BOARD OF HEALTH MEETING

January 29, 2025

SSM Algoma Community Room / Teams Meeting

www.algomapublichealth.com

Meeting Book - January 29, 2025, Board of Health Meeting

Table of Contents

Board of Health Meeting
AGENDA
Wednesday, January 29, 2025 - 5:00 pm
SSM Algoma Community Room | Videoconference

BOARD MEMBERS
Deborah Graystone
Sally Hagman
Julila Hemphill
Donald McConnell
Luc Morrissette
Sonny Spina
Sonia Tassone
Suzanne Trivers
Jody Wildman
Natalie Zagordo

APH MEMBERS
Dr. John Tuinema - Acting Medical Officer of Health & CEO
Rick Webb - Director of Corporate Services
Kristy Harper - Director of Health Promotion & Prevention / Chief Nursing Officer
Leslie Dunseath - Manager of Accounting Services
Leo Vecchio - Manager of Communications
Tania Caputo - Board Secretary

STAFF GUESTS: Sandra Dereski - Acting Manager of Infectious Diseases, Cassey Cassan - Health Promotion Specialist, Christina Luukkonen - Manager of Support Services , Amy McGregor - Supervisor of Support Services

1.0 Meeting Called to Order *Dr. J. Tuinema*

a. **Land Acknowledgment**
b. **Roll Call**
c. **Declaration of conflict of interest**

2.0 Election of Officers

a. **Appointment of Board of Health Chair for the year 2025.** *Dr. J. Tuinema*

b. **Appointment of Board of Health First Vice-Chair and Chair of the Finance and Audit Committee for the year 2025.** *Chair*

c. **Appointment of Board of Health Second Vice-Chair and Chair of the Governance Committee for the year 2025.** *Chair*

d. **Call for Committee Members for the Finance & Audit Committee and Governance Committee for the year 2025.** *Chair*

i. **Finance and Audit Committee call for members** :

ii. **Governance Committee call for members:**

e. **Slate of officers and committee members.** *Chair*

RESOLUTION

Be it resolved that the following is the Board of Health slate of officers and committee members for the year 2025.

Board of Health Chair:	
First Vice-Chair & Chair of the Finance and Audit Committee:	
Second Vice-Chair & Chair of the Governance Committee:	
Finance and Audit Committee members:	
Governance Committee members:	

3.0 Signing Authority *Chair*

RESOLUTION

THAT By-Law 95-2 identifies that signing authorities for all accounts shall be restricted to:

i) the Chair of the Board of Health
ii) one other **Board member, designated by Resolution**
iii) the Medical Officer of Health/Chief Executive Officer
iv) the Director of Corporate Services

SO BE IT RESOLVED that signing authority is provided to _____ as the one other **Board member, designated by resolution** until the next election of officers.

4.0 Adoption of Agenda *Chair*

RESOLUTION

THAT the Board of Health agenda dated January 29, 2025, be approved as presented.

5.0 Delegations / Presentations

Infectious Diseases - Syphilis and the SPRITE Study *S. Dereski / C. Cassan*

6.0 Adoption of Minutes of Previous Meeting *Chair*

RESOLUTION

THAT the Board of Health minutes dated November 27, 2024 be approved as presented.

7.0 Business Arising from Minutes

8.0 Reports to the Board

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

i. MOH Report - January 2025

RESOLUTION

THAT the report of the Medical Officer of Health and CEO for January 2025 be accepted as presented.

b. Finance and Audit

i. Financial Statements *L. Dunseath*

RESOLUTION

THAT the Board of Health approves the Unaudited Financial Statements for the period ending November 30, 2024, as presented.

9.0 New Business/General Business *Dr. J. Tuinema*

a. **Briefing Note - Algoma Ontario Health Team (AOHT) Partnership Agreement Renewal**

RESOLUTION

THAT the Board of Health approves the renewal partnership with the AOHT as a collaborative partner.

11.0 Correspondence for Information *Chair*

a. Letter to Algoma Public Health from the Township of Dubreiulville with resolution supporting APH Board resolution 2024-98 regarding **Perspectives from Northern Ontario for the Public Health Funding Review.** The letter is dated November 22, 2024

b. Letter to the Mayor of Sudbury from Public Health Sudbury & Districts regarding advocacy for the **Selection of Indigenous Municipal and Provincial Appointees for Board of Health for Public Health Sudbury & Districts,** dated December 5, 2024.

c. Letter to the Minister of Health from Public Health Sudbury & Districts regarding advocacy for the **Selection of Indigenous Municipal and Provincial Appointees for Board of Health for Public Health Sudbury & Districts,** dated December 5, 2024.

d. Report to the Middlesex-London Board of Health regarding advocacy for the **Monitoring Food Affordability and Implications for Public Policy and Action,** dated December 12, 2024.

e. Letter to the Medical Officers of Health and CEOs regarding **Strengthening Public Health** from the office of the CMOH dated December 23, 2024.

f. Letter to the Minister of Finance from the Association of Local Public Health Agencies (alPHa) regarding the **2024 Pre-Budget Submission: Public Health Programs and Services**, dated January 20, 2025.

g. alPHa Information Break - January 2025

12.0 Addendum *Chair*

13.0 In-Camera *Chair*

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.

14.0 Open Meeting *Chair*

Resolutions resulting from in-camera meeting.

15.0 Announcements / Next Committee Meetings: *Chair*

Finance & Audit Committee
Wednesday, February 12, 2025 @ 5:00 pm
Video Conference │SSM Algoma Community Room

Public Health Champion Awards Reception
Wednesday, February 26, 2025 @ 4:00 pm
In-person │APH Front Lobby - 294 Willow Ave

Board of Health Meeting
Wednesday, February 26, 2025 @ 5:00 pm
Video Conference │SSM Algoma Community Room

Governance Committee
Wednesday, March 19, 2025 @ 5:00 pm
Video Conference │SSM Algoma Community Room

16.0 Evaluation *Chair*

17.0 Adjournment *Chair*

RESOLUTION

THAT the Board of Health meeting adjourns.

Syphilis and the SPRITE Study

Sandra Dereski, Acting Manager of Infectious Diseases

Casey Cassan, Health Promotion Specialist

January 29, 2025

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Overview

Introduction to syphilis in Algoma

Role of APH + Infectious Diseases Program

The SPRITE Study

Next Steps

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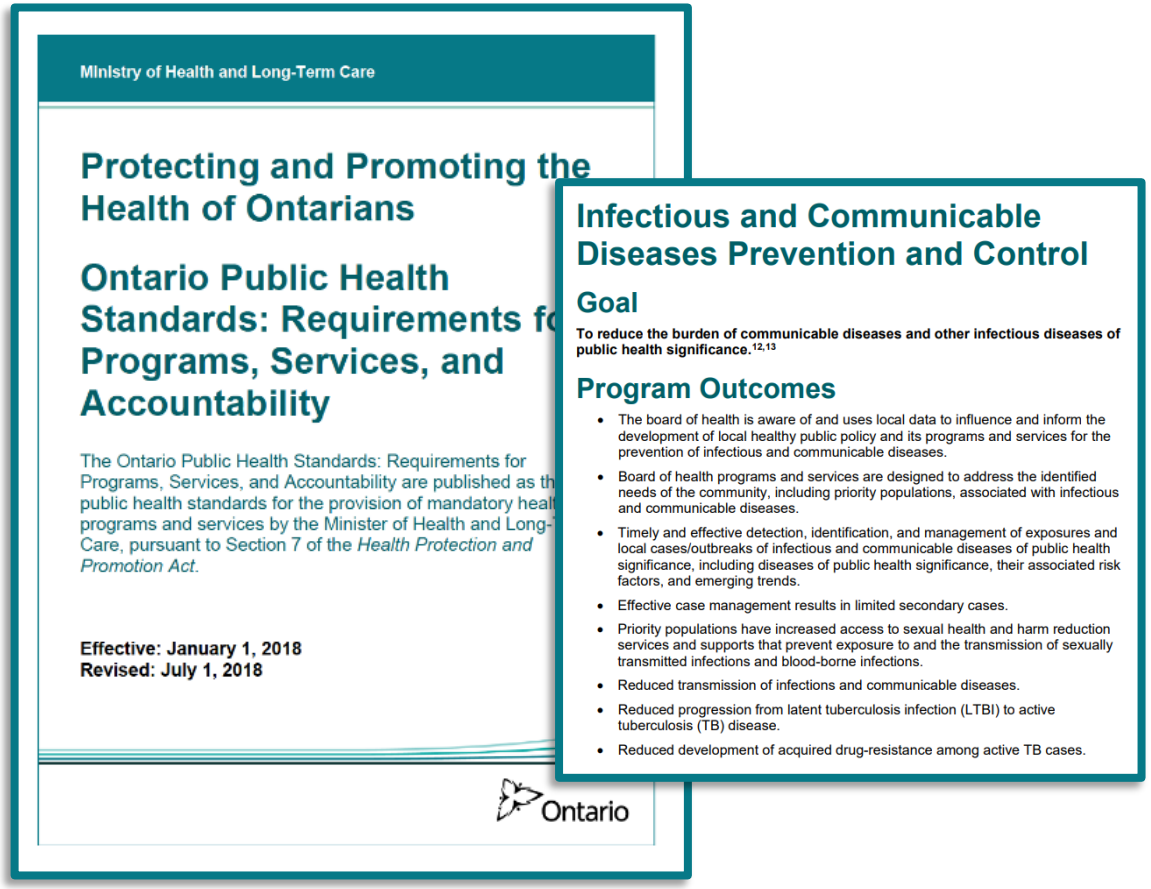
Strategic Directions

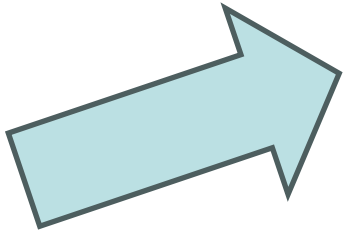
Advance the priority public health needs of Algoma's diverse communities.

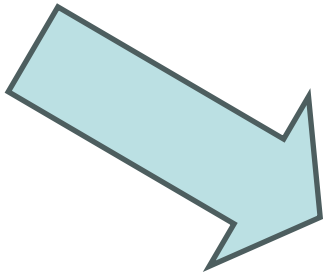
Improve the impact and effectiveness of Algoma Public Health programs.

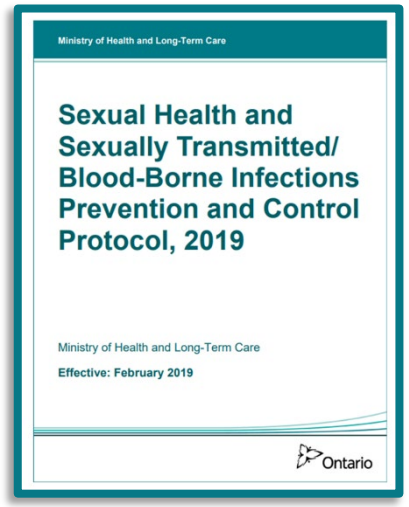
Grow and celebrate an organizational culture of learning, innovation, and continuous improvement.

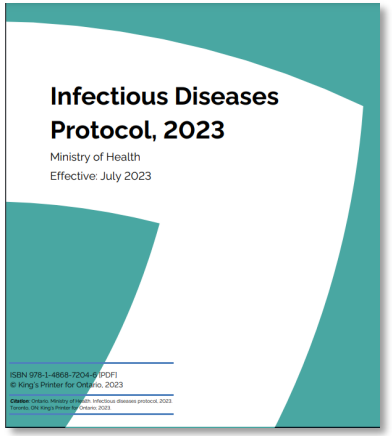
Ontario Public Health Standards











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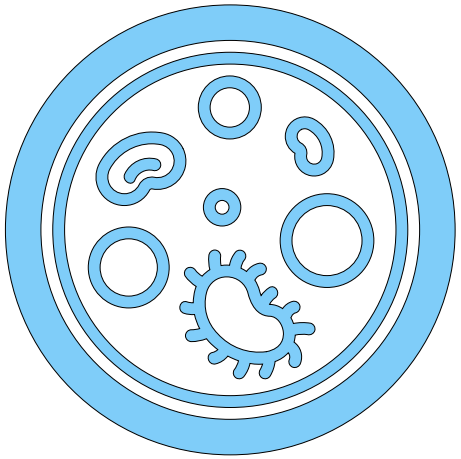
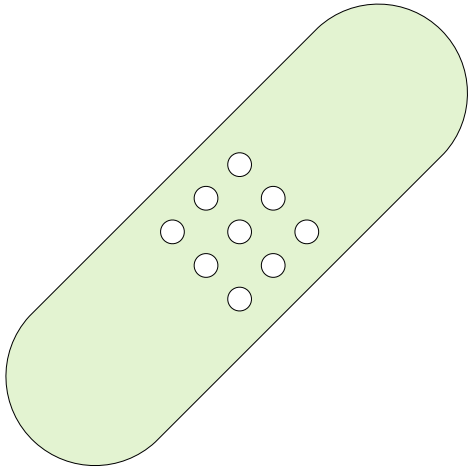
Ministry of Health, Ontario. Ontario Public Health Standards: Requirements for Programs, Services and Accountability. 2021.
https://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/protocols_guidelines/Ontario_Public_Health_Standards_2021.pdf

What is Syphilis?



Treatable bacterial STI spread through sexual contact & blood

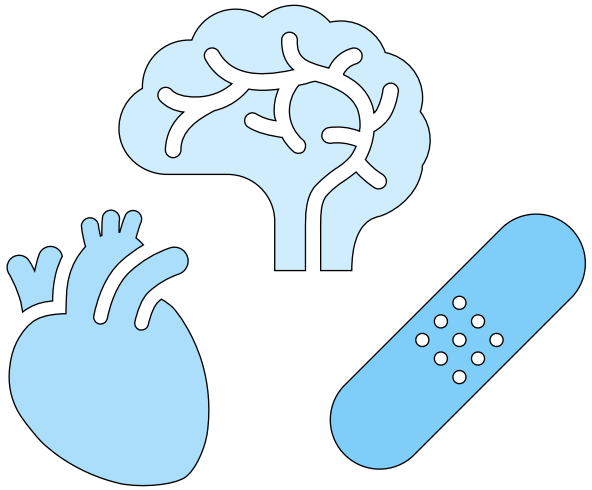


Primary symptom is a chancre (painless sore)

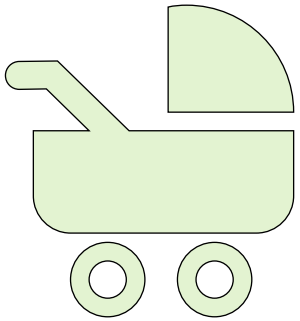
Disease of Public Health Significance (Reportable)

Public Health Ontario, Syphilis. 2025
https://www.publichealthontario.ca/en/Diseases-and-Conditions/Infectious-Diseases/Sexually-Transmitted-Infections/Syphilis
World Health Organization, Syphilis Fact Sheet. May 21, 2024.
https://www.who.int/news-room/fact-sheets/detail/syphilis

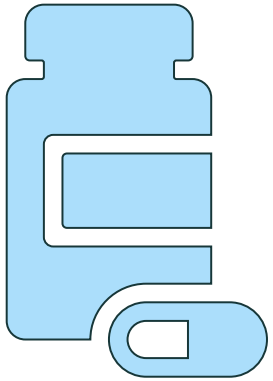
Complications of Syphilis



Life-threatening complications of the brain, heart, and/or other organs



Congenital syphilis and/or fetal death



Increased risk of other STIs

Government of Canada. Syphilis Guide: Risk factors and clinical manifestations. 2023. https://www.canada.ca/en/public-health/services/infectious-diseases/sexual-health-sexually-transmitted-infections/canadian-guidelines/syphilis/risk-factors-clinical-manifestation.html
The Society of Obstetricians and Genaecologists of Canada. Syphilis. N.d. https://www.sexandu.ca/stis/syphilis/
Canadian Paediatric Society. Diagnosis and Management of Congenital Syphilis – Avoiding Missed Opportunities. 2024. https://cps.ca/en/documents/position/congenital-syphilis
World Health Organization, Syphilis Fact Sheet. May 21, 2024.
https://www.who.int/news-room/fact-sheets/detail/syphilis

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Risk Factors of Syphilis

Behavioural Risk Factors	Epidemiological Risk Factors
• Barrierless sexual activity • Multiple sex partners • Substance use	• Population groups and/or communities experiencing high prevalence of syphilis • Homelessness and/or street involvement

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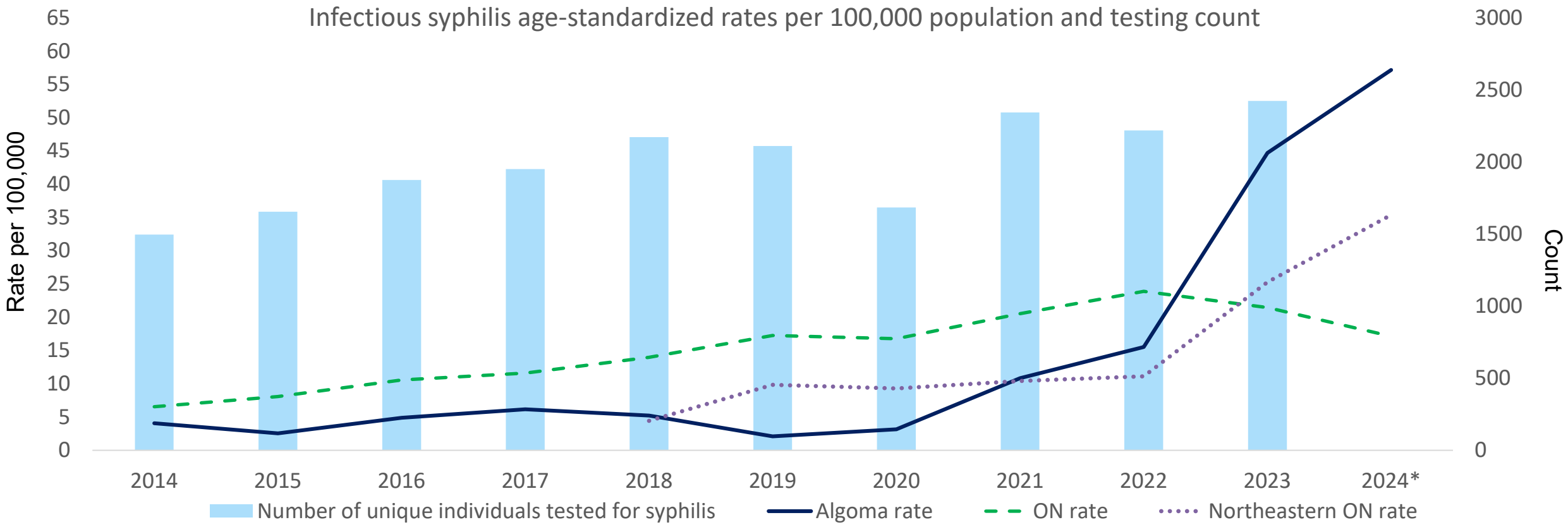
Government of Canada. Syphilis Guide: Risk factors and clinical manifestations. 2023. https://www.canada.ca/en/public-health/services/infectious-diseases/sexual-health-sexually-transmitted-infections/canadian-guidelines/syphilis/risk-factors-clinical-manifestation.html

Syphilis in Algoma



*Note that the rates for the year 2024 are still considered interim numbers.

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Syphilis data extracted from PHO ID query on January 3, 2025; Testing data extracted from PHOL data request March 5, 2024

The Role of Public Health

- ✓ Case & Contact Management (CCM)
- ✓ Health Care Provider (HCP) alerts & education – help with diagnosis, treatment, etc.
- ✓ Free condom distribution
- ✓ Disease surveillance
- ✓ Collaborate with partners to ensure access to clinical services
  - Increase local capacity for testing and treatment
  - Public Health Nurse Practitioner services available for clients without access
- ✓ Comprehensive health promotion planning

-> Opportunity to provide accessible testing to priority populations & reduce time between positive test & treatment!

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Now…The SPRITE Research Study!

- **S**yphilis **P**oint-of-Care **R**apid Testing & **I**mmediate **T**reatment **E**valuation
- Study is led by Southeast Health Unit (formerly KFL&A PH), with the goals of:

Monitoring metrics such as point-of-care rapid test (POCT) & immediate treatment performance in real-world settings

Understanding factors affecting delivery and usability of tests in a clinic and population health perspective

Developing a Community of Practice (CoP) among participating PHUs and another between PHUs and community-based organizations (CBOs) in their district

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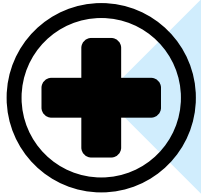
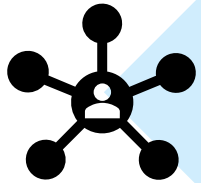
SPRITE @ APH



Host SPRITE events (testing & treatment)

Participate in CoP between SPRITE PHUs



APH-CBO knowledge exchange network

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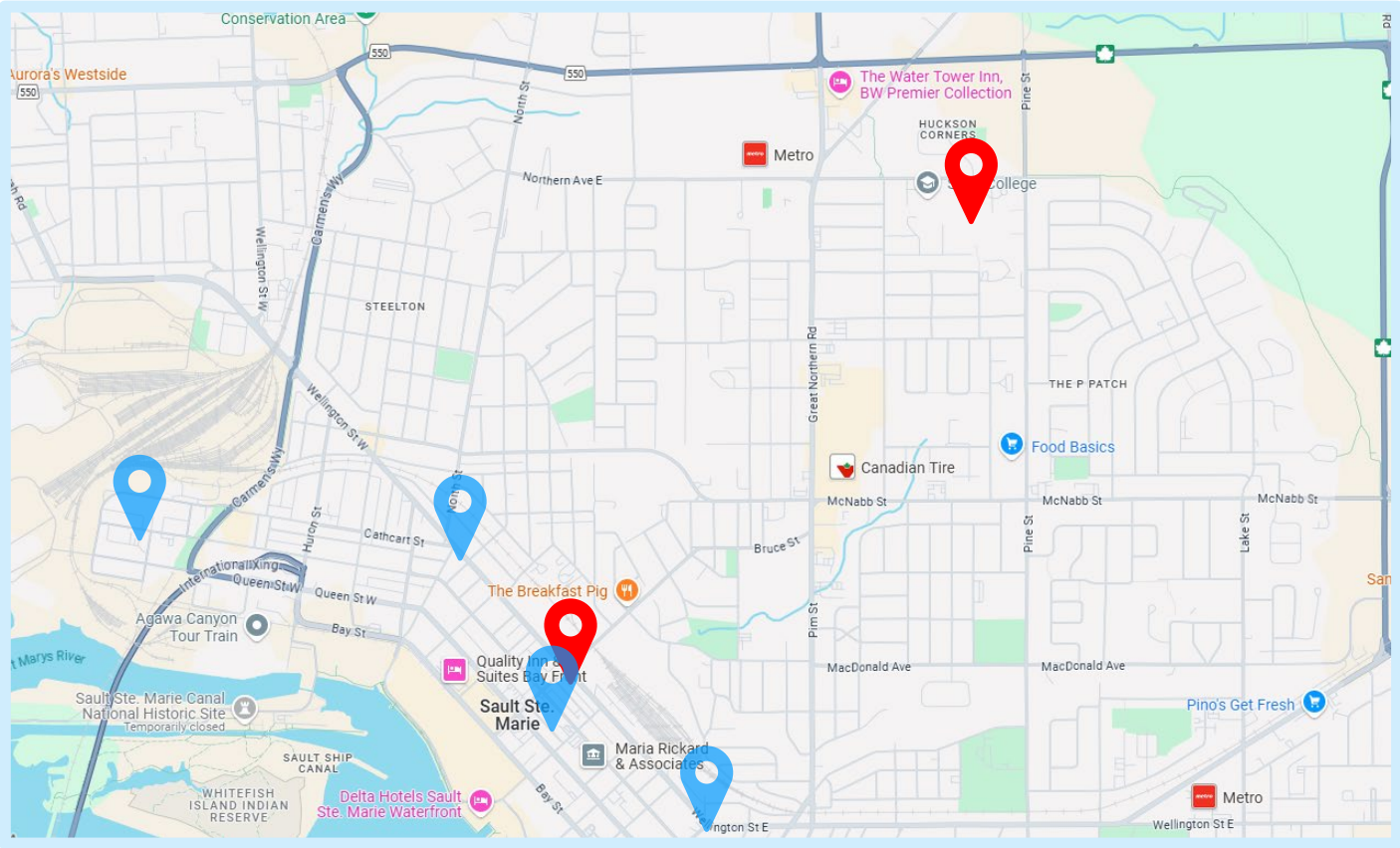
SPRITE Locations



Current test sites

Prospective test sites

Blind River

- APH Office

Elliot Lake

- APH Office
- The Beehive (CMHA)

Sault Ste. Marie

- APH (drop-in visits)
- HARP (316 Wellington St.)

Wawa

- Food Bank site

Map courtesy of Google Maps. https://www.google.ca/maps/place/Sault+Ste.+Marie,+ON/@46.5284314,-84.314624,15.25z/data=!4m6!3m5!1s0x4d36311508818c7b:0xc55b0eb513db21cd!8m2!3d46.5136494!4d-84.3357526!16zL20vMDFoaHli!5m1!1e1?entry=ttu&g_ep=EgoyMDI0MTIxMS4wIKXMDSoASAFQAw%3D%3D

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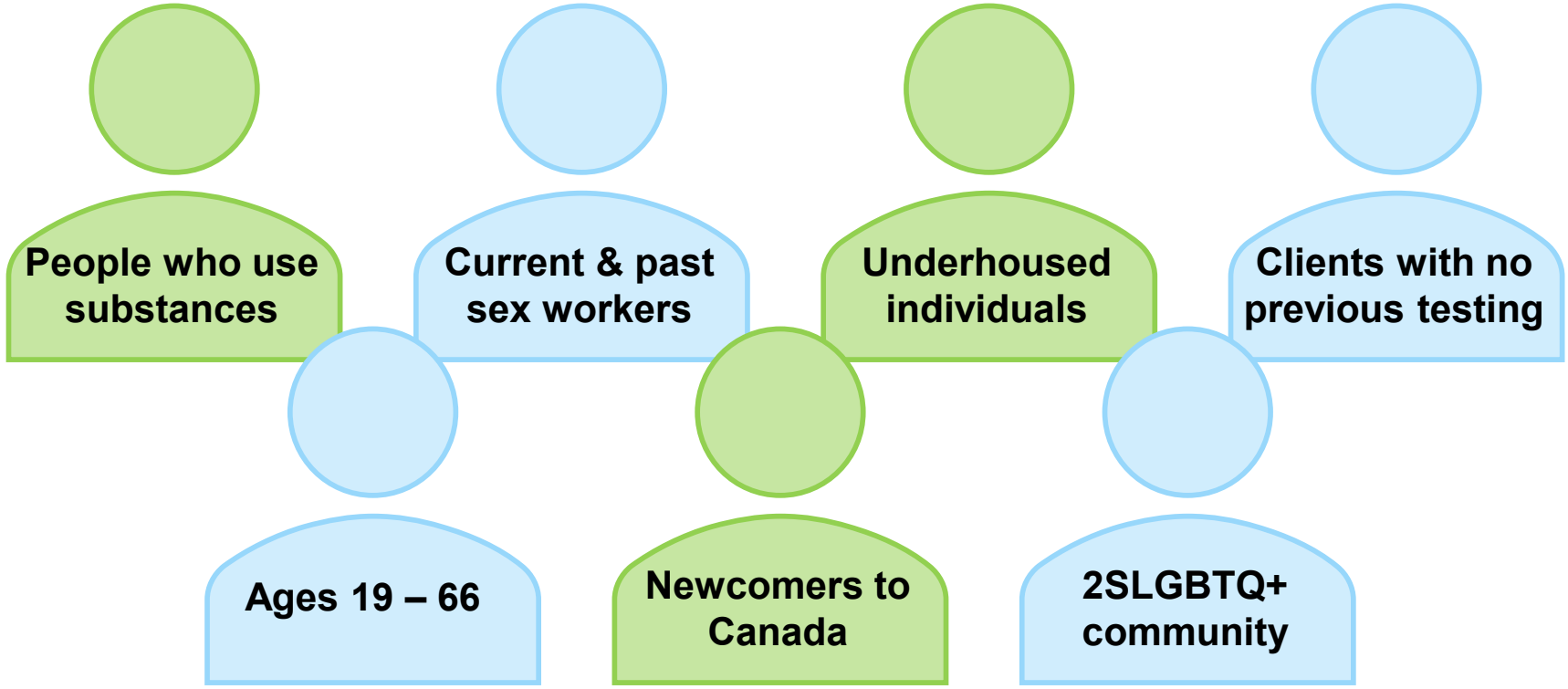
Who Have We Reached?



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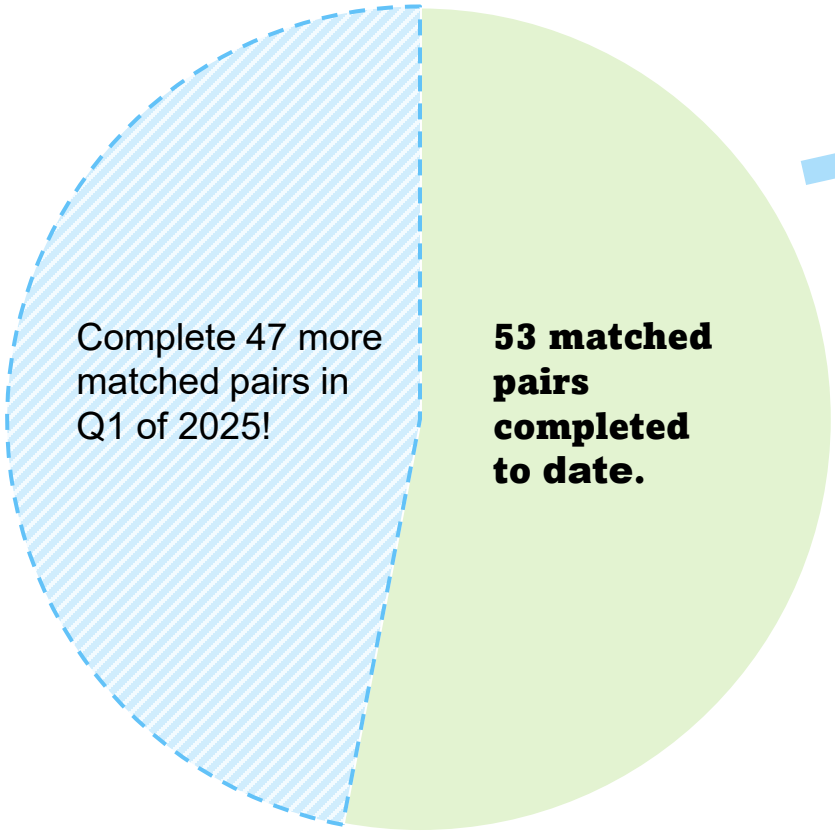
Results So Far (up to January 10, 2025)



7 clients had positive POCT

9 clients had positive blood test

Percent positivity in Algoma (2023)	**4%**
Percent positivity in SPRITE clients	**15%**

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What Have We Learned?

Strengths

- POCT allow for easy testing & reduce time between test and treatment
- Collaboration allows public health to go beyond what we can do at APH alone
- Outreach & incentivized testing were very effective for priority population attendance
- SPRITE allowed for immediate syphilis treatment

Limitations

- Clinic attendance requires word-of-mouth advertising
- Study was done in addition to staff's existing workload
- POCT show false positives and negatives in some situations

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What's Next For SPRITE?

- Complete 48 more POCT-serology matched pairs by March 2025
- Identify & partner with more CBOs district-wide
- Continue engaging with other PHUs to ensure highest quality research
- Start knowledge mobilization between APH & CBOs
- Use SPRITE findings to advocate for healthy public policy

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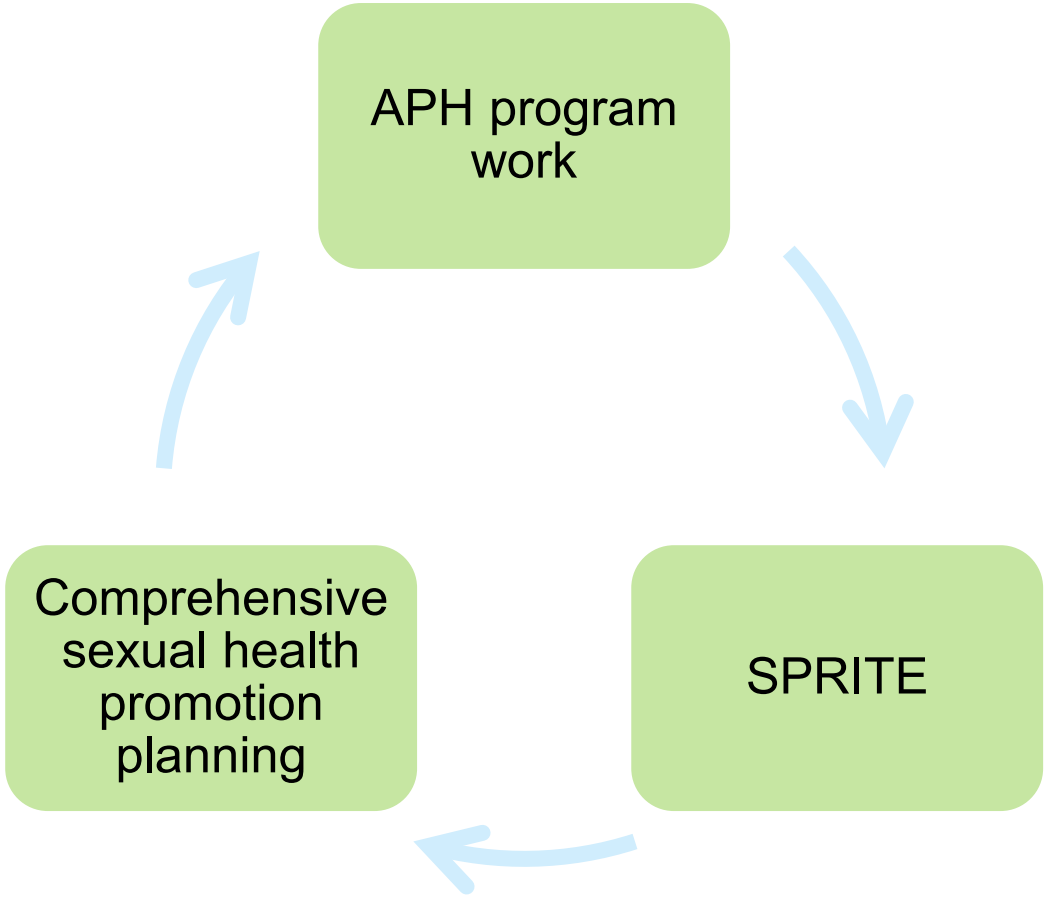
In Summary...



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Questions?

Chi-Miigwech. Merci. Thank You.

PUBLIC HEALTH

Algoma
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January 29, 2025

Report of the

Medical Officer of Health / CEO

Prepared by:
Dr. John Tuinema and the
Leadership Team

Presented to:
Algoma Public Health Board of Health

TABLE OF CONTENTS

APH AT-A-GLANCE

The new year brings changes to the landscape of local public health agencies in Ontario. On January 1st, the number of public health units (PHUs) changed from 34 to 29 as mergers were finalized. This means that the number of Northern PHUs changes from 7 to 6 with the merger of Porcupine and Timiskaming PHU. The new merged health unit will be known as Northeastern Public Health. They have much work to do to amalgamate their health units and we look forward to working with them in their new organization.

Mergers are just one aspect of Ontario's "Strengthening Public Health" initiative. Another aspect is the review of the Ontario Public Health Standards (OPHS). This was originally going to be implemented on January 1st, 2025, but delays have changed the implementation date to 2026. The final version of the new OPHS should be finalized by August. You can read the full Ministry of Health memo in the board package.

At the provincial level there has been a change in the Associate Chief Medical Officer of Health liaison for Northern PHUs. We are happy to welcome Dr. Kate Bingham to her new role and thank Dr. Fiona Kouyoumdjian and Dr. Wajid Ahmed, who jointly held this role, for their support over their tenure in that portfolio.

With the new year comes new changes to the board. APH thanks Matthew Shoemaker and Loretta O'Neill for their time serving on the board. We'd also like to welcome Sonny Spina and Natalie Zagordo, our newest board members. We will also have a new board chair this year. Sally Hagman has been our chair since 2021. It was no easy task being the chair of the Board of Health during the largest, most severe pandemic in over a century, so we are grateful for Sally's leadership during her tenure. We are looking forward to working with our new chair as we move beyond the pandemic and continue the important work of improving health for all in Algoma.

Algoma Public Health
(Unaudited) Financial Statements November 30, 2024

Algoma Public Health
Statement of Operations
November 2024
(Unaudited)

	Actual YTD 2024	Budget YTD 2024	Variance Act. to Bgt. 2024	Annual Budget 2024	Variance % Act. to Bgt. 2024	YTD Actual/ YTD Budget 2024
Public Health Programs (Calendar)						
Revenue						
Municipal Levy - Public Health	**$ 4,440,568**	$ 4,440,569	$ (1)	$ 4,440,569	0%	100%
Provincial Grants - Cost Shared Funding	**9,185,280**	9,185,193	87	10,020,210	0%	100%
Provincial Grants - Public Health 100% Prov. Funded	**2,137,487**	2,096,233	41,254	2,286,800	2%	102%
Provincial Grants - Mitigation Funding	**0**	0	-	0	-	-
Fees, other grants and recovery of expenditures	**514,020**	445,883	68,137	494,600	15%	115%
Total Public Health Revenue	**$ 16,277,355**	$ 16,167,878	$ 109,477	$ 17,242,179	1%	101%
Expenditures						
Public Health Cost Shared	**$ 13,743,602**	$ 13,701,965	$ (41,637)	$ 14,913,154	0%	100%
Public Health 100% Prov. Funded Programs	**2,258,160**	2,113,076	(145,084)	2,329,026	7%	107%
Total Public Health Programs Expenditures	**$ 16,001,762**	$ 15,815,042	$ (186,720)	$ 17,242,180	1%	101%
Total Rev. over Exp. Public Health	**$ 275,593**	$ 352,837	$ (77,244)	$ (0)		
Healthy Babies Healthy Children (Fiscal)						
Provincial Grants and Recoveries	**$ 760,506**	760,500	6	1,140,750	0%	100%
Expenditures	**733,977**	760,339	26,362	1,140,750	-3%	97%
Excess of Rev. over Exp.	**26,529**	161	26,368	-		
Public Health Programs (Fiscal)						
Provincial Grants and Recoveries	**$ -**	420,733	(420,733)	631,100	-100%	0%
Expenditures	**426,082**	422,326	(3,756)	631,100	1%	101%
Excess of Rev. over Fiscal Funded	**(426,082)**	(1,593)	(424,489)	-		
Fiscal Programs						
Revenue						
Provincial Grants - Community Health	**$ 158,104**	$ 158,102	$ 2	$ 262,153	0%	100%
Municipal, Federal, and Other Funding	**114,447**	114,447	-	114,447	0%	100%
Other Bill for Service Programs	**0**	0	-	-	#DIV/0!	#DIV/0!
Total Community Health Revenue	**$ 272,551**	$ 272,549	$ 2	$ 376,600	0%	100%
Expenditures						
Brighter Futures for Children	**79,074**	76,298	(2,776)	114,447	4%	104%
Nurse Practitioner	**109,820**	107,989	(1,831)	162,153	2%	102%
Stay on Your Feet	**60,999**	66,540	5,541	100,000	-8%	92%
Total Fiscal Community Health Programs	**$ 249,893**	$ 250,826	$ 934	$ 376,600	0%	100%
Total Rev. over Exp. Fiscal Community Health	**$ 22,658**	$ 21,723	$ 936	$ (0)		

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

Algoma Public Health
Revenue Statement
For Eleven Months Ending November 30, 2024
(Unaudited)

	Actual YTD 2024	Budget YTD 2024	Variance Bgt. to Act. 2024	Annual Budget 2024	Variance % Act. to Bgt. 2024	YTD Actual/ Annual Budget 2024	*Comparison Prior Year: YTD Actual 2023*	*YTD BGT 2023*	*Variance 2023*
Levies Sault Ste Marie	3,088,475	3,088,475	0	3,088,475	0%	100%	2,913,655	2,913,655	0
Levies District	1,352,093	1,352,094	(1)	1,352,094	0%	100%	1,275,562	1,275,562	0
Total Levies	**4,440,568**	**4,440,569**	**(1)**	**4,440,569**	**0%**	**100%**	**4,189,217**	**4,189,217**	**0**
MOH Public Health Funding	9,185,280	9,185,193	88	10,020,210	0%	92%	8,120,947	8,122,767	(1,820)
Total Public Health Cost Shared Funding	**9,185,280**	**9,185,193**	**88**	**10,020,210**	**0%**	**92%**	**8,120,947**	**8,122,767**	**(1,820)**
MOH Funding - MOH / AMOH Top Up	161,348	145,108	16,240	158,300	11%	102%	167,310	173,525	(6,215)
MOH Funding Northern Ontario Fruits & Veg.	107,617	107,617	0	117,400	0%	92%	107,622	107,617	5
MOH Funding Unorganized	486,200	486,200	0	530,400	0%	92%	486,200	486,200	0
MOH Senior Dental	1,267,489	1,267,475	14	1,382,700	0%	92%	1,235,017	1,237,729	(2,712)
MOH Funding Indigenous Communities	89,833	89,833	(0)	98,000	0%	92%	89,828	89,833	(5)
OTF COVID-19 Extraordinary Costs	25,000	0	25,000	0	#DIV/0!	100%	(6,954)	0	(6,954)
Total Public Health 100% Prov. Funded	**2,137,487**	**2,096,233**	**41,254**	**2,286,800**	**2%**	**93%**	**2,079,023**	**2,094,904**	**(15,881)**
Total Public Health Mitigation Funding	**0**	**0**	**0**	**0**	**#DIV/0!**	**0%**	**951,322**	**951,317**	**5**
Recoveries from Programs	22,869	27,500	(4,631)	29,600	-17%	77%	10,899	29,167	(18,268)
Program Fees	44,059	40,883	3,176	45,000	8%	98%	38,046	54,633	(16,587)
Land Control Fees	222,370	218,000	4,370	225,000	2%	99%	189,425	215,000	(25,575)
Program Fees Immunization	65,195	41,250	23,945	45,000	58%	145%	63,291	82,500	(19,209)
HPV Vaccine Program	11,118	15,000	(3,882)	20,000	-26%	56%	9,996	0	9,996
Influenza Program	445	0	445	16,000	#DIV/0!	3%	730	0	730
Meningococcal C Program	3,842	7,000	(3,158)	9,000	-45%	43%	1,479	0	1,479
Interest Revenue	134,476	96,250	38,226	105,000	40%	128%	159,963	30,052	129,911
Other Revenues	9,646	0	9,646	0	#DIV/0!	100%	5,200	13,750	(8,550)
Total Fees and Recoveries	**514,020**	**445,883**	**68,137**	**494,600**	**15%**	**104%**	**479,029**	**425,102**	**53,927**
Total Public Health Revenue Annual	**16,277,355**	**16,167,878**	**109,477**	**17,242,179**	**1%**	**94%**	**15,819,538**	**15,783,307**	**36,231**
Public Health Fiscal April 2024 - March 2025									
Infection Prevention and Control Hub	0	420,733	(420,733)	631,100	-100%	0%			
Total Provincial Grants Fiscal	**0**	**420,733**	**(420,733)**	**631,100**	**#DIV/0!**	**0%**	**0**	**0**	**0**

Algoma Public Health

Expense Statement- Public Health

For Eleven Months Ending November 30, 2024

(Unaudited)

	Actual YTD 2024	Budget YTD 2024	Variance Act. to Bgt. 2024	Annual Budget 2024	Variance % Act. to Bgt. 2024	YTD Actual/ Budget 2024	*Comparison Prior Year:* *YTD Actual 2023*	*YTD BGT 2023*	*Variance 2023*
Salaries & Wages	9,287,833	9,383,821	95,988	10,236,247	-1%	91%	$ 9,762,215	$ 9,930,308	$ 168,093
Benefits	2,428,766	2,470,605	41,839	2,665,034	-2%	91%	2,486,651	2,329,598	(157,053)
Travel	149,798	159,982	10,184	174,526	-6%	86%	166,128	145,567	(20,561)
Program	1,257,790	904,098	(353,692)	1,012,197	39%	124%	1,480,516	1,134,066	(346,450)
Office	51,501	55,367	3,866	60,400	-7%	85%	53,794	75,533	21,739
Computer Services	907,259	848,832	(58,427)	926,000	7%	98%	865,373	821,234	(44,139)
Telecommunications	236,922	223,669	(13,253)	244,000	6%	97%	268,217	242,915	(25,302)
Program Promotion	17,066	17,875	809	19,500	-5%	88%	32,405	41,250	8,845
Professional Development	53,574	46,847	(6,727)	51,105	14%	105%	43,167	73,722	30,555
Facilities Expenses	824,586	895,581	70,995	977,000	-8%	84%	861,624	846,997	(14,627)
Fees & Insurance	367,364	389,063	21,699	418,750	-6%	88%	392,955	368,208	(24,747)
Debt Management	419,302	419,303	1	457,421	0%	92%	419,302	419,302	0
	$ 16,001,761	$ 15,815,043	$ (186,718)	$ 17,242,180	**1%**	**93%**	$ 16,832,347	$ 16,428,700	$ (403,647)

Notes to Financial Statements – November 2024

Reporting Period

The November 2024 financial reports include eleven months of financial results for Public Health programming. All other non-funded public health programs are reporting eight months of results from the operating year ending March 31, 2025.

Statement of Operations (see page 1)

Summary – Public Health and Non-Public Health Programs

In June 2024, APH received the 2024 Amending Agreement from the Province identifying approved funding allocations for public health programs. Annual allocations for mandatory cost-shared programs and 100% funded public health programs are consistent with that previously communicated by the Province and in line with the Board approved budget, and thus, no updates have been made to the annual budget for public health programs.

In July 2024, APH received confirmation that the annual allocation for the Healthy Babies, Healthy Children program funded through the Ministry of Children, Community & Social Services has received a $73K base funding increase, which will be ongoing. This represents a 6.8% increase and is the first received since 2015. The funding increase is provided to help address increasing operational costs, and there is no expectation of service level expansion. The budget for this program has been updated to reflect new funding levels.

As of November 30, 2024, Public Health calendar programs are reporting a $77K negative variance – which is driven by a $187K negative variance in expenditures and a $109K positive variance in revenue.

Public Health Revenue (see page 2)

Our Public Health calendar revenues are within 1% variance to budget for 2024.

Per the 2024 grant and budget schedule of the funding and accountability agreement, provincial base funding allocated to APH has been restored to the level provided under the 2020 cost-share formula, as well as been allocated base funding growth of 1% over 2023 allocations.

In early January 2024, the Ministry requested public health units to forecast anticipated spend on COVID immunization programming for the months of January through March 2024 only. Based on the forecast provided, APH was approved for $25,000 in one-time program enhancement funding to help address base funding pressures for the first three months of the calendar year. Based on communications to date, there will be no further availability of COVID-19 extraordinary funds or mitigation funding in 2024. One time funding requests to address financial pressures above and beyond what can be supported by the cost shared budget were also not made available via the 2024 Annual Service Plan (which was due to the Ministry on April 2, 2024), nor were they made available in year.

In March 2024, the Ministry confirmed that IPAC Hub funding will continue in the 2024-25 fiscal year and in the years following, with formal planning and funding meetings with individual hubs to be forthcoming throughout the fiscal year. This funding has been provided to hubs across the province in

order to enhance IPAC practices in identified congregate care settings. Formal funding approvals for this initiative were received in early December 2024, which includes $316K in committed base funding and $316K in one-time funding for the 2024/25 fiscal year for a total of $631K for the current fiscal year.

Public Health Expenses (see page 3)

Program Expenses

There is a $354K negative variance associated with program expenses. The majority of this identified pressure is driven by demand for our Ontario Senior Dental program (externally sourced professional services for maintenance, preventative and denture services). We note that APH has requested an increase to base funding totaling $641K for the 100% funded Ontario Senior Dental program alongside the 2024 Annual Service Plan to fund these identified pressures. We await a response to this request; however, we continue to service our communities based on demand, considering conversations with the Ministry where APH has been instructed to continue programming as planned, with funding opportunities to continually be made available to address ongoing pressures.

Financial Position - Balance Sheet (see page 7)

APH's liquidity position continues to be stable and the bank has been reconciled as of November 30, 2024. Cash includes $2.1M in reserve funds.

Long-term debt of $4.1 million is held by TD Bank @ 1.80% for a 60-month term (amortization period of 120 months) and matures on September 1, 2026. $239k 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 November 2024	November 2024	December 2023
Assets		
Current		
Cash & Investments	$ 5,311,669	$ 4,663,966
Accounts Receivable	1,010,468	2,089,635
Receivable from Municipalities	35,888	6,482
Prepaid Expenses	175,435	128,517
Subtotal Current Assets	6,533,460	6,888,600
Financial Liabilities:		
Accounts Payable & Accrued Liabilities	1,169,298	1,402,404
Payable to Gov't of Ont/Municipalities	3,215,958	3,426,716
Deferred Revenue	277,871	280,411
Employee Future Benefit Obligations	2,835,275	2,835,275
Term Loan	3,308,095	3,308,095
Subtotal Current Liabilities	10,806,498	11,252,901
Net Debt	(4,273,038)	(4,364,301)
Non-Financial Assets:		
Building	23,072,474	23,072,474
Furniture & Fixtures	2,145,864	2,145,864
Leasehold Improvements	1,583,164	1,583,164
IT	3,372,128	3,372,128
Automobile	40,113	40,113
Accumulated Depreciation	-13,300,309	-13,300,309
Subtotal Non-Financial Assets	16,913,434	16,913,434
Accumulated Surplus	12,640,396	12,549,133

Algoma PUBLIC HEALTH
Santé publique Algoma
www.algomapublichealth.com

Briefing Note

To: The Board of Health for the District of Algoma Health Unit
From: Dr John Tuinema, MOH/CEO
Date: 1/29/2025
Re: Partnership Agreement Renewal - Algoma Ontario Health Team

☐ **For Information** ☐ **For Discussion** ☒ **For a Decision**

ISSUE:

Algoma Public Health (APH) and the Algoma Ontario Health Team's (AOHT) partnership agreement is due for renewal.

RECOMMENDED ACTION:

That APH renew our partnership with the AOHT as a collaborative partner.

BACKGROUND:

The Board of Health has previously agreed to partnership agreements with AOHT as a core partner. APH leadership regularly attends the meetings of the AOHT Leadership Council and provides input as relevant. AOHT is renewing and moving forward with a new agreement for partnerships that requires core partners to share in the legal liability of the AOHT. After considering the core functions and role of public health, reviewing the new agreement, and following discussion with AOHT leadership, APH has decided that we would be best suited to transition from being a "core" partner to a "collaborative" partner. This will still allow for APH to be an involved partner and continue to provide input and feedback, while not being required to take on liability for the AOHT.

ASSESSMENT OF RISKS AND MITIGATION:

As a core member, we are one of 22 voting members. As a collaborative member, APH would no longer be a voting member. Decisions at the AOHT typically involve downstream healthcare services outside of the usual scope of public health. APH would still be able to participate in AOHT leadership council meetings and provide input.

FINANCIAL IMPLICATIONS:

None

OPHS STANDARD:

Principles - Partnership, Collaboration, and Engagement

STRATEGIC DIRECTION:

2 d. Meaningfully engage clients, partners, and communities based on shared goals and accountabilities.

CONTACT:

Dr John Tuinema – Medical Officer of Health/CEO, Algoma Public Health

ÉQUIPE SANTÉ
ALGOMA ONTARIO
HEALTH TEAM

ALGOMA ONTARIO HEALTH TEAM
COLLABORATIVE DECISION MAKING AGREEMENT

This **Collaborative Decision Making Agreement** is made as of ~~April 1, 2024~~. (to be determined)

BETWEEN AND AMONG:

Algoma Public Health

(hereinafter "Member Organization")

-and-

Algoma Ontario Health Team
(hereinafter "Algoma OHT")

Background

1. Algoma Ontario Health Team was designated on July 23, 2020 by the Ministry of Health under the *Connecting Care Act, 2019*.
2. We are not a corporation, partnership, joint venture or other legal entity. We cannot contract except through our members. That means, for all employment agreements, technology agreements, funding agreements, leases, vendor/service contracts, and insurance packages etc. the fund holder, or a group of members to contract on behalf of all of us.
3. This Agreement governs how the Member Organizations will work together both before and after designation as an Ontario Health Team.

As the Algoma OHT functions as an Ontario Health Team under the *Connecting Care Act, 2019* and, as such, the Algoma OHT will be the recipient of funding from the Ministry of Health and/or Ontario Health. The Member Organizations will contribute resources (e.g., funds, people, capital, and facilities) to the shared priorities and accountabilities of the Algoma OHT as may be agreed, such contributions to be made recognizing different abilities and depth in resources and funding.

Definitions

In this Agreement:

(a) "**Agreement**" means this collaboration agreement, and includes all schedules, as amended from time to time.

(b) "**Confidential Information**" means information of a Member Organization that by its nature is confidential and proprietary but does not include information that:

(i) was known to or received by the receiving Member Organization before its receipt from the disclosing Member Organization (unless acquired on a confidential basis), and such knowledge or receipt is documented);

(ii) was public knowledge at the time received by the receiving Member Organization or later became public knowledge through no fault of the receiving Member Organization; or

(iii) was independently developed by a Member Organization without reference to the Confidential Information previously disclosed by a Member Organization.

(c) "**Project**" means a collaboration on specific strategies, initiatives, programs, and services as described in this Agreement.

(d) "**Project Agreement**" means any agreement executed by the participating Member Organizations and, where applicable, Participants, that sets out the details about a specific Project.

(e) "**Member Organizations**" means the signatories to this Agreement.

(f) "**Algoma OHT**" means the Algoma - Ontario Health Team, comprised of the Member Organizations.

Non-Derogation. Nothing in this Agreement shall derogate from the Member Organization's ongoing autonomy of its board of directors, or its right to safeguard the quality of health services provided by it, or to exercise its respective rights and meet its respective responsibilities under applicable laws and any government funding agreements.

Shared Vision, Guiding Principles, and Commitments

Member Organizations, as signatories to this agreement, agree to collaborate with the Algoma OHT and other Member Organizations on a shared vision, mission, and guiding principles.

Vision

An integrated health system focused on the unique needs of Algoma residents; where people receive seamless, excellent care where and when they need it.

Mission

The Algoma OHT will collaborate in a model of care that is person-centred, efficient, and simplified for both individuals and providers.

Guiding Principles

People and inclusion	• Engagements, planning and actions that are inclusive of diverse perspectives and needs of all people • Endeavour to attain perspectives of all relevant geographies and vulnerable populations • Design of population-based programing, aiming to improve health outcomes; acknowledging socio-demographic factors may put populations at greater risk • Provision of culturally sensitive and safe care • Commitment to engagement and reconciliation with the Indigenous population (e.g. development of work plan for enhanced cultural competency) • Commitment to both official languages (e.g. training opportunities and utilizations of resources and translation)
Access, responsiveness, and empowerment	• Focused efforts to improve health care equity, access and coordination • Person-centered and community-empowered decision-making and prioritization of needs and services • Commitment to responsiveness to individuals, families, partners and communities
Efficiency and efficacy	• Endeavour to remove waste and barriers within the system • Efforts to achieve collaborative solutions to identified gaps in services • Commitment to efficient, effective utilization and maximization of fiscal and human resources • Efforts to prevent redundancies and development of linkages to (and from) existing, relevant community tables/work groups/committees
Partnership and behaviour	• Demonstrations of mutual respect by all • Development of enhanced and trusting partnerships • Effective and transparent communication

Knowledge and quality	• Inclusion and analysis of relevant data and social determinants of health in planning, decision-making and continuous quality improvement efforts • Remain well-versed in Ontario Health's Quality expectations
Valuing of human resources	• Commitment to improving work-life of AOHT's collective workforce • Provision of shared educational opportunities for identified knowledge gaps

Commitments

Member Organizations will participate as contributing partners to the Algoma OHT objectives, mission, and vision. Member Organizations will be classified as one of three types of partners: core, collaborative or community.

Partnership types will be first determined by the primary sector served as identified by the member organization. If there is a difference in how the member organization views its level of participation in Algoma OHT, the Leadership Council will discuss a reasonable solution.

Member Organizations will participate in the Algoma OHT as one of the following partnerships:

	Core Partner	**Collaborative Partner**	**Community Partner**
Sectors included	Primary Care, Mental Health & Addictions, Acute Care, Home & Community Care Support Services, Home Care Providers Health Promotion, Social Services, Community Support Services, and Long Term Care	Congregate Care, Palliative Care, Rehabilitative Services, Specialized Services, Pharmacies, NFP with marginalized or specialty populations, and Maamwesying OHT.	Ontario Health North, relevant government ministries, Educational Institutions, Community PFACs, Advocacy Groups
Strategic alignment	Boards and leads agree to the vision and mission of the Algoma OHT. Strong alignment between organizational priorities and Algoma OHT strategy.	Boards and leads agree to the vision and mission of the Algoma OHT. Organizational strategic direction is informed by the Algoma OHT direction.	Understand the vision and mission of the Algoma OHT.
Decision-making roles and responsibilities	Directly involved in AOHT decision making. Provides strategic direction and prioritizes committee work.	Makes recommendations and provides input and expertise. Participates in committees reporting to the Leadership Council.	Is kept informed of Algoma OHT strategic directions and upcoming priorities.

Accountabilities and resource allocations	Assume leadership roles within AOHT committees and working groups. Commits resources to the AOHT (financial, human, communications, or in-kind). Signs Fund Holder and Indemnity Agreement.*	Participates in Algoma OHT committees and working groups based on expertise and alignment to organizational strategic direction.	May participate or partner in Algoma OHT exploration, consultations and on working groups based on expertise.
Commitments of membership	Attending 80% Leadership Council meetings (including sending decision-making delegate). Leading AOHT committees and working groups.	Attending 80% Leadership Council meetings (including sending decision-making delegate). Supporting AOHT committees and working groups.	

All Member organizations will review the Algoma OHT Terms of Reference outlined in ***Appendix 1*** for Algoma OHT Leadership Council Terms of Reference.

[1]*Medicine Professional Corporations are not required to sign the Fund Holder Indemnity Agreement to be considered a Core Partner.

Member Onboarding

As a member organization of the Algoma OHT, in all levels of partnership, the member must agree to engaging with the Algoma OHT

To become a member of the Algoma OHT will require the following three items:

1. Resolution from the organization's board of directors to join and adhere to the mission and vision of the Algoma OHT. If it is not reasonable to obtain a board resolution due to national boards, written commitment from senior leadership is sufficient.
2. Declare the primary sector the organization is representing within the Algoma OHT.
3. Senior leader to sign the Collaborative Decision Making Arrangement (CDMA).

Governance

The Algoma OHT will be governed by member organizations who have signed as partners and agree to the vision and mission of the Algoma OHT. Leadership Council will be the decision making body of the Algoma OHT, composed of representatives from Core Member Organizations. An Executive Committee will chair the Leadership Council with collaboratives reporting into Leadership Council focusing on project work, ensuring a variety of voices and effective OHT performance.

Leadership Council

Member organizations will establish the Leadership Council as the collaborative decision making body of the Algoma OHT. Leadership Council will be composed of representatives from all core partners. The mandate, and processes of the Leadership Council are set out in the Algoma OHT Leadership Council Terms of Reference.

Executive Committee

Member organizations will establish the Executive Committee (Tri-Chairs) or the Algoma OHT. The tri-chair shall be elected by Leadership Council and will be composed of:

1. Member of Leadership Council
2. Primary Care Provider
3. Patient/Client, Family or Caregiver

Collaboratives

To support the mission of the Algoma OHT, collaboratives will be established with membership from all partner types, but led by core partner representatives. Collaboratives will ensure that the critical work of the Algoma OHT is conducted in a representative and coordinated manner.

Patient/Client, Family, and Caregiver Involvement

Members of the Algoma OHT recognize the critical importance of patient and caregiver involvement in system transformation. Each member of the Algoma OHT will ratify within their organization the Patient, Family and Caregiver Declaration of Values for the Algoma OHT.

Patient/Client, Family, and Caregiver advisors will be engaged in different ways:

1. A Tri-Chair member will be a Patient/Client, Family, and Caregiver.
2. Advisors will be included directly in projects and committee work to reflect co-design principles.
3. Specific Patient, Family and Caregiver councils will be established based on Algoma OHT focused priorities and will support system-level work with a direct lens on primary care.

To become a patient/client, family or caregiver advisor, the individual must respond to an Expression of Interest (EOI) initiated by the Algoma OHT. After receiving an EOI response, the individual will engage in a short interview process. If selected, the individual will be oriented and onboarded, which includes signing confidentiality agreements and attesting to the alignment with the Algoma OHT's vision, mission and guiding principles.

Consensus Based Decision-Making

Members organizations of the Algoma OHT agree to adhere to a consensus based decision-making model which values a fair and collaborative approach and reduces barriers to decision

making. Consensus based decision-making starts with the identification of an opportunity, followed by open discussion, deliberation and a recommendation based on the discussion. The meeting chair will then ask partners to decide on the recommendation using one of the following four responses:

1. I support the recommendation;
2. I have concerns, but can live with the recommendation;
3. I have concerns and can live with the recommendation, but my organization will not implement or adopt the proposed solution within our policies, procedures, protocols, or services; or
4. I cannot support the recommendation and modification to the proposal is necessary.

If any Member Organization cannot support the decision (Number 4) or if 25% of the partners will not be able to implement the recommendation (Number 3), then the opportunity will be modified given the feedback provided by the partners. A reasonable number of modifications can be made before the proposal is determined to be abandoned.

To ensure success of the consensus based decision-making model, the following principles must be followed:

1. No votes - every Member Organization identifies their position using the model
2. Meeting quorum of 50% + 1 of all core partners (or participant on a collaborative) before a recommendation can be decided upon
3. All Member Organizations are expected to review recommendations with a person-focused and system level perspective

Privacy

For the purposes of the Algoma OHT:

(a) The Member Organizations will share personal health information with one another for the purposes of providing health services, and coordinating its provision, in accordance with applicable laws.

(b) Member Organizations will enter into a data sharing agreement in respect of sharing personal health information for all other purposes.

Confidentiality

Member Organizations shall not disclose any Confidential Information of another Member Organization to a third party, except: with written consent of the relevant Member Organization; to the extent that disclosure is necessary to meet applicable laws or governmental

or public authority directives or other requirements; or as permitted under the terms of this Agreement.

Loss or Compromise of Confidentiality

If a Member Organization discovers any loss or compromise of the Confidential Information of another Member Organization, it will notify the Member Organization promptly and cooperate with it to mitigate the loss or compromise. Upon request, each Member Organization shall return or destroy (with certification to the relevant Member Organization) all Confidential Information of the relevant Member Organization that it is not required to retain by applicable laws or other requirement. However, each Member Organization may, at its option, retain one copy of such Confidential Information in its files for archival purposes subject always to the obligations of confidentiality under this Agreement. Each Member Organization may use the Confidential Information of another Member Organization to exercise its rights and protect its interests under this Agreement and as required by applicable laws. For greater certainty, this provision applies to the Confidential Information of a Member Organization. Any loss or compromise of personal health information shall be addressed in accordance with applicable laws and any data sharing agreement entered into between and/or among the Member Organizations.

Public Notices and Media Releases

All notices to third parties and all other publicity concerning this Agreement or the Algoma OHT shall be planned, co-ordinated, and approved by the Leadership Council, and no Member Organization shall act unilaterally in this regard without the prior approval of the Member Organizations through the Leadership Council, except where required to do so by applicable laws or governmental or public authority requirements. The spokespersons for the Algoma OHT shall be such member or members of the Leadership Council as determined by the Leadership Council from time to time.

Dispute Resolution

The Member Organizations shall use their best efforts to avoid disputes by clearly articulating expectations, establishing clear lines of communication, and respecting each Member Organization's interests. However, if a dispute arises, the Member Organizations shall follow the below-mentioned procedures, acting in good faith:

(a) The Member Organizations shall engage in on-going communication and disclosure and shall provide information to each other and to the Leadership Council and its subcommittees and working groups to achieve the benefits of this Agreement.

(b) Each Member Organization will try to eliminate, minimize, or mitigate any conflict between the Algoma OHT and its other contractual and service obligations and relationships outside of the Algoma OHT.

(c) If a Member Organization becomes aware of any fact or circumstance that may harm that or another Member Organization's ability to perform its obligations under this Agreement or a Collaboration or Project Agreement, it will promptly notify the Leadership Council and the other Member Organizations of the nature of the fact or circumstance and its anticipated impact so that the Member Organizations through the Leadership Council may consider how to remedy, mitigate, or otherwise address the fact or circumstance.

(d) The Member Organizations shall use their best efforts to resolve any disputes in a collaborative manner through informal discussion and resolution. To facilitate and encourage this informal process, the Member Organizations involved in the dispute shall use their best efforts to jointly develop a written statement describing the relevant facts and events and listing options for resolution. If these efforts do not lead to a resolution, any involved Member Organization shall refer it to the Leadership Council.

(e) The Leadership Council shall work to resolve the dispute in an amicable and constructive manner. If the Leadership Council members have made reasonable efforts, and the dispute remains unresolved, the Leadership Council shall refer it to the Executive Committee (Tri-Chairs).

(f) The Executive Committee (Tri-Chairs) shall work to resolve the dispute in an amicable and constructive manner. If the Tri-Chairs have made reasonable efforts, and the dispute remains unresolved, the Executive Committee (Tri-Chairs) shall appoint a third-party mediator. Each party to the mediation shall pay its own costs of mediation. The costs of the mediator shall be split equally between the parties in dispute; that is, as an example, if one Member Organization ("**First Party**") is in dispute with all of the other Member Organizations ("**Second Party**"), then the costs of the mediator shall be split 50 % to the First Party and 50 % to the Second Party.

(g) If a dispute cannot be resolved, as determined by any Member Organization after following these procedures, a Member Organization may withdraw from the applicable Project, Project Agreement, or this Agreement.

Term, Termination, Withdrawal, and Expulsion

Term

This Agreement shall start on the date of this Agreement and shall continue indefinitely, unless terminated.

Termination of Agreement

The Member Organizations may only terminate this Agreement by mutual written agreement.

Withdrawal

A Member Organization may withdraw from this Agreement by providing at least 90 days' notice to the other Member Organizations.

Expulsion

A Member Organization may be expelled from the Algoma OHT, and thereby cease to be a party to this Agreement. Reasons for expulsion may include if the Member Organization is not meeting its commitments under this Agreement or a Project Agreement, no longer agrees to the vision of the Algoma OHT, or is disruptive to the consensual governing process at Leadership Council meetings. An expulsion may take place after following these procedures:

(a) All of the Leadership Council members, other than the member representing the Member Organization at issue, must unanimously agree that expulsion is advisable.
(b) Following such agreement, the Leadership Council members shall, in writing, notify the Member Organization at issue that it intends to recommend their expulsion to the other Member Organizations.

(c) If reasonable in the circumstances, as determined by the Leadership Council members, the Member Organization may be provided with an opportunity to rectify the issue(s) within a time period reasonably directed by such Leadership Council members.

(d) If it is not reasonable to allow for an opportunity for rectification or if rectification does not occur within the time period provided to the reasonable satisfaction of the other Leadership Council members, such Leadership Council members shall make a recommendation for expulsion to all of the other Member Organizations.

(e) All of the Member Organizations, other than the Member Organization at issue, shall consider the recommendation and must, in writing through their authorized signatories, unanimously agree to the expulsion. Upon such written agreement, this Agreement shall be deemed amended to remove the expelled Member Organization as a party.

(f) Submission to the dispute resolution procedures under this Agreement shall be a pre-condition to expulsion.

Consequences of Termination, Withdrawal or Expulsion

(a) A Member Organization who withdraws or is expelled from this Agreement shall cease to be a party to this Agreement and shall cease to be a member of the Algoma OHT.

(b) Termination of, or withdrawal or expulsion from, this Agreement shall not automatically constitute termination of, or withdrawal or expulsion from, any Project or Project Agreement.

(c) Withdrawal from or termination of a Project or a Project Agreement shall not automatically constitute withdrawal from or termination of this Agreement or any other Project or Project Agreement, as the case may be.

(d) A Member Organization who withdraws or is expelled from this Agreement or withdraws from a Project or Project Agreement, as the case may be, and shall remain accountable for its commitments and obligations, actions and omissions before the effective date of the withdrawal or expulsion and shall work with the Leadership Council to develop strategies to reasonably fill any resource or service gaps left by the withdrawing or expelled Member Organization.

General

Independent Contractors

The relationship between the Member Organizations under this Agreement is that of independent contractors. This Agreement is not intended to create a partnership, agency, or employment relationship between or among the Member Organizations. No Member Organization shall have the power or authority to bind another Member Organization or to assume or create any obligation or responsibility, expressed or implied, on another Member Organizations' behalf or in its name, nor shall it hold itself out to any third party as a partner, agent, or employee of another Member Organization. Each Member Organization shall be responsible and liable for its own employees, agents, and subcontractors, unless otherwise agreed to in a Project Agreement.

Notices

Where in this Agreement a Member Organization must give or make any notice or other communication, it shall be in writing and is effective if delivered personally or sent by electronic means addressed to the intended Member Organization at the address set below its respective signature. Notice or communication shall be deemed received one Business Day after delivery or sending. The address of a Member Organization may be changed by notice as provided in this Section. "**Business Day**" means any working day, Monday to Friday, excluding statutory holidays observed in Ontario.

Entire Agreement

With respect to its subject matter, this Agreement contains the entire understanding of the Member Organizations and supersedes all previous negotiations, representations, understandings, and agreements, written or oral, between and among the Member Organizations respecting the subject matter of this Agreement.

Amendment

This Agreement may be amended only by mutual written agreement. If a change in law or a directive from the Minister of Health or other governmental or public authority necessitates a change in the manner of performing this Agreement, the Member Organizations shall work cooperatively to amend this Agreement to accommodate the change. A Project Agreement may

be amended in accordance with the provisions of the Project Agreement without necessitating an Agreement amendment.

Assignment

No Member Organization may assign its rights or obligations under this Agreement without the prior written consent of the other Member Organizations. This Agreement inures to the benefit of and binds the Member Organizations and their respective successors and permitted assigns. Notwithstanding the foregoing, a Member Organization may assign this Agreement without consent in the event of an integration order of the Minister of Health.

No Waiver

No waiver of any provision of this Agreement is binding unless it is in writing and signed by the Member Organization entitled to grant the waiver.

Severability

Each provision of this Agreement is distinct and severable. Any declaration by a court of competent jurisdiction of the invalidity or unenforceability of any provision shall not affect the validity or enforceability of any other provision.

Counterparts

This Agreement may be executed in any number of counterparts, each of which shall be deemed to be original and all of which taken together constitutes one agreement. Delivery of an executed counterpart of this Agreement electronically in legible form shall be equally effective as delivery of a manually executed counterpart of this Agreement.

Governing Law

This Project Agreement is governed by, and interpreted and enforced in accordance with, the laws of the Province of Ontario and the laws of Canada applicable in the Province of Ontario.

Survival

The following survive a Member Organization's withdrawal or expulsion from or termination of this Agreement:

- Any information provided or data contributed to the work of the Algoma OHT prior to withdrawal or expulsion from or termination.
- Identification as an Algoma OHT Member Organization previous to the date of withdrawal or expulsion from or termination.
- Any financial or in-kind contribution will remain with the Algoma OHT.

Signatures

The Member Organizations have executed this Agreement.

IN WITNESS OF WHICH the Parties have signed and delivered this Agreement.

Algoma Ontario Health Team

Per: _____

Name: Victoria Aceti Chlebus

Title: Director, Integrated Care

Pursuant to 'Commitments' we hereby sign this CDMA acknowledging and committing to the role of:

☐Core Partner

Or -

X Collaborative Partner

Algoma Public Health

Per: _____ Per: _____

Name: _____ Name: _____

Title: _____ Title: _____

I have authority to bind the company. I have authority to bind the company

Appendix 1: Algoma OHT Leadership Council Terms of Reference

Algoma Ontario Health Team (AOHT) Leadership Council
Terms of Reference

Background

The Algoma Ontario Health Team (AOHT) was approved on the 23rd day of July, 2020 by the Minister of Health under the Connecting Care Act, 2019. This approval came with the intention to work together to achieve their shared vision of providing a continuum of integrated health, social and health promotion services to the persons to whom they provide care and services for the people of Algoma.

1.1 Mandate: The Algoma Ontario Health Team (AOHT) has a vision for an integrated health system focused on the unique needs of Algoma residents; where people receive seamless, excellent care where and when they need it. The Leadership Council's role is to provide a forum for its Members to plan, design, implement and oversee the AOHT.

1.2 Vision: An integrated health system focused on the unique needs of Algoma residents; where people receive seamless, excellent care where and when they need it.

1.3 Mission: The Algoma OHT will collaborate in a model of care that is person-centered, efficient and simplified for both individuals and providers.

1.4 Guiding Principles

People and inclusion	• Engagements, planning and actions that are inclusive of diverse perspectives and needs of all people • Endeavour to attain perspectives of all relevant geographies and vulnerable populations • Design of population-based programing, aiming to improve health outcomes; acknowledging socio-demographic factors may put populations at greater risk • Provision of culturally sensitive and safe care • Commitment to engagement and reconciliation with the Indigenous population (e.g. development of work plan for enhanced cultural competency) • Commitment to both official languages (e.g. training opportunities and utilizations of resources and translation)

Access, responsiveness, and empowerment	• Focused efforts to improve health care equity, access and coordination • Person-centered and community-empowered decision-making and prioritization of needs and services • Commitment to responsiveness to individuals, families, partners and communities
Efficiency and efficacy	• Endeavour to remove waste and barriers within the system • Efforts to achieve collaborative solutions to identified gaps in services • Commitment to efficient, effective utilization and maximization of fiscal and human resources • Efforts to prevent redundancies and development of linkages to (and from) existing, relevant community tables/work groups/committees
Partnership and behaviour	• Demonstrations of mutual respect by all • Development of enhanced and trusting partnerships • Effective and transparent communication
Knowledge and quality	• Inclusion and analysis of relevant data and social determinants of health in planning, decision-making and continuous quality improvement efforts • Remain well-versed in Ontario Health's Quality expectations
Valuing of human resources	• Commitment to improving work-life of AOHT's collective workforce • Provision of shared educational opportunities for identified knowledge gaps

Planning and Project Implementation

- Establish an overall strategic plan for the AOHT and develop an annual work plan consistent with the strategic plan;
- Identify and measure the priority populations for the AOHT and the impact of decisions on them;
- Develop the name and central brand for the AOHT;
- Identify, implement, and oversee Projects and Project Agreements; and
- Ensure there is a commitment to share information, set joint performance targets, align service delivery and quality improvement for identified projects.

Quality and Risk

- Review, collaborate on, and monitor safety and quality standards and performance and quality improvement for the AOHT;
- Identify risk issues and consider risk allocation, mitigation, and corrective actions for AOHT activities;
- Develop a complaints and significant event process for issues that impact more than one Member; and

- Develop a risk management process for issues that could negatively impact the AOHT.

Resources and Accountability

- Develop guidelines for the allocation and sharing of costs and resources, including funding earmarked for the AOHT as well as human resources, capital, and facilities and costs related to supporting the work of the AOHT;
- Review and collaborate on financial performance, resource allocation and use, best practice, and innovation;
- Develop clinical and financial accountability standards;
- Determine Membership fees to be paid by Members, if any; and
- Facilitate and oversee the development of a digital health strategy.

Engagement and Reporting

- Develop and implement a joint communications strategy, including communication to stakeholders and the community;
- Engage people, families and communities to ensure meaningful partnership and co-design across all OHT initiatives;
- Engage with and seek input from Members and Networks;
- Ensure engagement at a board to board level among Members; and
- Report from time to time to Members on the work of the Leadership Council and any subcommittees and working groups.

Governance and Compliance

- Evaluate and identify areas of improvement in the integrated leadership and governance structure of the AOHT on an ongoing basis, including the establishment of a standardized process to identify and admit additional Members to the AOHT;
- As part of efforts to set up a long-term governance structure for the OHT, engage the boards of each respective Member Organization to:
    - understand what it means to have a duty to an integrated local health system that serves the residents of Algoma
    - prioritize steps towards collaborative governance in the first year of operation
    - consider possible long-term options for collaborative governance;
- Discuss compliance with, and amendments to, these Terms of Reference, the Framework, or a Project Agreement;
- Facilitate dispute resolution; and
- Ensure compliance with all reporting requirements.

Integration

- Act as a forum for the defined geographic area to support any potential voluntary or involuntary integration initiatives ordered by the Ministry of Health and
- Develop recommendations vis-à-vis proposed integrations.

Other

- Perform the roles assigned to the Leadership Council under the Framework.

Membership

The Leadership Council shall be a representative group across Algoma, that includes both organizational and independent-level representation.

Member Organizations will participate as contributing partners to the Algoma OHT mission, vision, and guiding principles. Contributing partners will be classified as one of three types of partners: core, collaborative or community.

Partnership types will be first determined by the primary sector served as identified by the member organization. If there is a difference in how the member organization views its level of participation in Algoma OHT, the Leadership Council will discuss a reasonable solution.

	Core partner	Collaborative partner	Community partner
Sectors included	Primary Care, Mental Health & Addictions, Acute Care, Home & Community Care Support Services, Home Care Providers Health Promotion, Social Services, Community Support Services, and Long Term Care	Congregate Care, Palliative Care, Rehabilitative Services, Specialized Services, Pharmacies, NFP with marginalized or specialty populations, and Maamwesying OHT.	Ontario Health North, relevant government ministries, Educational Institutions, Community PFACs, Advocacy Groups
Strategic alignment	Boards and leads agree to the vision and mission of the Algoma OHT, strong alignment between organizational priorities and Algoma OHT strategy.	Boards and leads agree to the vision and mission of the Algoma OHT. Organizational strategic direction is informed by the Algoma OHT direction.	Understand the vision and mission of the Algoma OHT.
Decision-making roles and responsibilities	Directly involved in AOHT decision making. Provides strategic direction and prioritizes committee work.	Makes recommendations and provides input and expertise. Participates in committees reporting to the Leadership Council.	Is kept informed of Algoma OHT strategic directions and upcoming priorities.

Accountabilities and resource allocations	Assume leadership roles within AOHT committees and working groups. Commits resources to the AOHT (financial, human, communications, or in-kind). Signs the Fund Holder and Indemnity Agreement.*	Participates in Algoma OHT committees and working groups based on expertise and alignment to organizational strategic direction.	May participate or partner in Algoma OHT exploration, consultations and on working groups based on expertise.
Commitments of membership	Attending 80% Leadership Council meetings (including sending decision-making delegate). Leading AOHT committees and working groups.	Attending 80% Leadership Council meetings (including sending decision-making delegate). Supporting AOHT committees and working groups.	

[1]*Medicine Professional Corporations are not required to sign the Fund Holder Indemnity Agreement to be considered a Core Partner.

2.1 Tri-Chairs

The Leadership Council shall have a Tri-Chair model, which is elected for a two-year term by the majority vote of the Leadership Council. It should strike a balance representing administrative, clinical and patient leadership for the AOHT. The Tri-Chairs may alternate the meeting chair responsibilities, at their discretion and fully participate in deliberations as well as decision-making.

In addition to chairing responsibilities; the Tri-Chairs are responsible for:

- Acting on behalf of the Leadership Council (as the Executive Committee) in-between regularly scheduled meetings, including bringing those decisions (as information items) to the Leadership Council
- Preparing meeting agendas, including a governance calendar for future items
- Ensuring appropriate engagement of members and the regular evaluation of the governance model for the AOHT
- Providing day-to-day guidance, management and mentorship to the Administrative Director of the AOHT (Director, Integrated Care)

2.2 Meetings

Meetings shall be held at a minimum quarterly, and where possible be scheduled in advance according to a governance calendar. Ad hoc meetings may be called by the Tri-Chairs or at the

request of a minimum of 3 Members. Agendas will be sent in advance and indicate whether items are for information, discussion or approval. In an effort to foster transparency, guests are welcome to participate in all meetings, except for in-camera portions, but may not vote.

2.3 Quorum

Quorum will be a majority of Members, who may be present in-person or virtually. If a Member is not able to attend, the Member may send an alternate (who may count for quorum and vote). If quorum is not present, the Members present may meet for discussion purposes only and no decisions shall be made.

2.5 Minutes

Meeting minutes will document deliberations and recommendations. All minutes will be available as part of the AOHT repository that may be accessed by the public, except for any confidential or in-camera discussions. Discussion during meetings shall be open, frank, and free-flowing, and while contents of minutes will be shared, they will not include attribution of individual contributions.

CONSENSUS BASED DECISION MAKING

Unless otherwise specified approval of the Leadership Council, decisions will be made by consensus. Consensus means that each member is prepared to support the decision or, if applicable, recommend it to their board of directors, organization, or respective members, as the case may be, even if they do not agree with the decision/recommendation. In the event of a tie a majority vote by the tri-chairs will constitute the tie breaker. Moreover, all projects and initiatives moving forward require approval via vote of the lead (sponsor) organization. As such, Leadership Council cannot compel an organization to lead or act as the sponsoring organization of an initiative without its approval.

Member Organizations agree to adhere to a consensus based decision-making model, which values a fair and collaborative approach and reduces barriers to decision making. Consensus based decision-making starts with the identification of an opportunity, followed by open discussion, deliberation and a recommendation based on the discussion. The meeting chair will then ask partners to decide on the recommendation using one of the following four responses:

1. I support the recommendation;
2. I have concerns, but can live with the recommendation;
3. I have concerns and can live with the recommendation, but my organization will not implement or adopt the proposed solution within our policies, procedures, protocols, or services; or
4. I cannot support the recommendation and modification to the proposal is necessary.

If any Member Organization cannot support the decision (Number 4) or if 25% of the partners will not be able to implement the recommendation (Number 3), then the opportunity will be modified given the feedback provided by the partners. A reasonable number of modifications can be made before the proposal is determined to be abandoned.

To ensure success of the consensus based decision-making model, the following principles must be followed:

1. No votes - every Member Organization identifies their position using the model
2. Meeting quorum of 50% + 1 of all core partners (or participant on a collaborative)before a recommendation can be decided upon
3. All Member Organizations are expected to review recommendations with a person-focused and system level perspective

3.1 Annual Planning and Budgeting
The Leadership Council is responsible for creating an annual plan which will guide the activities of the OHT and delegate resources by the AOHT Transformation Office to support the deliverables. The budget will align with the annual plan to ensure there are appropriate resources to support the activities. An annual plan and aligned Implementation Fund budget will be approved by the Leadership Council prior to the beginning of the fiscal year.

3.2 Fund Manager
The Leadership Council shall, by majority vote, select a Member Organization to be a "Fund Manager" (for a term to be agreed) to, as directed by the Leadership Council receive, manage, distribute and keep accurate accounts of, pooled resources, including funding earmarked for the AOHT. The Administrative Director of the AOHT will be responsible for managing the funds, in accordance with the Fund Manager's policies and procedures, as well as ensuring that any funds are in accordance with the strategic priorities set out by the Leadership Council. The Fund Manager will submit financial reports and retain financial records for at least seven years.

3.3 Subcommittees and Working Groups
The Leadership Council has an Executive Committee that is comprised of the Tri-Chairs.

The Leadership Council may establish one or more subcommittees or working groups / action teams to assist it in fulfilling its role. The Leadership Council shall determine the mandate and composition of any such subcommittee or working group.

CONFIDENTIALITY
The Leadership Council members shall recognize that from time-to-time its members may have access to confidential information. All members are to respect the confidentiality of information received by, and discussions of, the Leadership Council that are identified as confidential or as part of in-camera discussions.

Policies
The Leadership Council may adopt policies, protocols and procedures to support the work of the Leadership Council and its subcommittees and working groups.

Review and Amendment
These Terms of Reference will be reviewed annually by the Leadership Council and may be amended with written agreement of the Leadership Council.

The Corporation of the Township of
La Corporation du Canton de
Dubreuilville

Prenez le temps de vivre Experience the Freedom

November 22, 2024

Algoma Public Health Board of Health

294 Willow Ave

SSM, On P6B 0A9

RE: Public Health Funding Review

At its regular meeting of November 13, 2024, our Municipal Council passed the following resolution:

24-237 Moved by: Councillor K. Lévesque
Seconded by: Councillor J. Hemphill

Whereas that the Council of the Corporation of the Township of Dubreuilville hereby wish to receive and approve the attached resolution dated September 25, 2024, from the Algoma Public Health Board of Health with regards to a request for support concerning the Public Health Funding Review and development of an equitable funding approach that delivers equitable per capita funding that takes into account public health agencies in the northern Ontario and their unique perspectives and circumstance, as presented.

Carried

Sincerely,

Lynne Blanchette

Lynne Blanchette
Office Coordinator

Enclosures Resolution No. 24-237

COUNCIL RESOLUTION

The Corporation of the Township of
La Corporation du Canton de
Dubreuilville
Prenez le temps de vivre Experience the Freedom

Moved By: Krystel
Seconded By: Julila

DATE: November 13, 2024
Resolution No. 24-287

Whereas that the Council of the Corporation of the Township of Dubreuilville hereby wishes to receive and approve the attached resolution dated September 25, 2024 from the Algoma Public Health Board of Health with regards to a request for support concerning the Public Health Funding Review and the development of an equitable funding approach that delivers equitable per capita funding that takes into account public health agencies in northern Ontario and their unique perspectives and circumstances, as presented.

Carried	Defeated	Deferred
✓		

RECORDED VOTE:	**YES**	**NO**
Councillor Hélène Perth	____	____
Councillor Krystel Lévesque	____	____
Councillor Julila Hemphill	____	____
Councillor	____	____
Mayor Beverly Nantel	____	____

Declaration of Pecuniary Interest and General Nature Thereof:

BOARD OF HEALTH

MOTION: 2024-98	Northern MOH Letter on Funding Review
DATE:	September 25, 2024
MOTION MOVED BY:	D. Graystone
SECONDED BY:	M. Shoemaker

Whereas the Office of the Chief Medical Officer of Health and the Ministry of Health is undertaking a review of the funding approach for local public health agencies; and

Whereas residents of Northern Ontario in general have poorer health outcomes compared to their southern counterparts, including a more than 50% higher average avoidable mortality rate in Northern Ontario[1], and a 64% higher avoidable mortality rate in Algoma specifically[2]; and

Whereas the *Perspectives from Northern Ontario on the Public Health Funding Review* letter outlines many of the equity considerations related to the funding approach for local public health agencies in northern Ontario;

Therefore Be It Resolved that the Board of Health for Algoma Public Health endorses the aforementioned letter; and

Further That the letter be shared with:

- local municipalities
- district Members of the Provincial Parliament
- alPHa
- Northern Health Units
- Dr. Kieran Moore, Chief Medical Officer of Health & Assistant Deputy Minister
- Liz Walker, Executive Lead, Office of the Chief Medical Officer of Health
- Colleen Kiel, Director, Public Health Strategic Policy, Planning and Communications Branch
- Brent Feeney, Director, Accountability and Liaison Branch
- Fiona Kouyoumdjian, Associate Chief Medical Officer of Health
- Wajid Ahmed, Associate Chief Medical Officer of Health

Motion: Carried ☑ Defeated ☐

[1] Public Health Ontario, "Potentially Avoidable Mortality Health Equity Snapshot," [Online]. Available: https://www.publichealthontario.ca/en/Data-and-Analysis/Health-Equity/Avoidable-Mortality-Health-Inequities. [Accessed 29 July 2024].

[2] Algoma Public Health. Algoma's Community Health Profile [Internet]. Sault Ste. Marie, Ontario: Algoma Public Health; 2024. Available from: www.algomapublichealth.com/CHP

August 16, 2024

To: Kieran Moore
Chief Medical Officer of Health & Assistant Deputy Minister

From: Medical Officers of Health
for the 7 Northern Ontario Local Public Health Agencies

Subject: **Perspectives from Northern Ontario for the Public Health Funding Review**

We are writing to you as the seven local public health agencies in Northern Ontario to share some perspectives unique to the North regarding the current Public Health Funding review.

Before we outline our perspectives, we do wish to note our support of the government undertaking a funding review. It has been our perspective, and that of the local public health field, that a funding approach that enables stable and predictable funding is needed so that we can adequately plan and deliver our services.

We understand that the provincial government is quite concerned by the difference in per capita funding between local public health agencies. We agree, this is something needing to be addressed, but that the goal should not be *equal* (per capita) funding across local public health agencies, but rather *equitable* funding which accounts for the circumstances of each health unit.

The following are some equity considerations that can strengthen and improve the validity of the funding approach for public health in Northern Ontario.

For clarity, our comments are intended to relate only to the base funding grants; we do not intend to make comment on the Unorganized Territories Fund, which we believe requires its own review (we welcome the opportunity for further discussion of this at a future date).

Considerations for Funding Public Health in Ontario

1. Geography

Northern Ontario has much larger service areas than in the rest of the province. Northern Ontario spans 90% of Ontario's land mass, but has only a minority of the province's population. [1] That has major implications in terms of service delivery:

- Our staff must travel long distances to deliver service. That has implications in both transportation costs as well as opportunity costs of staff time. Inflationary pressures have exacerbated these costs.

- Given some of our communities are very remote and inaccessible by roads, travel in many cases is not just by car, but by charter flight or boat. This further increases our travel costs.[1]

- Since the populations we serve in Northern Ontario are distributed over a large area, we do not benefit from the population density that facilitates economies of scale. That means we must plan and organize a service many times over. In Northern Ontario, we have 142 municipalities plus many other communities in unorganized territories, as well as First Nations communities, If delivering a vaccination program, for example, a northern local public health agency must plan, organize, travel, set-up, and deliver clinics in many locations, taking into account the lack of public transportation in and between most northern communities. These clinics will ultimately serve fewer people and cannot take advantage of the economies of scale possible in a southern Ontario city where only 2 or 3 fixed locations might be need.

- Our rural geography impacts the nature of services we must deliver as well. For example, since much more of our populations are living in rural and remote areas as compared to the rest of the province, we are much more involved with inspecting small drinking water systems and private drinking water testing. Unlike a municipality in southern Ontario that may have a few large municipal water treatment plants that aren't inspected by local public health, northern communities have a plethora of small drinking water systems that do need regular inspections. This adds significant costs to our budgets to travel to and conduct inspections as well as to transport well water samples to the lab. As well, even where a community may be on municipally treated water, these are smaller plants befitting the size of the municipalities without large public works departments operating them. Larger municipalities enjoy economies of scale

[1] While it may be argued that the Unorganized Territories Grant accounts for serving this population, and this does not impact the broader funding approach, we highlight (1) that some fly-in/boat-in communities are organized municipalities (e.g. Moosonee), and (2) in 2008, when local public health associations were asked to account for their true costs of delivering services to unorganized territories, it was concluded that costs were 99% higher than what the Unorganized Territory Grant provided [15], and so the cost-shared budget heavily supported delivery of services to these communities. Since 2008, the Unorganized Territory Fund has increased 41.3% [15] while cumulative CPI in Ontario has increased 47.1% [16], implying that the role of cost-shared funding has increased since then, especially after accounting for population growth.

from running large plants that foster expertise and sophistication, and comparably lower maintenance costs. Most northern Ontario municipalities don't enjoy these economies of scale, resulting in more common problems and interruptions to operations, and so more involvement by public health to assess risk, monitor water quality, and issue boil water advisories, and drinking water advisories.

- Technology, which may sometimes allow bridging distance through virtual delivery of services, is often not possible in Ontario's North or is very expensive to support. In 2023, the Canadian Government-sponsored Northern Ontario Broadband Report [2] found that only 26% of Northern Ontario communities met the standard of 50% of the population of the community having 10/50 Mbps internet speed. In many communities, and particularly spaces between them, mobile phone service is also spotty. The residents we serve in Northern Ontario therefore frequently do not have the ability to be served virtually.

2. Breadth, Diversity, and Complexity of Populations and Partners

The vast land area of the North also brings with it greater diversity in a few different dimensions:

- The North has 32% (142/444) of Ontario municipalities, but only 20.5% (7/34) of Ontario's health units.
- The North has 107 of the 134 First Nations Communities in Ontario (80%), and 78% of the on reserve population in Ontario (recognizing that the Census is an undercount of Indigenous population, so these numbers may underrepresent the true number). [3] Alongside these populations are Band Councils and Indigenous organizations with whom we engage to ensure we can provide services in a way that is welcome and meaningful, while navigating complex jurisdictional ambiguity.
- People in the North have much lower socio-economic standing. Between 2009 and 2018 Northern Ontario had an annual average of GDP growth [1] of 0.1% compared to 1.7% for Ontario as a whole [4]. Other social determinants of health track similarly in Northern Ontario, and so health outcomes are worse. For example, in 2021 if looking at Mortality from Avoidable Causes [5], the Northern health units had an average avoidable mortality of 323 deaths per 100,000 versus 204 for the rest of Ontario. In fact, the seven Northern health units rank in the top 8 health units for avoidable mortality, and occupy all of the top six positions. Worse social determinants of health put a greater burden on Northern local

public health agencies in terms of the number of clients needing our intervention, and the efforts we need to invest per person to mitigate inequities.

- For Indigenous populations in particular, in Ontario the median income for First Nations people living on reserve is $32,400, $44,000 for those living off reserve, and $50,400 for non-Indigenous people. [6] Similarly, “Low income” status is more prevalent among Indigenous people who live on reserve (33.7%) and off reserve (16.9%) compared to non-Indigenous people (9.9%). [7] With 78% of the on reserve Indigenous population of Ontario, this is a significant pressure on Northern local public health budgets.

- Northern Ontario has disproportionately more Francophones and French Designated Areas (Figure 1), legally obligating more resources be devoted to translation and to ensuring provision of French-language services. Public Health must also engage with Francophone communities and organizations who are numerous across the large Northern geography.

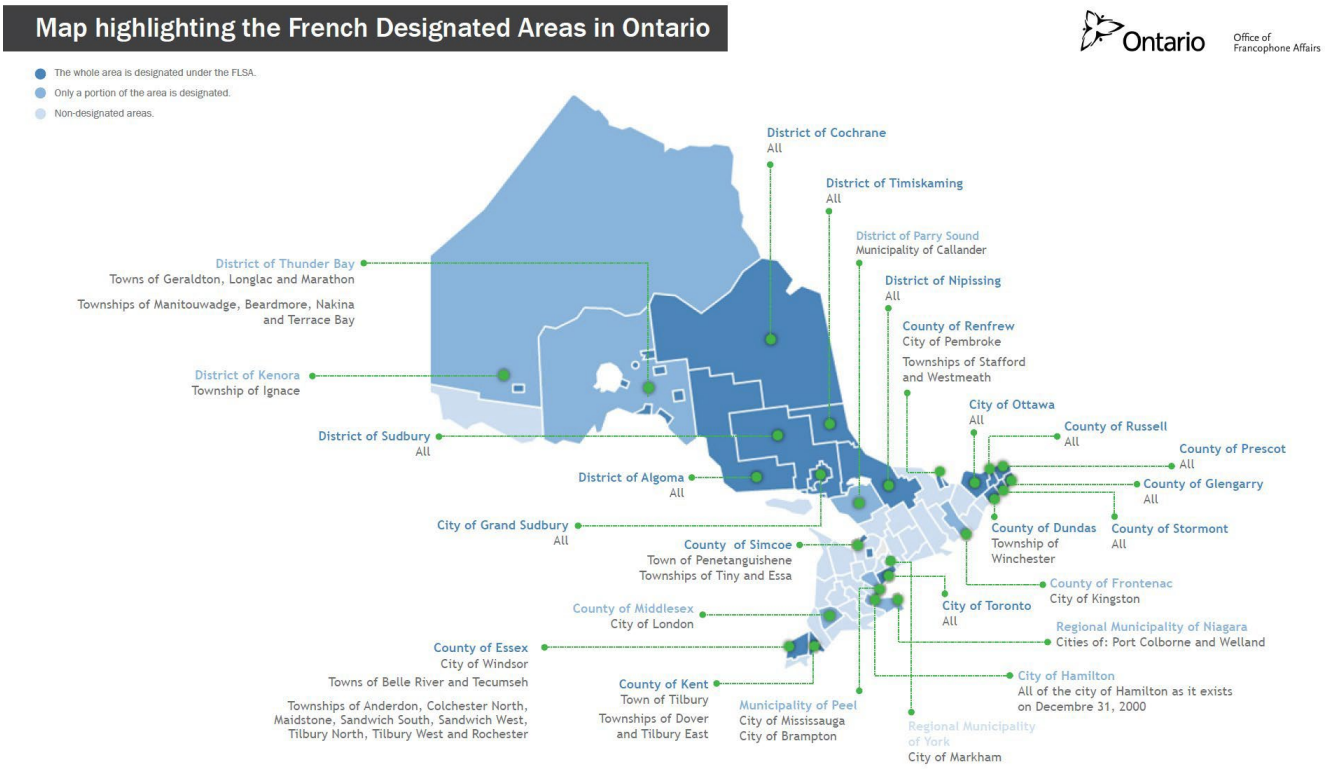

Figure 1. Designated French Language Areas in Ontario. [8]

The implication of this breadth and diversity of our populations and our partners is that it multiplies our workload: we have more municipal, Indigenous, and other partners with whom to engage; and we must meet people where they are with respect to language, Indigenous status, and social determinants of health, and invest in mitigating these. These are challenges not experienced as acutely in other parts of the province.

In addition, when attempting to work upstream, the complex patchwork of partners, many of whom are not well-funded, pose challenges to building coherent coalitions to advance advocacy or policy change for improvement of upstream health determinants.

3. Health Care Gaps

Northern Ontario is unfortunately lacking in health and dental care capacity. According to Ontario's Health Care Experience Survey for December 2019 (most recent results available) [9], 6.7% of Ontarians lacked a primary care provider, but that increased to 11.7% of residents of the North West LHIN and 11.8% of the North East LHIN. The Northern Sub-region reached as high as 29.0% of residents lacking a primary care provider.

In part, this is a function of primary care providers delivering acute care in much of Northern Ontario. In the North, family physicians routinely cover emergency departments, handle most obstetrics, are the primary surgical assists, and support long-term care, often working at multiple sites in a week.

It often falls to local public health to fill the gaps in primary care. For example, looking at the Fall 2023/24 COVID-19 vaccination program, pharmacies did not have the capacity to provide vaccinations in the North to the extent they did in the rest of the province (44.7% of vaccinations delivered by pharmacies in the North compared to 73.9% of vaccinations province-wide). Northern Public health units filled that gap, delivering 43.2% of COVID-19 vaccinations as compared to 15.7% Ontario-wide. Indeed, the six public health units with the lowest pharmacy delivery were all in Northern Ontario, and all 7 Northern Ontario PHUs were in the bottom 10 PHUs for pharmacy share of COVID-19 vaccinations. Despite the lack of pharmacy participation, Northern local public health agencies achieved above average vaccination coverage (17.9% to provincial average of 15.8%) through our efforts.

Table 1 Fall 2023/24 COVID-19 Vaccination Delivery [10] [11]

Public Health Unit	Proportion of Vaccines Delivered by Pharmacy	Proportion of Vaccines Delivered by Primary Care	Proportion of Vaccines Delivered by Public Health	Coverage Achieved
Ontario	73.9%	4.4%	15.7%	15.8%
Northern PHUs	44.7%	5.4%	43.2%	17.9%
Porcupine	21.2%	2.2%	66.0%	13.3%
Northwestern	16.2%	3.4%	71.8%	17.0%
Timiskaming	24.0%	12.3%	57.9%	17.2%
Algoma	65.4%	10.0%	18.6%	19.6%
Thunder Bay District	39.7%	8.5%	44.2%	19.9%
North Bay Parry Sound	48.8%	2.0%	43.8%	19.2%
Sudbury & Districts	54.8%	2.6%	36.9%	17.1%

Similar gaps in in primary health care capacity impact other program areas such as child health programming, sexual health programming, infectious disease programming, and rabies post-exposure prophylaxis.

Gaps in primary care can also increase rapidly with the closure of a single clinic or provider group. For example, in 2024, Sault Ste Marie experienced a dramatic announcement that 10,000 patients (8% of the entire health unit's population) would be de-rostered from their primary healthcare provider due to one provider group having difficulty recruiting primary care providers to replace retirements. [12]

There is also a lack of specialists in the North. Ontario's Health Care Experience Survey [9] shows that 65.2% of Ontarians must wait longer than 30 days for specialist care. However, that increases to 72.3% of residents in the North West LHIN and 73.8% of those in the North East LHIN. These specialist care gaps create particular challenges for public health follow-up. For example, in the follow-up and care of tuberculosis clients or syphilis infections, both of which have increased in incidence since the pandemic, most Northern communities do not have infectious disease specialists to oversee care, and primary care providers lack experience with these diseases. It falls on public health, who has some expertise from following all cases of these infections, to guide the health care system in care of such clients. This is not the norm in the rest of Ontario where greater clinical expertise exists.

4. Municipal Capacity

Just as local public health agencies struggle with the lack of economies of scale when delivering services to rural and remote populations, it should be observed that municipalities experience these same challenges with their services. Adding in the relatively lower economic opportunities in the North, Northern municipalities therefore have property tax bases that are very stretched. This makes it comparatively difficult for them to contribute to cost-shared funding of local public health. This should be considered in the obligation placed on municipalities in a new funding approach.

We believe all of the above make it more costly to deliver local public health in Northern Ontario, and that needs to be taken into account in the new funding approach.

We also wish to make a couple of comments on measures and metrics which may seem sensible to apply in the funding approach, but which have weaknesses when used for Northern geographies.

Caution on Applying Measures in Northern Ontario

1. Census Undercounting of Indigenous Populations

It is known that many Indigenous people do not complete the Canadian Census, and so the Census's counts for Indigenous population are significant undercounts throughout Northern Ontario. [12]

For example, the Health Counts Kenora project (Our Health Counts - WNHAC) used a respondent driven sampling approach and demonstrated that 76.9% of Indigenous people in the City of Kenora did not complete the 2016 census [7]. Using a conservative approach, "the Canadian Census undercounts Indigenous adults and children living in Kenora by at least 2.6 to 4.0 times." The 2016 Canadian Census reports that 3,155 Indigenous people lived in the City of Kenora; the 2021 Census reported 3,595. Both Thunder Bay and Timmins have also conducted similar counts and found significant undercounts.

As a population known to experience disproportionate health inequities, it is important that any new funding approach factor in the undercount of Indigenous peoples in the Census, and that this undercount is of a population that deserves disproportionate public health resources invested to address their health inequities.

In particular, as a new funding approach attempts to account better for population growth over time, it needs to be addressed that Northern Ontario is seeing significant growth in populations not well captured by the Census, such as Indigenous, anabaptist, and newcomer populations.

2. Inapplicability of ON-Marg in low population areas

The Ontario Marginalization Index is based on analysis at the Census dissemination area. Unfortunately, for much of Northern Ontario, there isn't sufficient population to have data for dissemination areas. For example, in Northwestern health unit, of 229 constituent dissemination areas, 101 (44%) have no data. Therefore, these areas are ignored in ON-Marg calculations. These areas that are excluded from ON-Marg calculations have many First Nation communities with low socioeconomic status and high deprivation, and so their exclusion has the impact of skewing ON-Marg metrics for Northern Ontario to appear less marginalized than is the reality.

Where dissemination areas do have data, that data is not always reliable. For example, on First Nations communities, the Low Income Measure input to ON-Marg has a flag of caution on interpretation, which means that the material deprivation dimension of ON-Marg should similarly be used in caution when looking at First Nations communities. The Northern public health units share land with 107 of the 134 First Nation communities in Ontario.

We appreciate that designing a funding approach for a diverse and complex group of local public health agencies is no easy task.

At its core, our fundamental message is that if a funding approach is to truly advance health outcomes and health equity across the province, health equity must be foundational in its design, and not be simply a variable included amongst many others. Metrics like per capita funding are attractive for their simplicity and ease of understanding. But that clarity in fact masks the complexities of serving Ontarians who are not uniform statistical units, but who live within diverse social contexts defined by countless inequities. We seek a funding approach that delivers not *equal* per capital funding, but *equitable* per capital funding.

We thank you for the consideration of the issues raised in this letter as you undertake the challenge of developing an *equitable* funding approach.

We would be very pleased to meet in the near future to discuss our perspectives further, and how we can support your team as the funding review proceeds.

And we look forward to there being an opportunity to review a funding proposal in the coming months before a final version is submitted for government approval.

Sincerely,

Lianne Catton (Aug 21, 2024 09:39 EDT)

Glenn Corneil (Aug 19, 2024 08:59 EDT)

Lianne Catton
Medical Officer of Health & CEO, Porcupine Health Unit

Glenn Corneil
Acting Medical Officer of Health & CEO, Timiskaming Health Unit

Janet DeMille
Medical Officer of Health & CEO, Thunder Bay District Health Unit

M. Mustafa Hirji
Acting Medical Officer of Health & CEO, Public Health Sudbury & Districts

John Tuinema (Aug 16, 2024 19:11 EDT)

Kit Ngan Young Hoon
Medical Officer of Health, Northwestern Health Unit

John Tuinema
Acting Medical Officer of Health & CEO, Algoma Public Health

Carol Zimbalatti (Aug 17, 2024 16:33 EDT)

Carol Zimbalatti
Medical Officer of Health & EO, North Bay Parry Sound District Health Unit

CC:

Liz Walker, Executive Lead, Office of the Chief Medical Officer of Health
Colleen Kiel, Director , Public Health Strategic Policy, Planning and Communications Branch
Brent Feeney, Director , Accountability and Liaison Branch
Fiona Kouyoumdjian, Associate Chief Medical Officer of Health
Wajid Ahmed, Associate Chief Medical Officer of Health

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[11] Ministry of Health, *COVID-19 Vaccination Program: Weekly Report,* 2024.

[12] "Community Update Regarding Primary Care. Group Health Centre.," 25 January 2024. [Online]. Available: https://ghc.on.ca/featured/community-update-regarding-primary-care-2/. [Accessed 9 August 2024].

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[14] Funding Review Working Group, "Public Health Funding Model for Mandatory Program: The Final Report of the Funding Review Working Group, Ministry of Health, 2013.

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Public Health
Santé publique
SUDBURY & DISTRICTS

December 5, 2024

VIA ELECTRONIC MAIL

Mayor Paul Lefebvre
Mayor of Greater Sudbury
PO BOX 5000, Station 'A',
200 Brady St.
Sudbury, ON P3A 5P3

Dear Mayor Lefebvre:

Re: Calling for the Selection of Indigenous Municipal and Provincial Appointees for Board of Health for Public Health Sudbury & Districts

On behalf of the Board of Health for Public Health Sudbury & Districts, I am writing to inform you of a recently adopted Board motion that calls for the appointment of Indigenous person(s) to the Board of Health when vacancies arise. Specifically, at its meeting on June 20, 2024, the Board of Health carried the following motion # 41-24,

> *WHEREAS the Board of Health for Public Health Sudbury & Districts is committed to ensuring all people in its service area, including Indigenous peoples and communities, have equal opportunities for health; and,*
>
> *WHEREAS on June 15, 2023, the Board of Health passed Motion #37-23 Indigenous Engagement Governance Reconciliation Framework which supports the advancement of the Indigenous Engagement Strategy at the governance level; and,*
>
> *WHEREAS Public Health Sudbury & Districts Indigenous Engagement Strategy's Strategic Direction 1 led to a commitment to promote the selection of Indigenous municipal and provincial appointees to the Board of Health;*

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f: 705.864.0820

toll-free / sans frais
1.866.522.9200

phsd.ca

THEREFORE BE IT RESOLVED THAT the Board of Health call upon the municipalities in the service area to advocate for the appointment of qualified Indigenous persons, who are grounded in community, have lived experience, are from this territory and reside in Public Health Sudbury & Districts; and

THAT the Board of Health call upon the municipalities in the service area to appoint qualified Indigenous persons, who are grounded in community, have lived experience, are from this territory and reside in Public Health Sudbury & Districts, where more than one representative appointment exists; and

THAT the Board of Health call upon the Province of Ontario to appoint qualified Indigenous persons, who are grounded in community, have lived experience, are from this territory and reside in Public Health Sudbury & Districts.

In Public Health Sudbury & District's service area, the total population of Indigenous people is 27,600, which is 14% of the population of the district. Of these individuals, 5,700 reside in the 13 First Nations communities in the district. The remaining are considered urban Indigenous people.[1] Indigenous people disproportionately experience "poorer reported physical and mental health status, and a higher prevalence of chronic conditions (e.g., asthma and diabetes) as well as disabilities compared to non-Indigenous people" (Hahmann & Kumar, 2022; Hahmann et al., 2019). In addition, the life expectancy of First Nations people, Métis and Inuit has been shown to be consistently and significantly lower than that of the non-Indigenous population (Tjepkema et al., 2019)," [2] as a direct result of the Canadian government's colonial policies, which have had a reverberating impact on today's systems.

The Board of Health, which governs Public Health Sudbury & Districts, plays a crucial role in addressing the health disparities faced by the Indigenous population. Its primary focus on planning and policy development, fiscal arrangements and labour relations, and accountability and reporting to the Ministry, positions it with a responsibility in this issue. The Board of Health's endorsement of The Indigenous Engagement Governance ReconciliAction Framework in June 2023 was a significant step in our commitment to reconciliation. The framework's first strategic direction is to inform our work through Indigenous community voices and information. The Board understands that it is imperative to the health of Indigenous peoples that an appropriate representative participate when decisions about Indigenous peoples are made. Having Indigenous representation on the Board of Health, will ensure alignment with this commitment. We also hope that it will

[1] Statistics Canada (2022) 2021Census
[2] Yangzom, K., Masoud, H., & Hahmann, T. (2023). Primary health care access among First Nations people living off reserve, Métis and Inuit, 2017 to 2020. Ottawa, Canada: Statistics Canada. Primary health care access among First Nations people living off reserve, Métis and Inuit, 2017 to 2020 (statcan.gc.ca)

contribute to answering the Truth and Reconciliation: Call to Action 23, which calls upon all levels of government to "Increase the number of [Indigenous] professionals working in the health-care field." [3]

As the only municipal council that can appoint more than one member to the Board of Health, the City of Greater Sudbury considering an Indigenous municipal appointee to the Board of Health when a vacancy arises is of particular salience. Public Health would be happy to provide a list of candidates for consideration when a vacancy arises.

Thank you for your ongoing partnership, including as we work towards reconciliation with Indigenous peoples.

Sincerely,

René Lapierre
Chair, Board of Health

cc: Dr. M. M. Hirji, Acting Medical Officer of Health and Chief Executive Officer
Dr. Kieran Moore, Chief Medical Officer of Health, Ministry of Health
Dr. Fiona Kouyoumdjian, Associate Chief Medical Officer of Health, Office of the Chief Medical Officer of Health, Ministry of Health
Nicole Visschedyk, Director of Indigenous Strategy and Engagement,Public Health Ontario
Ontario Boards of Health

[3] **National Center for Truth and Reconciliation. (2015).** ***Truth and Reconciliation Commission of Canada: Calls to Action*****. https://ehprnh2mwo3.exactdn.com/wp-content/uploads/2021/01/Calls_to_Action_English2.pdf**

Public Health
Santé publique
SUDBURY & DISTRICTS

December 5, 2024

VIA ELECTRONIC MAIL

Honourable Minister Sylvia Jones
Minister of Health
Ministry of Health
5th Floor, 777 Bay Street
Toronto, ON M5G 2C8

Dear Minister Jones:

Re: Calling for the Selection of Indigenous Municipal and Provincial Appointees for Board of Health for Public Health Sudbury & Districts

On behalf of the Board of Health for Public Health Sudbury & Districts, I am writing to inform you of a recently adopted Board motion that calls for the appointment of Indigenous person(s) to the Board of Health when vacancies arise. Specifically, at its meeting on June 20, 2024, the Board of Health carried the following motion # 41-24,

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>
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>
> *WHEREAS Public Health Sudbury & Districts Indigenous Engagement Strategy's Strategic Direction 1 led to a commitment to promote the selection of Indigenous municipal and provincial appointees to the Board of Health;*

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THEREFORE BE IT RESOLVED THAT the Board of Health call upon the municipalities in the service area to advocate for the appointment of qualified Indigenous persons, who are grounded in community, have lived experience, are from this territory and reside in Public Health Sudbury & Districts; and

THAT the Board of Health call upon the municipalities in the service area to appoint qualified Indigenous persons, who are grounded in community, have lived experience, are from this territory and reside in Public Health Sudbury & Districts, where more than one representative appointment exists; and

THAT the Board of Health call upon the Province of Ontario to appoint qualified Indigenous persons, who are grounded in community, have lived experience, are from this territory and reside in Public Health Sudbury & Districts.

In Public Health Sudbury & District's service area, the total population of Indigenous people is 27,600, which is 14% of the population of the district. Of these individuals, 5,700 reside in the 13 First Nations in the district. The remaining are considered urban Indigenous people.[1] Indigenous people disproportionately experience "poorer reported physical and mental health status, and a higher prevalence of chronic conditions (e.g., asthma and diabetes) as well as disabilities compared to non-Indigenous people" (Hahmann & Kumar, 2022; Hahmann et al., 2019). In addition, the life expectancy of First Nations people, Métis and Inuit has been shown to be consistently and significantly lower than that of the non-Indigenous population (Tjepkema et al., 2019)," [2] as a direct result of the Canadian government's colonial policies, which have had a reverberating impact on today's systems.

The Board of Health, which governs Public Health Sudbury & Districts, plays a crucial role in addressing the health disparities faced by the Indigenous population. Its primary focus on planning and policy development, fiscal arrangements and labour relations, and accountability and reporting to the Ministry, positions it with a responsibility in this issue. The Board of Health's endorsement of The Indigenous Engagement Governance ReconciliAction Framework, in June 2023 was a significant step in our commitment to reconciliation. The framework's first strategic direction is to inform our work through Indigenous community voices and information. The Board understands that it is imperative to the health of Indigenous peoples that appropriate representatives are present when decisions about Indigenous peoples are made. Having Indigenous representation on the Board of Health, will ensure alignment with this commitment. We also hope that it will

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[2] Yangzom, K., Masoud, H., & Hahmann, T. (2023). Primary health care access among First Nations people living off reserve, Métis and Inuit, 2017 to 2020. Ottawa, Canada: Statistics Canada. Primary health care access among First Nations people living off reserve, Métis and Inuit, 2017 to 2020 (statcan.gc.ca)

contribute to answering the Truth and Reconciliation: Call to Action 23, which calls upon all levels of government to "Increase the number of [Indigenous] professionals working in the health-care field." [3]

There is currently one vacancy for a provincial appointee to our Board of Health according to the Public Appointments Secretariat[4]. We request that your Ministry appoint an Indigenous Provincial appointee to this Board of Health position. Doing so would help advance reconciliation immensely, while also improving the health of a key population group. To facilitate such an appointment, we request that the Public Appointments Secretariat begin to advertise that position, noting a requirement for applicants to be of Indigenous background. Public Health will be pleased to work with local Indigenous candidates to encourage them to submit applications through the Public Appointment Secretariat.

Should your government wish to explore this further, we would be pleased to meet with the Chief Medical Officer of Health's team or others within your Ministry, as well as the Public Appointments Secretariat to begin to move this forward.

Thank you to your government for its commitment to improving the health of Indigenous people, and your partnership as we work towards reconciliation.

Sincerely,

René Lapierre
Chair, Board of Health

cc: Dr. M. M. Hirji, Acting Medical Officer of Health and Chief Executive Officer
Dr. Kieran Moore, Chief Medical Officer of Health, Ministry of Health
Dr. Fiona Kouyoumdjian, Associate Chief Medical Officer of Health, Office of the Chief Medical Officer of Health, Ministry of Health
Public Appointment Secretariat

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[3] **National Center for Truth and Reconciliation. (2015).** ***Truth and Reconciliation Commission of Canada: Calls to Action*****.** **https://ehprnh2mwo3.exactdn.com/wp-content/uploads/2021/01/Calls_to_Action_English2.pdf**

[4] **Public Appointments Secretariat: Health Unit Board—Sudbury and District. https://www.pas.gov.on.ca/Home/Agency/316**

Nicole Visschedyk, Director of Indigenous Strategy and Engagement,Public Health Ontario
France Gélinas, Member of Provincial Parliament, Nickel Belt
Jamie West, Member of Provincial Parliament, Sudbury
Michael Mantha, Member of Provincial Parliament, Algoma – Manitoulin
Association of Local Public Health Agencies
Ontario Boards of Health

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT
www.healthunit.com

MIDDLESEX-LONDON BOARD OF HEALTH

REPORT NO. 82-24

TO: Chair and Members of the Board of Health

FROM: Dr. Alexander Summers, Medical Officer of Health
Emily Williams, Chief Executive Officer

DATE: 2024 December 12

MONITORING FOOD AFFORDABILITY AND IMPLICATIONS FOR PUBLIC POLICY AND ACTION (2024)

Recommendation

It is recommended that the Board of Health:

1) *Receive Report No. 82-24 re: "Monitoring Food Affordability and Implications for Public Policy and Action 2024" for information; and*
2) *Direct staff to forward Report No. 82-24 re: "Monitoring Food Affordability and Implications for Public Policy and Action 2024" to Ontario boards of health, the City of London, Middlesex County, and appropriate community agencies*.

Report Highlights

- In 2023, 1 in 4 households in Middlesex-London were food insecure. This is a statistically significant increase from 2022.
- Local food affordability monitoring is a requirement of the Ontario Public Health Standards.
- The 2024 Ontario Nutritious Food Basket results demonstrate decreased food affordability and inadequate incomes to afford basic needs for many Middlesex-London residents.
- Food insecurity has a pervasive impact on health; and there is a need for income-based solutions.

Background

Food insecurity, defined as inadequate or insecure access to food due to financial constraints, is a key social determinant of health[1]. Food insecurity is a strong predictor of poor health and is associated with an increased risk of a wide range of physical and mental health challenges, including chronic conditions, non-communicable diseases, infections, depression, anxiety, and stress[2-9] (Appendix A). Poor diet quality costs Ontario an estimated $5.6 billion annually in direct healthcare and indirect costs (e.g., lost productively due to disability and premature mortality)[10].

As a result of systemic and structural inequities, racism, and colonization, food insecurity disproportionately affects certain populations[1,11,12]. Higher rates of food insecurity are found among Indigenous People, Black people, recent immigrants, female lone parent led households, low-income households, and other marginalized populations[1]. Although households whose main

income is from social assistance have the highest rate of food insecurity, 58.6% of food insecure households in Ontario rely on wages, salaries, or self-employment as their main income[1].

Routine monitoring of food affordability helps generate evidence-based recommendations for collective public health action to address food insecurity which is often tied to income inadequacy. The Ontario Public Health Standards require monitoring local food affordability as mandated in the Population Health Assessment and Surveillance Protocol, 2018. The Ontario Nutritious Food Basket (ONFB) is a survey tool that measures the cost of eating as represented by current national nutrition recommendations and average food purchasing patterns. The Ontario Dietitians in Public Health (ODPH), in collaboration with Public Health Ontario (PHO) develops, tests, and updates tools for monitoring food affordability for Ontario public health units. The costing tool uses a hybrid model of in-store and online data collection.

Local Food Insecurity

In 2023, 1 in 4 households in Middlesex-London were food insecure (25.1%, CI 21.8-28.4%)[13] (Appendix B). The rate was higher than in Ontario and the Peer Group comparator (i.e., mainly urban centres with moderate population density); however, this was not a statistically significant difference. The 2023 rate represents a statistically significant increase from 2022; and the highest rate reported in Middlesex-London since the Canadian Income Survey started measuring food insecurity in 2019. In 2022, 1 in 6 households in Middlesex-London were food insecure (17.5%, CI 14.1-20.9%)[13]. Local food insecurity rates are not yet available for 2024.

Nearly 44,000 more Middlesex-London residents lived in food insecure households in 2023 as compared to 2022[13,14]. An estimated 151,477 residents lived in food insecure households in Middlesex-London in 2023, as compared to 107,835 residents in 2022[13,14].

Local Food Affordability

Local food and average rental costs from May 2024 are compared to a variety of household and income scenarios, including households receiving social assistance, minimum wage earners, and median incomes (Appendix C, Appendix D). The scenarios include food and rent only and are not inclusive of other needs (i.e., utilities, Internet, phone, transportation, household operations and supplies, personal care items, clothing etc.). The household scenarios highlight that incomes and social assistance rates are not keeping pace with the increased cost of living.

A key indicator for food insecurity is the average monthly cost of a nutritious diet as a proportion of household income. Households with low incomes spend up to 47% of their after-tax income on food, whereas households with adequate incomes (family of 4) only spend approximately 12% of their after-tax income.

Comparing the monthly funds remaining after rent and food costs in 2024 to 2023 for various household scenarios illustrates that specific scenarios are falling further behind each year and provides evidence for the impact of income-based policy changes on food affordability.

Scenario	Monthly Funds Remaining After Rent and Food Costs		Income-Based Policy
	2023	2024	
Single Person ODSP	-$186	-$172	As of July 2023, ODSP rate increases are indexed to Ontario's Consumer Price Index.
Single Person OW	-$420	-$522	OW rate increases are not indexed to inflation.
Family of 4 Minimum Wage	$1,351	$1,579	As of 2015, under the Employment Standards Act, minimum wage rates are set and adjusted annually based on changes to Ontario's Consumer Price Index in the previous year.
Family of 4 Refugee Claimants Minimum Wage	N/A	$310	Refugee claimants are not eligible for the Canada Child Benefit. A refugee claimant is a person who left their country and is asking for protection in another country because it is unsafe to return to their home country.

ODSP = Ontario Disability Support Program
OW = Ontario Works

Monitoring food affordability data and methodology details, including cost adjustments required to compare the 2023 and 2024 scenarios, are included in Appendix C.

Public Health Action
Annually, the Health Unit monitors and reports on local food affordability, the impact of health inequities due to food insecurity, effective strategies to reduce these inequities, and shares this information with the municipalities, the public, and community partners.

Living wages help to protect individuals against food insecurity. A living wage is the hourly wage a full-time worker needs to earn to afford basic expenses and participate in community life. In Middlesex-London, the 2024 living wage was $19.50 per hour[15], an increase from $18.85 in 2023 and as compared to the Ontario minimum wage of $17.20. Local food costs, as estimated utilizing the ONFB, are shared with the Ontario Living Wage Network and used to calculate our regional living wage. The Health Unit re-certified as a living wage employer in 2024.

Over the past year, the Board of Health:
- Sent a letter to the federal government in support of S-233 and C-223 "An Act to develop a national framework for a guaranteed livable basic income" (Report No. 49-24). The Board's letter was endorsed by Haliburton, Kawartha, Pine Ridge District Health Unit and Peterborough Public Health.
- Sent a letter to the provincial government to advocate for increased social assistance rates in regards to the affordability of food (Report No. 25-23 Minutes).

The Association of Local Public Health Agencies (alPHa) endorsed ODPH-sponsored resolutions that included advocacy to the Province of Ontario to:
- Support income-related policies to reduce food insecurity, especially for households with children (A24-05)
- Utilize food affordability monitoring results from public health units in determining the adequacy of social assistance rates to reflect the current costs of living and to index Ontario Works rates to inflation (A23-05)

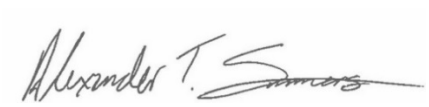
- Legislate targets for reduction of food insecurity as part of Ontario's plan for poverty reduction (A23-05)

Next Steps
Health Unit staff are exploring the development of a municipal primer on food insecurity as an important public health and local issue and actions municipalities can take to address it.

The ODPH Food Insecurity Workgroup and PHO are collaborating on a provincial food affordability report planned for release February 2025. The report will include various household and income scenarios utilizing data submitted by Ontario public health units, health outcomes of food insecurity, and discussion of income-based solutions.

Continued work is needed to address food insecurity and its significant health and well-being implications. MLHU can continue to highlight the need for upstream income-based solutions and changes and programs that address both food affordability and access.

This report was written by the Municipal and Community Health Promotion Team of the Family and Community Health Division.



Alexander Summers, MD, MPH, CCFP, FRCPC
Medical Officer of Health

Emily Williams, BScN, RN, MBA, CHE
Chief Executive Officer

This report refers to the following principle(s) set out in Policy G-490, Appendix A:

- The Population Health Assessment and Surveillance Protocol, 2018; and the Chronic Disease Prevention and Well-Being and Healthy Growth and Development standards, as outlined in the *Ontario Public Health Standards: Requirements for Programs, Services and Accountability*.
- The following goal or direction from the Middlesex-London Health Unit's Strategic Plan:
  - Our public health programs are effective, grounded in evidence and equity

This topic has been reviewed to be in alignment with goals under the Middlesex-London Health Unit's Anti-Black Racism Plan and Taking Action for Reconciliation, specifically recommendations:

Anti-Black Racism Plan Recommendation #37: Lead and/or actively participate in healthy public policy initiatives focused on mitigating and addressing, at an upstream level, the negative and inequitable impacts of the social determinants of health which are priority for local ACB communities and ensure the policy approaches take an anti-Black racism lens.

Taking Action for Reconciliation Supportive Environments: Establish and implement policies to sustain a supportive environment, as required, related to the identified recommendations.

References

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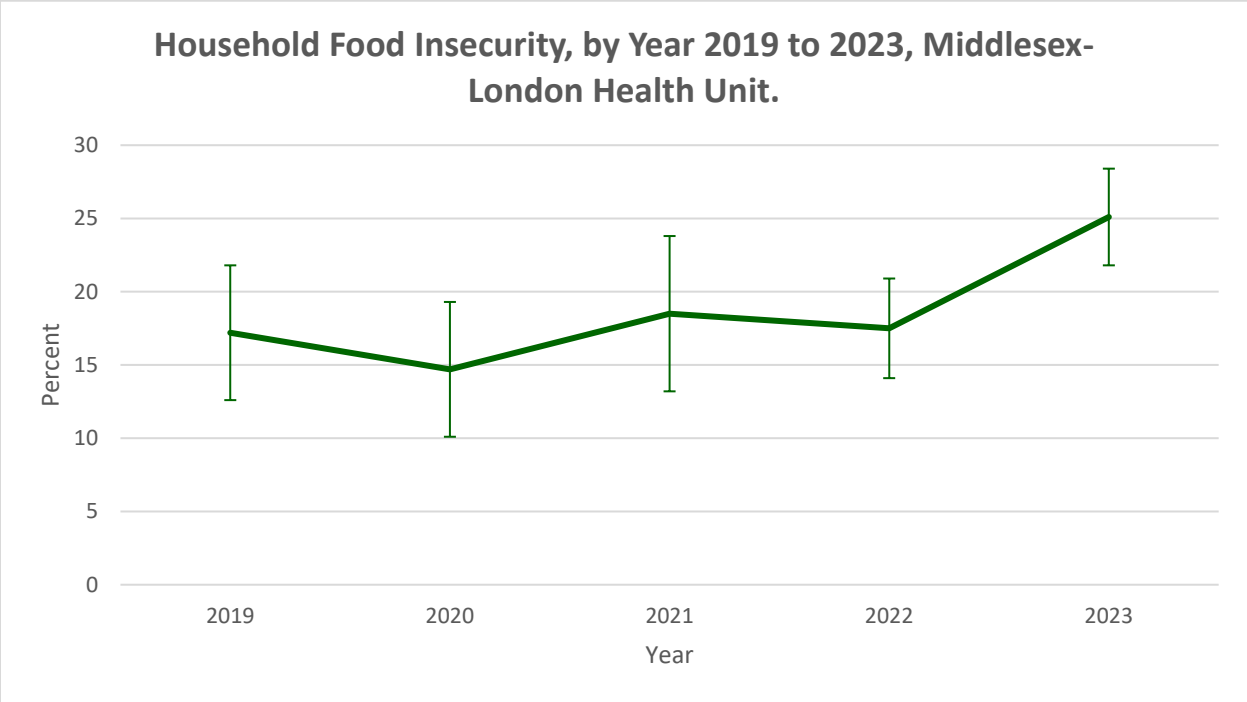

Indicator	Year	Geography	Per cent (%)	95% Confidence Interval (Lower)	95% Confidence Interval (Upper)	Margin of Error
Food insecure (household level)	2019	Middlesex-London Health Unit	17.2	12.5	21.8	4.6
Food insecure (household level)	2020	Middlesex-London Health Unit	14.7	10.1	19.3	4.6
Food insecure (household level)	2021	Middlesex-London Health Unit	18.5	13.2	23.7	5.3
Food insecure (household level)	2022	Middlesex-London Health Unit	17.5	14.1	20.9	3.4
Food insecure (household level)	2023	Middlesex-London Health Unit	25.1	21.8	28.4	3.3

Reference: Ontario Agency for Health Protection and Promotion (Public Health Ontario). Snapshots data file for household food insecurity (2019 to 2023 (annual, 2-year combined, 3-year combined). Retrieved from https://www.publichealthontario.ca/en/Data-and-Analysis/Health-Equity/Household-Food-Insecurity.

Middlesex-London Income and Cost of Living Scenarios for 2024

Income Source	Monthly Income[1]	Monthly Rent[2] / % Income		Monthly Food[3] / % Income		What's Left?[4] 2024	What's Left?[4,5] 2023
Single Person Ontario Works	$881	$988	112%	$415	47%	**-$522**	**-$420**
Single Person Ontario Disability Support Program	$1,465	$1,222	83%	$415	28%	**-$172**	**-$186**
Single Pregnant Person Ontario Disability Support Program	$1,505	$1,222	81%	$440	29%	**-$157**	**-$170**
Single Person Old Age Security/Guaranteed Income Security	$2,069	$1,222	59%	$296	14%	**$551**	**$553**
Single Parent with 2 Children Ontario Works	$2,670	$1,523	57%	$890	33%	**$257**	**$309**
Family of 4 Ontario Works	$2,908	$1,734	60%	$1,194	41%	**-$20**	**-$15**
Family of 4 Minimum Wage Earner (full-time)	$4,507	$1,734	38%	$1,194	26%	**$1,579**	**$1,351**
Family of 4 Median Income (after tax)	$9,685	$1,734	18%	$1,194	12%	**$6,757**	**$6,475**
Family of 4 Refugee Claimants Minimum Wage Earner (full-time)	$3,238	$1,734	54%	$1,194	37%	**$310**	**N/A**

The household scenarios spreadsheet is prepared annually by Ontario Dietitians in Public Health (ODPH) to support Ontario public health units to monitor local and provincial food affordability.

What's Left?[4]

People still need additional funds for childcare, utilities, Internet, phone, tenant insurance, transportation, household operations and supplies, personal care items, clothing, school supplies, gifts, recreation and leisure, out of pocket medical and dental costs, education, savings, and other costs.

Income [1]

WoodGreen Community Services calculated the incomes for each scenario.

Income estimates for each scenario include all family and tax benefit entitlements available to Ontario residents (e.g., Climate Action Incentive Payment, Ontario Trillium Benefit, Canada Child Benefit, GST/HST credit, Canada Worker Benefit). Individual incomes may be lower if individuals do not file their income tax and/or do not apply for all available credits and benefits.

The main income for each scenario was estimated for May/June 2024. The exception is median income obtained from Statistics Canada, as the most recent data are from 2022. Combined Ontario median income for couples with children was utilized, with deductions made for income tax, Employment Insurance, and Canada Pension Plan.

Rent [2]

Average apartment rental costs are estimates based on the Canadian Mortgage and Housing Corporation (CMHC) Ontario Rental Market Report. CMHC provides a consistent data source with a known methodology. CMHC does not publish a statistic if its reliability is too low or if publication would violate confidentiality rules. However, CMHC's data likely underestimate local rental costs, and as a result the amount of funds remaining for each scenario would likely be lower and the percentage attributable to rent would be higher.

The Rental Market Survey is conducted in urban areas with populations of 10,000 or more. The survey includes both new and existing units in privately initiated structures with at least 3 rental units. The cost for a new tenant would likely be higher, as current tenants are protected from large annual increases by Ontario's residential rent increase guideline.

Utility costs (e.g., heat, electricity, hot water) may or may not be included in the rental amounts.

CMHC cost estimates were for October 2023. Cost estimates were adjusted for inflation using the Consumer Price Index (CPI) for shelter in Ontario for the estimated increase from October 2023 to May 2024.

Accommodation size for most scenarios was selected based on suitability as defined by the National Occupancy Standard (NOS). The standard includes various criteria, including a maximum of 2 people per bedroom. Most scenarios utilize 1, 2, or 3-bedroom apartments, depending on the household size and composition. Exceptions were made for 2 scenarios where the suitable accommodation size may not be realistic due to what is available or affordable. The scenario with a single person receiving Ontario Works is costed with a bachelor apartment. The scenario with a single parent with 2 children receiving Ontario Works was costed with a 2-bedroom apartment.

Food[3]

Food costs are calculated using the Ontario Nutritious Food Basket (ONFB), which is based on the National Nutritious Food Basket (NNFB). The ONFB survey tool is revised annually by ODPH, in collaboration with Public Health Ontario (PHO). The ONFB measures the cost of basic eating that represents current nutrition recommendations and average food purchasing patterns.

The NNFB is based on Canada's Food Guide, national food intake data, and Dietary Reference Intakes (DRIs). The NNFB and Canada's Food Guide are not inclusive for all religious and cultural groups. The ONFB does not reflect sourcing of traditional Indigenous foods. These are significant limitations of this data collection and may limit the generalizability and relevance of the food costs to different population groups.

London Food Bank volunteers and a Western University Dietetic Practicum Student completed the food costing, with training and support provided by a Health Unit Registered Dietitian. Costing was conducted May 19 to June 1, 2024, at 10 full-service grocery stores in Middlesex County and the City of London, both online and in person, including premium and discount stores. Average costs were calculated for 61

food items. If preferred food items were unavailable, similar items (i.e., proxy items) were used with minor differences between nutrition and/or price.

An adjustment factor was applied to the food costs depending on the household size in the scenario to account for the additional costs per person to feed a small group and the lower costs per person to feed a larger group.

Comparing 2024 to Previous Year's Scenarios[5]

Adjustments to the food and rent costs for the 2023 and 2022 scenarios are required before comparison to the 2024 scenarios. Comparing 2024 food costs to years prior to 2022 is not appropriate due to methodology changes (e.g., introduction of online costing; revisions to the NNFB to be consistent with 2019 Canada's Food Guide, updated national food intake data, and updated DRIs).

Local food costing was not completed in 2020 or 2021 due to the COVID-19 pandemic.

Food Adjustments
In 2024, Health Canada adjusted the NNFB spreadsheet due to revisions to Dietary Reference Intakes for Energy for groups where the Estimated Energy Requirement (EER) increased by more than 100 kcal/day (i.e., Males 14-18 years old, Females 14-18 years old, Pregnant <19 years old y, Pregnant 19-30 years old, Pregnant 31-50 years old, Breastfeeding <19 years old, and Breastfeeding 19-30 years old).

The 2024 Monitoring Food Affordability in Ontario Master Spreadsheet was updated to reflect the increased EER for these groups. Weekly cost of ONFB in 2024 for these groups increased significantly compared to 2023 and 2022 due to the increased EER.

Rent Adjustments
In 2024, a CPI adjustment to rent costs was made to more accurately reflect actual local rental costs. This adjustment was not made in previous years. CMHC cost estimates were for October 2023. Cost estimates were adjusted for inflation using the CPI for shelter in Ontario for the increase from October 2023 to May 2024.

Data Sources

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Ministry of Health

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Ministère de la Santé

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Téléc. :416 325-8412

December 23, 2024

To: Medical Officers of Health and Chief Executive Officers

Re: Strengthening Public Health Updates

Dear Colleagues,

Further to the memo from Dr. Kieran Moore dated December 11, 2024, I am writing to share an update on the planned release and implementation of the revised Ontario Public Health Standards (OPHS) as well as public health funding.

The sector provided valuable input throughout the OPHS consultation, and the ministry is working to address and incorporate your feedback as well as exploring additional opportunities to further clarify responsibilities to reduce the workload burden at the local level.

The ministry recognizes boards of health require time to plan for the implementation of the revised OPHS. **Therefore, the revised OPHS and incorporated documents will be released to the sector by August 2025, with an effective date of January 2, 2026**.

Throughout 2025 the ministry will explore implementation supports via sector engagement, such as the OPHS Review Table.

The current OPHS and incorporated protocols and guidelines remain in effect, please find the current standards here.

As part of the Strengthening Public Health initiative, the ministry is providing growth base funding of 1% for three calendar years (2024, 2025, and 2026) to address the urgent need for stabilization while change processes are underway and undertaking a review of the provincial funding methodology for public health.

The ministry thanks everyone who participated in public health funding review engagement sessions over the summer, and we look forward to sharing more information on next steps, including timelines, as it is available.

Thank you for your continued collaboration in strengthening public health in Ontario. If you have any questions, please contact ophs.protocols.moh@ontario.ca.

Sincerely,

Elizabeth Walker
Executive Lead, Office of the Chief Medical Officer of Health, Public Health

c: Dr. Kieran Moore, MD, CCFP(EM), FCFP, MPH, DTM&H, FRCPC, FCAHS, Chief Medical Officer of Health and Assistant Deputy Minister, Public Health

alPHa
Association of Local PUBLIC HEALTH Agencies

alPHa's members are the public health units in Ontario.

alPHa Sections:

Boards of Health Section

Council of Ontario Medical Officers of Health (COMOH)

Affiliate Organizations:

Association of Ontario Public Health Business Administrators

Association of Public Health Epidemiologists in Ontario

Association of Supervisors of Public Health Inspectors of Ontario

Health Promotion Ontario

Ontario Association of Public Health Dentistry

Ontario Association of Public Health Nursing Leaders

Ontario Dietitians in Public Health

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The Honourable Peter Bethlenfalvy
Minister of Finance
Frost Building North, 3rd floor
95 Grosvenor Street
Toronto ON M7A 1Z1

January 20, 2025

Dear Minister Bethlenfalvy,

Re: 2024 Pre-Budget Submission: Public Health Programs and Services

On behalf of the Association of Local Public Health Agencies (alPHa) and its Boards of Health Section, Council of Ontario Medical Officers of Health Section, and Affiliate Organizations, we are writing to provide input on the financial requirements for a stable, locally based public health system as part of this year's pre-budget consultation.

We are pleased with the choices that have been made at the provincial level regarding Ontario's unique public health system, with approaches to reorganization, programming, and funding having been included in the ongoing Strengthening Public Health initiative that was first announced in 2023.

The four mergers involving nine of Ontario's public health units have been formally announced, and we are grateful for the ongoing support of the Ministry of Health, including commitments to providing the required financial resources, as we navigate the complex processes to finalize them. We are also grateful that it is recognized by all parties that mergers are not – nor are these intended to be – cost-saving exercises. This recognition also acknowledges that, despite the existence of the four new entities as of January 1 of this year, a great deal of work remains to realize the intended efficiencies through harmonizing resources and consolidating operations.

The second aspect of Strengthening Public Health is the revision of the Ontario Public Health Standards, which lay out in substantial detail the legislated expectations for programs and services of all Ontario boards of health. While this process is ongoing, early reviews suggest that these expectations are more likely to expand than to contract. Our members of course welcome any new responsibilities that are designed to improve population health and the resource commitments required to carry these out.

The third aspect of this initiative is a promise to review the public health funding model itself, which is currently shared between the Province (~75%) and obligated municipalities (~25%). These discussions have not yet begun, but we were grateful for the predictability afforded by the interim promise of 1% increases over the past three years. As we enter the final year of this pledge, we are looking forward to the more detailed discussion that has been promised.

While we are embracing the Strengthening Public Health approaches to addressing long-term stability and capacity, we want to be very clear that local public health is facing substantial budget pressures that need to be addressed now.

As the CMOH observed as part of the announcement of this initiative, the goal is to "optimize capacity, stability, and sustainability in public health and deliver more equitable health outcomes for Ontarians". He further observed that "there are long-standing challenges within the public health sector in Ontario related to capacity, stability and sustainability that have been identified through multiple reports over the past 20 years".

In his 2023 Annual Report, the CMOH urged an end to the "boom and bust" public health funding cycles that see the scaling back of resources that places public health systems at a disadvantage at the onset of each crisis. He emphasized the need to invest in public health up front and consistently, and repeated that such investments save money and provide long-term social and economic benefits (p. 11).

We acknowledge and appreciate the concrete financial commitments to public health that have been made in recent years (e.g. mitigation funding when the cost-sharing proportions were briefly changed, one-time investments related to the pandemic response, 1% year-over-year increases), but these have not and will not come close to addressing the longstanding and increasing capacity issues that local public health has experienced.

According to the Bank of Canada, inflation has averaged over 4% per year since 2020, which means that the 1% increases are insufficient and amount to de facto year-over-year funding cuts. In addition, inflation does not account for cost increases related to the decision to cost-share programs that were previously 100% funded by the Province, significant population growth, capital and technical expenditures, and increased expectations under the OPHS mandate.

As part of our 2023 budget submission, we included the following key findings. These needs are ongoing:

- Overall, the current funding envelope for public health units in Ontario is not sufficient to meet the provincially mandated standards. Though this has been the case for many years, our 2023 survey indicated that local public health units are projecting additional budget pressures from multiple sources in the coming years, including collective agreements, substantially increased inflationary pressures, the additional demands of the response to the co-circulation of respiratory diseases including flu, RSV and COVID-19, and the backlog of programs and services that has built up over nearly three full calendar years.

- Effectively meeting the Ontario Public Health Standards, excluding the Healthy Babies Healthy Children program for 2023 would have required an estimated $132M in total additional funding, representing an average increase of 11.8% across health units. This represents an increase of just 0.2% of the entire Ministry of Health budget.

- Effectively meeting the requirements of the Healthy Babies Healthy Children program for 2023 would have required an estimated $12.5M in total additional funding, representing an average increase of 13.8% across health units. This represents an increase of only 0.08% of the entire Ministry of Children, Community and Social Services budget.

Investments in public health generate significant returns, including better health, lower health care costs, and a stronger economy. According to the Ministry of Health's 2023-24 Budget, transfers to Ontario's Local Official Health Agencies amounted to $939,443,900, which was approximately 1.3% of the Ministry's entire operating budget for that year. Not only does this demonstrate a tremendous return on investment given the significant benefit to the health of the people of Ontario, but also that

even the high-percentage increases required for local public health to carry out its mandate would be relatively modest in dollar amounts.

alPHa has produced a series of infographics that demonstrate the return on investment that public health provides through programs and services that promote well-being, prevent disease and injury, and protect population health. In so doing, local public health supports the Ontario government in its goals to be efficient, effective, and provide value for money. The Ministry of Health's Strengthening Public Health initiative demonstrates the government's commitment to local public health, and we are asking that an explicit commitment be made to providing local public health agencies with the sufficient and sustainable funding required in the 2025 Budget.

We always welcome this opportunity to provide comments on desired spending priorities for the coming year and would like to note that many of our members will also be providing their own input. We strongly urge you to take each of these into careful consideration, as these will reflect the diverse local needs and priorities that will delve further into the details of public health work and the resources required to carry it out.

We look forward to working with you and welcome this opportunity to advocate for a sustainable and resilient public health system. Please have your staff contact Loretta Ryan, Chief Executive Officer, alPHa, at loretta@alphaweb.org or 647-325-9594 for any follow-up.

Sincerely,

Trudy Sachowski
alPHa Chair

Copy: Hon. Sylvia Jones, Minister of Health
Dr. Kieran Moore, Chief Medical Officer of Health, Ontario

Encl.

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

PUBLIC HEALTH MATTERS

Providing Leadership in Public Health Management

alPHa

Association of Local PUBLIC HEALTH Agencies

www.alphaweb.org

A PUBLIC HEALTH PRIMER

SPRING 2022

Public health champions health for all. Local public health agencies provide programs and services that promote well-being, prevent disease and injury, and protect population health. Our work, often done in collaboration with local partners and within the broader public health system, results in a healthier population and avoids drawing on costly and scarce health care resources.

OUR ASK

That decision makers acknowledge that local public health has been the backbone of Ontario's successful response to the pandemic and remains essential to the province's health and economic recovery, which will require sustained and sufficient resources and a stable structure embedded in local communities.

7,139,930

INDIVIDUALS VACCINATED WITH 3 DOSES IN ONTARIO AS OF MARCH 22, 2022

Source: Government of Ontario

1,140,865

CONFIRMED COVID-19 CASES IN ONTARIO AS OF MARCH 21, 2022

Source: Public Health Ontario

PUBLIC HEALTH RESPONSE

Ontario's 34 local public health agencies are the front line of the COVID-19 response.

Public health professionals are responsible for the following:

CASE AND CONTACT MANAGEMENT:
Identify and isolate cases.

DATA ANALYSIS:
Identify sources of infection and patterns of transmission.

OUTBREAK CONTROL:
Protect vulnerable populations in higher risk settings.

PUBLIC HEALTH MEASURES:
Implement and enforce measures to slow the spread of COVID-19.

ADVICE TO GOVERNMENT:
Provide expert input to inform government actions in the fight against COVID-19.

ADVICE TO THE PUBLIC:
Provide and reinforce expert advice to empower the public in the fight against COVID-19.

VACCINATION EFFORTS:
Lead the distribution and administration of COVID-19 vaccines in all Ontario communities.

- Population Health Assessment
- Health Equity
- Effective Public Health Practice
- Emergency Management
- Chronic Disease Prevention and Well-Being
- Food Safety
- Healthy Environments

PUBLIC HEALTH MATTERS

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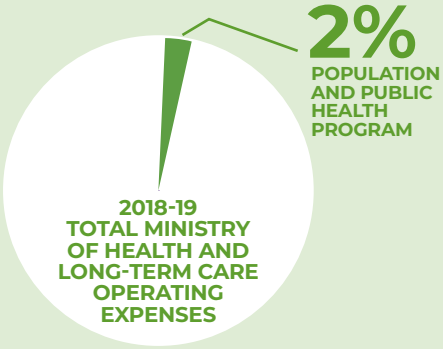
RETURN ON INVESTMENT

Investments in public health generate significant returns, including better health, lower health care costs, and a stronger economy.

According to the 2018-19 (former) Ministry of Health and Long-Term Care Expenditure Estimates, the operating estimate for the entire Population and Public Health Program (which includes internal Ministry expenses, funding for Public Health Ontario and the local grants) was **$1.267 billion**, or about **2%** of the total Ministry operating expenses.

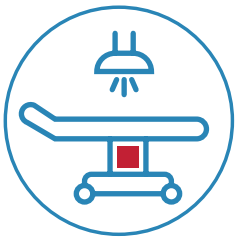
This demonstrates a tremendous return on investment given the significant benefit to the health of the people of Ontario.



IMPACT ON RESOURCES

The COVID-19 response **pre-empted most activities** mandated by the Ontario Public Health Standards.

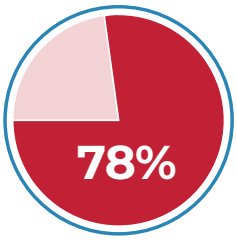
Suspension of routine public health programs and services is our equivalent of the health care system's "surgical backlog." We must resume these while we maintain an effective COVID-19 response.



The COVID-19 pandemic magnified existing **health inequities**.

This will put additional demands on Public Health resources to address them in the future.

Each of Ontario's 34 local public health agencies had to **divert on average 78%** of all available resources to the COVID-19 response.



A measurable uptick in **substance use** (e.g., alcohol and opioids), **mental health issues**, and factors that contribute to chronic diseases will put further demands on public health resources in the future.

Source: alPHa Report: Public Health Resilience in Ontario - Executive Summary
Source: alPHa Report: Public Health Resilience in Ontario – Report
*Please visit: **www.alphaweb.org***

PUBLIC HEALTH MATTERS #2 of Series

Providing Leadership in Public Health Management

alPHa Association of Local PUBLIC HEALTH Agencies

www.alphaweb.org

PUBLIC HEALTH FALL VACCINE SUCCESS

Local public health units increased vaccine coverage and provided vital protection against disease for residents across Ontario. The leadership provided by Ontario's local public health agencies on an unprecedented number of vaccine campaigns has resulted in exceptional vaccine uptake. This fall, Ontario's 34 local public health units intensified vaccine activities to combat the fall respiratory virus surge and other emerging public health issues.

PUBLIC HEALTH UNITS PREPARED FOR, COORDINATED, AND DELIVERED 7 VACCINE CAMPAIGNS

- COVID-19: pediatric, 5-17 booster, and bivalent
- Routine: influenza and student immunization and catch-up program
- Outbreak response: mpox & meningococcal B
- Promoted routine vaccines

COMMUNICATION AND PUBLIC EDUCATION ABOUT VACCINE CAMPAIGNS

3,300+ Social media posts

4,500,000+ Social media engagement and impressions

700+ Media releases, responses, and interviews

MORE CLINICS, INCREASED CAPACITY, BROADER OUTREACH, EXTRAORDINARY RESULTS

Ontario's 34 public health units led Ontario's vaccination campaigns with a focus on increased access, data-driven action, integrated services, and amplified messages.

FALL 2022 VACCINATION BY THE NUMBERS

1,100+ Fixed site clinics*

2,000+ Mobile clinics*

700+ Influenza clinics

1,000+ Student Immunization and catch-up clinics

400+ Mpox clinics

3,000+ Homebound vaccinations

** co-administration of multiple vaccines*

Population Health Assessment · Health Equity · Effective Public Health Practice · Emergency Management · Chronic Disease Prevention and Well-Being · Food Safety · Healthy Environments

January 11, 2023

PUBLIC HEALTH MATTERS

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PUBLIC HEALTH FALL VACCINE SUCCESS

ACCESS INCREASED

- Local public health units partnered with municipalities to run mobile vaccination buses. The buses aimed to decrease barriers to vaccination, services were offered at locations where people attend regularly (such as malls, grocery stores, local events, and parks), in remote locations, to at-risk communities, and in other underserved areas.
- Local public health units worked closely with Indigenous communities. For example, a local public health unit created and shared biweekly communication packages with local First Nations, urban Indigenous community groups and Métis partners to foster open communication, prompt sharing of public health guidance, and updates on vaccines.

DATA-DRIVEN ACTIVITIES

- Ontario's 34 local public health units used data to optimize vaccine coverage. This is exemplified through a local public health unit who used equity indicators to identify their highest priority neighbourhoods to target outreach and support. This geographically mapped information was posted publicly on a COVID-19 dashboard and used internally for health system planning. Vaccine strategies were employed, using mobile clinics, fixed sites, and organization partnerships (such as Ontario Health Teams and community clinics) in order to increase vaccination.

INTEGRATED SERVICES AND COMMUNITY OUTREACH

- Ontario's local public health units integrated services to have the greatest impact. For example, a local public health unit established 15 hubs throughout their community, offering services like dental screenings, mental health, addictions and substance use supports, COVID-19, flu and routine immunizations.
- Local public health units partnered with community agencies to enhance vaccine outreach and worked to help get residents vaccinated against COVID-19. In one local public health unit, this included the operation of Vaccine Engagement Teams comprised of over 150 health, community, and faith-based organizations and more than 700 community ambassadors reflecting the community's diversity.

AMPLIFIED MESSAGES

- Ontario's 34 local public health units employed traditional media tactics (such as news releases, media events, and social media) in addition to unique targeted local tactics. One example of this work is demonstrated by a local public health unit who worked with hospital partners to create a commercial that highlighted actions needed to reduce strain on hospital systems resulting from respiratory illnesses. The commercial plays before every movie at the local cinema, at hockey home games, and on local television.

Population Health Assessment | Health Equity | Effective Public Health Practice | Emergency Management | Chronic Disease Prevention and Well-Being | Food Safety | Healthy Environments

PUBLIC HEALTH MATTERS

Providing Leadership in Public Health Management

alPHa

Association of Local PUBLIC HEALTH Agencies

www.alphaweb.org

A BUSINESS CASE FOR LOCAL PUBLIC HEALTH

Public health champions health for all. Local public health agencies provide programs and services that promote well-being, prevent disease and injury, and protect population health. Our work, often done in collaboration with local partners and within the broader public health system, results in a healthier population and avoids drawing on costly and scarce health care resources.

OUR ASK

We are asking decision makers for their support for the goals and objectives of public health, with sustained and sufficient resources to ensure stability for Ontario's locally-based network of public health agencies.

Local public health remains essential to the province's population health and the associated economic prosperity.

Local public health supports the Ontario government in its goals to be efficient, effective, and provide value for money.

INVESTMENT IN LOCAL PUBLIC HEALTH

Investment in local public health includes the following returns:

REDUCED HOSPITALIZATIONS AND DEATHS:

Public health measures such as **vaccination, case and contact management, outbreak response, community infection control measures** reduced hospitalizations by 13 times during the COVID-19 pandemic.

Local public health is also central to responding to new infectious disease risks such as MPOX, reemerging pathogens like poliomyelitis and tuberculosis, and the return of annual seasonal epidemics such as influenza and respiratory syncytial virus (RSV).

SAFE COMMUNITIES:

Local public health protects our communities by working with municipalities to provide **safe water, safe food,** and **emergency preparedness** and **response.**

HEALTHY CHILDREN:

Local public health protects children through **promotion of healthy growth and development, vaccination, dental screening,** and **school health.**

- Population Health Assessment
- Health Equity
- Effective Public Health Practice
- Emergency Management
- Chronic Disease Prevention and Well-Being
- Food Safety
- Healthy Environments

PUBLIC HEALTH MATTERS

alPHa
Association of Local PUBLIC HEALTH Agencies

FUNDING

Local public health requires sufficient and sustainable base funding from the provincial government.

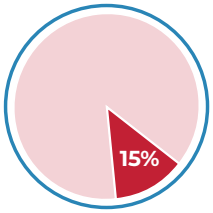
The end of mitigation funding ($46.8M) from the province would equal a **loss** to the overall funding of local public health programs.

A return to the previous **provincial-municipal** cost-sharing formula for all programs and services would help to offset this loss.

COVID-19 RECOVERY

In the wake of the COVID-19 pandemic, local public health has been working hard to put back in place its full range of programs, with progress being made on its recovery priorities (Public Health Resilience), and responding to seasonal respiratory viruses.

PUBLIC HEALTH LEADS TO HEALTH CARE SAVINGS



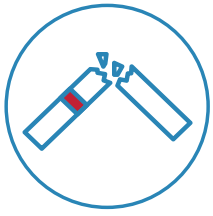
Health promotion and **disease prevention** are mandated roles for local public health agencies. In doing this, they also who work with the Ministry of Health and key stakeholders in addressing chronic diseases such as diabetes, heart disease and cancer.

HEALTH INEQUITIES DUE TO SOCIOECONOMIC POSITION CONTRIBUTED $60.7B = 15% OF ALL HEALTH CARE COSTS.

Smoking, alcohol, diet and **physical activity** improvements could prevent $89B in health care costs = 22% of all health care costs over 10 years.

Alcohol use is another major contributor to health care and societal cost. It is estimated that alcohol use costs the Ontario economy $5.3B in health care, law enforcement, corrections, prevention, lost productivity and premature mortality.

It is estimated that **diabetes** in Canada cost the health care system $15.36 billion over a 10 year period, affecting nearly 10% of the population.



Promotion of **tobacco cessation** and **tobacco control** reduced health care costs by 1.7% overall = $4.2B saved over 10 years.


Healthy Growth and Development


Immunization


Infectious and Communicable Diseases Prevention and Control


Oral Health


Safe Water

School Health


Substance Use and Injury Prevention

PLEASE ROUTE TO:
All Board of Health Members
All Members of Regional Health & Social Service Committees
All Senior Public Health Managers

January 16, 2025

January 2025 InfoBreak

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.

Leader to Leader - A message from alPHa's Chair - January 2025

Happy New Year!

Looking ahead - there is much optimism for 2025. There is no doubt that it is going to be an interesting and busy year ahead for alPHa, local public health, and for Ontario's public health system.

On your behalf, the 2024-2025 alPHa Board of Directors, are dedicated to their governance role as a uniquely qualified and unified leadership voice for Ontario's local public health system. Throughout 2025, alPHa representatives will continue to participate in various committees, focus groups, and public health tables to provide recommendations and advice to the province's policy influencers and key decision-makers. Collectively the alPHa Board of Directors and its members are advancing the cause of a resilient, sufficiently resourced, local public health system. alPHa's Chief Executive Officer and alPHa staff provide essential support for the Board of Directors and for alPHa Members in this work.

The foundation of alPHa and its success is built upon the support of its Members and the existing network of relationships with its Member local public health agencies. During 2025, alPHa is committed to continuing to value, support, and engage its Members, proactively, and meaningfully through regular updates via email, monthly in *Information Break*, on X (formerly known as Twitter), at Member-driven events, and with time sensitive updates and opportunities for consultations. alPHa's website www.alphaweb.org is a public portal of public health resources, while *Information Break* is your public health portal exclusive to alPHa Members.

On the horizon are key Member-engagement opportunities such as alPHa's 2025 Online Winter Symposium and alPHa's in-person 2025 AGM and Conference in Toronto. Online and in-person alPHa Member events are tremendous opportunities to network and to continue the important conversation on the role of local public health in the province's resilient public health system and its demonstrated role for the public health of all Ontarians.

Anticipation is building around alPHa's online 2025 Winter Symposium, Workshops, and Section meetings on February 14, 2025. An informative lineup of topics, with speakers including Ontario's Chief Medical Officer of Health, Dr. Kieran Moore; Principals of Strategy Corp, Sabine Matheson and John Perenack; and others. Founder and CEO of GenWell, Pete Bombaci, will be the keynote. He will talk about the importance of being a catalyst for action to meaningfully improve long-term health and well-being, reduce costs to the healthcare system, increase social cohesion and inclusivity, and drive economic and community benefit.

Pre-symposium workshops are included, at no additional cost, for each individual who registers for the alPHa 2025 Winter Symposium. On the afternoon of

Wednesday, February 12 is "Leading Change – The 5 Tensions to Manage Successful Transformation" with Tim Arnold. The following afternoon on Thursday, February 13 is "Harnessing the Power of 'Where' for Public Health Discussions" with Esri Canada. Registration to these workshops is automatic with your individual Symposium registration.

The road ahead for 2025 and beyond is clearly paved by alPHa's 2024-2027 Strategic Plan. The Winter Symposium coincides with the one-year anniversary of the release of the plan. Maria Sánchez-Keane, Principal, Centre for Organizational Effectiveness will report on the progress of the plan and alPHa's accomplishments. The alPHa Board of Directors and Executive Committee, supported by alPHa's Chief Executive Officer and staff, will continue to provide this strategic leadership with one, unified voice representing the public health system across its member constituents.

In my role as Chair of the alPHa Board of Directors, I will be attending the Rural Ontario Municipal Association (ROMA) 2025 Conference January 19 to 21, 2025 and The Ontario Public Health Convention (TOPHC) 2025 in March. If you are at either of these events, I look forward to the opportunity to connect. In the meantime, I will see you online at the alPHa 2025 Winter Symposium, and the alPHa BOH Section meeting.

Trudy Sachowski
Chair, alPHa Board of Directors

Registration for the alPHa 2025 Winter Symposium, Section Meetings, and Workshops is now open!

Registration is now open for the **online** 2025 Winter Symposium, Section Meetings, and Workshops that are taking place February 12-14! These events will discuss a variety of issues of key importance to public health leaders and you won't want to miss out.

alPHa would like to acknowledge and thank Simcoe Muskoka District Health Unit for being the co-host for the alPHa Winter Symposium. Their support and partnership have made these events possible.

A thank you also goes to the University of Toronto's Dalla Lana School of Public Health, Eastern Ontario Health Unit, Esri Canada, and GenWell for their generous event support.

On Friday, February 14, from 8:30 a.m. - 4:30 p.m., there is an exciting lineup of Symposium speakers and topics:

- *alPHa Update* with Trudy Sachowski, alPHa Chair, and Loretta Ryan, Chief Executive Officer, alPHa.
- *Building a More Connected Canada Where Everyone Thrives* with keynote speaker, Pete Bombaci, Founder & CEO, GenWell.

- *We've Merged! So, What's Next?* with Dr. Ethan Toumishey, Deputy MOH, South East Health Unit and Susan Stewart, Director, Merger Office.
- *alPHa Strategic Plan - Happy First Anniversary*, with Maria Sánchez-Keane, Principal, Centre for Organizational Effectiveness.
- *Update from Public Health Ontario* with Dr. Jessica Hopkins, Vice President and Chief, Communicable Disease Control, Public Health Ontario.
- *So, Still Can't Sleep at Night?* with Sabine Matheson and John Perenack, Principals, StrategyCorp.
- *Update from the Chief Medical Officer of Health*, Dr. Kieran Moore, Chief Medical Officer of Health.

The lineup of speakers and topics for the BOH Section meeting includes:

- *Mergers - Meet the New Chairs!* with Jan O'Neill, Board of Health, South East Health Unit (Additional names to be added…stay tuned!).
- *Boards of Health - Roles & Responsibilities* with James LeNoury, Principal, LeNoury Law, and Legal Counsel, alPHa.
- Association of Municipalities of Ontario (AMO) Update. This session includes their report titled, *Municipalities Under Pressure: The Human and Financial Cost of Ontario's Homelessness Crisis*, with Alicia Neufeld, Senior Manager, Policy, and Daniela Spagnuolo, Policy Advisor, AMO.

Please note, Affiliates are welcome and encouraged to attend the BOH Section Meeting.

In conjunction with the Symposium and Section meetings, we are holding two half-day workshops. The first one, *Leading Change – The 5 Tensions to Manage Successful Transformation*, with Tim Arnold, is on Wednesday, February 12, from 1 p.m. to 4 p.m. The workshop will help you to: embrace innovation and consistency; validate facts and feelings; focus on the short term and the long term; promote planning and action, and value complexity and simplicity. To learn more, click here.

On the afternoon of Thursday, February 13, from 1 p.m. to 4 p.m., we will hold the second workshop with Esri Canada. This workshop titled, *Harnessing the Power of 'Where' for Public Health Discussions*, is designed to assist alPHa Members to understand and recognize the growing value of maps and geographic technology to help solve some of Canada's most pressing public health challenges. Through a series

of presentations of real-world case studies and dynamic discussions, attendees will learn how geographic data, real-time maps, and new innovations in geographic technology are connecting Canadian public health teams to uncover local drivers of health inequity, strengthen health emergency preparedness, and improve collaborative decision-making. To learn more, click here.

These workshops are being offered at no additional cost to Symposium registrants and you will be registered automatically when you sign up for the Winter Symposium. Separate registrations are not available for individual events.

The following documents can be accessed by clicking on the links below:

- Event Poster
- Symposium Draft Program
- BOH Section Meeting Draft Agenda
- *Leading Change – The 5 Tensions to Manage Successful Transformation* Workshop Poster and Draft Agenda
- *Harnessing the Power of 'Where' for Public Health Discussion* Workshop Draft Agenda
- *Zoom Troubleshooting Tips*

Registration is for alPHa Members only, (please note, you do not need to create an account on the alPHa website in order to register for the event) and the cost is $399+HST (and is inclusive of the Symposium, Workshops, and Section Meeting. You also only need to register once to attend all of the events). **The closing date to register is Friday, February 7, 2025**. Cancellations and substitutions are permitted until February 7. Cancellations are subject to a $50 processing fee and must be received by February 7. No refunds will be issued after that date.

As an important reminder, badge sharing is not permitted, and one registration equals one Member. This is a vital way to ensure all attendees have paid and are supporting alPHa in doing so.

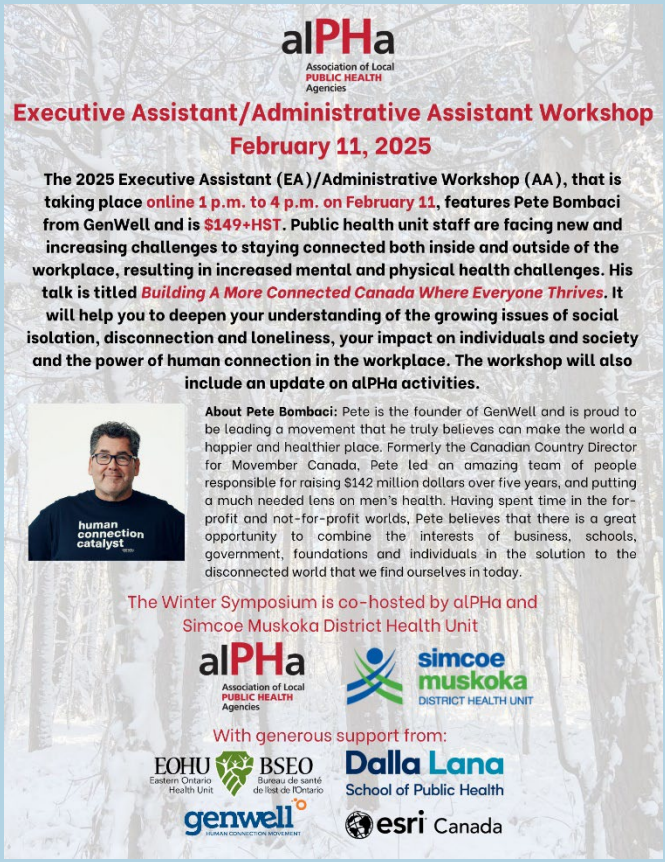
Please note, the best way to pay for your registration is via credit card or Electronic Fund Transfer (EFT). If it is not possible to pay via credit card or EFT, cheques may be sent to:

Association of Local Public Health Agencies

PO Box 73510, RPO Wychwood
Toronto, Ont.
M6C 4A7

If you have any questions regarding these events, please contact alPHa Staff at: info@alphaweb.org.

Calling all Executive Assistants/Administrative Assistants!



In case you missed it, registration has opened for the Executive Assistant/Administrative Assistant Workshop! This **online** event will be held on Tuesday, February 11, 2025 from 1 p.m. - 4 p.m., and is an opportunity to connect with colleagues from across Ontario and learn new skills. The cost is $149+HST and **the final day to register is Friday, February 7, 2025**.

alPHa would like to acknowledge and thank Simcoe Muskoka District Health Unit for being the co-host for the alPHa EA/AA Workshop. Their support and partnership have made this event possible. A thank you also goes to the University of Toronto's Dalla

Lana School of Public Health, Eastern Ontario Health Unit, Esri Canada, and GenWell for their generous event support.

The workshop, titled *Building A More Connected Canada Where Everyone Thrives*, is being led by Pete Bombaci, Founder & CEO, of GenWell. It will help you to deepen your understanding of the growing issues of social isolation, disconnection and loneliness, and the power of the human connection in the workplace. To learn more about this event, you can view the flyer here.

Please note, you do not need to create an account on the alPHa website in order to register for the workshop. Cancellations and substitutions are permitted until February 7. Cancellations are subject to a $50 processing fee. No refunds will be issued after that date. The best way to pay for your registration is via credit card or Electronic Fund Transfer (EFT). If it is not possible to pay via credit card or EFT, cheques may be sent to:

Association of Local Public Health Agencies
PO Box 73510, RPO Wychwood
Toronto, Ont.
M6C 4A7

As an important reminder, badge sharing is not permitted, and one registration equals one participant. This is a vital way to ensure all attendees have paid and are supporting alPHa in doing so.

While this workshop is geared to EAs/AAs, if there are other support staff from your health unit who would benefit from it, please share this invitation with them.

If you have any questions regarding this event, please contact alPHa Staff at: info@alphaweb.org.

We hope to see you online on February 11!

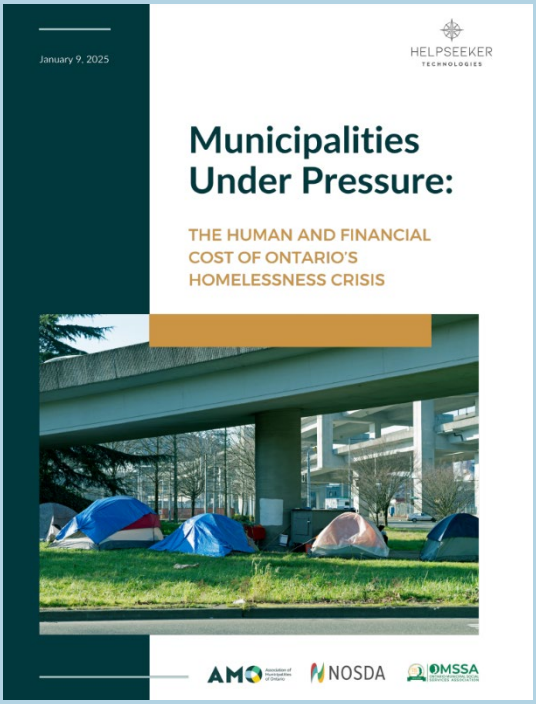
Rural Ontario Municipal Association (ROMA) Conference

This month, many alPHa Members, particularly from the Boards of Health Section, will be attending the ROMA Conference taking place from January 19-21, in Toronto. Whether you're an alPHa member attending the conference or participating in a delegation, here are some key alPHa resources:

- 2025 Pre-Budget Consultations - alPHa Deputation
- alPHa Letter - OAG Opioid Strategy
- alPHa's submissions on 2024 OPHS Review (includes the Statement of Principles) and OPHS Review Follow-Up
- alPHa's Resolutions from the 2024 AGM
- *Public Health Matters* Infographic – Business Case for Public Health
- "What is Public Health?"

Looking for more information? Visit our Boards of Health Resources webpage for documents to help you prepare for this event.

Association of Municipalities of Ontario (AMO) releases report on ending chronic homelessness



AMO, a non-profit organization representing all of Ontario's 444 municipal governments, has released a new research report documenting the growth in homelessness in recent years and outlining what is needed to reverse these trends. This research project was undertaken in partnership with the Ontario Municipal Social Services Association (OMSSA) and the Northern Ontario Service Delivery Association (NOSDA) while also being led by researchers at HelpSeeker Technologies.

The full report, key messages cover document, news release and a communications toolkit are now on the AMO website.

2025 Budget Consultations

Ontario

alPHa sent an e-mail to the Membership on December 3, 2024 regarding the Government of Ontario seeking input on the 2025 budget. You can submit your input via a survey, a written submission, or by mail.

On December 16, 2024, Paul Sharma, Affiliate Representative on the alPHa Board of Directors, gave a deputation regarding the Ontario budget, on behalf of the Association during a consultation session that took place in Mississauga. Please note, the speakers were limited to three minutes for presentation time. To view the deputation, click here.

alPHa will be providing a written submission and invites its Members to also do so. alPHa Members are encouraged to also send in a submission. Details can be found below and at www.ontario.ca/budgetconsultations.

You can share your ideas in the following ways:

- The online survey will close on February 3, 2025.
- Take the survey

- Submit your written ideas via the submission portal by February 3, 2025.
- Submit your proposal

- Mail your submission to:

The Honourable Peter Bethlenfalvy
Minister of Finance
c/o Budget Secretariat
Frost Building North, 3rd Floor
95 Grosvenor Street
Toronto, Ontario
M7A 1Z1

- Email: MOFconsultations@ontario.ca for more information.
- Questions? Email: MOFconsultations@ontario.ca

National Collaborating Centres for Methods and Tools: 2025 Knowledge Translation Graduate Student Awards

The National Collaborating Centres for Public Health (https://nccph.ca/) are now accepting applications for the 2025 Knowledge Translation Graduate Student Awards! Three prizes of $1500 will be awarded to recognize the work of graduate students related to knowledge translation in public health in Canada. The deadline for applications is February 10, 2025. Learn more about the awards here: https://www.nccmt.ca/impact/kt-student-awards-nccph.

Voluntary mergers for local public health agencies

Ontario

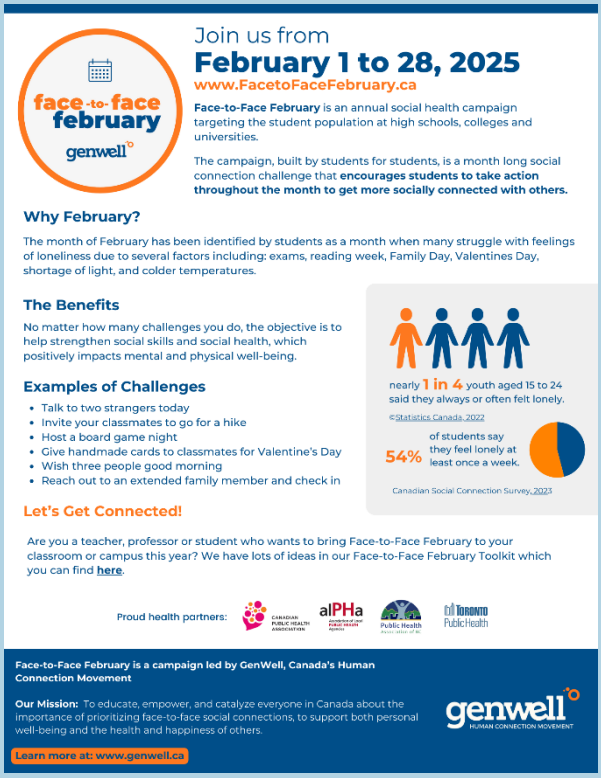
On December 2, 2024, the Government of Ontario made a number of announcements, including the voluntary mergers of nine local public health agencies. To read more, click here.

Ontario Public Health Directory: January 2025 update

The *Ontario Public Health Directory* has been updated and is available on the alPHa website. Please ensure you have the latest version, which has been dated as of **January 14, 2025**. To view the file, log into the alPHa website.

Please note, we will be updating the directory again soon with regards to the recently announced mergers.

GenWell: Face-to-Face February



In February, GenWell is launching its *Face-to-Face February* campaign. This is built by students, for students, and is a month-long social connection challenge that encourages students to take action throughout February to get more socially connected with others. To learn more, click here.

alPHa is very pleased to note that Pete Bombaci, from GenWell, will be conducting a workshop with the EAs/AAs on February 11. He will also be the opening keynote speaker at the Winter Symposium on February 14.

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 information, orientation materials, best practices, case studies, by-laws, Resolutions, and other resources. **In particular, alPHa is seeking resources to share regarding the province's Strengthening Public Health Initiative, including but not limited to, voluntary mergers and the need for long-term funding for local public health.** If you have a best practice, by-law or any other resource that you would like to make available via the newsletter and/or the website, 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 Boards of Health (Revised Jan. 2024)
- Review of Board of Health Liability, 2018, (PowerPoint presentation, Feb. 24, 2023)
- Legal Matters: Updates for Boards of Health (Video, June 8, 2021)
- Obligations of a Board of Health under the Municipal Act, 2001 (Revised 2021)
- Governance Toolkit (Revised 2022)
- Risk Management for Health Units
- The Ontario Public Health Standards
- Public Appointee Role and Governance Overview (for Provincial Appointees to BOH)
- Ontario Boards of Health by Region
- List of Units sorted by Municipality
- List of Municipalities sorted by Health Unit
- Map: Boards of Health Types

- Healthy Rural Communities Toolkit
- The Canadian Centre on Substance Use and Addiction
- NCCHPP Report: Profile of Ontario's Public Health System (2021)
- The Municipal Role of Public Health(2022 U of T Report)
- Boards of Health and Ontario Not-for-Profit Corporations Act

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Calling all Ontario Boards of Health: Level up your expertise with our training courses designed just for you!

Don't miss this unique opportunity to enhance your knowledge and strengthen local public health leadership in Ontario.

BOH Governance training course
Master public health governance and Ontario's Public Health Standards. You'll learn all about public health legislation, funding, accountability, roles, structures, and much more. Gain insights into leadership and services that drive excellence in your unit.

Social Determinants of Health training course
Explore the impact of Social Determinants of Health on public health and municipal governments. Understand the context, explore Maslow's Hierarchy of Needs, and examine various SDOH diagrams to better serve your communities.

Speakers are Monika Turner and Loretta Ryan.

Reserve your spot for in-person or virtual training now! Visit our website to learn more about the costs for Public Health Units (PHUs). Let's shape a healthier future together.

Additionally, thank you to all the public health agencies who have shown interest in our BOH courses. alPHa staff are currently coordinating the bookings and are pleased to see the uptake.

alPHa would like to thank Renfrew County and District Health Unit and North Bay Parry Sound District Health Unit for participating in the courses in November. We would also like to acknowledge City of Hamilton Public Health Services for participating on Monday, January 13.

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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. A complete online library of submissions is available here. These documents are publicly available and can be shared widely.

Public Health Ontario (PHO)

Public Health Ontario | Santé publique Ontario

New! Immunization Data Tool

PHO has published the new Immunization Data Tool! This new resource integrates and replaces existing immunization surveillance data previously reported on PHO's website. Users are able to explore different aspects of immunization coverage and vaccine safety, including trends over time, comparisons across public health units (including maps) and age groups. All data in the tool can be easily downloaded. We have also published an accompanying infographic that provides a summary of AEFIs reported in Ontario following vaccines administered in 2023. These resources do not include data on COVID-19 vaccines. As a result of the data integration in this new tool, PHO's Vaccine Safety Surveillance Tool is no longer be available.

Data and Epidemiological Summaries

- Mpox in Ontario
- Measles in Ontario
- SARS-CoV-2 Genomic Surveillance in Ontario
- Integrated Respiratory Virus Risk Indicators for Ontario
- Influenza Genomics Surveillance in Ontario: 2024-25 Early Season
- Chlamydia in Ontario: Focus on 2023
- Gonorrhea in Ontario: Focus on 2023
- Infectious Syphilis and Early Congenital Syphilis in Ontario: Focus on 2023
- Hepatitis C Surveillance Report

Recent Knowledge Products

- Prevention and Management of Avian Influenza in Health Care Settings
- Healthcare Utilization and Clinical Comorbidities among People Who Died of a Substance-Related Toxicity Death in Ontario
- Planning Health Promotion Programs

Events

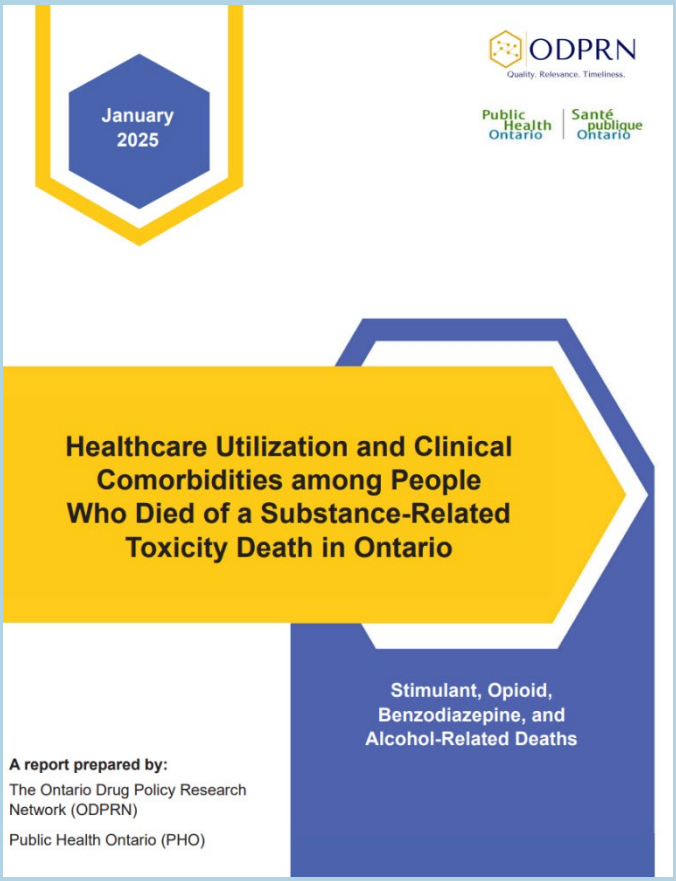
Be sure to keep an eye on PHO's Events page for their upcoming events.

- **20 January -** PHO Webinar: Vaping: Evidence on Dual Use with Tobacco Cigarettes
- **22 January -** PHO Webinar: Social Environments for Health Webinar Series Part Two: Stories from the Field

Recent Presentations

- Inflicted injuries among children and youth during the pandemic: A study across two Canadian provinces

Healthcare Utilization and Clinical Comorbidities among People Who Died of Susbtance-Related Toxicity Death in Ontario report released



On January 9, PHO and Ontario Drug Policy Research Network (ODPRN) released a report titled *Healthcare Utilization and Clinical Comorbidities among People Who Died of a Substance-Related Toxicity Death in Ontario*. They've also released an infographic.

The report highlights the high prevalence of healthcare needs and use among Ontarians who died of a substance-related toxicity. It provides insight into where and why individuals present to healthcare settings prior to death, with the goal of identifying gaps in access to care and supportive services for people who use substances.

Upcoming DLSPH Events and Webinars

Dalla Lana School of Public Health

- Climate Change & Youth Mental Health: Impacts and Opportunities for Action (Jan. 21)
- Conversations on Research Data Management in Health Sciences: Data Deposit (Jan. 21)

BrokerLink Insurance

Please note, alPHa's partnership with Aviva is no longer in place. All Members who are with Aviva are encouraged to explore insurance with BrokerLink.

alPHa Members qualify for exclusive insurance discounts with BrokerLink. We are excited to announce the 2025 Grand Group Giveaway! Get a quote on car or home insurance, and you could win a prize. Don't miss your chance to save on insurance and win some cash in BrokerLink's Grand Group Giveaway! Visit BrokerLink.ca/alPHa to learn more.

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alPHa's Strategic Plan

alPHa's 2024-2027 Strategic Plan is available here.

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alPHa's mailing address

Please note our mailing address is:
PO Box 73510, RPO Wychwood
Toronto, ON M6C 4A7

For further information, please contact info@alphaweb.org.

News Releases

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