifying the approved funding from the province for 2021 for public health. The Ministry of Health has approved one-time funding to support approximately 50% of estimated eligible COVID-19 extraordinary costs at this time and will work with APH to monitor and track more detailed and accurate requirements and spending for COVID-19 through in-year financial reports and make any adjustments to funding, as required, throughout the 2021 funding year. Management took the conservative approach and adjusted the 2021 budget to reflect the change in approved funding. This has resulted in a reduction to the 2021 public health calendar budget of $2.1M.

As of July 31, 2021, Public Health calendar program expenditures are reporting a $330k negative variance.

Total Public Health Revenues are indicating a $71k positive variance.

Public Health Revenue (see page 2)

Overall, Public Health calendar funding revenues are reporting a $71k positive variance budget. Land Control Fees are reporting a $91k surplus.

Mitigation funding from the province will continue for 2021 and 2022.

The COVID-19: School-Focused Nurses Initiative has been extended to June 2022.

Public Health Expenses (see page 3)

Salary & Wages
There is a $32k negative variance associated with Salary & Wages.

Benefits
There is a $111k negative variance associated with Benefits. This is due to higher than budgeted non-statutory benefits.

Travel
There is a $26k positive variance associated with Travel expenses. This is a result of APH employees working virtually as opposed to travelling throughout the district or attending meetings outside of the district.

Notes Continued…

Programs
There is a $149k negative variance associated with Programs. This is due to the high demand for professional services through the Ontario Sr. Dental Program, $87k over budget and COVID 19 Mass Immunization Supplies and third party professional services, $114k over budget. This is partially offset by the reduction in vaccine purchases, $30k under budget, for chargeable vaccines.

Professional Development
There is a $28k positive variance for Professional Development. At this time there has been limited spending for professional development, as staff availability is extremely tight and limited opportunities for professional development due to COVID-19.

Facilities Expenses
There is a $122k negative variance for Facilities Expenses. This is primarily due to the more than expected costs related to COVID 19 Response and Mass Immunization for janitorial services and security.

Recoveries
There is a $12k positive variance for Recoveries. This is due to Ministry of Children, Community and Social Services (MCCSS) funded programs permitting an increase to administrative recoveries until March 31, 2021, because of increased costs to support these programs due to COVID-19.

COVID-19 Expenses

COVID-19 Response
This program includes case and contact management as well as supporting the information phone lines. July YTD expenses were $2.8M and $380k for July. The majority of this consists of salaries and benefits costs of APH staff that under normal circumstances would be working in their assigned public health programs.

COVID-19 Mass Immunization
This program includes the planning, support, documentation, and actual needles in arms of the various COVID-19 vaccines. July YTD expenses were $2.2M and $539k for July.

Financial Position - Balance Sheet (see page 6)

APH's liquidity position continues to be stable and the bank has been reconciled as of July 31, 2021. Cash includes $1.40M in short-term investments.

Long-term debt of $4.47 million is held by TD Bank @ 1.95% for a 60-month term (amortization period of 180 months) and matures on September 1, 2021. $265k 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.

Algoma Public Health

Statement of Financial Position

(Unaudited)

Date: As of July 2021	**July 2021**	December 2020
Assets		
Current		
Cash & Investments	**$ 3,479,375**	$ 3,906,995
Accounts Receivable	**475,712**	935,870
Receivable from Municipalities	**524,380**	69,618
Receivable from Province of Ontario		
Subtotal Current Assets	**4,479,467**	4,912,483
Financial Liabilities:		
Accounts Payable & Accrued Liabilities	**1,723,387**	1,660,232
Payable to Gov't of Ont/Municipalities	**242,112**	1,673,441
Deferred Revenue	**673,323**	286,418
Employee Future Benefit Obligations	**3,117,450**	3,117,450
Term Loan	**4,466,918**	4,466,918
Subtotal Current Liabilities	**10,223,190**	11,204,458
Net Debt	**(5,743,723)**	(6,291,975)
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	**(11,199,609)**	(11,199,609)
Subtotal Non-Financial Assets	**18,530,764**	18,530,764
Accumulated Surplus	**12,787,041**	12,238,789

Governance Committee Meeting

September 8, 2021

Attendees Virtually:

Deborah Graystone - Chair

Tania Caputo - Board Secretary

Attended Virtually:

Sally Hagman
Musa Onyuna
Brent Rankin
Lee Mason

APHU Executive Attended Virtually:

Jennifer Loo – MOH
John Tuinema - AMOH

Policy #02-05-001 was discussed along with the skills matrix and recruitment of new board members. The committee decided to address the smaller municipalities with a presentation of the skills matrix by Sally and Lee through the Algoma District Municipalities Association and other groups to communicate our potential needs within the board. We also discussed communicating our needs to the Provincial Government through our MPP. The goal is to ensure a diverse and skills-based board.
It was determined that our board is functioning well with the current membership and that when legal or financial expertise is required for decision-making that outsourcing this expertise would be reasonable.
Further planning and discussion will continue in our next Governance meeting.

Policy #02-05-025 Board Member Remuneration was reviewed and approved with no amendments. Lee asked if there was a mechanism in place to ensure adherence to this policy, with special reference to the additional hours submitted by the Chair. The mechanism is in place since amendments made to remuneration of board members.

Policy #02-05-055 Board of Health Self-Evaluation was reviewed and approved with one minor amendment.

By-Law #06-01 Sewage Systems Part 8 of the Ontario Building Code Act was reviewed. A discussion occurred regarding the change in fees and how this has affected the Algoma Public Health budget. It was determined that once the final budget for the last year is reviewed, that the validity/effects of this policy can be reviewed.

By-Law #95-1 To Regulate Proceedings of the Board was reviewed. A discussion regarding the inclusion of an interpretation of “Conflict of Interest” be included. This amendment was made, and the policy approved.

There was a discussion regarding an APHU vaccine policy. Dr. Loo communicated that a current employee vaccination policy has been developed and is currently being refined to ensure adherence to recent provincial direction.
Dr. Loo also advised the committee that APHU is currently developing a Workplace Vaccine Policy Tool Kit which will be available to relevant community employers.

APPROVED BY:	Board of Health	**REFERENCE #:**	02-05-025
DATE:	Original: Mar 20, 2002 Revised: Nov 25, 2015 Revised: Nov 28, 2018 Revised: Nov 13, 2019 Reviewed: Sep 22, 2021	**SECTION:** **SUBJECT:**	Policies Board Member Remuneration/ Expenses for Attendance at Meetings and Conferences

POLICY:

Remuneration for Attendance at Board of Health Meetings

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

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

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

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

Remuneration for Attendance at Board of Health Functions

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

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

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

For example:

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

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

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

Attendance at Board and Committee Meetings (in person or electronically)	$110	meeting 4 hours or less
Attendance as above (including travel time)	$150	meeting and travel time greater than 4 hours
Attendance at Conferences	$180	per day
Additional duties of Board Chair		Apply the appropriate meeting rate for any required attendance at the request of the MOH

Expenses

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

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

3) The rate of reimbursement for the use of a personal automobile is the kilometre rate as per the current Travel Policy 02-05-20.

4) Travel Expense Claim Form is used to claim:
   a) kilometers travelled for attendance at Board functions (conferences, conventions or workshops).
   b) reasonable and actual expenses incurred respecting accommodation, food, parking and registration fees. Receipts are required. Refer to Travel Policy 02-05-20.

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

Eligible expenses are reimbursed for Board members only.

APPROVED BY:	Board of Health	**REFERENCE #:**	02-05-055
DATE:	Original: May 20, 2015 Revised: Jun 22, 2016 Reviewed: Jun 28, 2017 Revised: Nov 28, 2019 Revised: Sep 22, 2021	**SECTION:**	Policies
		SUBJECT:	Board of Health Monthly Meeting and Self-Evaluation Policy

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POLICY:

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

Annual self-evaluation

The self-evaluation process shall include consideration of whether:

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

Monthly Board meeting Evaluation

The Board of Health shall have meeting evaluation process that results in improved Board of Health meeting effectiveness. Meeting evaluation will be a standing agenda item on the Board Agenda, and evaluation forms including board member name will be completed before the meeting is adjourned and be collected by the recording secretary. At the conclusion of each meeting, the board members are encouraged to complete the electronic evaluation.
Meeting evaluation results will be reviewed by the Board of health Chair and presented to the Board of Health three (3) times a year

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

PROCEDURES:

Annual Self-Evaluation

Board of Health Member

1. Complete the Board of Health Self-Evaluation Survey including board member name at the June Board meeting.
2. The completed evaluations will be collected and the results compiled by the board secretary and forwarded to the Board Chair

Board Secretary

3. Will compile evaluations into a report and present at the September Board meeting as noted in the Board's annual work plan.

Monthly Board Meeting Evaluation

Board of Health Member

1. Complete the Board of Health Meeting Evaluation Survey after each regularly scheduled Board meeting.
2. The completed evaluations will be collected and the results compiled by the board secretary.

Board Secretary

3. Will compile evaluations and forward to the Board Chair to review three times per year.
4. Results will be ~~reported back to the Board in the Board package the following month~~ presented in the Board of Health meeting package three times per year.

KNOWLEDGE:

Board Member Self-Evaluation of Performance Template

Board Monthly Meeting Evaluation Template

APPROVED BY:	Board of Health	**BY-LAW #:**	06-01
DATE:	Original: Apr 19, 2006 Revised: Feb 18, 2015 Revised: Jun 28, 2017 Reviewed: Nov 20, 2019 Reviewed: Sep 22, 2021	**SECTION:**	Bylaws
		SUBJECT:	Sewage Systems Part 8 of the Ontario Building Code Act

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

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

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

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

PERMITS AND FEES

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

DATE OF EFFECT

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

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

L. Mason, Chair

I. Frazier, 1st Vice-Chair

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

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

Exemptions for Severance Applications:

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

Lot fees are exempt under the following conditions:

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

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

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

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

APPROVED BY:	Board of Health	**BY-LAW #:**	95-1
DATE:	Original: Dec 13, 1995 Revised: Sep 28, 2016 Revised: Jun 28, 2017 Reviewed: Nov 20, 2019 Revised: Sep 22, 2021	**SECTION:**	Bylaws
		SUBJECT:	To Regulate the Proceedings of the Board of Health

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The Board enacts as follows:

1. Interpretation

In this By-law:

a) "Act" means the Health Protection and Promotion Act. R.S.O. 1990, Chapter H.7 as amended;

b) "Board" means THE BOARD OF HEALTH FOR THE DISTRICT OF ALGOMA HEALTH UNIT, as prescribed;

c) "Chair" means the person presiding at the meeting of the Board;

d) "Chair of the Board" means the Chair elected under Section 57 of the Act which reads:

e) At the first meeting of the Board of Health in each year, the members of the Board shall elect one of the members to be Chair and one to be Vice-Chair of the Board for the year;

f) "Committee" means a committee of the Board, but does not include the Committee of the Whole;

g) "Committee of the Whole" means all the members present at a meeting of the Board sitting in Committee;

h) "Meeting" means a meeting of the Board;

i) "Member" means a member of the Board;

j) "Quorum" means a majority of the current members of the Board (MOHLTC Communication 2016) and that there must be at least five current members of the Board;

k) "Secretary" means the Secretary of the Board of Health;

l) Words that indicate singular masculine gender only shall include plural and/or feminine gender.

m) "Conflict of Interest" as per APH policy 02-05-015 Conflict of Interest.

2. General

a) The Board shall hold the first meeting of each year not later than the first day of February. At the first meeting of the Board in each year, members of the Board shall elect one member to be Chair, one member to be First Vice-Chair and one member to be Second Vice-Chair of the Board for the year. The First Vice-Chair shall chair the Finance and Audit Committee and the Second Vice-Chair shall chair the Governance Committee.

b) The Board shall consist of the members as prescribed under the Act;

c) Where a vacancy occurs in the Board by death, disqualification, resignation or removal of a member, the person or body that appointed the member shall appoint a person forthwith to fill the vacancy for the remainder of the term of the member.

d) In all the proceedings at or taken by this Board, the following rules and regulations shall be observed and shall be the rules and regulations for the order and dispatch of business at the Board, and in the Committee(s) thereof.

e) Except as herein provided, *Robert's Rules of Order* shall be followed for governing the proceedings of the Board and the conduct of its members.

f) A person who is not a member of the Board shall not be permitted to address the Board except upon invitation of the Chair subject to written request to the Secretary at least two weeks prior to the scheduled meeting.

g) In unusual circumstances persons who have not requested in writing to address the Board may address the Board provided two-thirds of the Board's members are in agreement.

3. Meetings

a) Regular Meetings:

i. The regular meetings shall be held at a date and time as stated in the Board's Activity Plan determined by the Board annually at its June meeting.;

ii. The Board may, by resolution, alter the time, day or place of any meeting;

iii. It is expected that commitments to regularly scheduled Board meetings be honoured by the Board members;

iv. Three consecutive absences from regular Board meetings by a member of the Board will be reviewed by the Chair of the Board with the member in question; following which, notification may be forwarded to the appropriate municipality, council or the province.

b) Special Meetings:

i. A special meeting of the Board shall not be called for a time which conflicts with a regular meeting previously called of (participating) council(s) or municipality(s).

ii. A special meeting may be called by the Chair of the Board of Health.

iii. The Secretary shall call a special meeting upon receipt of a petition signed by the majority of Board members, for the purpose and at the time mentioned in the petition.

4. Notice of Meetings:

a) The Secretary shall give notice of each regular and special meeting of the Board and of each Committee to the members thereof and to the heads of departments concerned with such meetings.

b) The notice shall be accompanied by the agenda and any other matter, so far as is known, to be brought before such meeting.

c) The notice for a regular meeting shall be delivered or sent by electronic means or courier to the residence or place of business of each member so as to be received no later than three working days prior to the day of the meeting.

d) The notice for a special meeting may be sent by telephone or by electronic means with the Secretary confirming receipt.

e) No errors or omissions in giving such notice for the meeting shall invalidate it or any action taken.

f) The notice calling a special meeting of the Board shall state the business to be considered at the special meeting, and no business other than that stated in the notice shall be considered at such meeting except with the unanimous consent of the members present and voting.

5. Preparation of the Agenda:

a) The Secretary shall have prepared for the use of members at the regular meetings, the Agenda as follows:

i. Call to Order
ii. Declaration of Conflict of Interest
iii. Adoption of Agenda
iv. Delegations / Presentations
v. Adoption of Minutes of Previous Meeting
vi. Business Arising from Minutes
vii. Report of Medical Officer of Health
viii. Reports of Committees
ix. New Business / General Business

x. Correspondence
xi. Items for Information
xii. Addendum
xiii. In-Camera
xiv. Open Meeting
xv. Announcements / Next Committee Meetings
xvi. Adjournment

b) For special meetings, the Agenda shall be prepared when and as the Chair of the Board may direct or, in default of such direction, as provided in the last preceding section so far as is applicable.

c) The business for each meeting shall be taken up in the order in which it stands upon the Agenda, unless otherwise decided by the Board.

6. Commencement of Meetings:

a) As soon as there is a quorum after the hour fixed for the meeting, the Chair of the Board or First Vice-Chair of the Board, if the Chair is not present or the Second Vice-Chair if the First Vice-Chair is not present shall take the Chair and call the members to order.

b) If the Chair or Vice-Chairs are not present, or their duly appointed representative, but a quorum is otherwise achieved, the Secretary shall call the members to order and a presiding officer shall be appointed by the Secretary to preside during the meeting or until the arrival of the person who ought to preside.

c) If there is no quorum within 15 minutes after the time appointed for the meeting, the Secretary shall call the roll and take down the names of the members then present. If an absence of an expected Quorum occurs due to a health emergency or to weather conditions and business must be expedited, the Board shall have the privilege of designating items of business as essential to be expedited at that meeting. Under these conditions the Board shall have the privilege of conducting the necessary items of business but such items shall be confirmed at the next meeting of the Board.

7. Rules of Debate and Conduct of Members of the Board

a) The Chair shall preside over the conduct of the meeting, including the preservation of good order and decorum, ruling on point of order and deciding all questions relating to the orderly procedure of the meetings, subject to an appeal by any member to the Board from any ruling of the Chair.

b) Each deputation will be allowed a maximum of one speaker for a maximum of 10 minutes, but a member of the Board may introduce a deputation in addition to the speaker or speakers. Normally, a deputation will not be heard on an item unless there is a report from staff on the item or upon agreement of two-thirds of the Board present.

i. The Board shall render its decision in each case within five (5) working days after deputations have been heard.

c) If the Chair desires to leave the Chair for the purpose of taking part in the debate or otherwise, the Chair shall vacate the Chair to one of the Vice-Chairs during the debate prior to the beginning of the debate, to fill his place until he resumes the Chair.

d) Every member, prior to speaking to any question or motion, shall be acknowledged by the Chair.

e) When two or more members ask to speak, the Chair shall name the member who, in his opinion, first asked to speak. The Chair shall develop a speakers list when more than one member wishes to address each item.

f) A member may speak more than once on a question, but after speaking shall be placed at the foot of the list of members wishing to speak.

g) A motion for introducing a new matter shall not be presented without notice unless the Board, without debate, dispenses with such notice by a majority vote and no report requiring action of the Board shall be introduced to the Board unless a copy has been placed in the hands of the members at least one day prior to the meeting, except by a majority vote, taken without debate.

h) Every motion presented to the Board shall be written.

i) Every motion shall be deemed to be in possession of the Board for debate after it is presented by the Chair, but may, with permission of the Board, be withdrawn at any time before amendment or decision.

j) When a matter is under debate, no motion shall be received other than a motion:

i. to adopt,
ii. to amend,
iii. to defer action,
iv. to refer,
v. to receive,
vi. to adjourn the meeting, or
vii. that the vote be now taken.

k) A motion
i. to refer or defer shall take precedence over any other amendment or motion except a motion to adjourn.
ii. ~~A motion~~ to refer shall require direction as to the body to which it is being referred and is not debatable.
iii. ~~A motion~~ to defer must include a reason and a time period for the deferral and is not debatable.

l) When a motion that the vote be now taken is presented, it shall be put to a vote without debate, and, if carried by a majority vote of the members present, the motion and any amendments thereto under discussion shall be submitted to a vote forthwith without further debate.

m) Any member, including the Chair, may propose or second a motion and all members including the Chair shall vote on all motions except when disqualified by reasons of interest or otherwise; a tie vote shall be considered lost. When the Chair proposes a motion, he shall vacate the Chair to one of the Vice-Chairs during debate on the motion and reassume the Chair following the vote.

8. Duties of the Secretary for the Board

a) It shall be the duty of the Secretary:

i. to attend or cause an assistant to attend all meetings of the Board;

ii. to keep or cause to be kept full and accurate minutes of the meetings of all the Board meetings, text of By-laws and Resolutions passed by it; and

iii. to forward a copy of all resolutions, enactments and orders of the Board to those concerned in order to give effect to the same.

iv. to give all notices required to be given to the members.

9. Appointment and Organization of Committees

a) At the first meeting in any year, the Board shall appoint the members required by the Board to standing committees(s) (Finance and Audit Committee, Governance Committee). When a new member(s) join the Board after the first meeting of the year the Board shall appoint the new member(s) to one of the standing committees.

b) The Board may appoint committees from time to time to consider such matters as specified by the Board.

10. Conduct of Business in Committees

a) The rules governing the procedure of the Board shall be observed in the Committees insofar as applicable.

b) It shall be the duty of the Committee:

i. to report to the Board on all matters referred to them and to recommend such action as they deem necessary;

ii. to report to the Board the number of meetings called during a year, at which a quorum was present, and the number of meetings attended by each member of the Committee; and

iii. to forward to the incoming Committee for the following year any matter undisposed of.

11. Procedures of the Board Covered by other By-laws

a) The procedures of the Board with respect to:

i. incurring of liabilities and paying of accounts;
ii. authority for expenditures;
iii. audits;
iv. budgets and settlements;

Shall be in accordance with the By-laws #95-2 and #95-3.

12. Corporate Seal

a) The corporate seal of the Board shall be in the form impressed hereon and shall be kept by the Chief Executive Officer/Chief Administrative Officer or the Chief Financial Officer.

13. Short Name

a) The Board will use the short name Algoma Public Health for signage, communications and promotional messaging and other matters as warranted.

14. Execution of Documents

a) The Board may at any time and from time to time, direct the manner in which and the person or persons who may sign on behalf of the Board and when required affix the corporate seal to any particular contract, arrangement, conveyance, mortgage, obligation, or other document or any class of contracts, arrangements, conveyances, mortgages, obligations or documents.

b) In general, unless changed by a resolution of the Board under clause 34 of this By-law, the following applies:

i. Budgets and Settlement Forms will be signed by the combination of Board member(s) and staff of the agency as required by Ministry specifications;

ii. Leases for real estate, mortgages or other loan documents will be signed by the Chair of the Board and by the Medical Officer of Health or Chief Executive Officer/Chief Administrative Officer;

iii. Leases or purchase agreements for vehicles, as approved in budgets, will be signed by the Director/Chief Financial Officer and/or the Medical Officer of Health or Chief Executive Officer /Chief Administrative Officer (should two signatures be necessary);

iv. Purchase of service agreements with service providers for programs will be signed by the Medical Officer of Health or CEO/CAO and by the appropriate program Director.

v. Purchase of service agreements with service providers for financial, building and

corporate services will be signed by the Medical Officer of Health or Chief Executive Officer/ Chief Administrative Officer and by the appropriate administrative manager or Director/Chief Financial Officer.

15. Duties of Officers

a) The Chair of the Board shall:

i. preside at all meetings of the Board;

ii. represent the Board at public or official functions or designate another Board member to do so;

iii. be ex-officio a member of all Committees to which he has not been named a member;

iv. complete an annual performance appraisal of the Medical Officer of Health/CEO/CAO using input from the Medical Officer of Health/CEO/CAO as well as the members of the Board, with the results of this appraisal being shared with the Board members in camera;

v. perform such other duties as may from time to time be determined by the Board.

b) The First Vice-chair shall have all the powers and perform all the duties of the Chair of the Board in the absence or disability of the Chair of the Board, together with such powers and duties, if any, as may be from time to time assigned by the Board. The Second Vice-Chair shall have all the powers and perform all the duties of the Chair of the Board in the absence or disability of both the Chair of the Board and the First Vice-chair, together with such powers and duties, if any, as may be from time to time assigned by the Board.

16. Amendments

a) The Board shall consist of the members as prescribed under the Act;Any provision contained herein may be repealed, amended or varied, and additions may be made to this By-law by a majority vote of members present at the meeting at which such motion is considered to give effect to any recommendation contained in a Report to the Board, and such report has been transmitted to members of the Board prior to the meeting at which the report is to be considered. No motion for that purpose may be considered unless notice thereof has been received by the Secretary two weeks before a Board meeting and such notice may not be waived, and in any event, no bill to amend this By-law shall be introduced at the same meeting as that at which such report or motion is considered.

17. Dismissal of Medical Officer(s) of Health

a) A decision by the Board of Health to dismiss a Medical Officer of Health from office is not effective unless:

i. the decision is carried by the vote of two-thirds of the members of the Board; and

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

b) The Board of Health shall not vote on the dismissal of a Medical Officer of Health unless the Board has given to the Medical Officer of Health:

i. reasonable written notice of the time, place and purpose of the meeting at which the dismissal is to be considered;

ii. a written statement of the reason for the proposal to dismiss the Medical Officer of Health; and

iii. an opportunity to attend and to make representation to the Board at the meeting. R.S.O 1990, c.H7, S.66(2)

18. Reporting of Medical Officer of Health to the Board of Health/CEO/CAO

a) The Medical Officer of Health/CEO/CAO of a board of health reports directly to the Board of Health on issues relating to public health concerns and to public health programs and services under this or any other Act. The Medical Officer of Health of a Board of Health is responsible to the Board for the management of the public health programs and services under this or any other Act. (HPPA, s.67(1) and (3))

b) The Medical Officer of Health/CEO/CAO of a board of health is entitled to notice of and to attend each meeting of the Board and every Committee of the Board, but the Board may require the Medical Officer of Health/CEO/CAO to withdraw from any part of a meeting at which the Board or a Committee of the Board intends to consider a matter related to the remuneration or the performance of the duties of the Medical Officer of Health/CEO/CAO. (HPPA, s70)

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

Original signed by
I. Lawson, Chair
G. Caputo, Vice-chair

Revised and passed by the Algoma Health Unit Board this 18th day of November 1998
Revised and passed by the Algoma Public Health Board February 2011
Revised and passed by the Algoma Public Health Board on this 28th day of October 2015
Revised and passed by the Algoma Public Health Board on this 28th day of September 2016
Revised and passed by the Algoma Public Health Board on this 28th day of June 2017

OFFICE OF THE MAYOR
CITY OF HAMILTON

September 15, 2021

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

RE: Support for a Local Board of Health

Dear Minister Elliott,

As the province of Ontario and Public Health Unit's across the province continue to respond to the COVID-19 pandemic, the City of Hamilton's Board of Health has been reflecting on our local pandemic response. COVID-19 has highlighted the importance of public health local responsiveness, particularly when dealing with local outbreaks. During the past eighteen months we have seen how local knowledge and partnerships has strengthened the pandemic response by better understanding the needs in the community and leveraging trusted relationships. The strength, timeliness, and flexibility of local collaboration can be seen through the implementation of various strategies, including increased public health measures, equitable access to COVID-19 testing, and an extremely complex and targeted vaccination strategy.

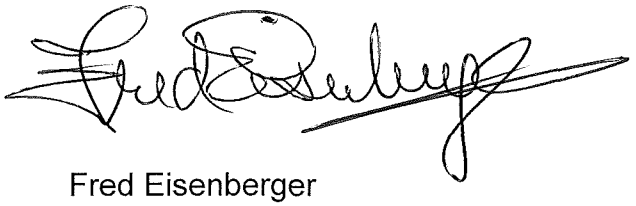
We are writing this letter to reiterate our position that a local, rather than regional governance is preferred to inform planning on how to strengthen and modernize the public health system. One of the current strengths of the governance system in Hamilton is the ties to the municipal sector which has a direct influence on opportunities for health where people live. As a governing body, the Hamilton Board of Health / Council can remain flexible and make decisions to increase, decrease or change service delivery based on local need. This has been particularly important throughout the pandemic as regular public health programs had to be flexible with the level of their operations to allow for resources to be shifted to essential services and the COVID-19 response. Maintaining the local voice supports ongoing advocacy of local need to ensure that priorities in the community are met, for example, the collection of local Social Determinants of Health Data which has allowed public health efforts to more effectively reach those who are disproportionately affected by the pandemic.

.../2

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

It is believed that if there is a shift to a regional board of health model, there will be a reduced local leadership voice in decision making. Due to this, it is important that public health governance remains local while ensuring accountability to municipalities, the province and the local population. Leveraging local responsiveness during the pandemic has reinforced our position that a local rather than regional governance remains the preferred model.

Sincerely,



Fred Eisenberger
Mayor

CC:
Andrea Horwath, MPP, Hamilton Centre
Paul Miller, MPP, Hamilton East – Stoney Creek
Monique Taylor, MPP, Hamilton Mountain
Sandy Shaw, MPP, Hamilton West – Ancaster – Dundas
Donna Skelly, MPP, Flamborough – Glanbrook
Council of Ontario Medical Officers of Health
Association of Local Public Health Agencies (alPHa)
Ontario Boards of Health

HALIBURTON, KAWARTHA, PINE RIDGE DISTRICT HEALTH UNIT

www.hkpr.on.ca • info@hkpr.on.ca
1-866-888-4577

September 16, 2021

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

Dear Minister Elliot,

I want to begin by thanking you and your government for your leadership and financial support during the COVID-19 pandemic. On behalf of the Board of Health for Haliburton, Kawartha, Pine Ridge District Health Unit (HKPRDHU), I have appreciated the province's announcements to date which have included a commitment to fund 100% of the costs related to the COVID-19 response as well as the continuation of mitigation funding for the year 2022.

I am writing today to specifically request ongoing government financial support for the following items that have not been captured by previous funding announcements:

1. Allocations to support program "restarts", "catchup", and broader recovery
2. Increased base funding to reflect the following demands on health unit resources:
    a. Endemicity of COVID-19 response activities
    b. Increased wage, benefit, and operational costs due to inflation
    c. Increased demand for health unit services to support population recovery from COVID-19 (e.g. mental wellness, harm reduction)

Since the start of the COVID-19 pandemic, HKPRDHU has responded to greater than 2,300 confirmed cases of COVID-19, 71 COVID-19 related outbreaks, responded to greater than 700 community complaints regarding infection prevention and control and enforcement for COVID-19 public health measures, and 6,930 COVID-19 related inquiries through our COVID-19 call centre. In addition, HKPRDHU has coordinated the implementation of COVID-19 vaccination across our jurisdiction with greater than 270,000 doses of vaccine administered.

Throughout the pandemic, resources at HKPRDHU have been diverted from pre-existing services to ensure a timely response to COVID-19 and prevent further spread of the virus throughout Ontario. Similar to other areas of the health sector, difficult decisions have been made about which programs to scale down (or stop) and which to continue. This has resulted in a backlog of services that includes the following:

- 2400 students that missed the school-based immunization program and an additional 1200 that have not been offered second doses to complete their full immunization series through the school program
- Greater than 70 small drinking water systems that require inspection in addition to the routine annual cohort for 2022
- 5300 children needing Oral health screening

…/2

We are reaching a point locally that if we don't start to catch up on these services the backlog will become too large of a hurdle to overcome. As such, we intend to build in capacity to begin addressing this issue but will require assurance from the Ministry that extraordinary costs associated with this will be covered.

It is now clear that COVID-19 will require dedicated attention for many years to come. Case and contact management, outbreak management, infection prevention and control, immunization, surveillance, communication, and enforcement activities will all see a baseline of increased work for the foreseeable future. To do this work well, we need to expand our public health workforce and provide opportunities for permanent positions.

Prior to COVID-19, local public health agencies had received only one increase to base funding in the past five years. Despite this, several new programs were introduced to the Ontario Public Health Standards, including Vision Screening and requirements to respond to Infection Prevention and Control Complaints and inspection of private swimming pools. Furthermore, due to inflation, wage, benefit, and operating costs continued to increase. This means that we were already under-resourced to respond to an infectious disease emergency as well as implement routine public health priorities prior to the pandemic.

Now, more than ever, our communities need a robust public health system to not only respond to the threat of newly emerging infectious diseases, but also help the population recover from the many collateral harms that have resulted throughout the pandemic response. Harms such as increased opioid overdose deaths and deterioration of children's mental health have been well documented over the last year. These are two key areas that local public health agencies have a clear mandate to address but will require the resources to do so.

For the above reasons, the Board of Health urges the provincial government to commit dedicated funding to support both catch-up and recovery of public health activities as well as the ongoing increased demands for health unit response to COVID-19. The COVID-19 pandemic has demonstrated the instrumental role that local public health agencies play in preventing and mitigating the spread of infectious diseases. As we look to the future, it is imperative that we support the recovery of public health in a comprehensive and sustainable way.

In writing this letter, we also call upon the Association of Local Public Health Agencies of Ontario to endorse/support this request.

Respectfully,

BOARD OF HEALTH FOR THE HALIBURTON, KAWARTHA,
PINE RIDGE DISTRICT HEALTH UNIT
Original signed by Mr. Elmslie

Doug Elmslie, Chair, Board of Health

DE/nb

Cc (via email): The Hon. Doug Ford, Premier
The Hon. Laurie Scott, MPP Haliburton-Kawartha Lakes-Brock
David Piccini, MPP Northumberland-Peterborough South
Dr. Kieran Moore, Ontario Chief Medical Officer of Health
Dr. Charles Gardner, Chair, Council of Medical Officers of Health
Association of Municipalities of Ontario
Ontario Boards of Health
Loretta Ryan, Association of Local Public Health Agencies

Northwestern Health Unit
www.nwhu.on.ca

210 First Street North
Kenora, ON P9N 2K4

August 27, 2021

Honourable Christine Elliott
Minister of Health / Deputy Premier
Ministry of Health
College Park 5th Floor
777 Bay Street, Toronto, ON M7A 2J3

VIA EMAIL: Christine.elliott@pc.ola.org

Dear Minister Elliott,

On behalf of the Board of Health for the Northwestern Health Unit (NWHU), we wish to express our appreciation for the guidance and leadership shown by the Government of Ontario through the COVID-19 Pandemic Response and Vaccine Rollout. As we progress further along the Roadmap to reopening and begin our own recovery discussions, the topic of modernization and a shift in the cost-sharing model are front and centre.

At the forefront of recovery for public health units and the municipalities we serve, and who contribute to public health funding, is financial stability. NWHU serves 19 municipalities in the province's Northwest; each of which generates much of its revenue through tourism and other economic development initiatives which have been significantly impacted by the pandemic. Mitigation funding received in recent years has been critical to the maintenance of public health programming by boards of health and in easing related financial impacts on our oblicated municipalities, especially during the pandemic response, which has required NWHU to augment its staffing and redeploy existing staff to the response.

As the pandemic continues to come under control, NWHU will shift into recovery mode, which will include several months' and even years' work to catch up on programming such as school immunizations, and will require us to maintain staffing levels sufficient for the resumption of our standard public health programming, and outstanding efforts related to pandemic control such as remaining case and contact management, child and youth vaccinations and the potential for booster vaccinations at some point in the future.

Mitigation funding will be crucial to ensure the success of public health programming; without it, public health activities including ensuring the safety of the school environment will be significantly challenged. Our obligated municipalities are not in a position to shift to substantially increased levies to support this work, and public health is not in a position to reduce its staffing to below pre-pandemic numbers and

still keep our communities safe through our programming which is a substantial risk if mitigation funding and/or an increase to our base budget in 2022 is not received.

The Board of Health for the Northwestern Health Unit endeavours to carry out its fiduciary responsibilities while balancing the needs of the population in our broad catchment area. We respectfully request that the Province of Ontario reconsider its approach to the funding of public health. Public health has been instrumental in the response to the COVID-19 pandemic, and will continue to play a large and important role in the recovery process, especially given the long list of inequities that the pandemic has uncovered in our population's access to health supports.

Sincerely,

Doug Lawrance	Marilyn Herbacz	Dr. Kit Young Hoon
Board of Health Chair	Chief Executive Officer	Medical Officer of Health

CC: Premier Doug Ford
Dr. Kieran Moore, Chief Medical Officer of Health
Greg Rickford, MPP Kenora-Rainy River
Sol Mamakwa, MPP Kiiwetinoong
Judith Monteith-Farrell, MPP Thunder Bay - Atikokan
Ontario Boards of Health
Member Municipalities (19)
Association of Local Public Health Agencies (alPHa)
Association of Municipalities of Ontario (AMO)

Northwestern Health Unit
www.nwhu.on.ca

210 First Street North
Kenora, ON P9N 2K4

August 27, 2021

VIA ELECTRONIC MAIL

The Honourable Christine Elliott
Deputy Premier and Minister of Health
Ministry of Health, 5th Floor
777 Bay Street
Toronto, ON M7A 2J3

Dear Minister Elliott:

Re: Support to Establish the Infection Prevention and Control (IPAC) Hub Model as an Ongoing Program

At its August 27, 2021 meeting, the Board of Health for the Northwestern Health Unit recognized the continued importance of supporting long-term care homes and other community congregate living settings through provincially funded infection protection and control (IPAC) measures. Northern health units are uniquely positioned, and the temporary funding for each board of health to be the "Hub" in the IPAC "Hub and Spoke" model has been particularly effective and continues to be critical to ensure vulnerable residents are protected and outbreaks of infections such as SARS-CoV-2 are prevented.

Infection Prevention and Control programming is a requirement of Boards of Health under the *Ontario Public Health Standards*. In December 2020, Northern public health units received temporary funding to establish local networks to enhance IPAC practices in community-based congregate living settings, which resulted in enhanced partnerships between Social Services Boards, Associations for Community Living, and increased staff and management capacity for this important work which is carried out across the Northwestern Health Unit catchment area and throughout Northern Ontario.

The establishment of IPAC Hubs is a strong first step in addressing the need for supports related to IPAC within congregate living facilities, as identified in *Ontario's Long-Term Care COVID-19 Commission April 2021 Final Report,* and while we would welcome the news of funding for this programming for the 2021/2022 period, **we would request that stable, annualized funding for this program be established in recognition of the criticality of the interventions.** Temporary or one-time funding does not allow us to successfully recruit trained professionals for the required positions, given the chronic recruitment challenges that have only been worsened by the pandemic.

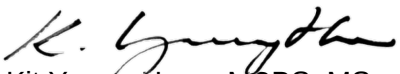
With this in mind, the Board of Health carried the following resolution #79-2021:

THAT the Board of Health for the Northwestern Health Unit make a request to the Provincial Government to make the IPAC Hub model an ongoing program with stable annual funding to provide for the protection from infectious diseases in community congregate living settings and long-term care homes.

AND FURTHER that this resolution be shared with Ministers of Health and Long-Term Care, area partners, Northern Boards of Health, Ontario Health, alPHa, and the Chief Medical Officer of Health.

Northwestern Health Unit is grateful to have been able to work with health units in the north to come together in support of protecting vulnerable residents from infectious diseases in long-term care and other congregate living settings; We thank you for the opportunity to do so.

Sincerely,



Kit Young Hoon, MBBS, MSc., MPH, FRCPC
Medical Officer of Health

cc: Honourable R. Phillips, Minister of Long-Term Care
Dr. K. Moore, Chief Medical Officer of Health, Ministry of Health
All Northern Ontario Boards of Health
C. Geiger, President and CEO, Public Health Ontario
M. Anderson, President and CEO, Ontario Health
B. Ktytor, Transitional Regional Lead (Northern Ontario)

From:	Tania Caputo
To:	"acadiandrillers@shaw.ca"; "b.rankin.3737@gmail.com"; Brent Rankin; "debbiegraystone@hotmail.com"; Deborah Graystone; Ed Pearce; "Ed Pearce"; "lctett@hspinc.ca"; Lee Mason; Louise Caicco Tett; "m.scott@cityssm.on.ca"; Mathew Scott; Micheline Hatfield; Musa Onyuna; Musa Onyuna; "ns-sentinel@bellnet.ca"; Sally Hagman; "sally.hagman@sympatico.ca"
Cc:	Jennifer Loo
Subject:	FW: August 2021 Issue of alPHa"s Information Break
Date:	Tuesday, August 17, 2021 11:26:00 AM
Attachments:	image003.png image004.png

From: allhealthunits <allhealthunits-bounces@lists.alphaweb.org> **On Behalf Of** Loretta Ryan
Sent: Friday, August 13, 2021 7:09 PM
To: All Health Units <AllHealthUnits@lists.alphaweb.org>
Cc: Board@lists.alphaweb.org
Subject: [allhealthunits] August 2021 Issue of alPHa's Information Break

PLEASE ROUTE TO:

All Board of Health Members
All Members of Regional Health & Social Service Committees
All Senior Public Health Managers

August 13th, 2021

This update is a tool to keep alPHa's members apprised of the latest news in public health including provincial announcements, legislation, alPHa activities, correspondence, and events. Visit us at alphaweb.org.

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COVID-19 Update

As part of the response to COVID-19, alPHa continues to represent the public health system and work with key stakeholders. To keep members up-to-date, alPHa shares Ministry of Health Situation Reports

and COVID-19-related news. If you are not receiving these, please get in touch with the contact person at your health unit who distributes information on behalf of alPHa.

Visit the Ministry of Health's page on guidance for the health sector
View the Ministry's website on the status of COVID-19 cases
Go to Public Health Ontario's COVID-19 website
Visit the Public Health Agency of Canada's COVID-19 website
alPHa's recent COVID-19 related submissions can be found here

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Hold the Date!
Fall and Winter Symposiums, Conference and AGM

Please hold the date for the alPHa's Fall Symposium on **Friday, November 19th, 2021**, the Winter Symposium on **Friday, February 25th, 2022** and the Conference and Annual General Meeting from **Sunday, June 12th – Tuesday June 14th, 2022.**

More details regarding the Fall Symposium will be available in the next newsletter.

alPHa Correspondence

Through policy analysis, 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. Correspondence since the last Newsletter include:

- July 27th, 2021 - alPHa Letter - A Cautious and Measured Reopening
- July 21st, 2021 - alPHa Letter - Resolution A21-2, Opioids
- July 21st, 2021 - alPHa Letter - Resolution A21-1, Vaping Products

A complete online library is available here.

Boards of Health: Shared Resources

A resource page is available on alPHa's website for Board of Health members to facilitate the sharing of and access to orientation materials, best practices, by-laws, resolutions, and other resources. If you have a best practice, by-law or any other resource that you would like to make available, please send a file or a link with a brief description to gordon@alphaweb.org and for posting in the appropriate library.

Resources available on the alPHa website include:

- Orientation Manual for Board of Health
- Review of Board of Health Liability (PowerPoint presentation
- Governance Toolkit
- Risk Management for Health Units

- Healthy Rural Communities Toolkit
- The Ontario Public Health Standards
- Public Appointee Role and Governance Overview
- Ontario Boards of Health by Region
- List of Units sorted by Municipality
- List of Municipalities sorted by Health Unit

PHO Resources

Vaccine Resources
PHO is actively monitoring, reviewing and assessing relevant research related to COVID-19 vaccines. Check out new vaccine resources or visit PHO's COVID-19 Vaccines page for more information.

- Adverse Events Following Immunization (AEFIs) for COVID-19 in Ontario: December 13, 2020 to August 7, 2021
- Ontario COVID-19 Data Tool
- COVID-19 Vaccine Uptake and Program Impact in Ontario: December 14, 2020 to August 7, 2021
- Technical Brief: COVID-19 Vaccines with World Health Organization (WHO) Emergency Use Listing (EUL)
- SARS-CoV-2 Infections after Vaccination – What We Know So Far
- Focus On COVID-19 vaccines: mRNA Vaccines
- Adverse Events of Special Interest (AESIs) for COVID-19 Vaccines Surveillance
- Myocarditis and Pericarditis Following COVID-19 mRNA Vaccines
- Adverse Event Following Immunization (AEFI) Reporting Form
- Confirmed Cases of COVID-19 Following Vaccination in Long-Term Care Homes & Retirement Homes in Ontario: December 14, 2020 to June 30, 2021

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Upcoming PHO Events

- August 17th: PHO Rounds: The Occurrence of Anaplasmosis and Passive Tick Surveillance Options in Ontario

Interested in our upcoming events? Check out our Events page to stay up-to-date with all PHO events. Missed an event? Check out our Presentations page for full recordings our events.

Upcoming DLSPH Events and Webinars

- August 25th: Dalla Lana Certificate in Health Impact

View all past webinars here.

News Releases

- Dr. Catherine Zahn appointed to become Deputy Minister of Health effective September 7, 2021

The most up to date news releases from the Government of Ontario can be accessed here.

Association of Local Public Health Agencies
480 University Avenue, Suite 300 | Toronto ON | M5G 1V2
416-595-0006 | www.alphaweb.org | info@alphaweb.org

Take Care,

Loretta

_____

Loretta Ryan, CAE, RPP
Executive Director
Association of Local Public Health Agencies (alPHa)
480 University Avenue, Suite 300
Toronto, ON M5G 1V2
Tel: 416-595-0006 ext. 222
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loretta@alphaweb.org
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