Algoma
PUBLIC HEALTH
Santé publique Algoma

November 27, 2024

BOARD OF HEALTH MEETING

Algoma Community Room / Videoconference

www.algomapublichealth.com

Meeting Book - November 27, 2024, Board of Health Meeting

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Board of Health Meeting
AGENDA

Wednesday, November 27, 2024 - 5:00 pm

SSM Algoma Community Room | Videoconference

BOARD MEMBERS	APH MEMBERS
Deborah Graystone	Dr. John Tuinema - Acting Medical Officer of Health & CEO
Sally Hagman - Chair	Rick Webb - Director of Corporate Services
Julila Hemphill	Kristy Harper - Director of Health Promotion & Chief Nursing Officer
Donald McConnell - 2nd Vice-Chair	Leo Vecchio - Manager of Communications
Luc Morrissette - 1st Vice-Chair	Leslie Dunseath - Manager of Accounting Services
Loretta O'Neill	Tania Caputo - Board Secretary
Matthew Shoemaker	
Sonia Tassone	
Suzanne Trivers	
Jody Wildman	

1.0 Meeting Called to Order *S. Hagman*

a. Land Acknowledgment

b. Roll Call

c. Declaration of Conflict of Interest

2.0 Adoption of Agenda *S. Hagman*

RESOLUTION

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

3.0 Delegations / Presentations

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

RESOLUTION

THAT the Board of Health meeting minutes dated October 23, 2024, be approved as presented.

5.0 Business Arising from Minutes

6.0 Reports to the Board *J. Tuinema*

a. Medical Officer of Health and Chief Executive Officer Reports

MOH Report - November 2024

- 2024 Public Health Champion Awards Launch

RESOLUTION

THAT the report of the Medical Officer of Health and CEO for November 2024 be accepted as presented.

b. Finance and Audit

i. Finance and Audit Committee Chair Report *L. Morrissette*

RESOLUTION

THAT the Board of Health accepts the November 6, 2024, Chair Report for the Finance and Audit Committee Meeting as presented.

ii. Unaudited Financial Statements ending September 30, 2024 *L. Morrissette*

RESOLUTION

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

iii. 2025 Recommended Capital and Operating Budget Report *L. Morrissette*

RESOLUTION

THAT the Board of Health has reviewed and accepts the recommendation of the Finance and Audit Committee to approve the 2025 Capital and Operating Budget Report.

c. Governance

i. Governance Committee Chair Report *D. McConnell*

RESOLUTION

THAT the Board of Health accepts the November 13, 2024, Governance Committee Chair Report as presented.

ii. Policy 02-05-020 Travel *D. McConnell*

RESOLUTION

THAT the Board of Health approves Policy 02-05-020 Travel as presented.

iii. Bylaw 06-02 Ontario Building Code Appointments *D. McConnell*

RESOLUTION

THAT the Board of Health approves Bylaw 06-02 Ontario Building Code Appointments as presented.

iv. Bylaw 95-1 To Regulate the Proceedings of the Board - (in addendum) *D. McConnell*

RESOLUTION

THAT the Board of Health approves Bylaw 95-1 To Regulate the Proceedings of the Board as presented.

7.0 New Business/General Business *S. Hagman*

8.0 Correspondence - requiring action *S. Hagman*

a. Provincial Funding Letter

RESOLUTION

THAT the Board of Health approves the Provincial Funding Letter as presented.

9.0 Correspondence - for information *S. Hagman*

a. alPHa Information Break - November 2024

b. alPHa Virtual Conference Report - November 2024

10.0 Addendum *S. Hagman*

a. Bylaw 95-1 - To Regulate the Proceedings of the Board

11.0 In-Camera *S. Hagman*

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

RESOLUTION

THAT the Board of Health go in-camera.

12.0 Open Meeting *S. Hagman*

Resolutions resulting from in-camera meeting.

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

Board of Health
Wednesday, January 22, 2025 @ 5:00 pm
SSM Algoma Community Room | Video Conference

Finance and Audit Committee Meeting
Wednesday, February 12, 2025 @ 5:00 pm
SSM Algoma Community Room | Video Conference

14.0 Adjournment *S. Hagman*

RESOLUTION

THAT the Board of Health meeting adjourns.

Algoma
PUBLIC HEALTH
Santé publique Algoma

November 27, 2024

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

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APH AT-A-GLANCE

Toxic Drugs in Algoma: Community Assessment and Next Steps

On November 29th, APH will release a report, "Toxic Drugs in Algoma: Community Assessment and Next Steps." This report intends to provide a deeper understanding of how the toxic drug crisis is experienced in Algoma. It examines epidemiological data as well as input from people with lived and living experience (PWLLE), family or friends of people who use(d) drugs, and community partners from a variety of sectors which was gathered through interviews and workshops. The report makes recommendations for how communities and partners could apply this evidence to their work.

To present this report APH is holding a half-day event where we will detail the findings of the report. We will also hear from a guest speaker who will discuss structural stigma followed by an opportunity for discussion amongst community partners.

Association of Public Health Epidemiologists of Ontario Symposium

In November, APH's epidemiologist and data analyst attended the Association of Public Health Epidemiologists of Ontario Symposium. This brought together epidemiologists from across the province to discuss the latest methods and tools in public health epidemiology. Our epidemiologist, Mehak Khanna gave a presentation titled "Syphilis in Algoma: Accessibility issues in Northern Ontario", which was very well received. The presentation detailed the current syphilis situation in Algoma, examined testing rates, and listed areas for potential future action.

Promoting Public Health

Public health plays a vital preventive role in our communities. This means that much of our success is measured by things that were prevented from happening in the first place, which doesn't make for very eye-catching promotion of the important work that we do. This means that although prevention is the most cost-effective means of improving our health, we'll never get the same headlines that acute illness and healthcare concerns do. Following the pandemic, APH aims to highlight the important roles we play outside of an emergency.

We're doing this in a number of ways. We promote public health by the work we do directly with clients, but much of the benefit we provide occurs outside of direct service delivery. The meal you enjoyed at a local restaurant didn't make you sick, thanks to a public health inspector, but you'll likely never meet the inspector who indirectly ensured your safety. To further promote this unseen work, we are sending out

regular emails to municipalities highlighting our work. On the more public-facing side of public health promotion, we have begun a review of our social media strategy in light of the ever-changing online landscape. I also recently published an opinion piece highlighting how public health is an important partner in tackling our primary care crisis by reducing the demand for healthcare services. You can view the letter here:

Sootoday

Sault Star

Elliot Lake Today

The Standard

Nominate a Public Health Champion for 2024

It’s time to celebrate the Public Health Champions in our communities!

Do you know an **adult, youth, or organization** working to protect and uplift our community’s health? Now is your chance to put their dedication in the spotlight. Whether it's through initiatives for health equity, fostering mental well-being, or leading impactful projects, these champions are creating a brighter, healthier future for all.

What is a Public Health Champion?

Public Health Champions are advocates for change, champions of well-being, and pioneers of health equity. They work to make our communities safer and healthier—no matter the age, background, or challenges.

Need some inspiration? Review our previous Public Health Champions and consider making a nomination.

This year, **we will be awarding a champion in the following categories:**

- **An adult (25 and over)**
- **A youth (24 and under)**
- **An organization**

What makes a Public Health Champion:

- An **advocate for positive change**: Collaborating with local leaders to bring healthier options, promote active lifestyles, or tackle climate challenges.
- A **connector of communities**: Creating spaces and activities that bring people together for health and wellness, from neighbourhood projects to volunteer-driven art.
- A **health equity warrior**: Raising awareness, supporting advocacy, and making Algoma more inclusive. They could be advancing mental health for youth or creating safer spaces for 2SLGBTQIA+ communities.

Eligibility

Nominees must live or operate in the Algoma district. Current Algoma Public Health board members and employees are not eligible.

How to Nominate

Nominations are open **November 27 – January 8, 2025**. Submit your entry by choosing one of these options:

1. **Online Form** – Submit directly through our website
2. **Email Submission** – Download and complete a fillable PDF, then email it to **communications@algomapublichealth.com**
3. **Mail or Drop-Off** – Complete and send a nomination form to:

    Algoma Public Health
    c/o Public Health Champion Award
    294 Willow Avenue
    Sault Ste. Marie, ON P6B 0A9

OR, drop off at one of our district offices in Wawa, Elliot Lake or Blind River.

All champions will be recognized at the Board of Health meeting on **January 22, 2025**.

Let's celebrate those who make Algoma healthier. Nominate a Public Health Champion today!

Finance and Audit Committee Chair Report
November 6, 2024

Attendees:
Luc Morrissette – Committee Chair
Sally Hagman
Suzanne Trivers
Jody Wildman

Regrets:
None

APH Members:
Dr. John Tuinema – Acting Medical Officer of Health & CEO
Rick Webb – Director of Corporate Services
Leslie Dunseath – Manager of Accounting Services
Tania Caputo – Board Secretary

After long discussions, the Finance and Audit Committee recommends that the Board of Health approve the 2025 Capital Budget Report as presented. We also recommend that the Board of Health approve the Public Health Funding Letter as presented and forward it to the other health units. We are sure we are not the only Board of Health with financial issues reaching a balanced budget. We also want to thank management and staff for working with the Finance and Audit Committee to bring forward this budget report. Staff will continue working on finding savings for next year's budget deliberation for 2026.

Respectfully submitted,

Luc Morrissette

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

Algoma Public Health
Statement of Operations
September 2024
(Unaudited)

Public Health Programs (Calendar)

	Actual YTD 2024	Budget YTD 2024	Variance Act. to Bgt. 2024	Annual Budget 2024	Variance % Act. to Bgt. 2024	YTD Actual/ YTD Budget 2024
Revenue						
Municipal Levy - Public Health	**$ 3,330,426**	$ 3,330,427	$ (1)	$ 4,440,569	0%	100%
Provincial Grants - Cost Shared Funding	**7,515,228**	7,515,158	70	10,020,210	0%	100%
Provincial Grants - Public Health 100% Prov. Funded	**1,751,183**	1,715,100	36,083	2,286,800	2%	102%
Provincial Grants - Mitigation Funding	**0**	0	-	0	-	-
Fees, other grants and recovery of expenditures	**408,388**	392,450	15,938	494,600	4%	104%
Total Public Health Revenue	**$ 13,005,225**	$ 12,953,134	$ 52,090	$ 17,242,179	0%	100%
Expenditures						
Public Health Cost Shared	**$ 11,288,549**	$ 11,274,033	$ (14,516)	$ 14,913,154	0%	100%
Public Health 100% Prov. Funded Programs	**1,853,404**	1,738,175	(115,229)	2,329,026	7%	107%
Total Public Health Programs Expenditures	**$ 13,141,953**	$ 13,012,208	$ (129,745)	$ 17,242,180	1%	101%
Total Rev. over Exp. Public Health	**$ (136,728)**	$ (59,074)	$ (77,655)	$ 0		

Healthy Babies Healthy Children (Fiscal)

Provincial Grants and Recoveries	**$ 570,384**	570,375	9	1,140,750	0%	100%
Expenditures	**567,670**	575,730	8,061	1,140,750	-1%	99%
Excess of Rev. over Exp.	**2,714**	(5,355)	8,070	-		

Public Health Programs (Fiscal)

Provincial Grants and Recoveries	**$ -**	0	-	-	#DIV/0!	#DIV/0!
Expenditures	**326,286**	-	(326,286)	-	#DIV/0!	#DIV/0!
Excess of Rev. over Fiscal Funded	**(326,286)**	-	(326,286)	-		

Fiscal Programs

Revenue						
Provincial Grants - Community Health	**$ 131,078**	$ 131,077	$ 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	**$ 245,525**	$ 245,524	$ 2	$ 376,600	0%	100%
Expenditures						
Brighter Futures for Children	**73,822**	57,223	(16,598)	114,447	29%	129%
Nurse Practitioner	**82,929**	81,415	(1,514)	162,153	2%	102%
Stay on Your Feet	**46,220**	50,381	4,161	100,000	-8%	92%
Total Fiscal Community Health Programs	**$ 202,970**	$ 189,019	$ (13,951)	$ 376,600	7%	107%
Total Rev. over Exp. Fiscal Community Health	**$ 42,555**	$ 56,505	$ (13,950)	$ (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 Nine Months Ending September 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	2,316,356	2,316,356	0	3,088,475	0%	75%	2,185,241	2,185,241	0
Levies District	1,014,070	1,014,071	(1)	1,352,094	0%	75%	956,672	956,671	1
Total Levies	**3,330,426**	**3,330,427**	**(1)**	**4,440,569**	**0%**	**75%**	**3,141,913**	**3,141,912**	**1**
MOH Public Health Funding	7,515,228	7,515,158	71	10,020,210	0%	75%	6,640,411	6,645,900	(5,489)
Total Public Health Cost Shared Funding	**7,515,228**	**7,515,158**	**71**	**10,020,210**	**0%**	**75%**	**6,640,411**	**6,645,900**	**(5,489)**
MOH Funding - MOH / AMOH Top Up	129,796	118,725	11,071	158,300	9%	82%	136,890	141,975	(5,085)
MOH Funding Northern Ontario Fruits & Veg.	88,051	88,050	1	117,400	0%	75%	88,054	88,050	4
MOH Funding Unorganized	397,800	397,800	0	530,400	0%	75%	397,800	397,800	0
MOH Senior Dental	1,037,037	1,037,025	12	1,382,700	0%	75%	1,004,569	1,012,687	(8,118)
MOH Funding Indigenous Communities	73,499	73,500	(1)	98,000	0%	75%	73,496	73,500	(4)
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	**1,751,183**	**1,715,100**	**36,083**	**2,286,800**	**2%**	**77%**	**1,693,855**	**1,714,012**	**(20,157)**
Total Public Health Mitigation Funding	**0**	**0**	**0**	**0**	**#DIV/0!**	**0%**	**778,354**	**778,350**	**4**
Recoveries from Programs	20,815	22,500	(1,685)	29,600	-7%	70%	9,009	27,500	(18,491)
Program Fees	37,114	33,450	3,664	45,000	11%	82%	30,072	44,700	(14,628)
Land Control Fees	164,090	202,000	(37,910)	225,000	-19%	73%	166,975	195,000	(28,025)
Program Fees Immunization	54,585	33,750	20,835	45,000	62%	121%	51,691	37,500	14,191
HPV Vaccine Program	9,605	15,000	(5,395)	20,000	-36%	48%	9,996	7,125	2,871
Influenza Program	445	0	445	16,000	#DIV/0!	3%	730	17,625	(16,895)
Meningococcal C Program	3,222	7,000	(3,779)	9,000	-54%	36%	1,479	5,250	(3,771)
Interest Revenue	110,565	78,750	31,815	105,000	40%	105%	134,996	24,588	110,408
Other Revenues	7,946	0	7,946	0	#DIV/0!	100%	0	11,250	(11,250)
Total Fees and Recoveries	**408,388**	**392,450**	**15,938**	**494,600**	**4%**	**83%**	**404,948**	**370,538**	**34,410**
Total Public Health Revenue Annual	**13,005,225**	**12,953,134**	**52,090**	**17,242,179**	**0%**	**75%**	**12,659,481**	**12,650,712**	**8,769**
Public Health Fiscal April 2024 - March 2025									
Infection Prevention and Control Hub	0	0	0	0	#DIV/0!	0%			
Total Provincial Grants Fiscal	**0**	**0**	**0**	**0**	**#DIV/0!**	**0%**	**0**	**0**	**0**

Algoma Public Health

Expense Statement- Public Health

For Nine Months Ending September 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	7,595,668	7,678,981	83,313	10,236,247	-1%	74%	$ 7,932,210	$ 8,124,797	$ 192,587
Benefits	2,037,166	2,081,734	44,568	2,665,034	-2%	76%	2,080,084	1,906,035	(174,049)
Travel	113,538	130,894	17,356	174,526	-13%	65%	138,599	119,100	(19,499)
Program	1,017,957	744,898	(273,059)	1,012,197	37%	101%	1,227,273	927,872	(299,401)
Office	47,293	45,300	(1,993)	60,400	4%	78%	44,825	61,800	16,975
Computer Services	781,850	694,499	(87,351)	926,000	13%	84%	675,602	671,919	(3,683)
Telecommunications	193,458	183,002	(10,456)	244,000	6%	79%	219,961	198,749	(21,212)
Program Promotion	14,798	14,625	(173)	19,500	1%	76%	29,101	33,750	4,649
Professional Development	33,360	38,329	4,969	51,105	-13%	65%	39,716	60,318	20,602
Facilities Expenses	660,890	732,748	71,858	977,000	-10%	68%	741,359	693,000	(48,359)
Fees & Insurance	302,909	324,132	21,223	418,750	-7%	72%	350,263	340,125	(10,138)
Debt Management	343,066	343,066	0	457,421	0%	75%	343,066	343,066	0
	$ 13,141,953	$ 13,012,208	$ (129,745)	$ 17,242,180	**1%**	**76%**	$ 13,822,059	$ 13,480,531	$ (341,528)

Notes to Financial Statements – September 2024

Reporting Period

The September 2024 financial reports include nine months of financial results for Public Health programming. All other non-funded public health programs are reporting six 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 September 30, 2024, Public Health calendar programs are reporting a $78K negative variance – which is driven by a $130K negative variance in expenditures and a $52K 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). As communicated by the Province, opportunities may become available in year based on ongoing assessments.

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. As continued funding has been confirmed, albeit allocations remain pending, APH continues to track activities related to this initiative as a separately 100% funded program outside of base provincial funding. Although formal funding approvals have not yet been received for the 2024/25 fiscal year, planning and discovery meetings with the Ministry remain ongoing.

Public Health Expenses (see page 3)

Travel Expenses
There is a $17K positive variance associated with travel expenses based on position vacancies, as well as staff continuing to take advantage of virtual options enforced during the pandemic when possible/beneficial.

Program Expenses
There is a $273K 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 response to this request, however 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.

Computer Services
There is a $87K negative variance associated with computer services based on the purchase of necessary network server equipment as approved by the Board in February 2024.

Facilities Expenses
There is a $72K positive variance associated with facilities expenses based on lower than budgeted utilities expenses and building occupancy costs aligned to the IPAC Hub 100% funded program.

Financial Position - Balance Sheet (see page 7)

APH's liquidity position continues to be stable and the bank has been reconciled as of September 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 September 2024	September 2024	December 2023
Assets		
Current		
Cash & Investments	$ 5,066,004	$ 4,663,966
Accounts Receivable	900,233	2,089,635
Receivable from Municipalities	21,630	6,482
Prepaid Expenses	277,498	128,517
Subtotal Current Assets	6,265,366	6,888,600
Financial Liabilities:		
Accounts Payable & Accrued Liabilities	1,063,822	1,402,404
Payable to Gov't of Ont/Municipalities	3,265,280	3,426,716
Deferred Revenue	280,311	280,411
Employee Future Benefit Obligations	2,835,275	2,835,275
Term Loan	3,308,095	3,308,095
Subtotal Current Liabilities	10,752,783	11,252,901
Net Debt	(4,487,416)	(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	12,426,017	12,549,133

Algoma
PUBLIC HEALTH
Santé publique Algoma

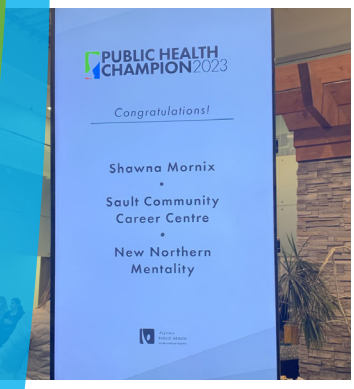
2025

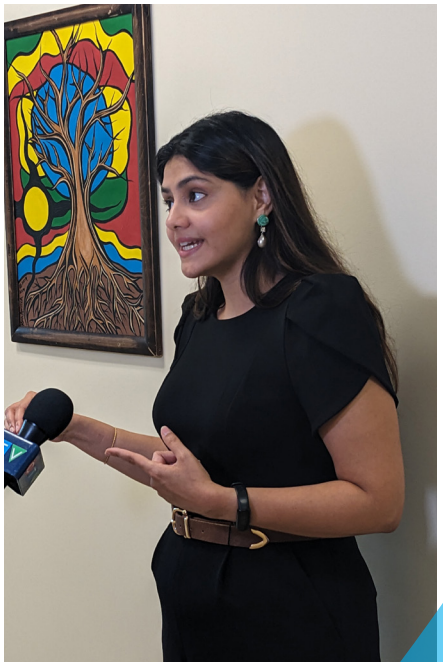
Recommended Capital and Operating Budget Report

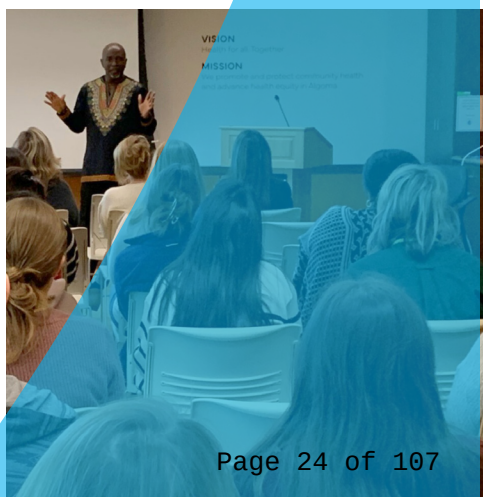
To: Finance and Audit Committee of the Board of Health for the District of Algoma Health Unit

From: Dr. John Tuinema, Acting Medical Officer of Health & Chief Executive Officer

November 6, 2024
For discussion & decision







Contents

Issue

Approval is being sought for the recommended 2025 Capital & Operating Budget for Algoma Public Health (APH). The draft budget was developed by the Executive Team and is recommended by the Medical Officer of Health. It is to be reviewed at the November 6, 2024, meeting of the Board of Health Finance & Audit Committee.

Recommended Action

THAT the Finance & Audit Committee of the Board of Health for the District of Algoma Health Unit approve the 2025 Capital & Operating Budget for Algoma Public Health in the amount of $17,865,786.

Alignment to Ontario Public Health Standards (OPHS, 2021)[1]

- As part of the *Organizational Requirements: Fiduciary Requirements Domain*, boards of health are accountable for using Ministry of Health (Ministry) funding efficiently and for its intended purpose and ensuring that resources are used efficiently and in line with local and provincial requirements.
- As part of the *Organizational Requirements: Good Governance and Management Practices Domain*, the board of health shall provide governance direction to the administration and ensure that the board of health remains informed about the activities of the organization on the following: delivery or programs and services; organizational effectiveness through evaluation of the organization and strategic planning; stakeholder relations and partnership building; research and evaluation; compliance with all applicable legislation and regulations; workforce issues, including recruitment of a medical officer of health and any other senior executives; financial management; and risk management.
- The board of health shall ensure that administration implements appropriate financial management by ensuring that expenditure forecasts are as accurate as possible.
- To support municipal budget planning, APH attempts to advise contributing municipalities of their respective levies as early as possible.

1. Budget Summary

The **recommended 2025 budget for public health programs and services is $17,865,786**. This represents an overall increase of 3.6% or $623,607 from the 2024 Board approved budget for public health programming.

The Executive Team continues to work diligently in the current dynamic fiscal environment to identify further opportunities for operational efficiencies to help balance pressures and ensure the maintenance of quality public health programs, as aligned with agency values of excellence, respect, accountability, transparency, and collaboration.

The recommended budget is driven by rises in inflation, historic and forecasted sub-inflationary provincial base funding, maintaining priority public health programs and services based on the existing Ontario Public Health Standards (OPHS) and the core functions of public health, and the assumption that APH will not have access to request additional funding in 2025 to address ongoing base funding pressures for cost-shared programming.

The breakdown of the recommended 2025 operating budget of $17,865,786 and a budget analysis is provided in **Table 1.0**. Comparisons are made between the recommended 2025 budget and the 2024 Board approved budget. For context, we recall that the 2022 and 2023 actual results include allocated COVID-19 extraordinary funding and one time funding for the Ontario Senior Dental Care Program (OSDCP), while based on known funding allocations at the

[1] Ministry of Health. Ontario public health standards: Requirements for programs, services, and accountability: Protecting and promoting the health of Ontarians [Internet]. 2021 [cited 2023 Oct 28]. Available from: https://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/

time of writing, the 2024 and 2025 budgets do not.[2] For additional reference, it is noted that unlike previous years, a forecasted 2024 budget has not been provided within the analysis table. At the time of writing, APH has not yet received formal confirmation of additional material funding allocated for the 2024 operating year and as such the original Board approved budget for 2024 is deemed the most appropriate for comparison. In previous years, supplementary allocations for COVID-19 extraordinary and other one-time funding allocations were known at the time of budget planning.

As evident in **Table 1.0**, and for all programs except those 100% provincially funded, APH's budget recommendation is built assuming there will be a $3.85 per capita levy increase in 2025 ($46.72 per capita, increased from $42.87 in 2024). This represents a 9% increase over the 2024 approved levy and is to be applied to the total amount levied across the participating municipalities of the Algoma district.

The following sections provide details on key 2025 budget factors.

[2] COVID-19 extraordinary funding was discontinued as of December 2023 and, at time of writing, APH has yet to receive confirmed OSDCP one-time allocations for 2024.

Table 1.0: Budget Analysis, 2022 – Recommended 2025

	2022	2023	2024	2025	% Change	$ Change
Revenues Summary	Actual	Actual	Budget	Recommended Budget	25 Bud vs 24 Bud	25 Bud vs 24 Bud
Province Portion of Jointly Funded Programs	8,773,422	8,861,200	10,020,210	10,120,503	1.0%	100,293
100% Provincially Funded Programs	3,455,953	3,398,438	2,286,800	2,309,963	1.0%	23,163
Province Mitigation Fund	1,037,800	1,037,800	0	0	0.0%	-
Municipal Levies	4,189,216	4,189,216	4,440,569	4,840,220	9.0%	399,651
Other Recoveries and Fees	459,114	593,000	494,600	595,100	20.3%	100,500
Total	**17,915,505**	**18,079,654**	**17,242,179**	**17,865,786**	3.6%	623,607
Expenses:						
Salaries and Wages	10,417,870	10,712,095	10,236,246	10,934,635	6.8%	698,389
Benefits	2,408,728	2,722,376	2,665,035	2,837,798	6.5%	172,763
Travel	138,138	172,278	174,525	170,550	-2.3%	(3,975)
Program	1,380,781	1,638,934	1,012,197	922,034	-8.9%	(90,163)
Equipment	82,545	82,404	30,000	50,000	66.7%	20,000
Office	56,380	53,638	60,400	62,400	3.3%	2,000
Computer Services	850,406	802,632	896,000	787,912	-12.1%	(108,088)
Telecommunications	326,935	332,288	244,000	227,952	-6.6%	(16,048)
Program Promotion	145,166	78,850	70,605	98,255	39.2%	27,650
Facilities Leases	184,172	198,519	207,000	214,767	3.8%	7,767
Building Maintenance	1,095,440	737,618	770,000	674,962	-12.3%	(95,038)
Fees & Insurance	362,383	362,155	418,750	427,100	2.0%	8,350
Expense Recoveries	-6,750	0	0	0	0.0%	-
Debt Management (I & P)	457,420	457,421	457,421	457,421	0.0%	-
Total	**17,899,614**	**18,351,208**	**17,242,179**	**17,865,786**	3.6%	623,607
Surplus/(Deficit)	**$ 15,891**	**$ (271,554)**	**$ -**	**$ -**		

2. 2025 Budget Background

To provide context for the recommended 2025 budget and increase in the total municipal levy rate applied to the district, a background is being shared to explain:

- **The state of public health funding and factors posing financial pressures for 2025**, including provincial announcements and anticipated public health sector changes, and inflation and sub-inflationary increases to public health provincial base funding.
- **Strategies enacted by APH to mitigate the impact of financial pressures and recommend a balanced budget**, including maximizing sources of one-time and/or 100% provincial funding, seeking additional funding sources, identifying efficiencies and cost-savings, and continued alignment of our work to the core functions of public health.

The recommended budget reinforces the minimum financial requirements needed to maintain mandatory public health programs and services to promote and protect community health and advance health equity across Algoma.

2.1 State of Public Health Funding and Financial Pressures

Similar to our 2024 recommended Capital and Operating Budget Report, two main factors continue to contribute to APH's financial pressures and reinforce the need for actions to mitigate the impact of those financial pressures, alongside an increase in municipal levy to balance the proposed 2025 budget.

These factors include:

- Provincial announcements and anticipated public health sector changes.
- Impacts of inflation and historic and forecasted sub-inflationary increases to public health provincial base funding.

2.1.1 Provincial Announcements and Anticipated Changes

As previously announced in August 2023, the provincial government outlined three (3) priorities for public health sector changes: supporting a coordinated approach to voluntary mergers for local public health units, a review of the Ontario Public Health Standards (OPHS), and a review of the ministry's funding methodology for public health. We outlined these priorities in our 2024 recommended Capital and Operating Budget Report, and a 2023 briefing note to the Board of Health[3] provided situational awareness and background on the structure, governance, and funding of local public health and APH.

In February 2024, after months of exploration and collaboration between the two health units and Boards, the APH Board of Health unanimously voted against a voluntary merger with Public Health Sudbury & Districts which made us ineligible for one-time merger funding.

Below is an update on the remaining two priority areas for APH:

(1) Review of the Ontario Public Health Standards (OPHS)

The province continues with its intent to identify roles and responsibilities that can be refined or stopped, and/or "re-levelled" to a regional or provincial level. However, while revised OPHS were originally planned for release in January of 2025, recent communication indicates there is not currently an estimated timeline for the revised OPHS to be released.

Nonetheless, in May of 2024, public health units were given the opportunity to review draft OPHS documents and provide feedback through a survey submission. As part of this review process, fifteen (15) documents were provided for review, including the draft OPHS and fourteen (14) proposed

[3] Loo J. Briefing note: BOH situational awareness of public health sector changes anticipated in 2024-2026 [Internet]. 2023 [cited 2023 Oct 28]. Available from: https://www.algomapublichealth.com/media/6803/meeting-book-september-27-2023-board-of-health-meeting-website.pdf

protocols[4]. Of note:

- The final updated OPHS are expected to have twenty-seven (27) protocols.
- Three (3) documents are planned for further staged review beyond the release of the updated OPHS including the Relationship with Indigenous Communities Protocol, the Infectious and Communicable Diseases Prevention and Control Standard, and the Immunization Standard.

Overall, while not final, **these early drafts indicate that the scope of public health will continue with an expansive focus[5] that includes addressing prevention, health promotion and upstream factors.** For 2025, we continue to plan and deliver programs and services as outlined in the current OPHS and as directed by the Ministry of Health.

(2) Review of the ministry's funding methodology for public health

Upon the ministry's announcement of its intention to review the funding methodology for public health, a new funding approach was intended to be communicated in spring of 2025 and implemented in 2026; however, at time of writing there is also currently no estimated timeline for this review or implementation.

In the interim, health unit base funding levels have been restored to the level provided under the 2020 cost-share formula, with increases in base funding to be capped at 1% per year for each year from 2024-2026, which continues to be insufficient to maintain operations due to inflation. **Section 2.1.2** provides further detail on inflation and sub-inflationary increases to public health funding from the province.

Local public health units have not yet been engaged on the review of the funding model for public health. However, Medical Officers of Health from seven (7) Northern public health units, including APH, submitted a letter to the Chief Medical Officer of Health and Assistant Deputy Minister regarding Northern Ontario perspectives for consideration in the public health funding model review[6].

This letter was included in the September 2024 Board of Health package and endorsed by the APH Board of Health; highlights of the considerations for funding public health in Northern Ontario are restated here:

- Geography: there is an increased cost to service delivery by car over large, sparsely populated geographical areas, and by boat or air travel where necessary to reach communities inaccessible by road; Northern Ontario public health units therefore do not benefit from economies of scale and plan and organize services many times over to reach rural and remote communities; and geography also impacts the nature of services we deliver such as our increased focus on inspections for small drinking water systems and private drinking water testing.
- Breadth, diversity, and complexity of populations and partners: Northern Ontario has proportionately more municipalities than it does Ontario public health units, 80% of the province's First Nations communities, a higher proportion of Francophones and French Designated Areas, and a lower socio-economic standing overall, all of which pose unique considerations for public health programs and services.
- Healthcare gaps: Northern Ontario communities lack health and dental care capacity; gaps in primary care impact local public health programming and services, such as increased need for immunizations, child health programming, sexual health programming, etc. For example, in the Spring of 2024,10 000 patients were de-rostered from their primary healthcare providers in Sault Ste Marie. Although it is not within our public health mandate to mitigate the impact of this development, APH is under significant pressure to help where we can. We have seen increases in demand for areas within our mandate due to reduced capacity in primary care. However,

[4] Ministry of Health, Office of Chief Medical Officer of Health. OPHS Review- Excerpt from alPHa Symposium June 2024 presentation [Internal document]. 2024. [cited 2024 October 29].
[5] National Academies of Sciences, Engineering, and Medicine. A Population Health Workforce to Meet 21st Century Challenges and Opportunities: Proceedings of a Workshop [Internet]. 2023 [cited 2023 Nov 4]. Available from https://nap.nationalacademies.org/catalog/27232/a-population-health-workforce-to-meet-21st-century-challenges-and-opportunities?utm_source=HMD+Email+List&utm_campaign=be6c81fa9d-EMAIL_CAMPAIGN_2023_08_29_06_29&utm_medium=email&utm_term=0_-be6c81fa9d-%5BLIST_EMAIL_ID%5D&mc_cid=be6c81fa9d&mc_eid=8b76a4e962
[6] Medical Officers of Health, Seven (7) Northern local public health agencies. Perspectives from Northern Ontario for the public health funding model review. 2024. [cited 2024 October 29]. Available from: https://www.algomapublichealth.com/media/hzpaprad/meeting-book-september-25-2024-board-of-health-meeting-website.pdf

unlike primary care, we cannot bill the province for each new patient and must manage this increased demand within existing budgets.

- Municipal capacity: Northern Ontario municipalities are affected by the same economies of scale challenges as public health units; coupled with relatively lower economic opportunities in the North, this results in property tax bases that are very stretched, making contributions to cost-shared funding of public health comparatively more difficult in Northern Ontario.
- Caution on applying measures in Northern Ontario: applying per capita measures in a public health funding model should take into consideration historic under-counting of Indigenous populations in the Census and inapplicability of the Ontario Marginalization Index in Northern Ontario communities, where there can be insufficient populations to produce this type of equity-focused measure (though the equity concerns certainly remain).

Overall, **Medical Officers of Health in Northern Ontario are seeking an equitable funding approach that accounts for the increased costs and needs associated with delivering public health programs and services in Northern Ontario**.

2.1.2 Inflation and Sub-inflationary Increases to Public Health Funding

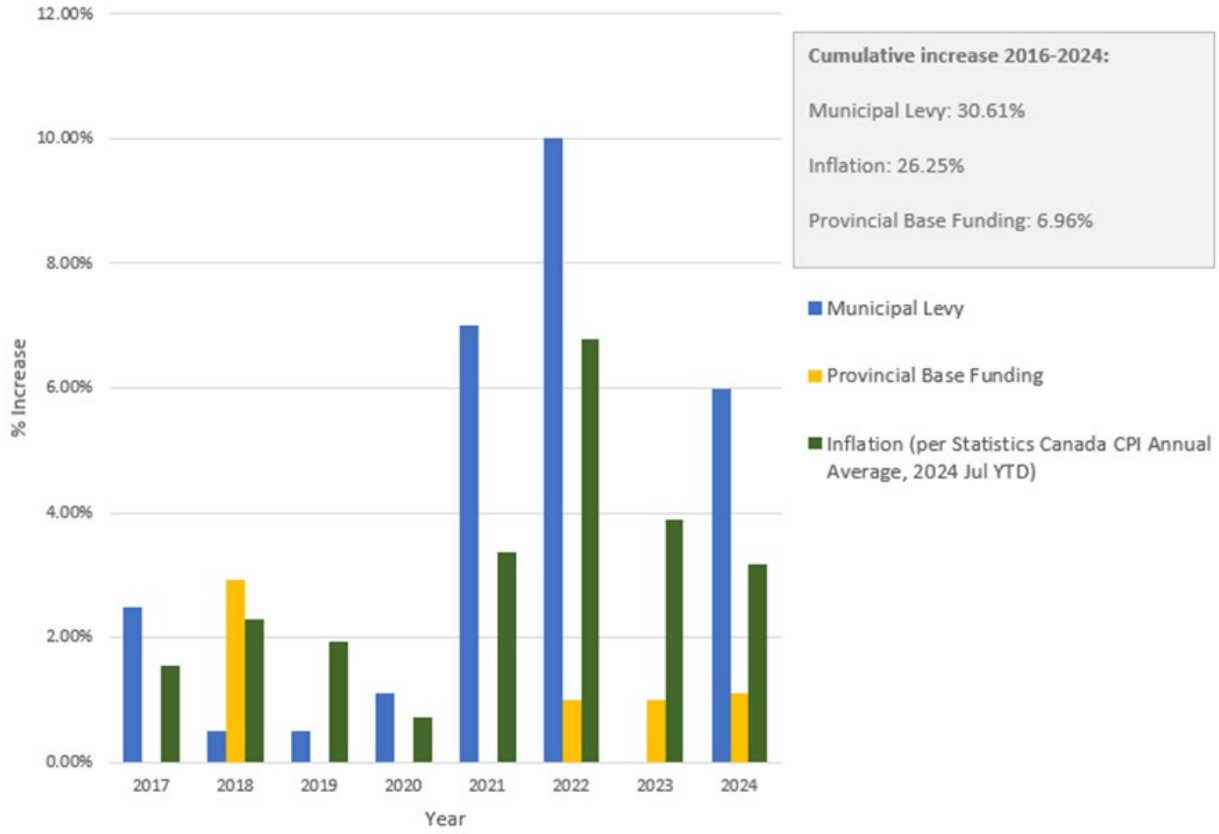
The continued gap between provincial base funding and general inflation has resulted in ongoing financial pressures for local public health.

Since 2016, provincial increases to base funding for cost-shared programs delivered by APH has cumulatively amounted to **6.96%**.

With the increases to base funding being capped at 1% for 2024-2026, provincial base funding remains insufficient to meet ongoing inflationary pressures which are estimated at **26.25%** since 2016.

Figure 1.0 summarizes historical trends in APH funding (both provincial and municipal sources) as compared to average Canadian inflation rates.

Figure 1.0: Public Health Funding vs. Canadian Inflation Rates, 2017-2024[7]



Over time, **Figure 1.0** shows that aside from an increase to provincial base funding in 2018 alongside release of revised OPHS, provincial base funding has not kept pace with inflation which affects both salary and benefit costs (see Section 7.1.1 for further information) as well as operating costs (see Section 7.2.2 for further information). The absence of provincial funding keeping pace with these factors necessitates valuable contributions from municipal levy to sustain the core functions of public health and service to Algoma communities.

As noted in our 2024 recommended Capital and Operating Budget Report, it bears repeating that in addition to not keeping pace with inflation, provincial funding for public health remains a relatively low portion of Ministry of Health spending despite recognition that investment in public health generates significant return on 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 approximately 2% of the total Ministry operating expenses.[8] A review of 2023-2024 estimated expenditures for the Ministry of Health indicates the Population and Public Health Program remains at approximately 2% of Ministry operating expenses.[9]

2.2 Strategies to Mitigate the Impact of Financial Pressures

To achieve a balanced budget, APH recognizes that we must continue to prioritize the health needs of our Algoma communities and be mindful of the impacts that any significant levy increase or workforce reduction would have on local municipalities and public health program and service delivery.

As further described below, Leadership has been working diligently to:

[7] Statistics Canada. Consumer price index, annual average, not seasonally adjusted [Internet]. 2023 [cited 2024 Oct 29]. Available from: https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1810000501&pickMembers%5B0%5D=1.2&cubeTimeFrame.startYear=2016&cubeTimeFrame.endYear=2023&referencePeriods=20160101%2C20230101

[8] Association of Local Public Health Agencies. Public health matters. 2022 [cited 2024 October 29]. Available from: alPHa_Public_Health_Matters_2022.pdf

[9] Ministry of Health. Expenditure estimates for the Ministry of Health (2023-2024).2023. [cited 2024 October 29]. Available from: https://www.ontario.ca/page/expenditure-estimates-ministry-health-2023-24

- Maximize one-time and 100% funded opportunities.
- Seek additional funding opportunities.
- Identify efficiencies and implement cost-saving measures; and
- Align prioritized work to core public health functions.

2.2.1 Maximizing One-Time and/or 100% Funding

To minimize the impact to public health cost-shared programs, APH continues to maximize one-time and/or 100% funding opportunities as available (e.g., Ontario Senior Dental Care Program (OSDCP), Infection Prevention and Control (IPAC) Hub, respiratory syncytial virus (RSV) and/or COVID-19 enhancement funding).

2.2.2 Seeking Additional Funding

APH's corporate, foundational, and public health teams continue to identify opportunities to apply for external grant and project funding. Grant funding, pending requirements, can provide additional, time-limited financial support for retaining or recruiting FTE and supporting priority public health work. In addition, APH has been exploring alternative capital project funding due to the lack of one-time provincial funding opportunities which have historically been provided but, at the time of writing, are unavailable in 2024, 2025 and for the foreseeable future.

Past successful applications include:

- Public Health Ontario Locally Driven Collaborative Project funding for knowledge mobilization initiatives.
- Canada Summer Jobs wage subsidies, to create quality summer work experiences for young people aged 15 to 30, which has supported administrative and project work across the agency.
- Northern Ontario Heritage Fund Corporation (NOHFC) funding for internship positions, to support Human Resources, Communications, and Emergency Management at APH.
- Health Canada HealthADAPT funding, along with 6 other Northern health units in 2020, for a two-year project to conduct a climate change and health vulnerability and adaptation assessment for Northern Ontario public health units.

Despite adding value, one-time funding poses recruitment and retention challenges for new positions that are only temporary in nature. It is also worth noting that preparing competitive grant applications takes time which cuts into base funding resources, creating a loss when unsuccessful. In our experience, the grant process rarely includes equity considerations and APH competes with larger, increasingly resourced centres. Over 2023-2024, APH submitted nine (9) grant applications for a combined $1,457,000 that were unsuccessful.

Of further note, reliance on one-time solutions to balance the budget for 2025 are not considered ideal, as current financial pressures are expected to outweigh funding growth for an indeterminable period.

2.2.3 Identifying Efficiencies and Cost-Savings

The APH leadership team continues to strategize to maximize current funding allocations and aggressively identify opportunities for operating efficiencies, leading to cost savings. Some examples of this include:

- Streamlining IT related services, including internet provision, videoconferencing, fax services, etc.
- Reducing the number of phone lines and cell phones.
- Sourcing lower cost, not-for-profit pricing where possible, such as for software licensing.
- Entering a third-party arrangement to hedge our natural gas expense by purchasing supply in bulk.

- Scrutinizing needs and exploring alternatives for building maintenance service contracts as they can be renewed, such as for janitorial services and security.
- Reducing external services and contractors for routine maintenance where possible. For example, repurposing existing internal positions for current needs such as building repairs and maintenance.
- Maintaining an agency-wide district travel calendar to coordinate travel of staff throughout the district with delivery of program material and supplies between APH offices, reducing the need for externally resourced delivery services.
- Gapping and reviewing positions where there are leaves or retirement, with a monthly review of gapped funding dollars and budgetary pressures.

On their own, opportunities to restrict expenses outside of labour and benefits (which currently represent 77% of the 2025 recommended budget) to balance the budget would not cover the entire estimated deficit, as most operational items are non-discretionary (e.g., utilities, insurance, etc.) and this course of action would severely restrict program work moving forward.

2.2.4 Aligning Prioritized Work to Core Functions

While the provincial government continues review of the OPHS, early drafts were shared with public health units in May of 2024 to provide an opportunity for local feedback. While not final, early drafts indicate that we can anticipate similar expectations around service delivery that are in alignment with public health's current roles and responsibilities.

The core functions of public health include[10]:

- Population health assessment
- Surveillance
- Disease and injury prevention
- Health promotion
- Health protection
- Emergency preparedness

In accordance, APH program teams have proceeded with program planning and Standard Implementation Plans (SIPs) have been prepared for 2025 through review of community health needs and priorities, anticipated public health work in 2025, and required resources. Information from Algoma's Community Health Profile (CHP)[11] that was publicly launched in September 2024 informs SIPs and prioritization of public health programs and services at APH.

3. Public Health Human Resource Overview

Despite historic challenges in recruitment and retention of skilled public health professionals in Northern Ontario and limitations posed by one-time funding, APH was successful in recruitment throughout 2024.

2024 Recruitment Snapshot

A snapshot of 2024 health human resource recruitment indicators is provided below. From January – October 3, 2024:

- Eight (8) permanent full-time and three (3) temporary employees have filled vacant positions.
- Three (3) temporary staff were awarded permanent full-time positions.

[10] Canadian Public Health Association. Public health in the context of health system renewal in Canada [Internet]. 2019 [cited 2024 October 29]. Available from: https://www.cpha.ca/public-health-context-health-system-renewal-canada
[11] Algoma Public Health. Algoma's Community Health Profile. 2024. [cited 2024 October 29] Available from: www.algomapublichealth.com/CHP

- Three (3) permanent employees were successful candidates for other permanent positions (e.g., in another program, leadership, or new position).
- One (1) temporary full-time employee has secured another temporary position (extending their contract).
- Three (3) permanent positions remain vacant in active recruitment.

Success Story: Recruitment of Dental Health Educators and Registered Dental Hygienists

As of October 2023, there were three (3) vacant Dental Health Educator positions and one (1) vacant Registered Dental Hygienist position. All positions were filled as of September 2024. Successful recruitment allowed the Oral Health team to offer an additional 200 appointments from May to September 2024. Furthermore, the Oral Health team can now offer an additional two (2) days of clinic per week on-going and are resuming oral screening in daycares again this fall.

4. 2025 Budget Financial Assumptions

Several assumptions were required to base the 2025 estimated expenses and revenues. They are as follows:

- Base funding for cost-shared mandatory programs will increase at an annual rate of 1.0% for 2025.
- As per the 2024 funding and accountability agreement, the Ministry will continue to support the Northern Ontario Fruit and Vegetable and Indigenous Communities programs at 100%, in addition to Mandatory Programs for Unorganized Territories, MOH/AMOH Compensation Initiative, and the OSDCP.

  Of note, for the 2024 funding year, APH was allocated 100% funding for the OSDCP in the amount of $1,382,700. Total actual expenditures for this program in 2023 amounted to $1,852,850 and expenditures for 2024 are forecasted at $1,855,717 (per APH's third quarter standards activity report due to the Ministry in November 2024). Although the Ministry has reiterated their ongoing dedication and support for this program, any further increases to committed base funding will be addressed in future years, once the impact of the new Federal Canadian Dental Care Plan can be estimated. For the 2025 budget, the Executive Team has assumed that 100% provincial funding for the OSDCP will remain at 2024 funding allocation levels, with any operating pressures to be identified and funded via the availability of one-time, in year funding requests from the Ministry.
- No additional funding will be provided by the Ministry to fund ongoing base funding and one-time pressures which include but are not limited to inflation, COVID-19 and other emerging disease responses, capital projects, workforce recovery & maintenance, etc. These anticipated costs will be managed within mandatory program base funding, impacting APH's ability to deliver and sustain ongoing support and services to our communities.
- One-time Infection Prevention and Control (IPAC) Hub funding will continue at current funding levels into the 2025/2026 fiscal year in order to support the continued implementation and operations of the Hub. Although formal base funding approvals for the current year have not yet been provided, in March 2024 the Ministry announced that this funding was confirmed to continue into the 2024/2025 fiscal year and in the years following at levels comparable to previous years allocations.
- A $399,651 (9%) increase to the total municipal levy rate applied by the District of Algoma Health Unit will be implemented.
- A vacancy factor of 2% has been incorporated into overall salaries, wages, and benefits ($275K).
- Fixed non-salary budgeted costs related to facilities, such as utilities and service contracts, have been estimated based on historical data, current contract rates, mobilized operational efficiencies, and assumed inflationary rates with a combined year over year decrease of 7.15% over the 2024 approved budget. A contingency representing 20% of the budgeted service contracts has been factored to support unforeseen necessary costs.

- APH's debt payment plan will continue to be managed with existing resources.
- Notwithstanding the need to prioritize programming in the context of identified local priorities, the requirements of boards of health remain the same, as articulated in the Health Protection and Promotion Act (HPPA)[12], related regulations, the OPHS, and related protocols and guidelines.
- As of the fall of 2024, despite the current review of the OPHS underway, local public health agencies have been instructed to base 2025 budgets on the current set of standards under the assumption that any forthcoming changes will not come into effect until 2026.

5. 2024 Grant Approval

The 2024 Ministry Program Based Grant approval was received and last revised as of June 2024.

- Allocated mandatory cost-shared program funding for 2024 restores provincial base funding to 2020 cost-share levels, as well as a 1% increase over 2023 allocations. Total 2024 funding of $10,020,300 increased from $9,921,000 in 2023 ($8.9M base funding and $1.0M mitigation funding).
- The grant allocation for the 100% provincial funding for Unorganized Territories/Mandatory Programs ($530,400), Unorganized Territories/ Indigenous Communities Program ($98,000) and the Unorganized Territories/Northern Fruit and Vegetable Program ($117,400) remain unchanged.
- The Ontario Seniors Dental Care Program (OSDCP) was allocated $1,382,700 and remains unchanged from 2023 allocation.
- The MOH/AMOH compensation initiative will continue to be based on the actual status of current MOH and AMOH positions.

6. Reserve Funds

As part of fiscally sound management, the Board of Health has long-established reserve funds for the agency since 2017. Reserve funds have been accumulated via excess municipal contributions due to an overestimate of expenses.

Financial reserves are a prudent and expedient way to provide the agency with resources for unforeseen emergencies, known future infrastructure investments and future planned projects that support the mission, vision, and strategic goals of APH.

The reserve funds balance totals $2.1M, which could support approximately 1.5 months of operations.

7. Recommended 2025 Budget

7.1 Operating Revenue

The 2025 operating revenues include Ministry funding for mandatory programs (historically cost shared), Ministry funding for other related programs (historically 100% provincially funded), Ministry Unorganized Territories funding, municipal funding by 21 municipalities, and interest and user fees.

There is no assumed change to funding for Unorganized Territories or the OSDCP. The Executive team is recommending a $399,651 (9.0%) increase to municipal funding over 2024.

7.1.1 Review of the Provincial-Municipal Cost Sharing Formula

The province has stated that they do not have specific cost-share ratio guidelines for the 2024 funding

[12] Government of Ontario. Health protection and promotion act, R.S.O. 1990, c.H7 [Internet]. 2021 [cited 2023 Nov 4]. Available from: https://www.ontario.ca/laws/statute/90h07

year and beyond.

As outlined above in section 2.1.1, despite the Ministry's initial expectation of implementing an updated funding methodology for public health in 2025, at the time of writing there is no longer an estimated timeline for this review to be communicated or implemented. Public health units across the province currently have varying cost-share ratios; as indicated via current in year reporting, municipal shares are estimated to vary anywhere between 20% of 52% at this time.

Traditionally, the Board of Health for Algoma Health Unit has contributed more than the minimum required cost-share ratio provided by the province, with the intention to contribute any surplus municipal levy contributions to the reserve funds.

For the recommended 2025 budget and based on the assumption of a $399,651 (9%) overall increase in the levy from obligated municipalities within the District of Algoma Health Unit and budgeted sub-inflationary increases to provincial funding, the cost-share ratio would be estimated at 68:32.

7.1.2 Provincial

The provincial government can grant funding to local public health as deemed appropriate and has shared responsibilities for the co-funding and delivery of provincial health programs, like public health, with municipal governments. [13]

Pursuant to section 76 of the Health Protection & Promotion Act, the Minister may make grants for the purposes of this Act on such conditions as he or she considers appropriate.[14]

There are few public health programs that receive one-time or 100% grant funding from the Ministry of Health (e.g., Ontario Senior Dental Care Program), with most programs and services being cost-shared.

7.1.3 Municipal

Municipal governments have a direct, legislated responsibility for financing public health programs and services and contribute to the funding of cost-shared programs.[13]

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

(a) The expenses incurred by or on behalf of the board of health of the health unit in the performance of its functions and duties under the HPPA or any other act; and

(b) The expenses incurred by or on behalf of the MOH of the board of health in the performance of his or her functions and duties under the HPPA or any other Act. [14]

As part of the recommended 2025 Operating & Capital Budget, the Executive Team is recommending a **9% overall increase** in the levy from obligated municipalities within the District of Algoma Health Unit. This equates to a **$399,651 increase** in revenues apportioned across the 21 municipalities in Algoma. Rates apportioned among the municipalities reflect current population counts per the 2021 Census Profile issued by Statistics Canada[15] (see **Appendix A**).

For context, **Table 2.0** illustrates historical changes and approved municipal per capita levy rates in Algoma from 2018 – 2025 (recommended).

[13] Smith R, Allin S, Rosella L, et al. Profiles of public health systems in Canda: Ontario [Internet]. 2021 [cited 2023 November 9]. Available from: https://ccnpps-ncchpp.ca/docs/2021-Profiles-of-Public-Health-Systems-in-Canada-Ontario.pdf
[14] Government of Ontario. Health protection and promotion act, R.S.O. 1990, c.H7 [Internet]. 2021 [cited 2024 October 29]. Available from: https://www.ontario.ca/laws/statute/90h07
[15] Statistics Canada. Census profile, 2021 census of population [Internet]. 2022 [cited 2023 Oct 10]. Available from: https://www12.statcan.gc.ca/census-recensement/2021/dp-pd/prof/index.cfm?Lang=E

Table 2.0: APH Historical Approved Levy Increases and Approved Per Capita Rates, 2012 – 2025 (Recommended)

Year	Levy Increase	Approved Rate
2018	0.50%	$33.63
2019	0.50%	$33.80
2020	1.12%	$34.18
2021	7.00%	$36.57
2022	10.00%	$40.23
2023	0.00%	$40.44
2024	6.00%	$42.87
2025 Budgeted	**9.00%**	**$46.72**

Based on a comparison of historical levied rates to corresponding revenue data for our contributing municipalities, on average, municipalities within the Algoma district contribute **approximately 1%** of their revenues towards the APH levy.

Value for Money: Per Capita Rate

When looking at the value for public health, as of 2024, the cost per capita in Algoma for public health services and programs was **$42.87/person** when using population counts from the 2021 Census Profile by Statistics Canada.[16]

Based on a recent survey of other Northern public health units related to 2024 municipal levy rates per capita (which included review of publicly posted Board packages and resolutions), we stress the value of services provided to our Algoma communities at a current rate of $42.87 per capita versus an average of $53.03 per capita levied by our neighbouring public health units[17]. The forecasted 2025 cost per capita is estimated at **$46.72/person**.

As evidenced through the programs and services provided by public health, municipalities across Algoma receive robust support for health protection, health promotion, and disease prevention among residents. When reviewing the cost of public health per capita, alongside the work that public health provides to support and protect community health and wellbeing, the 21 municipalities within Algoma **continue to receive exceptional value for local public health programs and services**.

The budgeted levy is **the minimum required to sustain local public health programming and our current workforce** given that provincial funding increases are capped at 1% for 2025, which is insufficient to meet ongoing and forecasted inflationary rates. Combined with budgeted non- labour related efficiencies, the recommended levy will limit impacts of financial pressures to the public health workforce and preserve health human resource capacity for the delivery of priority programming to promote and protect community health and advance health equity in Algoma.

7.2 Expenditures

As compared to the 2024 budget, the 3.6% overall recommended budget increase is comprised of an overall increase of 5.0% to salaries and benefits and a 1.4% overall decrease to operating expenses.

7.2.1 Salary and Benefit Changes

The 2025 expenditure comparisons with 2024 are made using the 2024 budgeted values (see **Table 1.0**).

- **Salary:** As compared to 2024, salaries are budgeted at an increase of $698,389 or 6.8%. The salary amount includes cost of living annual increases as required/anticipated under union collective

[16] Statistics Canada. 2023. (table). Census Profile. 2021 Census of Population. Statistics Canada Catalogue no. 98-316-X2021001. Ottawa. Released November 15, 2023. https://www12.statcan.gc.ca/census-recensement/2021/dp-pd/prof/index.cfm?Lang=E (accessed October 16, 2024).
[17] APH per capita rate is based on census and others may be based on MPAC.

agreements, staff movement along salary grids, and an assumed 2% vacancy factor. Although staff attributed to intentionally gapped leaves in 2024 have been returned to our workforce planning for 2025, no net new positions are included in our budgeted 2025 workforce with the exception of those aligned to 100% provincially funded programming.

- **Benefits:** As compared to 2024, benefits are budgeted at an increase of $172,763 or 6.5%. Historical utilization is factored heavily in the projection of the rates, in addition to expected market fluctuations. APH's health benefits are reviewed annually for utilization, any potential enhanced offerings and current fee guides by providers. Incorporated into budgeted benefits rates for 2025 are required updated contributions to Canada Pension Plan, employment insurance and OMERS pension plan, as well as recently negotiated benefit plan changes specific to union collective agreements.

7.2.2 Operating Expenditure Changes

As compared with the 2024 board approved budget, the 2025 recommended budget reflects an overall decrease of 1.4% ($247,545).

Operating expenditures have been budgeted by the Executive Team with consideration of both historical pre/post-pandemic and pandemic spend levels, current inflationary projections and in some cases, renewed contract agreement rates and mobilized efficiencies.

Expenditure lines with significant changes are detailed below, following the order of appearance in the budget summary (**Table 1.0**):

- **Program expenses:** Program expenses for 2025 are budgeted at a $90,163 (8.9%) decrease from 2024. Although APH is not anticipating material savings related to general program materials and supplies associated with cost-shared programs, the Executive Team continues to strategically align 100% funding for the OSDCP on staffing (versus historically being more evenly weighted between staffing and externally provided professional services). Due to this program's rapid expansion in the recent years, APH has had to continually align additional FTE to support program services, thereby reducing the amount of base budget dollars available to fund other program resources. The 2025 budget is built assuming that required external professional services and general supplies to meet the demand of the program that cannot be supported by currently allocated base funding levels, will be funded by supplementary, in year one-time funding requests.

  Program expenses include general program materials and supplies, purchased services, and professional fees (e.g., physician and/or denture service fees).

- **Equipment:** Equipment expenses are budgeted at a $20,000 (66.7%) increase over 2024 based on the anticipation of having to replace a number of staff laptops as they will be considered obsolete as of 2025 (i.e. no longer able to support required Microsoft upgrades due to age).

- **Computer services:** Computer services is budgeted at a $108,088 (12.1%) decrease over 2024 based on an ongoing thorough review and analysis of APH's software and IT support requirements (resulting in efficiencies, consolidation of services and negotiated reduced rates where possible).

- **Telecommunications:** The $16,048 (6.6%) decrease in budgeted telecommunications expenses is driven by ongoing efficiencies and alternative solutions being realized with the migration to a Microsoft 365 platform, as well as the rightsizing of our phone lines and cell phone requirements.

- **Program promotion:** Program promotion is budgeted at a $27,650 (39.2%) increase over 2024 based on anticipated professional development needs for APH staff in the coming year, as well as some larger scale, health promotion initiatives tied to priority work assessments planned for 2025.

- **Facilities leases:** The increase in facilities leases is driven by contracted renewal rates for each of our district offices.

- **Building maintenance:** Building maintenance is budgeted at a $95,038 (12.3%) decrease over 2024 based on a combination of efficiencies introduced into daily maintenance/monitoring of our main building at 294 Willow Ave., newly negotiated service provider contract rates, implementation

of internal solutions for maintenance that previously would have been outsourced and hedging of APH's natural gas usage.

8. Capital Budget

In accordance with APH's 2018-2030 Capital Asset Funding Plan (see **Appendix B**), the 2025 capital budget was forecasted to include $28,000 for a video conference system. At this point in time, these upgrades are not considered necessary.

Instead, the Executive Team is recommending a 2025 capital budget estimated at $362,000, which includes the following expenditures:

- In 2024, APH resurfaced two of our three parking lots as a preventive measure for more costly repairs at a later date. For 2025, APH is requesting as part of the capital budget to resurface the third parking lot which is estimated at a cost of $10,000.
- Based on a 2024 professional building status and efficiency review, it has been determined that the three boilers located at 294 Willow Avenue are near end of life as replacement parts from the original manufacturer are no longer available. Estimated replacement cost at this time is $300,000.
- Based on recommendations from professional architects and in anticipation of preparing a portion of the office space at 294 Willow Avenue for potential leasing opportunities, an estimated $40,000 is requested for the creation of one additional closed office space and one boardroom renovation.
- The floors within APH's district office located in Wawa, ON are deteriorated and in need of replacement as a leasehold improvement. This project is currently estimated at $12,000.

As we look into further years of the established Capital Asset Funding Plan, we note that forecasted expenditures for 2026 through 2030 are no longer considered to be accurate. We anticipate revisiting the Capital Asset Plan in 2025, with intentions to bring a revised version to the Board alongside the 2026 budget.

9. Conclusions

The recommended 2025 budget for public health programs and services is $17,865,786, representing an increase of $623,607 over 2024 budgeted funding. At a 3.6% increase over previous, the recommended budget is considered the minimum required to keep pace with the cost of inflation and sustain the delivery of core public health programs and services as mandated by the OPHS and required to support health for all.

Appendix A

Annual Municipal Levy Comparison, 2021 to Proposed 2025

Municipal Levy Historical Analysis	POP 2016 Census	2021 Approved Rate	2021 Approved Levy	2022 Approved Rate	2022 Approved Levy	POP 2021 Census*	2023 Approved Rate	2023 Approved Levy	2024 Approved Rate	2024 Approved Levy	2025 Proposed Rate	2025 Proposed Levy	Appointment of Costs	Proposed Net Change	APH Levy as a Percentage of Municipality Revenue
CITIES															
Sault Ste. Marie	73,368	36.57	2,683,386	40.23	2,951,725	72,051	40.44	2,913,655	42.87	3,088,475	46.72	3,366,437	69.55%	277,963	1.13%
Elliot Lake	10,741	36.57	392,852	40.23	432,137	11,372	40.44	459,870	42.87	487,462	46.72	531,334	10.98%	43,872	1.28%
					-										
TOWNS					-										
					-										
Blind River	3,472	36.57	126,986	40.23	139,685	3,422	40.44	138,382	42.87	146,684	46.72	159,886	3.30%	13,202	0.83%
Bruce Mines	582	36.57	21,286	40.23	23,415	582	40.44	23,535	42.87	24,947	46.72	27,193	0.56%	2,245	1.08%
Thessalon	1,286	36.57	47,034	40.23	51,737	1,260	40.44	50,953	42.87	54,010	46.72	58,871	1.22%	4,861	1.19%
					-										
VILLAGES/MUNICIPALITY					-										
					-										
Hilton Beach	171	36.57	6,254	40.23	6,879	198	40.44	8,007	42.87	8,487	46.72	9,251	0.19%	764	0.55%
Huron Shores	1,664	36.57	60,859	40.23	66,945	1,860	40.44	75,216	42.87	79,729	46.72	86,905	1.80%	7,176	1.09%
					-										
TOWNSHIPS					-										
					-										
Dubreuilville	613	36.57	22,420	40.23	24,662	576	40.44	23,293	42.87	24,690	46.72	26,912	0.56%	2,222	0.56%
Jocelyn	313	36.57	11,448	40.23	12,593	314	40.44	12,698	42.87	13,460	46.72	14,671	0.30%	1,211	0.89%
Johnson	751	36.57	27,467	40.23	30,214	749	40.44	30,289	42.87	32,106	46.72	34,996	0.72%	2,890	0.83%
Hilton	307	36.57	11,228	40.23	12,351	382	40.44	15,448	42.87	16,374	46.72	17,848	0.37%	1,474	0.88%
Laird	1,047	36.57	38,293	40.23	42,122	1,121	40.44	45,332	42.87	48,052	46.72	52,376	1.08%	4,325	1.33%
MacDonald, Meredithand Aberdeen Ad	1,609	36.57	58,848	40.23	64,733	1,513	40.44	61,184	42.87	64,855	46.72	70,692	1.46%	5,837	1.51%
Wawa (formerly Michipicoten)	2,905	36.57	106,247	40.23	116,872	2,705	40.44	109,387	42.87	115,950	46.72	126,386	2.61%	10,436	0.76%
The North Shore	497	36.57	18,177	40.23	19,995	531	40.44	21,473	42.87	22,761	46.72	24,810	0.51%	2,049	1.08%
Plummer Add'l	660	36.57	24,139	40.23	26,553	757	40.44	30,612	42.87	32,449	46.72	35,369	0.73%	2,920	1.07%
Prince	1,010	36.57	36,940	40.23	40,634	975	40.44	39,428	42.87	41,793	46.72	45,555	0.94%	3,761	1.60%
St. Joseph	1,240	36.57	45,352	40.23	49,887	1,426	40.44	57,666	42.87	61,126	46.72	66,627	1.38%	5,501	0.95%
Spanish	712	36.57	26,041	40.23	28,645	670	40.44	27,094	42.87	28,720	46.72	31,304	0.65%	2,585	0.98%
Tarbutt	534	36.57	19,531	40.23	21,484	573	40.44	23,171	42.87	24,562	46.72	26,772	0.55%	2,211	1.28%
White River	645	36.57	23,590	40.23	25,949	557	40.44	22,524	42.87	23,876	46.72	26,025	0.54%	2,149	0.68%
Total	104,127		3,808,378		4,189,216	103,594		4,189,216		4,440,569		4,840,220	100.00%	399,651	
YOY % Increase			**7.00%**		**10.00%**			**0.00%**		**6.00%**		**9.00%**			

*Statistics Canada. 2023. (table). Census Profile. 2021 Census of Population. Statistics Canada Catalogue no. 98-316-X2021001. Ottawa. Released November 15, 2023. https://www12.statcan.gc.ca/census-recensement/2021/dp-pd/prof/index.cfm?Lang=E (accessed October 16, 2024).

Appendix B

2018-2030 APH Capital Asset Funding Plan

See subsequent document.

Algoma
PUBLIC HEALTH
Santé publique Algoma

Appendix H

Algoma Public Health

2018 - 2030 Capital Asset Funding Plan

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2018 - 2030 Capital Asset Funding Plan

Purpose:

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

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

Operating Budget versus Capital Asset Plan:

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

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

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

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

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

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

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

Types of Capital Assets:

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

Computer Equipment/Furniture/Vehicles

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

Facilities – Maintenance, Repair and Replacement

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

Types of Financing Options Available to the Board of Health:

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

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

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

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

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

ALGOMA PUBLIC HEALTH
CAPTIAL ASSET PLAN

Item	Actaul Expenditure		Forecasted Expenditure											
	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	
Computer Equipment														-
Network Servers		4,000			200,000							200,000		400,000
Telephone System	150,000								150,000					150,000
Network Infrastructure		10,000	40,000		60,000									100,000
Polycom Video Conference System				28,000				28,000						56,000
Backup Data Storage		29,000									30,000			30,000
Computers	25,000	50,000	25,000	25,000	25,000	25,000	25,000	25,000	25,000	25,000	25,000	25,000	25,000	275,000
														-
Furniture and Equipment														-
Vaccine Refrigerators	29,000	14,500	7,000				7,000				7,000			21,000
Digital Sign	21,000													-
Vehicle														-
Truck (land control)						50,000								50,000
														-
														-
Leasehold Improvements														-
Blind River Office		5,000												-
Generator		30,000												-
Elliot Lake Office					7,000									7,000
Wawa Office			5,000											5,000
														-
Owned Facility:														-
294 Willow Avenue Building, Sault Ste. Marie														-
Municipal/Utility Services														-
Water Supply														-
Sanitary Supply														-
Storm Sewer														-
Gas Utility														-
Hydro Utility														-
Other Municipal/Utility Services														-
Site Finishes														-
Passenger Vehicle Parking Area - Pavement and Curbing							26,600							26,600
Roadways - Pavement and Curbing							17,500							17,500
Walkways, Sidewalks and Exterior stairs														-
Exterior Light Standards														-
Soft Landscaping and Picnic Facilities														-
Signage														-
Retaining walls and other Site Improvements														-
Site Drainage														-
Parking Gates														-
Other Site Finishes														-
Structural														-
Building Substructure, including foundations and basement walls														-
Building Superstructure														-
Interior Stairs														-
Roof Construction														-
Other Structural														-
Building Exterior														-
Foundation Wall														-
Cladding System														-
Exterior Sealants and Caulking														-
Entrances and Doors														-
Windows including Frames														-
Parapets and Canoples														-
Loading Dock														-
Other Building Exterior														-
Roof														-
Roof Assembly (waterproofing membrane and roof surface)					165,000									165,000
Flashing														-
Roof Drainage (eaves troughs/downspouts, roof drains)														-
Chimneys/Boiler Stacks														-
Skylights and other Roof Openings														-
Roof venting, if any														-
Other Roof														-
Building Interior														-
Interior Partitions and Doors														-
Flooring														-
Ceiling				60,000									60,000	120,000
Wall Finishes (Paint, Trim Baseboards, etc.)				45,000									45,000	90,000
Washroom Fixtures and Accessories (Towel dispensers, hand dryers, soap dispensers, change tables, partitions, etc.)														-
Presence of Mould														-
Other Building Interior														-
Mechanical and HVAC														-
Heating, Ventilating and Air Conditioning Systems							122,000							122,000
Building, Automation Systems, if any														-
Ductwork, if any														-
Vertical Transportation Devices, if any														-
Other Mechanical and HVAC														-
Plumbing														-
Plumbing fixtures														-
Domestic water distribution														-

ALGOMA PUBLIC HEALTH
CAPTIAL ASSET PLAN

Item	Actaul Expenditure		Forecasted Expenditure											
	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	
Sanitary waster														-
Rainwater drainage														-
Water Fountain														-
Electric														-
Primary Feed and Main Switchgear														-
Main Transformers														-
Step-down Transformers														-
Emergency Power Source or Generator														-
Distribution Systems and Panels														-
Interior Lighting														-
Exterior Lighting (Building-Mounted)														-
Automated Lighting Control System														-
Other Electrical														-
Fire Protection and Life Safety Systems														-
Water Reservoir, if any														-
Sprinkler and/or Standpipe System, if any														-
Fire Extingulshers														-
Fire Pumps, if any														-
Fire Alarm System and Voice Communication Systems, if any														-
Smoke and Heat Detectors and Carbon Monoxide Detectors, as applicable														-
Emergency Lighting and Exit Signage														-
Security System														-
Fire/Emergency Plans														-
Fire Separations (visual inspection and inclusion of info that is readily available)														-
Automatic door closers														-
Other Fire Protection and Life Safety Systems														-
Hazardous Materials														-
Asbestos														-
PCB's														-
Other Hazardous Materials														-
Subtotal	225,000	142,500	77,000	158,000	457,000	75,000	198,100	53,000	175,000	25,000	62,000	225,000	130,000	1,635,100
Contingency (10%)	22,500	14,250	7,700	15,800	45,700	7,500	19,810	5,300	17,500	2,500	6,200	22,500	13,000	163,510
Subtotal Including Contingency	247,500	156,750	84,700	173,800	502,700	82,500	217,910	58,300	192,500	27,500	68,200	247,500	143,000	1,798,610
Escalation Allowance	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	-
Escalation Total	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Estimate Financial Projections	247,500	156,750	84,700	173,800	502,700	82,500	217,910	58,300	192,500	27,500	68,200	247,500	143,000	1,798,610

Total Net Sq. Ft. of Owned Facility	74,000
Year Built	2011
Age (yrs.)	9
Reserve Term (yrs.)	20

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

2) Cost in 2017 dollars with no provision for escalation.
3) HST is excluded.

Algoma
PUBLIC HEALTH
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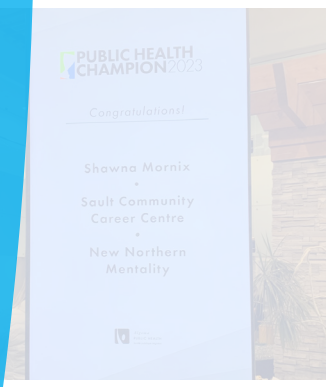
Blind River
9 Lawton Street

Elliot Lake
302 - 31 Nova Scotia Wal
(ELNOS Building)

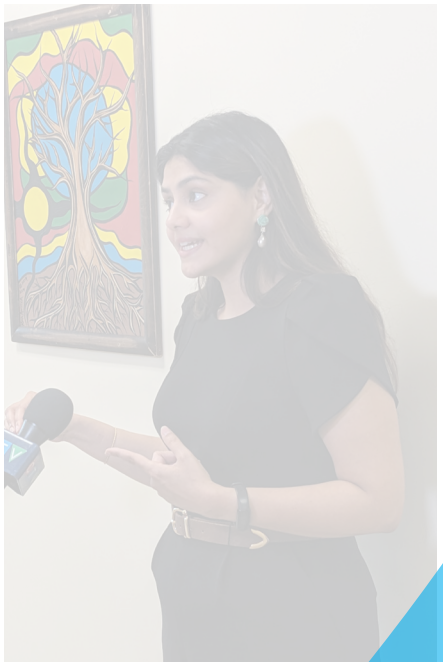
Sault Ste. Marie
294 Willow Avenue

Wawa
18 Ganley St.










Governance Committee Chair Report

November 13, 2024

Attendees:

Deborah Graystone

Don McConnell – Chair

Loretta O'Neill

Matthew Shoemaker

Sonia Tassone

Regrets:

None

APH Members:

Dr. John Tuinema – Acting Medical Officer of Health & CEO

Tania Caputo – Board Secretary

Minutes

- The Minutes of the Governance Committee meeting of September 18, 2024 were approved.

Policy Reviews

- Governance Committee Terms of Reference – This matter was reviewed in detail at the previous meeting and a number of changes identified. However, at the Committee's request, staff provided additional examples of governance committee terms of reference from other public health units. A final review of the APH Governance Committee Terms of Reference removed several items which are more properly the mandate of the Board or staff. These deletions include acting on behalf of the Board, supporting positive relationships with other stakeholders, approving measures of performance accountability, and undertaking Board education programs. Other changes were made to clarify wording. The revised Governance Committee Terms of Reference are recommended for approval to the Board of Health as amended.

- Policy and Bylaw Review Schedule – An updated version of this schedule was reviewed to ensure that all relevant Board policies and bylaws will be reviewed within the next two years.

- Travel – Policy 02–05–020 concerning Board and staff travel had been approved earlier this year. However, it was noted that while the Board Chair, Board members and staff require authorization to travel, the MOH/CEO is exempted from this policy. While this has not been a problem, the Committee is recommending that any travel by the MOH/CEO that is more than 200 km outside the province of Ontario requires approval from the Board Chair. The revised travel policy is recommended for approval to the Board of Health.

- Ontario Building Code Appointments – Bylaw 06-02 was reviewed and minor wording changes have been made. The revised bylaw is recommended for approval to the Board of Health as amended.

- To Regulate the Proceedings of the Board – Bylaw 95-1 was reviewed in detail. The reference to require the Chair to vacate the Chair to participate in a debate was considered unnecessary and removed. Several other minor editorial changes were made and the amended bylaw is recommended for approval to the Board of Health.

IN CAMERA

- The minutes of the previous in camera meeting were approved.

Travel Policy

REFERENCE #:	02-05-020	**DATE:**	Original: Mar 1991 Revised: Mar 22, 2023 Revised: Jun 28, 2023 Revised: May 22, 2024 Revised:
APPROVED BY:	Board of Health		
SECTION:	Policies		

PURPOSE:

The purpose of this document is to ensure that employees and board members understand the policy and procedures for Algoma Public Health (APH) business travel.

APH will reimburse employees and board members for all reasonable and necessary expenses while travelling on authorized APH business. APH assumes no responsibility to reimburse employees and board members for expenses that are not in compliance with this policy.

TRAVEL POLICY:

APH's Travel Policy must be followed, and the Travel Expense Report completed if any of the following conditions are true:

- An employee or board member travels outside the district of Algoma.
- An employee or board member requires accommodations within the district for at least one night.
- An employee or board member travels more than 250 km within one day.

Travel not meeting the above criteria may be eligible for compensation through the Kilometre Reimbursement Policy 01-03-002.~~Kilometre and Incidental Claim Expense Claim Policy (Reference# 01-03-002).~~

The below scenarios will serve as a guide:

Scenario One
An employee/board member travels between Sault Ste. Marie and Elliot Lake and spends~~will spend~~ one night in the destination location.
Departure time is 1:00 pm and return to Sault Ste. Marie at 3:00 pm the next day. Admissible meal expenses ~~would~~ include:

- Dinner the night of travel
- Breakfast the next day (assuming not provided at the hotel)
- Lunch the next day

Scenario Two
An employee/board member travels between Elliot Lake and Blind River and ~~-~~returns to origin the same day (114 total km).

- No admissible meal expenses are permitted.

Scenario Three
An employee/board member travels from Sault Ste. Marie to Toronto for a conference or seminar and will spend two nights in Toronto.
Departure time is 5:30 pm on Monday, and return home is Wednesday at 5:00 pm. Admissible meal expenses include:

- Dinner the night of travel
- Breakfast the next day (assuming it is not provided by the hotel/conference/seminar)
- Lunch the next day (assuming it is not provided by the conference/seminar)
- Dinner the next day (assuming it is not provided by the conference/seminar)
- Breakfast the second day (assuming it is not provided by the hotel/conference/seminar)
- Lunch the second day (assuming it is not provided by the conference/seminar)

Scenario Four
An employee/board member travels between Blind River and Sault Ste. Marie and returns to the original location the same day (284 total km). Admissible meal expenses include:

- Lunch for that day
- Dinner for that day only if the employee arrives home after 6:30 pm.

Scenario Five
An employee/board member travels more than 250 km within one day while conducting APH business.
- Departure time is 8:30 am. Return home by 4:30 pm the same day. Admissible meal expenses include:

- Lunch for that day

Scenario Six

An employee/board member travels from Sault Ste. Marie to Toronto for a meeting and will return on the same day.

Departure time is before 7:00 am. Return home after 6:30 pm the same day. Admissible meal expenses would include:

- Breakfast for that day
- Lunch for that day
- Dinner for that day (if the return flight is after 6:30 pm)

TRAVEL AUTHORIZATION:

All employees/board members who travel outside the district of Algoma must be pre-approved. Employee travel must be pre-approved by their respective Manager. Manager travel outside the district of Algoma must be pre-approved by their respective Director. Director travel outside the district of Algoma must be pre-approved by the MOH/CEO or designate from the Executive team. Travel by the MOH/CEO or Board Chair requires prior approval from the other if the destination is more than 200 km outside Ontario... ~~For employees, a travel authorization form must be completed when travelling outside of the district of Algoma~~.

Board member travel must be pre-approved by the Board Chair or designate.

Given the level of responsibility, MOH/CEO / Board Chair travel does not require prior authorization unless the destination is more than 200 km outside Ontario; however, any expenses related to MOH/CEO travel

must be approved by the Chair of the Board or Vice-Chair of the Board or designate. Board Chair travel expenses must be approved by the Vice-Chair or Board designate

METHOD OF TRAVEL:

Employees/board members are responsible for making travel arrangements that account for safety and convenience and should take the most economical method of transportation. If an employee chooses to take a more expensive mode of travel based on personal preference, APH will cover the cost of the most economical rate to that location, and the employee will be required to pay any additional costs. If the employee chooses this option, it must be preapproved by the employee's manager.

Air Travel

When booking air travel, the employee must engage an APH Clerical/~~Administrative~~Executive Assistant to book the flight on the employee's behalf.~~ Air Travel must be booked through *Maritime Travel* at~~

~~(705) 942-2800 or 1 (800) 461-7261.~~ Reservations should be made several weeks in advance to ensure flight availability and acquire reasonable pricing.~~ Economy flights are to be booked.~~ Board members will work with the Secretary of the Board to book travel via air.

~~Once booked, an itinerary will be e-mailed to the employee/board member. It is advisable to carry the itinerary at the time of travel. Travelers must carry government-issued photo identification to receive their boarding pass.~~

~~APH will pay Maritime Travel directly. When completing the Travel Expense Report, populate Section (B) CHARGED TO COMPANY as it relates to the respective flight.~~

APH will reimburse employees/board members for ~~1st checked baggage fee charged by certain airlines. APH will not reimburse employees/board members for additional checked baggage fees. APH will not reimburse employees/board members for~~the first checked baggage fee charged by certain airlines. APH will not reimburse employees/board members for additional checked baggage fees or fees associated with overweight bags.

APH will reimburse employees/board members for airport parking or taxi services to and from the airport if it is~~-~~more economical or practical.

Personal Automobiles

Per kilometre~~,~~ reimbursement for employees ~~is~~ will be provided at the most recently posted Canada Revenue Agency reasonable per-kilometre allowance rate~~-~~and updated annually on April ~~0~~1 of each year. Distance should be calculated using the quickest route using route internet maps (e.g. Google Maps).

~~If requested, employees/board members should be able to provide verification of kilometres travelled.~~

For reference, the following is provided:

Algoma Public Health
Round Trip Kilometres (as per Google Maps)

From/To	294 Willow Avenue, Sault Ste. Marie	9 Lawton Street, Blind River	302-31 Nova Scotia Walk, Elliot Lake	18 Ganley Street, Wawa
294 Willow Avenue, Sault Ste. Marie	N/A	284	396	450
9 Lawton Street, Blind River	284	N/A	114	734
302-31 Nova Scotia Walk, Elliot Lake	396	114	N/A	844
18 Ganley Street, Wawa	450	734	844	N/A

Car Rental

If required and economically prudent, employees/board members may rent vehicles while on APH business with Management approval. Mid-sized vehicles must be reserved unless a larger vehicle is required to accommodate the number of travellers sharing the vehicle.

APH has special rates for car rentals with a preferred provider in Sault Ste. Marie. The Manager of Accounting Services will notify APH employees of our preferred provider on an annual basis. ~~with Enterprise Rent-A-Car. Reservations may be made directly with *Enterprise Rent-A-Car* at 705-254-3227 and~~ Preferred providers ~~billed to~~bill APH directly.

Note: Employees/board members will not be reimbursed for any traffic or parking tickets resulting from business travel.

ACCOMMODATIONS:

Employees/board members are expected to stay in a s~~S~~tandard-type room in a good-standing hotel. The employee/board member is entitled to an individual room.

Hotel reservations will be made by the travelling employee. For board members, the Secretary to the Board will make hotel reservations. Where possible, the accommodations chosen should be a government-approved hotel offering government rates or the host hotel of the conference or seminar. Employees/Board Secretary should inquire about the possibility of obtaining a government rate~~. Once a confirmation number for the reservation is provided, the employee/board member should carry it with them during their travels.~~

Algoma Public Health has secured corporate rates with a number of hotels within the District of Algoma. . Employees will be provided with a list of preferred providers annually by the Manager of Accounting Services. Preferred provider hotels bill APH directly and employees should first attempt to book rooms from the preferred providers list.~~Algoma Public Health has secured corporate rates with the following hotels within the District of Algoma. based on price and proximity to APH offices. Employees will be provided with a list ofr preferred providers annually by the Manager of Accounting Services.: Preferred provider hotels bill APH directly and employees should first attempt to book rooms from the preferred providers list.~~

~~**Sault Ste. Marie, ON**~~

~~**Quattro Hotel & Conference Centre**~~
~~229 Great Northern Road,~~
~~Sault Ste. Marie, ON, P6B 4Z2~~

~~**Algoma's Water Tower Inn & Suites**~~
~~360 Great Northern Rd~~
~~Sault Ste. Marie, ON, P6B 4Z7~~

~~Tel: 705-942-2500~~ ~~Tel: 705-949-8111~~

~~**Wawa, ON**~~

~~**Algoma Motel & Cabins**~~
~~164 Mission Rd~~
~~Wawa, On, P0S 1K0~~
~~Tel: 705-856-7010~~

~~**Wawa Motor Inn**~~
~~118 Mission Rd~~
~~Wawa, On, P06 1K0~~
~~Tel: 705-856-2278~~

~~**Elliot Lake, ON**~~

~~**Hampton Inn**~~
~~279 Highway 108 North~~
~~Elliot Lake, ON P5A 2S9~~
~~Tel: 705-848-4004~~

~~**Blind River**~~

~~**Lakeview Inn**~~
~~143 Causley St~~
~~Blind River, ON P0R 1B0~~
~~Tel: 705-356-0800~~

~~**Pier 17 Hotel**~~
~~1 Causley St~~
~~Blind River, ON P0R1B0~~
~~Tel: 705-356-1717~~

~~When travelling for APH business and the employee/board member will be spending the night in the above communities, employees/Board Secretary must attempt to book the accommodations at one of the hotels listed above. This is the only scenario where APH will be billed directly for accommodations. The travelling employee/Board Secretary must secure a signed Purchase Order with the associated hotel prior to booking accommodations.~~ The travelling employee or a clerical employee may prepare a ~~the~~ Purchase Order on behalf of the travelling employee. When completing the Travel Expense Report, employees are required to populate Section (B) CHARGED TO COMPANY as it relates to their respective hotel stay.

When travelling to all other locations, employees/board members (excluding those employees with a corporate credit card) must pay for hotel expenses using a personal credit card. The employee/board member will subsequently be reimbursed by APH when submitting their expense form by populating Section (A) REIMBURSABLE EXPENSES as it relates to their respective hotel stay.

If an employee has been issued a corporate credit card, it may be used to pay for hotel expenses. When completing the Travel Expense Report, populate Section (B) CHARGED TO COMPANY as it relates to the respective hotel stay.

Cancellations

It is the responsibility of the employee/~~Secretary to the Board~~Executive Assistant to cancel a hotel reservation in the event of a change. To avoid charges, the employee/~~Secretary to the Board~~Executive Assistant should be familiar with the hotel's cancellation policy. The employee/~~Secretary to the Board~~ Executive Assistant should record the cancellation number in case of a billing dispute.

MEALS & OTHER EXPENSES:

Alcohol is not a reimbursable expense.

Original itemized receipts are required for ~~meals and other~~ allowable expenses, such as parking, taxis, and buses~~,~~ in order to be eligible for reimbursement. Original itemized receipts must state the date, place and cost (credit card receipts that do not identify the items will not be accepted). If an itemized receipt cannot be provided (i.e. the i~~I~~temized receipt is misplaced), a written explanation reviewed and approved

by the employee's direct manager must be submitted to explain why the receipt is unavailable, and a description itemizing and confirming the expenses must be provided.~~;~~

Reimbursement for meal expenses will be ~~based~~ on a per diem basis ~~on actual expenses incurred *up to*~~ based on the rates set out in the chart below.~~-~~ These rates ~~includes~~include taxes and gratuities. No receipts are required.

Meals	**~~Maximum Amount~~Travel Per Diem**
Breakfast	$15.00
Lunch	$25.00
Dinner	$35.00

~~**APH will not provide a per diem to employees**. These rates are not an allowance. They are for individual meals – you must have eaten the meal to be able to submit a claim for reimbursement.~~

~~Reimbursement is for restaurant or prepared food only.~~

~~Reimbursement for groceries must have prior approval, and a written rationale must be submitted with the claim. If prior approval is provided, the itemized receipt must clearly indicate which items (s) relate to each particular meal up to the maximum amounts noted above.~~

If meals are provided at the event or part of the hotel booking, the employee will not be eligible for per diem reimbursement (i.e. if breakfast is provided at the hotel or conference, the employee will not be eligible to submit expenses for breakfast on the date of the conference).

~~When more than one meal is claimed for any day, you may allocate the combined maximum rates between the meals. For example, if you will be eating breakfast and lunch, the combined rate is $40.00. This now becomes the maximum rate for the two meals, regardless of what you spend on each meal.~~

APH will be responsible for the expenses incurred by an APH employee/board member only.

As meals are reimbursed on a per diem basis APH credit cards should not be used for meals during business related travel.~~One receipt, per meal, per employee/board member is required. However, if an employee has been issued a corporate credit card, it may be used to pay for meal expenses for themselves and other APH employees/board members~~

~~. All names of the APH employees/board members whose meals were charged on the corporate credit card must be noted on the back of the original itemized receipt. When completing the Travel Expense Report, the employee whose corporate credit card has been used is required to populate Section (B) CHARGED TO COMPANY as it relates to the respective meals charged to the corporate credit card. The maximum reimbursable rates, as set out in this policy, will apply to all employees when using a corporate credit card for meals.~~

TIPS/GRATUITIES

Employees/board members ~~You~~ may be reimbursed for reasonable gratuities for ~~meals and~~ taxis (15-18%). Keep a record of gratuities paid.

- ~~15%-18% on a meal and a taxi fare~~
-

TRAVEL ADVANCES

APH will not provide travel advances.

EXPENSE REPORTS:

Employees/board members must submit an expense report within 15 business days of the completion of each trip. Any expenses submitted after that time may not be reimbursed by APH. Expense reports must be approved by the employee's Manager. Managers have their expense report approved by their Director. Directors have their expense report approved by the MOH/CEO. The MOH/CEO must have expenses approved by the Chair of the Board or Vice-Chair of the Board. Board members must have expenses approved by the Chair of the Board/ Vice-Chair of the Board. The Chair of the Board must have expenses approved by the Vice-Chair.

Original itemized receipts must be attached to the expense report. ~~Expense reports are to be submitted to Clerical in Accounts Payable. Employees/board members will be reimbursed for expenses via the cheque run to ensure prompt reimbursement of expenses~~. Expense reports are to be submitted to the clerical in Accounts Payable. Employees/board members will be reimbursed for expenses via the cheque run to ensure prompt reimbursement.

TRAVEL REIMBURSEMENT THROUGH MINISTRY/THIRD PARTY:

APH recognizes there are times when an employee/board member will be travelling, and the expenses incurred are to be submitted to the Ministry/Third Party for reimbursement. When such a situation arises, the employee/board member is expected to follow the rules outlined in the Ministry/Third Party Travel Policy. The Ministry/Third Party travel policy will supersede APH's travel policy ~~with regards to~~ regarding allowable reimbursable expenses and dollar amounts. Any travel ~~that is~~ considered reimbursable through the Ministry/Third Party must be approved at the Director level or above.

In order to keep track of costs and ensure no duplication of employee/board member reimbursement, APH should be reimbursed by the Ministry/Third Party directly. Under no circumstance should an employee/board member receive a cheque from the Ministry/Third Party directly.

In situations where the employee/board member is travelling, and the Ministry/Third Party will reimburse APH, the following must be adhered to:

- The Ministry/Third Party expense report is to be completed with a copy submitted to the ~~APH's~~ clerical in Accounts Payable (Director to ensure both the original expense report and the copy are identical prior to any report being submitted to the Ministry/Third Party and APH Accounts Payable).

- The Ministry/Third Party expense report and original itemized receipts will be submitted to the Ministry/Third for APH to be reimbursed (this expense report must include expenses incurred by both the employee/board member and APH).

- The Ministry/Third Party expense report and copies of itemized receipts will be submitted to APH for employee/board members to be reimbursed. This is the only circumstance where copies of itemized receipts will be accepted by APH. Expense reports must be submitted within 15 business days after each trip.

- APH will reimburse the employee/board member.

- APH will be reimbursed by the Ministry.

NOTE: ~~Flights are to be booked through Maritime Travel~~. Flights are to be booked through APH's preferred provider as prescribed by the Manager of Accounting Services. Hotels are to be paid using the employee's personal credit card in this circumstance~~.~~

Reference:

- Kilometre Reimbursement 01-03-002
- Travel Expense Report

Ontario Building Code Appointments

REFERENCE #:	06-02	**DATE:**	Original: Apr 19, 2006 Revised: May 23, 2018 Reviewed: Jun 24, 2020 Revised: Sep 28, 2022
APPROVED BY:	Board of Health		
SECTION:	Bylaws		

Being a By-law of the Board of Health of Algoma Public Health to appoint a Chief Building Official and Inspectors for the purposes of the enforcement of the Ontario Building Code (OBC) Act respecting sewage systems.

WHEREAS the Building Code Act, S.O. 1992, Chapter 23, provides that a Board of Health appoints a Chief Building Official and such Inspectors as are necessary for the purpose of enforcement of the Act;

AND WHEREAS the Board of Health of Algoma Public Health deems it desirable to appoint a Chief Building Official and Inspectors for the enforcement of the Building Code Act for the purposes of sewage systems, in the jurisdiction of Algoma Public Health;

AND WHEREAS the Building Code Act, S.O. 1992, Chapter 23, Section 7.1. requires the establishment and the enforcement of a code of conduct for the Chief Building Officials and Inspectors;

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

1. (a) The Manager of Environmental Health shall be appointed as the Chief Building Official (CBO).

(b) In the absence of the CBO, at the manager level, an OBC trained inspector with CBO designation shall be appointed by the Manager of Environmental Health as their temporary alternate (Temporary Acting CBO). The chair of the Board of Health will be notified of this temporary alternate appointment. Any dispute arising during the absence of the CBO can be heard by the Temporary Acting CBO.

(c) The CBO or Temporary Acting CBO shall have all the powers and duties as set out in Section 1. 1(6) of the Building Code Act, S.O. 1992 for CBO.

(d) The CBO or Temporary Acting CBO shall meet the qualifications and registration as required in Section 3.1.2, Division C, Part 3 of the Ontario Building Code and register annually on the Ministry of Housing and Municipal Affairs Quarts website ~~only when~~for the duration that they are appointed as CBO.~~.~~

2. OBC trained inspector(s) that meet the qualifications under Part 8 of the Building Code shall register annually on the Ministry of Housing and Municipal Affairs Quarts website. ~~and registration as required in~~ OBC inspectors are appointed under Section 3.1.4, Division C, Part 3 of the Ontario Building Code to carry out duties for Part 8- Sewage Systems on behalf of Algoma Public Health. ~~Code shall be appointed as Inspectors for purposes of Part 8 under the Code.~~

The CBO and CBO trained inspectors shall act in accordance with the policies and procedures governing employees at APH including the Code of Conduct.

READ AND PASSED IN OPEN MEETING THIS 28th DAY OF SEPTEMBER, 2022

S. Hagman, Chair

L. Mason, 1st Vice-Chair

Enacted and passed by the Algoma Health Unit Board on this 16th day of April 2006
Original signed by
G. Caputo, Chair
A. Northan, MOH

Revised and passed by the Algoma Public Health Board on this 17th day of March 2010
Revised and passed by the Algoma Public Health Board on this 18th day of February 2015
Revised and passed by the Algoma Public Health Board on this 28th day of June 2017
Revised and passed by the Algoma Public Health Board on this 23 day of May 23, 2018
Revised and passed by the Algoma Public Health Board on this 28th day of September, 2022

To Regulate the Proceedings of the Board of Health

REFERENCE #:	95-1	**DATE:**	Original: Dec 13, 1995 ~~Revised: Jun 28, 2017~~ Reviewed: Nov 20, 2019 Revised: Sep 22, 2021 Revised: Sep 28, 2022 Revised:
APPROVED BY:	Board of Health		
SECTION:	Bylaws		

The Board enacts as follows:

1. Interpretation

In this By-law:

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

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

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

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

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

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

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

g) "Conflict of Interest" as per A.P.H. policy 02-05-015: Conflict of Interest.

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

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

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

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

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

~~m)a) "Conflict of Interest" as per A.P.H. policy 02-05-015: Conflict of Interest.~~

2. General

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

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

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

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

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

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

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

3. Meetings

a) Regular Meetings:

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

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

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

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

b) Special Meetings:

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

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

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

4. Notice of Meetings:

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

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

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

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

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

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

5. Preparation of the Agenda:

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

i. Call to Order

ii. Declaration of Conflict of Interest

iii. Adoption of Agenda

iv. Delegations / Presentations

v. Adoption of Minutes of Previous Meeting

vi. Business Arising from Minutes

vii. Report of Medical Officer of Health

viii. Reports of Committees

ix. New Business / General Business

x. Correspondence requiring action

xi. ~~Items~~ Correspondence for Information

xii. Addendum

xiii. In-Camera

xiv. Open Meeting

xv. Announcements / Next Committee Meetings

xvi. Adjournment

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

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

6. Commencement of Meetings:

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

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

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

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

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

b) Each deputation will be allowed a maximum of one speaker for a maximum of ~~10~~ 5 minutes, but a member of the Board may introduce a deputation in addition to the speaker or

speakers. Normally, a deputation will not be heard on an item unless there is a report from staff on the item or upon agreement of two-thirds of the Board present.

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

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

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

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

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

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

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

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

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

i. to adopt,

ii. to amend,

iii. to defer action,

iv. to refer,

v. to receive,

vi. to adjourn the meeting or

vii. that the vote be now taken.

~~k)~~j) A motion

i. to refer or defer shall take precedence over any other amendment or motion except a motion to adjourn.

ii. to refer shall require direction as to the body to which it is being referred and is not

debatable.

iii. to defer must include a reason and a time period for the deferral and is not debatable.

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

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

8. Duties of the Secretary for the Board

It shall be the duty of the Secretary:

a) to attend or cause an assistant to attend all meetings of the Board;

b) to keep or cause to be kept full and accurate minutes of the meetings of all the Board meetings, text of by-laws and resolutions passed by it; and

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

d) to give all notices required to be given to the members.

9. Appointment and Organization of Committees

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

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

10. Conduct of Business in Committees

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

b) It shall be the duty of the Committee:

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

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

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

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

The procedures of the Board with respect to:

a) incurring of liabilities and paying of accounts;

b) authority for expenditures;

c) audits;

d) budgets and settlements;

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

12. Short Name

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

13. Execution of Documents

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

b) In general, unless changed by a resolution of the Board, the following applies:

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

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

iii. Leases or purchase agreements for vehicles, as approved in budgets, will be signed by the Senior Financial Leader of A.P.H. and/or the Medical Officer of Health or a Senior Administrative Leader (should two signatures be necessary);
/

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

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

corporate services will be signed by the Medical Officer of Health/CEO or Senior Financial Leader of APH. ~~or~~ Senior Administrative Leader.

14. Duties of Officers

a) The Chair of the Board shall:

i. preside at all meetings of the Board;

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

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

iv. complete performance appraisals according to Policy #02-05-080 of the Medical Officer of Health/CEO~~/CAO~~ using input from the Medical Officer of Health/CEO~~/CAO~~ as well as the members of the Board, with the results of this appraisal being shared with the Board members in-camera;

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

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

15. Amendments

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

16. Dismissal of Medical Officer(s) of Health

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

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

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

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

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

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

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

17. Reporting of Medical Officer of Health/CEO to the Board of Health

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

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

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

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

Revised and passed by the Algoma Health Unit Board this 18th day of November 1998
Revised and passed by the Algoma Public Health Board February 2011
Revised and passed by the Algoma Public Health Board on this 28th day of October, 2015
Revised and passed by the Algoma Public Health Board on this 28th day of September 2016
Revised and passed by the Algoma Public Health Board on this 28th day of June 2017
Revised and passed by the Algoma Public Health Board on this 22nd day of September 2021
Revised and passed by the Algoma Public Health Board on this 28th day of September 2022
Revised and passed by the Algoma Public Health Board on this

Algoma
PUBLIC HEALTH
Santé publique Algoma
www.algomapublichealth.com

November 27, 2024

The Honourable Sylvia Jones
Deputy Premier/Minister of Health
Ministry of Health
5th Floor, 777 Bay Street
Toronto, ON M7A 2J3

Dear Minister Jones:

On behalf of the Board of Health for the District of Algoma, I would like to thank you for your commitment to strengthening public health in Ontario. A strong public health system promotes health, protects us from illness, alerts us to emerging health threats, and responds to critical public health emergencies. All of this translates into better health for Ontarians and helps reduce healthcare spending by reducing the overall burden of illness we face as a province.

A strong public health system requires adequate resources to carry out the important work of preventing illness and injury. Capping increases to public health base funding for local public health agencies at 1% for each of the three years from 2024 through 2026 is inadequate to meet the emerging economic realities faced by the sector. Inflation has significantly raised costs, particularly in the last three to four years. Our staff have worked diligently to find cost-saving measures, including taking the difficult step of laying off staff members to balance our 2023/2024 budget. While we have had success in finding savings elsewhere, this alone is not enough to close the gaps we still face. Since 2016, inflationary pressures are estimated to amount to approximately 26.25%, while provincial increases to funding for our health unit cumulatively amount to 6.96%. The disparity between the two has forced us to request unparalleled increases to the municipal levy, amounting to 30.61% over the same time period, in order to close the gap and maintain services within our communities.

Delivering public health services in Northern Ontario comes with significant challenges. These challenges were recently detailed in a letter sent to the Chief Medical Officer of Health and addressed to your attention on September 25th, 2024. These challenges continue and municipalities in the North face their own challenges when it comes to funding as well. Municipal property tax bases are already stretched and municipalities face the same inflationary pressures.

Relying on municipalities to fill this gap is not a sustainable model for public health in Northern Ontario, particularly given the significant toll the social determinants of health have on our people. The work of

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

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

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

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

public health is made much more complex by this reality, and we cannot benefit from economies of scale in the same way that Southern Ontario communities can, given our vast geography. We live in a health unit where driving from our most eastern community to our most western community would take approximately 5.5 hours, the same distance as travelling from Toronto to Montreal. This means the public health needs of a community on one side of our geography can be vastly different than those on the other and the costs to provide those services are much greater.

We understand that the Ministry is reviewing the funding formula for public health but that this review will take some time before completion. Regarding the funding review, we refer back to the important consideration we laid out in our aforementioned letter sent on September 25th, 2024. In the meantime, we urge the government to reconsider the 1% provincial funding cap to address the rapidly rising costs that are putting continued strain on municipal budgets. We see the benefits of public health in our communities firsthand and happily support their endeavours, but municipalities should not be the sole backstop against sub-inflationary provincial funding increases.

Sincerely,

Sally Hagman,
Chair, Board of Health
District of Algoma Health Unit

Luc Morrissette,
Chair, Finance and Audit Committee,
District of Algoma Health Unit

CC: Honourable Doug Ford, Premier of Ontario
Honourable Marit Stiles, Leader of Opposition
France Gélinas, Provincial Health Critic
Honourable, Michael Mantha, MPP – Algoma-Manitoulin
Honourable, Carol Hughes, MP Algoma-Manitoulin-Kapuskasing
Kieran Moore, Chief Medical Officer of Health
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
Northern Medical Officers of Health
Local municipalities
The Association of Local Public Health Units (alPHa)

Tania Caputo

From: allhealthunits <allhealthunits-bounces@lists.alphaweb.org> on behalf of alPHa communications <communications@alphaweb.org>
Sent: Monday, November 18, 2024 2:32 PM
To: AllHealthUnits@lists.alphaweb.org
Cc: board@lists.alphaweb.org
Subject: [allhealthunits] November 2024 InfoBreak

View this email in your browser

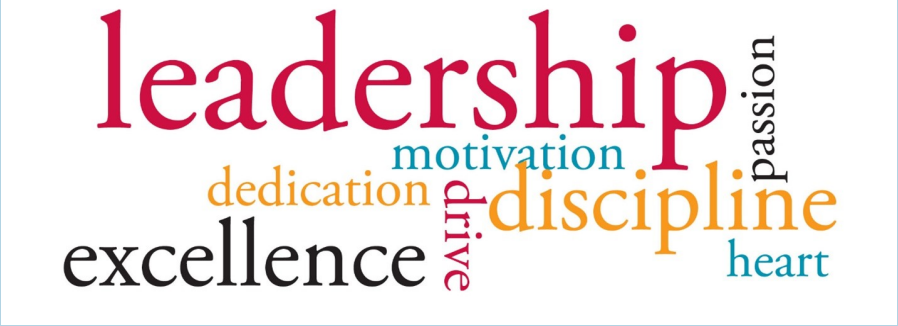
PLEASE ROUTE TO:
All Board of Health Members
All Members of Regional Health & Social Service Committees
All Senior Public Health Managers

November 18, 2024

November 2024 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 - November 2024



"Everyone has the chance to lead if they choose to take what they've been given and make something extraordinary happen."

Extraordinary! That is the only way to sum up the alPHa 2024 Fall Symposium, Section Meetings and Workshops held during the week of November 5 to 8, 2024.

As a precursor to the line-up of alPHa members' events, alPHa provided a virtual forum and workshop for Executive and Administrative Assistants, who work in public health units, as an opportunity to connect with their colleagues from across the province. This well attended event featured sessions covering Public Health and Artificial Intelligence, Board of Health Governance, and local alcohol strategies.

The *Artificial Intelligence (AI) and Public Health* all day workshop on November 6, was an opportunity to achieve a shared understanding of the risks and benefits of AI for local public health agencies and the public we serve. Academic, government and industry leaders in AI provided alPHa participants insight into a better understanding of the necessary governance and infrastructure requirements for successful AI integration and suggested practical, actionable steps. Thank you to Steven Rebellato, member of the alPHa Board of Directors, and alPHa Chief Executive Officer, Loretta Ryan, for spearheading the workshop. This builds on alPHa's Resolution A24-02 Artificial Intelligence for Enhanced Public Health Outcomes and alPHa AI resources.

On November 7, *Reducing Alcohol Harms in Ontario: Canada's Guidance on Alcohol and Health and Public Education* Workshop continued alPHa's support for Resolution A24-03 A Proposal for a Comprehensive Provincial Alcohol Strategy: Enhancing Public Health through Prevention, Education, Regulation and Treatment. It was an interactive session with presenters from the Canadian Centre on Substance Use and Addiction and public health leaders discussing strategies and opportunities to integrate Canada's Guidance on Alcohol and Health into local health promotion campaigns.

The important conversation on the critical role of local public health in Ontario's public health system continued on November 8 at alPHa's 2024 Fall Symposium and Section Meetings. The opening remarks and the Land Acknowledgement reflected on Treaties Recognition Week and the importance of these historic agreements honouring the wisdom, resilience, culture, and traditions of those who negotiated these treaties and others who followed like the Hon. Murray Sinclair, the Chief Commissioner of the Truth and Reconciliation Commission of Canada - a trailblazing Indigenous leader who passed away earlier in the week. Welcoming remarks came from the Hon. Doug Ford, Premier of Ontario, and Robin Jones, President, Association of Municipalities of Ontario. A fulsome morning agenda included updates on alPHa's 2024-2027 Strategic Plan, followed by panels from Public Health Ontario, public health leadership who spoke on mergers past and present, and StrategyCorp provided insight on Ontario's current political landscape. Dr. Daniel Warshafsky, Associate Chief Medical Officer of Health, provided updates on behalf of Dr. Kieran Moore, Ontario Chief Medical Officer of Health. The afternoon concurrent sessions focussed on the respective Sections. Speakers, presenters, moderators, Dalla Lana School of Public Health, Eastern Ontario Public Health, all of those who participated, and the events' organizer alPHa's Chief Executive Officer, Loretta Ryan, and alPHa staff - collectively made the 2024 Fall Symposium and the concurrent Section sessions a resounding success. Thank you!

The 2024-2025 alPHa Board of Directors held its regular board meeting on November 7. Along with regular board business and updates from the Sections and the public health Affiliates, the Board of Directors discussed the policy revisions required for full compliance with Ontario's Not-for-Profit Corporations Act, development of the next *Public Health Matters* infographic, the provincial Strengthening Public Health initiatives, and updates from the Office of the Chief Medical Officer of Health.

alPHa holds over 100 meetings a year! The alPHa Board of Directors, and other alPHa representatives, are participants in various committees, focus groups and public health tables providing recommendations and advice on the provincial public health initiatives, collectively advancing the cause of a resilient, sufficiently resourced, local public health system. Thank you to alPHa's Board of Directors and alPHa members for your public health leadership.

Respectfully,

Trudy

Trudy Sachowski
Chair, alPHa Board of Directors

2024 alPHa Fall Symposium Resources

Thank you to all of the alPHa members who attended this year's Fall Symposium. We were glad to see so many of you engaged in discussions and dialogue on key public health issues. A special thanks goes to alPHa Chair, Trudy Sachowski, for chairing the event. We would also like to thank BOH Section Chair, René Lapierre, and COMOH Section Chair, Dr. Lianne Catton, for chairing their meetings.

A huge shoutout goes to Obadiah George from the Dalla Lana School of Public Health and Andy Morrisson from the Eastern Ontario Health Unit for their generous event and technical support. The event would not have been possible without them!

Thank you to all those who submitted videos from their public health units. We had a strong response and we greatly appreciate your participation.

Lastly, we would like to note and thank the alPHa staff for all of their work to make the Symposium, workshops, Section meetings, and Board meeting a success.

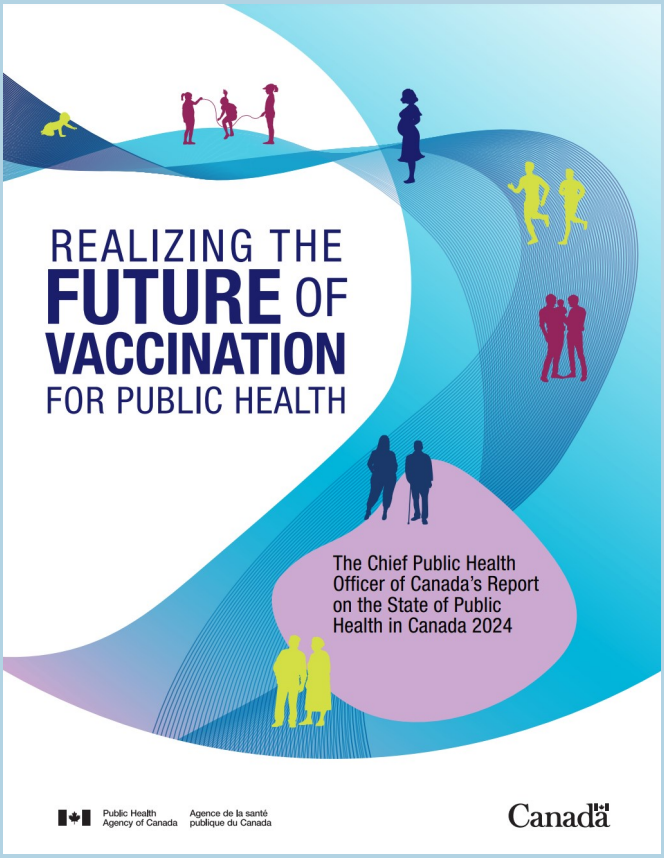
Presentations from this year's Fall Symposium are now available. Please note, you will need to log in to the members' side of the website to view the presentations. You can do so here. Please note, we are continuing to receive these, so please check back often.

If you have not yet filled out the after-event survey, there is still time to do so. You can be entered into a draw for a gift card. The link to the survey is here and the final date to fill it out is Friday, November 22.

Hold the dates for the 2025 alPHa Winter Symposium!

Please don't forget to save the dates for the upcoming alPHa Winter Symposium. This **online** event will be held February 12-14. There is already an exciting and jam-packed lineup in the works, and you won't want to miss out! More information will be available in the new year.

Chief Public Health Officer of Canada - 2024 Annual Report



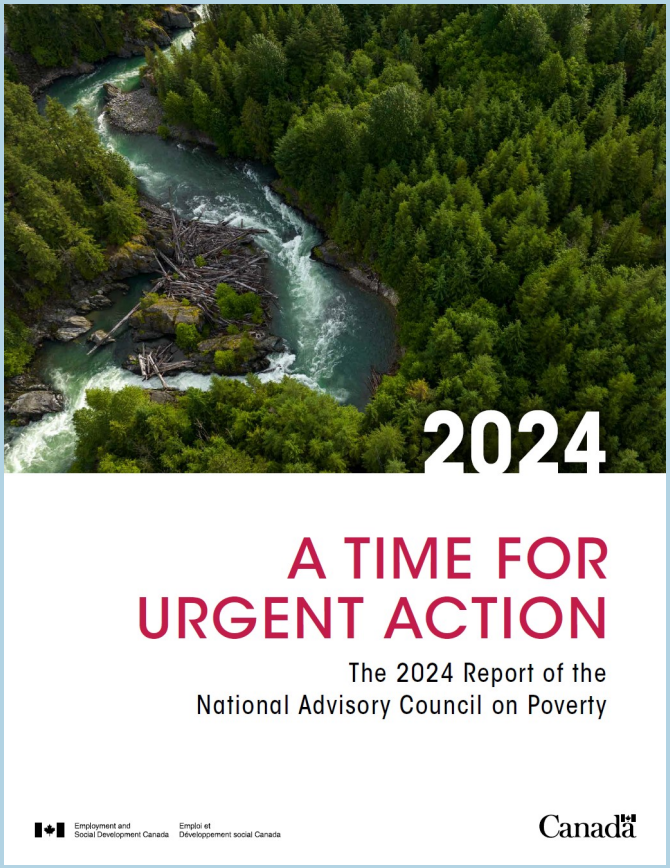
Last month, the Chief Public Health Officer of Canada, Dr. Theresa Tam, released her Realizing the Future of Vaccination for Public Health report. It covers the importance of vaccines and it "offers a vision and framework to realize the full potential of vaccination in Canada, so that everyone, at every stage of life, can experience the benefits of vaccination for health and well-being."

Additionally, the report lays out how public health can continue to take a leadership role by:

- Harnessing vaccination to promote health for all people across the life course;
- Facilitating collaboration across systems and with communities; and,
- Preparing for and adapting to evolving health, technology, and sociocultural contexts.

To read more, click here.

National Advisory Council on Poverty - 2024 report



Last month, the National Advisory Council on Poverty released their report, A Time for Urgent Action: The 2024 Report of the National Advisory Council on Poverty. They noted "the poverty rate increased for the second consecutive year in 2022. The 2022 poverty rate was up 2.5 percentage points from 2021 and 3.5 percentage points from 2020. This represents 1.4 million more people living in poverty in Canada in 2022 compared to 2020." To read more, click here.

EAs/AA Workshop: Thank you to all who attended!

The 2024 Executive Assistant/Administrative Assistant Fall Virtual Workshop, which was held on November 5, was a resounding success!

We would like to thank all those who attended. Your lively participation was appreciated.

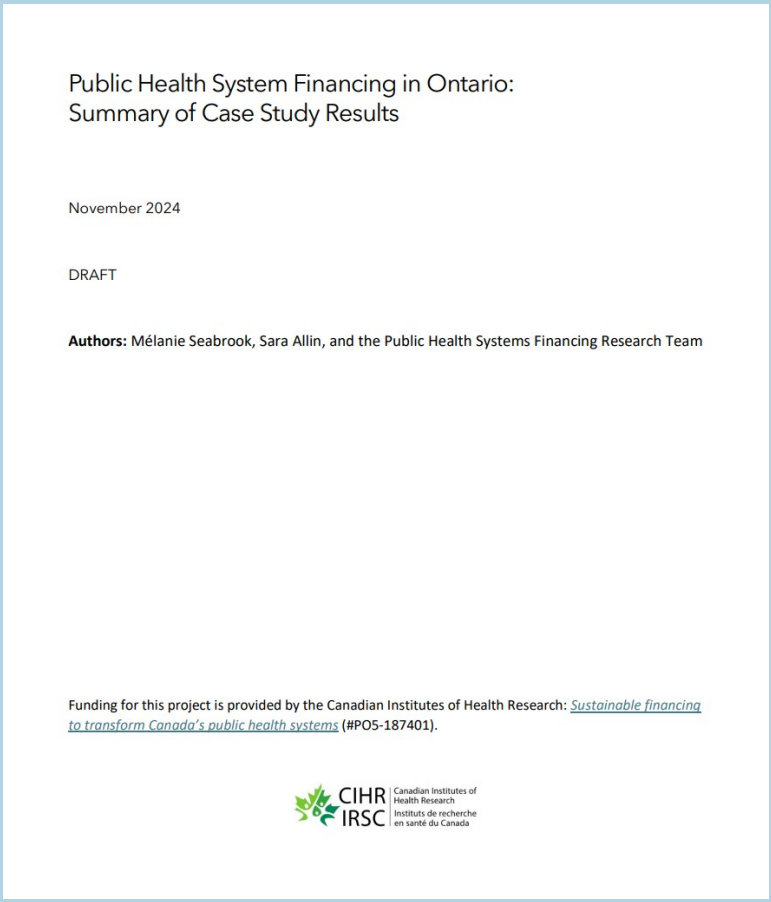
A shoutout also goes to Melissa Ziebarth, from Renfrew County and District Health Unit, for creating the workshop poster.

As a reminder, please fill out the survey here. You can be entered into a draw for a gift card. The final date is Tuesday, November 19, 2024.

Ontario Public Health Directory: **September 2024 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 **September 18, 2024**. To view the file, log into the alPHa website.

Public Health System Financing in Ontario



Public Health System Financing in Ontario:
Summary of Case Study Results

November 2024

DRAFT

Authors: Mélanie Seabrook, Sara Allin, and the Public Health Systems Financing Research Team

Funding for this project is provided by the Canadian Institutes of Health Research: *Sustainable financing to transform Canada's public health systems* (#PO5-187401).

CIHR IRSC Canadian Institutes of Health Research / Instituts de recherche en santé du Canada

"This case study of Ontario is part of a comparative multi-province study aiming to shed light on public health system financing processes and uncover potential strategies for supporting stable public health funding. The study builds on previous research led by the North American Observatory on Health Systems and Policies (NAO) that profiled various provincial public health systems (Smith et al., 2022). It also supports the Chief Public Health Officer's call for sufficient and stable public health funding (Tam, 2021). The study is led by Dr. Sara Allin (NAO, University of Toronto), with the support of a team of researchers, advisors, knowledge users, and trainees from across Canada." To read the results, please click here. And, to view the Policy Research Brief, click here.

This week is Talk to a Stranger Week!

GenWell, alPHa's newest Workplace Health and Wellness partner, is promoting Talk to a Stranger Week, which is being held this week (November 18-24, 2024). This campaign is an opportunity to build a sense of connection and community that many need in a post-pandemic world. It is seizing the opportunity that many of us have each day to make a difference in our own lives, and the lives of others, by simply saying hello, smiling, or striking up a conversation with a stranger. To learn more, click here.

Looking for a team activity?

Leaders FOR Leaders
Building Teams. Developing Leaders.

Tim Arnold, a long-standing alPHa presenter, has shared an icebreaking activity you might find useful for a future staff meeting. To learn more, please click here.

Boards of Health: Shared Resources

A resource page is available on alPHa's website for Board of Health members to facilitate the sharing of and access to 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)
- 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

- Risk Management for Health Units
- 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

Affiliates update

Affiliates

Association of Local Public Health Agencies

Association of Public Health Epidemiologists in Ontario

Association of Public Health Epidemiologists in Ontario (APHEO)

Highlights from APHEO's 2024 Fall Symposium:

APHEO hosted our first in-person conference since 2019 on Friday, November 8. Fifteen local public health units presented their recent advances in epidemiology and analytics.

Meaningful democratization of data was a common thread, with deep work among local epidemiologists and program colleagues to select relevant data stories and insights for decisions. Many health units are leveraging interactive dashboards, complemented by presentations and reports for interpretation.

Behind the scenes, epi teams are making strides in **data processing automation**. Forum discussions highlighted the value of collaboration to share data preparation efficiencies while supporting the unique data needs of local communities.

Calling all Ontario Boards of Health: Level up your expertise with our NEW 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.

BrokerLink Insurance

In partnership with alPHa, BrokerLink is proud to offer preferred home and auto insurance rates for members, click here to get a quote. As a homeowner, there are several ways you should prepare your home for winter, and it is best to start before the cold weather hits. Have a worry-free winter this year by following our tips and tricks to winterize your home here.

Job postings

Below is a list of health units that are hiring. For more information, and to view all of the postings, please click here.

- Algoma - Immunization Manager - Application deadline: November 28, 2024
- Algoma - Public Health Inspector - Application deadline: Open until filled
- Halton - Business Planning Advisor - Application deadline: November 25, 2024

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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

Enhancements to the Ontario Virus Respiratory Tool

Public Health Ontario (PHO) has updated the Ontario Respiratory Virus Tool (ORVT) to provide more comprehensive data on respiratory virus activity in Ontario for the 2024-2025 season. Key enhancements include:

• The summary section has been expanded to include projections for COVID-19, influenza, and RSV activity for the next two weeks, influenza strain details, and an overall assessment of RSV activity.
• Streamlined laboratory testing data using Ontario Laboratories Information System (OLIS) data from June 23, 2024.
• A new COVID-19 episodes indicator to approximate COVID-19 cases using data from OLIS.
• An expanded Outbreaks section, with indicators to describe severity
The tool will be updated weekly on Fridays at 11:30 a.m., with data up until the previous Saturday.

For more information about the updates, please read our News post.

Additional Resources

• FAQ: Cold Plunge Tanks and Pools

• Pertussis in Ontario: January 1 – September 30, 2024

• Mpox in Ontario

• Measles in Ontario

• SARS-CoV-2 Genomic Surveillance in Ontario

• Integrated Respiratory Virus Risk Indicators for Ontario: October 27, 2024 to November 9, 2024

Events

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

• **Nov 19**: Rethink the Rx: Reducing Unnecessary Antibiotic Prescribing in Primary Care

Recent Presentations

• PHO Webinar: Don't Know Where to Start? Try an Organizational Risk Assessment!

- PHO Rounds: Respiratory Season 2024–25 Part 1: Surveillance and Testing
- PHO Rounds: Respiratory Season 2024–25 Part 2: Overview of Influenza, COVID-19, and RSV Immunization
- Automated Opioid News Event-based Surveillance (AONES) Project

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Upcoming DLSPH Events and Webinars

Dalla Lana School of Public Health

- CANSSI Ontario STatistics Seminars (CAST): Lisa Strug (Nov. 21)
- Nature Master Class: Communicating to Non-Research Audiences (Dec. 4)

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alPHa's Strategic Plan

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

alPHa's mailing address

Please note our mailing address is:
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alPHa Virtual Conference

Wednesday, November 6, 2024

Stephen Robellato – Moderator
Loretta Ryan CEO – alPHa

Artificial Intelligence Laying the Groundwork for AI to Advance Public Health
~ Dr. Laura Rosella

- AI has surpassed humans at a number of tasks, and the rate at which humans are being surpassed at new tasks is increasing
- Very powerful AI systems are fairly likely to be developed in the next decade
- AI is not one thing nor is it applied one way
- AI is descriptive predictive causal inference – it will cover what is happening, what will happen, why does it happen and what should I do about it. (Recommendations)
- There is a greater demand for data to support public health decision-making – demand and scope is increasing – speed, transparency
- Emerging data for public health is increasing
- But the impact is limited at this time
- Public Health needs to be totally engaged in this movement
- AI is working when fewer people are developing diseases or poor health outcomes that are predictable, promoting health in our environments and communities reduction in health inequities
- AI training includes short courses, scholarships, internships, community-building
- Tensions include algorithmic bias, precision public health, discomfort with the Black Box (we can't see what's going on), building responsible AI for health
- AI is being applied in public health through exposure assessment from environmental images, exposure assessment from wearables, administrative tasks, Chatbots, surveillance using text-based sources, population risk stratification
- AI was used with the first warnings of the Wuhan virus – focused on detecting early threats
- Food exposures are automatically categorized
- Lead poisoning validation of a machine-learning model
- Predicting vaccine hesitancy in metropolitan areas using machine learning models on public tweets
- The analytics can monitor social determinants of health
- We can make use of these multiple sources of data, leading to actions taking place
- There is still strong human oversight for decision-making – using in conjunction with other inputs to support decision-making
- Need alignment with Public Health Goals, data needs to be effective and sustainable as well as safe and ethical for successful deployment in public health
- Six priority areas for public health organizations to advance AI into practice include governance, infrastructure, workforce partnerships, good AI practices, equity and bias
- Workforce capacity building, high-quality evidence of impact on health outcomes, Human AI design, clear accountability, human oversight over decisions, independent certification and oversight, value to public health workforce and Modernized deployment infrastructure
- There is a report on Artificial Intelligence in Canada for Public Health
- Opportunities for AI & public health will allow multi-modal data to be processed and used in real-time, and AI solutions scaled and widely adopted
- Humans are the key to getting there – data analytics are necessary but not sufficient to enable an effective public health system; they are a tool to complement other analytical tools
- Public health has critical expertise and perspectives to share how AI is to be further integrated into our society
- Slides will be made available on the alPHa website

Privacy Consideration for AI in the Health Sector
Nicole Minutti, Senior Health Policy Advisor
Information and Privacy Commissioner of Ontario

- The privacy commissioner of Ontario – funded by the government but independent of the government
- The IPC has a broad mandate and role

Health Policy

- Consult with government regarding proposed health-related legislation and regulation and legislation
- Provide guidance for the health sector and public
- Participate in speaking engagements and provide presentations
- Conduct three-year reviews of prescribed entities, persons and organizations
- Participate in consultations with health sector organizations' policies
- Conduct research on access and privacy issues relevant to the health sector
- Consult with Ontario Health regarding interoperability standards

Tribunal

- Investigate privacy complaints under PHIPA
- Resolve access to information/correction appeals
- Issue access and privacy decisions
- Receive/investigate point-in-time privacy breach reports

Communications

- Respond to questions from the public regarding PHIPA through info@ipc.on.ca
- Provide information to the public, including on our website https://www.ipc.on.ca/en
- Receive annual statistical reporting of breaches and prepare annual reports

The Personal Health Information Act, 2004 ~ Application of OHIPA

- Ontario's Personal Health Information Act (PHIPA) sets out rules for the collection, use and disclosure of personal health information for health information custodians

Personal Health information

- PHI is identifying information about an individual in oral or prescribed form that:
    - Relates to an individual's physical or mental health
    - Relates to the provision of health care to the individual
    - Is a plan that sets out the home and community care services to be provided by a funded health service provider or Ontario Health Team
    - Relates to the payments or eligibility for health care
    - Relates to the donation of body parts or bodily substances
    - Is the individual's health number
    - Identifies and individuals substitute decision-maker

Health Information Custodians include:

- Healthcare practitioners who provide healthcare
- Group practices of health care practitioners who provide health care
- Health services providers that are part of an Ontario Health Team and community care service
- Hospitals, psychiatric facilities and independent health facilities
- Long-term care homes, retirement homes and homes for special care
- Pharmacies, ambulance services, labs and specimen collection centres
- Centres, programs or services for community health or mental health whose primary purpose is the provision of health care

- Medical Officers of Health of a board of health(public health units)
- Minister/Ministry of Health

Agents:
- A person that, with the authorization of a custodian, acts for or on behalf of the custodian with respect to PHI
- Custodians remain responsible for any PHI that is collected, used, disclosed, retained or disposed of by their agents

Electronic Service Providers (ISP):
- Is a person who supplies services that enable a custodian to collect, use, modify, disclose, retain or dispose of PHI electronically
- ESPs must comply with prescribed requirements
- When the ESP is not an agent of the custodian:
    - It shall not use any PHI to which it has access except as necessary in the course of providing the services
    - It shall not disclose the PHI
    - It shall not permit any person acting on its behalf to access the information unless the person complies with the restrictions that apply to the ESP

Duties of Custodians and their Agents
- Custodians have a number of duties under PHIPA, which generally fall into four categories:
    - Collection, use and disclosure
    - Access and correction
    - Transparency
    - Security

These duties continue to apply when custodians develop, maintain, procure, implement and use artificial intelligence (AI) technologies.

Collection, Use and Disclosure
Under PHIPA, custodians are not permitted to collect, use or disclose PHI unless:
    - The individual consents, or
    - The collection, use or disclosure is permitted or required by PHIPA

Custodians are also responsible for taking steps to ensure that they have the authority to collect, use and disclose PHI.

PHIPA's "limiting principles"
- Custodians are not permitted to collect, use or disclose PHI if other information will serve that purpose
- Custodians are not permitted to collect, use or disclose more PHI than is reasonably necessary for the purpose

Access:
- Individuals have a right of access to their health records with some exceptions
- Custodians must respond within 3 days(with the possibility of a 30 day extension)

Correction
- Individuals may request correction of their health records
- Custodians must respond within 30 days
- If the individual shows it is not accurate, custodians must correct the record unless
    - It was not originally created by the custodian and they do not have sufficient expertise, knowledge or authority to correct the record; or it consists of professional opinion or observation that was made in good faith

Transparency
Contact Person – The custodian must designate a contact person responsible for:

- Facilitating their compliance with PHIPA
- Ensuring all agents are appropriately informed of their duties under PHIPA
- Responding to inquiries from the public about their information practices
- Responding to requests for access to or correction of health records and
- Receiving complaints from the public about their compliance with PHIPA

Written Public Statement – Custodians must make available to the public a written statement that:

- Provides a general description of their information practices
    - Describes how to contact the contact person
    - Describes how to obtain access to or request correction of a health record and
    - Describes how to make a complaint to the custodian and to the Commissioner

If a custodian uses or discloses PHI without consent outside the scope of the information practices described in the written public statement, the custodian must inform affected individuals at the first reasonable opportunity
Breach Notification to Affected Individuals – if PHI is stolen, lost, used or disclosed without authority, custodians must:

- Notify individuals at the first reasonable opportunity and
- Inform the individuals in the notice that they are entitled to make a complaint to the IPC
- Point in Time Breach Reporting to IPC – Custodians must notify the IPC of a breach when it is discovered in certain circumstances when PHI has been used or disclosed without authority, PHI has been stolen, etc.)

Annual Statistical Reporting to IPC – in addition to the point–in–time reporting requirements, custodians are required to report breaches to the IPC on an annual basis
Security – Custodians must take reasonable steps to ensure that PHI is protected against theft, loss and unauthorized collection, use or disclosure, unauthorized copying, modification or disposal. Custodians are also required to ensure that records of PHI in their custody or control are retained, transferred and disposed of in a secure manner.

Bill 194: "Strengthening Cyber Security and Building Trust in the Public Sector Act, 2024 ~ The Ontario government has introduced this Bill aimed at strengthening digital infrastructure and data privacy protections within public entities and services in Ontario. The draft legislation includes provisions that:

- Require public sector entities to develop and implement cyber security programs and submit reports to the Minister of Public and Business Service Delivery on cyber security
- Regulate how public sector entities, identified by regulation, use AI systems
- Allow the government to make regulations on how children's aid societies and school boards collect, use, retain or disclose digital information relating to individuals under age 18.
- Increases to authority of the IP to investigate and respond to privacy breaches and
- Inappropriate use of personal data

"The legislation, as drafter, would establish significant regulation-making powers in respect of cyber security, AI systems and digital technologies affecting individuals under the age of 18. The IPC agrees that these areas of societal activity pose high risk to Ontarians' privacy and human rights and require urgent government intervention. However, as currently worded, Schedule 1 of Bill 194 lacks the statutory protections needed to protect with privacy and human rights and fails to provide the level of transparency and accountability that are necessary to secure Ontarians' trust in how the government will effectively govern these high-risk areas."

IPS's Recommendations in its Submission on Bill 194
General recommendations for Schedule 1 (Enhancing Digital Security and Trust Act, 2024)

1. Include a purpose clause at the outset of the Act.
2. Make the act subject to independent oversight and enforcement.
3. Make a production of regulations under the act subject to public consultations.
4. Require the minister to consult with the IPC prior to making (or proposing) regulations or issuing directives that may impact privacy or access rights.

5. Make ministerial directives transparent to the public.
6. Include a whistleblower protection provision.

Recommendations specific to the cyber security portion of a cyber-security portion of Schedule 1

1. Explicitly set out the core elements of cyber security program.
2. Require notification of the IPC when cyber security incidents affect personal information.
3. Require the minister to prepare an annual report on its cyber related responsibilities.

Recommendations specific to the AI portion of Schedule 1

1. Codify fundamental AI principles and guardrails into the statute.
2. Adopt a risk-based regulatory approach for AI.
3. Specify no-go zones.

Recommendations specific to digital technologies affecting children

1. Strength protections for children under existing privacy laws (instead of under 194)
2. Expand the application of ministerial directive and regulations related to technical standards to cover all service providers under the Child Youth and Family Services Act.

Recommendations specific to Schedule 2 (FIPPA)

1. Introduce data minimization principles
2. Strengthen privacy impact assessment requirements
3. Broaden the grounds for individuals to bring complaints to the IPC
4. Broaden scope of IPC's investigative powers
5. Enable IPC to disclose information, as necessary
6. Include a recipient rule.
7. Deem children's information as sensitive
8. Protect whistleblowers from employer reprisal
9. Remove expanded powers for Service Ontario from FIPPA
10. Include a mandatory review period.

Principles for the Development and Deployment of AI Technologies from the IPC's submission on Bill 194

- There are many sets of principles related to AI that have been developed worldwide – across these we can see universal principles emerging
- At a fundamental level, public sector entities developing or deploying AI systems must ensure that such systems are:
    - Valid and reliable – before AI technologies are adopted by public sector entities, the technologies should meet independent testing standards for validity and reliability. And any tested technologies should demonstrably work as intended in the environments in which they will be used. Some considerations for the health sector - what testing has been conducted to ensure the validity and reliability of the AI model? Was the testing conducted by a trusted third party? How often will the model be re-evaluated? How accurate, up-to-date and relevant is the AI model and the data it was trained on? How will custodians be notified when the AI model's performance falls below certain thresholds? What steps has the custodian taken to ensure that the AI model's outputs are regularly checked for accuracy? Does the custodian have policies, procedures and practices in place to ensure that the AI model's outputs are checked for accuracy before any records of PHI created or altered by an AI model are used or disclosed?
    - Safe – AI Technologies should be configured to support human life, physical and mental health, economic security and the environment. They should be monitored and evaluated throughout their lifespan to confirm they continue to support these objectives and can withstand unexpected events or deliberate efforts that cause them to behave in harmful ways not intended or anticipated by the developers, operators or users of these AI systems. Considerations for the Health Sector include: What policies, procedures and

practices are in place to ensure ongoing monitoring and testing of the AI model to ensure ongoing safety? What mechanisms are in place to flag inaccuracies (including hallucinations) and potential biases to the custodian and developer? What sort of "circuit breaker" mechanisms are in place that would stop the AI model from operating and/or flag when it is producing unexpected and potentially harmful outputs? What steps has the custodian taken to ensure that sufficient protections are in place to ensure that records of PHI are securely retained, transferred and disposed of when using AI technologies? What steps has the custodian taken to protect PHI from unauthorized collection use, or disclosure through the use of AI technology?

- Privacy protective – AI technologies should be developed or adopted using a privacy by design approach that anticipates and mitigates privacy risks to individuals and groups. This means, among other things, requiring clear lawful authority to collect process, retain, and use personal data in relation to AI systems, including training data. Systems must build in measures to ensure the accuracy of AI outputs and protect all inferences about individuals resulting from these outputs that are about individuals as personal information. AI systems must also be designed to protect the security of personal information from unauthorized access or cyber security threats. Individuals should be informed of the intended use of AI technology to process their personal information and, where appropriate, have an opportunity to opt out of an automated decision in preference for a human decision maker. Considerations for the health sector include: What policies, procedures and practices does the custodian have in place to make visible, explainable, and understandable how the AI technology works? What mechanisms are in place to ensure that individuals are able to understand when and what records of the PHI have been generated or altered by an AI technology or what decisions have been made about them using AI technology? Is the custodian's contact person adequately prepared to meet their responsibilities under PHIPA with regard to the AI technology? Does the custodian's description of its information practices, contained its written public statement, adequately address the custodian's use of the AI technology? What steps has the custodian taken to ensure it is able to meet its breach notification and reporting obligations under PHIPA if PHI is stolen, lost, used or disclosed without authority through the use of the AI technology?
- Transparent
- Accountable considerations for the health sector include: Do the policies, procedures and practices of the custodian address the custodian's compliance with PHIPA with regard to AI technologies and include a clear AI governance framework that clearly sets out the custodian's accountabilities and those of its agents? What assessments have been conducted prior to developing, maintaining, procuring, implementing and using an AI technology – e.g. privacy impact assessment (PIA), threat risk assessment, (TRA), AI specific assessment such as an algorithmic impact assessment (AIA), or vendor assessment? What recourse options are available to individuals to enable them to challenge the decisions made about them through the use of an AI technology including the accuracy of any PHI that is generated or altered by the AI technology. What training is in place for custodians and their agents to ensure they understand their obligations?
- Human Rights affirming – AI technologies should be designed to be fair and equitable. They must respect and affirm human rights for individuals and communities. AI technologies should also be purposefully designed to address and redress historical discrimination and bias so that individuals and communities affected by AI systems do not experience ongoing discrimination based on equal application of logics of a given AI technology or its outputs. Considerations for the health sector include: What steps has the custodian taken to ensure that the AI technology "benefits the people of Ontario while protecting fundamental rights and freedoms guaranteed by the Canadian Charter of Rights and Freedoms and the Human Rights Code? What steps have been taken to help ensure that the AI technology will provide a net benefit to society and produce fair and equitable outputs? What bias or other assessments have been conducted to help ensure that the AI technology has adequately mitigated the risk of bias in the model? How often

will this assessment be repeated? What steps have been taken to ensure that the AI technology has not been designed (inadvertently or not) to produce biased outputs? What steps have been taken by the custodian to ensure that appropriate methods and techniques are in place to minimize the potential impacts of biased data used to train the AI model?

Innovative and Responsible Integration of AI in Public Health: A Legal and Practical Lens - Mary Jane Dykeman, INQ Law

- Artificial intelligence: Are you bracing or embracing?
- AI has been around for many decades, for most your whole life: Canada the building ground; active learning more recent but not new
- The boost: compute; Gen AI
- Governments increasingly acknowledging such that Canada announced $2.4B AI investment; compute a cornerstone
- US and EU regulatory frameworks are closer to fully baked, Canada is slower
- Information security – cyber-attacks, including ransomware, are increasingly common; keeping records on-premises versus using a cloud solution.
- Public trust in organizations' handling of data stands to be eroded
- Revolving standards – interoperability, AI systems, ethical standards cyber security, ethics frameworks, risk management and AI, and more
- Personal Health Information Protection Act, 2004 includes rules on collection, use, disclosure of personal health information (PHI) Who is the health information custodian? (HIC) including medical officers of health.
    - Consent, capacity and substitute decision-making
    - Information and Privacy Commissioner of Ontario (IPC) as the regulator – fines and penalties (new IPC powers on administrative monetary penalties in addition to Attorney General prosecutors)
- Duties to safeguard PHI with access and correction rules (exemptions for labs, research settings
- The starting point – most often when we are looking at use of data, much less incorporating emerging technologies, we ask, for what purposes – clinical, research, quality improvement (QI), health system planning and in this case, health protection and promotion. And of course, what legal authority do we have to use and disclose it?
- Does it need to be personal health information (PHI) or personal information (PI) or could it be de-identified …
- Consent/Notice – Broad strokes in the health system
- No consent is required to use PHI for internal purposes such as risk management, error management QI (PHIPA)
- No consent is required to disclose PHI to improve or maintain the quality care of an individual (or similarly situated individual(s), as long as the threshold of ‘shared client’ is met
- We don’t ask individuals (or their SDMs) for permission to use most new technologies: new thing re what notice looks like – is AI different? Should it be?
- We rely on implied consent or express consent, for health care purposes; but do we need to do a better job in telling the story of shared data platforms, ML & AI, the incredible use of cases and outcomes we hope for – including in public health

AI and the opportunity

- Already much discussion about big data and our unparalleled ability to harness data we have with the right rigor;
    - Data strategy entails knowing the data we have; privacy and security (check); AI governance and international thoughtful use cases
    - Public engagement and ++ change management processes
- The legal and ethical challenges lie in
    - Finding appropriate legal authority to collect, use and disclose the data
    - Modernization of the laws including re public health unity

    - Identifying what type of consent/notice is required/optimal - including where we will be further inviting the public as active participants in public health (including re wearable's)
    - What is our promise we make about our use of these technologies?
- Ask – Consent – set aside assumptions about certain populations (e.g. historically clients with mental illness asked less often to participate in research, or fundraise – missing the opportunity to engage meaningfully)
- Are there better ways to tell the story (i.e. tell the truth) such that people will want to engage and be part of the potential and promise of emerging tech, including AI and machine Learning in public health
- Or, that at a minimum they are aware of what is deployed and how society may benefit
- Tell – Notice – well acknowledged that in many places, including in public health, it would be "impractical" due to volume of data
- Are we being transparent, promising good governance and engendering trust?
- A pause on de-identification – much data use and disclosure will be in identifiable form
- In other instances, including research, we need to address de-identification head on
- What is de-identification really? (PHIPA definition, more recent amendments, versus 'coded' now in use in parts of Ontario's health sector)
    - De-identified historically meant, cannot be re-identified
    - Coded means, it can be, with permission of the health information custodian under PHIPA
- IPC Decision 175 (IQVIA case re: sale of de-identified data derived from PHI in the EMR of primary health care practitioners
    - Notice of information practices
    - Contractually binding recipients of de-identified data
    - Assessing the risk of re-identification
- Mobile apps – what can we learn – some health practitioners are using (and some have developed) mobile apps in clinical practice for health wellness, symptom tracking and more
- Diligence: Terms of use, Privacy policies, Community rules, Vendor profile, visibility
- Evolution of the AI conversation – Focus on AI (and its points of entry): public trust, ethical aspects, accuracy, biases; risk assessment tools
- Establish what problems we are trying to solve in adopting AI such as better outcomes, administrative efficiencies, all of the above for the win
- Lessons learned from Unity Health Toronto with its 50+use cases now deployed
- Legal trends – some say that if AI is instituted, the most pressing legal issue will be whom does an affected person sue if it goes wrong e.g. Air Canada case of 'lying bot', and not the right lens
- Arguably focus should first and quickly be on, how does AI develop if it is 'data hungry" and needs to be fed voluminous amounts of information to achieve machine learning
- Then along came Chat GPT – a game changer and catalyst because we could not afford to say 'we aren't doing this yet' (we believe, you are)
- This triggers the discussion of tech-high risk attracting the suite of bias and algorithmic, impact assessment, versus some that are set and forget including AI scribes
- And in practice – there is a great (app, devise, tool, system)
    - This is happening and we need the organization's blessing
    - Help us make it happen (don't impede us)
- Key elements include: what legal authority, consent v. notice, if at all, governance (let's talk next about what a governing body should be thinking about to govern AI/AI governance)
- Lifecycle – who needs to authorize (AI policy), and is the solution enterprise-wide?

INQ steps:

1. Define governance objectives
2. Assessment of current AI use
3. Determine future AI cases
4. Accountability and oversight mechanisms
5. Risk impact assessments
6. Development of Ethical Principles, Guidelines and Policies

7. Develop key performance indicators (KPIs)
8. Integration of AI Audit and Compliance Tools
9. Skills and Capacity Building
10. Establish feedback loops
11. Continuous improvement and adaptation
12. Reporting
13. Other: Key Risks of AI systems; determining high impact AI Systems (and required actions); vendor assessments for AI – specific checklist for AI procurers

Provincial Cyber Security Operating Model: Acute Hospital Walls and Beyond
Stephen Lloyd, Director Ontario Health Cyber Security Centre

Ontario Health Cyber Security Centre supports a vision for the management of cyber security risk across the provincial health sector and is predicated on support the delivery of cyber security capabilities at the provincial regional and health service provider levels. There is a capacity gap between the attackers and the defenders but that gap is closing in. Criminal and underground economy is targeting the Ontario heal sector with ransom ware being the primary threat.
There is a progression of the CSOM with primary care, long-term care and public health units. The provincial cyber security operation model includes the Ontario Health Cyber Security Centre (OHSCS) interacting with Regions, Local Delivery Groups, Hybrid SOC and Health Service Providers. There is a control pathway linking initial coverage to maturity and quality. There are 10 local delivery groups across the province support 100% of the acute sector.
Critical success factors include:

- Planning – Having a clear objective to improve information security capabilities across the entire health sector with a strong mandate and authority
- Processes – agile projects to build upon early successes, course correct as needed, incremental progress with broad stakeholder involvement
- People with competencies related to information security, program management, business/health care & communication as well as high performing teams/receptive leaders at all levels (provincial, regional and local) with commitment & passion from leadership and participants.
- Governance – leverage established governance structures (macro, meso, micro) with consistent message and support from all levels, setting context that the model and approach are evolving while knowing what good enough looks like

CSOM is a robust model developed to integrate and support all areas of the health sector. The model is based on industry standards adopted by the province. The model can be scaled and replicated using an iterative approach. The model offers and shared services approach built on leading standards, frameworks and capabilities. MOH approved the proposal to progress strategy related to primary care integration within the CSOM.

Human-Centred Design for AI ~ Nadine Hare
Innovation Fellow at WCH Adjunct Professor at OCAD U, University of Toronto

Design is a discipline of study and practice focused on the interaction between a person – a ‘use’ and the environment, taking into account the aesthetic, functional, contextual, cultural and societal considerations.

From design to human-centred design and design thinking is an approach to innovation that draws on designers’ ways of thinking and working. Assets that are a human-centred and hands-on approach to problem-solving leads to innovation and more impactful solutions.

Design goes across a wide array of fields from product, growth of profit (tangible) to societal change, tackling complex problems (intangible). Design can tackle challenges such as:

- When/why do intelligent systems miss the mark? Why do even the best AI solutions sometimes feel uncomfortable to use?
- How do we design for trust in complex AI systems?
- When can efficiency compromise empathy?
- How can we simplify complex AI interactions?

Human-Centred Design reframes organizational challenges as human-centered problems. (E.g. the challenge might be improving medication adherence among patients.) The assumption is that patients don't understand how to take their medication properly. Through the empathy lens – adherence is not a key goal for people themselves - experimenting with medication is a way to regain power in a medication system that feels… deeply disempowering. In reframing the challenge, how might we support people in regaining power in other ways? How might we support "safer" experimentation?
Human Centred Design aims to create products/services/experiences that are useful, useable, desirable, efficient and effective as well as being ethical sustainable and future facing. Human Centred Design relies on interdisciplinary collaboration, ever-learning cycles and iterative prototyping. It also relies on interdisciplinary collaborations – beyond traditional "experts" to communities themselves. It is a set of mindsets and tools that help navigate complexity to find ways for change by finding root causes.

Considering the design principles that were shared:

- What feels exciting about these principles?
- What feels challenging?
- How might they shift how you currently work or approach challenges/projects?

Ethics and AI ~ Ethics is concerned with: values, principles or duties underlying decisions/actions; situations where important values, principles or duties may conflict or be in tension & the intentional anticipation and resolution of these conflicts and tensions in practice.

Ethical Imperative: "Artificial intelligence is a new frontier for the health sector. As so often happens, the speed of technological advances has outpaced our ability to reflect these advances in sound public policies and address a number of ethical dilemmas. Many questions do not yet have answers and we are not yet sure we know all the questions that need to be asked"

Ethical principles include:

1. Protect autonomy
2. Promote human well-being, human safety and public interest
3. Ensure transparency, explainability and intelligibility
4. Foster responsibility and accountability
5. Ensure inclusiveness and equity
6. Promote AI that is responsive and sustainable.

Dr. Jennifer Gibson, University of Toronto, Dalla Lana School of Public Health

Ontario Health Data Council Report: A Vision for Ontario's Health Data Ecosystem

Vision: Data driving better and more equitable health, leading to healthier Ontarians
Mission: Enable ethical, timely and responsible access and use of health data for individuals, communities and populations in Ontario
Ethical principles & data sovereignty are values which guide and set expectations for decision-making and actions
Recommendations:
Use data better and do good with data related to:

- Health – integrate and use health data to advance health and equity outcomes for people, communities and populations

- Equity – promote health equity through appropriate data collection analysis and use

Have responsive and inclusive governance:

- Governance – establish system-level trustworthy governance and policies for health data as a public good
- Sovereignty – respect and support First Nations, Inuit and Metis Peoples' Data Sovereignty.

Enable accountability

- Stewardship – build data stewardship capacity and enable sharing by default

Mission-Driven AI in Public Health ~ How will we know if advances in AI are having a positive impact for public health?

- Fewer people developing diseases or poor health outcomes that are preventable
- Promoting health in our environments and communities
- Reduction in health inequities

Deep Medicine – How Artificial Intelligence can make health care human again

Eric Topol – "It's our chance, perhaps the ultimate one to bring back real medicine: presence. Empathy. Trust. Caring. Being Human." Topol 2019

Pain Points – Resource constraints, technical, legal and social risks, data access and quality, innovation vs. adoption capacity, environmental impact, public trust

See the World Health Organization – Ethics and governance of artificial intelligence for health – guidance on large multi-modal models

AI is inevitable, so all we can do is manage its risks. AI will make things better and should be used. All we need to do is mitigate the risks. AI is not the problem. People are the problem. All we need to do is weed out the bad actors. AI is highly regulated. All we must do is follow the rules.

Guiding Ethical Questions for Boards

1. Will this AI application enhance the health of the population or improve our ability to meet population health needs?
2. Is this AI application a wise and just use of resources?
3. Will this AI application be acceptable to the population being observed

Bill 194: Ontario Public Sector toward AI
David Goodis and Mary Jane Dykeman, INQ Law

Bill 194 backdrop

- Strengthening cyber security and building trust in the public sector act 2024 – arguably, the most significant change to public sector privacy legislation in 20 years and likely the response to privacy law modernization in Canada and around the world (EU Act, QC, federal bill C-27)
- Tabled in Ontario Legislation May 13, 2024 by the Minister of Public and Business Service Delivery and Procurement
- AI Second Reading Standing Committee on Justice Policy
- Schedule 1 is related to cyber security children's privacy: artificial intelligence
    - FIPPA institutions: Ministries, agencies, colleges, universities, hospitals, Public Health Ontario
    - MFIPPA institutions – public health units, children's aid societies, school boards
    - Much is left to regulation but we get some hint of what regulations might contain
- Schedule 2 FIPPA amendments relates to FIPPA Institutions duties & IPC powers/duties
    - New institution duties include: reporting privacy breached to IPC annually, conduct privacy impact assessments, protect personal information, notify IPC/individuals of a privacy breach

- Cabinet may make regulations for public sector entities including: implement cyber programs (with specific elements) and report cyber incidents to minister or specified individual situations (content may vary with incident type)
- New IPC powers/duties include: reviewing institution's information practices, report the number of privacy, use, complaints/reviews to legislation annually and consult with policy and other privacy commissioner. Schedule 2: New institution duties include: current FIPPAs 34 required detailed annual statistical report to IPC and reporting the number of thefts/losses/unauthorized uses/disclosures of PI
- Before conducting PI institution must prepare written assessment that contains: (s 38(3))
    - Purpose of collection, use, disclosure, and why necessary
    - Legal authority for CUD
    - Types of PI and how each is used/disclosed
    - Sources of PI
    - Titles of officers/employees/consultants/agents who have access
    - Limitations/restrictions on CUD
    - Time PI retained
    - Explanation of safeguards (administrative/technical/physical)
    - Explanation of risks of theft/loss/unauthorized use/disclosure
    - Steps to prevent theft/loss/unauthorized use/disclosure
    - Steps to mitigate risks to individuals in event of breach
    - New(?) duty to protect PI
    - Institution must take reasonable steps to ensure PI is protected
    - Institution must take reasonable steps to ensure records containing PI protected against unauthorized copying/modification/disposal
    - Not really new …moved from regulations to statue
    - New duty to report privacy breach to individual
    - Institution must report to individual theft/loss/unauthorized use/disclosure if reasonable to believe reasonable risk of serious bodily harm (RROSH) to individual (s.40.1) – unless notice prohibited by law
    - Timing: as soon as feasible after institution determines breach
    - Notice must include statement that individual may complain to IPC – one year limit on complaint (IPC may extend)

Automated Opioid News Event –based on Surveillance Project ~ Allison Maier (KFLAPH)

Background: The issue and idea – introduction of fentanyl and pandemic worsened drug poisoning crisis – lead to improved harm and harm reduction surveillance – surveillance still limited in ability to detect contamination events and novel negative outcome – use large non-traditional data sources (Event-Based Surveillance) and AI to filter and synthesize the information

Project Objectives – HO – funded Locally Driven Collaborative Project of 11 PHUs, Queen's University and ODPRN to:

- Develop and test data pipelines to process near-real-time news data feeds.
- Build an interactive dashboard that synthesizes extracted information
- Create an AI model that filters articles and extract critical information
- Evaluate the process of developing and deploying AI in a public health unit

Organization Support and Infrastructure requires – leadership buy-in, culture of innovations, collaboration with IT

Tool Development: AI Components include:
Filtering and classifying articles:

- Filtering and classifying articles: including two techniques – rule based pruning, vector categorization, near duplicate remove, on premise solutions and annotated datasets

    - Tool Development: knowledge exchange – familiarity with original and extracted data, collaboration with end users, openness about limitations and supporting appropriate interpretation

- Extraction includes: structured text retrieval, large language models – currently cloud (Open AI) but exploring on-premises solutions
- Next steps include: model evaluation, Sustainability – funding for paid services, support for ongoing staff time in maintenance for AI components as well as Expansion – other opioid-related data sources and other public health topics

Revolutionizing ISPA – the Power of Automation in Ontario – Dr. Kyle Wilson PhD, MBA, MSc, VP – Information Systems & Digital Innovation

"Despite excitement and perceived opportunities for AI to support public health, a key barrier is that many local public health units do not currently have the capacity of resources for dedicated AI-related work"

A highlighted Project: AI for Vaccine Records

ISPA Notification Process Enhancements: shifted from provincial tools to a flexible, in house document generation tool. It has successfully sent over 12,000 tailored immunizations notices in the 2023/34 school year as well as achieving better clarity and reduced administrative workload ~ 1/12 the tie and 1/3 the half
AI and the Future of Society – AI increasingly integrated into our lives with wearable/implantable devices and augmented reality offer new frontiers. AI agents (virtual and physical) will impact every industry. Emergence of new health and equity challenges as well as the decrease of manual repetitive inefficient processes

Artificial Intelligence and Public Health – Steven Rebellato, VP, SMDHU

Website Chatbot – lessons learned to date:

- De-identified data + PHIPPA + 'agent' for AI vendors + Patriot Act
    - Identifiable data (URL, personal health information) needs to be de-identified
    - Data processing agreement, training data and destruction
    - Need to understand that data flow and clear process for destruction of digital records
    - Legal costs and consultation

- Patriot Action
    - Location of servers (Canada vs. USA/globally)

- Training a bot is remarkably different than training a human
    - Using human ('polite') language does not work
    - Be direct, be decisive

- Traditional evaluation will not work with a bot given its ability to learn and execute immediately

AI Scribe
Who is involved?

- PHO – LDCP grant
- WDGPH (pilot), SMDHU (pilot), TPH (knowledge user), University of Toronto
- Liaison with Ontario MD, Cyber security Ontario

What are we doing?"

- Integrate AI Scribe technology into public health case management for Diseases of Public Health Significance (DPHS)

Why are we doing this (design?)?

- Enhance efficiency and reduce the administrative burden on case investigators

AI Scribe: Lessons learned to Date

- Early in adoption
- Procurement + Ontario MD pilot
- How to evaluate
- Confidentiality
- Consent
- Data security
- Legal and implementation costs

Take Away Messages – AI Scribe and chatbot

- Human centred design
- Consideration of solution objectives
- Building the necessary infrastructure to ensure success organizationally
- Understand the risks and benefits or each
- Policy – need for Agency policy before engagement
- Current and future workforce

Requirements for successful deployment in public health
Aligned with Public Health Goals

- Fewer people develop diseases or poor health outcomes that are preventable
- Promoting health in our environments and communities
- Reduction in health inequities
- Sustainable

Effective:

- Independently tested and verified
- Consistent and accurate in real-world settings
- Scalable across different populations
- Oversight and responsive

Safe and Ethical:

- Data privacy & security
- Human oversight on decisions
- Legal and regulatory compliance
- Avoid bias, discrimination; equitable access

Thursday, November 7, 2024

Reducing Alcohol Harms in Ontario: Canada's Guidance on Alcohol and Health and Public Education ~ Bryce Barker

Canada's Low Risk Alcohol Drinking Guidelines

- There is a continuum of risk related to cancer where 1 to 2 drinks per week is low risk (1:1000); 3 to 6 drinks per week increases the risk of breast and colon cancer (1:100) & or more standard drinks per week increases the risk of heart disease or stroke (1:100)

Recommendations:

1. To reduce the risk of harm from alcohol, it is recommended for people living in Canada to consider reducing their alcohol use – standard drink is a bottle of beer, a bottle of cider a 5 oz. class of wine or a 1.5 ounce glass of spirits
2. Consuming more than 2 drinks in one occasion is associated with an increased risk of harms to self and others, including injuries and violence
3. When pregnant or trying to get pregnant, there is no known safe amount of alcohol use. When breast feeding, not drinking alcohol is safest.

Commissioned Reviews: Alcohol and mental health – there is a bi-directional relationship between alcohol and mental health: alcohol use is associated with the onset or worsening of depression, anxiety and suicidal ideation, while those conditions may, in turn, lead to increase use of alcohol as self-medication. More research is required.

Sex and Gender – above the upper limit of the moderate risk zone for alcohol consumption, the health risks increase more steeply for women than for men. Far more injuries, violence and deaths result from men's alcohol use, especially in the case of per occasion drinking.

Harm reduction – less consumption means less risk of harm from alcohol – carcinogen, risk factor for most cardiovascular disease, injuries, road crashes and violence

Clinical implementation & Knowledge Mobilization – in addition to prompting reflection on the risk from alcohol use alone, people with a personal or family history of an alcohol-attributable condition should be encouraged to reduce their level of consumption even further or consider abstinence.
Alcohol attributable cancer death percentages include oral 34%, Oropharynx 33%, esophagus 32%, larynx 22%, colorectal 11% and breast 7%

World Heart Federation Policy Brief (2021) – "Contrary to popular opinion, alcohol is not good for the heart. Research in the latest decade has led to major reversals in the perception of alcohol in relation to health in general and cardiovascular disease in particular. Risks due to alcohol consumption increase for all major cardiovascular diseases, including hypertensive heart disease, cardiomyopathy, atrial fibrillation and flutter and stroke.

Ontario Alcohol Use, 15 years and older: 27% are drinking no alcohol, 30% are drinking 1-2 drinks per week, 12% are drinking 3-6 drinks per week and 31% are drinking 7 or more standard drinks per week.

People drink for enjoyment, to alter mood, to avoid boredom, to escape problems and to get drunk. Social effect motives include socializing, celebrating special events, increasing power and social ritual.

Benefits of alcohol reduction include: decreased calories (weight loss), improved sleep (more energy), improved cognition and memory, improved mood, decreased blood pressure, decreased blood sugar, decrease triglycerides, decreased liver fat, improved sex life, improved immune function, decreased cancer risk, decreased risk of accidents and injuries, improved relationships and financial savings.

Suggestions to decrease alcohol:
1. Keep track of how many drinks you have per week
2. Decide on a weekly drinking target and stick to your limit
3. Eat before and while you are drinking
4. Choose drinks with a lower percentage of alcohol
5. Drink slowly, in small sips
6. Always have water on hand
7. Alternate between alcohol and non-alcoholic beverages
8. Explore alcohol-free products
9. Have alcohol free weeks or do alcohol free activities

Rethink your drinking (RYD) is an initiative with the 7 public health units in Southwestern Ontario. The group was established 12 years ago, shortly after the release of the 2011 Low-risk Alcohol Drinking Guidelines. You can find this on campaign at www.rethinkyourdrinking.ca . Based on positive feedback, the RYD campaign evolved into 2 province wide campaigns between 2016-18(with 29 of the 36 PHU's participating). After 2 successful province-wide campaigns, RYD returned to SW Group due to changes in provincial funding and focus. COVID put a pause on regional work. With the release of the 2023 Guidance on Alcohol and Health, the group reconvened and prioritized work to revamp RYD (2023/24)

A collaborative approach provides a strong partnership with the Canadian Centre on Substance Use and Addiction. The objectives of the RYD website is to increase awareness/knowledge of: cancer connections and continuum of risk drinking alcohol as well as specific resource to support the public and healthcare provider as well as providing a unified public health voice from Southwestern Ontario.

Key Messages of the RYD website include:

- Alcohol research has changed. It might be time to rethink your drinking
- Canada's Guidance on Alcohol and Health provides evidence-based information to help individuals make informed decisions about alcohol
- You need to understand what a standard drink is to accurately know the amount of alcohol you are drinking and related risk
- There are situations when NO alcohol use is particularly important including if you are pregnant, trying to get pregnant or breastfeeding
- Alcohol causes cancer along with other health effects

Successes include:

1. Health unit collaboration – pooling staff resources, financial commitment and ability to prioritize work
2. Partnership with the Canadian Centre on Substance Use and Addiction – copyright permissions, editing, endorsement, promotion, etc.
3. Strong media/website development company – efficient, communicative, organized and prompt turnaround.

Drink Less, Live More National Campaign – all ads click through to
www.drinklesslivemore.ca/boiremoinscestmieux.ca

Website: alcohol@ccsa.ca

Canada's Guidance on Alcohol and Health and Young Adults – Drinking is a leading cause of death and social issues in young people. Intoxication is associated with: high risks of injuries, aggression and violence, dating violence and worsening academic performance. Youth under legal drinking age should delay drinking for as long as possible.
In Canada 70% of 15-17 year olds don't drink while 29% of youth 18 & 19 don't drink; 22% of 15-17 year olds drink 1-2 drinks per week while 23% of 18&19 year olds drink 1-2 drinks per week; 5% of 15-17 year olds drink 3-6 drinks per year compared to 24% of 18 &19 year olds; 3% of 15 – 17 year olds drink 7 or more drinks per week compared to 24% of 18 & 19 year olds.
Per occasion drinking – consuming more than 2 drinks on one occasion is associated with an increased risk of harms to self and others, including injuries and violence.
Sex & Gender: At seven or more standard drinks of alcohol a week, the health risks increase more steeply for females than for males. Far more injuries, violence and deaths result from men's alcohol use, especially in the case of per occasion drinking.

"Before the Floor" is a campaign to reduce binge drinking in a high-risk young adult population – Dr. Piotr Oglaza, MOH & CEO for KFL&A Public Health & Susan Stewart, Director, Community Health and Well-Being KFL&A Public Health

"Peer Crowds" are the aggregate peer groups with similar values, lifestyles, styles of dress, media consumption habits, influences and social tendencies. While a young adult has a local peer group, they socialize with, both the individuals and their peers belong to a larger peer crowd that shares significant cultural similarities across geographic areas.

Formative research into 'Partier" peer crowds shows that they care a lot about their appearance, style and social status. They have an active social life that they like to share on social medial and are afraid of social rejection. Partier culture revolves around drinking activities like going to bars or clubs.

Rather than tell them to change who they are, we need to show them how to change their behaviour while maintaining their identity and values. The goal is to reduce binge drinking among the "partier" peer crowd aged 19 to 24 years of age.
Objectives:

1. Increase brand recall and association with drinking responsibly
2. Increase knowledge about responsible drinking practices
3. Increase relevance of risks associated with binge drinking
4. Increase the belief that drinking more responsibly is important to them and fits their lifestyle

Campaign implementation key messages:
Primary drinking tips:

1. Drink water in-between alcoholic drinks to control how much you drink
2. Eat before drinking to slow the absorption of alcohol
3. Pace yourself. Take a few sips at a time and try to make each drink last about an hour.
4. Stop drinking one to two hours before the end of the evening

Lessons learned:

- Facilitators – short form and vertical viewing content on videos as well as focus groups
- Barriers – include multi step engagement requests and rejection of ads on social media platforms

Another campaign was the True North Strong using peer crowd segmentation approach – commercial tobacco and vaping prevention focused targeting the outdoor peer crowd

Straight Up Facts – Thunder Bay: www. straightupfacts.ca

alPHa Strategic Plan Update – Trudy Sachowski, alPHa Board Chair
Strategic Direction

- Be the unified voice and a trusted advisor on public health – activities and examples are listed on www.alphaweb.org
- Advance the work of local public health through strategic partnerships and collaborations such as:
    - Ministry of Health (MOH)
    - Office of the Chief Medical Officer of Health
    - Public Health Ontario (POH)
    - alPHa Affiliate Organizations
    - Association of Municipalities of Ontario (AMO)
    - Ontario Medical Association (OMA)
    - Other Public Health Associations
    - Dalla Lana School of Public Health

On the alPHa Website:

- Workplace Health and Wellness focuses on workplace health
- Support sustainability of Ontario's public health system
- Resources for Boards of Health – BOH Orientation Manual and BOH Governance Toolkit
- Deliver member services to local public health leaders
- BOH Training Courses

- Highlights of alPHa Strategic Plan Activities

Friday, November 8, 2024

alPHa Symposium

Opening Remarks:
Trudy Sachowski ~ alPHa Board Chair
Doug Ford ~ Premier of Ontario
Robin Jones ~ AMO President

alPHa Update from the Board with Questions posed

2024-2027 Strategic Plan

Update from Public Health Ontario – Driving Quality in Public Health – Dr. Tamara Wellington

Vision – internally recognized evidence, knowledge and action for a healthier Ontario
Mission – we enable informed decisions and actions that protect and promote health and contribute to reducing health inequities
Mandate – we provide scientific and technical advice and support to clients working in government, public health, health care, and related sectors.

Strategic direction is connected and mutually reinforcing. When taken together, complemented by our Indigenous Strategy, they will advance public health and the health system and drive performance improvement;

1. Strategic Direction 1 – lead provincial public health data transformation, leveraging advanced analytics to drive evidence-informed practice and decision making
2. Strategic Direction 2 – strengthen laboratory leadership, advance genomics for public health action, and sharpen the focus on complex microbiology testing
3. Strategic Direction 3 – advance public health and health workforce capacity and knowledge to improve population health outcomes
4. Strategic Direction 4 – accelerate moving evidence to action as the convener and integrator of expertise on public health issues and drive quality improvement for public health

PHO's Focus on Quality Improvement

What we do – bring together key partners to develop shared goals and metrics to measure the performance of public health in Ontario to drive continuous quality improvement.

What success looks lie – working in partnership with local public health units, we will have implemented a performance scorecard that reports on metrics that show the impact of public health and supports continuous quality improvement of public health programs.

Synergy and alignment with the renewal of the Ontario Public Health Standards (OPHS)

- Proposed program planning, evaluation and quality standard
- Providing quality improvement training to public health professionals aligns with goals and requirements within this standard
- PHO's work will be complementary to any OPHS standard of program planning, evaluation and quality

IDEAS Training (adapted)

- IDEAS program is an example of one area PHO is starting with on the road to strategic plan implementation

- Existing accredited quality improvement training program developed by the University of Toronto
- Aims to promote a common quality improvement language in the Province of Ontario
- Pilot program for public health professionals launched on October 29, 2024; modified for public health
- Anchored in adult learning principles, uses a case-based approach
    - Based on feedback from public health leaders, pilot offering includes a customized case study with a focus on quality improvement for public health inspections
- Interactive vs. didactic delivery

Why is PHO offering this pilot?

- Providing standard training and building QI capacity across LPHAs creates opportunities for standardized and consistent approaches for quality improvement
- As a convener, PHO will bring together a wide range of expertise on QI and public health to tackle critical issues
- Bringing together key partners will also enable development of shared goals and metrics to measure the performance of public health in Ontario
- Pilot will inform future QI training model

Nest steps:

- Planning further opportunities to get input from leaders on where PHO can support building capacity for quality improvement
- Subject to the evaluation, future iterations of the adapted IDEAS training will focus on other priority areas for quality improvement and will be delivered using a regional model
- Receive feedback and suggestions to make the content and tools discussed more applicable for public health audience (evaluation)
- Planning further opportunities to get input from leaders on where PHO can support building capacity in this area
- Subject to the evaluation, future iterations of the training will focus on other priority areas for quality improvement and will be delivered using a regional model
- PHO will continue working with U of T CPD program to customize training
    - Will engage SMEs and PHUs

Results of engagement survey on public health recovery, renewal and resilience building post pandemic – speaker Julia Rotenberg, GM and CNO, York Regional Public Health

- Available on: https://www.nccmt.ca/knowledge-repositories/public-health-evidence-syntheses/556

Update on Public Health Workforce Burnout – Dr. Jessica Hopkins, VP & Chief Communicable Disease Control, PHO

- Phase 1 - Presented to alPHa June 2023 – Canadian public health workforce survey on burnout completed and published
- Phase 2 – today 2024 – Canadian local public health physician and residents survey and focus groups
    - Inventory of strategies being used in Canadian public health organizations
    - Literature review in progress
- Phase 3 – Evaluation of strategies to prevent/mitigate burnout in the public health workforces currently in use in Ontario - planned

Background – Canadian public health workforce survey 2023 – prevalence of burnout was 79% among all participants and 75% among Medical Officers of Health

- Information collected
    - Demographic and work characteristics
    - Oldenberg burnout inventory scores (validated too to measure burnout0
    - Stanford Professional Fulfillment Index scores
    - Depression & anxiety screening tools

What did we learn?

- 118 participants completed the burnout inventory (response rate estimated 40-60%)

Demographic characteristics – majority of participants were women (56%) between the ages of 30-49 years (60%) and worked as an MOH/AMOH/equivalent (67%)
Work characteristics

- Most worked in hybrid settings (65%), in large urban and rural jurisdictions (51%)
- Many were threatened, assaulted, or bullied during the pandemic (41%)
- most do not intend to leave or retire with the next year

Results: Prevalence of burnout overall was 63.6% among all participants

- 73.7% met criteria for exhaustion
- 72.9% met criteria for disengagement

Impacts of Burnout (Secondary Outcomes)

- The odds of having low professional fulfillment are 12.5 higher (95%) for individuals with burnout compared to those without burnout
- Compared to those without burnout, individuals with burnout have:
    - 4.79 times higher odds of screening positive on the Generalized Anxiety Disorder screen tool
    - 2.10 times higher odds of screening positive on the Patient Health Questionnaire Screening tool
    - social media and/or verbal comments: majority reported feelings of hyper vigilance, anxiety or other negative mental health concerns
        - threats, on line bullying, including by professional colleagues
        - "I received hundreds of very harsh emails"
    - Poor supervision/lack of support and resources "Inappropriate involvement of certain leaders in our teamwork – led to fearful environment"
    - Lack of mental health support within organization and lack of awareness "decisions in the organization did not take into account the wellbeing of workings. No interventions were made in that spirit."

Key Findings

- Burnout levels among Canadian public health physicians & residents have improved since 2023, but remain high
- Professional fulfillment is significantly lower among those with burnout

What's need?

- Evidence-based strategies to address burnout at individual; organizational and system levels
- Ability to count and follow the public health workforce across Canada over time, including trends in burnout/recover and intention to leave the workforce

What are we doing?

- Systematic review of interventions to prevent and mitigate burnout public health professionals – compare to environmental scan
- Evaluation of strategies in PHUs and residency program
- Working with colleagues on a project looking at counting/following public heath workforce (CHR grant)

Public Health Unit Mergers:

Dr. Miriam Klassen, MOH & CEO Huron Perth PH

Principles – Staff Engagement – Communication – Shared Commitment to Vision – Change Management – Transformational Leadership
Timeline – 1990's merger explorations – 2016 – 2018 Work Plan started – January 1, 2020 HPPH formalized as per Health Protection and Promotion Act

Lessons Learned

- Prepare for a marathon, not a sprint
- Develop mission, vision, values with staff input a.s.a.p.
- Have open, honest timely communications
- A shared vision – together we are stronger
- Support staff PH&S

Peter McKenna, Chair, Board of Health, Leeds Grenville and Lanark District HU

- LGL board updated strategic priorities
- LGL number one strategic priority was to embrace Ontario's public health system changes

South East Transition Team (SERR)

- 3 health units to merge
- Over 500,000 people served in new South East Health Unit region
- 20,000 square kilometers
- Sustainable, local, people first and evidence based
- Future vision – integrate services and culture, enhance services in rural and northern areas; adapt to changes in funding model and programs/services with a strong and nimble public health voice locally and provincially

So, What's Still Keeping You Up at Night? – Sabine Matheson & John Perenack, Principals, Strategy Corp.

- Ford Government is in a strong position - 41% for conservatives, 21% for NDP, 27% for Liberals and 7% for Green party as of October 24. Angus Reid polls support this.
- Northern Ontario has strong NDP & Liberal Representation with the exception of the Kenora/Rainy River area (blue) and Southern Ontario is primarily blue
- Opposition Party Leaders – 22% more have an unfavorable impression of Liberal leader Bonnie Crombie
- 15% more have an unfavourable impression of NDP leader Marit Stiles
- The positive: there are still a lot who report that they "don't know" yet

Top 5 Issues vs. "Good Job/Very Good Job" – some key numbers are moving on"

- Healthcare
- Cost of Living
- Housing Affordability
- Public Safety
- Jobs/Economy

Public Opinion about Homeless Encampments – 84% of Ontarians believe homeless encampments are a problem with 54% thinking they are a big problem; 43% believe the provincial government is most responsible followed by the federal government at 32$ and 1 in 4 think it's a municipal government responsibility.

- 42% of PC Party supporters don't think that the party is doing enough about homeless encampments
- 80% of those polled prefer a more supportive approach while 20% want to see the encampments removed and laws enforced

Timeline to provincial election: fall economic statement, December – January pre-budget consultation, Mid-Feb March: Provincial budget election platform

Update from the Chief Medical Officer of Health ~speaking on behalf of Dr. Kiernan Moore, Dr. Daniel Warshafsky, and Assistant to the Chief Medical Officer of Health

- No notes were taken!

Boards of Health Section Meeting – moderated by Renee Lapierre, Executive Committee Chair

Overview of alPHa~ Trudy Sachowski

- Discussing strategic partnerships
- Key Resources for members including: foundational documents, alPHa correspondence, communications (Information Break), Ministry of Health (Health Protection and Promotion Act and Ontario Public Health Standards), Resolutions, BOH Orientation Manual and BOH Governance Toolkit, New BOH Training Courses on Governance and Social Determinants of Health
- All of the above are found on www.alphaweb.org

Public Health CEO Reflections:
Cynthia St. John, CEO Southwestern Public Health
Marilyn Herbacz, CEO Northwestern Health Unit
Dr. Den Blanchette, CEO Windsor-Essex Country Health Unit

alPHa Legal Counsel – Update for Boards of Health Risk Management for a Governance Board – A Balancing Act – James LeNoury, Legal Counsel alPHa

Spokesperson Tips ~ Roberta Ryan:
Ensure your face is properly lit. A window, light in front of you or a ring light will provide better results than overhead lighting. Do not backlight your camera. If there is a window behind your desk, close the blinds change your camera angle or move away from the window. Virtual backgrounds work well. Be mindful you will come in and out of the picture if you move around a lot (especially your hands) while speaking. Check if your organization uses a virtual background and if you have permission to use it/there is an expectation to use it. Close out other applications and do not leave these running while you are presenting. Resist the urge to multitask! Multiple applications can distract you, you can open the wrong presentation, and cause your screen to freeze which can be very frustrating! Reporters are often seeking information related to statistics, facts, and other background material. Be prepared for these requests to back up your statements.

- Always tell the truth
- Don't imply incorrect information
- If you do not know an answer, do not give false information
- If you promise to get back with further information, do so
- Follow the protocol of your organization
- If you are drawn off topic, refocus the interview back to your key messages (bridging).
- You don't have to answer every question (blocking)

Spokesperson Tips: Key Messages

- If you are being interviewed or presenting at an event, ensure that you know your organization's key messages and that you focus on those as much as possible
- Do not mistake a meeting or an interview for a casual conversation
- Do not get drawn into speculating on Hypothetical situation
- Do not speak on another's behalf. Let others speak for themselves
- Do not repeat negative questions – respond positively
- Do not be defensive – stay calm and cool
- Do not use negative body language. Use positive body language
- Do not use complex terms that are not understood by the audience
- Be careful of using jargon and acronyms
- Do not over-answer a question as talking too much can dilute your main points and may cause you to wander off topic

- You can also lose the attention of the listener
- Do not say ‘no comment’ – this appears evasive and untruthful
- Do not go off the record as everything is on record and any interview can be recorded
- Circle back with your staff team after your interview or presentation. Write down your thoughts and, if possible, keep a record or what was posted or printed about it.