

Sudbury & District Board of Health - Regular Meeting - November 19, 2015

Sudbury & District Board of Health - Regular Meeting - ADD DATE

1. CALL TO ORDER

-

Page 7

2. ROLL CALL

-

Page 8

3. REVIEW OF AGENDA / DECLARATION OF CONFLICT OF INTEREST

Declarations of Conflict of Interest

Page 9

Nov Board Agenda

Page 10

4. DELEGATION / PRESENTATION

- i) Achieving Healthy Weights in the Sudbury and Manitoulin Districts
Tracey Weatherbe, Manager, Health Promotion and Sandra Laclé, Director, Health Promotion

5. CONSENT AGENDA

- i) Minutes of Previous Meeting

a. Sixth Meeting - October 15, 2015

Page 16

- ii) Business Arising from Minutes

- iii) Report of Standing Committees

a. Board of Health Finance Standing Committee Meeting Notes, November 2, 2015

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- iv) Report of the Medical Officer of Health / Chief Executive Officer

MOH/CEO Report, Nov 2015

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v) Correspondence

a. Enforcement of the Immunization of School Pupils Act (ISPA)

Sudbury & District Board of Health Motion #25-15

Letter from the Middlesex-London Health Unit to the Minister of Health and Long-Term care dated October 15, 2015 Page 45

b. Healthy Babies Healthy Children (HBHC) Program

Sudbury & District Board of Health Motion #28-15

Letter from the Middlesex-London Health Unit to the Minister of Children and Youth Services and the Minister of Health and Long-Term Care dated October 15, 2015 Page 46

Letter from the Wellington-Dufferin-Guelph Public Health to the Minister of Children and Youth Services dated November 4, 2015 Page 47

c. Northern Ontario Evacuations of First Nations Communities

Sudbury & District Board of Health Motion #32-15

Letter from the Perth District Health Unit to the Premier of Ontario dated October 26, 2015 Page 51

Letter from the Algoma Public Health to the Premier of Ontario dated October 28, 2015 Page 52

d. Ministry of Health and Long-Term Care One-Time Funding for 2015-16 re Panorama

Letter from the Minister of Health and Long-Term Care dated October 30, 2015 Page 53

e. Reinstatement of the Long-Form Census

The Globe and Mail Article, November 5, 2015 Page 54

The Star Article, November 5, 2015 Page 56

Letter of Congratulations from the Sudbury & District Health Unit to the Prime Minister of Canada dated November 9, 2015 Page 59

f. Amendments to the Ontario Public Health Standards Protocols

Memo from the MOHLTC to Board of Health Chairs dated October 26, 2015 Page 61

Letter from the MOHLTC to the Board of Health Chairs dated October 14, 2015 Re: Reporting of Infection Prevention and Control (IPAC) lapses Page 64

g. Price Report

Letter from the Association of Local Public Health Agencies (aLPHa) Board President to the Minister of Health and Long-Term Care dated October 20, 2015 Page 65

h. Nutritious Food Basket

Letter from the Wellington-Dufferin-Guelph Board of Health to the Minister Responsible for the Poverty Reduction Strategy/Deputy Premier dated November 4, 2015 Page 67

i. Syrian Refugee Crisis

Letter from the Minister of Health and Long-Term Care dated Nov 12, 2015 Page 69

vi) Items of Information

a. aLPHa Information Break

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November 3, 2015 Page 72

b. Times Colonist: Trevor Hancock: How we keep Canada healthy is a great story, October 28, 2015 Page 74

c. Sudbury Star article: City (of Greater Sudbury) gets bad grade for health, October 25, 2015 Page 76

d. SDHU's 2015 Flu Shot Clinics Page 78

e. Remarks from the Minister of Health and Long-Term Care to the 2015 HealthAchieve Conference Page 79

MOTION: Approval of Consent Agenda Page 87

6. NEW BUSINESS

i) Assessor's Report: Algoma Public Health

SDHU's Review of the Assessors Report on Algoma Public Health Unit Page 88

Graham Scott's Assessors Report on Algoma Public Health Unit, April 24, 2015 Page 92

MOHLTC's Action on Assessor's Report, June 2015 Page 148

ii) Public Health Funding

Letter and Resolution from the Association of Local Public Health Agencies (aLPHa) Board to the Minister of Health and Long-Term Care dated November 3, 2015 Page 151

Letter from the Leeds, Grenville & Lanark District Health Unit to the Minister of Health and Long-Term Care dated October 22, 2015 Page 156

Letter from the Elgin St. Thomas Public Health to the Minister of Health and Long-Term Care dated November 2, 2015 Page 158

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iii) 2016 Cost-Shared Budget

Briefing Note from the Sudbury & District Health Unit's Medical Officer of Health and Chief Executive Officer dated November 12, 2015 Page 161

Appendix A: 2016 Budget Principles Page 168

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RISE AND REPORT

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iv) Cannabis

Centre for Addiction and Mental Health Cannabis Policy Framework, October 2014, Executive Summary Page 178

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MOTION: Cannabis Regulation and Control: Public Health Approach to Cannabis Legalization Page 182

v) Smoke-Free Multi-Unit Housing

Northwestern Health Unit Motion 88-2015 dated October 23, 2015 Page 183

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vi) Staff Appreciation Day

Briefing note from the Medical Officer of Health and Chief Executive Officer dated November 12, 2015 Page 187

MOTION: Staff Appreciation Day Page 189

vii) Annual Board Self-Evaluation

7. ADDENDUM

MOTION: Addendum

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8. ANNOUNCEMENTS / ENQUIRIES

For completion

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9. ADJOURNMENT

MOTION: Adjournment

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The Chair will call the meeting to order and welcome members.

Board of Health attendance is taken and recorded.

The Chair will ask Board members whether there are any conflicts of interest.

This is an opportunity for Board members to announce a conflict which would then eliminate the individual(s) from any discussion on that topic.

**AGENDA – SEVENTH MEETING
SUDBURY & DISTRICT BOARD OF HEALTH
BOARDROOM, SECOND FLOOR, SUDBURY & DISTRICT HEALTH UNIT
THURSDAY, NOVEMBER 19, 2015 - 1:30 P.M.**

- 1. CALL TO ORDER**
- 2. ROLL CALL**
- 3. REVIEW OF AGENDA / DECLARATIONS OF CONFLICT OF INTEREST**
- 4. DELEGATION / PRESENTATION**
 - i) Achieving Healthy Weights in the Sudbury and Manitoulin Districts**
 - Tracey Weatherbe, Manager, Health Promotion Division
 - Sandra Laclé, Director, Health Promotion Division
- 5. CONSENT AGENDA**
 - i) Minutes of Previous Meeting**
 - a. Sixth Meeting – October 15, 2015
 - ii) Business Arising From Minutes**
 - iii) Report of Standing Committees**
 - a. Board of Health Finance Standing Committee Meeting Notes, November 2, 2015
 - iv) Report of the Medical Officer of Health / Chief Executive Officer**
 - a. MOH/CEO Report, November 2015
 - v) Correspondence**
 - a. Enforcement of the Immunization of School Pupils Act (ISPA)**

Sudbury & District Board of Health Motion #25-15

 - Letter from the Middlesex-London Health Unit to the Minister of Health and Long-Term Care dated October 15, 2015
 - b. Healthy Babies Healthy Children (HBHC) Program**

Sudbury & District Board of Health Motion #28-15

 - Letter from the Middlesex-London Health Unit to the Minister of Children and Youth Services and the Minister of Health and Long-Term Care dated October 15, 2015
 - Letter from the Wellington-Dufferin-Guelph Board of Health to the Minister of Children and Youth Services dated November 4, 2015

c. Northern Ontario Evacuations of First Nations Communities

Sudbury & District Board of Health Motion #32-15

- Letter from the Perth District Health Unit to the Premier of Ontario dated October 26, 2015
- Letter from the Algoma Public Health to the Premier of Ontario dated October 28, 2015

d. Ministry of Health and Long-Term Care (MOHLTC) One-Time Funding for 2015-16 re Panorama

- Letter from the Minister of Health and Long-Term Care dated October 30, 2015

e. Reinstatement of the Long-Form Census

- The Globe and Mail Article, November 5, 2015
- The Star Article, November 5, 2015
- Letter of Congratulations from the Sudbury & District Health Unit to the Prime Minister of Canada dated November 9, 2015

f. Amendments to the Ontario Public Health Standards Protocols

- Memo from the MOHLTC to Board of Health Chairs dated October 26, 2015
- Letter from the MOHLTC to the Board of Health Chairs dated October 14, 2015 Re: Reporting of Infection Prevention and Control (IPAC) lapses

g. Price Report

- Letter from the Association of Local Public Health Agencies (alPHa) Board President to the Minister of Health and Long-Term Care dated October 20, 2015

h. Nutritious Food Basket

- Letter from Wellington-Dufferin-Guelph Board of Health to the Minister Responsible for the Poverty Reduction Strategy/Deputy Premier dated November 4, 2015

i. Syrian Refugee Crisis

- Letter from the Minister of Health and Long-Term dated November 12, 2015

vi) Items of Information

- | | | |
|----|---|--------------------------------------|
| a. | alPHa Information Break | October 15, 2015
November 3, 2015 |
| b. | Times Colonist: Trevor Hancock: How we keep Canada healthy is a great story | October 28, 2015 |
| c. | Sudbury Star article: City (of Greater Sudbury) gets bad grade for health | October 25, 2015 |
| d. | SDHU's 2015 Flu Shot Clinics | |
| e. | Remarks from the Minister of Health and Long-Term Care to the 2015 HealthAchieve Conference | November 4, 2015 |

APPROVAL OF CONSENT AGENDA

MOTION: THAT the Board of Health approves the consent agenda as distributed.

6. NEW BUSINESS

i) Assessor's Report: Algoma Public Health

- Sudbury & District Health Unit's Review of the Assessors Report on Algoma Public Health Unit
- Graham Scott's Assessors Report on Algoma Public Health Unit, April 24, 2015
- Ministry of Health and Long-Term Care's Action on Assessor's Report, June 2015

ii) Public Health Funding

- Letter and Resolution from the alPha Board to the Minister of Health and Long-Term Care dated November 3, 2015
- Letter from the Leeds, Grenville & Lanark District Health Unit to the Minister of Health and Long-Term Care dated October 22, 2015
- Letter from the Elgin St. Thomas Public Health to the Minister of Health and Long-Term Care dated November 2, 2015

PROVINCIAL PUBLIC HEALTH FUNDING

MOTION: THAT the Sudbury & District Board of Health endorse the correspondence and resolution concerning the public health funding formula, passed October 30, 2015 from the alPha Board of Directors;

AND FURTHER THAT the Sudbury & District Board of Health call on the Ministry of Health and Long Term Care to increase investments in public health, ensuring Ontarians benefit from a world-class public health system within Ontario's transformed health system;

AND FURTHER THAT this motion be forwarded to constituent municipalities, the Association of Municipalities of Ontario, the Federation of Northern Ontario Municipalities, Ontario Boards of Health, the Association of Local Public Health Agencies, and other local partners.

iii) 2016 Cost-Shared Budget

- Briefing Note and Appendices from the Sudbury & District Health Unit's Medical Officer of Health and Chief Executive Officer dated November 12, 2015

IN CAMERA

IN CAMERA

MOTION: That this Board of Health goes in camera. Time: _____ p.m.

- Personal matters involving one or more identifiable individuals, including employees or prospective employees
- Labour relations or employee negotiations

RISE AND REPORT

RISE AND REPORT

MOTION: That this Board of Health rises and reports. Time: _____ p.m.

2016 COST-SHARED BUDGET

MOTION: THAT the Sudbury & District Board of Health approve the 2016 operating budget for cost-shared programs and services in the amount of \$22,873,326.

iv) Cannabis

- Centre for Addiction and Mental Health Cannabis Policy Framework, October 2014, Executive Summary
- Liberal Platform on Marijuana

CANNABIS REGULATION AND CONTROL:

Public Health Approach to Cannabis Legalization

MOTION: WHEREAS the election platform of Canada's recently elected federal government includes the intention to legalize, regulate, and restrict access to marijuana; and

WHEREAS within the current criminalization context, cannabis is widely used in the SDHU catchment area: 23.5% of youth used in the previous 12 months, 52.3% of people aged ≥19 have tried cannabis and 13% currently use cannabis; and

WHEREAS the health risks of cannabis use are significantly lower than tobacco or alcohol but are increased in those who use it frequently, begin at an early age and/or who have higher risk of cannabis-related problems (i.e. certain psychiatric conditions, cardiovascular disease, pregnancy); and

WHEREAS a public health approach focused on high-risk users and practices – similar to the approach favoured with alcohol and tobacco that includes strategies such as controlled availability, age limits, low risk use guidelines, pricing, advertising restrictions, and general and targeted prevention initiatives – allows for more control over the risk factors associated with cannabis-related health and societal harms; and

WHEREAS the Ontario Public Health Standards require boards of health to reduce the frequency, severity, and impact of preventable injury and of substance misuse;

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health support a public health approach to the forthcoming cannabis legalization framework, including strict health-focused regulations to

**reduce the health and societal harms associated with cannabis use;
and**

FURTHER THAT this resolution be shared with the Honourable Prime Minister of Canada, local Members of Parliament, the Premier of Ontario, local Members of Provincial Parliament, Minister of Health and Long-Term Care, Federal Minister of Health, the Attorney General, Chief Medical Officer of Health, Association of Local Public Health Agencies, Ontario Boards of Health, Ontario Public Health Association, the Centre for Addiction and Mental Health, and local community partners.

v) Smoke-Free Multi-Unit Housing

- Northwestern Health Unit Motion 88-2015 dated October 23, 2015
- Smoke-Free Housing Ontario Coalition Advocacy Letter dated October 10, 2014

ENDORSEMENT OF ACTION FOR SMOKE-FREE MULTI-UNIT HOUSING

MOTION: WHEREAS smoking in multi-unit housing results in significant exposure to the health-harming effects of tobacco smoke; and

WHEREAS area municipalities and service boards that are landlords of multi-unit housing can adopt no-smoking policies that set an example and protect health, such as that adopted by the Manitoulin Sudbury District Services Board to support smoke-free social housing effective January 1, 2015;

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health support the Northwestern Health Unit motion (88-2015) on smoke-free multi-unit housing, the efforts of the Smoke-Free Housing Ontario Coalition and others, in the following actions and policies to reduce the exposure of second-hand smoke in multi-unit housing:

- (1) Encourage all landlords and property owners of multi-unit housing to voluntarily adopt no-smoking policies in their rental units or properties;**
- (2) Advocate that all future private sector rental properties and buildings developed in Ontario should be smoke-free from the onset;**
- (3) Encourage public/social housing providers to voluntarily adopt no-smoking policies in their units and/or properties;**
- (4) Advocate that all future public/social housing developments in Ontario should be smoke-free from the onset;**
- (5) Encourage the Ontario Ministry of Housing to develop government policy and programs to facilitate the provision of smoke-free housing.**

FURTHER BE IT RESOLVED THAT a copy of this motion be submitted to the Smoke-Free Housing Ontario Coalition, the Ontario Minister of Municipal Affairs and Housing, local members of Provincial Parliament (MPP), the Chief Medical Officer of Health, the Association of Local Public Health Agencies (alPHa), all Ontario Boards of Health, the Association of Municipalities of Ontario, the Federation of Northern Ontario Municipalities and SDHU municipalities for their information and support.

vi) Staff Appreciation Day

- Briefing note from the Medical Officer of Health and Chief Executive Officer dated November 12, 2015

STAFF APPRECIATION DAY

MOTION: THAT this Board of Health approve a Staff Appreciation Day for the staff of the Sudbury & District Health Unit during the upcoming holiday season. The Staff Appreciation Day may be taken between the dates of December 1, 2015, to February 29, 2016. Essential services will be available and provided at all times during the holiday period except for statutory holidays when on-call staff will be available.

vii) Annual Board Self-Evaluation

- Briefing note from the Medical Officer of Health and Chief Executive Officer dated November 12, 2015

7. ADDENDUM

ADDENDUM

MOTION: THAT this Board of Health deals with the items on the Addendum.

8. ANNOUNCEMENTS / ENQUIRIES

Please remember to complete the Board Evaluation following the Board meeting:
<https://fluidsurveys.com/s/sdhuBOHmeeting/>

9. ADJOURNMENT

ADJOURNMENT

MOTION: THAT we do now adjourn. Time: _____ p.m.

**MINUTES – SIXTH MEETING
SUDBURY & DISTRICT BOARD OF HEALTH
SUDBURY & DISTRICT HEALTH UNIT, BOARDROOM
THURSDAY, OCTOBER 15, 2015, AT 1:30 P.M.**

BOARD MEMBERS PRESENT

Claude Belcourt
René Lapierre
Ken Noland
Mark Signoretti

Janet Bradley
Stewart Meikleham
Rita Pilon
Carolyn Thain

Jeffery Huska
Paul Myre
Paul Schoppmann

BOARD MEMBERS REGRETS

Robert Kirwin

Ursula Sauvé

STAFF MEMBERS PRESENT

Sandra Laclé
Dr. P. Sutcliffe

Marc Piquette
Shelley Westhaver

Rachel Quesnel

Media

R. LAPIERRE PRESIDING

1.0 CALL TO ORDER

The meeting was called to order at 1:30 p.m.

2.0 ROLL CALL

3.0 REVIEW OF AGENDA / DECLARATION OF CONFLICT OF INTEREST

There were no declarations of conflict of interest.

It was clarified that there are no addendum nor incamera agenda items today.

4.0 DELEGATION / PRESENTATION

i) Lean @ SDHU

- Lisa Schell, Manager, Clinical and Family Services Division
- Annie Berthiaume, Specialist, Quality and Monitoring, Corporate Services

A. Berthiaume and L. Schell were welcomed to provide an overview of Lean, an example of a SDHU team Lean initiative and the next planned steps of the SDHU Lean journey.

L. Schell described the SDHU's Control of Infectious Diseases (CID) program's Lean review project which was to review and examine key elements of programming as well as to identify inefficiencies and waste with the ultimate goal of optimizing available resources on the go-forward. Many benefits have been identified through the CID Lean review such as increased efficiencies, as well as opportunities to provide more comprehensive client centered care.

All SDHU management have received training on Lean and a few Lean projects have already been completed. Every division has identified at least one Lean project that they will conduct

from now until March 2016 and a total of eight Lean projects are underway. Just-in-time Lean training has been taking place for staff and the SDHU is building capacity. Storyboards will be available for staff to share successes and lessons learned.

The SDHU's goal of Lean is to identify and eliminate wastes as well as for staff to critically think about their work in terms of making the best use of their time in a most efficient process.

Questions and comments were entertained and speakers thanked for their presentation.

5.0 MINUTES OF PREVIOUS MEETING

i) Fifth Meeting – September 17, 2015

41-15 APPROVAL OF MINUTES

Moved by Noland – Meikleham: THAT the minutes of the Board of Health meeting of September 17, 2015, be approved as distributed.

CARRIED

6.0 BUSINESS ARISING FROM MINUTES

None.

7.0 REPORT OF BOARD COMMITTEES

i) Board of Health Finance Standing Committee

- Minutes dated September 23, 2015

C. Thain shared highlights of the inaugural meeting of the Board of Health Finance Standing Committee. She noted that the Committee will meet again on November 5, 2015, to review the draft 2016 budget which staff will bring forward to the November Board meeting. Due to the full discussion on budget and funding at this September meeting, the insurance review was deferred to that November meeting.

8.0 REPORT OF THE MEDICAL OFFICER OF HEALTH / CHIEF EXECUTIVE OFFICER

i) October 2015 – Medical Officer of Health / Chief Executive Officer Report

Words for Thought includes an illustration of how healthy populations are essential for healthy economies. The World Economic Forum report makes the case that increasing investment in health results in individual and societal/population benefits that can be sustainable and reinforcing. This supports the important health equity work of local public health units. Dr. Sutcliffe noted that the SDHU recently launched a new *You Can Create Change* social marketing campaign to inform people about social and economic determinants of health and encourage people to take action to improve health equity. The campaign will be rolled out over the next few months with a variety of initiatives in a cost effective manner.

There are no new updates on the recruitment of an Associate Medical Officer of Health for the Sudbury & District Health Unit as this point.

Board members interested in attending the one-day workshop *Managing Uncertainty: Risk Management*, in Toronto on November 5, 2015, are asked to advise R. Quesnel as soon as possible.

Currently, the response rate for the annual Board self-evaluation of performance is 38% with 5 out of 13 responses received to date. The survey gives Board members a chance to reflect on their individual performance, the effectiveness of Board policy and processes, and the Board's overall performance as a governing body. Dr. Sutcliffe reminded Board members that in addition to being an internal tool to ensure compliance with the Ontario Public Health Organizational Standards, the Board self-evaluation survey is part of the SDHU's Performance Monitoring Plan.

Universal Influenza Immunization Program (UIIP)'s provincial launch date is October 26. Board members will be encouraged to roll up their sleeves just before or following the November Board meeting to receive their influenza vaccine. Locally, immunization will start on October 21 for the higher risk population. We expect some changes with this year's campaign as many local pharmacies will be offering to provide the flu vaccine to individuals over the age of five.

Questions and comments were entertained.

42-15 ACCEPTANCE OF REPORTS

Moved by Meikleham – Noland: THAT the Report of the Medical Officer of Health and Chief Executive Officer for the month of October 2015 be accepted as distributed.
CARRIED

9.0 NEW BUSINESS

i) Items for Discussion

a) Performance Monitoring Plan

- Strategic Priorities Narratives Report by the Joint Board/Staff Performance Monitoring Working Group

Dr. Sutcliffe noted that the Strategic Priorities Narratives Report is developed by SDHU staff to assist with monitoring the integration of the strategic priorities within the SDHU's programs and services. It is shared with the Board in the spring, summer, and fall of every year for the duration of the 2013–2017 Strategic Plan.

Joint Board/Staff Performance Monitoring Working Group member, C. Thain was pleased to provide highlights from the fall 2015 Strategic Priority Narratives Report which was reviewed by the Working Group on September 29.

Narrative topics are sought out by divisional directors and five topics are selected to be included in the narrative report. The report includes narratives that span across all divisions and are varying service scopes.

This report highlights significant programs or services that exemplify efforts in meeting the SDHU's five 2013-2017 strategic plan priorities. These narratives demonstrate the integration of our strategic priorities into our daily work and provide an opportunity to describe key work being conducted for and with the communities serviced.

The report will be shared widely with external agencies.

b) Nutritious Food Basket

- Nutritious Food Basket Infographic: Limited Incomes = A Recipe for Hunger
- 2015 Nutritious Food Basket Scenarios

Annually, each health unit looks at the costs within their jurisdiction of healthy eat in accordance with the Canada Health Guide and compares one year over another. An Infographic displays the cost of groceries for a month for a family of four as \$874 leaving little money to pay for other costs of living such as utilities and transportation. The motion tabled today is yet another motion on this matter to further our advocacy efforts.

43-15 NUTRITIOUS FOOD BASKET 2015: LIMITED INCOMES = A RECIPE FOR HUNGER

Moved by Noland – Meikleham: WHEREAS the Sudbury & District Board of Health has monitored the cost of healthy eating on an annual basis since 2008 in accordance with the Nutritious Food Basket Protocol and the Population Health Assessment and Surveillance Protocol per the Ontario Public Health Standards; and

WHEREAS the 2015 costing results continue to demonstrate that individuals and families living on low incomes cannot afford food after paying for housing and other necessities and therefore may be at higher risk for food insecurity; and

WHEREAS food insecurity means inadequate or insecure access to food because of financial constraints and has serious public health implications; and

WHEREAS a basic income guarantee is a cash transfer from government to citizens not tied to labour market participation that can ensure everyone has an income sufficient to meet basic needs; and

WHEREAS basic income guarantee is similar to the income guarantees provided in Canada for seniors and children, which have contributed to health improvements in those groups; and

WHEREAS basic income guarantee is a simpler and more transparent approach to social assistance and has the potential to eliminate poverty;

WHEREAS the Association of Local Public Health Agencies endorsed the concept of basic income guarantee;

THEREFORE BE IT RESOLVED that the Sudbury & District Board of Health urge provincial and federal governments to prioritize and investigate a joint federal-provincial basic income guarantee as a policy option for reducing poverty;

FURTHER THAT while basic income guarantee is being investigated, ask the Province to increase social assistance rates to reflect the actual cost of nutritious food and adequate housing as informed by the current results of the Ministry of

Health and Long-Term Care's Nutritious Food Basket and the Canada Mortgage and Housing Corporation Rental Income (Ontario) reports;

FURTHER THAT the Sudbury & District Board of Health request that the Province index social assistance rates to inflation to keep up with the rising cost of living;

FURTHER THAT the Sudbury & District Board of Health share this motion and supporting materials with appropriate community agencies, boards, and municipalities throughout the catchment area.

CARRIED

c) Board of Health Proceedings – Consent Agenda

- Proposed Board of Health Manual Revisions:
 - E-I-11 Preparation of the Agenda - Procedure
 - G-I-30 By-Law 04-88

The concept of a consent agenda was introduced and supported at the September Board meeting. Revisions to the Board Manual are proposed today for the Board's approval to implement a Board consent agenda effective November 2015.

Questions were entertained.

44-15 BOARD OF HEALTH MANUAL

Moved by Schoppmann – Meikleham: THAT the Board of Health, having reviewed the revised Procedure E-I-11 and By-Law 04-88, approves the contents therein for inclusion in the Board of Health Manual.

CARRIED

d) Public Health Funding Review

- Resolution from the Board of Health for the Porcupine Health Unit dated September 18, 2015
- Resolution from the Board of Health for the Grey Bruce Health Unit dated September 25, 2015
- Ministry of Health and Long-Term Care Public Health Funding Model Share Status for the SDHU
- Memo from the Association of Local Public Health Agencies' Executive Director dated October 8, 2015

Dr. Sutcliffe noted that the Association of Local Public Health Agencies (alPHA) is currently finalizing a motion regarding the MOHLTC's recently announced public health funding formula and public health funding envelope for 2015. Although the alPHA motion is not finalized, Dr. Sutcliffe is aware of its focus and content given she is on the alPHA board. The motion is proposed to endorse concerns expressed by local Boards such as Porcupine and Grey Bruce. The main components of the anticipated motion as identified in the alPHA memo were recapped and include advocating to the Ministry to maintain an annual minimum growth; advocating that there be a comprehensive monitoring strategy to understand implementation impacts of the funding model on the public health system; and reexamination of the funding envelope for public health.

It was clarified that today's resolution is not seeking support the alPHa motion itself at this point as it is not finalized but rather supports alPHa's advocacy work on behalf of the 36 local health units regarding the provincial funding formula.

Once the alPHa motion is finalized, it will be shared with the Board. It is expected that the motion will come forward for this Board's endorsement at the next Board meeting.

45-15 PROVINCIAL PUBLIC HEALTH FUNDING FORMULA

Moved by Meikleham – Noland: That the Sudbury & District Board of Health endorse the correspondence concerning public health funding, dated September 21, 2015 from the Porcupine Health Unit and dated September 25, 2015 from the Grey Bruce Health Unit; and

That the Sudbury & District Board of Health endorse the public health funding advocacy work planned by the Association of Local Public Health Agencies (alPHa) as communicated on October 8, 2015, directing the Medical Officer of Health to work with alPHa in support of this advocacy.

CARRIED

ii) Correspondence

a) Enforcement of the Immunization of School Pupils Act (ISPA)

Sudbury & District Board of Health Motion #25-15

- Letter from the Chatham-Kent Board of Health to the Minister of Health and Long-Term Care dated September 21, 2015
- Letter from the Durham Region Council to the Premier of Ontario dated September 29, 2015
- Letter from the Peterborough County-City Board of Health to the Minister of Health and Long-Term Care dated September 30, 2015

No discussion.

b) Healthy Babies Healthy Children (HBHC) Program

Sudbury & District Board of Health Motion #28-15

- Letter from the Durham Region Council to the Premier of Ontario dated September 29, 2015

No discussion.

c) Northern Ontario Evacuations of First Nations Communities

Sudbury & District Board of Health Motion #32-15

- Letter from the Peterborough County-City Board of Health to the Premier of Ontario dated September 30, 2015

No discussion.

d) Basic Income Guarantee

- Letter from the Peterborough County-City Board of Health to the Federal Minister of Health and the Provincial Ministers of Labour, Health and Long-Term Care, Children and Youth Services and Poverty Reduction Strategy dated September 30, 2015

No discussion.

e) Energy Drinks

- Letter from the Peterborough County-City Board of Health to the Minister of Health and Long-Term Care dated September 30, 2015

No discussion.

f) Acting Chief Medical Officer of Health

- Email from the Office of the Chief Medical Officer of Health dated October 1, 2015

No discussion.

46-15 ACCEPTANCE OF NEW BUSINESS ITEMS

Moved by Meikleham – Schoppmann: THAT this Board of Health receives New Business items 9 i) to ii).

CARRIED

10.0 ITEMS OF INFORMATION

- | | | |
|-----|--|--|
| i) | aIPHa Information Break | September 16, 2015
September 29, 2015 |
| ii) | aIPHa Workshop – Managing Uncertainty: Risk Management on November 5, 2015 | Workshop Flyer |

Items were received for information.

11.0 ADDENDUM

No addendum.

12.0 IN CAMERA

13.0 RISE AND REPORT

No incamera

14.0 ANNOUNCEMENTS / ENQUIRIES

Board members were encouraged to complete the Board evaluation regarding today's Board meeting.

15.0 ADJOURNMENT

47-15 ADJOURNMENT

Moved by Noland – Schoppmann: THAT we do now adjourn. Time: 2:17 p.m.

CARRIED

(Chair)

(Secretary)

**UNAPPROVED MEETING NOTES
BOARD OF HEALTH FINANCE STANDING COMMITTEE
SUDBURY & DISTRICT HEALTH UNIT, BOARDROOM
MONDAY, NOVEMBER 2, 2015, AT 9:30 A.M.**

BOARD MEMBERS PRESENT

Claude Belcourt

René Lapierre

Carolyn Thain

STAFF MEMBERS PRESENT

Colette Barrette
Dr. P. Sutcliffe

Marc Piquette

Rachel Quesnel

C. THAIN PRESIDING

1.0 CALL TO ORDER

The meeting was called to order at 9:31 a.m.

2.0 ROLL CALL

3.0 REVIEW OF AGENDA / DECLARATION OF CONFLICT OF INTEREST

There were no declarations of conflict of interest. It was previously communicated via email that the insurance items deferred at the September 23 meeting are deferred to the new year.

4.0 APPROVAL OF BOARD OF HEALTH FINANCE STANDING COMMITTEE MEETING NOTES

03-15 APPROVAL OF MINUTES

Moved by Lapierre – Belcourt: THAT the meeting notes of the Board of Health Finance Standing Committee meeting of September 23, 2015, be approved as distributed.

CARRIED

5.0 NEW BUSINESS

5.1 2016 Program-Based Budget

Dr. Sutcliffe noted that the many hours have been devoted to discussing and developing a budget for the 2016 year that is presented today.

This Committee was apprised that the Association of Local Public Health Agencies (ALPHA) advocacy motion regarding the newly announced public health funding is expected to be finalized shortly. If the motion is shared before the November Board meeting, a supporting motion will be tabled for the Sudbury & District Board of Health's consideration.

Five Year Projections: A five year projection summary from 2016 to 2020 shows the cumulative deficit resulting from a 0% provincial grant on the SDHU's budget. The projection makes a number of assumptions but demonstrates the order of magnitude of the local budget impact of the new funding formula.

It was recapped that the Health Protection and Promotion Act stipulates that Board approves the budget and obligated municipalities are responsible for the payment and that

the province may make grants. Ministry grants are for up to 75% of board approved budgets but have been significantly under that for the majority of boards in the last number of years. Dr. Sutcliffe clarified that the municipal share is allocated on a per capita basis.

With these fiscal constraints, the SDHU senior management team has been proactive in exploring all cost savings measures, efficiencies, and possible revenue options. Staff have been kept apprised and invited to submit cost saving suggestions anonymously. Information sessions have been held with all management, the two unions, and three separate all staff meetings were held to explain the new funding formula model and resulting financial impact. Staff were also informed of our advocacy efforts and current budgeting process. A summary of the Q&As from these sessions has been shared with the staff.

Budget Principles: Further to the Board Finance Standing Committee's feedback at the September 23, 2015, meeting, senior management finalized the principles and ensured they were applied when developing the proposed budget.

Dr. Sutcliffe clarified that the SDHU values are weaved into the principles. With the addition of language relating to balance, the Board Finance Standing Committee supported the principles which will be appended to the budget briefing note that will be tabled at the November Board meeting.

Proposed Cost Reduction Initiatives for 2016: Senior Management has done a lot of work to consider and propose sustainable cost saving initiatives being tabled today.

Each of these initiatives were described and supported:

- Summer student budget reduction
- Professional membership reductions
- Divisional meeting reduction
- Reduce physician fees
- Travel vaccine consultation fees
- Discontinuation of Children's Water Festival
- Smoke-free Ontario administration fees

Dr. Sutcliffe will further explore and assess the feasibility of further increasing or charging fees as a future option.

04-15 IN CAMERA

Moved by Belcourt – Lapierre: That this Board of Health Finance Standing Committee goes in camera. Time: 10:29 a.m.

CARRIED

- Personal matters involving one or more identifiable individuals, including employees or prospective employees
- Labour relations or employee negotiations

05-15 RISE & REPORT

Moved by Belcourt – Lapierre: That this Board of Health Finance Standing Committee rises and reports. Time: 11:38 a.m.

CARRIED

5.1 2016 Program-Based Budget (Cont'd)

C. Barrette was invited to review the financial statements for the proposed 2016 cost-shared budget.

The summary page with revenues includes a 0% provincial grant for 2016 results in a decrease in MOHLTC revenue of \$297,834.

The 2016 starting position without applying any cost saving strategies is \$23,813,914. Total expenditures after applying \$440,588 worth of cost saving strategies totals \$23,373,326. It was agreed that the starting position column was included for the information of the Finance Committee but will be removed from the statements for the Board meeting. Suggestions were made for the narrative of the Board briefing note.

Discussion ensued regarding the change in staff development allocation. This should be noted in the cost saving strategies along with the other strategies. This will be included on the statements going to the Board and will result in some adjustments to the financial statements as reviewed today.

The history on including the Vector Borne Disease control contingency in the statements will be explored to determine whether the amount can be removed from the statements as it has no impact and causes confusion. If it is removed from the statements, a note will be included in the levy notices to constituent municipalities regarding the 2016 budget.

It was clarified that the per capita is based on the MPAC data and shifts yearly based on population. The Board Finance Standing Committee supported that the proposed cost-shared budget for 2016 be recommended to the full Board for approval at its November 19, 2015 meeting.

Next Steps: Dr. Sutcliffe will finalize the Board budget briefing note that summarizes the proposed cost-shared budget and highlights context and changes in revenues and expenses. The Chair of the Board Finance Standing Committee will provide highlights at the Board meeting and Dr. Sutcliffe will review the budget details. The Board will discuss aspects incamera prior to considering the motion to approve the budget.

The Committee Chair recognized Dr. Sutcliffe and staff for the hard work completed in order to develop the recommended budget. Committee members congratulated staff in their preparation of a responsible budget in a short time and development of principles to guide difficult discussions.

Committee members were reminded that the incamera discussions are confidential and that the Board Chair is the official spokesperson for the Board.

6.0 ADJOURNMENT

06-15 ADJOURNMENT

Moved by Lapierre – Belcout: THAT we do now adjourn. Time: 12:09 p.m.

CARRIED

(Chair)

(Secretary)

Unapproved

Medical Officer of Health/Chief Executive Officer Board Report, November 2015

Words for thought...

The well-being of patients—putting patients first—is what motivates me as the Minister. It's what motivates me as a family doctor and as a public health specialist. It's what motivated me before I got into politics. And it will motivate me long after I leave the political world.

So here at HealthAchieve, I want to talk about how that commitment we all share, to the well-being of our patients, must drive system transformation. And how, by embracing new ways of doing things, we can build a system that better understands and meets the needs of our patients—no matter their background, their income, or where they live.

...

These are questions our ministry is considering, always guided by the recognition that... home care leadership, our coordinators and our care providers... all of them are essential and their functions remain necessary in an integrated future.

As we move forward, we will continue to benefit from your advice and expertise. But what I'm certain of is that we must never take our eyes off the goal of true integration.

End-to-end, population-based integration across the health care system. That includes public health; it includes primary care; and it includes home and community care.

An integrated system, for the benefit of our patients.

Integration is not a new idea. And the people in this room have been instrumental in driving integration in our health care system. Across all of our LHINs, across all of our hospitals and our CCACs and our primary care organizations and our providers, you have taken the lead on projects that have improved patient outcomes by delivering integrated health care.

But our work has only begun. To truly transform our health care system into one that puts patients first, we cannot limit integration, using it on a project-by-project basis. We need system-wide integration.

Let me give you an example. Hospitals in rural Ontario, in collaboration with the Ontario Hospitals Association, have been leading change that captures exactly what I mean—focusing on end-to-end integration of services from public health, primary care, mental health, the management of chronic diseases, acute care, home and community care, long-term care, and palliative care.

Source: Remarks to the 2015 HealthAchieve Conference
Dr. Eric Hoskins
Minister of Health and Long-Term Care
Date: November 4, 2015

Chair and Members of the Board,

The Minister's remarks in this month's Words for Thought allude to significant system-wide change. The themes perhaps most relevant to public health are those of health equity, population health and integration. Through my work with the Association of Local Public Health Agencies (alPHA) and the Council of Ontario Medical Officers of Health (COMOH), I am keenly aware of the potential for change on the horizon for the public health system. Our organization is well placed to contribute to change dialogue and it is my hope that we will be consulted on any efforts to improve the public health system for Ontarians.

In line with our efforts to keep abreast of change initiatives within the health system, I attended the October 14 event, Health Quality Transformation 2015 hosted by Health Quality Ontario (HQO), and took the opportunity to share public health initiatives including the Sudbury & District Health Unit (SDHU)'s health equity work such as the recently launched *You Can Create Change* campaign. I have also been invited to participate at the HQO's first Health Equity Summit on December 3, 2015, in Toronto. As the provincial advisor on health care quality, HQO has started its journey to help improve health equity in Ontario.

This one-day invitational event will include approximately 100 thought leaders, experts, partners, and individuals with lived experience from across the province to help influence HQO's strategy for health equity.

GENERAL REPORT

1. Local and Provincial Meetings

In October, I began the first BYOL (Bring Your Own Lunch) session with staff, which will occur on about a monthly basis. My intention is that these sessions will provide an opportunity for more informal chats and exchange of ideas and information between staff and me who may drop by. It is an opportunity to listen, discuss, and participate in topics that are front of mind.

I participated in the Association of Local Public Health Agencies (aLPHa) Executive Committee teleconference meeting on October 30, 2015, the COMOH Executive Committee teleconference meeting on November 10, 2015, and will be participating in the monthly Provincial/Public Health Unit Conference call along with my provincial colleagues on November 19, 2015.

COMOH held a face-to-face section meeting in Toronto on November 4, 2015, where all Ontario MOHs had an opportunity to discuss local common and provincial public health issues, such as public health funding, built environment and UIIP.

On November 5, 2015, I attended the Risk Management Workshop hosted by aLPHa for all Ontario Boards of Health. Board member, Carolyn Thain and Marc Piquette, Director of Corporate Services were registered; however, the morning flight to Toronto was cancelled. Of note is the follow up that we are doing with the risk management presenter who is from the Ontario Internal Audit, Health Audit Service Team of the Ontario Government. We are hoping to engage with the presenter to assist the SDHU its work to further systematize our risk management work in line with the Organizational Standards. I expect that there will be lots more to come on this topic in the near future.

2. Algoma Public Health

I continue to provide month-to-month MOH coverage for Algoma Public Health by providing at a distance medical officer of health (versus CEO) consultation and participated at their October 28, 2015, Board of Health meeting by teleconference.

The SDHU's senior management team has reviewed the APH Assessor Report to ensure compliance and quality control measure are in place. A report is attached for the Board's information under items of information.

3. Board of Health Reminders

Board members are welcomed to have their flu shot at the SDHU on November 19, between noon and 1 p.m. or immediately following the Board meeting. Please announce your arrival at the main reception and staff will accompany you to the meeting location for your flu shot.

The Board social gathering, initially planned for after the November Board meeting, has been cancelled. Sweet treats will be available during the Board meeting.

Board members are reminded that there is no regular Board meeting in December. The date of the next Board meeting is Thursday, January 21, 2016. I take this opportunity to wish everyone a wonderful holiday season and a happy new year. I look forward to continuing to work with all of you in the New Year.

4. Cultural Competencies Training

From October 20–22, 2015, the SDHU hosted full-day Anishnawbek (First Nations) cultural competency training sessions for all SDHU staff members. Maya Chacaby from the Ontario Federation of Indigenous Friendship Centres provided the training to over 260 individuals. The training is important foundational work for SDHU staff, supporting the development of our own public health competencies relating to diversity and inclusiveness, and supporting our ability to create strong relationships with Anishnawbe peoples and agencies serving this population. The training highlighted the history of First Peoples, the implications of policy objectives of the government as well as the tremendous gifts and strengths of these communities. Through self-reflection and self-discovery, staff were able to identify strategies to improve our practices to equip ourselves better to working together with the Anishnawbe people to improve health outcomes across the range of social determinants of health.

This work is in line with the 2012 Sudbury & District Board of Health motion directing the MOH to engage in dialogue with area First Nation leaders to explore needs and potential strategies for strengthening public health programs and services. In addition to the recent training, a number of meetings with partners have occurred since the Board motion, at both the senior management level as well as among staff and managers as they implement their work within the communities we serve.

5. SDHU Health Equity Campaign – You Can Create Change

The SDHU's You Can Create Change campaign is still underway. This campaign, which is part of the SDHU's Health Equity Communications and Social Marketing Plan, aims to shift the conversation about health equity in our communities and, more importantly, encourage community members to take health equity action. This month, a number of new messages are being promoted through various media, including a billboard and posts on the SDHU Facebook page and Twitter account (SD_PublicHealth). Messages include *"Good education builds healthy futures"*, *"Reducing poverty boosts everyone's chance to contribute"*, and *"Many people have to choose between food and their prescription meds"*. Staff are being encouraged to take action and create awareness by sharing campaign images with partners and by retweeting, liking and sharing messages on Twitter and Facebook. For more information and for ideas on how to take health equity action, individuals are invited to visit a special section of the SDHU website (www.sdhu.com/change).

6. Sudbury & District Health Unit's Workplace United Way Campaign

This year, SDHU's United Way workplace campaign is occurring between November 10 and November 27, 2015. Staff and Board of Health members are once again being asked to show their generosity and commitment to addressing social determinants of health. Board members will be

provided with donation forms at the November 19 Board of Health meeting. The SDHU's United Way Committee's goal is to raise \$16,000 for this year's United Way campaign. The contributions raised will support the funding of 46 social service programs within the Greater Sudbury area that help so many in our community.

7. SDHU Performance Targets for the Accountability Agreement Indicators

The SDHU is demonstrating good performance for the twenty-four Public Health Accountability Agreement performance indicators established by the MOHLTC. The SDHU is on track for compliance with 22 indicators. In the six-month period covered by this report, these two indicators require variance reports to the MOHLTC:

- 1) % of vaccine wasted by vaccine type that is stored/administered by the public health unit (HPV)
- 2) % of vaccine wasted by vaccine type that is stored/administered by the public health unit (influenza)

8. Financial Report

The September financial statements reflect the Ministry of Health and Long-Term Care (MOHLTC) approved funding. The positive variance in the cost-shared program is \$270,870 for the period ending September 30, 2015. Gapped salaries and benefits account for \$58,325 or 21.5% with operating expenses and other revenue accounting for \$212,545 or 78.5% of the variance. The operating and revenue variance is attributable to timing and calendarization of revenue and expenses.

Additional one-time operating pressures were identified, approved and are reflected on the September 2015 financial reporting in the amount of \$22,871 as follows:

- **Staffing** - \$19,836
- **Infrastructure** - Replacement of chairs \$3,035

9. Quarterly Compliance Report

The SDHU is compliant with the terms and conditions of our Public Health Accountability Agreement. The SDHU has procedures in place to uphold the Ontario Public Health Organization Standards, to provide for the effective management of our funding and to enable the timely identification and management of risks.

The SDHU has paid all payable remittances for employee income tax deductions and Canada Pension Plan and Employment Insurance premiums, as required by law to September 25, 2015, on September 30, 2015. The Employer Health Tax has been paid as required by law, to September 30, 2015, with a cheque dated October 15, 2015. Workplace Safety and Insurance Board premiums have also been paid, as required by law, to September 30, 2015, with a cheque dated October 31, 2015. There are no outstanding issues regarding compliance with the Occupational Health & Safety Act, Ontario Human rights Code, or Employment Standards Act.

Following are the divisional highlights including the twice-yearly more detailed report from the Corporate Services Division.

CORPORATE SERVICES DIVISION

1. Accounting

The 2015 funding approval was received on September 9, 2015, just after the September 4 announcement of the implementation of the new public health funding formula. Since then finance staff have been busy working on mapping the implications of the new funding formula and supporting the development of the recommended 2016 cost shared operating budget by the Executive Committee and the Board of Health Finance Committee.

2. Facilities

1300 Paris Street Projects: The repair work on the drainage system under the carport area and asphalt resurfacing has been completed. Improvements to mechanical systems were completed to balance cooling for our vaccine room but we are proceeding with procurement and installation of an updated system that will provide a more permanent and reliable solution. Carpet replacement was completed in the entire Clinical and Family Services division, which now completes the entire main floor.

District Office Projects: A new UPS (backup power supply) was installed at the Rainbow Centre to allow critical systems such as the vaccine fridge/freezer to stay online during power failures.

3. Human Resources

Health and Safety: We continue to work to achieve and maintain compliance with the Occupational Health & Safety Act (OHSA) and SDHU health and safety policies and procedures. Recent activities include regular Joint Health and Safety Committee (JHSC) meetings, training on the Internal Responsibility System, WHMIS, fire safety, first aid, emergency preparedness and workplace violence and harassment, and implementation of amendments to the OHSA (Bill 18) defining workers to include unpaid co-op placements and other unpaid learners.

Psychological/Mental Health and Safety: The SDHU has endorsed the National Standard for Psychological Health & Safety in the workplace and the JHSC, SDHU Wellness Committee and others have been working together to improve the psychological and mental health of employees. Recent activities include, for example, our ongoing participation in the Elephant in the Room Campaign to eliminate the stigma associated with mental illness.

Accessibility for Ontarians with Disabilities Act (AODA): The following activities were identified within the SDHU Accessibility Plan and were completed during this period:

- The Canadian Hearing Society provided sensitivity training.
- The new website has been launched and is AODA compliant.
- AODA training including provisions of the Human Rights Code as it pertains to persons with disabilities was provided to all employees, volunteers and all other persons who provide goods, services or facilities on behalf of the organization.
- The SDHU style guide is being reviewed and updated to enhance accessibility with a focus on actions like using accessible fonts and colour contrast.

Privacy: All staff continue to receive privacy and access to information training during orientation. The SDHU Privacy Officer (PO) will attend the PHIPA summit in December 2015. The PO and Manager of Information Technology are working with Clinical & Family Services in the utilization of the new Ministry electronic patient information systems to ensure PHIPA compliance.

Access to Information Requests: We have experienced a significant increase in the number of formal information requests from the public and we have noticed a change in the complexity of the requests as well. In 2014, we received a total of 16 formal requests compared to 6 in 2013. To date in 2015, we have received 15 formal requests. In some cases our decisions have been appealed to mediation and/or the Information and Privacy Commissioner.

4. Information Services

Records Management/SharePoint Project: The Phase I implementation was completed in RRED and has commenced in Environmental Health. The Records and Information Management Project Educator continues to provide SharePoint training and has attended a Clinical Services Management meeting to provide a show and tell.

Refresh: The annual refresh of our computer systems was completed with replacement of “E” series laptops, which were consumer-grade with improved systems. Solid State Drives (which are encrypted) are replacing hard drives that are at the end of their three-year cycle.

Helpdesk System: We are working to align Spiceworks, the asset management system that is a part of our helpdesk system, with Microsoft’s equivalent in order to ensure that we have a solid asset management system in place to more accurately reflect yearly refresh cycles.

IT infrastructure: The SDHU phone system has been upgraded to a newer version. IT staff are currently working with internal staff to achieve improved call routing. Options include the use of an automated call menu to connect callers to the required internal resource.

District Offices: We are currently working with OTN to provide our own connectivity for videoconferencing in our Sudbury East, Chapleau, Sudbury and Rainbow Centre locations. This is necessary as OTN is attempting to use existing client connectivity where it exists (given the high costs of their own connectivity services provided by Bell throughout the Northeast). Where no connectivity is available, OTN can continue to provide services at a cost of \$250 per month per system. All of our current connections can provide adequate bandwidth except for Sudbury East which is currently a wireless connection. We are determining the best option for this office.

5. Volunteer Resources

Seventy-six (76) volunteers are actively involved in assisting staff to plan and deliver programs and services. Health Unit volunteers have contributed 562 hours from April 2015 to September 2015.

6. Quality & Monitoring

Lean @ SDHU: At its June meeting, senior management approved a Lean implementation plan, which includes training for and implementation of small-scaled Lean projects. Eleven lean projects were submitted from teams and divisions across the Health Unit. Thus far, two projects have been completed, three are in-progress, five are yet to be started, and 57 staff have received training on Lean. All projects are planned to be completed by March 2016.

Lean review of the Controlled Infectious Disease (CID) program: The report on the Lean review of the Control of Infectious Diseases program was recently finalized. This review was led by the Leading Edge Group, which is an external company specializing in Lean methodology. The report recommendations are currently being reviewed by the Clinical and Family Services Management team. Next steps are also being planned and include the sharing of results with CID program staff.

Organizational Standards: We continue to await the release of the Ministry of Health and Long-Term Care risk assessment tool, which will review public health unit compliance with the Ontario Public Health Organizational Standards. The Ministry had previously advised that the tool was anticipated to be ready for release this year.

Locally Driven Collaborative Project (LDCP): The SDHU is a co-applicant in the submission of a grant proposal for a one-year Public Health Ontario funded Locally Driven Collaborative Project (LDCP). The project is focused on continuous quality improvement and titled “Strengthening Continuous Quality Improvement in Ontario’s Public Health Units”. Funding approvals are expected to be received at the end of December. The project team includes 17 public health units as well as an academic partner from Brock University.

CLINICAL AND FAMILY SERVICES DIVISION

1. Control of Infectious Diseases

Influenza: There have been no cases of influenza A or B identified during the month of October.

The SDHU has administered 1 803 doses of influenza vaccine since the start of our influenza vaccination program on October 21, 2015. As of October 27, 31 617 doses of influenza vaccine have been distributed to health care providers across the district. For this influenza season we have 50 participating pharmacies and seven community health agencies.

Respiratory Outbreaks: There has been one identified respiratory outbreak in a long-term care home during the month of October. Causative organism for this outbreak was identified as Rhinovirus.

2. Family Health

Prenatal Education: In October, 18 pregnant women and their support persons attended ‘in-person’ prenatal classes at SDHU’s main site and 16 clients registered for online prenatal.

Breastfeeding: On October 3, Family Health team staff and community partners including Our Children, Our Future and the Sudbury Community Midwives hosted the Breastfeeding Challenge at Silver City. Families were invited to attend the screening of “Milk”, a documentary that puts the spotlight on childbirth and post-natal period when women and infants are at their most vulnerable. Approximately 79 people attended the event with 29 mothers who latched their babies at the designated time.

Eight mothers attend the breastfeeding support group at the Minnow Lake site.

On October 9, Family Health team staff presented Part 2 Breastfeeding and Beyond: Feeding Infants and Young Children 6 – 24 months learning module to NOSM residents and interested clinician across the North.

On November 3, the SDHU took part in the Baby Friendly Initiative (BFI) pre-assessment site visit. The site visit is a mandatory requirement of the “advanced” category of our accountability agreement indicator. Lead Assessor, Marg Lasalle, with the Breastfeeding Committee of Canada spent a full day interviewing the Medical Office of Health, Director of Clinical and Family Services, Managers of teams who provide direct breastfeeding care, staff from multiple divisions and from the district offices, as well as some of our clients. Initial feedback was positive and the SDHU was recognized for its hard work in its journey towards BFI designation. The assessor will provide a formal report to the SDHU within the next six weeks. Staff will review the recommendations and begin preparing for the final site visit in 2016.

Positive Parenting Program (Triple P): Family Health team staff are offering one-to-one parenting to 5 parents of teens, 2 parents are participating in Level 4 Group (0-12 years), and 3 parents are taking part in Level 5 Transitions program for divorced/separated parents. SDHU continues its partnership with the Aboriginal Peoples Alliance of Northern Ontario (APANO) where staff facilitated a parenting discussion group with 8 participants. A staff member is hosting parenting discussion groups with 5 parents at St-David’s School who are also helping to plan topics for upcoming months and recruiting new parents into the group. In partnership with NOAH (New Opportunities and Hope), staff had a parenting display at a family event in the Ryan Heights neighbourhood to raise awareness about parenting supports that are available for families. Approximately 10 families stopped at the display.

Child Health Community Events: The Family Health team dietitian facilitated a healthy eating presentation to 6 participants from the Children’s Aid Society of the districts of Sudbury and Manitoulin.

Staff from the Family Health and School teams co-facilitated a resiliency presentation to the Chief Youth Advisory Council on October 13, 2015.

3. Sexual Health / Sexually Transmitted Infections (STI) / Blood Bourne Infections (BBI) including Human Immunodeficiency Virus (HIV) Program

During the month of October, the sexual health team responded to 9 community requests for presentations to 226 participants. The presentations focused on a variety of sexual health topics such as healthy relationships, birth control options, and the prevention and treatment of sexually transmitted infections.

The Sexual Health team participated in the annual “Zombie Cemetery” hosted by Memorial Hospital’s simulation laboratory. This annual Halloween event, for Grade 10 and 11, takes students through an interactive “Zombie Cemetery”. While the students are waiting to walk through the cemetery, they viewed a variety of displays targeting their age group. The Sexual Health team provided information about the Sexual Health Clinic’s services and MyTest. The event was a great success with 150 participants from College Notre Dame, St Charles College and Lockerby.

Since the launch of MyTest, March 31, 2015, 70 individuals have tested through the program resulting in one gonorrhea and 10 chlamydia infections being confirmed and treated.

ENVIRONMENTAL HEALTH DIVISION

1. Control of Infectious Diseases

During the month of October, 10 sporadic enteric cases and five infection control complaints were investigated. Two enteric outbreaks were declared in institutions.

2. Food Safety

The recall of Summer Fresh Brand 4 Cheese and Crab Dip, due to possible contamination with *Listeria monocytogenes*, prompted public health inspectors to conduct checks of 39 local premises. All affected establishments had been notified, and subsequently had removed the recalled product from sale.

Public health inspectors issued five charges to four food premises for infractions identified under the Food Premises Regulation.

In October, staff issued 23 Special Event Food Service Permits to various organizations for events serving approximately 4 000 attendees.

Through Food Handler Training and Certification Program sessions offered in October, 83 individuals were certified as food handlers.

3. Health Hazard

In October, 35 health hazard complaints were received and investigated. Three of these complaints involved marginalized populations.

4. Ontario Building Code

During the month of October, 40 sewage system permits, 9 renovation applications, and 5 consent applications were received.

Fourteen mandatory maintenance inspections of private septic systems were completed for the Source Water Protection program in October.

5. Rabies Prevention and Control

Nineteen rabies-related investigations were carried out in the month of October. One specimen was submitted to the Canadian Food Inspection Agency Rabies Laboratory for analysis, and was subsequently reported as negative.

One individual received rabies post-exposure prophylaxis due to exposure to a wild animal.

6. Safe Water

Public health inspectors investigated three blue-green algae complaints in the month of October, all of which were subsequently confirmed as blue green algae capable of producing toxin.

During October, 64 residents were contacted regarding adverse private drinking water samples. Public health inspectors investigated five regulated adverse water sample results.

Additionally during the month of October, two boil water orders, and one drinking water advisory were issued. Furthermore one boil water order, and one drinking water advisory were rescinded.

7. Tobacco Enforcement

In October, tobacco enforcement officers charged three individuals for smoking on school property, and two retail employees for selling tobacco to a person who is less than 19 years of age.

HEALTH PROMOTION DIVISION

1. Healthy Weights

The first meeting of the City of Greater Sudbury Healthy Kids Community Challenge Advisory Panel was held on October 28, 2015. This is a community-led program where partners from different sectors (e.g., public health, education, recreation and local businesses) work together to implement activities to promote healthy weights for kids. The City of Greater Sudbury received \$1,125,000 over a 3-year period to implement local activities based on specific themes related to healthy eating, physical activity and adequate sleep. The principles underpinning the Healthy Kids Community Challenge include: focus on healthy kids; positive health messages; supportive environments and systems; and support for health equity. The funding will be used to support program coordination and activities, such as implementing new and innovative programming, providing education and training, making policy and environmental changes, and evaluating the success of the program.

The Manitoulin Island Healthy Kids Community Challenge held a successful kick-off event on Friday, October 30, 2015. The program's community champion, Grand Council Chief Patrick Madahbee, and the project manager addressed the crowd and described the program, which is led by Noojmowin Teg Health Centre. Several partners, including SDHU Health Promotion staff from the Mindemoya and Sudbury offices, attended the launch of the community-led program.

Together, Health Unit staff representing healthy eating, food safety, and substance and alcohol misuse prevention programming submitted feedback and recommendations on the draft regulations to support Ontario's menu labelling legislation. The Healthy Menu Choices Act, 2015, which will come into effect on January 1, 2017, requires food service premises with 20 or more outlets, that are selling prepared, ready-to-eat food, to post calories on their menus.

2. Injury Prevention

In partnership with the Manitoulin Injury Prevention Coalition, Manitoulin Island staff promoted National Teen Driver Safety Week. Messages for school announcements were shared with Manitoulin Secondary School to raise awareness about the dangers of texting and driving and safe driving practices.

Chapleau staff helped to support local falls prevention programming by arranging for an older adults walking group to use the halls of the local secondary school for bi-weekly walking programs. This provides the group with a safe walking environment.

Car seat clinics and babyRIDE spot-checks were hosted throughout Espanola, Manitoulin Island and Sudbury East district office areas at the end of September and early October. During the two sessions hosted by the Espanola District Office, a total of 28 car seats were installed. On Manitoulin Island, a total of 15 car seats were inspected at the clinics and an additional 2 during a pre-booked appointment. In Markstay, 4 seats were inspected and 3 others were scheduled for alternate appointment times. Safety resources from the Ministry of Transportation were also distributed to clients.

In partnership with the Sudbury Road Safety committee, the SDHU will be launching the "Do the Bright Thing When Walking after Dark" campaign for the month of November in a variety of venues and locations. Various campaign activities include billboards located on major streets in the city and small electronic screens located throughout the city.

Members of the Injury Prevention team hosted a second community consultation for the development of a comprehensive child car seat safety strategy on October 27. Twenty participants took part representing a variety of sectors including the Ministry of Transportation, Children's Aid Society of Sudbury, Sudbury Best Start Hubs, Our Children Our Future, Jump Baby Sudbury, Centre Pivot Du Triangle Magique Daycare, Canadian Automobile Association Sudbury, N'Swakamok Native Friendship Centre, YMCA Sudbury Newcomer Services, and the Health Unit.

On October 15, public health nurses (PHNs) from the Injury Prevention team attended the North East Geriatric Medicine Refresher Day, with 200 medical health care professionals and agencies attending, to promote Stay On Your Feet and distribute to medical health care professionals the new falls self-administered risk assessment brochure. This brochure was produced in partnership with the five Northern Health Units and the NE LHIN and will also be distributed via our local community flu clinics, primary care providers and SOYF Coalition members.

November is Falls Prevention Month. On November 17, 2015, the SDHU Falls Prevention PHNs, in partnership with the local Stay On Your Feet Falls Prevention Coalition, 5 North East health units, Sudbury Rising Stars and older adults will be joining the regional NE LHIN media launch of Stay On Your Feet (SOYF) campaign to raise awareness of falls prevention and to promote SOYF. Newly developed resources promoting the self-administered risk assessment falls tool, a television commercial and a poster promoting SOYF will be highlighted.

3. Prevention of Substance Misuse

An abstract was submitted and accepted to the Ontario Public Health Association Fall Forum. Members of the Substance Misuse Prevention team provided a presentation on media advocacy efforts titled "Mixers: Innovative Efforts 4 Change" on October 29, 2015.

The plan for the Manitoulin Drug Strategy is nearing completion, and consultations with Sudbury East have begun following a request to develop a local drug strategy.

The Community Drug Strategy for the City of Greater Sudbury was brought to City Council for endorsement and was unanimously approved on October 20, 2015. The Steering Committee met on October 30, 2015, to begin to move the Strategy forward.

4. School Health

In October, the School team and Family team managers presented the resiliency model to 20 children and youth service providers and members of the Partners of Children and Youth table (PCY). These members, who are executive level children and youth services providers, were asked to consider the resiliency model evidence and data gathering potential, when undertaking their strategic planning discussions. The resiliency model presented is linked closely to initiatives from different sectors such as the Ministry of Education, Ministry of Children and Youth Services, Ministry of Health and Long-Term Care and to several projects in the community such as the Drug Strategy, Triple P, and Move on Mental Health.

The School Health Promotion team is in its third year of delivering the Northern Fruit and Vegetable Program (NFVP) to our schools. The program, which is voluntary, is currently servicing 76 of 87 eligible schools from 6 school boards, and is geared towards students in Junior Kindergarten to Grade 8. More than 15,600 students have been receiving fresh, washed and cut fruit and vegetables from the Ontario Fruit and Vegetable Grower's Association. An evaluation was conducted at the end of year one and year two, and the results have been promising thus far. Likeability of fruits and vegetables that are offered in the program has increased. In addition, there has been an increased number of students who are consuming fruits and vegetables more than five times per week.

The team is currently preparing a communication plan to increase awareness of the benefits of increased fruit and vegetable consumption that will be rolled out during the third and final year of the program

In Sudbury East, staff connected with the new principal of École St-Charles to discuss school programming and the new SDHU website content for educators, school staff and families. The SDHU was also invited to attend the school's open house where a display was set-up with information on healthy lunches and Triple P.

In Chapleau, meetings were held with principals of the five local schools to discuss school needs and Health Unit programming. Health unit services were discussed and the new website was promoted.

5. Tobacco Control

In October 2015, public health staff delivered a number of comprehensive tobacco control presentations to community members. A PHN delivered a presentation to a group of 42 NOSM Family Medicine students on how to address smoking cessation with patients. You Can Make It Happen kits, a comprehensive source of tools and resources about tobacco cessation for healthcare providers, were also distributed to participants.

A Laurentian University Nursing student on placement (working) with the Tobacco and Injury Prevention team delivered a presentation to a group of 25 Personal Support Workers at the St. Albert's Learning Centre on smoking cessation, cessation services and You Can Make It Happen.

Health promoters from the Tobacco and Injury Prevention team delivered a half-day workshop to a group of 25 North East Tobacco Control Area Network (NE TCAN) youth and Youth Engagement Coordinators on effective program planning and considerations for developing a campaign to increase the public awareness on new tobacco laws.

On October 28, the SDHU launched a campaign to raise awareness on tobacco cessation targeting young adults. The campaign is being launched in Cineplex, Tim Hortons' drive-throughs, post-secondary institutions, inside bus panels and on social media, including Facebook and Twitter. A total of 80 posters of the campaign were also printed and distributed to district offices for dissemination in their community.

As part of our quit smoking services at the SDHU, a total of 56 information and recruitment letters regarding the Quit Smoking Clinic Voucher Program were mailed out to all pharmacies within our SDHU catchment area. A total 31 participating pharmacies received a letter outlining updates about the program and a total of 25 non-participating Pharmacies received a letter of recruitment outlining information and benefits of participating in the program.

6. Early Detection of Cancer and UVR Exposure

In recognition of Breast Cancer Awareness Month, Health Promotion staff partnered with the Cancer Prevention & Screening Network – North East and Regis Inc. hair salons to pilot the Stylists Save Lives campaign at 11 salons in North East Ontario region, 6 in our catchment. The campaign uses the theoretical foundation that stylists in salons can utilize their intimate relationships with clients to act as lay health educators and provide valuable cancer screening information. Prior to the campaign start, staff from the Health Unit and from the North East Cancer Centre delivered campaign materials and trained each salon and its staff on the campaign including key messages, how to start conversations about cancer screening, troubleshooting of potential questions, proper tracking and dissemination of campaign materials.

In late October, Espanola Office staff attended a local breast cancer awareness event at the Espanola Express Junior A hockey game attended by 100 local residents. The event featured the hockey players wearing pink jerseys and skate laces to show their support for breast cancer awareness. To complement the information display booth supported by health unit staff, messages about the importance of cancer screening were announced over the speaker both pre-game and during intermissions.

As members of the Cancer Prevention & Screening Network – North East, Health Promotion staff participated in a consultation, hosted by the North East Cancer Centre, to inform the development of its next three-year Northeast Regional Cancer Plan. The Plan will outline the actions to improve cancer services in northeastern Ontario, including cancer prevention and screening, and will support implementation of the Ontario Cancer Plan IV (2015-2019).

7. Workplace Health

Cambrian College put together a small showcase event to ensure students joining the workforce are aware of workplace health and safety resources in their community. A booth was set up highlighting workplace wellness. Approximately 70 individuals visited the display, took a copy of the newsletter and engaged in discussion about the resources found in the newsletter. The topics of interest included alcohol, tobacco cessation, physical activity, stress management, supportive work environments, and policy development.

RESOURCES, RESEARCH, EVALUATION AND DEVELOPMENT (RRED) DIVISION

1. Population Health Assessment and Surveillance

The *Quarterly Reportable Diseases Report* for July to September 2015 has been compiled in conjunction with the Clinical and Family Services Division and circulated to the SDHU Outbreak team, specialists, program managers, and the Executive Committee. These 'snapshots' of the quarter's information available through the integrated Public Health Information System (iPHIS) include cases diagnosed in the SDHU area that were reported and confirmed.

The first of the 2015–2016 season's *Bi-weekly Acute Care Enhanced Surveillance* reports was generated and shared with Clinical & Family Services and Environmental Health. The bi-weekly reports provide enhanced surveillance during the months from October to May, and summarize Influenza-Like-Illness (ILI), respiratory, enteric, and other diseases of concern in the SDHU service area.

2. Health Equity

In October 2015, the Health Equity Knowledge Exchange Resource Team hosted two health equity orientation sessions for placement students. The sessions provided an introduction to health equity, the 10 promising practices to reduce social inequities in health, and the implementation of health equity programming at the SDHU. Five fourth year nursing students, a fourth year social work student, and a science communication graduate student attended the sessions.

3. Research and Evaluation

On October 6, 2015, staff from the Health Unit co-presented with staff from the Durham Region Health Department, for the Public Health Ontario (PHO) Grand Rounds. The presentation focused on the results of a one-year research project titled *Beyond BMI: Investigating the Feasibility of Using Electronic Medical Records and NutriSTEP® for Childhood Healthy Weights Surveillance* – a PHO

funded Locally Driven Collaborative Project. The SDHU was a co-applicant on this research project, and is currently working with Durham Region Health Department to co-lead a renewal research project for another two years, building off the findings from year one.

4. Staff Development

On October 29, 2015, the RRED Division hosted a half-day Knowledge Exchange Symposium for SDHU staff. The purpose of the Symposium is to share information across divisions as it relates to projects, activities, programs, and new knowledge. Topics included: Building Resilient Schools, Public Health Ethics, Food Safety, NutriSTEP, Low-Risk Alcohol Drinking Guidelines, the Baby-Friendly Initiative, and the *You Can Create Change* Health Equity Campaign.

5. Presentations

On October 22, 2015, a presentation was delivered to 45 first and second year Family Medicine residents at the Northern Ontario School of Medicine. The presentation provided an overview of public health's legislative requirements, governance, standards, structures and functions and how these interact within the broader health care system. The SDHU as an organization was highlighted. Particular attention was focused on highlighting the determinants of health and population-based approaches to improving the health of the population.

Respectfully submitted

Original signed by

Penny Sutcliffe, MD, MHSc, FRCPC
Medical Officer of Health and Chief Executive Officer

Sudbury & District Health Unit
STATEMENT OF REVENUE & EXPENDITURES
For The 9 Periods Ending September 30, 2015

Cost Shared Programs

	Annual Budget	Budget YTD	Current Expenditures YTD	Variance YTD (over)/under	Balance Available
Revenue:					
MOHLTC - General Program	14,893,000	11,318,668	11,318,668	(0)	3,574,332
MOHLTC - Unorganized Territory	813,000	600,735	600,735	(0)	212,265
MOHLTC - VBD Education & Surveillance	65,000	48,704	48,704	0	16,296
MOHLTC - VBD Contingency	375,000	0	0	0	375,000
MOHLTC - SDWS	106,000	79,500	79,500	(0)	26,500
MOHLTC - CINOT Expansion	24,800	21,955	21,955	(0)	2,845
Municipal Levies	6,641,127	4,980,794	4,980,795	(0)	1,660,332
Municipal Levies - Small Drinking Water Syst	47,222	35,417	35,417	(0)	11,805
Municipal Levies - VBD Education & Surveill	21,646	16,234	16,234	0	5,412
Municipal Levies - VBD Contingency	125,000	0	0	0	125,000
Municipal Levies - CINOT Expansion	10,503	7,877	7,877	0	2,626
Interest Earned	85,000	50,916	50,916	(0)	34,084
Total Revenues:	\$23,207,298	\$17,160,800	\$17,160,801	\$(0)	\$6,046,497
Expenditures:					
Corporate Services:					
Corporate Services	4,405,670	3,529,154	3,642,045	(112,890)	763,626
Print Shop	262,837	196,706	159,902	36,804	102,935
Espanola	120,927	92,040	92,249	(209)	28,678
Manitoulin	124,866	95,086	93,636	1,451	31,230
Chapleau	98,398	75,137	71,029	4,108	27,369
Sudbury East	16,486	12,405	12,255	150	4,231
Volunteer Services	6,358	3,567	949	2,618	5,409
Strategic Engagement	141,175	28,307	30,799	(2,492)	110,376
Total Corporate Services:	\$5,176,717	\$4,032,402	\$4,102,863	\$(70,461)	\$1,073,854
Clinical and Family Services:					
General	1,051,132	790,083	774,184	15,899	276,948
Clinical Services	1,286,489	1,013,128	1,074,212	(61,084)	212,277
Branches	341,475	262,521	205,015	57,506	136,460
Family	641,117	491,264	490,269	995	150,848
Risk Reduction	146,964	107,911	107,910	1	39,054
Intake	321,601	244,853	246,378	(1,525)	75,223
Clinical Preventative Services - Outreach	140,503	109,759	104,127	5,632	36,376
Sexual Health	924,267	707,593	691,967	15,626	232,300
Influenza	0	0	2,289	(2,289)	(2,289)
Meningitis	0	0	(833)	833	833
HPV	0	0	(2,389)	2,389	2,389
Dental - Clinic	721,812	536,358	514,790	21,567	207,022
CINOT Expansion - Clinic	35,303	25,160	29,954	(4,794)	5,349
Family - Repro/Child Health	1,171,830	892,118	839,446	52,673	332,385
Total Clinical Services:	\$6,782,493	\$5,180,748	\$5,077,321	\$103,427	\$1,705,172
Environmental Health:					
General	785,386	595,825	579,700	16,125	205,686
Environmental	2,524,675	1,890,089	1,860,633	29,456	664,041
Vector Borne Disease (VBD)	586,646	67,259	60,164	7,095	526,482
Small Drinking Water System	169,994	124,622	114,937	9,685	55,057
Total Environmental Health:	\$4,066,701	\$2,677,795	\$2,615,435	\$62,360	\$1,451,267
Health Promotion:					
General	1,395,281	1,099,165	1,036,989	62,176	358,292
School	1,253,405	916,843	903,879	12,964	349,526
Healthy Communities & Workplaces	246,532	203,253	192,239	11,014	54,293
Branches	559,349	425,725	419,131	6,594	140,217
Nutrition & Physical Activity	1,221,571	896,075	868,275	27,800	353,296
Injury Prevention	400,924	288,754	282,546	6,208	118,378
Tobacco By-Law	331,408	244,932	237,857	7,075	93,551
Alcohol and Substance Misuse	282,288	211,633	201,815	9,818	80,473
Total Health Promotion:	\$5,690,757	\$4,286,381	\$4,142,732	\$143,649	\$1,548,026
RRED:					
General	1,467,889	1,082,633	1,055,890	26,743	411,999
Health Equity Office	22,740	10,847	5,695	5,152	17,045
Total RRED:	\$1,490,629	\$1,093,480	\$1,061,585	\$31,895	\$429,044
Total Expenditures:	\$23,207,298	\$17,270,805	\$16,999,935	\$270,870	\$6,207,362
Net Surplus/(Deficit)	\$0	\$(110,005)	\$160,865	\$270,870	

Sudbury & District Health Unit 2010-2015

Cost Shared Programs

STATEMENT OF REVENUE & EXPENDITURES

Summary By Expenditure Category

For The 9 Periods Ending September 30, 2015

	BOH Annual Budget	Budget YTD	Current Expenditures YTD	Variance YTD (over) /under	Budget Available
Revenues & Expenditure Recoveries:					
Funding	23,405,955	17,330,538	17,330,539	(1)	6,075,415
Other Revenue/Transfers	1,065,517	893,625	954,978	(61,353)	110,538
Total Revenues & Expenditure Recoveries:	24,471,471	18,224,164	18,285,518	(61,354)	6,185,954
Expenditures:					
Salaries	15,576,350	11,868,067	11,845,503	22,564	3,730,847
Benefits	4,216,805	3,251,213	3,215,452	35,761	1,001,353
Travel	276,074	203,163	175,376	27,787	100,698
Program Expenses	1,466,596	696,979	651,669	45,310	814,926
Office Supplies	80,420	57,675	50,041	7,634	30,379
Postage & Courier Services	72,230	51,672	37,454	14,218	34,776
Photocopy Expenses	82,100	60,303	40,966	19,337	41,134
Telephone Expenses	59,466	44,391	40,769	3,622	18,697
Building Maintenance	391,196	333,301	417,817	(84,516)	(26,621)
Utilities	195,265	146,449	141,800	4,649	53,465
Rent	239,198	179,398	173,227	6,172	65,971
Insurance	111,340	106,340	109,390	(3,050)	1,950
Employee Assistance Program (EAP)	34,969	26,226	22,651	3,575	12,318
Memberships	34,840	32,063	31,311	752	3,528
Staff Development	213,444	171,646	134,741	36,904	78,703
Books & Subscriptions	18,610	13,363	8,748	4,615	9,862
Media & Advertising	166,577	78,078	42,126	35,952	124,451
Professional Fees	423,722	315,801	314,826	975	108,896
Translation	59,065	45,096	34,961	10,135	24,104
Furniture & Equipment	30,142	22,231	19,517	2,714	10,625
Information Technology	723,063	630,715	616,307	14,407	106,756
Total Expenditures	24,471,471	18,334,169	18,124,652	209,517	6,346,819
Net Surplus (Deficit)	0	(110,005)	160,865	270,870	

Sudbury & District Health Unit
SUMMARY OF REVENUE & EXPENDITURES
For the Period Ended September 30, 2015

100% Funded Programs

Program	FTE	Annual Budget	Current YTD	Balance Available	% YTD	Program Year End	Expected % YTD
Pre/Postnatal Nurse Practitioner	704	139,000	107,034	31,966	77.0%	Dec 31	75.0%
SFO -TCAN - Prevention	724	97,200	21,934	75,266	22.6%	Dec 31	75.0%
SFO - Tobacco Control Area Network - TCAN	725	285,800	181,274	104,526	63.4%	Dec 31	75.0%
SFO - Local Capacity Building: Prevention & Protection	726	190,500	155,524	34,976	81.6%	Dec 31	75.0%
SFO - Tobacco Control Coordination	730	100,000	78,670	21,330	78.7%	Dec 31	75.0%
SFO - Youth Engagement	732	80,000	46,542	33,458	58.2%	Dec 31	75.0%
Infectious Disease Control	735	479,100	373,596	105,504	78.0%	Dec 31	75.0%
LHIN - Falls Prevention Project & LHIN Screen	736	100,000	46,378	53,622	46.4%	Mar 31/15	50.0%
MOHLTC - Special Nursing Initiative	738	180,500	138,819	41,681	76.9%	Dec 31	75.0%
MOHLTC - Northern Fruit and Vegetable Funding	743	150,100	85,842	64,258	57.2%	Mar 31/15	66.7%
Food Safety - Haines Funding	750	36,500	10,002	26,498	27.4%	Dec 31	75.0%
Triple P Co-Ordination	766	105,600	50,499	55,101	47.8%	Dec 31	75.0%
Healthy Babies Healthy Children	778	1,476,897	1,094,816	382,081	74.1%	Dec 31	75.0%
Healthy Smiles Ontario (HSO)	787	457,300	292,971	164,329	64.1%	Dec 31	75.0%
Anonymous Testing	788	59,393	26,838	32,555	45.2%	Mar 31/15	50.0%
MHPS- Aboriginal Diabetes	792	175,000	75,680	99,320	43.2%	Mar 31/15	50.0%
Total		4,112,890	2,786,419	1,326,471			

October 15, 2015

VIA ELECTRONIC MAIL

The Honourable Eric Hoskins, Minister
Ministry of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, Ontario M7A 2C4

Dear Minister Hoskins,

At its September 17, 2015, meeting, the Middlesex London Board of Health passed a motion to endorse correspondence from Dr. Penny Sutcliffe, Medical Officer of Health, Sudbury & District Health Unit, to your Ministry. Dr. Sutcliffe's June 30th letter (attached) addresses several challenges to public health created by the July 14th legislative changes to the Immunization of School Pupils' Act (ISPA).

Yours truly,



Ian Peer
Chair, Middlesex-London Board of Health

cc:

Dr. Penny Sutcliffe, MOH, Sudbury and District Health Unit
Ms. Linda Stewart, Executive Director, aPHa

Page 45 of 196

October 15, 2015


The Honourable Tracy MacCharles, Minister
Ministry of Children and Youth Services
14th Floor, 56 Wellesley St. West
Toronto, ON M5S 2S3

The Honourable Eric Hoskins, Minister
Ministry of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, Ontario M7A 2C4

Dear Minister MacCharles and Minister Hoskins,

At its September 17, 2015, meeting, the Middlesex London Board of Health passed a motion to endorse correspondence from Dr. Penny Sutcliffe, Medical Officer of Health, Sudbury & District Health Unit, to the Minister of Children and Youth Services. Dr. Sutcliffe's June 30th letter (attached) addresses the challenges Health Units have to meet Ministry expectations under the Healthy Babies Health Children Program.

Yours truly,



Ian Peer
Chair, Middlesex-London Board of Health

cc:
Dr. Penny Sutcliffe, MOH, Sudbury and District Health Unit
Ms. Linda Stewart, Executive Director, alpha

Page 46 of 196

November 4, 2015

VIA REGULAR MAIL AND EMAIL

The Honourable Tracy MacCharles
Minister of Children and Youth Services
Ministry of Children and Youth Services
14th Floor, 56 Wellesley Street West
Toronto, ON M5S 2S3

Dear Minister MacCharles:

Re. Healthy Babies Healthy Children Program Funding

On November 4th, 2015 at a regular meeting of the Board of Health for Wellington-Dufferin-Guelph Public Health, the Board considered the attached resolutions from Sudbury District Health Unit and Grey Bruce Health Unit regarding the Healthy Babies Healthy Children Program. As with many boards of health across the province, the Board of Health for Wellington-Dufferin-Guelph Public Health has been increasingly challenged to meet Ministry expectations for HBHC service provision within the 100% funding envelope. The following motion was passed:

"That the Board of Health for Wellington-Dufferin-Guelph Public Health supports the resolutions from Sudbury and District Health Unit and Grey Bruce Health Unit advocating to the Minister of Children and Youth Services to fully fund all program costs related to the Healthy Babies Healthy Children program, including all staffing, operating and administrative costs."

We are committed to providing high quality service and support to vulnerable families in our community.

Sincerely,



Doug Auld
Chair, WDGPB Board of Health

cc Ontario Public Health Units – via email
Ted Arnott, MPP – via email
Honourable Liz Sandals, MPP, Minister of Education – via email
Sylvia Jones, MPP – via email
Randy Pettapiece, MPP – via email

Page 47 of 196

August 6, 2015



The Honourable Tracy MacCharles
Minister of Children and Youth Services
14th Floor, 56 Wellesley Street West
Toronto ON M5S 2S3

Dear Minister MacCharles:

Re. Healthy Babies Healthy Children Program

On July 24, 2015 at a regular meeting of the Board for the Grey Bruce Health Unit, the Board considered the attached resolution from Sudbury District Health Unit regarding the Healthy Babies Healthy Children Program. The following motion was passed:

Motion No: 2015-62

Moved by: David Shearman Seconded by: Gary Levine

“That the Board of Health for the Grey Bruce Health Unit supports the resolution from Sudbury and District Health Unit advocating to the Minister of Children and Youth Services to fully fund all program costs related to the Healthy Babies Healthy Children program, including all staffing, operating and administrative costs.”

Carried

Sincerely,

A handwritten signature in black ink, appearing to read "Hazel Lynn".

Hazel Lynn MD, FCFP, MHSc
Medical Officer of Health

Cc: All Ontario Boards of Health

Encl.

Page 48 of 196

Working together for a healthier future for all.

101 17th Street East, Owen Sound, Ontario N4K 0A5 www.publichealthgreybruce.on.ca

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June 30, 2015

2015 JUN 30 10:10 AM

BOH Correspondence 4

The Honourable Tracy MacCharles
Minister of Children and Youth Services
Ministry of Children and Youth Services
14th floor, 56 Wellesley Street West
Toronto, ON M5S 2S3

Dear Minister MacCharles:

Re: Healthy Babies Healthy Children Program

The Healthy Babies Healthy Children (HBHC) program is a 100% funded Ministry of Child and Youth Services (MCYS) program provided by all 36 Ontario Boards of Health. Established in 1998, HBHC supports healthy child development by identifying vulnerable families and providing or connecting them with appropriate supports.

As with many boards of health across the province, the Sudbury & District Board of Health has been increasingly challenged to meet Ministry expectations for HBHC service provision within the 100% funding envelope. At its meeting on June 18, 2015, the Board of Health carried the following resolution #28-15:

WHEREAS the Healthy Babies Healthy Children (HBHC) program is a prevention/early intervention initiative designed to ensure that all Ontario families with children (prenatal to age six) who are at risk of physical, cognitive, communicative, and/or psychosocial problems have access to effective, consistent, early intervention services; and

WHEREAS the Healthy Babies Healthy Children program is a mandatory program for Boards of Health; and

WHEREAS in 1997 the province committed to funding the Healthy Babies Healthy Children program at 100% and the HBHC budget has been flat-lined since 2008; and

WHEREAS collective agreement settlements, travel costs, pay increments and accommodation costs have increased the costs of implementing the HBHC program, the management and administration costs of which are already offset by the cost-shared budget for provincially mandated programs; and

WHEREAS the HBHC program has made every effort to mitigate the outcome of the funding shortfall, this has becoming increasingly more challenging and will result in reduced services for high-risk families if increased funding is not provided.

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health direct staff to prepare a budget and program analysis of the HBHC program, outlining pressures and options for mitigation, detailing program and service implications of these options as compared against MCYS expectations; and

FURTHER THAT the Sudbury & District Board of Health advocate strongly to the Minister of Children and Youth Services to fully fund all program costs related to the Healthy Babies Healthy Children program, including all staffing, operating and administrative costs.

FURTHER THAT this motion be forwarded to the Association of Local Public Health Agencies, the Chief Medical Officer of Health and all Ontario Boards of Health.

It remains our priority to ensure that the HBHC program can effectively identify and support children and families most in need throughout the Sudbury/Manitoulin District. We look forward to further dialogue with MCYS on how we can best achieve this goal together.

Thank you for your attention to this important public health issue.

Sincerely,



Penny Sutcliffe, MD, MHSc, FRCPC
Medical Officer of Health and Chief Executive Officer

cc: Chief Medical Officer of Health (Acting)
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Ontario Boards of Health



Perth District Health Unit

653 West Gore Street
Stratford, Ontario N5A 1L4
(519) 271-7600 • www.pdhu.on.ca

October 26, 2015

The Honourable Kathleen Wynne
Premier of Ontario
Legislative Building, Queens Park
Toronto, ON M7A 1A1
premier@ontario.ca

Dear Premier Wynne:

RE: Northern Ontario Evacuations of First Nations Communities

At its meeting held on October 21, 2015, the Board of Health for the Perth District Health Unit considered correspondence forwarded and supported by Peterborough County-City Health Unit (also referencing Sudbury District Board of Health, and the Thunder Bay District Board of Health) regarding evacuations of First Nations communities in Northern Ontario.

The member municipalities of the Perth District Health Unit received evacuees from the James Bay area in 2008. The Board of Health remains deeply concerned that the First Nations communities of the James Bay Coast and Northwestern Ontario continue to require close to annual evacuation due to seasonal flooding and forest fires.

The Board of Health for the Perth District Health Unit supports the recommendation to 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 floods and forest fires.

Thank you for your attention to this important matter.

Sincerely,

Teresa Barresi, Chair
Board of Health, Perth District Health Unit

TB/mr

Cc: Hon. Eric Hoskins, Minister of Health and Long-Term Care
Hon. Yasir Naqvi, Minister of Community Safety and Correctional Services
Hon. David Zimmer, Minister of Aboriginal Affairs
Hon. Michael Gravelle, Minister of Northern Development and Mines
Hon. Bill Mauro, Minister of Natural Resources and Forestry
Linda Stewart, Executive Director, Association of Local Public Health Agencies
MPP Randy Pettapiece
Ontario Boards of Health



October 28, 2015

The Honourable Kathleen Wynne
Premier of Ontario
Legislative Building, Queen's Park
Toronto, ON M7A 1A1

Dear Premier Wynne,

Re: Northern Ontario Evacuations of First Nations Communities

At its meeting on September 22, 2015 the Board of Health for the District of Algoma Health Unit considered the correspondence forwarded by the Sudbury and District Health Unit in regards to the evacuations of First Nations communities in Northern Ontario.

This Board supports their recommendations as outlined in their attached letter and hopes that you will consider the need for a proactive, planned and adequately resourced evacuation system to ensure the safety of all First Nations Communities affected.

Thank you for your consideration.

Sincerely,

Lee Mason
Chair, Board of Health

Attachment

Cc: Hon. Dr. Eric Hoskins, Minister of Health and Long-Term Care
Hon. David Orazietti, MPP for Sault Ste. Marie
Michael Mantha, MPP for Algoma-Manitoulin
Association of Local Public Health Agencies
Ontario Boards of Health

**Ministry of Health
and Long-Term Care**

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iApprove-2015-00948

OCT 30 2015

Mr. René Lapierre
Chair, Board of Health
Sudbury and District Health Unit
1300 Paris Street
Sudbury ON P3E 3A3

Dear Mr. Lapierre:

I am pleased to advise you that the Ministry of Health and Long-Term Care will provide the Board of Health for the Sudbury and District Health Unit up to \$107,400 in one-time funding for the 2015-16 funding year to support the planning, preparation, and deployment activities for Panorama.

The Executive Director of the Public Health Division will write to the Sudbury and District Health Unit shortly concerning the terms and conditions governing this funding.

Thank you for your dedication and commitment to Ontario's public health system.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'E. Hoskins'.

Dr. Eric Hoskins
Minister

c: Dr. Penny Sutcliffe, Medical Officer of Health, Sudbury and District Health Unit

THE GLOBE AND MAIL

POLITICS

Liberals to restore mandatory long-form census

Gloria Galloway

OTTAWA — The Globe and Mail

Published Thursday, Nov. 05, 2015 11:11AM EST

Last updated Thursday, Nov. 05, 2015 1:42PM EST

The new Liberal government is bringing back the mandatory long-form census that was cancelled by the Conservatives in 2010 – but there may be no penalties for those who refuse to complete the survey.

In a symbolic first gesture of the incoming government of Justin Trudeau, who has been trying to emphasize his openness and interest in evidence-based decision making, two cabinet ministers were dispatched Thursday morning to announce that the long-form census would once again be mandatory.

Navdeep Bains, the new Minister of Innovation, Science and Economic Development, and Jean-Yves Duclos, the Minister of Families, Children and Social Development, told reporters that the Liberal plan for “open and fair” government will start with the reinstatement of the requirement to complete the long-form census.

The Liberals say making the survey voluntary actually cost the Conservative government \$22-million so their plan will save money.

“We have seen the comments of the academic community over the last few years and also the reaction of Statistics Canada, a very professional agency,” said Mr. Duclos, the former head of the economics department at Laval University. “I think all of this has been telling us that the past is the past. We can’t change that. We are moving to 2016 with a better system that will be less costly and more reliable and people like me are delighted.”

When the Conservatives moved to make the National Household Survey voluntary, they were widely criticized by scientists and others who warned that the data collected would be of poor quality and would make decisions difficult for public officials and private companies who relied on the information. It also prompted the resignation of Munir Sheikh, Canada’s chief statistician, who said the integrity of his institution was being compromised.

At the time, there was widespread concern that the continuity of the data that had been collected every five years for decades would be lost – and that census-over-census comparisons would no longer be possible.

Mr. Bains acknowledged that the long-term quality of the information has been hurt by the non-mandatory nature of the 2011 census which was completed by just 68.6 per cent of households across the country compared to the usual response rate which has been about 95 per cent.

Until the Conservatives changed the law, anyone who refused to complete the census forms could have been hit with a fine of as much as \$500 and a jail term of up to three months – though no one ever spent time behind bars for failing to co-operate.

But neither Mr. Bains nor Mr. Duclos could point to specific penalties that will be imposed under their government's plan to reinstate the mandatory nature of the questionnaire. Instead, they said, the government would be relying on public education and the desire of Canadians to do what is right.

"If you speak to Canadians and you get them engaged in the process, they will fill out the information, and that's what we are focusing on because we need good, reliable data," said Mr. Bains. "The law is the law and that does not change."

Follow Gloria Galloway on Twitter: @glorgal [<https://twitter.com/@glorgal>]

News / Canada

Canada's long-form census is back for 2016

A day after taking office, the Liberal government announced the 61-question long census form will be restored for 2016 census



SEAN KILPATRICK / THE CANADIAN PRESS

There was no long-form for the last census in 2011, but the new Liberal government is bringing it back for the 2016 census.

By: Bruce Campion-Smith Ottawa Bureau, Published on Thu Nov 05 2015

OTTAWA—The portrait of Canada is being restored.

Just a day after taking office, the Liberal government announced Thursday that the mandatory long-form census — axed by the Conservatives in 2010 — will be reinstated for the 2016 census.

“Today, Canadians are reclaiming their right to accurate and more reliable information,” said Navdeep Bains, the newly named minister of Innovation, Science and Development.

With the next census, communities will “once again have access to high-quality data they require,” said Bains, the MP for Mississauga-Malton.

He portrayed the decision as the first step of the Liberals’ commitment to “open and fair government.”

The announcement rolls back one controversial decision by Conservatives and one that prompted critics to charge that the Stephen Harper government was turning its back on fact-based decision-making.

During the census — done every five years — most Canadian households get an eight-question form. However, a longer, more detailed, 61-question form was distributed to one-in-five households.

With questions on everything from income, cultural heritage, education, work habits, even details of where people live, it gave researchers a rich source of data to build an understanding of Canadian society.

The data was used in myriad ways, planning everything from public health to transit and rural development.

"The use is almost never-ending," Ian McKinnon, chairperson of the National Statistics Council, the senior advisory body to the chief statistician at Statistics Canada told the Star.

Yet in 2010 that lengthy census form was scrapped by the Conservatives, who said its questions were intrusive, even though the data is kept confidential.

The government was unmoved by the protests and warnings that the lack of detailed data would harm everything from urban planning to business forecasts.

The Conservatives replaced the long-form census with a voluntary "National Household Survey" for the 2011 census. A poor response rate in some geographic areas and among some segments of society has led to problems with the data.

And Bains said Thursday that the voluntary survey actually cost an estimated \$22 million more than the mandatory form it replaced, even though it delivered poorer results.

That's in part because the survey went to more households — one-in-three.

"Making it mandatory will actually be less expensive and it'll be on budget and on time," Bains said.

Bains was reluctant to discuss the penalties for those who fail to fill out the mandatory forms, saying only "the law is the law."

McKinnon said the data produced by the mandatory long form census is "more robust" than the voluntary survey.

While he said Statistics Canada worked "extraordinarily hard" to make the survey data "as useful as possible" it was no longer as trusted as the benchmark for the Canadian statistical system.

Conservative MP Tony Clement, who was the minister in charge of Statistics Canada at the time of the 2010 change, appeared to express some regret for the move Thursday.

"Looking back on it, I would say that it would have been better to have a much broader review of data collection in our country and come up with a better system," Clement said.

"Other countries are moving away from traditional census taking and moving towards the data collection on a broader scale to get the data that is necessary for researchers, for businesses and academics," he said.

"That discussion never really happened and I think that it should happen at some point," he said.

Reaction to the announcement was swift as a variety of organizations cheered the news that the long-form census was returning.

"We are now back on track to knowing who we are, in all our diversity," Stephen Toope, president of the Federation for the Humanities and Social Sciences, said in a statement.

With files from Joanna Smith



Sudbury & District

Health Unit

Service de
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1.866.522.9200

www.sdhu.com

November 9, 2015

VIA ELECTRONIC MAIL

The Right Honourable Justin Trudeau
Prime Minister of Canada
Office of the Prime Minister
80 Wellington Street
Ottawa, Ontario K1A 0A2
Email: pm@pm.gc.ca

Dear Prime Minister:

Re: 2016 Census Long Form

I am writing to congratulate the federal government on your decision to reinstate the mandatory long form for the 2016 Census.

As the Medical Officer of Health responsible for public health programs and services in Ontario's Sudbury and Manitoulin districts, I can testify to the value to the public health system of the long form Census questionnaire. Our region includes a diverse population of urban/rural and significant Aboriginal and Francophone populations. The data from the census long form is critical to our understanding of how to best meet the health needs of this population.

Public health units and other government and non-government agencies use the data from the Census long form for health assessment, program planning and evaluation, and identification of priority populations. At the Sudbury & District Health Unit, we have produced fact sheets, health status reports, and demographic profile reports using the data from the Census long form. The Census long form provides valuable high quality data not available from other sources.

I am confident that the reinstatement of the mandatory Census long form will restore the high standard of quality of demographic and socioeconomic data for which Canada was known worldwide. The changes will result in renewed ability to compare data to previous years and to monitor trends. In addition, this change will result in proper representation of vulnerable sub-populations who were less likely to complete a voluntary survey, and for whom evidence-informed Public Health services and programs are indispensable.

Thank you for your attention to and quick action on this important issue. As a public health physician I am highly supportive of your government's commitment to providing the highest quality information to guide health and social policy.

Sincerely,

P. Sutcliffe, MD, MHSc, FRCPC
Medical Officer of Health and Chief Executive Officer

Letter
Re: 2016 Census Long Form
November 9, 2015
Page 2

cc: The Honourable Jane Philpott, Minister of Health, Government of Canada
The Honourable Navdeep Singh Bains, Minister of Innovation, Science
and Economic Development, Government of Canada
The Honourable Eric Hoskins, Minister of Health and Long-Term Care, Government
of Ontario
Marc Serré, Member of Parliament, Nickel Belt
Paul Lefebvre, Member of Parliament, Sudbury
Carol Hughes, Member of Parliament, Algoma – Manitoulin - Kapuskasing
Dr. Gregory Taylor, Chief Public Health Officer, Public Health Agency of Canada
Dr. David Williams, Interim Chief Medical Officer of Health, Ministry of Health and
Long-Term Care
Linda Stewart, Executive Director, Association of Local Public Health Agencies
René Lapierre, Chair, Sudbury & District Board of Health

**Ministry of Health
and Long-Term Care**

Executive Director's Office

Public Health Division
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October 26, 2015

MEMORANDUM

TO: Board of Health Chairs
Medical Officers of Health and Associate Medical Officers of Health

RE: Amendment to the Protocols under the Ontario Public Health Standards -Infection Prevention and Control Practices Complaint Protocol, 2015; Infection Prevention and Control in Personal Services Settings Protocol, 2015; and Infectious Diseases Protocol, 2015.

As a follow-up to my October 14th email please find below a summary of the amendments to the following protocols:

- The *Infection Prevention and Control Practices Complaint Protocol*;
- *Infection Prevention and Control in Personal Services Settings Protocol*; and
- *Infectious Diseases Protocol*.

The protocols were revised to reflect specific transparency reporting requirements as per the Minister's commitment to enhanced transparency communicated last December and public health unit (PHU) feedback provided from consultation conducted in winter 2014.

Additional revisions to the protocols were incorporated as part of the ongoing Protocol Review process. These changes were made by the Ministry of Health and Long-Term Care (the ministry) based on input from Public Health Ontario (PHO) and PHUs.

Amendments in the *Infection Prevention and Control Practices Complaint Protocol* include:

- Clarification of requirements for:
 - responding to complaints involving the conduct of health professionals governed by a regulatory college, including a requirement to contact the regulatory college,
 - conducting an assessment of the premises in situations involving a regulated health professional, and advising the regulatory college if the board of health's assessment indicates that an infection prevention and control (IPAC) lapse has occurred;
 - steps of an assessment, further investigation, and the responsive actions required;
- Incorporating a new Reporting section to specify the new requirements regarding public reporting of IPAC lapses; and a Glossary to provide the definitions of an IPAC lapse and Regulatory College; and
- Minor wording changes to clarify language.

.../2

The revised document is available in English and French, respectively, through the Ontario Public Health Standards (OPHS) website at the following links:

http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/infection_prevention_complaint.pdf

http://www.health.gov.on.ca/fr/pro/programs/publichealth/oph_standards/docs/infection_prevention_complaintf.pdf

Amendments in the *Infection Prevention and Control in Personal Services Settings Protocol* include:

- Clarification of requirements for:
 - expectations on the purpose of annual routine inspections;
 - use of a risk-based approach for inspections conducted beyond the annual routine inspection and those in response to complaints;
 - boards of health to address personal service settings on-call issues within their current on-call system;
- Including a requirement to maintain an inventory of all personal services settings including contact information and location;
- Incorporating a new Reporting section to specify the new requirements regarding public reporting of IPAC lapses; and
- Expansion of the Glossary to include definitions of IPAC lapse, regulatory college, personal services, and risk-based approach and revisions to the definition of risk assessment to improve applicability.
- Structural and minor wording changes to clarify language.

The revised document is available in English and French, respectively, through the OPHS website at the following links:

http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/infection_prevention_personal_services.pdf

http://www.health.gov.on.ca/fr/pro/programs/publichealth/oph_standards/docs/infection_prevention_personal_servicesf.pdf

Additional changes have been made to the *Infectious Diseases Protocol* to reflect the new definitions under the *Child Care and Early Years Act, 2014* and are available in English and French, respectively, through the OPHS website at the following links:

http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/infectious_diseases.pdf

http://www.health.gov.on.ca/fr/pro/programs/publichealth/oph_standards/docs/infectious_diseasesf.pdf

The ministry will communicate further details regarding these changes to PHUs via regular communications to ensure continued compliance with the *Health Protection and Promotion Act* and the OPHS.

.../3

I would like to express my thanks to you and your staff for your ongoing work in upholding the OPHS and Protocols to ensure the continued strength of the public health system in Ontario.

Original signed by

Roselle Martino
Executive Director

c: Dr. David C. Williams, Acting Chief Medical Officer of Health
Dr. Peter Donnelly, President and Chief Executive Officer, Public Health Ontario
Dr. George Pasut, Vice-President, Science and Public Health, Public Health Ontario
Dr. Brian Schwartz, Chief, Communicable Diseases, Emergency Preparedness and Response, Public Health Ontario
Lisa Fortuna, Director, Communicable Diseases, Emergency Preparedness and Response, Public Health Ontario

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HLTC2976MC-2014-330

October 14, 2015

Dear Board of Health Chairs and Medical Officers of Health:

As part of my responsibilities as Minister of Health and Long-Term Care, I am releasing the amended Ontario Public Health Standards (OPHS) and related Protocols to require reporting of infection prevention and control (IPAC) lapses.

Transparency is a key priority in ensuring Ontarians receive the care they need and I would like to thank you for submitting your Transparency Plans and committing to making transparency a priority objective in your work.

To support this work, the new requirements make reporting practices more transparent and ensure that all Ontarians have access to timely, useful and accurate information. This will assist the public in making informed decisions regarding their health.

Further details have been provided in the new *Infection Prevention and Control Lapse Disclosure Guidance Document*. The requirements outlined in this guidance document are mandatory activities for boards of health to undertake.

All revised documents are effective immediately, are attached for your reference and will be available in English and French later in the month through the OPHS website:
http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/.

I would like to express my thanks to you and your staff for your ongoing work in upholding the OPHS and Protocols to ensure the continued strength of the public health system in Ontario.

If you have any questions regarding the changes please do not hesitate to contact the ministry by email at OPHS.Protocols.moh@ontario.ca.

Yours sincerely,

Dr. Eric Hoskins
Minister

c: Dr. Robert Bell, Deputy Minister
Dr. David C. Williams, Acting Chief Medical Officer of Health
Roselle Martino, Executive Director, Public Health Division

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

alPHA Sections:

Boards of Health
Section

Council of Ontario
Medical Officers of
Health (COMOH)

**Affiliate
Organizations:**

ANDSOOHA - Public
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Health Inspectors of
Ontario

Health Promotion
Ontario

Ontario Association of
Public Health Dentistry

Ontario Society of
Nutrition Professionals
in Public Health

October 20, 2015

Hon. Eric Hoskins
Minister of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, Ontario M7A 2C4

Dear Minister Hoskins,

Re: Primary Health Care Expert Advisory Committee Report – Patient Care Groups

On behalf of member Medical Officers of Health, Boards of Health and Affiliate organizations of the Association of Local Public Health Agencies (alPHA), I am writing today to provide our comments on the Primary Health Care Expert Advisory Committee's report, *Patient Care Groups: A new model of population based primary health care for Ontario*.

alPHA's Board of Directors was pleased to welcome committee co-chair Dr. David Price and member Carol Timmings to its most recent meeting for a valuable discussion of the report's recommendations and the roles being proposed for public health.

We are very pleased that a key feature of the proposed model is the recognition that health is determined by many factors beyond the health system and that partnerships between primary care and other sectors will be pursued to build a culture that supports community health and wellbeing.

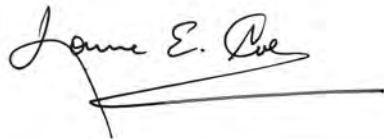
We welcome the emphasis placed on public health's partnerships outside of Ontario's health care system (e.g. the education, transportation, environment and municipal sectors) as important considerations in system redesign, having recognized them not only as factors in overall health but also as important linkages that will provide conduits for people to access primary care services that they need, when they need them.

We are conscious of the priority that has been placed by your Government on health system reform and agree with its aims to improve quality and ensure sustainability. While we are not taking a position on the model proposed in this report as a means to achieve it, we believe that it contains recommendations for public health sector contributions that are worthy of further exploration. For example, Dr. Price underscored the potential of utilizing public health's surveillance and analysis expertise to conduct population-based needs assessments to inform the effective local allocation of primary health care resources.

As your Government examines these and other recommendations in the report, we look forward to opportunities to engage in careful consideration of how the public health sector's mandate, functions, expertise, capacity and linkages can be reinforced and utilized in partnership with the primary care sector to improve health outcomes. This would best be accomplished by ensuring substantive public health sector involvement at the system-level planning tables that are established to oversee the next steps in primary care reform.

We look forward to learning more about your plans to proceed with primary care reform and will welcome further discussions about the important contributions that our members can make on behalf of Ontario's public health sector.

Sincerely,

A handwritten signature in black ink, reading "Lorne E. Coe". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Lorne Coe,
President

COPY: Dr. Bob Bell, Deputy Minister, Health and Long-Term Care
Dr. David Williams, Interim Chief Medical Officer of Health
Roselle Martino, Executive Director, Public Health Division
Martha Greenberg, Assistant Deputy Minister, Health Promotion Division
Sharon Lee Smith, Associate Deputy Minister, Policy and Transformation

November 4, 2015

DELIVERED VIA E-MAIL

dmatthews.mpp@liberal.ola.org

Minister Responsible for the Poverty Reduction Strategy/Deputy Premier
99 Wellesley Street West
4th Floor, Whitney Block
Toronto, ON M7A 1W3

Attention: The Honourable Deborah Matthews, MPP

Dear Minister Matthews:

Re: Results of 2015 Nutritious Food Basket for Wellington-Dufferin-Guelph Public Health

The results of the 2015 Nutritious Food Basket (NFB) for Wellington-Dufferin-Guelph Public Health (WDGPH) have been released. In 2015, the cost of the NFB in WDG for a reference family of four is **\$209.42 per week**. The list of foods used in the survey represents nutrition recommendations and food purchasing patterns of Canadians and includes foods from the four food groups of Canada's Food Guide.

The results of this report have raised significant concern among the members of WDGPH Board of Health about poverty and food insecurity. When housing costs and other basic living expenses are considered, many individuals and families with a limited income do not have adequate funds to purchase nutritious food on a consistent basis. Local data shows that since 2009 when the new nutritious food basket protocol was implemented, there has been a 25% increase in the cost of food over a 7 year period. These issues pose serious health risks for the public health of our community.

This report clearly shows that low-income individuals and families do not have enough money to pay for their basic needs including shelter and healthy food. For example, a case scenario of a single person on Ontario Works fares the worst in this respect as 92% of their income may go to rent leaving insufficient money (8% of income) left over to purchase any food or cover basic expenses. According to the nutritious food basket data, a basic cost to eat healthy for a single person on Ontario works is estimated to be 41% of their income.

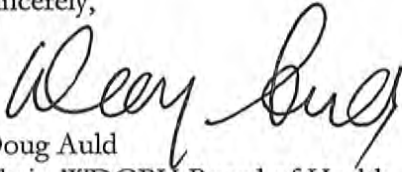
Page 67 of 196

.../2

The report suggests that poverty reduction must remain a high priority for the government. We are aware that the government is taking steps to improve poverty. We are conscious of the 2010 review of Ontario's social assistance system that was completed to ensure that social assistance programs make certain that Ontarians can afford to make healthy choices. We also are aware that the government released a Poverty Reduction Strategy 2014 annual report that highlighted some progress. Although we applaud this progress, there is much more that could be done to ensure that everyone in Ontario can afford to eat healthy. WDGPH Board of Health is requesting the provincial government to increase social assistance basic allowance rates to an amount that is adequate to cover basic living expenses, including the cost of healthy eating as determined by the food costing survey. This will allow low income individuals and families to afford to eat healthier and ultimately reduce lifestyle related chronic disease which can contribute to lower healthcare costs.

We look forward to your urgent attention to address the economic barriers that people living with low-incomes experience in accessing healthy food.

Sincerely,



Doug Auld
Chair, WDGPH Board of Health

c.c. The Honourable Liz Sandals, MPP and Minister of Education – via e-mail
Ted Arnott, MPP – via e-mail
Sylvia Jones, MPP – via e-mail
Randy Pettapiece, MPP – via e-mail
Eric Hoskins, Minister, Ministry of Health & Long-Term Care – via e-mail
Dr. Nicola Mercer, MOH & CEO, WDGPH – via e-mail
Ontario Public Health Units

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November 12, 2015

MEMORANDUM TO: Health workers, health sector employers and other health system partners

FROM: Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care

RE: Syrian Refugee Crisis

The Federal government indicated as part of their election platform, and has subsequently reconfirmed, their commitment to resettle 25,000 government-assisted refugees to Canada before the end of 2015. There are many unknowns at this point including confirmation of resettlement locations, timing and pacing of resettlement and total numbers of refugees.

What is known is that Ontario will likely be a major point of entry for incoming refugees over the next few months and we need to ensure the health system is ready, willing and able to assist. Refugees typically face greater settlement and integration challenges than other newcomers. Many refugees have experienced prolonged periods in refugee camps, trauma, violence, and limited access to health care and education. As part of the immigration process, refugees undergo medical screening at their point of departure, are assessed by Quarantine Officers at an airport upon arrival in Canada and will require medical assessment and ongoing care once they have settled into temporary accommodations. Ontario's health system will be called upon to assist.

The Ministry of Health and Long-Term Care is currently undertaking advanced planning with provincial and federal partners to prepare Ontario's health, social services, education and housing sectors for a large influx of refugees to ensure supports are available for all refugees.

As more information is made available, we will communicate with partners across the health system to ensure local plans can be put into place to provide all the necessary supports this at-risk population deserves.

Health system partners may direct any questions to the ministry's Health Care Provider Hotline by email at emergencymanagement.moh@ontario.ca or by phone at 1-866-212-2272.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Eric Hoskins'.

Dr. Eric Hoskins
Minister of Health and Long-Term Care

c: Deputy Minister Dr. Bob Bell



Information Break

October 15, 2015

This semi-monthly update is a tool to keep alPHa's members apprised of the latest news in public health including provincial announcements, legislation, alPHa correspondence and events.

Ontario Offers Nasal Spray Flu Vaccine for Children

The Province of Ontario recently announced that beginning October 26, a nasal spray flu vaccine will be available to children and youth aged 2 to 17 years as an alternative to an injection in the arm. Parents will still have the option to choose the vaccine in an injectable form for their children. Both vaccine forms will offer protection against four flu viruses this season.

[Read the government's news release here](#)

2016 Annual Conference Committee

Thank you to everyone who volunteered to participate on alPHa's program planning committee for its 2016 Annual Conference, which will take place in June of next year. We have now finalized the committee's membership and look forward to scheduling the first meeting in two weeks. Look for updates on the conference theme and program in this space.

alPHA Risk Management Workshop - November 5, 2015

If you hadn't already heard, alPHA is hosting a workshop for boards of health, *Managing Uncertainty: Risk Management for Ontario Boards of Health*, on November 5. This day-long event is ideal for board of health members, medical and associate medical officers of health, and directors/senior public health managers who are interested in learning more about how to reduce risk in their organization. Special guest speakers include Graham Scott, a well-known expert in the assessment of boards and management teams, as well as senior staff from Algoma Public Health and KFL&A Public Health, both of whom have undergone a provincial assessment process. Pre-registration is required for this event. Hope you can attend!

[Click here to register online and for further details.](#)

Upcoming alPHA Events

November 4, 2015 - COMOH Section General Meeting, DoubleTree by Hilton Hotel Downtown Toronto. [Click here for details.](#)

November 5, 2015 - Managing Uncertainty: Risk Management Workshop for Ontario Boards of Health, Toronto. [Click here for details.](#)

June 5, 6 & 7, 2016 - alPHA Annual General Meeting and Conference - 30th Anniversary, Novotel Toronto Centre, 45 The Esplanade, Toronto, Ontario.

alPHA is the provincial association for Ontario's public health units. You are receiving this update because you are a member of a board of health or an employee of a health unit.

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Information Break

November 3, 2015 - CORRECTION*

This semi-monthly update is a tool to keep alPHa's members apprised of the latest news in public health including provincial announcements, legislation, alPHa correspondence and events.

*** NOTE: Yesterday's email contained several broken links in the "Government Items" section. These have been corrected below. Apologies for any inconveniences this may have caused.**

Government Items of Public Health Interest

Here is a roundup of a number of recent government announcements and releases that may be of interest to public health:

[Ontario Government and OPSEU Ratify New Collective Agreement](#)

[Ontario Releases Report by Expert Advisory Panel on Homelessness](#)

[Manitoba Expands HPV Immunization Program to Male Students](#)

[Ontario Helping Cities Become More Bike-Friendly](#)

Federal Liberal Party Platform Planks on [Healthier Kids](#), [Interim Federal Health Program](#), [Long-Form Census](#), [Fighting Poverty](#) and [more](#)

[Public Health Ontario Report on Mandatory Bike Helmet Legislation](#)

[Ontario Reports on Elliot Lake Recommendations](#)

alPHa Risk Management Workshop - Nov. 5, 2015

Our risk management workshop for board of health members and senior public health unit staff will be held this week on Thursday, November 5 at the DoubleTree by Hilton Hotel in downtown Toronto. The day-long interactive session features special guest speakers Graham Scott, Corinne Berinstein, and senior staff from the Algoma and KFLA health units. Pre-registration is required for this event. Hope to see you there.

[Click here for more information on the workshop.](#)

Recent alPHA Correspondence

On behalf of members, alPHA recently wrote to Ontario's health minister Dr. Eric Hoskins with comments on the new public health funding model. The letter was accompanied by a resolution passed by the alPHA Board of Directors. *(To view the letter and resolution, click on the first link below to get to our Correspondence page and then click on the item "alPHA Letter/Resolution - PH Funding Formula" at the top of the correspondence list).* Also in October, alPHA responded to the May 2015 report by the provincial Primary Health Care Expert Advisory Committee that articulates a role for the public health sector in a population-based model of primary care reform.

[Read alPHA's correspondences and resolution on the above here](#)

[Read the Primary Health Care Expert Advisory Committee's report here](#)

Upcoming alPHA Events

November 4, 2015 - COMOH Section General Meeting, DoubleTree by Hilton Hotel Downtown Toronto. [Click here for details.](#)

November 5, 2015 - Managing Uncertainty: Risk Management Workshop for Ontario Boards of Health, Toronto. [Click here for details.](#)

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TIMES COLONIST

Trevor Hancock: How we keep Canada healthy is a great story

Dr. Trevor Hancock / Times Colonist

October 28, 2015 12:01 AM

CBC-TV is airing Keeping Canada Alive, a series full of the usual dramatic life-and-death stories of health care, as well as some segments about family practice and home care. But nothing about keeping people healthy in the first place, no stories about the great work public health and its allies do every day to keep Canadians out of the health-care system.

So here are my suggestions for Keeping Canada Healthy, a followup TV series that CBC should do. Public health might not be as gripping, but it is at least as important in reducing disease, injury, disability and premature death as anything the health-care system does.

Episode 1: Yes, you can drink the water.

Most Canadians are fortunate in being able to turn on the tap and get safe drinking water. In this episode, we look at the workings of a municipal water-treatment plant and follow a public-health inspector as she tests the water quality in a small water-supply system.

We also visit a First Nations community under a boil-water advisory — one of 118 in Canada, 25 of which are in B.C. We learn about the problems faced by these communities, and what is being done to ensure they, too, have clean, safe water.

Episode 2: You can breathe the air, too.

Outdoor air pollution still kills and sickens thousands of people in Canada every year. We begin in Hamilton, Ont., where Clean Air Hamilton has been working since 1998, with considerable success. There we attend some of the events that are part of their annual Smart Commute Week.

But we spend 90 per cent of our time indoors, so mostly we breathe indoor air. One of public health's great accomplishments has been making smoking socially unacceptable. So not only do we have marked reductions in tobacco-caused death and disease, we also have non-smoking areas everywhere.

We accompany one of B.C.'s tobacco-enforcement officers as they enforce the Tobacco Control Act in their communities, ensuring public spaces are smoke-free and tobacco is not sold to minors.

Episode 3: Smallpox, diphtheria, tetanus, polio — what are they?

Our great-grandparents knew and feared these diseases, but they are largely unknown today. In fact, smallpox was eradicated globally in 1980. The chief public health officer of Canada noted in his 2008 report that "in Ontario alone, 36,000 children died from diphtheria between 1880 and 1929," while "at its peak in 1953, polio caused nearly 500 deaths in Canada" and left many others disabled.

The low levels of these and other infectious diseases today is due to a combination of public health actions — notably immunization — and broader social changes, such as improved living conditions and nutrition. But our lack of familiarity with these diseases means that today — mistakenly — some fear the vaccine more than the disease.

In this episode we follow a team of public-health nurses organizing an immunization campaign, accompany a hospital infection-control nurse in her work, and visit research labs where vaccines against such modern-day scourges as malaria and HIV are under development.

Episode 4: Safe food — mostly.

Historically, our food was often the source of infectious diseases, and while food safety is still a challenge, it is greatly improved. We accompany a public-health inspector as he inspects restaurants and other food establishments, visit a slaughterhouse to see how our meat is kept safe and accompany a team from the Canadian Food Inspection Agency and provincial and local staff as they work to identify and control an outbreak of salmonella.

Episode 5: Healthy food — not so much.

The chief public health officer also noted that “Canada’s first food guide was introduced in 1942 to reduce nutritional deficiencies resulting from wartime food rationing.” The nutritional quality of our diet remains a challenge, although these days poor nutrition is more likely due to over-eating, too much salt, fat and sugar, and too little fruit and vegetables.

In this episode we spend time with community nutritionists and other public health staff as they work to improve food security locally, visit a school that is removing junk food and pop and creating healthy meals, and drop by a community garden, where they are not only growing food but building community.

If not CBC, maybe B.C.’s Knowledge Network could take this on — it needs doing.

Dr. Trevor Hancock is a professor and senior scholar at the University of Victoria’s school of public health and social policy.

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NEWS LOCAL

City gets bad grade for health

By Keith Dempsey, For The Sudbury Star
Sunday, October 25, 2015 10:50:35 EDT PM



In April, Statistics Canada rated Sudbury as the happiest city in Canada. Now, a data-based journalism website, 10and3.com, has rated the Nickel City as one of the unhealthiest cities in this country.

Sudbury and the surrounding district is ranked 91st out 101 for health, with particularly high rates of smoking, diabetes, and cancer.

Sudbury had a 8.5% asthma rate, while our cancer incidence percentage was 427.1 per 100,000 people, the diabetes rate measured 8.8%, and 38.7% are considered overweight. Sudbury's "good perceived mental health" is at 72.8%; 22.5% of Sudburians smoke; and 83.6% of people have regular access to a doctor.

The Canadian average for asthma rate is 8.3%, the cancer incidence percentage rate is 404.9 per 100,000, the diabetes average is 6.3%, the average overweight percentage is 34.0%, the good perceived mental health average percentage is 72.2%, the average daily smoking percentage is 15.3%, and the average percentage of people having regular access to a doctor is 84.9%.

The country was divided into 117 health regions - the most detailed subdivision of the country that StatsCan uses to track health data - and looked at seven health indicators from StatsCan's 2013 health profile: the rate of asthma, diabetes and cancer, access to medical doctors, daily smoking rate, rate of overweight residents, and perceived mental health.

"What we did was dove in depth into one region, in particular in Saskatchewan," Arik Motskin, one of the contributing authors of the study, said. "We didn't mean to pick on them but what we discovered in the Prince Albert area were things that affects a lot of the regions that performed poorly in general, and the stories that we discovered there are applicable to a lot of places. Firstly, there's some behavioural issues in an area that can be a factor. For instance, the smoking rate in Sudbury is 22.5% and that's high. That's a behavioural kind of issue, for whatever cultural reasons and whatnot."

An aging population will have more higher rates of diabetes and cancer, so depending on what the demographic challenges are in a region, that plays into the numbers.

"We're not experts in what's going in Sudbury, but I'm sure there's some combination of pockets of low income, pockets of demographic type of challenges," Motskin said.

"What we've discovered is presenting this data this way, in an open way, is a little bit eye-opening for people," Motskin added. "I think a lot of our readers have just been surprised -- 'so many of my neighbours smoke, or so many of my neighbours are overweight', so I think getting the numbers out there, having this recognition that your community might be having a problem, is very critical. What to do about it is something that has to happen at the local level. If one of the issues is people aren't getting outdoors enough and exercising, then that's something the community has to fix."

He's not saying that is the root of the issue for Sudbury, but it could be.

"I think what readers and residents can do is have an awareness," Motskin said. "And then you can go out and tackle this challenge, be vocal about it. It can be dire when over 20% of a region is smoking; it's kind of disappointing, I would think."

The 10 least healthy regions, according to the study, are Prince Albert Parkland, Gaspé (Quebec), Timiskaming, Porcupine (Timmins), Campbellton (New Brunswick), Côte-Nord (Quebec), Eastern Ontario Health Unit, Nord-du-Québec, Prairie North (Saskatchewan), and Lanaudière (Quebec).

The 10 healthiest regions are York, North Shore/Coast Garibaldi (B.C.), Richmond (B.C.), Halton (Ont.), Chaudière-Appalaches (Quebec), Calgary, Toronto, Fraser North (B.C.), Peel, and Vancouver.

I Stopped My Hair Loss

naturalwellbeing.com/hair-growth

"I Spend Thousands on Hair Growth Then I Found This \$39 Solution".

2015

flu shot clinics

Date	Time	evenings	by appointment	Location
21-Oct	9:00 a.m. to 4:00 p.m.		+	SDHU Main Office
	9:00 a.m. to 2:00 p.m.			Health Sciences North
22-Oct	9:00 a.m. to 7:00 p.m.	+	+	SDHU Main Office
23-Oct	9:00 a.m. to 4:00 p.m.		+	SDHU Main Office
26-Oct	9:00 a.m. to 7:00 p.m.	+	+	SDHU Main Office
27-Oct	9:00 a.m. to 4:00 p.m.		+	SDHU Main Office
	12:00 p.m. to 4:00 p.m.			ParkSide Centre
28-Oct	9:00 a.m. to 4:00 p.m.		+	SDHU Main Office
	9:00 a.m. to 2:00 p.m.			Laurentian University
29-Oct	9:00 a.m. to 4:00 p.m.		+	SDHU Main Office
	9:30 a.m. to 4:30 p.m.		+	SDHU Chapleau Office
	3:00 p.m. to 7:00 p.m.	+		Garson Community Centre / Arena
	3:00 p.m. to 6:30 p.m.	+		St. Mary Catholic School
30-Oct	9:00 a.m. to 4:00 p.m.		+	SDHU Main Office
2-Nov	9:00 a.m. to 4:00 p.m.		+	SDHU Main Office
3-Nov	9:00 a.m. to 4:00 p.m.		+	SDHU Main Office
	3:00 p.m. to 7:00 p.m.	+		Onaping Falls Lions Club
	3:30 p.m. to 6:30 p.m.	+		Central Manitoulin Public School
4-Nov	9:00 a.m. to 7:00 p.m.	+	+	SDHU Main Office
	8:30 a.m. to 3:30 p.m.		+	SDHU Mindemoya Office
5-Nov	9:00 a.m. to 4:00 p.m.		+	SDHU Main Office
	9:00 a.m. to 3:30 p.m.		+	SDHU Espanola Office
6-Nov	9:00 a.m. to 4:00 p.m.		+	SDHU Main Office
7-Nov	10:00 a.m. to 4:00 p.m.			New Sudbury Centre
	9:00 a.m. to 4:00 p.m.		+	SDHU Main Office
9-Nov	9:00 a.m. to 4:00 p.m.		+	SDHU Main Office
10-Nov	9:00 a.m. to 4:00 p.m.		+	SDHU Main Office
12-Nov	9:00 a.m. to 4:00 p.m.		+	SDHU Main Office
13-Nov	9:00 a.m. to 4:00 p.m.		+	SDHU Main Office
14-Nov	10:00 a.m. to 4:00 p.m.			Southridge Mall
16-Nov	9:00 a.m. to 4:00 p.m.		+	SDHU Main Office
17-Nov	9:00 a.m. to 4:00 p.m.		+	SDHU Main Office
18-Nov	9:00 a.m. to 7:00 p.m.	+	+	SDHU Main Office
19-Nov	9:00 a.m. to 4:00 p.m.		+	SDHU Main Office
20-Nov	9:00 a.m. to 4:00 p.m.		+	SDHU Main Office
21-Nov	9:00 a.m. to 4:00 p.m.		+	SDHU Main Office

Remarks to the 2015 HealthAchieve Conference

Dr. Eric Hoskins

Minister of Health and Long-Term Care

4 November 2015

CHECK AGAINST DELIVERY

Good morning everyone. Thank you for that very kind introduction.

And thank you for inviting me to be here for HealthAchieve.

I have heard from so many of you that this year's conference has been especially inspiring – and that inspiration comes from the outstanding sessions HealthAchieve has organized, from the speakers you've heard, and of course, from the quality of the conference attendees.

But I also think a good amount of that inspiration comes from this year's theme—Innovation.

Hearing innovative ideas, meeting people like you who have overcome challenges by breaking with the status quo, by embracing a relentless drive to think bigger—that inspires me. And let me tell you, as Ontario's Minister of Health and Long-Term Care, I couldn't be more inspired by the work that you do and the innovation you achieve.

As a government and a system, we need to do a lot more to embrace innovation—but we're committed to rising to that challenge. I hope you had the chance to visit our government's booth to learn about some of the ways we are embracing innovation, and helping to bring your innovative ideas to fruition.

I also hope you had the opportunity to meet our new Chief Health Innovation Strategist, Bill Charnetski. Bob Bell and I are so excited to have Bill on our team.

Innovation, of course, is about more than new technologies. Innovation is fundamentally about new ideas: identifying a need and coming up with a new way of meeting it. So we need to embrace new ideas as well as new technologies, if we are to transform our system for the better.

System transformation—it's an idea and a process that I spoke about last year, and it's an idea that Minister Matthews has spoken about too. It's almost like HealthAchieve has become the podium of record for Ministers of Health to talk about system transformation.

And that's fair—system transformation is a complex undertaking, and you're a sophisticated audience, made up of leaders from across the health care system.

After all, you've lived system transformation. Ontario's hospitals, especially, have been some of our most innovative partners as we move to a more patient-centred system.

We haven't made it easy for you—I know that by holding the line on budget increases, the government has asked a lot of you. But you've responded by being the best partners we could hope to have. You've responded by showing leadership, dedication, and a fundamental commitment to the well-being of your patients.

That fundamental commitment is not unique to hospitals and to those who make them run. It is what motivates every single one of us here in this room to get out of bed in the morning, whether you work on the front-lines or whether you work to keep the lights on.

The well-being of patients—putting patients first—is what motivates me as the Minister. It's what motivates me as a family doctor and as a public health specialist. It's what motivated me before I got into politics. And it will motivate me long after I leave the political world.

So here at HealthAchieve, I want to talk about how that commitment we all share, to the well-being of our patients, must drive system transformation. And how, by embracing new ways of doing things, we can build a system that better understands and meets the needs of our patients—no matter their background, their income, or where they live.

Today, here at HealthAchieve, I want to invite you to join me in breaking from the status quo.

Together with you—always as partners—we will embrace true system transformation. We will embrace change.

Change that is bold.

Change that doesn't just tinker around the edges.

Change that improves the structure of our system in a profound way, always focused on better access for our patients and better care when they need it most.

I want to talk to you today about why I believe we must undertake structural change to our health care system.

And then I want to talk to you about how we'll achieve our goals.

For me, as a lifelong physician and public health specialist, who has worked around the world to provide care to those in need, the “why” of system transformation is a quintessentially Canadian idea. It is the fundamental promise of our universal health care system.

It is the promise that every person, no matter who they are, no matter where they live or how much they earn... every person deserves equitable access to health care.

Fundamentally, for me, the “why” of system transformation, is health equity.

A couple of weeks ago, Health Quality Ontario released their annual Measuring Up report. I was pleased to see in that report that we're doing well or holding steady on a number of important

indicators. But one area where we need to improve—and where we can't afford to delay—is in closing the gaps that exist between different geographic areas of the province.

And when you see that data, you see that geography is only part of the story. We're talking about gaps in our success at treating populations with low socio-economic status. We're talking about populations where we haven't done enough to address the social determinants of health.

And HQO's findings are just one example.

Dr. Kwame McKenzie and his team have been working on this issue for years at the Wellesley Institute, and the Toronto Central LHIN has been focusing on health equity, including at its recent symposium less than two months ago.

A movement is building across the country for equitable access to drugs through a national pharmacare program – and I'm proud to have brought together my provincial and territorial colleagues to make the point loud and clear that the time has come for national pharmacare – that no one should have to choose between paying for medication or putting food on the table.

And I will continue to advocate for national pharmacare with our new federal government, and at our January provincial/territorial health ministers' meeting in Vancouver.

The movement for greater health equity is building. And it is informed by solid evidence.

To take the example just of Toronto, the disparities in health equity here are much too stark. In his groundbreaking report, Dr. David Hulchanski at the University of Toronto identified three cities within Toronto—the three Toronto's—characterized by serious income polarization.

Now, we know that income is a key social determinant of health. But what the Three Toronto's study illuminated is that Torontonians with the highest income also live in areas of the city with the highest concentration and best quality of health care services.

In other words, they don't just have better outcomes—which is what we already know very well about social determinants of health—but better access.

And that's a stark illustration of exactly what our challenge really is.

Several years ago, when our government released the Poverty Reduction Strategy with the goal of lifting children out of poverty, we called it Breaking the Cycle.

It's time we also broke the cycle of poor health outcomes and fulfill our responsibility as a health care system to deliver universal and equitable access to services.

After all, putting patients first... truly putting patients first... is not about prioritizing our easiest patients. It's prioritizing the patients who need our services the most. And bringing those services to them. It's about embracing a population-based approach to delivering care.

As a policy-maker, I am well aware that delivering on a promise of health equity isn't something the health care system can do alone.

True health equity requires a "Health in All Policies" approach. It requires breaking down the silos between health policy and social policy. It requires better integration not just within a system, but across government.

In the months and years ahead, you have my commitment that I will do my part at the government level—I will be an active champion for health equity, for Health in All Policies, working across government and with my Cabinet colleagues on a strategy to address the social determinants of health, to improve the health equity of all Ontarians.

And as we take on that work, there is a central role that our health care system must play. In short, we must lead the way.

We must move beyond a system where care is good quality, but is too often fragmented, disconnected, or siloed.

We must reorganize our system in a bold and transformational way so that we can deliver on our promise of health equity—of equitable access. We must build a system that best meets the needs of Ontarians, that closes gaps, and brings services to the people who need them most.

That is a system that puts patients first. That is the "why" of system transformation.

But just as important as the "why," is the question of "how."

I believe that a system that best meets the needs of patients in an equitable way is one that is truly population-focused, and that is deeply integrated at the local level.

That starts with strong local governance.

And that was the driving force behind the creation of our Local Health Integration Networks – that local governance is the best way to meet a population's local needs, not by managing everything from our offices here in Toronto.

I have had the pleasure of travelling to meet with most of the LHIN boards across the province, and I've been so impressed with their depth of local knowledge, and with the capacity that each of our LHINs has shown to be true local managers of the health care system.

LHINs know the needs of their population – and they know the partners and service providers who care for that population.

They've become much more sophisticated and they must continue to evolve.

LHINs have the capacity to play a role that better acknowledges the true importance of local decision-making and local management.

And that includes primary care.

As part of our recent discussions on the future of our health care system, we have benefited immensely from the work of a number of skilled experts—including the recommendations of Dr. David Price and Elizabeth Baker, along with their fellow panel members.

In their report, they call for primary care providers to be better integrated among themselves, and within the health care system at the local level.

Though the Baker-Price report is just one voice, it is a powerful one. And it has reinforced my belief that primary care is an important bedrock of our health care system. It must be organized around the needs of patients, and around the local population that we serve.

As we move forward with implementing our primary care guarantee—that every Ontarian who wants one will have a primary care provider—and with our commitment to significantly improve same-day or next-day access to care, I look forward to consulting with all of our health care system leaders on the best way to achieve this transformation.

But make no mistake—I believe that if we are to transform our system to one that is focused on population health and equitable access, the time is right for more local governance, and for our LHINs to play a much greater role.

After all, there is perhaps no more important quality of a health care system that puts patients first than the quality of being integrated. That goes for our system of primary care, but you know it's true for our system as a whole.

And that means our home and community care system as well.

We have begun to take important steps to transform our home and community care system so that it delivers better and more consistent care for the patients who rely on our services.

We have followed the advice of experts like Gail Donner and her panel. They told us to ensure that form follows function—that we focus first on offering more consistent services that meet the needs of the local population—before we have the much-needed discussion on structure.

With that in mind, I launched our home and community care roadmap, with 10 concrete steps we will take to improve the patient, client, and caregiver experience in home and community care. We have begun to implement the roadmap, including the first phase of our bundled care projects—they were pioneered at St. Joe's in Hamilton with their Integrated Funding Model—and they're a real example of integrated care at the local level.

Now the time has come for us to have a conversation about the structure of the system.

We owe it to patients and providers to be bold—we owe it to them to be transformational.

We should ask ourselves—to deliver better results for our patients, to deliver more equitable access to the services our population needs, is it time to reconsider the relationship between our CCACs and the LHINs? Is it time to consider deeper integration? And might that be the best way to provide consistent and targeted care that addresses the needs, first and foremost, of the local population?

These are questions our ministry is considering, always guided by the recognition that... home care leadership, our coordinators and our care providers... all of them are essential and their functions remain necessary in an integrated future.

As we move forward, we will continue to benefit from your advice and expertise. But what I'm certain of is that we must never take our eyes off the goal of true integration.

End-to-end, population-based integration across the health care system. That includes public health; it includes primary care; and it includes home and community care.

An integrated system, for the benefit of our patients.

Integration is not a new idea. And the people in this room have been instrumental in driving integration in our health care system. Across all of our LHINs, across all of our hospitals and our CCACs and our primary care organizations and our providers, you have taken the lead on projects that have improved patient outcomes by delivering integrated health care.

But our work has only begun. To truly transform our health care system into one that puts patients first, we cannot limit integration, using it on a project-by-project basis. We need system-wide integration.

Let me give you an example. Hospitals in rural Ontario, in collaboration with the Ontario Hospitals Association, have been leading change that captures exactly what I mean—focusing on end-to-end integration of services from public health, primary care, mental health, the management of chronic diseases, acute care, home and community care, long-term care, and palliative care.

End-to-end integration. That's the end-state of an initiative called Rural Health Hubs, and in the coming weeks, I will be announcing the first successful sites.

I love Rural Health Hubs because they move the yardstick forward on integration—by leaps and bounds. They do it in a population-based way. And they address that important equity of access issue for people who live in rural communities.

Greater equity through greater integration. I believe that is the future of our health care system. And we have evidence that it works.

Look at the success of our Health Links – which target the province’s most complex patients.

With their emphasis on care coordination and integrated care, Health Links have been tremendously effective at bringing care to the people who need it most.

Through our 82 Health Links, nearly 10,000 of the patients most in-need have individualized, coordinated care plans.

Care coordinators have helped to break down the silos in our system, filling in gaps, and helping patients navigate the system... patients most at-risk of falling through the cracks.

They have shown that integrated care can deliver better results not just when it comes to individual patient outcomes, but when it comes to health equity as well. After all, we know that these five percent of patients that Health Links target often experience precarious housing, with higher incidents of poverty and other social determinants of health.

Some of the most innovative Health Links have recognized the importance of health equity in everything they do. They have sought not just to integrate service providers within the health care system; they have reached out to include and integrate a broader range of social service providers, like those that provide housing.

Because as we work together to improve health equity—to bring services to the people who need them most—integration will only make our efforts more effective. It can only lead to better outcomes for our patients.

Today—as I’ve laid out my vision of the “why” and the “how” of the changes we hope to make—I’ve asked you to join me in envisioning a system transformed... a system that delivers equitable access to the services our patients need... A system that sends care where it’s needed most... A system that puts patients first and is singularly focused on their well-being.

We have made great strides together in moving toward that system. But there is much more work to do, and lots of changes to make.

But we can do it together. There are no partners I would rather have than this dedicated group of people who, day-in-and-day-out, strive always to provide the best care to the people who depend on us.

Over the coming months, my ministry will be actively engaging with stakeholders and the public as I develop my plan for the next steps of system transformation.

I hope you will join us, and contribute your expertise, your experiences on the front-lines, and yes, your frank advice. We can’t succeed without it.

This is not work that will be easy. But it is, ultimately, work that we have done before. It is putting patients first; it's what you do every day, and it's what you do better than anyone else.

It bears repeating—there are no partners I'd rather have as we take on the kinds of changes we've envisioned here today.

Stronger local governance. Greater integration.

And ultimately, more equity... more care...for those Ontarians who need it most.

Thank you.

APPROVAL OF CONSENT AGENDA

MOTION: THAT the Board of Health approves the consent agenda as distributed.

Sudbury & District Health Unit Review of the Assessors Report on Algoma Public Health Unit

The purpose of this document is to review key observations arising from the Algoma Public Health Unit Assessors Report written by Graham W. S. Scott (2015) pursuant to his appointment under s. 82(3) of the *Health Protection and Promotion Act*, to consider these observations in light of the SDHU context and identify any recommendations. Report findings/observations/recommendations are listed, applied to the SDHU context and any resulting actions required are identified.

Report finding/observation/recommendation	SDHU Context	Recommended Actions Required
Governance expectations were not adequately informed by the Ontario Public Health Organizational Standards, Public Health Funding and Accountability Agreement and general principles of good governance.	SDHU provides annual BoH orientation regarding governance expectations. This includes recommendation to review alPHa's BOH orientation module. The Board Manual reflects OPHOS and principles of good governance.	Continued vigilance to ensure awareness and practice of governance expectations. Document BOH member completion of the alPHa BOH orientation module. Ensure key PHFAA principles relevant to governance are adequately reflected in the Board manual in the next review cycle. The Ministry of Health and Long Term Care, Public Health Division is hiring a governance consultant to work with APH and provide governance recommendations for public health. Results are expected in 2016. SDHU will assess implications subsequent to receiving these recommendations.
APH credit card used for personal purposes resulting in misappropriation of provincial funds and Ministry recovery of funds.	SDHU has clear policies regarding use of corporate credit cards and controls to monitor use. SDHU utilizes a control form requiring signature of both the card holder and the supervisor.	None
The Board should be aware of the requirements of the Public Health Funding and Accountability Agreement.	This is an item noted in the terms of reference of the new Finance Committee.	Provide review of agreement to Finance Standing Committee.

Report finding/observation/recommendation	SDHU Context	Recommended Actions Required
		Ensure key PHFAA principles are reflected in the board manual in the next review cycle.
<p>The Board failed to provide appropriate monitoring/oversight with respect to a number of issues.</p> <p>Examples: lack of full participation by BoH members; lack of corporate policies; lack of board/committee oversight; finance committee; operations; CFO appointment; Algoma Medicinal Alliance.</p>	<p>The SDHU BoH orientation focuses BoH members on their important governance monitoring and oversight role.</p>	<p>Continued vigilance to ensure BoH awareness and involvement with significant financial, operational or organizational issues recognizing their governance role.</p> <p>Continue to monitor evaluation results carefully for any early warning signs of potential issues.</p>
<p>Failure to understand the broader aspects of conflict of interest.</p>	<p>The SDHU has established policy and practices regarding conflict of interest. Practices in this area are appropriate and consistent with stated policy.</p>	<p>Review the Board of Health manual to ensure that the PHFAA provisions on conflict of interest are reflected and/or amend as required.</p> <p>Add “Conflict of Interest” to BOH and committee agenda’s.</p> <p>Consider updating of conflict of interest content in the BoH orientation materials in the next review cycle.</p>
<p>The decline in the Board’s public meetings (and an increase in closed sessions), the board/management relationship and failure to provide adequate briefing materials on major issues in advance of Board decision-making.</p>	<p>The SDHU demonstrates strong compliance with open/closed meeting rules of the Municipal Act. The BoH evaluation assesses adequacy of materials and the governance environment. Briefing notes/materials are used extensively.</p>	<p>Continue to monitor evaluation results carefully for any early warning signs of potential issues.</p>

Report finding/observation/recommendation	SDHU Context	Recommended Actions Required
Failure to recognize the need for BoH member training in governance procedures.	<p>The SDHU has a comprehensive BoH member orientation to familiarize members with governance procedures.</p> <p>The SDHU monitors Board Governance best practices and updates the BOH member orientation program as required.</p>	<p>Continue to monitor member feedback and respond appropriately.</p> <p>Continue to monitor Board Governance best practices and update Board orientation materials and opportunities accordingly.</p>
<p>Failure to recognize and address staff morale issues.</p> <p>Internal communication was cited as an area for improvement.</p>	<p>SDHU has conducted periodic employee surveys and reported results to the BoH. There is a BoH indicator related to staff engagement. The BOH has set a reporting frequency for this indicator and requires “year over year” reporting for comparison purposes.</p> <p>SDHU has strong practices related to internal communications.</p>	None
Governance review by external expert recommended.	SDHU monitors governance best practices and regularly reviews/updates governance practices.	Governance review results are expected in 2016. SDHU will assess implications upon receipt of the results.
Proposes the concept of regular performance and compliance audits.	<p>The government is currently conducting audits of local public health units to ensure compliance with requirements.</p> <p>SDHU conducts BoH member evaluations and review of the BoH manual annually.</p>	Monitor reported findings of Ministry audits, consider SDHU context and implement changes as necessary.
The BoH should be a skill based board with appointments made on the basis of specific governance skills/expertise including: strategic planning, governance, health, finance, engineering, business management,	The Ministry response to the report indicated that they would seek the cooperation and commitment of municipalities to ensure appointment of a skills based board and the hiring of a	Comply with any resulting regulatory/practice changes.

Report finding/observation/recommendation	SDHU Context	Recommended Actions Required
<p>risk management, human resources, information systems, communications, etc.</p> <p>There were a number of recommendations regarding how to implement this proposal including:</p> <ul style="list-style-type: none"> • Amend HPPA regulations to establish joint nominations committee to appoint municipal members/citizens with a priority on skills/expertise while recognizing geographical requirements • Use of citizen appointees without the work burdens of councilors; • Cooperative appointments (municipalities and province) to ensure the skill sets required; 	<p>governance consultant to assist with the appointment process.</p> <p>Awaiting Ministry/Government communications as to next steps.</p>	
<p>Merger options (APH and SHDU) were explored in the report. The report cites pros of merger as including:</p> <ul style="list-style-type: none"> • Continuity in APH leadership/minimize transitions • Greater breadth/scope of service • Cost efficiencies <p>Cons were listed as:</p> <ul style="list-style-type: none"> • Realignment needs • Loss of management jobs • Combined geography (no APH/SDHU) 	<p>The Ministry response to the report merger recommendations was that this option would be considered more broadly in the context of the Minister's mandate to conduct a review focused on improved outcomes and value for money of all public health units.</p>	<p>Await Ministry direction.</p>

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

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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 Oraziotti, the Mayor of Sault Ste Marie, Christian Provencano, 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.

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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***

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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

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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]

[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

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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 devices. 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].

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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

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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.

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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 October 22nd with a deadline of October 31st. The RFP was posted on the APHU website and the MOH requested it also be sent to healthier@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.

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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 ICFO 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.

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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.

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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]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[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]

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

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

This came to a head in meetings January 14-16th, 2015 between the Senior Management Team, Dr. Barker and Chair Mr. Bruni [REDACTED]
[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]
[REDACTED]
[REDACTED]
[REDACTED]
[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 starting 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.

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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]
[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]
[REDACTED]
[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]
[REDACTED]
[REDACTED]
[REDACTED].

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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

[REDACTED]

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 rationale 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. Page 123 of 196

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 APHU was discussed and in certain cases absent himself. How would that relate to his oversight of APHU'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?

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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] [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]
[REDACTED]
[REDACTED]
[REDACTED].

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[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]

[REDACTED]

[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

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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.

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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.

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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.

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Recommendation #15B

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

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 Gravelle, 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

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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 Oraziotti, MPP
- Mayor Christian Provencano, 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.

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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*.

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.

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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.

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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.

alPHa's members are
the 36 public health
units in Ontario.

alPHa Sections:

Boards of Health
Section

Council of Ontario
Medical Officers of
Health (COMOH)

**Affiliate
Organizations:**

ANDSOOHA - Public
Health Nursing
Management

Association of Ontario
Public Health Business
Administrators

Association of
Public Health
Epidemiologists
in Ontario

Association of
Supervisors of Public
Health Inspectors of
Ontario

Health Promotion
Ontario

Ontario Association of
Public Health Dentistry

Ontario Society of
Nutrition Professionals
in Public Health

November 3, 2015

Hon. Eric Hoskins
Minister of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, Ontario M7A 2C4

Dear Minister Hoskins:

Re: Public Health Funding Model

On behalf of member Medical Officers of Health, Boards of Health and Affiliate organizations of the Association of Local Public Health Agencies (alPHa), I am writing today to provide our comments following the October 2nd alPHa Board of Directors dialogue with Ministry staff about the development and implementation of the Public Health Funding Formula that was announced to our members on September 4th 2015.

We were very pleased to welcome Paulina Salamo and Brent Feeney from the Public Health Division and Brian Pollard from the Health Sector Models Branch to our meeting. They provided us with details about the development of the new public health funding model, its relationship to the fiscal management of the health care sector as a whole and its implementation in the short term. This and the ensuing dialogue were very helpful to us in formulating the following comments.

We recognize the fiscal challenges that Ontario continues to face and understand the reality that governments are under intense pressure to demonstrate fiscal accountability to the public. We fully understand that there was a need to develop a defensible formula for how tax dollars are allocated to boards of health, and appreciate that efforts were made to develop an evidence-informed model that would facilitate their equitable distribution.

As you are likely aware, our members have been awaiting the release of the Funding Review Working Group's report, Public Health Funding Model for Mandatory Programs (December 2013), for nearly two years, with the expectation that an opportunity to provide fully informed feedback on the proposed recommendations would be afforded to them prior to a Government response. As it was not offered, we are taking this opportunity to present our initial response.

Page 1 of 3

Our major concern is about the cumulative impact of the new approach to funding boards of health in the coming years. Boards of health have received modest funding increases in recent years even while other parts of the health sector have been frozen, and this underscores the essential roles boards of health play in the prevention of disease and the protection and promotion of health in Ontario. We would argue that imposing a freeze on boards of health, which, as annual costs rise, is essentially a cut to health protection, prevention and promotion, will have negative impacts on the communities served by boards of health.

Many of Ontario's boards of health experience difficulties in meeting the public health needs of their communities, let alone their health promotion and protection obligations at current funding levels. If these levels remain static or decline for the foreseeable future, cuts to already stretched services will be inevitable and it is not unreasonable to assume that the impact of such cuts will be magnified in the smaller health units, where health status is poorer and the capacity to improve it is already limited. This, we fear, may inadvertently demonstrate public health's value-for-money as negative health outcomes and increasing pressures on local health care providers rise in correlation to ever-increasing limitations on the capacity of local boards of health to mitigate them.

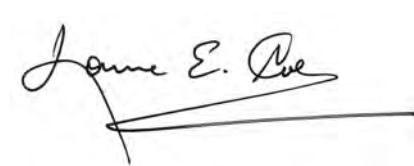
In the broader context of health system transformation, we continue to argue that curtailing investments in demonstrably cost-effective upstream health promotion and protection interventions is short-sighted. The Commission on the Reform of Ontario's Public Services (chaired by Don Drummond), recommended a heightened focus on public health's role in preventing health problems, having observed a correlation between health outcomes and the amount provinces spend on public health. The Commission also recommended avoiding applying the same degree of fiscal restraint to all parts of the health system.

In your strategic plan for Ontario's health care system, *Patients First: Action Plan for Health Care*, you recognize the importance of supporting people to be as healthy as possible. We share that primary interest with you and are concerned about the erosion of what is arguably the best local public health system in Canada. Local boards of health need to continue to build and maintain capacity to work with communities to effect healthy conditions in which people can thrive in good health.

We know that the new funding model comes with the understanding that, as a new model, it will need to be evaluated, revised and improved. We urge you to work closely with us to establish a process to review the model with a view to exploring whether relatively minor changes can result in a distribution of growth money that may better reflect the needs of boards of health and the communities they serve across Ontario.

For your consideration, we have attached the resolution passed by alPha's Board of Directors following the October 2nd meeting. We look forward to working with you to ensure that Ontario's boards of health can fulfill their mandates and continue their essential role in making Ontario the healthiest place in which to grow up and grow old.

Yours truly,

A handwritten signature in black ink, appearing to read "Lorne E. Coe", with a long horizontal line extending from the end of the signature.

Lorne Coe
President

COPY: Hon. Kathleen Wynne, Premier of Ontario
Hon. Charles Sousa, Minister of Finance
Dr. Bob Bell, Deputy Minister, Health and Long-Term Care
Dr. David Williams, Chief Medical Officer of Health (A)
Roselle Martino, Executive Director, Public Health Division
Jackie Wood, Assistant Deputy Minister (A), Health Promotion Division
Laura Pisko, Assistant Deputy Minister (A), Health Promotion Division
Sharon Lee Smith, Associate Deputy Minister, Policy and Transformation
Paulina Salamo, Director (A) Public Health Standards, Practice and Accountability Branch
Brent Feeney, Manager, Funding and Accountability Unit (MOHLTC)
Brian Pollard, Director, Health Sector Models Branch (MOHLTC)
Victor Fedeli, Critic, Finance (PC)
Catherine Fife, Critic, Finance (NDP)
Jeff Yurek, Critic, Health (PC)
France G  linas, Critic, Health and Long-Term Care (NDP)
Gary McNamara, President, Association of Municipalities of Ontario (AMO)
Chairs, Boards of Health

ATTACHED: Resolution

alPHA Board of Directors' Resolution

Passed October 30, 2015

TITLE: Public Health Funding Formula

- WHEREAS public health interventions result in significant improvements in the health of the population and cost savings in the health care system; and
- WHEREAS the reviews of the Walkerton E.coli outbreak in 2001 and the SARS epidemic in 2005 resulted in widespread recognition that Ontario's public health system had significant weaknesses and that investments were required to create a robust public health system essential for the protection of the health of the citizens of Ontario; and
- WHEREAS investments in Ontario's public health system have occurred since the SARS epidemic, however, public health programs delivered through boards of health still only receive 1.4 percent or \$700.4 million of the \$50.2 billion total Ministry of Health and Long Term Care 2015-16 budget; and
- WHEREAS grants provided by the Ministry of Health and Long-Term Care, enabled by the *Health Protection and Promotion Act*, constitute the majority of funding for boards of health in Ontario; and
- WHEREAS the majority of the remaining funding for boards of health comes from the obligated municipalities as assigned in the *Health Protection and Promotion Act*; and
- WHEREAS the Ministry of Health and Long-Term Care has accepted the recommendations contained in the December 2013 report: *Public Health Funding Model for Mandatory Programs: The Final Report of the Funding Review Working Group*; and
- WHEREAS the intent of the recommendations was to develop a funding model for grants from the Ministry of Health and Long-Term Care to boards of health that identify an appropriate funding share for each Board that reflects its needs in relation to all other; and
- WHEREAS in 2015, the Ministry of Health and Long-Term Care began the application of the public health funding model recommended in the Report without further consultation with boards of health; and
- WHEREAS boards of health have been advised to plan for 0% funding increases for the foreseeable future; and
- WHEREAS funding increases at or near 0% are de facto cuts as annual costs rise; and
- WHEREAS the primary goals of boards of health are to prevent illness and to protect and promote the health of Ontarians; and

WHEREAS the impacts on public health programming, municipal funding contributions and population health outcomes resulting from the changes to the Ministry of Health and Long-Term Care's funding model need to be examined with a view to quality improvement;

NOW THEREFORE BE IT RESOLVED THAT alPHa urge the Ministry of Health and Long Term Care to commit to maintaining a minimum cost of living annual growth rate for grants provided to all boards of health to fund public health programs;

AND FURTHER THAT alPHa urge the Ministry of Health and Long-Term Care to make an evidence-informed decision to adjust upwards the overall percentage of the Ministry's total budget that is allocated to fund public health programs delivered through boards of health;

AND FURTHER THAT alPHa urge the Ministry of Health and Long-Term Care to engage in a process to implement a comprehensive monitoring strategy in close consultation with Ontario's boards of health to evaluate the impacts of the new funding model, both in terms of health outcomes and total public health expenditures at the local level.

October 22, 2015

Minister Eric Hoskins
Ministry of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor St.
Toronto, ON M7A 2C4

Dear Minister Hoskins:

The Leeds, Grenville and Lanark District Health Unit is concerned about the decision of your ministry to use the funding model of the 2013 report, *Public Health Funding Model for Mandatory Programs: The Final Report of the Funding Review Working Group*, to allocate the increase in the provincial public health budget to the mandatory public health programs in each health unit.

This funding model has the following limitations:

- The use of 2006 census data – The model used 9 year old data to allocate funding in 2015. The population has changed significantly in that time and this is not reflected in the model used to allocate provincial funding in 2015.
- Lack of census data on smaller rural communities - Given the census is now voluntary, many parts of the province, particularly rural areas including several areas in Lanark, Leeds and Grenville, do not have census data for their population. This will affect the validity of the model results.
- The equity adjusted model assumes that the appropriate allocation of public health resources is primarily driven (65% of the model) by the social determinants of health e.g. income, education, ethnicity, housing, and language. While these factors do influence health, public health services are primarily directed to the population as a whole. For example, dental screening programs reach all children in the population, public health inspections in food premises, childcare, and long-term care homes benefit the entire population, and public information and education on healthy child development and healthy living is for everyone. The MOHLTC has provided 100% funding for nurses working with priority populations and the Ministry of Children and Youth Services provides the Healthy Babies Healthy Children Program for those who need extra support in parenting often associated with young age, low income, and lack of education. These are more appropriate mechanisms to address inequity in the population.

The Board of Health is also concerned that the MOHLTC 2015 is not investing adequately in public health programs and services given their focus is health promotion and prevention leading to increased quality of life, mental health and resiliency, workplace productivity, and reduced use of the health care system.

Minister Eric Hoskins
Page 2
October 22, 2015

One of the goals of the MOHLTC is “helping people stay healthy”¹, but the lack of adequate investment in public health limits how this can be achieved.

The Leeds, Grenville and Lanark District Health Unit Board of Health requests that you invest appropriately in public health programs and services in Ontario, and reconsider the use of the equity adjusted model to allocate public health funding to local public health agencies in the future. We would be pleased to be part of the consultation process to achieve these goals.

Sincerely,



Anne Warren
Board Chair

¹ <http://www.health.gov.on.ca/en/common/ministry/default.aspx>



**ELGIN ST. THOMAS
PUBLIC HEALTH**

November 2, 2015

The Honourable Eric Hoskins
Minister of Health
Ministry of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4

Dear Mr. Hoskins,

RE: Public Health Funding

On October 14, 2015, the Board of Health for Elgin St. Thomas Public Health considered the attached resolutions from Porcupine and Grey Bruce Health Units and passed the following resolution:

Moved by: David Marr

Seconded by: Dave Mennill

WHEREAS the Ministry of Health and Long-Term Care has, on September 4, 2015, released the 2013 report of the Funding Review Working Group with respect to a public health funding model for Mandatory programs, which it has accepted for the 2015 budget year and beyond; and

WHEREAS, based upon current information, the model indicates that approximately 80% of Public Health Units in the Province of Ontario are overfunded, which in and of itself calls into question, the validity of said model; and

WHEREAS, in some large centres there is a possibility that these extra public health funds could effectively be consumed by larger municipal budgets and not utilized for additional public health services; and

WHEREAS, under this model, health units who have been identified as being overfunded, may have many years of shrinking public health services, in the face of higher costs, due to having to deal with a flat lined budget allocation; and

Page 158 of 196

WHEREAS, public health program and service delivery is designed to create healthy Ontarians and communities and thereby reducing the burden of illness and disease; and

WHEREAS, the percentage of public health funding in the overall provincial health budget is approximately 2%; and

NOW THEREFORE BE IT RESOLVED THAT, the Board of Health for Elgin St. Thomas Public Health support the resolutions from the Grey Bruce and Porcupine Health Units and opposes this new funding model and the radical long-term shifting of public health resources to wealthier urban centres of the Province; and

FURTHER THAT, the Board of Health for Elgin St. Thomas Public Health calls for the Ministry of Health and Long-Term Care to reverse their decision to support this report, and revise the funding formula which appears biased against smaller, Northern and Rural Health Units and develop a funding formula that addresses the needs of smaller, northern and rural health units; and

FURTHER THAT, the Board of Health of Elgin St. Thomas Public Health calls for the Ministry of Health and Long-Term Care to increase the total funding envelope for public health to reduce the need for other acute health care services for Ontarians and communities; and

FURTHER THAT, this resolution be forwarded to the Premier of Ontario, the Minister of Health and Long-Term Care, AMO, ROMA, alPha, Local MPs and MPPs, All Municipalities in Elgin St. Thomas and All Ontario Boards of Health.

Carried.

Sincerely,

A handwritten signature in black ink that reads "Heather Jackson". The signature is written in a cursive, flowing style.

Heather Jackson, Chair
Elgin St. Thomas Board of Health

HJ:ke

PROVINCIAL PUBLIC HEALTH FUNDING

MOTION: **THAT the Sudbury & District Board of Health endorse the correspondence and resolution concerning the public health funding formula, passed October 30, 2015 from the alPHa Board of Directors;**

AND FURTHER THAT the Sudbury & District Board of Health call on the Ministry of Health and Long Term Care to increase investments in public health, ensuring Ontarians benefit from a world-class public health system within Ontario's transformed health system;

AND FURTHER THAT this motion be forwarded to constituent municipalities, the Association of Municipalities of Ontario, the Federation of Northern Ontario Municipalities, Ontario Boards of Health, the Association of Local Public Health Agencies, and other local partners.

Briefing Note

To: René Lapierre, Chair, Sudbury & District Board of Health
From: Dr. Penny Sutcliffe, Medical Officer of Health/Chief Executive Office
Date: November 12, 2015
Re: Recommended 2016 Cost-Shared Operating Budget

☐ For Information

☐ For Discussion

☒ For a Decision

Issue:

The management of the Sudbury & District Health Unit (SDHU) is seeking approval of the 2016 operating budget for cost-shared programs and services. The recommended budget has been reviewed and is recommended by the Board of Health Finance Standing Committee.

Recommended Action:

THAT the Sudbury & District Board of Health approve the 2016 operating budget for cost-shared programs and services in the amount of \$22,873,326.

Budget Summary:

- 1.1** The recommended 2016 budget for cost-shared programs and services is \$22,873,326 and as compared with the 2015 Board of Health approved budget, represents a 0.55% overall decrease. As compared with the 2015 Board-approved budget, the 0.55% reduction is the result of a 2.0% reduction in the cost-shared provincial grant and a 2.5% increase in the municipal levy.
- 1.2** The recommended 2016 budget includes cost reduction initiatives that are necessary in order to attain a balanced budget for 2016 and in anticipation of ongoing funding pressures. Management has worked extremely hard in the context of significant fiscal pressures to achieve this important goal. Significant budget reductions resulting from the cost reduction initiatives were necessary as a result of budget pressures attributable to the province-wide implementation of the new public health funding formula.

¹ Strategic Priorities:

1. Champion and lead equitable opportunities for health
2. Strengthen relationships
3. Strengthen evidence-informed public health practice
4. Support community actions promoting health equity
5. Foster organization-wide excellence in leadership and innovation

The following sections provide additional information on the key 2016 budget highlights.

2.0 Budget Background

- 2.1 **Government background:** On September 4, 2015, the Ministry of Health and Long-Term Care (MOHLTC) provided an update on the public health funding review and informed boards of health that the Ministry had accepted the 2013 *Public Health Funding Model for Mandatory Programs* recommendations of the Funding Review Working Group and would begin the process of implementing the new mandatory program funding formula in 2015. The adopted public health funding model identifies an *appropriate share* for each board of health that reflects its needs *in relation to* other boards of health. It does not identify appropriate *funding levels* for boards of health.

The Ministry advised health units that the 2.0% growth funding available in 2015 for mandatory programs would be distributed proportionately only to the eight health units that had not reached their model-based share. Health units were also advised that base funding for mandatory programs would not be reduced.

The Ministry informed boards of health that the Ontario Public Health Standards and the Organizational Standards will be reviewed in 2016. The goals of these reviews have not yet been communicated.

The Ontario Government and the MOHLTC continue to operate in an environment of fiscal constraint with aggressive targets to achieve a balanced budget. The Ministry has clearly advised health units that they should not assume growth funding. In addition, health units have been advised that any future growth funding approved by the ministry will be allocated based on the new funding formula. It is understood that this means that the SDHU will not receive any growth funding for the foreseeable future.

The SDHU has communicated with all employees about the new funding formula and its impacts. The SDHU has conducted manager and staff information sessions. Sessions were also held with the Canadian Union of Public Employees and Ontario Nurses Association to support information sharing and dialogue.

- 2.2 **SDHU 2015 Grant Approval:** The funding announcement received in September advised that as a result of the new funding formula, our requested 2.0% increase, or (\$297,860), was not approved and that the provincial share of our mandatory cost shared operating budget was frozen at 2014 base funding. The flat-lined or 0% per cent adjustment means significant constraints for the long term as a result of continued increases in our salary, benefit and operating expenses. These constraints require that all potential revenue sources and a broad range of cost reduction initiatives be considered.

For context, the Sudbury & District Board of Health has experienced the following historical growth in provincial MOHLTC funding for cost-shared programs:

¹ Strategic Priorities:

1. Champion equitable opportunities for health in our communities.
2. Strengthen relationships with priority neighbourhoods and communities and strategic partners.
3. Strengthen the generation and use of evidence-informed public health practices.
4. Support community voices to speak about issues that impact health equity.
5. Maintain excellence in leadership and agency-wide resource management as key elements of an innovative learning organization.

Year	Growth (%)
2015	0.0
2012 - 2014	2.0
2011	3.0
2010	3.0
2009	3.6
2008	5.0

The funding of public health units is governed by the *Health Protection and Promotion Act* (HPPA) which provides that obligated municipalities shall pay the expenses incurred in the performance of the required functions and duties in accordance with the Act, regulations and guidelines. The HPPA notes that the Minister may make grants on such conditions considered appropriate.

The 5 year projected deficits for the SDHU prior to implementing any cost saving strategies are as follows (note that these projections incorporate a number of “reasonable worst case scenario” assumptions both on the revenue and cost side and are intended to illustrate the order of magnitude of the anticipated fiscal pressures):

5 Year Projected Deficits					
	2016	2017	2018	2019	2020
Funding Assumptions:	Year 1	Year 2	Year 3	Year 4	Year 5
MOHLTC	0.00%	0.00%	0.00%	0.00%	0.00%
Municipal	2.50%	2.00%	2.00%	2.00%	2.00%
Projected surplus or (deficit)	(562,645)	(753,236)	(947,176)	(1,144,551)	(1,345,446)

- 2.3 **2016 Budget Principles:** The Executive Committee and the Board Finance Committee developed budget principles, (Appendix A), consistent with the SDHU vision, mission, values and guiding principles which were used to guide deliberations and to promote a transparent budget process; a process which occurred in the context of anticipated significant long-term fiscal constraints. Budget proposals were assessed for fit with these principles as was the final recommended budget in its entirety.
- 2.4 **Program and service requirements:** The Public Health Accountability Agreement includes fourteen mandatory performance indicators, and one monitoring indicator. Based on the experience to date, the SDHU is demonstrating good performance in meeting performance targets.

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5. Maintain excellence in leadership and agency-wide resource management as key elements of an innovative learning organization.

- 2.5 The recommended 2016 budget is presented without the VBD Contingency Control Measure of \$500,000 which was included in prior budgets. The elimination of the contingency measure revenues and expenses results from a MOHLTC change to considering and funding extraordinary costs related to control measures based on in-year requests to the MOHLTC.

3. Recommended 2016 Budget

Revenues:

- 3.1 Cost-shared programs and services are funded through the province, municipalities, and other sources of revenue such as interest revenue, user fees and transfers from reserve, if required. The province also contributes funding for services to Unorganized Territories.

- The recommended budget is presented with a flat-line or 0% growth over the 2015 ministry approved Unorganized Territories funding. As a result of the implementation of the new funding formula for Unorganized Territories funding, the SDHU anticipates no increases related to the delivery of services to the Unorganized Territories for the next several years.

The SDHU has experienced the following historical growth in Unorganized Territories funding:

Year	Growth (%)
2015	1.5
2012 - 2014	2.0
2008 - 2011	5.0

- The 2016 recommended budget is presented with a \$31,000 increase to the revenue stream. The increase is the result of incorporating a consultation fee to the existing travel vaccine user fees and from the recovery of administrative expenses from the recently increased Smoke-Free-Ontario funding.
- The recommended 2016 budget retains the current 70:30 Ministry/Municipal funding ratio. The Board of Health is reminded that in order to maintain previously established service levels, the Board, in prior years, had decided to maintain this investment in order to not erode gains made during periods of public health investment and renewal.

Expenditures:

- 3.2 The **0.55% overall decrease** over the 2015 cost-shared budget is comprised of the following:

¹ Strategic Priorities:

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5. Maintain excellence in leadership and agency-wide resource management as key elements of an innovative learning organization.

Benefits decreases	-0.29%
Salary cost increases (negotiated scheduled rate increases and step increases)	0.96%
Operating cost reductions	-1.22%
Overall Decrease	-0.55%

3.3 **Salary and benefit changes** As compared with 2015, the salary and benefit budget lines reflect changes of 1.41% increase and 1.55% decrease, respectively.

- **Salary:** The impact of rate increases and staff movement on salary grids results in a 1.41% increase over the 2015 salary budget.
- **Benefits:** The 2016 budget is reporting an overall decrease of 1.55% from the 2015 benefit costs. The reported decrease in benefit costs is because the 2015 renewal rates were significantly lower than estimated at the time of 2015 budget approval. We continue to work closely with the benefit consultant to ensure costing estimates reflect trend analysis and to ensure accurate estimates are provided for budget deliberations.

3.4 **Vacancy Rate:** The 2016 recommended budget does not include a vacancy rate. This is no longer a feasible strategy given the deficit reduction targets for 2016 and beyond.

3.5 **Cost Reduction Initiatives:** The introduction of the new public health funding model and the projected flat lining of the provincial funding for SDHU mandatory cost shared budget for a significant number of years resulted in a need to consider a wide range of cost reduction initiatives. Staff were invited to submit cost reduction initiatives through anonymous electronic submission or through a physical drop box. Over 100 staff ideas have been submitted. The ideas cover a broad range in terms of scope, impact and complexity. Many of these ideas are reflected in the cost reduction initiatives formally reviewed in budget deliberations and a number of ideas are reflected in the recommended budget. We continue to receive, assess, prioritize and act on the ideas submitted.

The cost reduction initiatives incorporated into the 2016 budget were reviewed in detail by the Executive Committee and the Board of Health Finance Standing Committee using the budget principles. A chart list of recommended cost reduction initiatives is provided below. (Additional cost reduction considerations that are subject to open meeting exemptions will be discussed in camera.)

¹ Strategic Priorities:

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2. Strengthen relationships with priority neighbourhoods and communities and strategic partners.
3. Strengthen the generation and use of evidence-informed public health practices.
4. Support community voices to speak about issues that impact health equity.
5. Maintain excellence in leadership and agency-wide resource management as key elements of an innovative learning organization.

		Cost Saving
#	Initiatives	2016
1	Summer Student Reduction	\$27,964
2	Professional membership Reductions	\$2,640
3	Divisional Meeting Reduction	\$5,000
4	Physician Fees Reduction	\$20,000
5	Travel Vaccine Consultation Fees	\$20,000
6	Children's Water Festival Discontinuation	\$6,000
7	Smoke Fee Ontario Administration Fees	\$13,896
8	Staff Development Reduction	\$122,057
	Total	\$217,557

3.6 **Non-salary changes:** As compared with 2015, the non-salary budget line reflects an overall 9.87% decrease. All expenditures were reviewed and adjustments were made to reflect efficiencies or reallocations between lines. Expenditure lines with significant changes are highlighted below:

- **Staff Development:** the decrease is resulting from the implementation of the related cost reduction initiative, reducing staff development from 1.3% to 0.5% of eligible salaries.
- **Health Services/Purchased Services:** this decrease is in part due to the initiative adjusting physician fees to reflect decreasing usage trends related to revised screening guidelines.
- **Expense Recoveries:** This increase is related to incorporating the initiative to implement a consultation fee to our existing travel vaccine user fees and the initiative to implement an administrative fee from increased Smoke-Free-Ontario 100% funding.
- **Rent:** The decrease to this line results from a budget correction, stating rental charges as per lease agreement.
- **Media and Advertising:** This decrease is the result of reductions from within divisional budgets and a cost reduction initiative.

3.7 **Schedules:** **Appendix B** provides the recommended 2016 cost-shared operating budget details for Health Unit divisions, expenditure categories, revenue sources, and municipal levies.

¹ Strategic Priorities:

1. Champion equitable opportunities for health in our communities.
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4. Support community voices to speak about issues that impact health equity.
5. Maintain excellence in leadership and agency-wide resource management as key elements of an innovative learning organization.

4.0 Conclusion – Recommended 2016 Cost-Shared Operating Budget

The recommended 2016 budget for cost-shared programs and services is \$ 22,873,326 and as compared with the 2015 Board of Health approved budget, represents a 0.55% overall decrease. As compared with the 2015 Board-approved budget, the 2.67% reduction is the result of a 2.0% reduction in the cost-shared provincial grant and a 2.5% increase in the municipal levy.

The 2016 budget is recommended as a budget that recognizes the significant long-term impacts of the implementation of the new cost shared funding formula and implements a number of difficult cost reduction initiatives that are consistent with our budget principles in order to achieve a balanced budget. This budget seeks to maintain critical public health capacity while adapting to the new funding formula.

¹ Strategic Priorities:

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2. Strengthen relationships with priority neighbourhoods and communities and strategic partners.
3. Strengthen the generation and use of evidence-informed public health practices.
4. Support community voices to speak about issues that impact health equity.
5. Maintain excellence in leadership and agency-wide resource management as key elements of an innovative learning organization.

O: October 19, 2001
R: October 2015

Appendix A

2016 Budget Principles

The following are the guiding principles for the 2016 SDHU budget deliberations.

The principles are based on Board Finance Committee and Senior Management deliberations. They are intended to promote a transparent budget process; a process which is occurring in the context of anticipated significant long term fiscal constraints.

All budget proposals are assessed for degree of fit with these principles. The final recommended budget is also assessed in its entirety with the objective of ensuring an overall balance in the application of the principles.

Guiding principles:

1. We will maintain our **long term focus on health**. This requires an appropriate balance of responsiveness to health protection and immediate needs (e.g. immunizations, environmental health hazards, communicable disease control, tobacco enforcement, etc.) with investment in longer term health promotion (e.g. healthy eating, child resiliency, municipal policies, etc.).
2. We will ensure that we build and maintain **surge capacity**, enabling us to respond to unplanned/unexpected new and emerging threats to people's health (e.g. community communicable disease outbreaks, industrial or natural hazards, etc.).
3. SDHU programs will continue to strive to improve **equity in health** consistent with our strategic plan vision, mission and strategic priorities. We will do this by focusing on evidence-informed local public health practice to promote health equity (i.e. 10 promising practices) and by ensuring upstream work with partners on the social determinants of health.
4. We will work to ensure our fiscal path forward is congruent with our values, interpreted generally in this context as follows:
 - a. **Accountability** – due consideration is given to the Accountability Agreement, particularly the Performance Indicators, the OPHS and its review, Organizational Standards, SDHU Performance Monitoring Plan; transparency is part of accountability and includes clearly articulated budget principles and assumptions including at least three-year forecasting
 - b. **Caring leadership** – compassion guides our approach to changes that directly or indirectly impact on staff
 - c. **Collaboration** – collaboration is sought out within the SDHU and with partners to achieve efficiencies to respond to needs
 - d. **Diversity** –the diversity of our clients/populations is respected, positioning the SDHU to plan for and respond to needs (e.g. geographic, language, cultural, etc.)
 - e. **Effective communication** – this is key to change management and is front of mind for internal and external audiences; communication is bilateral and input/feedback is actively sought
 - f. **Excellence** – trade-offs are carefully thought through to ensure service excellence is not sacrificed (e.g. evaluation, data, teaching, etc.)

- g. **Innovation** – innovative ideas are actively sought to respond to public health needs with increased efficiencies; there is active engagement with processes that will assist with innovation and continuous improvement

SUDBURY & DISTRICT HEALTH UNIT
Recommended 2016 Cost Shared Budget

Description	BOH 2015 Approved	Recommended 2016 Budget	Increase (Decrease)	% Change Inc/(Dec)
	a	b	(b - a)	
Revenue				
MOHLTC - General Programs	15,190,834	14,893,000	(297,834)	
MOHLTC - Unorganized Territory	800,980	813,000	12,020	
MOHLTC - Vector Borne Disease (VBD) Educ. & Su	64,939	65,000	61	
MOHLTC - CINOT Expansion	31,510	24,800	(6,710)	
MOHLTC - SDWS	106,000	106,000	-	
Municipal Levies	6,641,127	6,807,155	166,028	
Municipal Levies - Vector Borne Disease (VBD) Edu	21,646	21,646	-	
Municipal Levies - CINOT Expansion	10,503	10,503	-	
Municipal Levies - Small Drinking Water Systems	47,222	47,222	-	
Interest Earned	85,000	85,000	-	
Total Revenue	22,999,761	22,873,326	(126,435)	-0.55%
Expenditures				
Corporate Services				
Corporate Services	4,095,440	4,150,846	55,406	
Print Shop	262,383	211,219	(51,164)	
Espanola	120,700	92,204	(28,496)	
Manitoulin Island	124,639	125,708	1,069	
Chapleau	98,171	98,585	413	
Sudbury East	16,486	16,486	-	
Volunteer Resources	6,838	6,838	-	
Total Corporate Services	4,724,657	4,701,885	(22,771)	
Clinical Services				
Clinical Services - General	977,354	1,041,498	64,144	
Clinic	1,222,355	1,217,881	(4,473)	
Drug	341,475	342,399	923	
Family Team	639,452	648,589	9,137	
Risk Reduction	134,516	98,302	(36,214)	
Intake	313,081	306,216	(6,865)	
Clinical Outreach	140,503	139,150	(1,353)	
Sexual Health	943,426	940,742	(2,684)	
Dental	796,577	805,584	9,007	
CINOT Expansion	42,013	35,303	(6,710)	
Reproductive & Child Health	1,301,502	1,165,023	(136,479)	
Total Clinical Services	6,852,253	6,740,688	(111,566)	
Health Promotion				
Promotion - General	1,270,557	1,089,021	(181,536)	
School	1,379,670	1,413,698	34,028	
Workplace	333,065	180,720	(152,345)	
Branches (Espanola/Manitoulin)	542,638	295,926	(246,711)	
Nutrition & Physical Activity Team	1,212,088	1,288,172	76,084	
Branches (Sudbury East/Chapleau)	-	304,286	304,286	
Injury Prevention	453,648	460,061	6,413	
Tobacco Cessation	369,847	360,655	(9,192)	
Alcohol and Substance Misuse	293,928	292,207	(1,721)	
Strategic Engagement Unit	337,047	506,341	169,294	
Total Health Promotion	6,192,488	6,191,087	(1,400)	
RRED				
RRED	1,496,160	1,511,663	15,504	
Health Equity Office	15,240	15,240	-	
Total RRED	1,511,400	1,526,903	15,504	
Environmental Health				
Environmental Health - General	786,954	771,116	(15,838)	
Environmental	2,676,092	2,676,862	770	
Vector Borne Disease	86,585	86,585	(0)	
Small Drinking Water Systems	169,333	178,200	8,867	
Total Environmental Health	3,718,964	3,712,763	(6,201)	
Total Expenditures	22,999,761	22,873,326	(126,435)	-0.55%
Net Surplus (Deficit)	(0)	(0)	(0)	

SUDBURY & DISTRICT HEALTH UNIT
Recommended 2016 Cost Shared Budget

Revenue by Funding Agency			
	2015 BOH Approved	2016 Recommended Budget	Increase (Decrease)
Ministry of Health and Long-Term Care			
Official Local Health Agency	15,190,834	14,893,000	(297,834)
Unorganized Territories	800,980	813,000	12,020
Vector Borne Disease- education & surveillance	64,939	65,000	61
Small Drinking Water System	106,000	106,000	-
CINOT Expansion	31,510	24,800	(6,710)
Total MOHLTC	16,194,263	15,901,800	(292,463)
Municipalities			
Official Local Health Agency	6,641,127	6,807,155	166,028
Vector Borne Disease- education & surveillance	21,646	21,646	-
Small Drinking Water System	47,222	47,222	-
CINOT Expansion	10,503	10,503	-
Total Municipalities	6,720,498	6,886,526	166,028
Other Revenue			
Transfer from Working Capital Reserve		-	-
Interest	85,000	85,000	-
Total Other	85,000	85,000	-
Grand Total	22,999,761	22,873,326	(126,435)

Sudbury & District Health Unit
Recommended 2016 Cost Shared Budget

Expenditures By Category

Description	2015 BOH Approved Budget	2016 Recommended Budget	Change (\$) Inc/(Dec)
Salaries	15,778,322	16,000,615	222,293
Benefits	4,373,643	4,305,854	(67,788)
Total Salaries & Benefits	20,151,964	20,306,470	154,505
Staff Development	244,710	121,219	(123,491)
Health Services / Purchased Services	399,809	334,845	(64,964)
Expense Recoveries	(920,617)	(951,431)	(30,814)
Rent	239,198	221,384	(17,814)
Media & Advertising	143,504	125,886	(17,618)
Office Equipment & Utilization	75,235	61,035	(14,200)
Office Supplies	135,464	126,225	(9,239)
Translation	54,550	47,300	(7,250)
Telephone Expenses	190,986	189,275	(1,711)
Furniture & Equipment	17,730	16,130	(1,600)
Memberships	31,567	30,027	(1,540)
Travel	283,931	282,434	(1,497)
Rent Revenue	(66,550)	(67,881)	(1,331)
Books & Subscriptions	17,110	16,750	(360)
Postage & Courier Services	72,230	71,975	(255)
Vector Borne Disease - education and surveillance	45,264	45,081	(183)
Professional Fees	40,990	40,990	-
Information Technology	559,540	559,540	-
Rent surplus transferred to reserve	55,744	55,744	-
Utilities	195,265	195,840	575
Insurance	101,714	103,774	2,060
Building Maintenance	362,501	364,898	2,397
Program Expenses	567,922	575,817	7,895
Total Operational Expenses	2,847,797	2,566,857	(280,940)
Total Expenditures	22,999,761	22,873,326	(126,435)

SUDBURY & DISTRICT HEALTH UNIT

Recommended 2016 Cost Shared Budget

Municipal Levy

	2015	2016
Total Budget	22,999,762	22,873,326
Municipal Levy	6,641,127	6,807,155
Municipal Levy - Vector Borne Disease	21,646	21,646
Municipal Levy CINOT Expansion	10,503	10,503
Municipal Levy Small Drinking Water System	47,222	47,222
Total Levy**	6,720,498	6,886,526

	2015	%	2015	2016		Monthly
	Population*	Population	Levy	Levy	Difference	Billing
Assiginack (Township of)	767	0.457%	30,578	31,471	893	2,623
Baldwin (Township of)	514	0.306%	20,363	21,073	710	1,756
Billings (Township of)	516	0.307%	20,498	21,142	644	1,762
Burpee and Mills (Township of)	276	0.164%	11,089	11,294	205	941
Central Manitoulin (Township of)	1,767	1.053%	70,767	72,515	1,748	6,043
St. Charles	1,154	0.688%	45,565	47,379	1,814	3,948
Chapleau (Township of)	2,025	1.207%	81,520	83,120	1,601	6,927
French River	2,408	1.435%	95,431	98,822	3,391	8,235
Espanola Town	4,470	2.663%	180,513	183,388	2,876	15,282
Gordon/ Barrie Island	443	0.264%	18,145	18,180	35	1,515
Gore Bay Town	793	0.472%	31,922	32,504	582	2,709
Markstay-Warren	2,360	1.406%	94,826	96,825	1,998	8,069
Northeastern Manitoulin & the Islands (Town)	2,225	1.326%	88,845	91,315	2,470	7,610
Nairn & Hyman (Township)	408	0.243%	16,264	16,734	471	1,395
Killarney	350	0.209%	14,180	14,393	213	1,199
Sables-Spanish River (Township of)	2,785	1.659%	111,896	114,247	2,351	9,521
City of Greater Sudbury	144,212	85.924%	5,773,378	5,917,248	143,869	493,104
Tehkummah (Township of)	363	0.216%	14,651	14,875	224	1,240
TOTAL	167,836	100%	6,720,431	6,886,526	166,095	573,877
Per Capita Rate			39.750	41.03	1.28	

Municipal Levy Increase/-Decrease over previous year

2.5%

* Population data per 2015 Ontario Population Report, Municipal Property Assessment Corporation

** The above levy excludes VBD Control Measures Contingency. It will be billed only if expenditures deemed necessary by the Medical Officer of Health

IN CAMERA

MOTION: **THAT this Board of Health goes in camera. Time:_____p.m.**

IN CAMERA

- Personal matters involving one or more identifiable individuals, including employees or prospective employees
- Labour relations or employee negotiations

RISE AND REPORT

MOTION: **THAT this Board of Health rises and reports. Time: _____p.m.**

2016 COST-SHARED BUDGET

MOTION: THAT the Sudbury & District Board of Health approve the 2016 operating budget for cost-shared programs and services in the amount of \$22,873,326.

CANNABIS POLICY FRAMEWORK

October 2014

*A PAHO / WHO
Collaborating Centre*

*Fully affiliated with the
University of Toronto*

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Executive summary

Cannabis is a favourite recreational drug of Canadians, along with alcohol and tobacco. Like those drugs, cannabis (popularly known as marijuana) is associated with a variety of health harms. Unlike those drugs, cannabis is illegal, prohibited under the same federal and international drug statutes as heroin and cocaine.

The landscape of cannabis policy is changing. The Netherlands, Portugal, and more recently Uruguay and US states Colorado and Washington have reformed their approach to cannabis control. Here in Canada, changes to the rules of the federal Medical Use of Marijuana program are expected to lead to an increase in the number of registered users over the next few years. Public support for reform of Canada's cannabis laws continues to grow. Meanwhile, we continue to improve our understanding of the health risks of cannabis use.

As Canada's leading hospital for mental illness, the Centre for Addiction and Mental Health (CAMH) offers evidence-based conclusions about cannabis and measures aimed at reducing harm. CAMH has reviewed the evidence on cannabis control and drawn the following conclusions:

- Cannabis use carries significant health risks, especially for people who use it frequently and/or begin to use it at an early age.
- Criminalization heightens these health harms and causes social harms.
- A public health approach focused on high-risk users and practices – similar to the approach favoured with alcohol and tobacco – allows for more control over the risk factors associated with cannabis-related harm.

From these conclusions follows another:


- Legalization, combined with strict health-focused regulation, provides an opportunity to reduce the harms associated with cannabis use.

This approach is not without risks. A legal and unregulated or under-regulated approach may lead to an increase in cannabis use. Finding the right balance of regulations and effectively implementing and enforcing them is the key to ensuring that a legalization approach results in a net benefit to public health and safety while protecting those who are vulnerable to cannabis-related harms.

CAMH neither makes a moral statement on cannabis nor encourages its use. Despite the prohibition of cannabis, more than one third of young adults are users, and our current approach exacerbates the harms. It's time to reconsider our approach to cannabis control.

[Justin Trudeau](#)[The Platform](#)[Your MPs](#)[Liberal](#)

[RealCHANGE.ca](#)[Fair and Open Government](#)



MARIJUANA

We will legalize, regulate, and restrict access to marijuana.

Canada's current system of marijuana prohibition does not work. It does not prevent young people from using marijuana and too many Canadians end up with criminal records for possessing small amounts of the drug.

Arresting and prosecuting these offenses is expensive for our criminal justice system. It traps too many Canadians in the criminal justice system for minor, non-violent offenses. At the same time, the proceeds from the illegal drug trade support organized crime and greater threats to public safety, like human trafficking and hard drugs.

To ensure that we keep marijuana out of the hands of children, and the profits out of the hands of criminals, we will legalize, regulate, and restrict access to marijuana.

We will remove marijuana consumption and incidental possession from the Criminal Code, and create new, stronger laws to punish more severely those who provide it to minors, those who operate a motor vehicle while under its influence, and those who sell it outside of the new regulatory framework.

We will create a federal/provincial/territorial task force, and with input from experts in public health, substance abuse, and law enforcement, will design a new system of strict marijuana sales and distribution, with appropriate federal and provincial excise taxes applied.

Source: <https://www.liberal.ca/realchange/marijuana/>

CANNABIS REGULATION AND CONTROL
Public Health Approach to Cannabis Legalization

MOTION: **WHEREAS** the election platform of Canada's recently elected federal government includes the intention to legalize, regulate, and restrict access to marijuana; and

WHEREAS within the current criminalization context, cannabis is widely used in the SDHU catchment area: 23.5% of youth used in the previous 12 months, 52.3% of people aged ≥19 have tried cannabis and 13% currently use cannabis; and

WHEREAS the health risks of cannabis use are significantly lower than tobacco or alcohol but are increased in those who use it frequently, begin at an early age and/or who have higher risk of cannabis-related problems (i.e. certain psychiatric conditions, cardiovascular disease, pregnancy); and

WHEREAS a public health approach focused on high-risk users and practices – similar to the approach favoured with alcohol and tobacco that includes strategies such as controlled availability, age limits, low risk use guidelines, pricing, advertising restrictions, and general and targeted prevention initiatives – allows for more control over the risk factors associated with cannabis-related health and societal harms; and

WHEREAS the Ontario Public Health Standards require boards of health to reduce the frequency, severity, and impact of preventable injury and of substance misuse;

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health support a public health approach to the forthcoming cannabis legalization framework, including strict health-focused regulations to reduce the health and societal harms associated with cannabis use; and

FURTHER THAT this resolution be shared with the Honourable Prime Minister of Canada, local Members of Parliament, the Premier of Ontario, local Members of Provincial Parliament, Minister of Health and Long-Term Care, Federal Minister of Health, the Attorney General, Chief Medical Officer of Health, Association of Local Public Health Agencies, Ontario Boards of Health, Ontario Public Health Association, the Centre for Addiction and Mental Health, and local community partners.

No. 88 -2015

MOTION/RESOLUTION

Moved by 

Seconded by

WHEREAS tobacco use is the leading cause of preventable death and disability in Canada, accounting for the deaths of approximately 13,000 people in Ontario alone each year;¹ and

WHEREAS second-hand smoke kills 1,000 Canadians annually;^{2,3} and

WHEREAS approximately one-third of Ontarians living in multi-unit housing (MUH) report regular exposure to second-hand smoke that originates in neighbouring units, and 80% would choose a smoke-free building if the choice existed;⁴ and

WHEREAS Ontarians spend most of their time at home, and it is in this environment where exposure continues to be reported; and

WHEREAS indoor air studies show that, depending on the age and construction of a building, up to 65% of the air in a private residence can come from elsewhere in the building⁵ and no one should be unwillingly exposed or forced to move due to unwanted second-hand smoke exposure; and

WHEREAS second-hand smoke in multi-unit housing can lead to third-hand tobacco exposure as semi-volatile and volatile organic chemicals like nicotine and polycyclic aromatic hydrocarbons (carcinogens, also known as PAHs) are oily or waxy and more likely to stick to surfaces than be removed by ventilation; and

WHEREAS 5.6% of residents age 12 and up in the Northwestern Health Unit catchment area are exposed to second-hand smoke in their home;⁶ and

¹ <http://www.mhp.gov.on.ca/en/smoke-free/default.asp> Accessed August 17 2010

² Health Canada, 2004. "Cigarette Smoke: It's Toxic." Second-hand Smoke: FAQs & Facts. 2004. www.hc-sc.gc.ca/hlvs/tobac-tabac/second/fact-fait/tox/index_e.html (Accessed Jan. 2006)

³ Makomaski-Illing EM and Kaiserman MJ, 1999. Mortality attributable to tobacco use in Canada and its regions- 1998. *Canadian Journal of Public Health* 1999; 95(1):38-44. www.cpha.ca/shared/cjph/archives/abstr04.htm#38-44 (Accessed Dec. 2005)

⁴ Smoke-Free Housing Ontario. 80% of People Living in Apartments, Condos and Co-ops Want to Live Smoke Free. Press release 8 December 2011. <http://www.newswire.ca/en/story/892061/80-of-people-living-in-apartments-condos-and-coops-want-to-live-smoke-free>.

⁵ "Second-hand smoke in Multi-Unit Dwellings." Non-Smokers' Rights Association (2011). Available from <http://www.nsra-adnf.ca/cms/page1433.cfm>.

⁶ Canadian Community Health Survey, 2011/2012 <http://www12.statcan.gc.ca/health-sante/82-228/details/page.cfm?Lang=E&Tab=1&Geo1=HR&Code1=3549&Geo2=PR&Code2=35&Data=Rate&SearchText=Northwestern%20Health%20Unit&SearchType=Contains&SearchPR=01&B1=All&Custom=&B2=All&B3=All>

WHEREAS 36.1% of residents who live in multi-unit housing in the Northwest Tobacco Control Area Network report tobacco smoke entering their home in the past 6 months.⁷

NOW THEREFORE BE IT RESOLVED THAT the Board of Health for the Northwestern Health take the following actions to reduce exposure to second-hand smoke in multi-unit dwellings:

1. Encourage all landlords and property owners of multi-unit housing to voluntarily adopt no-smoking policies in their rental units or properties.
2. Encourage public/social housing providers to voluntarily adopt no-smoking policies in their units and/or properties.
3. Encourage the Ontario Ministry of Municipal Affairs and Housing to develop government policy and programs to facilitate the provision of smoke-free housing; including:
 - a. Ensuring all future private sector rental properties and buildings developed in Ontario should be smoke-free from the onset;
 - b. Ensuring all future public/social housing developments in Ontario should be smoke-free from the onset.

FURTHERMORE BE IT RESOLVED, that a copy of this resolution be sent to the Smoke-Free Ontario Housing Coalition, the Ontario Minister of Municipal Affairs and Housing, local Members of Provincial Parliament (MPP), the Chief Medical Officer of Health, the Association of Local Public Health Agencies, all Ontario Boards of Health, the Kenora District Services Board, the Rainy River District Social Services and Administration Board, and Northwestern Health Unit obligated municipalities for their information and support.

⁷ Centre for Addiction and Mental Health Monitor, 2011/2012 http://otru.org/wp-content/uploads/2014/10/update_aug2014_v2.pdf

	Yea	Nay	Abstained	Disclosure of Interest
C. Baron				
D. Brown				
Y. Kirlew				
J. Roy				
J. Ruete				
P. Ryan				
T. Sachowski				
S. Smith				
B. Thompson				

Date: October 23, 2015

Chair.....

October 10, 2014

Dear colleague,

Re: Act now to reduce the impact of second-hand smoke exposure in multi-unit housing in Ontario

As you are aware, tobacco use is the number one cause of preventable disease and death in Ontario. Every year, more than 13,000 people in Ontario die because of tobacco use – one person almost every 40 minutes. Tobacco is the only legal product that, when used as intended, kills half of its users prematurely. It can also kill others through involuntary exposure to second-hand smoke (SHS).

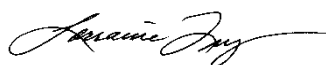
Approximately one third of Ontarians living in multi-unit housing (MUH) report regular exposure to SHS that originates in neighbouring units, and 80% of Ontarians would choose a smoke-free building if the choice existed.¹ However, many stakeholders in the housing sector erroneously believe that no-smoking policies are illegal, unenforceable or discriminatory and so many Ontarians continue to be involuntarily exposed to SHS in their home.

Studies have demonstrated that there is no safe level of exposure to SHS—all exposure is harmful and should be eliminated. According to the U.S. Department of Health and Human Services, exposure to SHS among children and adults causes a range of adverse health effects, including premature death and disease.² Second-hand smoke is a serious problem for many Ontario residents living in apartments and condominiums, especially those who suffer from chronic health conditions such as heart disease, asthma, allergies, diabetes, and respiratory illnesses. Ontarians spend most of their time at home, and it is in this environment where exposure continues to be reported. For many forced to breathe their neighbour's smoke, the only remedy is to move; however, moving is not always an option for people with disabilities, older adults or those with limited incomes. This is why we need to work toward making smoke-free housing in Ontario the norm, not the exception.

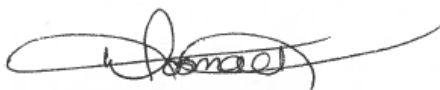
The 2010 Tobacco Strategy Advisory Group (TSAG) report³ regarding Ontario's renewed Smoke-Free Ontario Strategy contains a number of recommendations pertaining to MUH. First and foremost, the report recommends continuing and intensifying a voluntary approach to smoke-free MUH. **The primary goals of the Smoke-Free Housing Ontario Coalition are to facilitate the adoption of no-smoking policies within the housing sector and to create a favourable environment to foster the adoption of those policies. We seek your endorsement in helping us achieve this end.**

Please submit a letter of endorsement of the Smoke-Free Housing Ontario Coalition to either of co-chairs Lorraine Fry at lfry@nsra-adnf.ca or Donna Kosmack at donna.kosmack@mlhu.on.ca. Endorsements are being compiled online the Smoke-Free Housing Ontario website www.smokefreehousingon.ca. A sample statement of endorsement, and a space for your endorsement signature is attached.

Sincerely,



Lorraine Fry
Executive Director, Non-Smokers' Rights Association



Donna Kosmack
Manager, SW Tobacco Control Area Network

¹ Smoke-Free Housing Ontario. 80% of People Living in Apartments, Condos and Co-ops Want to Live Smoke Free. Press release 8 December 2011. <http://www.newswire.ca/en/story/892061/80-of-people-living-in-apartments-condos-and-co-ops-want-to-live-smoke-free>.

² U.S. Department of Health and Human Services. The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General. 2006.

³ *Building on our Gains, Taking Action Now: Ontario's Tobacco Control Strategy for 2011-2016*. Report from the Tobacco Strategy Advisory Group to the Minister of Health Promotion and Sport, October 18, 2010. <http://www.mhp.gov.on.ca/en/smoke-free/TSAG%20Report.pdf>.

ENDORSEMENT OF ACTION FOR SMOKE-FREE MULTI-UNIT HOUSING

MOTION: WHEREAS smoking in multi-unit housing results in significant exposure to the health-harming effects of tobacco smoke; and

WHEREAS area municipalities and service boards that are landlords of multi-unit housing can adopt no-smoking policies that set an example and protect health, such as that adopted by the Manitoulin Sudbury District Services Board to support smoke-free social housing effective January 1, 2015;

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health support the Northwestern Health Unit motion (88-2015) on smoke-free multi-unit housing, the efforts of the Smoke-Free Housing Ontario Coalition and others, in the following actions and policies to reduce the exposure of second-hand smoke in multi-unit housing:

- (1) Encourage all landlords and property owners of multi-unit housing to voluntarily adopt no-smoking policies in their rental units or properties;
- (2) Advocate that all future private sector rental properties and buildings developed in Ontario should be smoke-free from the onset;
- (3) Encourage public/social housing providers to voluntarily adopt no-smoking policies in their units and/or properties;
- (4) Advocate that all future public/social housing developments in Ontario should be smoke-free from the onset.
- (5) Encourage the Ontario Ministry of Housing to develop government policy and programs to facilitate the provision of smoke-free housing.

FURTHER BE IT RESOLVED THAT a copy of this motion be submitted to the Smoke-Free Housing Ontario Coalition, the Ontario Minister of Municipal Affairs and Housing, local members of Provincial Parliament (MPP), the Chief Medical Officer of Health, the Association of Local Public Health Agencies (ALPHA), all Ontario Boards of Health, the Association of Municipalities of Ontario, the Federation of Northern Ontario Municipalities and SDHU municipalities for their information and support.

Briefing Note

To: René Lapierre, Chair, Sudbury & District Board of Health
From: Dr. Penny Sutcliffe, Medical Officer of Health/Chief Executive Officer
Date: November 12, 2015
Re: Staff Appreciation Day

☐ For Information

☒ For Discussion

☒ For a Decision

Issue:

The purpose of this briefing note is to provide background information on the Board of Health Staff Appreciation Day.

Recommended Action:

That the Board of Health approve the following motion:

Motion: **THAT this Board of Health approve a Staff Appreciation Day for the staff of the Sudbury & District Health Unit during the upcoming holiday season. The Staff Appreciation Day may be taken between the dates of December 1, 2015, to February 29, 2016. Essential services will be available and provided at all times during the holiday period except for statutory holidays when on-call staff will be available.**

Background:

- The Sudbury & District Board of Health has provided the Staff Appreciation Day (previously the Board Float) in a variety of ways for an extensive history dating back to the year 1975. The gift of one day with pay was established as a symbol of appreciation from the Board of Health to all Health Unit staff and is subject to annual approval by the Board of Health.
- Originally the day was to be taken during the Christmas holiday period. This was subsequently changed in recognition of our cultural diversity to allow the use of the day within the period from December 1 to February 28 unless otherwise designated by the Board of Health motion. If an employee does not take the day within the designated timeframe, it is lost and cannot be carried forward.

2013–2017 Strategic Priorities:

1. Champion and lead equitable opportunities for health.
2. Strengthen relationships.
3. Strengthen evidence-informed public health practice.
4. Support community actions promoting health equity.
5. Foster organization-wide excellence in leadership and innovation.

Employees qualify for the staff appreciation day based on the following:

- Permanent full-time employees who have completed their probationary period in or before the calendar year in which the Board approved day shall be granted (full day or 7.0 hours).
- Permanent less than full-time employees who have completed their probationary period in or before the calendar year in which the Board approved day shall be granted and who work a minimum of 17.5 hours per week (half day or 3.5 hours).
- Temporary/contract employees on a full-time or part-time basis who have more than one-year of service on the last day of the calendar year in which the Board motion is passed (part-time 3.5 hours/full-time 7.0 hours).

The SDHU collective agreements with ONA and CUPE reference the Staff Appreciation Day noting that scheduling will be subject to a “mutually agreeable time” and recognize that the Staff Appreciation Day is contingent upon Board of Health approval.

Given the extensive history of Board of Health approval of the Appreciation day it is recognized as a part of the SDHU organizational culture. Many employees every year submit emails, letters and notes to express their gratitude for the recognition provided by the Board of Health to their daily efforts and contributions to local public health.

Financial Implications:

Not Applicable

Strategic Priority:

5

2013–2017 Strategic Priorities:

1. Champion and lead equitable opportunities for health.
2. Strengthen relationships.
3. Strengthen evidence-informed public health practice.
4. Support community actions promoting health equity.
5. Foster organization-wide excellence in leadership and innovation.

STAFF APPRECIATION DAY

MOTION: THAT this Board of Health approve a Staff Appreciation Day for the staff of the Sudbury & District Health Unit during the upcoming holiday season. The Staff Appreciation Day may be taken between the dates of December 1, 2015, to February 29, 2016. Essential services will be available and provided at all times during the holiday period except for statutory holidays when on-call staff will be available.

BRIEFING NOTE

To: René Lapierre, Chair, Sudbury & District Board of Health

From: Rachel Quesnel, Secretary to the Board of Health
Dr. Penny Sutcliffe, Medical Officer of Health and Chief Executive Officer

Re: Board Member Self-Evaluation of Performance Results

Date: November 12, 2015

☐ For Information

☒ For Discussion

☐ For a Decision

Issue:

At its meeting of September 17, 2015, a confidential self-evaluation using a 22-question survey tool was distributed to Board of Health members. The evaluation is part of the Board's ongoing commitment to good governance and continuous quality improvement and is consistent with C-I-12 and C-I-14 of the Board of Health Manual.

Board members were informed that the results would be confidentially compiled by the Secretary to the Board and reported at its regularly scheduled November 2015 meeting. This briefing note constitutes the evaluation report.

Recommended Action:

That Board of Health members review and discuss the results of the self-evaluation and ensure continued reflection and improvement.

Board Member Self-Evaluation of Performance:

Methods

- The Board of Health Member Self-Evaluation of Performance survey consists of 22 items on performance and processes. Board members of Health members are asked to rate each of the items as either "Strongly Agree", "Agree", "Disagree", "Strongly Disagree" or "Not Applicable". The survey also contains three open-ended questions.
- The self-evaluation questionnaire was distributed to all Board of Health members in the September 17, 2015 Board of Health meeting agenda package via the MOH report.
- Board of Health members were sent an email reminder to complete the survey by the Secretary to the Board of Health on September 24, 2015.
- The survey was also included in the October 15 Board of Health Meeting package and members were reminded to complete the survey by October 19, 2015.
- On October 22, 2015, an extension was given for Board of Health members to complete the survey by October 28, 2015
- The Secretary of the Board of Health collaborated with the Resources, Research, Evaluation and Development (RRED) Division to tabulate and summarize the survey results. The Medical Officer of Health was consulted once the results had been compiled in order to maintain anonymity.

Results

- 9 out of 13 surveys distributed were returned and analyzed (response rate of 69% compared to an 84.6 % response rate in 2014).
- The following table summarizes the responses to each of the 22 rated questions. Non-responses were excluded from the analysis.

Part 1: Individual Performance	Strongly Agree	Agree	Disagree	Strongly Disagree	Not Applicable
1. As a BOH member, I am satisfied with my attendance at meetings	8	1	0	0	0
2. As a BOH member, I am satisfied with my preparation for meetings.	5	4	0	0	0
3. As a BOH member, I am satisfied with my participation in meetings.	2	6	0	0	0
4. As a BOH member, I understand my roles and responsibilities.	3	5	1	0	0
5. As a BOH member, I understand current public health issues.	2	7	0	0	0
6. As a BOH member, I have input into the vision, mission and strategic direction of the organization.	3	4	1	0	1
7. As a BOH member, I am aware and represent community perspective during board meetings.	5	4	0	0	0
8. As a BOH member, I provide input into policy development and decision-making.	1	6	2	0	0
9. As a BOH member, I represent the interests of the organization at all times.	8	1	0	0	0

Other comments or suggestions pertaining to your role as a Board of Health member:

- Many times I find that management and staff at the SDHU make up and bring forward the agenda and there does not seem to be room for board members to add or request agenda items be added.
- I am new to the Board and still learning. I expect the effectiveness of my contributions will increase as my knowledge of public health grows, and the relationships with staff and other Board members strengthens
- Timely information, clarification etc. provided to me by SDHU administration team has been key in assisting my individual performance.
- I am inconsistent in my verbal participation although well prepared My goal is to increase my participation
- Not sure what the role is of the Board/Executive

Part 2: Board of Health Processes	Strongly Agree	Agree	Disagree	Strongly Disagree	Not Applicable
1. The BOH is compliant with all applicable legislation and regulations.	8	1	0	0	0
2. The BOH ensures members are aware of their roles and responsibilities through orientation of new members.	7	2	0	0	0
3. The BOH is appropriately informed about financial management, procurement policies and practice, risk management and human resources issues.	6	2	0	1	0
4. The BOH holds meetings frequently enough to ensure timely decision-making.	7	2	0	0	0
5. The BOH bases decision making on access to appropriate information with sufficient time for deliberations.	6	3	0	0	0
6. The BOH is kept apprised of public health issues in a timely and effective manner.	8	1	0	0	0
7. The BOH sets bylaws and governance policies.	5	3	1	0	0
8. The BOH remains informed with issues pertaining to organizational effectiveness through performance monitoring and strategic planning.	6	3	0	0	0
<p><u>Other comments or suggestions pertaining to Board of Health policy and process:</u></p> <ul style="list-style-type: none"> • I believe the SDHU has a great team that keeps board members informed to the best of their abilities at all times. • With such a large change in the Board composition this year, we are still gelling. A lot of work was done by the past board so we have not yet needed to revisit some key fundamentals • I do miss the accreditation process and report following it .I felt this was affirmation that the required policies were in place & up to date etc. It was nice to hear this from off-site personnel and know how we compared to our peers. • I feel there hasn't been anything yet pertaining to governance issues 					

Part 3: Overall Performance of the Board of Health	Strongly Agree	Agree	Disagree	Strongly Disagree	Not Applicable
1. The BOH contributes to high governance and leadership performance	3	4	1	0	1
2. The BOH oversees the development of the strategic plan	3	3	1	0	1
3. The BOH ensures planning processes consider stakeholder and community needs.	5	2	2	0	0
4. The BOH ensures a climate of mutual trust and respect between themselves and the Medical Officer of Health (MOH).	9	0	0	0	0
5. The BOH as a governing body is achieving its strategic outcomes.	6	3	0	0	0
<p><u><i>Other comments or suggestions pertaining to overall performance of the Board of Health:</i></u></p> <ul style="list-style-type: none"> • No concerns. • I would like to see a higher commitment to attendance and participation by all BOH members. I think we miss some valuable voices. • Occasionally, board members seem to challenge decisions of a day to day nature which is not our area of expertise. The SDHU managers are very helpful and respectful in responding to this. 					

Summary

The 2015 Sudbury & District Board of Health Member Self-Evaluation of Performance questionnaire gives Board members a chance to reflect on their individual performance, the effectiveness of Board policy and processes, and the Board's overall performance as a governing body. Board of Health self-evaluation of performance is an internal SDHU tool to ensure compliance with the Ontario Public Health Organizational Standards. In addition, the Board self-evaluation survey is part of the SDHU's Performance Monitoring Plan. Results should be interpreted with caution due to the small number of respondents.

Overall results from the self-evaluation questionnaire indicate that the Board of Health members have a positive perception of their governance process and effectiveness. In all sections of the survey (individual performance, Board of Health processes, and overall performance of the Board of Health), the majority of respondents either strongly agreed or agreed with all of the statements. Additional comments that were provided by the Board of Health members in each section were positive and constructive. Overall, the members have a positive perception of their governance process and effectiveness. Comments also suggest, however, that Board members could benefit from additional orientation to the governance roles and expectations.

Next year's annual self-evaluation survey will include a question relating to the effectiveness of the Consent Agenda: *The consent agenda is helpful in enabling the Board to engage in detailed discussion of important items.*

ADDENDUM

MOTION: THAT this Board of Health deals with the items on the Addendum.

The Board Chair will inquire whether there are any announcements and or enquiries.

Please remember to complete the Board Evaluation following the Board meeting:
<https://fluidsurveys.com/s/sdhuBOHmeeting/>

ADJOURNMENT

MOTION: THAT we do now adjourn. Time: _____ p.m.