# Meeting Book - ADDENDUM: June 18, 2015, Board Meeting

10. ADDENDUM

Sudbury & District Health Unit
Service de santé publique

**ADDENDUM – FOURTH MEETING**
**SUDBURY & DISTRICT BOARD OF HEALTH**
**JUNE 18, 2015**

## 10. ADDENDUM

### DECLARATION OF CONFLICT OF INTEREST

**i) Algoma Public Health**

- Assessor's Report on Algoma Public Health, *April 24, 2015*
- Ministry of Health and Long-Term Care Actions on Assessor's Report, *June 2015*
- Letter from the District of Algoma Health Unit Board of Health Chair to the Sudbury & District Board of Health Chair dated June 17, 2015

**ii) Association of Local Public Health Agencies (alPHa) Resolutions Session, 2015 Annual General Meeting (AGM)**

- Disposition of Resolutions, *June 2015*

**iii) 2014 Snapshot of Public Health – Sudbury East Report, June 2015**

**iv) Northern Ontario Evacuation of First Nation Communities – Resolution 50-2015**

- Letter from the Thunder Bay District Health Unit Medical Officer to Dr. Sutcliffe dated April 13, 2015

**NORTHERN ONTARIO EVACUATIONS OF FIRST NATIONS COMMUNITIES**

**MOTION:** **WHEREAS the evacuation and relocation of residents of a number of First Nations communities in Northwestern Ontario and along the James Bay Coast, is required on a close to annual basis due to seasonal flooding and risk of forest fires; and**

**WHEREAS a safe, effective, and efficient temporary community relocation is challenging within the current reactive model; and**

**WHEREAS a proactive, planned and adequately resourced evacuation system would ensure the maintenance of quality evacuation centers in pre-selected host municipalities, as well as appropriate infrastructure to ensure the health and safety of evacuees in a culturally acceptable manner; and**

**WHEREAS the Thunder Bay District Board of Health passed a motion on March 18, 2015, and has submitted a letter dated April 10, 2015 to the Honourable Kathleen Wynne requesting that the provincial government address the ongoing lack of resources and infrastructure to ensure the safe, efficient and effective temporary relocation of First Nations communities in Northwestern Ontario and the James Bay coast when they face environmental and weather related threats in the form of seasonal flooding and forest fires;**

**THEREFORE BE IT RESOLVED THAT the Sudbury and District Board of Health support the Thunder Bay District Board of Health's resolution 50-2015 dated March 18, 2015; and**

**FURTHER THAT a copy of this motion be forwarded to the Premier of Ontario, Ministers responsible for Health and Long-Term Care, Community Safety and Correctional Services, Aboriginal Affairs, Northern Development and Mines, Natural Resources and Forestry, local area Members of Provincial Parliament and all Ontario Boards of Health.**

# Assessors Report

# On

# Algoma Public Health Unit

## Pursuant to Section 82(3)

## *Health Protection and Promotion Act*

***Graham W. S. Scott, C.M; Q.C.***

***Assessor***

*April 24, 2015*

## Table of Contents

# Section A
# Appointment and Process Overview

## 1. Appointment

On February 25, 2015, I was appointed Assessor of the Algoma Public Health Unit pursuant to Section 82(1) of the *Health Protection and Promotion Act*, S.D. Ontario 1983 (HPPA). The Appointment is found in Appendix B.

The Assessment was established as a result of growing concern with regard to the governance and operations of the Algoma Public Health Unit (APHU). In parallel with this Assessment the government has appointed the Ontario Internal Audit Division Forensic Audit Team to carry out an investigation.

The Terms of Reference set out the objectives of the assessment and are found in Appendix C.

## 2. Process of Assessment

I interviewed all current and most former board members who have served in the past 2 years. Only one, a retired member, declined to speak with me. I interviewed current and former staff members including the former Medical Officer of Health, Dr. Allen Northan (Dr. Northan), the acting Medical Officer of Health, Dr. Penny Sutcliffe, the acting CEO, Connie Free, members of the Executive Management Team and other members of the staff of APHU. I also interviewed the former interim CFO, Shaun Rootenberg also known as Shaun Rothberg (Mr. Rootenberg), who volunteered to meet me for an interview. Dr. Kim Barker (Dr. Barker) provided a written statement and some additional answers through her lawyer but did not agree to a one on one interview. I spoke with the MPP, the Honourable David Orazietti, the Mayor of Sault Ste Marie, Christian Provensano, and the CEO of the Group Health Centre (GHC) Alex Lambert. Most of the interviews were in person at the offices of APHU in Sault Ste Marie on February 26th and 27th and March 2nd, 3rd, 5th, 6th, 24th and 25th 2015. The remainder were in Toronto or by telephone. A complete list of those interviewed is found in Appendix A.

I reviewed the HPPA, the Audit of the District of Algoma Health Unit by the Ontario Internal Audit Division of the Ministry of Finance (OIAD) March 2014, the KPMG Organizational and Operational Review (KPMG Review), the Terms of Reference of the Ontario Internal Audit Division Forensic Audit Team, the Public Health Funding and Accountability Agreement (PHFAA) and the Ontario Public Health Organizational Standards (OPHS) issued by the Ministry of Health and Long Term Care (MOHLTC). I reviewed numerous internal documents, e-mails, other communications, the by-Laws and board minutes of the APHU.

## 3. Balancing the Interests in the Delivery and Funding of Public Health Programs

HPPA creates a regime that constitutes a balancing act between the role of the provincial government which establishes a comprehensive mandatory public health program for the Province, while at the same time requiring the municipalities to share in the cost and delivery of programs.

The purpose of HPPA is to provide for the organization and delivery of public health programs and services, the prevention of disease, the promotion of good health and the protection of the health of the people of Ontario. [ S2.]

Accountability for the discharge of these crucial public services is divided among:

- The provincial government, which determines mandatory programs and services which must be delivered by every local health unit;
- The Chief Medical Officer of Health for Ontario;
- The Medical Officer of Health (MOH) for each health unit, who possesses extensive statutory powers and responsibilities quite independently of any reporting relationship with the local board of health and who is required under S. 67 to report directly to the board on issues relating to public health concerns and to public health programs and services under HPPA and all other provincial statutes; and
- Local Boards of Health.

The local municipalities served by each board must pay the expenses of the board of health. The province pays an estimated 75% or more of the approved costs of the health units operations through a combination of a

grant and specifically designated 100% funded programs. Given the municipal contribution the size of the health unit budget is an important consideration in developing municipal budgets.

Through this process of joint provincial/municipal responsibility, the province ensures the delivery of mandatory programs and the municipalities' interests are seen to be protected because they have the majority of appointees to the local health board, which approves the budget and oversees the effectiveness of the health programs to protect their communities.

The essential linchpin in the effectiveness of the public health unit rests in having an effective board of health. The board must recognize its responsibility for the quality and success of the operations of the health unit and be particularly aware of its accountabilities and responsibilities flowing from the PHFAA. The board is largely reliant on its MOH, who is effectively the CEO of the health unit carrying responsibility for both medical and administrative matters under the HPPA. The MOH position is pivotal. The MOH must ensure the budget is sufficient to meet public health needs while administering a health unit that is efficient and cost effective. The combination of board oversight and the operational leadership of the MOH should provide the province, the municipalities and their residents with assurance that they are receiving their public health programs and that they are delivered at a reasonable cost.

# Section B
# The Structure of APHU

## 1. Board Appointments

The Board currently consists of ten (10) members for 2015. Eight (8) of the ten (10) are municipal members and two (2) are appointed by the province. The municipal representation currently consists of five (5) who are elected to municipal councils and three (3) that are unelected but appointed by the relevant municipal council.

The HPPA s.49 (2) provides that *"There shall not be fewer than three nor more than thirteen municipal members of each Board of Health"* and that Lieutenant-Governor-in-Council may appoint members but they shall be less than the number of municipal members.

## 2. Board Governance

The governance and accountability of all corporations - private, public and not for profit - has been a subject of intensive debate and reform for the last two decades and has seen considerable work done on "best practices" to advance the quality of governance oversight and the accountabilities expected of boards.

There can be no single code of practice to meet the many different corporate structures that exist but the concept of "best practice" provides enormous guidance to all boards as they seek to excel in meeting their responsibilities and accountabilities.

Most non-profit boards operate under corporations legislation but the boards of public health operate under the HPPA which contains little specific guidance in governance processes but has a provision to incorporate some aspects of the new Not for Profit Corporations Act.

## 3. Management

The management of a public health unit is headed up by the MOH. HPPA S67 (1) provides that the MOH reports directly to the board of health and sub sections (2) and (3) establish that employees report to the MOH and the MOH is responsible for management of public health programs and services. In most cases the MOH also is effectively the CEO. In certain circumstances

the MOH is supported by a COO or equivalent that supports the MOH in day to day administrative matters.

Dr. Barker succeeded Dr. Northan on August 1, 2013 as the Medical Officer of Health for the APHU carrying responsibility for both the medical and CEO function. Dr. Barker resigned as MOH on January 21, 2015 and was replaced by Acting MOH Dr. Penny Sutcliffe, currently the MOH of Sudbury and District Health Unit (SDPHU). Connie Free, Director of Clinical Services, was appointed as the Acting CEO. Shortly thereafter Ms Free resigned from the APHU and was replaced by Sandra Lacle as Acting CEO. Ms. Lacle had held the same position reporting to Dr. Sutcliffe at SDPHU. Until permanent arrangements are in place the APHU is guided by two very skilled leaders from the SDPHU.

# Section C
# Board Governance

## 1. Background

In October 2012, Dr. Barker received an offer of employment from APHU for the position of MOH with an agreed start date of July 15th 2013. Her predecessor Dr. Northan agreed to stay on until August 1st, 2013 to assist the transition.

In June of 2013, prior to Dr. Barker's arrival, an anonymous tip led to the discovery of [redacted]. Neither Dr. Northan nor the Board were aware of the [redacted] activity.

Immediately before taking up her position, Dr. Barker was advised that [redacted] involved a substantial loss of financial resources over a period of years from the APHU [redacted]. This provided a particularly unpleasant starting point for Dr. Barker.

On becoming aware of the allegations [redacted], the Executive Director of Public Health Division, Roselle Martino wrote to the Board Chair Marchy Bruni (Mr. Bruni) on August 16, 2013:[1]

> *The report identifies funds, including provincial funds provided to APH under the terms of APH's Public Health Accountability Agreement dated January, 2011 ("Agreement"), that were allegedly misappropriated through the improper use of a corporate credit card.*
>
> *I am writing to inform you that the Ministry of Health and Long-Term Care ("Ministry" intends to recover from APH all provincial funds provided under the Agreement that have been used for purposes other than those approved under the Agreement or such other agreements as may have applied to the relevant funds. This includes funds that have been identified by the KPMG report as being expended for personal purposes, as well as any other funds that may be* ***identified***

[1] Letter to Marchi Mr. Bruni from Roselle Martino,

*as being applied toward expenses that are personal in nature based upon further review.*

*The Ministry intends to expeditiously demand repayment of those funds in accordance with Section 15.1 of the Agreement (and in accordance with its rights under predecessor agreements).*

Subsequently, Dr. Arlene King, Ontario's Chief Medical Officer of Health issued the following statement on August 28th, 2013:

*"The Chair of the District of Algoma Board of Health commissioned a forensic audit which identified funds that may have been misspent. The majority of funding for local boards of health is provided by the ministry.*

*In response to the forensic audit's findings, the ministry notified the board of health of its intention to recover any misused funding, while also ensuring that the health unit is able to deliver necessary services. The ministry has further requested that the board of health provide details as to what additional measures have been or will be put in place to prevent any misuse of public funds.*

*Additionally, the ministry has ordered that an independent audit be conducted, starting today, by the Ontario Internal Audit Division to assess operational, financial and related oversight processes at the board of health. This audit will help to ensure that provincial funds are used only in compliance with the Accountability Agreement between the board of health and the ministry."*[2]

Consequently by the end of the summer of 2013, the Algoma Public Health Board (Board) found itself with a new MOH, a substantial loss of funds and expectations of financial recovery of substantial lost resources.

## 2. State of Governance Expectations

In order to consider the subsequent work of the Board in addressing these circumstances a review of the governance picture at that time is an important starting point.

[2] Media release of Ontario Chief Medical Officer of Health, August 28th, 2013

The MOHLTC published the OPHS on February 18, 2011 to "establish the management and governance requirements for all boards of health and public health units".[3] Subsequently a training webinar was held on April 12, 2011.

These standards provide an outline of expectations for the effective governance of boards and effective management of public health units. Boards are accountable for implementing the requirements established in the OPHS with the:

> *"objective of developing strong governance and management practices"*[4] and *"helping boards of health stay on course toward improving outcomes, identifying gaps in training, leadership, and resources, and encouraging collaboration to reach goals."*[5]

While these guidelines are by no means comprehensive they certainly should make all boards of health aware of the quality of board performance expected.

For example:

> *"...be aware of current and emerging best practices regarding board operations..."*[6]
>
> *"Board of health members must also have an understanding of their duties and responsibilities as individuals and as a group, and must have an understanding of evaluation to improve effectiveness as a board".*[7]
>
> *"While the board of health as a governing body typically delegates the day-to-day management of the public health unit to the MOH, CEO and other senior management, Board members retain responsibility for oversight and monitoring of the organization's operations and performance."*[8]

[3] OPHS Page 3
[4] ibid
[5] Ibid page 5
[6] Ibid page 6
[7] Ibid page 7
[8] Ibid page 6

The OPHS goes on to spell out fiduciary duties of care, loyalty and good faith as well as elaborating on other expectations. I do not intend to reproduce that document but simply use the above quotes to underline key areas public health boards are expected to address to meet their basic obligations of oversight. While the public health boards are not directly governed by the former Corporations Act or the new Not-for-Profit Corporations Act, the principles laid out in the OPHS and in common board practice are hardly new in the world of board governance and reflect practices that go back not just decades but centuries!

If the Board failed to read the OPHS and missed the seminar then they should have been reminded by Public Health Funding and Accountability Agreements (PHFAA), which the board must approve annually, that reiterates governance expectations of the APHU.

The failure of the Board to appreciate and follow the principles in the OPHS, the PHFAA and in common board practice governing the affairs of a corporation is simply unacceptable for a Board responsible for oversight of almost $21 million of taxpayer's dollars. The failure constitutes a breakdown in both responsibility and accountability.

### 3. Board Governance Performance

Since the publication of the OPHS in 2011 the Board has had two Chairs and two MOHs and signed two PHFAAs with the Ministry.

While I suggest that there was no need to await the 2011 publication of the OPHS to recognize that good governance practices were not being exercised by the Board it would seem impossible to ignore the Ministry's expectations and the Board's undertakings. Further the webinar in 2011 provided all boards in the province an opportunity to measure their performance against the reasonable expectations of the government. In any event the subsequent performance makes it clear that the Board did not act on them.

The failure to comply or even meaningfully debate these expectations can only be attributed to complacency. There are probably a number of possible reasons for complacency. The Board up until 2012 was lead by Chair Guido Caputo who held office for 13 years and an MOH who held office for over 20 years. By the accounts of those interviewed, governance consisted of the affairs of APHU being overseen by a triumvirate of the Chair, the MOH and the Business Administrator.

Board meetings involved staff presentations on their activities and on a positive note there was an effort to hold meetings around the District to provide public access to the Board. That said, the actual work of the Board was dominated by the triumvirate and this seems to have satisfied the Board that that constituted sufficient oversight. Individuals I spoke with underlined that the MOH ran a very "tight ship" and that the board constituted a "rubber stamp". In fact the APHU appeared to be functioning successfully and consequently it was easy for the Board to play a passive role comfortable in the view that the MOH had everything in hand. The fact that on the surface all appeared to be going well for many years did not justify a passive role by the Board. Generally, a more accountable process of oversight strengthens the performance of an organization and helps enhance its efficiency and effectiveness.

Indeed, while the health unit appeared to function adequately and without obvious major problems for a substantial period under the leadership of the MOH, the Board Chair, and the Business Administrator [redacted], underlines the potential problems caused by sidelining the Board as the overseer of the actions of the health unit. While theft and similar occurrences have occurred under the watchful eye of organizations with high performing boards, no board with good oversight would have been content to rely on an unquestioned administration. The impact of the lack of oversight was underlined by the audit of the OIAD and the KPMG Review. They noted the lack of sound administrative policies governing the operations of the unit and other areas where detailed Board or Board committee scrutiny of the financial affairs of the organization were absent. Clearly many of these matters would have been addressed by better board oversight.

When the new Board Chair, Mr. Bruni was elected to office at the beginning of calendar 2012 he was a product of a Board that had a well-established practice of leaving most matters in the hands of the Board Chair and MOH.

In the summer of 2013 the Board Chair and Dr. Barker were faced with the need to find the funding within APHU's operations to compensate the MOHLTC for the [redacted] funds. As this involved well over half a million dollars it created a considerable challenge to both find the money and respect the

directive from Dr. King that the recovery should not impact on the APHU's ability deliver necessary services.

Not only did past practices have to be corrected, the Board needed to assure itself of the progress and the effectiveness of the MOH and the Administration in addressing the challenge.

While the Board tended quite properly to look to the MOH and her Management Team to develop the operational solutions to the new financial reality, it did not seem to recognize that the events called for the Board to address two very important aspects of board governance. Firstly, to consider how it should behave in the future as a Board in carrying out its role of oversight and secondly, to look carefully at its role in addressing the process of management of the expectations arising from the OIAD Audit and the KPMG review. Instead, with few exceptions, it fell back on its established practice of relying on the relationship of the Chair and MOH to handle matters.

The Chair may have been somewhat more at arm's-length from the MOH than his predecessor but there was no marked change in the way the Board did business. Consequently, Board oversight continued to be based in taking comfort in the proposition that as long as you had confidence in the MOH/CEO as the "one employee of the Board" that constituted adequate oversight. This is particularly puzzling given the arrival of a new, inexperienced MOH who might have benefited considerably from constructive Board oversight and the ability to take advantage of the potential value-added experience of the Board.

This approach resulted in a serious lack of oversight and accountability in the period September 2013 to January 2015.

The combination of having a new MOH, inexperienced in leading a health unit and the upsetting experience of having [redacted] occur under their watch did not result in the Board taking a hard look at the shortcomings in their own performance. This in no small way contributed to a number of problems which are expanded upon in greater depth in subsequent parts of this report but they included:

- Failure to move quickly to establish a finance and audit committee and to establish a process or committee to monitor

progress on implementation of the recommendations of the OIAD and KPMG Review;

- Failure to have any concept of oversight of the performance of operations, except through the exposure of the reports of the MOH;
- Failure to scrutinize the appointment process and qualifications of the Interim Chief financial Officer (ICFO);
- The decline in subjects covered in open public meetings, the board member/management relationship and the failure to provide adequate briefing materials on major issues requiring a decision before meetings;
- Failure to understand the broader aspects of conflict of interest; and
- Failure to recognize the need for training in Board governance procedures.

### *1.1: Failure to move quickly to establish a finance and audit committee and to establish a process or committee to monitor progress on implementation of the recommendations of the OIAD and the KPMG Review*

Section 3.4 of the audit done by the Ontario Internal Audit Division (OIAD) recommended *"...the DAHU Board establish an appropriate committee structure to support the functioning of the Board".*

The Board response to the recommendation was that they were *..."considering the development of board committees at this time."*

In fact some Board members had been pushing for a finance committee for some time. Notwithstanding the Board's response there was, among a number of Board members, a lack of enthusiasm with regard to even the need for a finance committee. The issues around developing appropriate terms of reference for the committee and the lack of an accountant on the Board appeared to constitute the reasons for delay resulting in the loss of a year before the committee began to do any meaningful work. The only process in place to follow up on the recommendations was to look at the various new policies developed and presented by the MOH and the staff over the year. Again it is hard to understand the lack of urgency given the

experience from [redacted]. The concept of failure of oversight arising from [redacted] clearly did not register with the Board.

### *1.2: Failure to have any meaningful oversight of the performance of operations, failure to scrutinize the appointment process and qualifications of the ICFO*

Adopting the concept that the MOH is the "only employee" the Board showed little interest in pursuing matters that went beyond the formal reports of the MOH and the ICFO. This was particularly important as it was the period when the new MOH was learning her new responsibilities and the ICFO was addressing some of the most important matters before them.

MOH on her part did attempt to move to address the matters urgently realizing that they simply could not wait. She recognized the need to find a CFO to address the skills that were lacking in internal financial leadership and the need to address the restructuring of the APHU necessary to find efficiencies in operations to address [redacted] and the capital debt.

In these areas she made a [redacted] that might have been avoided or limited had there been meaningful Board involvement in overseeing the financial issues and restructuring. Any "value-added" advice and guidance that the Board might have been able to provide her in the recovery process was not available.

Further, the Board was of little assistance to the MOH in her pursuit of either the permanent or ICFO. Both the minutes and interviews showed that in matters of recruitment and reorganization the MOH was largely left to her own devises. At the request of the MOH, two directors did assist in the first round of interviews for a permanent Business Administrator (later the title changed to CFO) but thereafter there was no Board involvement.

The failure of the Board to follow up and pursue their questions as to the background of the ICFO is particularly hard to understand given their recent experience [redacted].

The KPMG Review indicated that the management structure should be adjusted. The MOH, after serving notice that she was planning to realign her Management Team, simply reported on the new structure with little interest and scrutiny from the Board. The restructuring of the Management Team was extensive and significant as it involved a radical change in

operational culture from the regime of the previous MOH. The approach adopted by the MOH in introducing the new management structure created serious future management problems that went unnoticed by the Board.

A prudent board would have probed as to the reasons for the changes and expected to hear of advantages and potential disadvantages flowing from them. This is appropriate oversight. It does not interfere with the responsibility of the MOH to make personnel decisions, but takes an interest in the rationale and potential implications for the future effectiveness of the operations. This lack of interest in how the new MOH addressed personnel issues left the Board largely ignorant of the impact of the changes that occurred. Greater interest might have resolved serious problems. The lack of Board interest may also have indirectly weakened the sense of accountability of the MOH to the Board in addressing personnel decisions.

The need for changes in Board oversight was not totally ignored in Board meetings. As matters progressed particularly from the beginning of 2014 until the restructuring of the Board after the municipal elections, serious differences began to develop among Board members. Minority concerns ranged from voices focused on the development of a finance committee, voices determined that major board governance reform should happen, and voices that felt that Director's questions were not being properly addressed. This resulted in divisions that led to some underlying acrimony. There was no organized resistance and some of the dissenters on some issues did not join in dissent on others. Differences in debate were generally carried out in a respectful manner. In general, a majority of the Board consisted of those comfortable with the status quo and those not supportive of "rocking the boat". That said, one could not say that there was a formal opposition to the Board Chair and the majority. As a result there was no easy way of pushing issues on the agenda that were not endorsed by the Chair and MOH.

### *1.3: The decline in public meetings, the board member/ management relationship and the failure to provide adequate briefing materials on major issues before meetings requiring a decision*

The principal report to the Board in public session was the MOH's report which was intended to provide the Board with an update of APHU activities.

Her predecessor had tended to provide shorter reports and have various managers make presentations on matters relevant to their work and of interest to the Board. The MOH's reports were quite comprehensive as to operations and it was clear that she put considerable effort into them. It was however simply an overview and most controversial matters of substance seemed to be addressed in-camera.

The period 2013-2015 was marked by a couple of interesting practices. One was the move to do much of the Board business in-camera. An overview of the minutes support the view that almost half the items were in-camera and most would not fall under a category such as a confidential personnel matter, a planned purchase of land, labour negotiations etc. that would suggest an in-camera meeting was necessary. The test seemed to be that if it might be controversial it went in-camera. This raises the question of whether they missed the point of having public meetings if they used them simply for standard reporting.

Secondly, the ICFO and the MOH thought it appropriate to interview an OIC appointee post appointment and complain to the local MPP about the qualifications of appointees. Such concerns, whether they seem to have merit or not, are certainly not the prerogative of management, unless concerns involve interference in business operations by the director in question which should be brought to the Board Chair. Formally passing judgement on the skills of board members is not a management role but the occurrence certainly speaks to attitudes as to the role of the Board.

One appropriate practice carried out by the Board was the process of Board evaluation. The evaluations done during the period signaled issues needing attention that were not addressed. The greatest value of a good board evaluation process is the ability to look at the results and identify problem or potential problem areas. Once identified it is possible to have a Board discussion and as appropriate take steps to address the issues. If one uses the test of whether most questions show a majority satisfied then there is substantial opportunity lost. An unhappy but solid minority in the negative on key questions should result in a constructive response. Failure to recognize what constitutes a red flag in the review of the responses renders the practice of little value. Unfortunately proper discussion on the Evaluation became indefinitely postponed.

Importantly there was very little useful material provided to the directors in advance of the meetings and material was light to non-existent for some of the important in-camera meetings. One related feature of the style of the MOH, and for the period in which the ICFO was in office, was a desire by both to move quickly to act in some cases without appropriate consultation or caution. Again given the importance of the subject matter and a new MOH the steady hand of an experienced, questioning, Board could have made a difference.

### *1.4: Failure to understand the broader aspects of conflict of interest*

In addition to the usual provisions and the use of common sense when considering the potential for conflict of interest, the PHFAA drives home the importance of keeping on top of potential conflicts.

*Section* 7.2

*Conflict of Interest Includes. For the purposes of this Article, a conflict of interest includes any circumstances where:*

*(a) The Board of Health; or*

*(b) Any person who has the capacity to influence the Board of Health's decisions, has outside commitments, relationships or financial interests that could, or could be seen to, interfere with the Board of Health's objective, unbiased, and impartial judgement relating to its obligations under this agreement and the use of the grant. (Italics and underling added)*

*Section* 7 (3) requires disclosure to the Province which may prescribe terms and conditions.

The PHFAA is approved by the Board and signed by the Board Chair and MOH and as funding is dependent on it, it is reasonable to expect considerable debate on it prior to approval. As will be apparent, conflict of interest was forgotten in some crucial aspects of the work of the Board and the MOH.

In the case of the Board, questions of conflict were not pursued in relation to the work of the auditors or of counsel to the Board. Clearing the air may have been all that was required but the failure to note the conflicts real or

potential and to adequately discuss them, falls well short of the Board's fiduciary responsibility.

### *1.5: Failure to recognize the need for training in Board governance procedures*

Any reading of the OPHS, the PHFAA, the KPMG Review, and the OIAD Audit combined with the arrival of the new MOH should have alerted the Board that business as usual was not the prudent option.

Two members of the Board attended a governance program and reported back and eventually their summary was distributed to all Board members but had no meaningful response and no action or follow up. Even a rudimentary review could well have resulted in many useful improvements.

Many boards have an informal session at the end of the meeting without staff so that the board members are able to discuss issues that are more effectively addressed without staff present. These may be internal to the Board or matters concerning the performance of staff. These meetings did not occur at the Board either because they were unaware of the practice or possibly because it was not consistent with the dominant position of the MOH in the Board tradition. Given some of the developments it is difficult to believe it would not have been a constructive practice that might have forced some needed discussion.

In my assessment the Board did not provide appropriate oversight of the operations of APHU and its failure to deliver on the expectations of good corporate governance substantially contributed to the problems encountered in the period 2013 through 2015. Major corrections need to be undertaken in Board governance if future problems of recent magnitude are to be avoided in the future.

# Section D
# Administration

## 1. The MOH

Dr. Barker's arrival was welcomed.

There was a widely held view that she would bring with her new ideas and a fresh vision that would continue to build on the positive reputation of APHU. Her medical credentials were strong and she had an impressive presence. This initial view was enhanced by her apparent interest in the APHU between the time she was appointed and when she officially began work. She seemed to have a vision for the future and an ability to effectively communicate externally.

It is apparent that the Board did not appreciate the challenge the MOH faced in terms of establishing her leadership. Given the lack of CEO experience in large organizations it is doubtful that the MOH herself appreciated the substantial amount of change management required.

She did, however, quickly understand the need for action on learning of the [redacted] and the need to find a replacement for the Business Administrator and the need to restructure the Management Team.

Her first two major steps, the appointing of an ICFO and realignment of the Management Team, were not at all well executed and established a negative path from which she never recovered. These two badly managed processes, combined with her leadership inexperience, [redacted].

Her leadership management inexperience consisted of:

- An apparent lack of understanding of the painstaking work that is required to take a command and control organization that had experienced the same leadership for two decades and convert it into an effective team under her leadership;
- Limited experience with board governance and understanding her role in relation to the Board;
- A desire to act quickly with little consultation with her Management Team on the issues;

- A tendency to provide external undertakings without having fully understood the consequences;
- A lack of appreciation of her duty to the Board; [redacted].

Her first decision involved getting her financial house in order. She initiated proper processes in the search for a permanent CFO and her judgement that the position had to be enhanced in salary and title from Business Administrator to CFO was reasonable. Slow progress in the search led to an apparent determination by her that the length of time in hiring a new permanent CFO made the appointment of an ICFO necessary in order to address the many issues coming out of the [redacted].

The MOH went to the Board on October 16, 2013 and subsequently advised the Manager of HR on or about October 17th that the board had approved a salary increase to $150,000 and a job title change to CFO from Business Administrator.

The MOH Indicated she was under pressure from the MOHLTC to get an ICFO and recommended that an RFP be sent out to obtain a recruitment firm. An RFP for the recruitment firm was issued October22nd with a deadline of October 31st. The RFP was posted on the APHU website and the MOH requested it also be sent to healther@phelpsgroup.ca , elek@ambitsearch.com, recruit@basy.ca , Toronto@odgersberndtson.ca and rhulse@mindspanrecruiting.com .

Five completed submissions were received from Odgers Berndtson, Mindspan, Ambit, HAYS and Hudson Group Consulting. The EA to the MOH and the Manager of HR made recommendations to the MOH. The MOH disagreed with their recommendations and endorsed Mindspan.

On November 15th the Manager of HR informed the MOH that they should advertise through normal channels for the ICFO as the consultants' proposals were too expensive. The MOH responded [redacted] that the Manager of HR had a week to find someone and she would not participate in the interviews. She [redacted] said she would participate.

From here things began to deteriorate. The MOH [redacted] and without the involvement of HR went to the Board on November 20th and recommended the appointment of Shaun Rothberg (Shaun Rootenberg) as the ICFO.

The process was flawed for the following reasons:

- She did not make appropriate recruitment arrangements with HR;
- She rejected, without apparent reasons, the recommendations of staff as to the best respondents to the RFP for consultants to find an ICFO. She had a preference for Mindspan, [redacted];
- No contract was entered into with any of the Applicants including Mindspan, which was led by Ron Hulse;
- [redacted];
- Mr. Rootenberg was contracted by the MOH through Ron Hulse of RHulse26 Consulting without explanation;
- [redacted];
- [redacted];
- [redacted];
- She gave the Board a brief overview of his experience but no additional detail was provided even when requested.

[redacted]. The failure of the Board to provide adequate oversight and follow up is no defence for the behaviour of the MOH.

Internally the appointment was seen by senior management and staff [redacted], as a Board endorsement without knowing what had been said at the Board as the announcement and explanation to the Board was made in-camera.

Senior management rapidly became aware that Mr. Rootenberg was not only the ICFO but also the chief informal advisor to the MOH. It was not unusual for Mr. Rootenberg to raise a matter with a fellow member of senior Management Team only to have the MOH make a subsequent decision that appeared based on the position taken earlier by Mr. Rootenberg in the conversation with the manager.

High on the list of responsibilities of the ICFO was the need to address the concerns of the MOHLTC with regard to the recovery of funds lost [redacted] and the outstanding debt faced by the APHU arising from the construction of the new building. This along with his responsibility for finding ways to cut costs and enhance the revenue stream was not likely to endear him to staff. The combination of a tough job [redacted] certainly paved the way for speculation and suspicion among staff and indeed consternation where departments and staff were affected or potentially affected, by his actions. This was underlined by the ICFO raising issues around the performance of managers and staff that would subsequently be reflected in the views of the MOH.

At roughly the same time that the ICFO was joining management, the management style of the MOH was beginning to become apparent. She was seen to be inclined not to make use of her Management Team in decision making and to take positions externally without consulting her team, often catching them off guard with regard to internal communications and public positioning. [redacted]. In short there was concern by the Management Team that they were not part of the decision making process and that decisions were being taken by the MOH, often influenced by the ICFO and others outside the APHU, rather than tested and worked through the Management Team process.

The KPMG review provided the basic platform from which both the MOH and the IFCO acted to address challenges facing the APHU. Regrettably, this Review was not used to prepare the Management Team and indeed the staff as a whole for some of the tough choices that lay ahead. Nor were some of the realities relayed to staff, thus widening the gap of understanding of what might be necessary, while denying the full opportunity for management to participate in problem solving.

Early actions with regard to human resource matters, mental health, sexual health and coordination with GHC served as examples of important policy

issues where the Management Team and the responsible managers were often not consulted or their advice was ignored.

One important spinoff of this sense of being ignored in significant management decisions was that most of the managers began to meet informally and compare notes as to how matters were being handled and wondering how they should cope.

In parallel with this the MOH was considering a restructuring of the Management Team due at least in part to recommendations from the KPMG Review. The Review noted that the direct reports to the MOH consisted of eleven managers and recommended the need for an efficient reorganization. The MOH had advised the Board in September 2013 that she was going to carry out a reorganization of management but the evidence suggests she developed the approach without any meaningful consultation with the Management Team to lay the groundwork for such a difficult undertaking.

On December 20th, 2013 the MOH assembled the senior managers and announced that she had discovered that they were "insubordinate" as they had been meeting behind her back and that she had the right to fire them all. She further accused them of preparing a letter to the Board challenging her leadership. The development of such a letter has been strongly denied by all witnesses I interviewed.

Rather than developing an approach to set the stage, such as consulting individually with her Program Managers, the MOH [redacted] with an announcement of her reorganization which created four Directors as direct reports that would constitute her new senior executive team, and demotion of the other Program Directors to Managers, who were red lined. She also announced three Managers that were being dropped.

She selected her four executives by advising them individually that she had chosen them and gave them 24 hours to accept or reject. She did not meet individually with the Program Directors that she demoted to Managers. Quite aside from raising questions by making the choices without any posting or competition for these key posts by tying the charge of "insubordination" to the selection of the four new positions and the demotion of the others she immediately created a serious trust problem among all senior personnel.

The unfolding of this process created a natural suspicion that the selection of the four may have involved the four attributing negative intentions to the

other Managers. Consistent with her tendency to engage in limited consultation with her Managers, she made these moves without meaningful consultation with anyone except possibly the ICFO who had strong views both positive and negative with regard to the competencies of various Managers.

These two events appeared to deliver the message that posting and competitions and appropriate HR processes were no longer important and to underline that consultative teamwork was at best secondary. It is difficult to work in a healthy environment when, in addition to not knowing where you stand with the MOH, the individual Manager's position was undermined with fellow management colleagues.

In early March 2014, the MOH advised her Managers that she had retained the services of an Executive Leadership Coach and that all of them would be independently and confidentially interviewed as part of the process. This was a positive move by Dr. Barker to enhance her skills in organization management and strengthen her performance as a manager and leader. [redacted], she moved to retain the coach based on word of mouth and again she acted without consulting HR and seeking a supplier on a competitive basis.

The Coach's interviews took place in March and April and the Coach provided a summary for a feedback meeting on April 16th to the MOH and the Management Team.

The leadership findings on the positive side indicated that among other things the MOH was seen to have strong potential with key words like visionary, courageous, optimistic and good at building external relationships. [redacted]

While there was follow up into November and constructive discussion, there is little evidence of major improvement on the fundamental issues of trust and communication.

The Executive Team began meeting weekly at the end of January 2014 and so several months overlapped with the coaching sessions. There is little indication at the end of the year that the problems identified in the coaching process had altered the MOH's management style.

Following Mr. Rootenberg's departure at the end of May, as a result of his initiative to lease space in the APHU premises, a process was in place to explore the establishment of a Starbucks franchise in the late summer and early fall. Mr. Rootenberg decided to compete for the franchise. As the process unfolded the MOH remained involved, [redacted]

This once again raised questions of the [redacted] and further deepened the resentment among Management [redacted]

This came to a head in meetings January 14-16th, 2015 between the Senior Management Team, Dr. Barker and Chair Mr. Bruni [redacted] These meetings resulted in the final loss of confidence in Dr. Barker by both the senior Management Team and the Board Chair [redacted].

## 2. The ICFO

Mr. Rootenberg arrived in SSM in the summer of 2013 at approximately the same time as Dr. Barker was assuming her duties as MOH.

In late summer and through much of the fall he was in the APHU premises using an office from time to time. [redacted].

The MOH hired him effective November 25th, 2013 through the offices of RHulse26 Consultants as ICFO in a process described in the previous section. Mr. Rootenberg held the position through May of 2014. On completion of his work he remained in the SSM area and was often seen around the APHU premises.

[redacted] This led to questions as to the role of the MOH and the Board in the decision making.

[redacted], there is no evidence that I have encountered that suggested his work as ICFO was inappropriate. He approached his work with energy and vigor and moved quickly to address many of the serious issues facing the APHU. He was project oriented and obviously used the KPMG Review as a major staring point particularly dealing with projects to increase revenue and provide an asset base for the APHU to be able to address its outstanding capital debt to the Royal Bank.

It must be recognized that it is hard to win a popularity contest as an ICFO when you have to address a report that shows salaries markedly higher than in other Health Units in Sudbury and Thunder Bay, when the new building is housing staff in 70,000 square feet, up from the previous occupancy of 33,000, has more executive staff than its partners in Thunder Bay and Sudbury, has a sizable debt without adequate security to support it and a desperate need for cash. Most of these challenges were not known or fully understood by staff or in the District.

In addition to these challenges, Mr. Rootenberg had no real knowledge of the front line health operations of the APHU and the fundamental differences

between government financing and private sector financing. Further, as Mr. Rootenberg was also inclined to move quickly and confidently he did not always do as much ground work as desirable or listen well to internal professional advice which detracted from the quality of some of his decisions. To further complicate matters, the financial and operational challenges outlined in the KPMG Review, which he was acting on, were not well understood internally so there was little shared understanding of urgency that might have resulted in a smoother relationship with the other Managers.

On the positive side, he had considerable success in restructuring the ownership of the APHU building and land, providing necessary security for the capital debt which required important negotiations with SSM, Sault College and the Bank. Although not without controversy, he completed a successful contract negotiation with CUPE.

On the mixed side he renegotiated the telephone and IT contracts on the basis of an asset sale and lease back arrangement. While this produced much needed cash for the debt pressures, it involved a major sale of government assets that should have received the Ministry's approval. A common arrangement in the private sector, it had less obvious value in a government context and the MOH should have received MOHLTC clearance before proceeding with this initiative which might well have been denied. Mr. Rootenberg did receive Board approval and praise for his work.

He moved the Health Promotion Centre from the Cambrian Mall to the new premises although there is some debate as to whether it resulted in much savings as the Cambrian Mall still had a year to go on its lease. While the move was logical and it is not clear there were any savings, it was welcomed by the Health Promotion staff.

On the negative side, he moved too quickly in attempting to lease the vacant parts of the building and did not take into account imperatives of professional/client management, causing both dislocation and considerable angst among staff.

It is important to note that as ICFO, through the combination of successes and mistakes there is no suggestion of any action that resulted in personal benefit. It should be noted that he reported regularly to the Board on his work and was praised and complimented by them. Had the board been more

engaged in oversight and in recognition of its responsibilities it might have helped guide him in the operational areas [redacted]

Following his departure, he looked into the possibly of personally obtaining a Starbucks Franchise which would compete for lease space on the premises. [redacted]

His involvement in the Algoma Medicinal Alliance (AMA) is addressed separately.

### 3. The Executive Team and Management

The Executive team consists of the three Directors, the CFO and is chaired by the MOH. The remainder of the Management Team consists of the Managers which number eleven in total.

As referenced above, the manner in which the Directors were chosen and the remaining Program Directors demoted to Managers had a major impact on morale. Not only had the ground work not been done to provide a full rationale for the move but the environment around the decision being announced created distrust and suspicion around all those involved. As was apparent in the report of the leadership Coach, as reported above, these concerns continued to impact the thinking of both the Executive and the Management Teams.

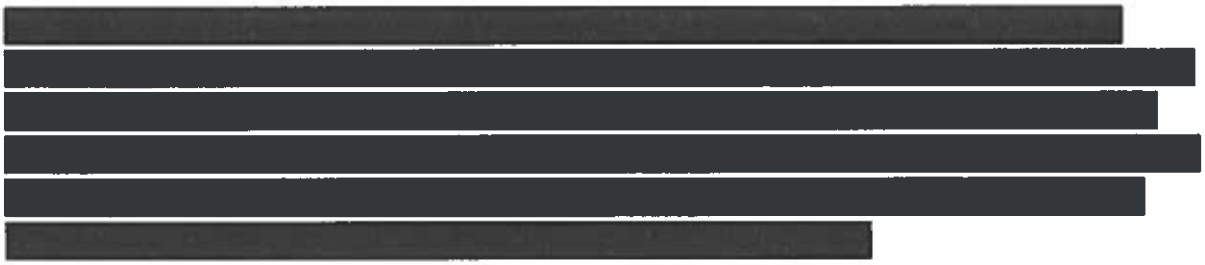
Strangely, the management restructuring announcement to staff commenced [redacted] so that the bad news dominated the remainder of the announcement rather than having it focus positively on the restructuring of management into a new team as the highlight. It also raised questions as to how [redacted].

Obviously the lack of trust and suspicion among and between the Executive Team and the broader membership in the Management Team impacted their

working relationships with each other. This combined with the limited consultations between the MOH and the Management Team, often led to caution in the way Managers approached each other and constantly raised questions of who was aware of developments and who was not. The result was a large degree of paralysis in downward communication and in providing clear advice to non-management staff. In some cases, members of the broader Management Team limited their engagement with others as they felt they were constantly on the defensive. This breakdown in normal communication simply worsened relations not only among Managers but weakened the confidence of staff in the leadership of their Managers. The damage that has been done to trust and confidence should not be underestimated.

Rebuilding confidence and trust and the overhaul of the whole approach to internal communications must be an absolute priority for the new leadership of APHU.

## 4. Front Line staff



After some initial concerns about the implications of coming forward with their views to the Assessor, this was more than made up for in the latter part of the process by very straightforward interviews where staff appeared to be very frank in their assessments.

The most common complaint was that they felt cut off from communication as to what was going on in the organization. They felt there was little interest in communicating with them, that they often became aware of changes outside normal communication channels and that they had trouble getting information or confirmation from their Managers. They were concerned that for the most part they were not getting leadership from management and were too often told when seeking advice and guidance to "work it out for yourself". There was also a sense that management could

not get their act together and that there had been too many shuffles of Managers resulting in some not adequately knowing their jobs. There was a general loss of confidence in the enforcement of corporate policies, one example being the policy on workplace harassment. Another important complaint was that there was not much in the way of open competition for positions and that there was, at a minimum, a lack of clarity in the rational concerning organizational changes. It is worth noting that several on the Management Team acknowledged that the environment for management communications was poor and interrelationships between some Managers and some Managers and staff was very difficult.

The specific issue of the office facilities at Elliott Lake was not part of my mandate but it did include issues of staff morale and corporate performance.

The situation in Elliott Lake is at best unsatisfactory and while the problems initiated by the Mall collapse can hardly be laid at the doorstep of APHU, the long delays and the failure of the Board and the MOH to appear to give very high priority to resolving them or to at least be seen to be front and centre in supporting the staff cope with the issues in the interim, is difficult to understand. It may be demanding to give satellite offices the attention that they feel they deserve but to appear to abandon them or not provide decent quality relief is not acceptable.

# Section E
# Algoma Medicinal Alliance Ltd

**Background**

The Algoma Medicinal Alliance (AMA) appears to have originated as the result of an idea initiated by Mr. Rootenberg. He apparently sold to Mr. Amit Sofer (Mr. Sofer) the concept of developing a facility in SSM. This entailed the creation of a corporation and the preparation of an application to the Government of Canada to become a licensed producer under the Marihuana (marijuana) for Medical Purposes Regulations. The decision to pursue a federal license was thought to be substantially strengthened by demonstrated strong community support for what might otherwise be seen locally as controversial.

In late November, Dr. Barker states that she was approached by Mr. Sofer and others to participate as a public health expert on the Board of a local marijuana venture that was supported by among others SSM city officials, the local police chief and APHU's legal counsel.

AMA was incorporated on the 28th of January 2014. The initial Directors included Dr. Barker, whose application is dated January 20th 2014 and Mr. Bruni whose application is dated January 22nd 2014.

Dr. Barker was of the view that the presence of AMA would be beneficial both financially and scientifically to APHU and would provide considerable medical research potential.

At the Board meeting on February 19th the Board went in-camera and an item listed on the Board agenda as New Project was introduced. Guests present at the in-camera meeting for this item were Mr. Sofer and Joe Fratesi, CAO of SSM. No documentation had been provided in advance so the Directors were being confronted with the proposal and related issues without advance warning. It should be noted here that Dr. Barker in her statement suggested the meeting was in January but there is no support for this in the minutes or from any other witnesses.

Mr. Sofer made a presentation on the AMA plan and stated that he was not asking for any money or proposing partnership or public endorsement but simply wanted the Board to approve Mr. Bruni to go on the Board of AMA to

look after the interests of APHU. According to the written statement of Dr. Barker, Mr. Sofer proposed that each of SSM and APHU would receive 5% of the profits of the venture if successful. SSM CAO Joe Fratesi would also go on the Board.

The proponents talked about the strong local support, the creation of 100 jobs and what a boost this would be for the local economy. A number of Directors felt they were being put in a difficult position and were reluctant to be negative particularly as there were so many prominent people in the community supporting it, including the Chief of Police and APHU's lawyer who was also the lawyer for AMA. According to Dr. Barker both she and Mr. Rootenberg met with the local MPP about the venture and got his help to meet with the federal MP to obtain his support. The Directors then passed a resolution approving the appointment of Mr. Bruni.

The AMA Application was finalized and bound at APHU and sent to the Offices of Controlled Substances in Ottawa.

Mr. Rootenberg recalls that the AMA Board members and some supporters met from time to time thereafter until the process was derailed [redacted] But until that time the AMA application was very much alive in the federal application process.

**APHU and the Policy Issues**

The policy issues around the use of marijuana are controversial and the deep involvement of APHU as a public agency deserved far more discussion than it got at the Board level.

While the failure to address fundamental issues is not acceptable, it should be noted that the Board did not know at the time of the meeting and were not informed at the meeting that:

- The company had already been incorporated twelve days before the Board meeting with Mr. Bruni already seated as a founding Director on the Board of AMA;
- That Barker was a founding Director of the Board of AMA, had been doing work on behalf of AMA and would have an ongoing role in support of the AMA application;

- That resources of the APHU had been used to help develop the AMA Application; and
- Dr. Barker coordinated at APHU both the program of local endorsements and the security clearances for the AMA Board members as part of the federal application process.

There are several matters which are important that the Board should have considered in addressing the involvement of the APHU in this arrangement with AMA:

- Is it appropriate for a public health unit to provide endorsement, direct or implied, to any for-profit business? What about support for a local health spa?
- Should a publicly funded public health unit be seen to be supporting a private sector for-profit drug application? If AMA is appropriate for a relationship with a public health unit why not a multi-national drug supplier?
- Although Mr. Sofer said he was not asking for an endorsement or partnership, the close arrangement with joint directors, the same corporate counsel and the promise of profit sharing [redacted].
- Where should the APHU draw the line between being booster for a local health project and maintaining its professional independence in pursuing its provincial and municipal health obligations to the District?
- What if developers in another community such as Blind River or Elliott Lake should decide to make a competing application?
- What were the formal understandings between AMA and APHU and why were they not spelled out in writing for the Board to consider?
- Mr. Bruni as the Chair and Director of APHU would have to declare a conflict at meetings of the AMA Board when the relationship with AHPU was discussed and in certain cases absent himself. How would that relate to his oversight of AHPU's interests?
- What is the potential for conflict of interest, particularly if AMA was to be successful?
- Had the Ministry been formally informed as the principal funder or in accordance with 7.3 of PHFAA?

These are just some of the reasonable questions that justified full debate at the Board.

Due to this lack of knowledge and the short notice given to the Directors prior to the in-camera meeting they cannot be blamed for another obvious question as to why was the decision was made to keep the matter in-camera rather than in the public meeting?

There would surely have been many more questions had the Board been aware that the MOH and the Chair were already on the AMA Board.

The Board's lack of adequate attention to conflict of interest has been addressed in Section C on page 18. *Section* 7.2 of the PHFAA should have required the special attention of the Board Chair and Dr. Barker as the MOH. Further *Section* 7.3 should have encouraged the Chair and or Dr. Barker as MOH to inform the Province of their involvement and of the involvement of the APHU.

The whole AMA involvement with APHU is difficult to explain and to justify.

The development of a licensed marijuana growing facility might well have been a positive development for growth and employment in SSM that could legitimately draw on the support of the City, as well as federal and provincial political leaders. The logic that applies to SSM support does not apply to a municipal/provincial public agency which has a very different public mandate focused on community health for a very large region beyond SSM. It has no mandate to utilize its time and resources for economic development or to endorse or appear to endorse a for-profit local development project.

In any event, any action by the APHU to step beyond or extend that mandate requires a lot more attention than was provided by the Board. This applies even more directly to its Chair, the MOH and the ICFO who had far more extensive knowledge of the situation than the rest of the Board.

It is important to note that there is no evidence that any of the subjects of this Assessment including the Chair, the Board, the MOH or the ICFO received any financial advantage as a result of their involvement in this project. Had the project been successful it is possible the circumstances might have changed.

## Section F
## Employment Contracts

The Terms of Reference 3 (b) require me to review:

> *"contracts for senior management positions, including contracts for the Chief Financial Officer position or other related positions".*

There are two significant contracts, one dealing with the employment of Dr. Barker as MOH and the other dealing with the contract employing Mr. Rootenberg as Acting CFO.

I have not provided in this report the details of these contracts as the public disclosure of all or part of these contracts may raise third party confidentiality issues. I have provided my assessment to the Minister.

# Section G
# Conclusions

## APHU

APHU as an organization is unhappy, organizationally weak and suffering from poor morale. This must be addressed urgently if APHU is to return to a healthy, efficient and well governed workplace environment. Failure to address it will lead to increased problems and a weakening of service to its clients.

The only good news is that staff at APHU is optimistic about the appointment of Dr. Penny Sutcliffe as Acting MOH and Sandra Lacle as the Acting CEO. Both have strong track records and are skilled at providing health unit leadership. They will no doubt do an excellent job in their acting capacity but what is urgently required is stability and ongoing, permanent leadership.

## Board

Pursuant to my Terms of Reference as Assessor under S. 82 of the HPPA it is my opinion that the APHB has failed to ensure adequacy of the quality of administration and management of its affairs and has not met the requirements of HEPPA and PHFAA nor the governance expectations under the OPHS.

It is my opinion that the Board for the most part operated as a rubber stamp influenced by a tradition of relying on the leadership of the Chair and MOH underscored by the mantra that the CEO is the only employee of the Board and that somehow this constituted sufficient exercise of their responsibility, accountability and oversight. This approach appeared at least on the surface as successful under the guidance of the previous Board Chair Guido Caputo, Dr. Northan, and his Business Administrator Jeff Holmes.

The most obvious weakness in this passive approach by the Board became apparent [redacted] which placed the Board and Management structure under the scrutiny of the KPMG Review and the OIAD. Both these reports provided thoughtful and valuable insight as to the weakness of APHU and provided between them a useful blueprint to begin a governance and operational recovery.

As a minimum these reports [redacted] itself should have provided a wake-up call and underlined the consequences of the lack of effective Board oversight.

Surprisingly they did not. While some Board members began to develop concerns about whether they were providing the guidance they should, the predominant view remained that the status quo was satisfactory and with good, new MOH leadership things would correct themselves. This passive approach failed to take into account that the Board had a role to play to help a new MOH who would [redacted] have to address the substantial change management issues that arise after such a dominant and long serving MOH retired.

This failure of the APHB to address these matters in my opinion calls for substantial change in the Board, an immediate need for a governance review and guidance to build a governance structure that provides effective oversight and that is truly responsible and accountable for the success or failure of the operations of the APHU.

The recommendations which follow are designed to lead to the changes necessary to ensure the recovery and future stability of APHU.

## Administration

1. MOH

The MOH, Dr. Barker arrived on a very positive note. She was seen initially to be a compelling leader and a likely agent for change. She also seemed to be ready to build solid external relationships.

[redacted]

[redacted]

The next MOH is going to be faced with a huge challenge and it will be imperative that the MOH has established team leadership ability and management skills or the position should be split providing the MOH with an experienced COO or CAO to guide the business operations.

## 2. Executive Team

The Executive team concept made a great deal of sense and reflected much of the KPMG Review recommendations, but the way in which it was implemented proved to be most unfortunate and sent a very negative signal through the system which remains entrenched today.

The whole Management Team, both the Executive and the Managers, has struggled and there is a need to take a hard look at the performance of all Directors and Managers going forward.

All vacancies should involve thorough and appropriate HR processes with an emphasis on internal competitions. That said, the new leadership must have some flexibility to consider proven performers from the outside as a major rebuilding lies ahead and in the short term not all the talent required can be expected to exist internally.

## 3. Staff

While the staff has continued to serve its clients to the best of its ability, there is no doubt that there has been a breakdown in communication and in the stability of management systems resulting in declining morale. This is urgent to address through effective communication and a focus on the delivery of quality management.

Staff must be made to feel they are part of the APHU team and are governed openly and with well understood policies and practices.

The Board and Management must give high priority to resolving the situation in Elliott Lake and notwithstanding tight resources should act to ensure that, pending the move to adequate quarters, that they are sufficiently supported to do their work in the community.

# Section H
# Recommendations

In making these recommendations I am aware of the considerable limitations imposed by HPPA and its regulations on the structure of the organization of APHU and much will depend on either changes to the legislation and/or a high degree of cooperation between municipalities and the government if the problems plaguing APHU are to be adequately addressed. Starting at the top is essential. It is important that the Board set the example as a body dedicated to excellence in providing leadership and accountability in the oversight of the APHU.

Boards can and do serve a very valuable role in public administration in Canada as they can and do in the private sector. Boards, however, have a mixed record when it comes to effectively carrying out their responsibilities. The role of boards is complex, particularly in large organizations, and there is a considerable expectation in the public sector that they are ensuring that their organization is efficiently and effectively run and is accountable to its funders in carrying out its mandate.

There are several high profile examples of failure by both private sector and public sector Boards from which there are valuable lessons learned. These lessons are most often added to the compendium of "best corporate practices". They are unfortunately of little value when existing boards fail to take them into account.

In the private sector, publicly held companies are open to shareholder accountability annually. In the case of provincially funded non-profit organizations there is not much government oversight of board activities and corporate performance beyond the annual exercise of accountability agreements which are not objectively monitored. The concept of regular performance and compliance audits of government funded organizations would be valuable in keeping the board as well as the organization alert to their performance responsibilities and accountabilities. A performance and/or a compliance audit every couple of years in the case of APHU would have almost certainly resulted in better governance and avoided many of the problems that arose due to lack of guidance or inadequate oversight.

Health Units have substantial amounts of public funds to be managed and most importantly have major responsibility for the health of the residents of the communities they serve. Further, in many of their responsibilities the failure of one unit can create serious problems for the well-being of other jurisdictions. Consequently, the establishment of a high performing board is very much in the broad public interest.

High performing boards should have a substantial skills base among its directors. The current system of appointment of directors to public health unit boards does not advance the concept of a skills based board and it is quite possible that a board can comprise capable people who do not possess the mix of skills desirable for a strong board. In both cases where I have been the Assessor, I believe that the boards in question would have benefited from following a skill based formula for building the board's membership. A skills based board consists of board members who are appointed on the basis of specific governance skills and expertise required to ensure the board has the ability to effectively meet its responsibilities and accountabilities. In addition to a generic appreciation of the roles of a modern board, this could include:

*Strategic planning;*
*Municipal governance;*
*Health professionals;*
*Finance and Accounting;*
*Environmental Engineering;*
*Business management experience;*
*Risk management;*
*Human resources;*
*Information systems;*
*Communications; etc.*

The building of a skill based board is by no means simple but it is in my view very much in the public interest. In order to find the right mix of board members it is helpful to have a substantial population to draw from as the individuals required are not always easy to find given the demand from hospitals and other non-profit organizations that utilize skill based boards. Currently there are more than two health units for every LHIN in the Province. Certainly some consolidation of health units would not only

introduce efficiencies but importantly, advance the size of the citizen pool from which to build a skill based board.

Building a skill based board calls for greater cooperation between municipalities, who have the power to appoint the majority of board members and the province with the power to appoint the minority. The municipalities and the province should work from properly developed guidelines for the selection of directors.

The following recommendations impact the traditional role of the municipal appointment process to agencies but without impacting the overall municipal influence in the governance of the Health Unit. I am recommending that municipal councils consider appointing local citizens with the required governance skills in lieu of an elected councillor. This arises not from a lack of respect of the skills of councillors but from recognition of growing demands of board governance in public agencies and the competing demands on the time and priorities of elected officials. In many communities, the municipal councillors have stepped down from local hospital boards due to the recognition that the demands on their time have made it difficult to meet their legal obligations to the board while attempting to address their heavy duties as an elected official. The governance of health units is equally demanding and while it is possible to balance both, it is far more difficult in today's world of increasing expectations of governance and board accountability.

**Recommendation #1**

All members of the Board of APHU, whether appointed by the municipalities or the province, except those new members appointed for the first time following the municipal elections in 2014, should step down voluntarily or be removed by the municipalities and the province. This is not intended to be a personal reflection on the motives of any of the individual Directors, who no doubt believed they were appropriately serving the community, but it is essential to provide a needed fresh start for APHU.

**Recommendation #2**

The Board should be a skill based Board.

**Recommendation #3**

Municipalities should look carefully at the advantage of appointing future Board members that do not have the demanding work burden of elected councillors, recognizing that the work burden on a properly functioning skill based board will be more demanding than the expectations of the current Board.

**Recommendation #4**

Two options are proposed for addressing the realignment of governance. However, Recommendations 1, 2, and 3 above apply to both options.

Option #1 is based on merging the APHU with the SDPHU Region to have an Algoma-Sudbury Public Health Unit with one Board.

Option #2 is based on correcting the existing problems by reorganizing the current APHU Board structure. Many of the recommendations remain similar in both options.

**Option #A – Merging Algoma and Sudbury**

**Recommendation #5A**

The Lieutenant-Governor in Council should act to amend the regulations under the HPPA to permit the merger of the District of Algoma Public Health Unit with the District of Sudbury Public Health Unit.

**Recommendation #6A**

The two Boards should establish a Transition Team consisting of three remaining members of the APHU Board and three members of the SDPHU Board with an Independent chair jointly selected by the Transition Team.

**Recommendation #7A**

The Transition Team should immediately hire governance consultants to provide advice on building a sound, skills based governance structure that will provide the tools for effective oversight, governance and accountability. Given the substantial changes a merger involves and the culture change in building a skills based Board, it is crucial that the Transition Team retain

experienced governance consultants that can take them through the basics of good governance and introduce them to appropriate best practices.

**Recommendation #8A**

Section 49 (2) of HPPA restricts Municipal Representation to a maximum of thirteen (13). Recognizing the size and scope of the geographic areas to be included in the merged organization, the total number of municipal and provincial appointees should be limited to no more than sixteen (16) which would permit up to ten (10) municipal appointees. Municipal membership from Algoma and Sudbury regions would be equal - for example five (5) and five (5). The province, although permitted up to one less than the number of municipal appointees under current legislation, should informally agree to appoint no more than six (6) which would still be a greater number than the past provincial appointment practice.

**Recommendation #9A**

The Lieutenant-Governor-in-Council should amend the regulations to require that the municipalities establish a joint nominations committee to appoint a slate of municipal members that could be a combination of municipal council members and citizen members and that would place priority on the skills and expertise required by the Board while recognizing geographical realities.

**Recommendation #10A**

The Transition Team should work with the municipalities and the province to develop an effective process for the nomination and appointment of Board members that would advance the recruitment of members possessing the skills needed in making their respective appointments to the Board.

**Recommendation #11A**

The Acting MOH and Acting CEO should remain in place at the APHU for the remainder of the fiscal year and the search for an Algoma MOH/CEO is discontinued.

**Recommendation #12A**

The Transition Team would make recommendations as appropriate to both Boards and the MOHLTC to address issues including but not limited to:

- The redeployment of employees between the health units and all related labour issues;
- The realignment of management positions; and
- The reallocation of assets and liabilities between the Units.

**Recommendation #13A**

The Merger should be completed no later than March 31, 2016.

***Option #B Restructuring Algoma***

**Recommendation #5B**

The Lieutenant-Governor- in-Council should amend the regulations to require the municipalities to establish a joint nominations committee to appoint a slate of municipal members that could be a combination of municipal council members and citizen members, and that would place priority on the skills and expertise required by the Board while recognizing geographical requirements.

**Recommendation #6B**

The municipalities and the province should work together to respect the skills needed in making their respective appointments to the Board.

**Recommendation #7B**

The municipalities and province should fill the vacancies created as a result of Recommendation #1 and should do so cooperatively to ensure appointees with the skill sets required.

**Recommendation #8B**

The Board should immediately hire a governance consultant to guide the Board in building a sound governance structure that will provide the tools for effective oversight. Most Board members, new and old, admitted to having little governance training. It is therefore crucial that the Board retain experienced governance consultants that can take the Board through the basics of good governance and introduce them to appropriate best practices.

**Recommendation #9B**

To avoid further delay in effective management of finances the Board should immediately look at "best practices "in not-for-profit corporations to develop terms of reference for the Finance and Audit Committee.

**Recommendation #10B**

The Board must move quickly to appoint a new MOH or MOH/CAO combination. As the Board will be in transition due to the recommended changes above, the selection committee should be drawn from among the existing new members.

**Recommendation #11B**

The Board should be assisted by an experienced recruitment firm in the MOH/CAO search as the choice of leadership will be crucial and a thorough assessment process will be required.

**Recommendation #12B**

With the need to build strong and stable leadership the candidate should not be a combination MOH/CAO appointment unless the MOH has demonstrated substantial leadership experience in leading a sizable operation. If the candidate is a strong professional but without established corporate leadership skills then a Chief Operating Officer or Chief Administrative Officer is required to work closely with the MOH.

**Recommendation #13B**

The Acting CEO should carry out a review of all corporate policies and examine them against best practices in other Ontario Public Health Units both as to coverage and content.

**Recommendation #14B**

The Board and Management should give priority to resolving the physical facilities issues in Elliott Lake and provide interim support as required. Staff in Elliott Lake should be kept informed of progress.

**Recommendation #15B**

The Board should seek a new accountancy firm through an RFP process [redacted]

## Options Pros and Cons

### Option #A Merging Algoma and Sudbury

Pros:

- Will ensure continuity in leadership and reorganization with the continued leadership of the Acting MOH and Acting CEO.
- Will minimize upheaval in the management as it avoids four changes to leadership in Algoma in three years.
- Will provide both the APHU Board and the Sudbury District PHU Board with a governance review and facilitate the move to skills based Board.
- May provide the potential for greater breadth and depth of service due to the greater reach.
- Will result in greater cost efficiencies being achieved.

Cons:

- Will create the need for realignment of the SPHU.
- Will result in some loss of management jobs.
- There will no longer be an Algoma or Sudbury specific Unit.

### Option #B

Pros:

- The APHU is retained in the Algoma District.
- The APHU will cover a known and smaller geographical area.
- Will result in greater efficiencies being achieved.
- Will not impose some restructuring on Sudbury.

Cons:

- Finding an experienced MOH will be difficult and finding a MOH/CAO combination may lead to a long exercise.
- The APHU will be without permanent leadership for most of the calendar year and will go through another major leadership change.
- Will result in the loss of some management jobs.

***Assessors Preference***

While I am confident that both options can work, I believe on balance that Option # A is the better Option of the two.

There has been a substantial period of dysfunctional leadership and management in the APHU and it is important for all involved, management and staff, that as soon as possible there be a return to stability and confidence in the processes that govern day to day life and work in the Unit.

Although it is early days, I think that the leadership of Dr. Sutcliffe and Sandra Lacle has already brought some welcome stability to APHU and that continuity is extremely important after the considerable upheaval that has marked the last two years. The process of finding an experienced MOH may prove extremely difficult as there is a shortage of potential candidates in the province and it may be that a combination of MOH and CAO will be needed which could add considerable time required under Option# B to get new leadership in place.

I believe strongly that good Board leadership is far more likely with a skills based Board and regular reviews of governance. Option # A should also prove beneficial to the governance of SPHUB.

## **Appendix A**: Interviews

I wish to express my thanks and appreciation to all who spoke frankly with me in this assessment process. I particularly appreciate the individual staff members who voluntarily came forward notwithstanding some individual reservations about the process. Whether Board member, Management or staff, all made a significant contribution to the assessment.

1. **Members of the Board of Algoma Public Health**
   - Marchy Bruni, Board Chair - *Sault Ste. Marie (councillor)*
   - Janet Blake, Vice Chair - *Province of Ontario (appointee)*
   - Robert Ambeault* - *Blind River; Spanish; North Shore (councillor)*
   - Carmen Bondy** - *Province of Ontario (appointee)*
   - Brenda Davies* - *Sault Ste. Marie (appointee)*
   - Tom Farquhar* - *Elliott Lake (councillor)*
   - Ian Frazier** - *Sault Ste. Marie (appointee)*
   - Sue Jensen** - *Blind River(councillor)*
   - Debbie Kirby - *Province of Ontario (appointee)*
   - Karen Marinich* - *Province of Ontario (appointee)*
   - Candice Martin** - *Elliot Lake (councillor)*
   - Lee Mason** - *Bruce Mines; Hilton Beach; Hilton; Jocelyn; Johnson; Laird; MacDonald, Meredith & Aberdeen Additional; Plummer Additional; Prince; St. Joseph; Tarbutt and Tarbutt Additional (appointee)*
   - Gordon Post* - *Bruce Mines; Hilton Beach; Hilton; Jocelyn; Johnson; Laird; MacDonald, Meredith & Aberdeen Additional; Plummer Additional; Prince; St. Joseph; Tarbutt and Tarbutt Additional (appointee)*
   - Ron Rody - *Wawa (councillor)*
   - Dennis Thompson** - *Thessalon, Huron Shores (appointee)*

* Former board members

** New board members

## 2. Executive and Staff of APHU

- Stephanie Blaney, PHN Vaccine Preventable Disease
- Blythe Carota, PHN Sexual Health and Bargaining President for ONA
- Sherri Cleaves, Manager, Environmental Health
- Stephanie Caughill, PHN Sexual Health
- Cathy Donnelly CUPE and Rochella Robson, Clerical Support and CUPE President
- Mary Dubreuil, Clerical Support Payroll and CDP
- Denise Foster, Heather Robson and Helen Kwolek, PHN Genetics Program
- Connie Free, Acting CEO
- Chris Giroux, IT Support
- Lorraine Gravellle, PHN CDP/IP and Healthy Schools program;
- Carolyn Kargiannakis, PHN Sexual Health
- Christina Luukkonen, Secretary to the Board
- Bob Moulton, Elliott Lake on Behalf of Elliott Lake Office
- Trina Mount, former Secretary to the Board and Secretary to the Executive Committee
- Jan Metheany, Manager, Community Mental health
- Tim Murphy, Communication Specialist
- Danuta Nameth, NP Sexual health
- Justin Pino, CFO
- Antoinette Tomie, Director of Human Resources and Corporate Services
- Leo Vecchio, Media Coordinator
- Laurie Zeppa, Director Community Services

## 3. Medical Officers of Health

- Dr. Allen Northan, Former MOH for APHU
- Dr. Penny Sutcliffe, MOH and CEO for Sudbury and District Public Health Unit and acting MOH for APHU

4. **Others:**
    - Alex Lambert, CEO, Group Health Centre
    - Hon. David Orazietti, MPP
    - Mayor Christian Provensano, Sault Ste Marie
    - Shaun Rootenberg, Former Interim CEO of APHU
    - Sandra Lacle***

*** I did not interview Sandra Lacle as she arrived near the time of my last visit to SSM. We have however had a number of valuable discussions with her.

# Appendix B: Appointment


**NOTICE OF APPOINTMENT OF ASSESSOR**

**Section 82(1) of the *Health Protection and Promotion Act***

Whereas I am authorized to appoint assessors for purposes of the *Health Protection and Promotion Act* ("Act"),

And whereas I am of the opinion that an assessment of the Board of Health for the District of Algoma Health Unit is necessary for the purposes set out in section 82(3) of the Act,

Therefore by means of this Notice, I appoint Graham Scott as an assessor under the Act, effective immediately, to hold office at pleasure to conduct an assessment of the Board of Health for the District of Algoma Health Unit according to the Terms of Reference attached to this Notice of Appointment.

This appointment shall expire 45 days from the date noted below.

Minister of Health and Long-Term Care February 25, 2015

## Appendix C: Terms of Reference

**ASSESSMENT OF THE BOARD OF HEALTH FOR**

**THE DISTRICT OF ALGOMA HEALTH UNIT**

**TERMS OF REFERENCE**

**January 2015**

**OBJECTIVES:**

1. To assess the quality of the management or administration of the affairs of the Board of Health for the District of Algoma Health Unit (the "Board") under s. 82(3)(c) of the *Health Protection and Promotion Act* ("HPPA");

2. To ascertain whether the Board is complying in all other respects with the HPPA and the regulations under s. 82(3)(b) of the HPPA; and,

3. To make a written assessment report for the Minister of Health and Long-Term Care that makes recommendations about any issues relating to the assessment's purposes in objectives 1 and 2 above, including but not limited to the Board's:
   a) governance and administration,
   b) contracts for senior management positions, including contracts for the Chief Financial Officer position or other related positions,
   c) the relationship (if any) between Algoma Medicinal Alliance Limited or any related companies and the Board and its medical Officer of health,
   d) public health leadership and program management,
   e) human resource management, and
   f) quality assurance and risk management.

**RESPONSIBILITIES OF ASSESSOR:**

1. Carry out the assessment of the Board in accordance with the rights, duties and powers of an assessor under s. 82 of the HPPA.

2. Review relevant materials and examine any records or documents of the Board, including but not limited to, financial and bookkeeping records and minutes and by-laws of the Board that is relevant to the assessment.

3. Interview the members of Board, selected staff, current and former Medical Officers of Health for the Board (including those who have served in acting capacities), municipal officials and other key stakeholders.

4. In the event that the Assessor needs to consult with external parties, whether for expert advice, or other purposes, the Assessor must seek prior written approval of the Ministry.

5. Prepare a written report with key findings and recommendations for areas of improvement, including action steps to be considered by the Board, the Ministry of Health and Long-Term Care, and other applicable stakeholders.

6. Determine whether, in your opinion as an assessor under s. 82 of the HPPA, the Board has,

   a) failed to ensure the adequacy of the quality of the administration or management of its affairs; and/or,

   b) failed to comply in any other respect with the HPPA and its regulations.

7. In the event that the Assessor makes findings or recommendations or uncovers information which indicate any possible criminal wrongdoing on the part of any person or persons, the Assessor shall report the findings, recommendations or information to the Ontario Provincial Police (OPP) as appropriate.

**ACCOUNTABILITY:**

Reports to the Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care.

**TIMELINES AND DELIVERABLES:**

The Assessment must be completed within 45 days of the date of the Assessor being appointed. At the end of the 45 day period, the final report must be provided to the Minister of Health and Long-Term Care

# Board of Health for the District of Algoma Health Unit
# Assessment Report – Executive Summary
# June 2015

On February 25, 2015, the Minister of Health and Long-Term Care appointed Mr. Graham Scott as an Assessor under the authority of section 82(1) of the *Health Protection and Promotion Act* (HPPA) to conduct an assessment of the Board of Health for the District of Algoma Health Unit.

Mr. Scott carried out an assessment of the Board of Health for the purposes of assessing governance, including the quality of the management or administration of the affairs of the Board of Health, and ascertaining whether the Board of Health was complying in all other respects with the HPPA and the regulations.

The Assessment was completed within 45 days of the date of appointment. Mr. Scott presented his report to the Minister of Health and Long-Term Care. The report and recommendations have been accepted.

The Assessor notes shortfalls with respect to the governance and oversight provided by the APHB. The public health of local residents in the District of Algoma remains the priority for the Ministry and actions will be taken to ensure that the Board of Health is performing its duties and responsibilities under the *Health Protection and Promotion Act*.

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## Overview of Findings:

In his assessment, Mr. Scott found that the Board of Health for the District of Algoma Health Unit failed to meet its obligations under the HPPA, which has had a negative impact on the operations of both the Board of Health and District of Algoma Health Unit. In summary:

Board of Health

- The Board of Health has failed to ensure the adequate management and administration of its affairs and has not met certain requirements of the HPPA, Public Health Funding and Accountability Agreement (Accountability Agreement), nor the governance expectations under the Ontario Public Health Standards (OPHS).
- The predominant view at the Board of Health is that status quo is satisfactory and that leadership and management issues would improve with a new Medical Officer of Health. This passive approach failed to take into account that the Board of Health had a role to play.

District of Algoma Health Unit

- The public health unit is organizationally weak as staff are unhappy and suffering from poor morale. Failure to address this immediately will lead to increased problems and a weakening of service to its clients.
- Stability and ongoing permanent leadership is urgently required.

Executive Team

- All vacancies should involve thorough and appropriate human resources processes with an emphasis on increased opportunities for internal candidates to advance. The choice of leadership is crucial and a thorough assessment process will be required.

**Board of Health for the District of Algoma Health Unit**
**Assessment Report – Executive Summary**
**June 2015**

Staff

- While staff continue to serve their clients to the best of its ability, there has been a breakdown in communication and sudden changes in management composition and structure, resulting in declining morale. Staff must feel that they are part of the District of Algoma Health Unit team and are governed effectively and with well understood policies and practices.

**Recommendations:**

Mr. Scott's report included four (4) recommendations for the Ministry's consideration as follows:

1. All members of the Board of Health for the District of Algoma Health Unit, whether appointed by the municipalities or the province, except those new members appointed for the first time following the municipal elections in 2014, should step down voluntarily or be removed by the municipalities and the province. It is essential to provide a needed fresh start for the organization.

2. The Board of Health should be a skills-based Board.

3. Municipalities should look carefully at the advantage of appointing members other than Municipal Council Members on the Board of Health for the District of Algoma Health Unit, given the demanding work burden of elected councillors.

4. Two (2) options are proposed for addressing the realignment of governance:
   i. Merge the Board of Health for the District of Algoma Health Unit with the Board of Health for the Sudbury and District Health Unit; or,
   ii. Reorganize the current Board of Health for the District of Algoma Health Unit structure.

**Ministry Actions:**

The Ministry takes the Assessor's report and recommendations very seriously. The Ministry has an interest in ensuring accountability for the expenditure of public funds and ensuring the proper quality of the management or administration of the affairs of all Boards of Health in Ontario.

The Ministry is committed to undertake a review of the Board of Health for the District of Algoma Health Unit's current governance structure immediately and is undertaking a number of steps in this regard.

The option to merge the District of Algoma Health Unit with the Sudbury and District Health Unit will be considered more broadly in the context of the Minister of Health and Long-Term Care's mandate to conduct a review focussing on improving patient outcomes and value for money of all public health units.

## Board of Health for the District of Algoma Health Unit
## Assessment Report – Executive Summary
## June 2015

The Minister of Health and Long Term Care has called for the immediate and voluntary resignation of municipal and provincial members who sat on the Board of Health prior to the 2014 municipal election.

The Ministry will also seek the cooperation and commitment of municipalities within the District of Algoma to ensure Board of Health members who are appointed have the necessary and appropriate skills to exercise and ensure appropriate governance and accountability. A governance consultant will also be hired to work with the municipalities within the District of Algoma to assist with the appointment process.

The Ministry will work expeditiously with the Board of Health for the District of Algoma Health Unit in the recruitment and appointment of a full-time Medical Officer of Health. Once appointed, the Ministry will support the Medical Officer of Health in fulfilling his or her duties under the HPPA.

The Ministry will continue to work with the Association of Local Public Health Agencies (alPHa) to enhance Board of Health member orientation practices and processes to ensure a focus on effective board governance practices for non-profit organizations.

The Ministry will require the Board of Health for the District of Algoma Health Unit to attest that they are in compliance with the requirements as set out in the Ontario Public Health Organizational Standards. The standards include specific requirements around orientation and training of Board of Health members, Board of Health self-evaluation, leadership and trusteeship. Further, the ministry will provide additional tools to support the Board of Health's ability to assess and determine risk, and meet accountability requirements established by the Ministry.

The Ministry will continue to conduct regular follow-up audits of the Board of Health for the District of Algoma Health Unit to ensure compliance with requirements related to financial, operational, and value for money aspects of transfer payment funding.

Algoma
PUBLIC HEALTH
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June 17, 2015

René Lapierre
Chair, Sudbury & District Board of Health
1300 Paris Street
Sudbury, ON P3E 3A3
c/o quesnelr@sdhu.com

Dear Mr. Lapierre,

On behalf of the Board of Health for the District of Algoma Health Unit, I wish to express my gratitude for your support to our Board during this time of transition, and in particular for provision of Acting Medical Officer of Health and Acting Executive Director support.

Both the Acting Medical Officer of Health and the Acting Executive Director have provided solid leadership and support to the Board and to the Health Unit during their tenure with us. The Board is sending this letter as a token of its appreciation and thanks.

Sincerely,

Lee Mason

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

cl

cc: Minister Hoskins, Minister of Health and Long Term Care
Dr. David Mowat, Chief Medical Officer of Health
Roselle Martino, Executive Director Public Health Division

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alPHa
Association of Local
PUBLIC HEALTH
Agencies

# June 2015

# DISPOSITION OF RESOLUTIONS

**alPHa Resolutions Session, 2015 Annual General Meeting**
**Monday, June 8, 2015**
**North Victoria Ballroom, 2nd Floor**
**Marriott Ottawa**
**100 Kent Street**
**Ottawa, Ontario**

## RESOLUTIONS CONSIDERED AT
## June 2015 alPHa Annual Conference

| Resolution Number | Title | Sponsor | Action from Conference |
|---|---|---|---|
| A15-1 | Applying a Health Equity Lens | alPHa Board of Directors | Carried |
| A15-2 | National Universal Pharmacare Program | Haliburton, Kawartha Pine Ridge District Health Unit | Carried as amended |
| A15-3 | Amending Public Pools Regulation 565 | Association of Supervisors of Public Health Inspectors of Ontario | Carried as amended |
| A15-4 | Public Health Support for a Basic Income Guarantee | Simcoe Muskoka District Health Unit | Carried as amended |
| A15-5 | Provincial Availability of Naloxone | Windsor-Essex County Board of Health | Carried as amended |
| A15-6 | Physical Literacy in Educational and Childcare Settings | Chatham-Kent Board of Health | Carried as amended |
| A15-7 | Increasing the Minimum Legal Age for Access to Tobacco Products in Ontario to 21 | alPHa Board of Directors | Carried |

**alPHa RESOLUTION A15-1**

**TITLE:** **Applying a Health Equity Lens**

**SPONSOR:** **alPHa Board of Directors**

WHEREAS alPHa's membership passed resolution A09-5 endorsing the content and recommendations of the World Health Organization Commission on Social Determinants of Health (WHO-CSDH): Call to Action for Ontario Public Health; and

WHEREAS alPHa' Board of Directors has endorsed the attached, *Position Statement on Applying a Health Equity Lens.*

**NOW THEREFORE BE IT RESOLVED** that the Association of Local Public Health Agencies (alPHa) advocate to the Ministry of Health and Long-Term Care for the consistent use of a health equity lens in the Ministry's public health programming, and to continue to promote and support the use of a health equity lens in other parts of the health system;

**AND FURTHER** that alPHa advocate to the Ontario provincial government for a Health in All Policies (HIAP) framework which would include the use of a health equity lens in ministries affecting equitable access to the social determinants of health such as Finance, Children and Youth Services, Community and Social Services, Health and Long-Term Care, Education, Municipal Affairs and Housing, Environment and Climate Change, Economic Development, and Employment and Infrastructure;

**AND FURTHER** that alPHa advocate for other health organizations to incorporate and apply a health equity lens through the use of health equity focused tools in all their activities.

**ACTION FROM CONFERENCE:** **Resolution CARRIED**

alPHa Association of Local PUBLIC HEALTH Agencies

**alPHa RESOLUTION A15-2**

**TITLE:** **National Universal Pharmacare Program**

**SPONSOR:** **Haliburton Kawartha Pine Ridge District Health Unit**

WHEREAS the World Health Organization's Right to Health, which includes essential drugs in the core content of minimum rights and the state is obligated to fulfill the rights; and

WHEREAS in 1964 a national universal pharmacare program to cover the costs of outpatient prescription medications was recommended be included in the national Medicare system by the Royal Commission on Health Services; in 1997 the National Forum on Health recommended a universal first dollar pharmacare program; and in 2002 the Romanow Commission recommended catastrophic drug coverage as a first step towards a pharmacare program and still the Government of Canada has not included pharmacare under the *Canada Health Act*; and

WHEREAS Canada is the only Organization for Economic Co-operation and Development (OECD) country with a universal public health care system that does not provide coverage for prescription medications; and

WHEREAS Canadians pay among the highest per capita spending on prescription drugs of the OECD countries; and

WHEREAS the ability to fill a prescription for medication depends on whether and to what extent a person has access to either a private or public insurance plan or if an individual is able to pay out of pocket if a person has no insurance plan; and

WHEREAS 1 in 10 Canadians are unable to fill a prescription because of cost, which in turn compromises the ability to reach optimal level of health and can drive up health care costs in other areas including more physician visits and hospitalizations; and

WHEREAS the current system is a combination of private and public insurance plans that are expensive, not sustainable and inequitable; and

WHEREAS the Government of Canada has a responsibility under the *Canada Health Act* to protect, promote and restore physical and mental well-being of persons and enable reasonable access to health care services without causing barriers, including financial barriers; and

WHEREAS a national, universal pharmacare program would enable all Canadians access to quality, safe and cost effective medications, improve health outcomes and generate cost savings;

*continued*

**NOW THEREFORE BE IT RESOLVED** that the Association of Local Public Health Agencies (alPHa) urges the Government of Canada and the Province of Ontario to move forward with the development and implementation of a national, universal pharmacare program;

**AND FURTHER** that the Association of Local Public Health Agencies (alPHa) advises the Prime Minister of Canada of this resolution and copies the Ministers of Finance Canada and Health Canada, the Chief Public Health Officer, Leader of the Opposition, Leader of the Liberal Party, Premier of Ontario, Ministers of Finance and Health and Long-Term Care and the Chief Medical Officer of Health and the Council of the Federation;

**AND FURTHER** that the following organizations be copied and asked for their support: Canadian Medical Association, Canadian Nurses Association, Canadian Pharmacists Association, Canadian Life and Health Insurance Association, Ontario Medical Association, and the Registered Nurses Association of Ontario.

**ACTION FROM CONFERENCE:** **Resolution CARRIED AS AMENDED**

**alPHa RESOLUTION A15-3**

**TITLE:** **Amending Public Pools Regulation 565**

**SPONSOR:** **Association of Supervisors of Public Health Inspectors of Ontario**

WHEREAS swimming pools, spas, wading pools and splash pads have been implicated in drownings, fatal and near-fatal injuries and water-borne illness including gastrointestinal disease and skin infections and;

WHEREAS recent waterborne outbreaks have been documented where parasites, for which conventional disinfection is ineffective, have been identified as the causative organism; and

WHEREAS proper filtration and the use of ultra-violet light could provide the necessary protection for public pool users but neither is currently required in legislation; and

WHEREAS drowning is considered to be the second leading cause of preventable death in Canada among children; and

WHEREAS the Office of the Chief Coroner of Ontario of has recommended the implementation of admission standards for public swimming pools to improve surveillance over activities of young children in order to prevent drowning fatalities of young children in public swimming pools; and

WHEREAS the existing enforcement strategies available to public health staff for non-critical regulatory infractions in public pools are unwieldy, time-consuming and not cost-effective; and

WHEREAS this deficiency could be rectified by the provision of short-form wording and set fines; and

WHEREAS existing regulations do not apply to facilities such as wading pools and splash pads ; and

WHEREAS Ontario Regulation 565 (Public Pools) was enacted in 1990 and its requirements have not substantially changed since then;

**NOW THEREFORE BE IT RESOLVED** that the Association of Local Public Health Agencies (alPHa) request that the Ministry of Health and Long-Term Care undertake a review of Ontario Regulation 565 and introduce such amendments as are necessary to address the deficiencies identified in this motion and any others that may arise from this review.

**ACTION FROM CONFERENCE:** **Resolution CARRIED AS AMENDED**

alPHa
Association of Local PUBLIC HEALTH Agencies

**alPHa RESOLUTION A15-4**

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

**SPONSOR:** **Simcoe Muskoka District Health Unit**

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

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

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

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

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

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

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

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

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

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

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

*Continued*

**AND FURTHER** that alPHa request that the federal Ministers of Employment and Social Development, Labour, and Health, as well as the Ontario Ministers Responsible for the Poverty Reduction Strategy, Seniors, Labour, Children and Youth Services, and Health and Long-Term Care, prioritize joint federal-provincial consideration and investigation into a basic income guarantee, as a policy option for reducing poverty and income insecurity and for providing opportunities for those in low income;

**AND FURTHER** that the Prime Minister, the Premier of Ontario, the Chief Public Health Officer, the Chief Medical Officer of Health for Ontario, the Canadian Public Health Association, the Ontario Public Health Association, the Federation of Canadian Municipalities, and the Association of Municipalities of Ontario be so advised.

**ACTION FROM CONFERENCE:** **Resolution CARRIED AS AMENDED**

**alPHa RESOLUTION A15-5**

**TITLE:** **Provincial Availability of Naloxone**

**SPONSOR:** **Windsor-Essex County Board of Health**

WHEREAS approximately 50,000 Ontarians are addicted to opioids; and

WHEREAS opioids may cause fatal overdoses if taken incorrectly; and

WHEREAS 5,935 fatal opioid-related overdoses occur in Ontario between 1991 and 2010; and

WHEREAS opioid-related overdoses account for 12.1% of the deaths among 25-34 year olds and rose from 3.3% of the deaths to 12.1% of the deaths of that population from 1991-2010; and

WHEREAS a harm reduction program to address opioid overdoses is consistent with the requirements of the Ontario Public Health Standards to prevent substance misuse; and

WHEREAS naloxone is a medication that can reverse the symptoms of an opioid overdose, potentially reducing harm; and

WHEREAS naloxone is a medication without additive or abusive properties and has no "street" value; and

WHEREAS several Ontario Public Health Units have successfully implemented their own local naloxone programs, effectively reversing opioid overdoses; and

WHEREAS the provincial Expert Working Group on Narcotic Addiction has recommended that the ministry "increase and sustain the availability of naloxone overdose prevention kits and harm reduction information via public health units across the province"; and

WHEREAS current opioid overdose prevention programs, including those at Public Health Units, are limited in their service to at-risk populations by the types of programs – Public Health Units that manage a core needle Exchange program (NEP), community-based organizations that have been contracted by Public Health Units to manage an NEP, and Ministry-funded Hepatitis C Teams – as well which clients they can serve, i.e., those currently enrolled in an NEP;

**NOW THEREFORE BE IT RESOLVED** that the Association of Local Public Health Agencies requests that the Ministry of Health and Long-Term Care develop and implement a provincial Naloxone Strategy that would include and expand access to Naloxone to a minimum of:

*continued*

- Not-for-profit agencies, Emergency Departments, Correctional Facilities, Paramedics/Emergency Medical Technicians, and organizations that service individuals at risk of opioid overdose,
- Individuals that prescribe to, support and/or care for individuals at risk of opioid overdose, and
- Any individual living in Ontario that is 16 years of age and older and dependent on opioids;

**AND FURTHER** that the Premier of Ontario, the Minister of Health and Long-Term Care, the Associate Minister of Health and Long-Term Care, the Chief Medical Officer of Health for Ontario, Public Health Ontario, the Centre for Addiction and Mental Health, the College of Physicians and Surgeons of Ontario, the Ontario Public Health Association, and the Association of Municipalities of Ontario, the Expert Working Group on Narcotic Addition and the Municipal Drug Strategy Co-ordinator's Network of Ontario be so advised.

**ACTION FROM CONFERENCE:** **Resolution CARRIED AS AMENDED**

**alPHa RESOLUTION A15-6**

**TITLE:** **Physical Literacy in Educational and Childcare Settings**

**SPONSOR:** **Chatham-Kent Board of Health**

WHEREAS less than 10% of Canadian children and youth are meeting minimum recommendations for physical activity and more than one-third were considered overweight or obese in 2009-2011; and

WHEREAS physical inactivity is linked to a number of preventable chronic diseases and is associated with increasing healthcare costs; and

WHEREAS individuals who are physically literate have the knowledge, skills, and attitudes to lead physically active lives; and

WHEREAS the Ontario Ministry of Education is provincially mandated to oversee both publicly-funded education and licensed childcare settings; and

WHEREAS physical literacy is a clearly stated outcome objective of the Health and Physical Education Curriculum, yet it is not currently measured; and

WHEREAS principals report that delivery of the Health and Physical Education curriculum varies significantly depending on the expertise and comfort level of the teacher; and

WHEREAS only 19.9% of Ontario Elementary Schools have a full or part-time specialist teacher assigned to teach health and physical education; and

WHEREAS neither the Ministry of Education nor School Boards currently ensure every child receives 20 minutes of sustained daily physical activity;

**NOW THEREFORE BE IT RESOLVED** that the Association of Local Public Health Agencies request the Ontario Ministry of Education and its stakeholders to provide for the public health, safety, and welfare of all Ontario residents by enhancing the development of physical literacy in educational and childcare settings through:

1. Adopting a mandatory assessment of physical literacy for elementary and secondary students across the province;

2. Ensuring that quality daily health and physical education programming is delivered by health and physical education specialists in all Ontario elementary and secondary schools;

3. Evaluating compliance and enforcing the Daily Physical Activity (Policy/Program Memorandum No. 138) requirement;

4. Providing ongoing staff training related to physical literacy for all teachers, early childhood educators, and childcare providers;

5. Strengthening the Day Nurseries Act/Child Care and Early Years Act to promote and support physical literacy development in licensed childcare settings; and

6. Making health and physical education credits a mandatory requirement for grades 9-12.

**AND FURTHER** that the Premier of Ontario, Minister and Associate Minister of Health and Long Term Care, Minister of Education, Minister of Children and Youth Service, Minister of Tourism, Culture and Sport, the Chief Medical Officer of Health, and the ADM of the Health Promotion Division are so advised.

**ACTION FROM CONFERENCE:** **Resolution CARRIED AS AMENDED**

**alPHa RESOLUTION A15-7**

**TITLE:** **Increasing the Minimum Legal Age for Access to Tobacco Products in Ontario to 21**

**SPONSOR:** **alPHa Board of Directors**

WHEREAS more than 13,000 people die in Ontario from tobacco-related diseases every year, making it the number one cause of death and disease in Ontario; and

WHEREAS scientific studies have concluded that cigarette smoking causes chronic lung disease, coronary heart disease, stroke, cancer of the lungs, larynx, esophagus, mouth, and bladder, and contributes to cancer of the cervix, pancreas, and kidneys; and

WHEREAS The Ontario Government estimates that tobacco-related disease costs Ontario's health care system an estimated $2.2 billion in direct health care costs and an additional $5.3 billion in indirect costs such as time off work each year; and

WHEREAS the age of initiation for tobacco use has been identified as a critical factor in determining use in adulthood, with 90% of adults who become daily smokers having reported first use of cigarettes before reaching 19 years of age, and almost 100 percent reporting first use before age 26; and

WHEREAS Smoking prevalence declined rapidly between 2000 and 2009 among Ontarians aged 15-19, from approximately 1 in 4 to less than 1 in 10, but has remained steady in the 6 years since then; and

WHEREAS The U.S. Institute of Medicine (IOM) committee concluded that increasing the MLA for tobacco products from 19 to 21 will likely result in a 15% reduction in initiation rates of tobacco use by adolescents in the 15 to 17 years age group; and

WHEREAS the alPHa Board of Directors supports the vision of a tobacco-free Ontario and further supports activities that contribute to the realization of that vision; and

WHEREAS Ontario law acknowledges the harms of tobacco use by prohibiting the sale or furnishing of cigarettes, tobacco products or smoking paraphernalia to minors; and

WHEREAS The Smoke-Free Ontario Act already prohibits the sale or supply of tobacco to a person who appears to be less than 25 years old unless he or she provides proof of age;

**NOW THEREFORE BE IT RESOLVED** that the Association of Local Public Health Agencies call on the Ontario Government to amend the Smoke-Free Ontario Act to prohibit the sale and supply of tobacco to a person who is less than 21 years old.

**ACTION FROM CONFERENCE:** **Resolution CARRIED**

# 2014 Snapshot of Public Health

## Sudbury East | Sudbury & District Health Unit


Sudbury & District Health Unit
Service de santé publique


**The Sudbury East area** is comprised of four very vibrant communities – each led by engaged municipal leaders working to ensure area residents and visitors experience the best that the region has to offer. In May 2015, a number of these Sudbury East municipal leaders met with the Sudbury & District Health Unit (SDHU) to explore public health issues and opportunities for the region.

This snapshot of public health was developed in follow up to the May meeting. It provides a brief overview of the public health system and the SDHU, and highlights public health activities in Sudbury East during the 2014 calendar year.

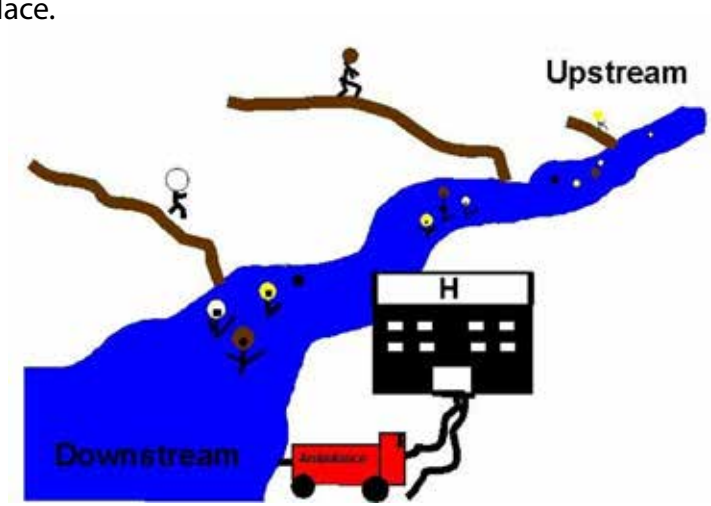
In the sections that follow, readers will find a snapshot of public health activities – highlighting the public health work of the SDHU that is done in collaboration with the public, community agencies, and municipalities. At the May meeting, municipal leaders told the SDHU that such an overview would be helpful in sharing the local public health story and in informing people from the area about how their public health dollars are being spent to promote and protect the health of everyone.

The Sudbury & District Health Unit is proud to work in partnership with the following Sudbury East communities:

- The Corporation of the Municipality of St. Charles,
- The Municipality of French River,
- The Municipality of Markstay-Warren,
- The Corporation of the Municipality of Killarney.

## Public Health in Ontario

Public Health works "upstream " to promote and protect health and prevent people from becoming sick. If we can imagine the health system as a continuum, the treatment services of hospitals would be at one end and public health would be at the other, working to keep people from needing hospitals and other health care services in the first place.




Like with fire, police, and education services, public health is a "public good": publicly funded and always there for us. Public health works behind the scenes to promote our health (e.g. helping municipal councils make bylaws for healthier food options in recreational centres) and front and centre to protect our health (e.g. issuing boil water advisories when drinking water is unsafe).

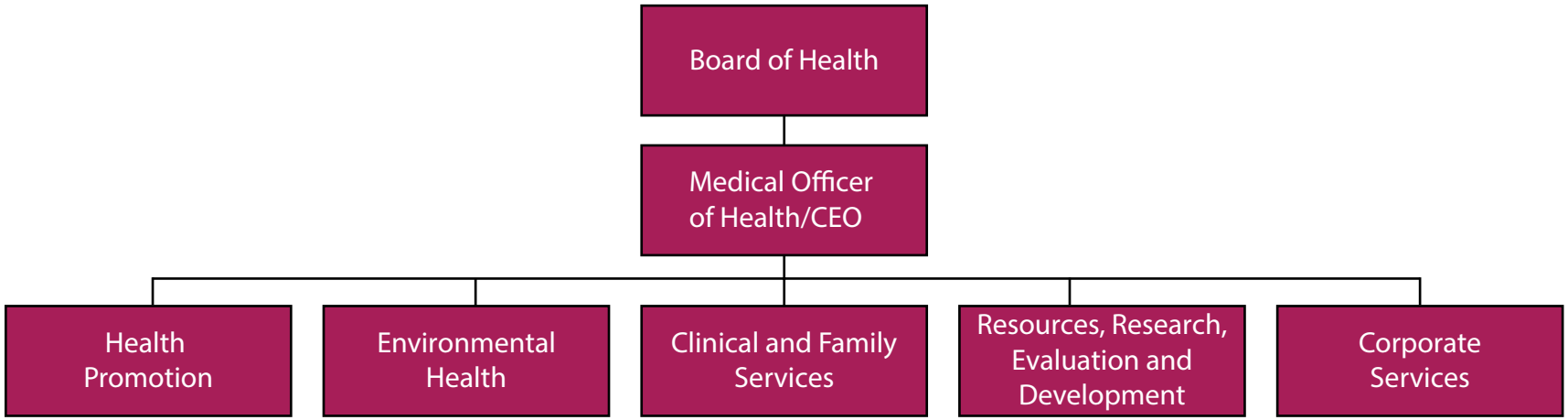
In Ontario, there is a provincial network of 36 non-profit public health units, all responsible for delivering standard public health programs and services, and for upholding the public health law. About every 25¢ of local municipal funding for public health is matched by 75¢ from provincial funding. The law specifies that municipal funding to public health is on a per capita basis.

The 36 health units, together with provincial ministries and agencies, primary health care providers and laboratories, comprise the formal public health system of the province.

## Your Local Public Health Unit—Our Structure

The SDHU is governed by an autonomous board of health. Sudbury & District Board of Health members are determined by the legislation and the membership includes municipally elected representatives and citizen representatives from across the SDHU area. Sudbury East is represented by one individual who has historically been a local mayor or councillor.

The Sudbury & District Health Unit works hard to meet the needs of the diverse population we serve and to meet our legislative requirements. To do this, the SDHU is organized into five divisions each reporting to the Medical Officer of Health.




### Did you know?

The SDHU employs a number of public health professionals to carry out its mission and public health mandated programs. These include but are not limited to a public health physician (Medical Officer of Health), public health nurses, public health inspectors, dental educators and hygienists, dietitians, and epidemiologists. We also employ a number of technical and support staff who assist in the operational functions of the organization and the work we do in the various communities throughout Sudbury East.

# Public Health Activities in Sudbury East in 2014

The SDHU actively supports health in Sudbury East by providing services to ***protect*** and to ***promote*** health. The following is a snapshot of these Sudbury East public health activities that occurred in 2014. Together, they paint a picture of the variety and volume of local public health work.

## Health Protection

The SDHU delivers a number of services designed to protect the health of its communities. These services include for example, immunizations, health hazard investigations, sexual health services, food safety, and safe water initiatives. The snapshots in the section below highlight the health protection services provided by the SDHU to Sudbury East communities in 2014.

Health Protection
Health Protection
Health Protection

### Control of Infectious Diseases and Infection Control

- Cold chain visits and provision of publicly funded vaccines to all health care providers in Sudbury East
- Provision of school immunizations:
    - Hepatitis B, Meningitis, and Human Papillomavirus vaccines administered at school clinics at the 6 area elementary schools in September, December, May, and June
    - Adacel vaccine (teenage booster) offered at the one area secondary school in February and March
    - Immunization at the Sudbury East district office location upon request (approximately 5 requests per year for this service)
- 4 sporadic cases investigated
- 13 inspections of day nurseries and personal service settings

## Sexual Health Program

- Sexual health clinic held every 5 weeks at École secondaire de la Rivière-des-Français
- Wellness Fair held in March 2014 with 70 participants attending and receiving information about our services
- Presentation in June 2014 at Alpha en partage (local adult learning centre)

## Healthy Babies, Health Children Program

- 403 home visits
- 34 families followed
- 38 referrals to community services

## Dental Services

- 9 schools visited for dental screening program, 7 of which received a second visit for the preventative and follow-up program
- Families of referred children offered assistance and preventive care through the Children in Need of Treatment Program (CINOT)

## Food Safety

- 190 inspections of food premises
- 12 food complaints
- 18 food recalls with follow-up response
- 17 special event food permits
- 9 consultations/inquiries

# Health Protection

Health Protection
Health Protection

## Health Hazards

- 10 health hazard complaints investigated (includes: mould, insects/cockroaches/birds, housing complaints, rodents/vermin, sewage backup spills, heating complaints, garbage and waste, miscellaneous complaints)
- 1 consultation/inquiry

## Vector Borne Diseases, Rabies, and Lyme Disease

- 7 mosquito traps set
- 149 mosquitoes trapped
- 2 pools tested for Eastern Equine Encephalitis (EEE) or West Nile virus (WNv)
- 9 animal exposures/0 animals submitted
- 1 tick submitted for testing

## Drinking Water

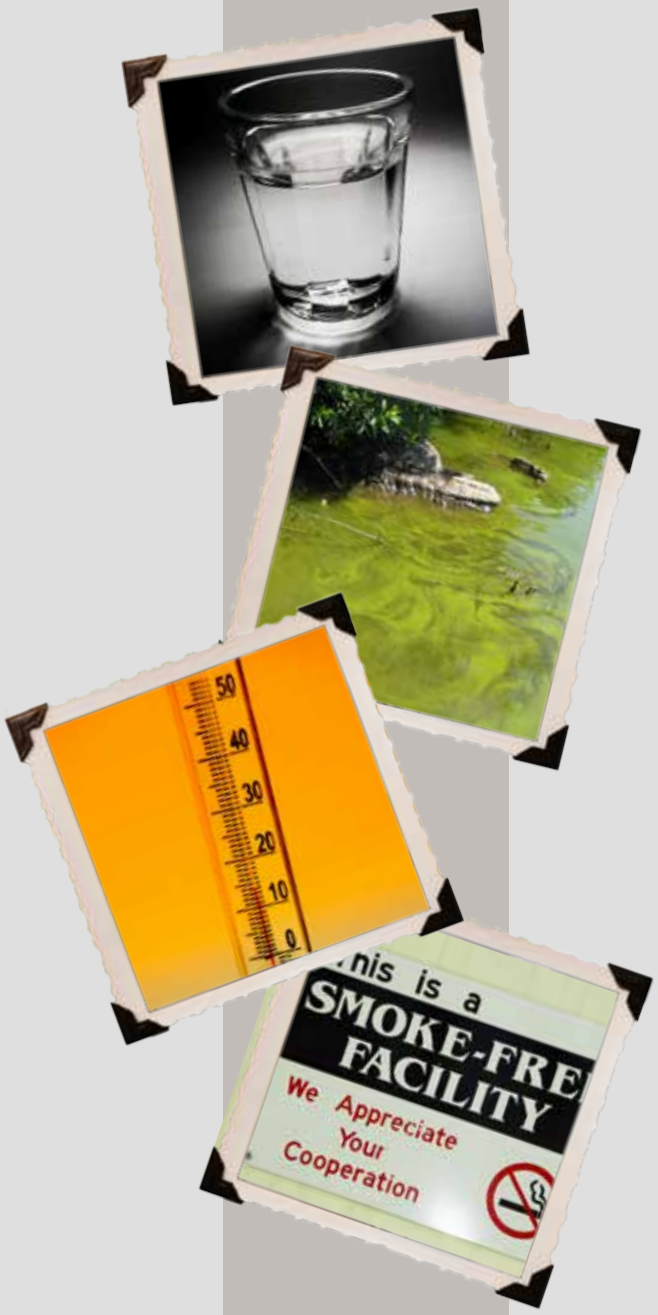
- 17 boil water advisories/orders
- 1 drinking water advisory/order
- 2 blue-green algae advisories
- 233 adverse drinking water reports investigated

## Small Drinking Water Systems

- 93 small drinking water systems (SDWS)
- 27 SDWS risk assessments completed
- 27 SDWS directives completed
- 1 charge issued

## Part 8 Land Control (under Ontario Building Code)

- 268 inspection activities
- 66 sewage system permits processed




## Recreational Water and Safe Water

- 1 beach inspected weekly
- 6 beach inspections/35 bacteriological samples
- 2 public swimming pool and spa inspections
- 3 bacteriological samples
- Presentations to lake stewardship committees provided upon request

## Extreme Weather Alerts

- "Beat the Heat" information packages distributed to local schools, daycares, physicians and other health professionals

## Smoke-Free Ontario Act Enforcement

- Inspections of all tobacco vendors and secondary schools for compliance with the Smoke-Free Ontario Act conducted
- 1 sales/supply charge

# Health Promotion

Public health also plays a key role in the promotion of health and prevention of chronic diseases and injuries. We do this through the delivery of a number of health promotion programs and services including for example, healthy eating and healthy weights, falls prevention, substance misuse and tobacco use prevention, and child and reproductive health. This section includes Sudbury East statistical and narrative information about a broad range of health promotion programs provided in 2014 by the SDHU. Many of these programs are delivered in collaboration with important partners such as other service agencies, community groups, schools, and municipalities.



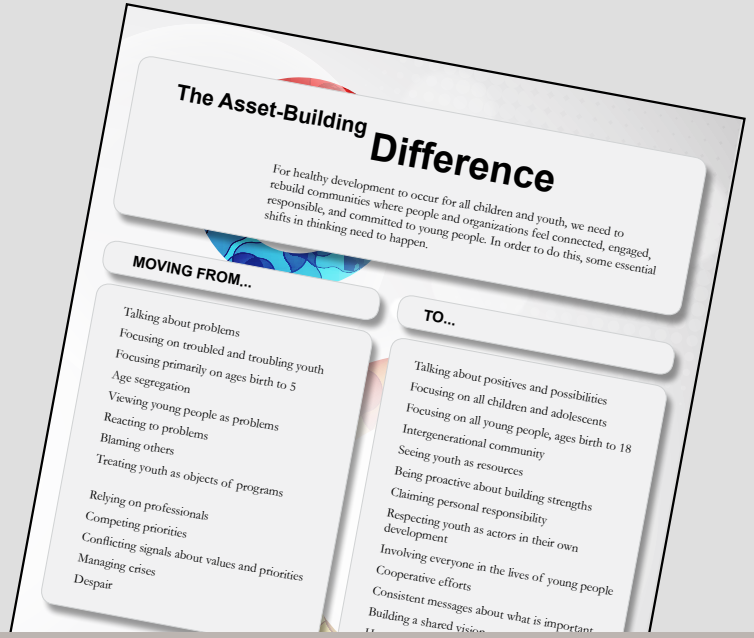
## Tobacco Use Prevention

In May 2014, the Manitoulin-Sudbury District Services Board (DSB) passed a Smoke-Free Housing policy, which came into effect in January 2015. The Sudbury & District Health Unit provided support to the implementation of the policy by delivering education and information sessions to all the DSB housing units. A total of three presentations were provided to 32 housing unit residents. Smoking cessation resources and local support for quitting smoking were particularly highlighted by public health staff. Additional tobacco use prevention and cessation efforts for Sudbury East area residents include the distribution of information to workers through a newsletter, and the promotion and implementation of campaigns targeted to students and young adults (e.g. wouldrather . . ., Leave the Pack Behind), and to adults (e.g. Driven to Quit).

- 3 presentations on smoking cessation to 32 housing unit residents
- Distribution of smoking cessation information throughout the district
- Promotion of local and provincial smoking cessation campaigns and resources for community members

## School Health

Over the past three years, the SDHU's Sudbury East district office has invested in the development of a strong working relationship with École secondaire de la Rivière-des-Français. Results from an initial assessment completed by students at the school were used to plan and implement various programs to work to enhance the school's resiliency levels. To increase community cohesiveness and the relationship between the students and their community, local seniors have had numerous opportunities to work alongside the students in various projects, such as the creation of historical videos about our ancestors in the French River area. The approach has also been introduced to local partners such as the Centre de santé communautaire de Sudbury Est (Sudbury East Community Health Centre), the French River Nurse Practitioner Led Clinic, the OPP, and the Municipal Economic Development staff.




- Strong partnership with local secondary school, with a focus on resiliency and community cohesiveness
- Strengths-based approach promoted via training for school staff and local partnerships

ealth Promotion

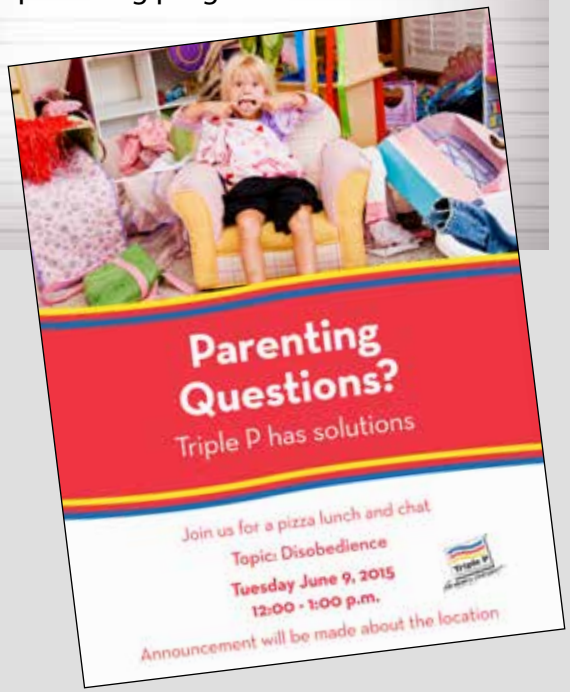
Health Promotion

## Did you know?

In order to meet the unique need of the communities within Sudbury East, the SDHU has aligned its highly skilled and trained staff to provide quality public health services. The SDHU has an office in St. Charles from which two full-time, bilingual public health nurses provide area health promotion and family health programming. Other services are provided to Sudbury East where and when needed by public health inspectors and pubic health nurses who travel from the SDHU main office in the City of Greater Sudbury.

## Triple P Parenting Program

The SDHU actively participates in the work of the local Triple P program, an evidence-based parenting program offering group and individual support and advice for parents. Health Unit staff have fostered links with the child and family social worker and Community Care Access Centre mental health and addictions nurses. Programming is coordinated and delivered based on service provider requests and parent needs. Additionally, members of the Sudbury East Triple P group attempt to address barriers for parents wanting to access parenting programs.




- Participation in quarterly Sudbury East Triple P meetings
- Close to 20 referrals to the Triple P program from local community agencies
- Collaboration with Our Children Our Future to offer car seat safety, physical literacy, and healthy eating programming in Sudbury East

Health Promotion
Health Promotion
Health Promo

## Prevention of Substance Misuse

In efforts to reduce injury and illness related to alcohol use, a "Safer Bars" training session was offered to 14 participants from across the region in Markstay-Warren. Participants included a municipal Chief Administrative Officer, a recreation staff, an alcohol establishment owner, employees of an alcohol establishment, community event coordinators, municipal volunteers, and proprietors. In addition, Canada's Low-Risk Alcohol Drinking Guidelines (LRADG) were promoted through a display and the dissemination of brochures.

- "Safer Bars" training session offered to 14 participants
- Promotion of Low-Risk Alcohol Drinking Guidelines through a variety of methods

## Healthy Eating

In the fall 2014, SDHU staff held two consultations with community members and partners in municipalities of Markstay-Warren and St. Charles, and French River regarding community food programming, such as emergency food programs (i.e. food banks) and community-based programs (i.e. community kitchens, and community gardens). As a result of these consultations, programs and linkages have been enhanced in various communities throughout Sudbury East.

Building on the community's interest and readiness to minimize the barriers to obtaining fresh produce, the SDHU has worked collaboratively with volunteers from Markstay-Warren and the health promoter from the French River Nurse Practitioner-Led Clinic in Alban to implement the Good Food Box (GFB) Program in Sudbury East, with host sites in Markstay, Warren, Noëlville, and Alban.


SDHU staff promoted the GFB program through local media outlets in Sudbury East. Additionally, SDHU staff actively supported efforts to secure funding for the now-established, French River Community Garden, and remain dedicated partners on the sub-committee Villages amis des aînés, amis de tous – French River Community Garden.

In the No Time to Wait: Healthy Kids in the Sudbury and Manitoulin Districts Report Card, SDHU committed to working more closely with municipal leaders to improve access to nutritious food and beverage choices in municipally-funded venues. Recognizing the influence of the food environment on healthy eating, the municipalities of Markstay-Warren and French River demonstrated their leadership by supporting an SDHU-led food options survey of patrons and vendors in local recreation facilities.

- 2 consultations on food programming
- Implementation of Good Food Box program with 4 host sites
- Establishment of a community garden
- Implementation of a food options survey for recreation facilities

Health Promoti
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# Health Promotion

## Healthy Communities

With approval from local municipal staff, and funding through the Healthy Communities Fund, the SDHU helped coordinate and conduct Rural Active Living Assessments (RALA) in the Municipalities of Markstay-Warren and Killarney. RALAs assist rural communities (population of 10,000 or less) by assessing the physical environment and amenities, town characteristics, and community programs and policies. The tool enables communities to identify areas of improvement to better support active living among residents. Staff met with representatives from the Municipality of Killarney as well as with community leaders from Markstay-Warren to review their area specific RALA results and recommendations, and to explore several options for moving forward. Municipalities have used the RALA findings to advocate for and implement practical improvements to enhance local recreation infrastructure and programming, and SDHU staff have continued to assist with these efforts.

SDHU staff provided seven letters of support for various community-led recreation grant applications, including the French River Active Parks Association's effort to build a community splash pad, and the Markstay Revitalization Committee's efforts to construct a permanent outdoor skating rink.

In order to support local recreation efforts, the Health Unit, through the Healthy Community Fund, financially supported the attendance of municipal recreation leaders from Killarney, Markstay-Warren and St. Charles at the Northeastern Ontario Recreation Association (NeORA) Educational Forum and Trade Show in Sturgeon Falls.

- Rural Active Living Assessments in 2 communities
- 7 letters of support for recreation grant applications
- Support for 4 municipal leaders to participate in NeORA Educational Forum and Trade Show

## Summary

The Sudbury & District Health Unit is part of a provincial system of public health that works "upstream" to promote health and prevent disease. Locally, the SDHU provides a broad range of programs and services in collaboration with local community partners and community members throughout the Sudbury and Manitoulin districts and the City of Greater Sudbury.

This snapshot of public health was developed at the request of Sudbury East municipal leaders in order to provide a picture of SDHU activities in Sudbury East during the 2014 calendar year. The variety and volume of programming to meet local needs is impressive.

The Sudbury & District Health Unit is grateful to the leadership of the following Sudbury East communities for their keen interest in public health in their communities:

- The Corporation of the Municipality of St. Charles
- The Municipality of French River
- The Municipality of Markstay-Warren
- The Corporation of the Municipality of Killarney

Sudbury & District Health Unit staff is passionate about their work and keen to work with partners to support health and ensure opportunities for health for all throughout Sudbury East and beyond!

### Did you know?

Public health staff can be reached at any time from 8:30 to 4:30, Monday to Friday through main office for routine business, and are available 24/7 for after-hours emergencies at 705.688.4366.

Sudbury & District Health Unit
Service de santé publique

www.sdhu.com

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SDHealthUnit

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TBDHU.COM

April 13, 2015



Dr. Penny Sutcliffe
Sudbury & District Health Unit
1300 Paris Street
Sudbury Ontario P3E 3A3

**Re: Northern Ontario Evacuation of First Nation Communities**
**Resolution 50-2015**

Dear Dr. Sutcliffe,

Annually, many of the First Nation Communities in northern Ontario and the James Bay coast face the reality or possibility of forced evacuation and temporary relocation of many of their vulnerable citizens for periods of time due to the risks of forest fires and flooding.

The existing Emergency Management Ontario process of dealing with this annual event continues to prove difficult to undertake on a reactive basis. The Thunder Bay District Board of Health in its March 18th, 2015 meeting passed the attached resolution calling on the Premier of Ontario and specific members of cabinet to urgently address this matter and to seek of more proactive, planned and resourced facilitation of such evacuations.

The resolution proposes that the planned allocation of resources to receptive municipalities in northern Ontario in consultation with First Nation leadership will ensure the safety and community infrastructure of evacuated or partially relocated First Nation communities and by having quality evacuation centres in pre-planned receptive municipalities, community infrastructure will help to ensure the ongoing health and safety of their most vulnerable citizens.

Experience over the past few years has not been positive and has resulted in large expenditure of resources. Investment up front by the federal and provincial government of pre-selected host northern municipalities will in the long run be both cost saving and reduce health care system costs and ensure quality care of the citizens of effected communities.

The consideration and support of this resolution by your *council/board* is requested and to encourage the provincial government to review existing protocols and plans to ensure a better and safer First Nation evacuation/relocation process.

Yours truly,

Chair
David C. Williams MD, MHSc, FRCPC(C)
Medical Officer of Health
P: (800) 294-6630
F: (807) 625-5973

Enclosure

\ktd

Thunder Bay District Health Unit

# Board of Health Resolution

MOVED BY: Ms. M. Harding SECONDED BY: Mr. B. Kamphof

SOURCE: TBDHU Board of Health DATE: March 18, 2015 **Page 1 of 2**

RESOLUTION NO.: 50-2015

ITEM NO.: 8.4

| X | CARRIED | X | AMENDED | | LOST | | DEFERRED/ REFERRED |
|---|---|---|---|---|---|---|---|

CHAIR

**RE: Report No. 18-2015 (Medical Officer of Health)**
**Community Evacuation Resources Northwestern Ontario**

THAT with respect to Report No. 18 – 2015 (Medical Officer of Health), we recommend that:

WHEREAS the frequent evacuation and relocation of large parts of various First Nation communities in Northwestern Ontario and along the James Bay Coast continued to be required due to seasonal flooding and the risk of forest fires that occurs practically on an annual basis;

AND WHEREAS the current methods requiring the cooperation of many different components of the provincial, federal, municipal, health care and First Nation communities and their respective health services and programs is too complicated to be undertaken on a sudden case by case demand basis;

AND WHEREAS the uniqueness of each First Nation's community infrastructure is critical for the ongoing care of its elderly, peripartum, mental health and drug addiction treatment community members;

AND WHEREAS an investment in resources and planning for a designated site(s) in northwestern Ontario could greatly improve the quality, efficiency and cultural acceptance of temporary community relocation;

AND WHEREAS the Joint Emergency Management Steering Committee (JEMS) had produced an Ontario Mass Evacuation Plan for the Far North in 2012 the remaining plans for the near North and Southern Ontario are still to be developed;

AND WHEREAS there is uncertainty if the Joint Emergency Management Steering Committee has met in the past year, produced the outstanding plans or reviewed the existing Far North plan;

THEREFORE BE IT RESOLVED THAT with respect to report No. 18 – 2015 (Medical Officer of Health) the Thunder Bay District Board of Health requests the Government of Ontario, the Premier of Ontario, the Minister of Health and Long Term Care, the Minister of Community Safety and Correctional Services and the Minister of Aboriginal Affairs to urgently review and reappoint a current Joint Emergency Management Steering Committee with membership updated to represent key stakeholders;

AND THAT the Joint Emergency Management Steering (JEMS) Committee as a first mandate review on an urgent basis the previously passed Ontario Mass Evacuation Plan for the Far North (2012) to ascertain its effectiveness in dealing with the annual threat and reality of First Nation Community Evacuation in the Northern Ontario;

AND THAT the JEMS committee review and recommend a request for proposals from Municipal partners for the procurement, implementation and ongoing maintenance of permanent resources, including facilities that would be culturally and community acceptable for the evacuation/relocation of First Nation Communities during emergency situations or needs;

AND THAT this resolution be forwarded to the Honourable Michael Gravelle Minister of Northern Development and Mines, and the Honourable Bill Mauro, Minister of Natural Resources.

*FOR OFFICE USE ONLY --- RESOLUTION DISTRIBUTION*

| | *TO:* | *INSTRUCTIONS:* | *TO:* | *INSTRUCTIONS:* |
|---|---|---|---|---|
| *1* | Dr. Williams | | | |
| *2* | K. Allan | | | |
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April 10, 2015

Honourable Kathleen Wynne
Premier of Ontario
795 Eglinton Avenue East, Unit 101
Toronto, ON N4G 4E4

Dear Premier Wynne,

**Re: Community Evacuation Resources Northwestern Ontario: "Thunder Bay District Board of Health Resolution 50-2015"**

The Board of Health for the District of Thunder Bay urgently requests your office to address the attached resolution dealing with the ongoing lack of resources and infrastructure to ensure the safe, efficient and effective temporary relocation of First Nation communities in Northwestern Ontario and the James Bay coast when they face the environmental and weather related threats this spring resulting in forest fires and flooding.

Ongoing climate change and the limited amount of snowfall in Northwestern Ontario have raised the level of concern and probability of more evacuations this spring and early summer. Over the past quarter of a century there have been evacuations of one or more of these communities annually with only a few years when no evacuations occurred. Thus the planning should move from being reactive only, to being proactive.

The province through the passing and amendment of the Emergency Management and Civil Protection Act, R.S.O. 1990 (EMPCA) the advent of Emergency Measures Ontario (EMO), the Provincial Emergency Operations Centre (PEOC), the creating of the Medical Emergency Operations Centre (MEOC) has created provincial resources to deal with urgent and sudden emergencies in the province of Ontario supported by the creation of Emergency Operations Committees (EOC) in the municipalities of Ontario.

In recognition of the uniqueness of First Nation community evacuations, its cross jurisdictional challenges with the Federal government and First Nation leadership sought to develop a more coordinated and facilitated approach to deal with this

unique and all too frequent event(s) created the Joint Emergency Management Steering (JEMS) Committee co-chaired (according to existing Terms of Reference on the Government web page) Emergency Management Ontario and Northern Affairs Canada. Attempts to get the updated list of committee members and minutes over the past year have not been readily available.

The JEMS committee under its Terms of Reference was responsible to develop and maintain the Ontario Mass Evacuation Plans (OMEP) three components. Thus far only the Far North plan has been posted and it is uncertain if the other two plans have been developed. Furthermore it is uncertain if the original Far North Plan has been evaluated or reviewed since its approval in 2012.

Experience in the past two years has raised increasing concerns about the reactive component of the OMEP for the Far North noting that the rapid search for receptive municipalities is becoming more difficult. The impact of this uncertainty and changing sites negatively effects community infrastructure with its dismantling there is a raising of health concerns/risks for their most vulnerable populations (elderly, chronically ill, mental health clients and peripartum mothers and newborns) and resulting in extensive costs of moving community members to and from various locations around the province. Furthermore many communities in northwestern Ontario are undergoing community wide detoxification of many members who were addicted to prescribed opioids with programs approved in the past by Health Canada and prescribed by various health agencies. A quality and safe relocation of the community involves more than just getting people out of the community. While their homes are at risk their collective households should be considered even more valued.

The Board of Health for the Thunder Bay District is asking the government of Ontario to urgently reconvene the JEMS committee for the purpose of reviewing the performance of the OMEP for the Far North for the purpose of establishing a more pro-active, preventive and culturally acceptable working relationship with selected municipalities in northwestern and northeastern Ontario.

Such agreements including consultation with First Nation/Tribal Councils and the Federal agencies should include the shared resourcing of such municipalities with the finances, facilities and services to permit a quality, effective and efficient temporary relocation of First Nation communities that would not only prevent injury but also maintain levels of community and vulnerable citizen wellness during such natural events, that will unfortunately probably only increase in frequency with the effects of climate change.

Yours respectfully,

David C. Williams MD, MHSc, FRCPC(C)
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Enclosure

cc. Hon. E. Hoskins, Minister of Health and Long Term Care
Hon. Y. Naqvi, Minister of Community Safety and Correctional Services
Hon. D. Zimmer, Minister of Aboriginal Affairs
Hon. M. Gravelle, Minister of Northern Development and Mines
Hon. B. Mauro, Minister of Natural Resources and Forestry
Boards of Health and Medical Officers of Health of Northern Ontario
Municipal Councils of the Thunder Bay District

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**NORTHERN ONTARIO EVACUATIONS OF FIRST NATIONS COMMUNITIES**

**MOTION:** **WHEREAS the evacuation and relocation of residents of a number of First Nations communities in Northwestern Ontario and along the James Bay Coast, is required on a close to annual basis due to seasonal flooding and risk of forest fires; and**

**WHEREAS a safe, effective, and efficient temporary community relocation is challenging within the current reactive model; and**

**WHEREAS a proactive, planned and adequately resourced evacuation system would ensure the maintenance of quality evacuation centers in pre-selected host municipalities, as well as appropriate infrastructure to ensure the health and safety of evacuees in a culturally acceptable manner; and**

**WHEREAS the Thunder Bay District Board of Health passed a motion on March 18, 2015, and has submitted a letter dated April 10, 2015 to the Honourable Kathleen Wynne requesting that the provincial government address the ongoing lack of resources and infrastructure to ensure the safe, efficient and effective temporary relocation of First Nations communities in Northwestern Ontario and the James Bay coast when they face environmental and weather related threats in the form of seasonal flooding and forest fires;**

**THEREFORE BE IT RESOLVED THAT the Sudbury and District Board of Health support the Thunder Bay District Board of Health's resolution 50-2015 dated March 18, 2015; and**

**FURTHER THAT a copy of this motion be forwarded to the Premier of Ontario, Ministers responsible for Health and Long-Term Care, Community Safety and Correctional Services, Aboriginal Affairs, Northern Development and Mines, Natural Resources and Forestry, local area Members of Provincial Parliament and all Ontario Boards of Health.**