The Corporation of the City of Sault Ste. Marie
Council Correspondence

February 4, 2022

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January 26, 2022

BOARD OF HEALTH MEETING

Videoconference

www.algomapublichealth.com

Meeting Book - January 26, 2022, Board of Health Meeting

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Board of Health Meeting
AGENDA
January 26, 2022 at 5:00 pm
Video/Teleconference

BOARD MEMBERS	APH MEMBERS
Sally Hagman	Dr. Jennifer Loo - Medical Officer of Health & CEO
Ed Pearce	Dr. John Tuinema - Associate Medical Officer of Health &
Deborah Graystone	Director of Health Protection
Lee Mason	Antoniette Tomie - Director of Corporate Services
Micheline Hatfield	Laurie Zeppa - Director of Health Promotion & Prevention
Musa Onyuna	Leo Vecchio - Manager of Communications
Brent Rankin	Liliana Bressan - Research Policy Advisor
Matthew Scott	Leslie Dunseath - Financial Analyst
Louise Caicco Tett	Tania Caputo - Board Secretary
Matthew Scott	Tanya Storozuk - Executive Assistant

* ***Recorded proceedings are available upon request***

1.0 Meeting Called to Order *J. Loo*

a. Land Acknowledgment

b. Declaration of Conflict of Interest

2.0 Election of Officers

a. Appointment of Board of Health Chair for the year 2022. *J. Loo*

b. Appointment of Board of Health First Vice-Chair and Chair of the Finance and Audit Committee for the year 2022. *Chair*

c. Appointment of Board of Health Second Vice-Chair and Chair of the Governance Committee for the year 2022. *Chair*

d. Call for Committee Members for the Finance & Audit Committee and Governance Committee for the year 2022. *Chair*

3.0 Signing Authority *Chair*

RESOLUTION

THAT By-Law 95-2 identifies that signing authorities for all accounts shall be restricted to:
i) the Chair of the Board of Health
ii) one other Board member, designated by Resolution
iii) the Medical Officer of Health/Chief Executive Officer
iv) the Director of Corporate Services

4.0 Adoption of Agenda *Chair*

RESOLUTION

THAT the Board of Health agenda dated January 26, 2022 be approved as presented.

5.0 Delegations / Presentations

6.0 Adoption of Minutes of Previous Meeting *Chair*

RESOLUTION

THAT the Board of Health minutes dated November 23, 2021 and November 24, 2021 be approved as presented.

7.0 Business Arising from Minutes *Chair*

8.0 Reports to the Board

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

i. MOH Report - January 2022

RESOLUTION

THAT the report of the Medical Officer of Health and CEO for January 2022 be accepted as presented.

b. Finance and Audit *L. Dunseath*

i. Financial Statements

RESOLUTION

THAT the Board of Health approves the Financial Statements for the period ending November 30, 2021 as presented.

c. Governance *L. Dunseath*

ii. 02-05-065 Algoma Board of Health Reserve Fund

RESOLUTION

THAT the Board of Health has reviewed and approves policy **02-05-065 Algoma Board of Health Reserve Fund**, as presented.

9.0 New Business/General Business *Chair*

a. Public Health Champion Award

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

10.0 Correspondence *Chair*

11.0 Items for Information *Chair*

a. alPHa 2022 Winter Symposium

b. alPHa PH Resilience Report

c. alPHa Information Break

12.0 Addendum *Chair*

13.0 In-Camera *Chair*

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

RESOLUTION

THAT the Board of Health go in-camera.

14.0 Open Meeting *Chair*

Resolutions resulting from in camera meeting.

15.0 Announcements / Next Committee Meetings: *Chair*

Finance & Audit Committee
Wednesday, February 9, 2022 @ 5:00 pm
Video Conference │SSM Algoma Community Room

Governance Committee Meeting
Wednesday, March 9, 2022 @ 5:00 pm
Video Conference │SSM Algoma Community Room

Board of Health Meeting
Wednesday, February 23, 2022 @ 5:00 pm
Video Conference │SSM Algoma Community Room

16.0 Evaluation *Chair*

17.0 Adjournment *Chair*

RESOLUTION

THAT the Board of Health meeting adjourns.

Algoma
PUBLIC HEALTH
Santé publique Algoma

January 26, 2022

Report of the

Medical Officer of Health / CEO

Prepared by:
Dr. Jennifer Loo and the
Leadership Team

Presented to:
Algoma Public Health Board of Health

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APH AT-A-GLANCE

COVID-19 Pandemic Response in Algoma

Algoma has experienced a dramatic shift in its pandemic landscape during the transition from 2021 to 2022. In November of 2021, a surge of the COVID-19 Delta variant required additional measures and restrictions at the local level, including reduced gathering limits via a Section 22 Class Order from the Medical Officer of Health, as well as letters of instructions to local business for increased distancing and masking requirements, and the pausing of high risk activities such as high contact team sports in the extracurricular and community setting. This was followed by the December arrival of a province-wide surge of Omicron – a variant of the coronavirus which is much more transmissible than Delta, albeit with a 54% lower risk of hospitalization and death. Notably, two doses of COVID-19 vaccine no longer provides strong protection against symptomatic disease from Omicron, and a third dose booster of the vaccine is recommended in Ontario for all adults 18 and over.

Due to the rapid transmission of Omicron and the risk of overwhelming provincial hospital and ICU capacity from large volumes of cases, province-wide restrictions were once again implemented in early 2022, with Ontario returning to a modified Step Two of the Roadmap to Reopen until at least January 27, 2022. The high rates of transmission have also required a change in testing strategy province-wide, such that laboratory-based PCR testing is preserved for people who live, work, and volunteer in highest risk settings, such as acute care hospitals, long term care homes, and other congregate living settings. Similarly, case and contact management and outbreak management are now carried out in ~~the~~ highest risk settings only.

At the time of writing, APH's teams are supporting the management of over 600 active cases in highest risk settings, as well as outbreaks in eight highest risk institutional settings. Although no longer considered high risk settings, Algoma's workplaces and schools continue to be supported by APH's healthy workplace and school teams that are providing consultation as well as resources, such as template notification letters and guidance documents, for these sectors.

Organizational resourcing of the latest surge in pandemic response continues to maximize internal redeployment of staff, and leverage the collaboration of external partners. Furthermore, APH has already filled eight of the 15 new full time, permanent positions budgeted for 2022, as approved by the BOH. These include seven new full time, permanent frontline staff positions, and one full time management position.

COVID-19 Immunization Update

As of January 17, 2022, 241,334 total doses of COVID-19 vaccine have been administered to Algoma residents. Of all eligible Algoma residents aged 5 years or over, over 87% have received at least one dose of a COVID-19 vaccine, and over 81% have received two doses. Furthermore, of all eligible adults 18+ in Algoma, about 52% have received a 3rd booster dose. When considering the total Algoma population, 78%, or over 91,000 residents, have received at least two, if not three doses of vaccine and are well-protected from severe disease from COVID-19, including from the Omicron variant. About 19,000 Algoma residents remain unimmunized with any dose of COVID-19 vaccine, of which about 14,000 are currently eligible for immunization based on age.

APH and community immunization partners have continued to provide third dose boosters to all eligible adults 18 and over, first and second doses to children aged 5 to 11 years, and are actively preparing to provide fourth doses to eligible residents of long-term care and retirement homes, elder lodges, and prioritized congregate care settings. At the time of writing, about 55% of Algoma children aged 5 to 11 have received at least one dose of paediatric COVID-19 vaccine.

PROGRAM HIGHLIGHT

Topic: Community safety and wellbeing plans: Working upstream with municipalities and partners

From: Kristy Harper, Manager of Community Wellness & School Health Program, Chief Nursing Officer

Policy Framework for Public Health Programs and Services Goal[1]: To improve and protect the health and well-being of the population of Ontario and reduce health inequities.

Program Standard Requirements[1] addressed in this report:

- The board of health shall engage in multi-sectoral **collaboration with municipalities** and other relevant stakeholders in decreasing health inequities in accordance with the *Health Equity Guideline, 2018* (or as current).
- The board of health shall engage in community and **multi-sectoral collaboration with municipal** and other relevant partners to promote healthy built and natural environments in accordance with the *Healthy Environments and Climate Change Guideline, 2018* (or as current).
- The board of health shall develop and implement a program of public health interventions using a comprehensive health promotion approach that is informed by **consultation and collaboration** with local stakeholders in the health, education, **municipal**, non-governmental, social, and other relevant sectors, and:
    - Addresses chronic disease risk and protective factors to reduce the burden of illness from chronic diseases in the health unit population;
    - Supports healthy growth and development in the health unit population; and
    - Addresses risk and protective factors to reduce the burden of preventable injuries and substance use in the health unit population.

Key Messages

- Municipal councils in Ontario were mandated to develop and adopt Community Safety and Wellbeing (CSWB) plans by July 1, 2021, as per an amendment to the *Police Services Act, 1990*. CSWB plans shift the focus of safety and wellbeing efforts from a reactive, incident-based approach to a more collaborative, proactive approach that focuses on social development, prevention, and risk intervention.
- Algoma Public Health (APH) provided consultation and guidance for several municipal CSWB plans adopted in Algoma. APH was well positioned to provide strategic direction for CSWB plans, due to alignment with the *Ontario Public Health Standards*[1] and public health expertise in population health assessment, research, planning, evaluation, and evidence-informed decision-making with consideration of health equity and social determinants of health and safety.
- Seven CSWB plans have been developed by local municipalities, independently and jointly, with the most commonly identified health and safety priorities being mental health and substance use.

Community Safety and Wellbeing Planning

On January 1, 2019, new legislative requirements mandating community safety and wellbeing (CSWB) planning under the *Police Service Act, 1990* came into effect for municipal councils in Ontario.[2] Under the new legislative requirements, municipal councils were responsible for developing and adopting CSWB plans within two years, by working in partnership with a multi-sectoral advisory committee.[2]

The intent of CSWB plans was to **support a collaborative approach to service delivery** by working across a variety of sectors, agencies, and organizations to proactively design and implement evidence-informed programs and strategies that address local health and safety priorities (i.e. risk factors) related to crime and complex social issues (i.e. poverty, substance use, etc.) on a more sustainable basis.[3]

Rationale for CSWB Plans

Crime prevention has traditionally been a responsibility of police, courts, and corrections, which has resulted in systemic reliance on reactionary and incident driven responses to crime.[4, 5] This **reactionary approach is considered inefficient, ineffective, and unstainable** for creating safe places to live, work, and play.[4] Unsustainability has been recognized through increases in police and public safety costs in Canada that have not correlated to a decrease in community crime, resulting in increased spending on reactionary approaches and reduced ability to invest in early intervention and prevention.[5, 6]

Instead, evidence has demonstrated that **addressing the causes** of crime through evidence-informed, **pre-crime prevention initiatives** yields greater return on investment, and increases community safety at a lesser cost to municipalities.[5, 6] In addition, leadership in crime prevention, or creating safe communities and addressing determinants of crime, must come from many sectors.[4] Therefore, there was a need to modernize how we look at service delivery to ensure priority populations and those most vulnerable receive the services they need, when they need them, by the right service providers.[3] Municipalities were considered the best suited to identify local issues and problems and the conditions that contribute to these problems when it comes to crime prevention at the local level.[5,6]

Goal and Framework for CSWB Plans

The goal of CSWB planning is to create communities across Algoma where all people are safe, have a sense of belonging, have access to services, and are able to meet their basic needs for education, health, food, housing, and social and cultural expression, all of which are basic determinants of health.[3, 7]

To create an efficient and effective plan for making communities healthier and safer, the Ministry of Community Safety and Correctional Services' (MCSCS) CSWB framework outlined four areas of focus:

1. **Social development** – addressing the underlying conditions that shape health and wellbeing;
2. **Prevention** – proactively reducing identified risk factors before they escalate;
3. **Risk intervention** – mitigating situations of elevated risk and minimizing harm; and
4. **Incident response** – maintaining critical and non-critical incident response efforts, as the last line of reactive support during crises or criminal situations.[2]

As the most upstream element in the framework, the social development domain includes long-term investments to social determinants of health and addressing complex social issues, such as mental health, homelessness, and poverty, through an integrated multi-sectorial approach that will improve quality of life over time.[2] The social development domain is most aligned to the upstream approaches of public health in addressing the social determinants of health to prevent inequities, or differences in health and safety among community members based on factors that can be changed by social action.[1] While planning in all four areas of the framework is necessary, the majority of **investment should be in social development and prevention** to reduce the number of

persons in Algoma who require incidence response or reactionary support once a situation concerning health or safety has escalated.[3]

As part of the CSWB framework and legislation, municipalities were required to establish a multi-sectoral advisory committee including representatives from, but not limited to, local health and mental health services, education, community and social services, children and youth services, custodial services to children or youth, municipal council members, and police service boards.[3] Municipalities were also required to conduct consultation with the advisory committee, members of the public, Indigenous communities, and community organizations to develop a CSWB plan that:

- Identified local priority risk factors based on community consultation and data sources;
- Developed evidence-based programs and strategies to address risk factors, with primary focus on social development and prevention actions; and
- Outlined measurable outcomes to ensure strategies are effective and community health and safety outcomes are achieved.[2, 3]

Overall, the CSWB goal and framework were aligned to APH's vision, to **create and sustain healthy communities**, and strategic direction to **advance health equity** by working with partners to support the improvement of health, economic and social conditions in Algoma. [8] Similarly, CSWB plan requirements aligned to Foundational Standards of population health assessment, health equity, and effective public health practice.[1] Local public health is required to monitor trends over time and use population health information and a systematic, evidence-informed decision making process in the planning of interventions to respond to current and emerging local needs.[1]

Involvement of Local Public Health

APH delivers programs and services across **21 municipalities** in Algoma. To do so effectively, we balance valuable local input with inter-municipality co-operation in the governance of area-wide service delivery of programs.

To prepare for CSWB planning, APH staff participated in regional training provided by the Government of Ontario, developed an internal inventory of resources and indicators that related to CSWB, and maintained alignment of staff within 2020 and 2021, as part of prioritized core public health programming, to support municipalities and community partners in this work.

APH expressed interest to municipalities to be involved as a member of CSWB Advisory Committees, and was prepared to provide support for various aspects of the CSWB process as aligned to the mandate of public health. Supports available to municipalities included:

- Access to data, including data on social determinants of health and population health indicators;
- Access, analysis, and determination of local applicability of evidence-based strategies in each of the four framework domains to address identified CSWB priorities (e.g. Downtown Crime Prevention Evidence Brief developed for City of Sault Ste. Marie, 2021);
- Knowledge and experience in identifying potential monitoring processes and outcome measures; and
- Support for collaborative processes, community engagement, and community-based planning.

Although public health was not named within the advisory committee requirements set by the MCSCS, APH has been an active partner in providing input and/or reviewing the plans for Sault Ste. Marie and Prince Township, City of Elliot Lake, Central Algoma, North Shores, and Township of Macdonald, Meredith and Aberdeen Additional & Township of Laird. APH has been involved as part of the municipality's CSWB advisory committee as a health sector representative, or a sub-committee providing input to the plan, such as through involvement in the Algoma Leadership Table and Social Equity Committee for Sault Ste. Marie.

CSWB Snapshot: Priorities Identified Across Algoma

Across Algoma, seven CSWB plans were created and five were reviewed by APH, with few municipalities opting to form joint plans due to limited capacity, shared service providers, and similar needs across communities. The plans highlighted various health and safety priorities, as detailed in *Table 1.0*.

Table 1.0: CSWB Priorities across Algoma

Municipalities*	CSWB Plan Priority Risks
Sault Ste. Marie and Prince Township [9]	• Mental health and addictions • Poverty, including housing, food security, workforce entry, and crisis diversion and resolution
City of Elliot Lake[10]	• Sexual assault as a source of crime and safety risk • Senior isolation, including the health and mental health challenges associated with isolation • Youth engagement, including opportunity for those facing socio-economic challenges to access
Central Algoma[11] ○ Hilton Township, Township of Plummer Additional, Township of St. Joseph, Bruce Mines, Jocelyn, Tarbutt Township, Village of Hilton Beach, and Township of Johnson	• Mental health, substance use, and social isolation • Crime prevention, including traffic- and road-related safety and injury prevention
North Shores[12] ○ Town of Spanish, Township of the North Shore, Town of Blind River, Municipality of Huron Shores, and Town of Thessalon	• Substance use and addictions • Mental health • Policing and crime prevention • Housing
Township of Macdonald, Meredith and Aberdeen Additional & Township of Laird[13]	• Community crime risk (violent crimes, property crimes, and domestic disturbances) • Mental health • Substance use and drug-related occurrences • Additional: Housing, food security, and workforce entry
Wawa◆[14]	• Policing • Housing • Mental health, addictions and general health services • Social development (children/youth)
Township of White River◆[15]	• Mental health, addictions and general health • Housing • Policing • Transportation – local and regional • Supports for transient populations

*Notes: *A CSWB plan was not available online for Dubreuilville at the time of writing. ◆APH was not involved in this plan.*

Among the priorities selected by communities and Advisory Committees, **mental wellness and substance use and addictions** were identified as top priorities by nearly all communities in Algoma, followed by housing and crime prevention and policing. The community priorities and risks identified align to the mandate of public health within the *Ontario Public Health Standards*[1], including:

- **Substance Use and Injury Prevention**: To reduce the burden of preventable injuries and substance use.
- **Chronic Disease Prevention and Well-being:** To reduce the burden of chronic diseases of public health importance and improve wellbeing.
- **Health Equity**: Decrease health inequities such that everyone has equal opportunities for optimal health and can attain their full health potential without disadvantaged due to social position or other socially determined circumstances.

- **Healthy Environments**: To reduce exposure to health hazards and promote the development of healthy built and natural environments that support health and mitigate existing and emerging risks, including the impacts of a changing climate.

Municipalities as Key Partners in Public Health

Population health, safety, and overall wellbeing is influenced by a wide range of factors, requiring public health to collaborate with many levels of government, health facilities, academic institutions, community organizations, and partners from education, labor, law enforcement, and a wide variety of other sectors.[16] One of public health's most essential partners at the local level includes municipalities

As outlined in the *Health Promotion and Protection Act*, municipalities in Ontario co-fund public health with the provincial government. However, beyond the fundamental funding of public health, municipalities play an important role within the health care system, population health, and the social determinants of health, and have a valuable role in broader community health and wellbeing planning.[17]

Residents often look to their municipal council to represent the community's concerns about health services, needs, and priorities.[17] Similarly, by working on the ground with various agencies and organizations, municipalities also have a multi-sector understanding of local needs.[17] This understanding by municipalities makes collaboration between public health and municipal governments paramount to developing comprehensive approaches to public health that address emerging needs and social determinants of health influencing local health and wellbeing.[17]

By collectively working towards the development of innovative, risk-driven strategies that are focused on addressing the risk and protective factors underpinning priorities within CSWB plans, there will be increased opportunities for public health to support the adoption of a **'health in all policies' approach within municipal governments**, which is the broadest, municipal-level intervention available to improve overall population health and reduce existing health inequities.[18, 19]

Next Steps: 2022 and Beyond

Working with our local municipalities, APH has continued to focus on the overall health and wellbeing of Algoma, by preventing disease and implementing interventions aimed at keeping people healthy and safe in the community, especially during the COVID-19 pandemic.[20, 21]

As communities continue to navigate the pandemic, it has been challenging for municipalities and partners to move CSWB plans into action. Throughout 2022, APH will continue to support municipalities and partners in revisiting plans and preparing for implementation. CSWB plans will be one of many tools used to guide Algoma municipalities, community partners and public health to collaborate in a more sustainable, innovate, and risk-driven way that focuses on evidence-informed upstream approaches to enhance community safety and wellbeing, especially as we navigate our recovery from the pandemic.[4]

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Algoma Public Health
(Unaudited) Financial Statements November 30, 2021

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Algoma Public Health
Statement of Operations
November 2021
(Unaudited)

	Actual YTD 2021	Budget YTD 2021	Variance Act. to Bgt. 2021	Annual Budget 2021	Variance % Act. to Bgt. 2021	YTD Actual/ YTD Budget 2021
Public Health Programs (Calendar)						
Revenue						
Municipal Levy - Public Health	**$ 3,808,378**	$ 3,808,378	$ 0	$ 3,808,378	0%	100%
Provincial Grants - Cost Shared Funding	**7,982,436**	7,982,436	(0)	8,708,100	0%	100%
Provincial Grants - Public Health 100% Prov. Funded	**4,970,926**	4,923,546	47,380	5,184,386	1%	101%
Provincial Grants - Mitigation Funding	**951,322**	951,324	(2)	1,037,800	0%	100%
Fees, other grants and recovery of expenditures	**406,085**	356,171	49,914	418,330	14%	114%
Total Public Health Revenue	**$ 18,119,147**	$ 18,021,855	$ 97,293	$ 19,156,994	1%	101%
Expenditures						
Public Health Cost Shared	**$ 14,920,537**	$ 16,105,226	$ 1,184,689	$ 17,561,209	-7%	93%
Public Health 100% Prov. Funded Programs	**1,470,892**	1,463,000	(7,892)	1,595,786	1%	101%
Total Public Health Programs Expenditures	**$ 16,391,430**	$ 17,568,226	$ 1,176,796	$ 19,156,995	-7%	93%
Total Rev. over Exp. Public Health	**$ 1,727,718**	$ 453,629	$ 1,274,089	$ 0		
Healthy Babies Healthy Children (Fiscal)						
Provincial Grants and Recoveries	**$ 712,011**	712,011	-	1,068,011	0%	100%
Expenditures	**642,599**	712,740	(70,141)	1,068,011	-10%	90%
Excess of Rev. over Exp.	**69,412**	(729)	70,141	-		
Public Health Programs (Fiscal)						
Provincial Grants and Recoveries	**$ 1,104,219**	1,162,420	58,201	1,883,241		
Expenditures	**545,484**	787,568	(242,084)	1,883,241		
Excess of Rev. over Fiscal Funded	**558,735**	374,852	183,883	-		
Community Health Programs (Non Public Health)						
Calendar Programs						
Revenue						
Provincial Grants - Community Health	**$ -**	$ -	$ -	$ -		
Municipal, Federal, and Other Funding	**71,858**	71,858	-	71,858	0%	100%
Total Community Health Revenue	**$ 71,858**	$ 71,858	$ -	$ 71,858	0%	100%
Expenditures						
Child Benefits Ontario Works	**0**	-	-	-	#DIV/0!	#DIV/0!
Algoma CADAP programs	**71,858**	71,858	-	71,858	0%	100%
Total Calendar Community Health Programs	**$ 71,858**	$ 71,858	$ -	$ 71,858	0%	100%
Total Rev. over Exp. Calendar Community Health	**$ -**	$ -	$ -	$ -		
Fiscal Programs						
Revenue						
Provincial Grants - Community Health	**$ 1,354,896**	$ 1,356,497	$ (1,601)	$ 2,059,744	0%	100%
Municipal, Federal, and Other Funding	**85,836**	76,298	9,538	114,447	13%	113%
Other Bill for Service Programs	**0**	0	-	-		
Total Community Health Revenue	**$ 1,440,732**	$ 1,432,795	$ 7,937	$ 2,174,191	1%	101%
Expenditures						
Brighter Futures for Children	**79,413**	76,298	(3,116)	114,447	4%	104%
Infant Development	**417,010**	430,245	13,235	644,317	-3%	97%
Preschool Speech and Languages	**369,464**	434,954	65,491	733,971	-15%	85%
Nurse Practitioner	**109,885**	108,769	(1,116)	162,153	1%	101%
Stay on Your Feet	**59,198**	66,667	7,469	100,000	-11%	89%
Rent Supplements CMH	**233,492**	279,535	46,043	419,303	-16%	84%
Bill for Service Programs	**9,855**	0	(9,855)	(0)		
Misc Fiscal	**-**	-	-	-	#DIV/0!	#DIV/0!
Total Fiscal Community Health Programs	**$ 1,278,317**	$ 1,396,468	$ 118,150	$ 2,174,191	-8%	92%
Total Rev. over Exp. Fiscal Community Health	**$ 162,415**	$ 36,327	$ 126,088	$ -		

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

Algoma Public Health

Revenue Statement

For Eleven Months Ending November 30, 2021

(Unaudited)

	Actual YTD 2021	Budget YTD 2021	Variance Bgt. to Act. 2021	Annual Budget 2021	Variance % Act. to Bgt. 2021	YTD Actual/ Annual Budget 2021	*Comparison Prior Year:* *YTD Actual 2020*	*YTD BGT 2020*	*Variance 2020*
Levies Sault Ste Marie	2,683,388	2,683,388	0	2,683,388	0%	100%	2,507,837	2,507,837	0
Levies District	1,124,992	1,124,992	0	1,124,992	0%	100%	1,051,395	1,051,395	0
Total Levies	**3,808,380**	**3,808,380**	**0**	**3,808,380**	**0%**	**100%**	**3,559,232**	**3,559,232**	**0**
MOH Public Health Funding	7,982,436	7,982,436	0	8,708,100	0%	92%	6,181,048	5,771,614	409,434
MOH Funding Needle Exchange	0	0	0	0	0%	0%	(4,659)	59,308	(63,967)
MOH Funding Haines Food Safety	0	0	0	0	0%	0%	22,550	22,550	0
MOH Funding Healthy Smiles	0	0	0	0	0%	0%	705,739	705,742	(3)
MOH Funding - Social Determinants of Health	0	0	0	0	0%	0%	306,533	165,440	141,093
MOH Funding Chief Nursing Officer	0	0	0	0	0%	0%	30,375	111,386	(81,011)
MOH Enhanced Funding Safe Water	0	0	0	0	0%	0%	14,211	14,208	3
MOH Funding Infection Control	0	0	0	0	0%	0%	165,172	286,374	(121,203)
MOH Funding Diabetes	0	0	0	0	0%	0%	96,250	137,500	(41,250)
Funding Ontario Tobacco Strategy	0	0	0	0	0%	0%	278,232	397,467	(119,235)
MOH Funding Harm Reduction	0	0	0	0	0%	0%	137,500	137,500	0
MOH Funding Vector Borne Disease	0	0	0	0	0%	0%	27,175	99,638	(72,463)
MOH Funding Small Drinking Water Systems	0	0	0	0	0%	0%	17,400	63,800	(46,400)
Total Public Health Cost Shared Funding	**7,982,436**	**7,982,436**	**0**	**8,708,100**	**0%**	**92%**	**7,977,526**	**7,972,527**	**4,999**
MOH Funding - MOH / AMOH Top Up	193,741	139,412	54,329	152,086	39%	127%	143,797	139,412	4,385
MOH Funding Northern Ontario Fruits & Veg.	107,622	107,617	5	117,400	0%	92%	107,622	107,617	5
MOH Funding Unorganized	486,200	486,200	0	530,400	0%	92%	486,200	486,200	0
MOH Senior Dental	639,739	639,742	(3)	697,900	0%	92%	613,359	639,742	(26,383)
MOH Funding Indigenous Communities	89,828	89,826	2	98,000	0%	92%	89,828	73,500	16,328
One Time Funding (Pandemic Pay)							143,600	143,600	0
OTF COVID-19 extraordinary costs mass imms	3,460,750	3,460,750	0	3,588,600	0%	96%	0	0	0
Total Public Health 100% Prov. Funded	**4,977,880**	**4,923,546**	**54,334**	**5,184,386**	**1%**	**96%**	**1,584,406**	**1,590,070**	**(5,664)**
Total Public Health Mitigation Funding	**951,322**	**951,324**	**(2)**	**1,037,800**	**0%**	**92%**	**951,322**	**951,322**	**(0)**
Recoveries from Programs	27,134	26,690	444	28,010	2%	97%	27,303	25,236	2,067
Program Fees	100,607	100,505	103	105,320	0%	96%	170,524	184,510	(13,987)
Land Control Fees	264,965	155,000	109,965	160,000	71%	166%	194,522	155,000	39,522
Program Fees Immunization	4,100	45,826	(41,726)	45,000	-91%	9%	36,427	105,417	(68,990)
HPV Vaccine Program	0	0	0	12,500	0%	0%	0	3,000	(3,000)
Influenza Program	0	0	0	25,000	0%	0%	0	1,500	(1,500)
Meningococcal C Program	0	0	0	7,500	0%	0%	0	625	(625)
Interest Revenue	12,805	18,150	(5,345)	20,000	-29%	64%	18,969	36,667	(17,698)
Other Revenues	(10,477)	10,000	(20,477)	15,000	-205%	-70%	5,541	32,000	(26,459)
Total Fees and Recoveries	**399,134**	**356,171**	**42,963**	**418,330**	**12%**	**95%**	**453,285**	**543,955**	**(90,669)**
Total Public Health Revenue Annual	**18,119,153**	**18,021,857**	**97,296**	**19,156,996**	**1%**	**95%**	**14,525,772**	**14,617,106**	**(91,334)**
Public Health Fiscal April 2021 - March 2022									
Vaccine Refrigerators	4,940	4,934	6	7,400	0%	67%			
Infection Prevention and Control Hub	590,328	648,536	(58,208)	1,060,000	-9%	56%			
Practicum	13,331	13,334	(3)	20,000	0%	67%			
School Nurses Initiative	465,504	465,500	4	700,000	0%	67%			
Sr Dental Capital Upgrades	30,116	30,116	0	95,841	0%	31%			
Total Provincial Grants Fiscal	**1,104,219**	**1,162,420**	**(58,201)**	**1,883,241**	**-5%**	**59%**	**0**	**0**	**0**

Algoma Public Health

Expense Statement- Public Health

For Eleven Months Ending November 30, 2021

(Unaudited)

	Actual YTD 2021	Budget YTD 2021	Variance Act. to Bgt. 2021	Annual Budget 2021	Variance % Act. to Bgt. 2021	YTD Actual/ Budget 2021	*Comparison Prior Year:* *YTD Actual 2020*	*YTD BGT 2020*	*Variance 2020*
Salaries & Wages	9,699,388	10,760,075	1,060,686	11,771,802	-10%	82%	$ 8,665,562	$ 8,744,789	$ 79,227
Benefits	2,239,976	2,391,592	151,616	2,605,536	-6%	86%	2,020,797	2,079,179	58,382
Travel	135,670	158,500	22,830	172,909	-14%	78%	98,492	175,083	76,591
Program	1,285,206	1,034,069	(251,137)	1,107,190	24%	116%	508,732	600,545	91,813
Office	49,729	52,287	2,558	57,040	-5%	87%	41,946	64,858	22,912
Computer Services	752,281	882,828	130,547	959,676	-15%	78%	791,363	794,090	2,727
Telecommunications	337,256	386,100	48,845	421,200	-13%	80%	270,390	244,314	(26,076)
Program Promotion	69,947	76,138	6,190	83,035	-8%	84%	31,195	87,909	56,713
Professional Development	33,398	69,208	35,811	75,500	-52%	44%	11,467	124,208	112,741
Facilities Expenses	1,144,853	1,133,335	(11,519)	1,236,365	1%	93%	785,979	709,882	(76,097)
Fees & Insurance	301,103	292,775	(8,328)	305,300	3%	99%	252,410	244,390	(8,020)
Debt Management	422,736	422,492	(244)	460,900	0%	92%	422,490	422,492	1
Recoveries	(80,113)	(91,171)	(11,058)	(99,459)	-12%	81%	(95,105)	(75,481)	19,624
	$ 16,391,430	$ 17,568,226	$ 1,176,796	$ 19,156,994	**-7%**	**86%**	$ 13,805,719	$ 14,216,258	$ 410,539

Notes to Financial Statements – November 2021

Reporting Period

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

Statement of Operations (see page 1)

Summary – Public Health and Non Public Health Programs

APH received the 2021 Amending Agreement from the province identifying the approved funding from the province for 2021 for public health. The Ministry of Health has approved one-time funding to support eligible COVID-19 extraordinary costs in the amount of $3,588,600 year to date, based on our second quarter Ministry submission of actual and forecasted costs for the 2021 year. They will continue to work with APH to monitor and track more detailed and accurate requirements and spending for COVID-19 through in-year financial reports and make any adjustments to funding, as required, throughout the remainder of 2021 funding year. Of note is that for the November 2021 financials, Management has taken the conservative approach and adjusted the 2021 budget to reflect actual approved funding (including the additional $1,534,200 in COVID extraordinary cost reimbursement approved in November).

As of November 30, 2021, Public Health calendar program expenditures are reporting a $1,177K positive variance.

Total Public Health Revenues are indicating a $97k positive variance.

Public Health Revenue (see page 2)

Overall, Public Health calendar funding revenues are reporting a $97k positive variance budget. Land Control Fees are reporting a $110k surplus.

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

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

Public Health Expenses (see page 3)

Salary & Wages
There is a $1,061k positive variance associated with Salary & Wages driven by position vacancies.

Benefits
There is a $152k positive variance associated with Benefits.

Notes Continued…

Travel
There is a $23k positive variance associated with Travel expenses. This is a result of APH employees working virtually as opposed to travelling throughout the district or attending meetings outside of the district.

Programs
There is a $251k negative variance associated with Programs. This is due to the high demand for professional services through the Ontario Sr. Dental Program which is $132k over budget. Remaining supplies, purchased services and third party professional service fees are over budget by$117K which is largely driven by ongoing requirements in the COVID 19 Mass Immunization program.

Computer Services
There is a $131k positive variance associated with computer services. This is due to delayed hiring of IT support staff and software implementation.

Professional Development
There is a $36k positive variance for Professional Development. At this time there has been limited spending for professional development, as staff availability is extremely tight and limited opportunities for professional development due to COVID-19.

COVID-19 Expenses

COVID-19 Response
This program includes case and contact management as well as supporting the information phone lines. November YTD expenses were $4.4M. The majority of this consists of salaries and benefits costs of APH staff that under normal circumstances would be working in their assigned public health programs.

COVID-19 Mass Immunization
This program includes the planning, support, documentation, and actual needles in arms of the various COVID-19 vaccines. November YTD expenses were $3.6M.

Financial Position - Balance Sheet (see page 6)

APH's liquidity position continues to be stable and the bank has been reconciled as of November 30, 2021. Cash includes $1.40M in short-term investments. APH has received two lump sum payments totaling $3,396,425 from the province for COVID extraordinary costs (of the total $3,588,600 approved year to date). Further funding will be provided for extraordinary costs and will be determined based on Q3 & Q4 forecasted submissions to the province.

Long-term debt of $4.47 million is held by TD Bank @ 1.80% for a 60-month term (amortization period of 120 months) and matures on September 1, 2026. $265k of the loan relates to the financing of the Elliot Lake office renovations, which occurred in 2015 with the balance, related to the financing of the 294 Willow Avenue facility located in Sault Ste. Marie. There are no material accounts receivable collection concerns.

Algoma Public Health

Statement of Financial Position

(Unaudited)

Date: As of November 2021	November 2021	December 2020
Assets		
Current		
Cash & Investments	$ 7,155,956	$ 3,906,995
Accounts Receivable	310,003	935,870
Receivable from Municipalities	136,168	69,618
Receivable from Province of Ontario		
Subtotal Current Assets	7,602,127	4,912,483
Financial Liabilities:		
Accounts Payable & Accrued Liabilities	2,130,366	1,660,232
Payable to Gov't of Ont/Municipalities	377,079	1,673,441
Deferred Revenue	568,676	286,418
Employee Future Benefit Obligations	3,117,450	3,117,450
Term Loan	4,466,918	4,466,918
Subtotal Current Liabilities	10,660,489	11,204,458
Net Debt	(3,058,363)	(6,291,975)
Non-Financial Assets:		
Building	22,867,230	22,867,230
Furniture & Fixtures	1,998,117	1,998,117
Leasehold Improvements	1,572,807	1,572,807
IT	3,252,107	3,252,107
Automobile	40,113	40,113
Accumulated Depreciation	-11,199,609	(11,199,609)
Subtotal Non-Financial Assets	18,530,764	18,530,764
Accumulated Surplus	15,472,401	12,238,789

APPROVED BY:	Board of Health	**REFERENCE #:**	02-05-065
DATE:	Original: Jun 17, 2015 Revised: Jun 24, 2017 Reviewed: Apr 24, 2019	**SECTION:**	Policies
		SUBJECT:	Algoma Board of Health Reserve Fund

Purpose:

To provide guidance on the establishment, maintenance, and use of a reserve fund.

Policy:

The Board of Health for the Algoma Public Health has established reserves as follows:

Background:

The Health Protection and Promotion Act (the "Act") requires, in section 72(1), that the expenses incurred by or on behalf of a Board of Health and the Medical Officer of Health/Chief Executive Officer (MOH/CEO) in the performance of their functions and duties under the Act or any other act shall be borne and paid by the Municipalities in the health unit served by the Board of Health.

Section 72(5) (1) of the Act requires the Board of Health to cause the preparation of an annual estimate of expenses for the next year. Such estimate of expenses may from time to time be too high or too low, resulting in an excess or a shortfall respectively of funds paid by the Municipalities.

The Board of Health considers it prudent and expedient to establish reserve funds, which include reserves, into which, inter alia, any excess funds received in any year be paid to be applied to cover any shortfall of funds in future years.

Section 417(1) of the Municipal Act empowers the Board of Health in each year to provide in its estimate of expenses for the establishment or maintenance of a reserve fund for any purpose for which it has authority to expend funds.

Section 417(2) of the Municipal Act only requires the approval of the Councils of the majority of the Municipalities in a health unit for the establishment and maintenance of a reserve fund if the Board of Health is required to obtain such approval for capital expenditures.

Section 52(4) of the Act only requires the Board of Health to seek the approval of the Councils of the majority of Municipalities in a health unit for capital expenditures made to acquire and hold real property.

To obviate the need to seek the approval of the Councils of the majority of the Municipalities in the Algoma Health Unit to establish and maintain a reserve fund, the reserve fund will contain a restriction that the funds therein shall not be used for capital expenditures to acquire real property without first obtaining the approval of the Councils of the majority of the Municipalities in the Algoma Health Unit as required by section 52(4) of the Act.

Motion: 2015-91 ALGOMA BOARD OF HEALTH UNIT RESERVE FUNDS

THEREFORE BE IT RESOLVED THAT

1) The Board of Health forthwith establish and maintain reserve funds for Working Capital, Land Control, Human Resources Management, Public Health Initiatives and Response, Corporate Contingencies, and Facility and Equipment Repairs and Maintenance; and,
2) The reserve funds shall be used and applied only to pay for expenses incurred by or on behalf of the Board of Health and the Medical Officer of Health in the performance of their functions and duties under the Health Protection and Promotion Act or any other Act; and,
3) None of the reserve funds shall be used or applied for capital expenditures to acquire and hold real property unless the approval of the Councils of the majority of the Municipalities in the Algoma Health Unit have been first obtained pursuant to section 52(4) of the Act; and,
4) The Board of Health in each year may provide in its estimates for a reasonable amount to be paid into the reserve funds provided that no amount shall be included in the estimates which is to be paid into the reserve funds when the cumulative balance of all the reserve funds in the given year exceeds 15 percent of the regular operating revenues for the Board of Health approved budget for the mandatory cost-shared programs and services; and,
5) All lease revenues, received by the Board of Health under leases of part of its premises, in excess of the actual operating costs attributable to the leased premises, shall be paid annually into the reserve funds; and,
6) Any over-expenditures in any year shall be paid firstly from the reserve funds, and only when the reserve funds shall have been exhausted will the Board of Health seek additional funds from the Municipalities to pay for such over-expenditures; and,
7) Any excess revenues in any year resulting from an overestimate of expenses shall be paid into the reserve funds; and,
8) The MOH/CEO shall, will Board approval, in each year direct the allocation of excess funds to such reserve fund or funds as the MOH/CEO shall decide; and,
9) The MOH/CEO shall be entitled to transfer funds from one reserve fund to another reserve fund at any time and from time to time.

The MOH/CEO shall be responsible for the management of the reserves in accordance with respective Board of Health motions and Board By-law 2015-1.

The approval of the Board of Health shall be required for any transfers from the Board's reserves that constitute part of the annual budget approval process or that are in excess of $50,000 per transaction.

Algoma Public Health

Public Health Champion(s) & Young Public Health Champion Award

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Local public health in action

The COVID-19 pandemic has continued to challenge individuals, businesses, and communities across Algoma. We have worked together during these times of great change and disruption to support one another and support our communities. It is by working together that we will continue to stay healthy and safe - and together, we will get through this.

This year, our **Public Health Champion** awards and **Young Public Health Champion** award will honour Algoma residents who have stepped to keep our communities safe and healthy throughout 2021, and demonstrated exemplary kindness, compassion, and community spirit while helping others overcome the challenges related to COVID-19.

To mark the fact that we have been living in the face of the COVID-19 pandemic for nearly two years, we encourage nominations where champions have persevered with their efforts throughout the marathon of the pandemic and sustained a positive impact to others.

2021 Public Health Champion(s)

A Public Health Champion may be an individual or group of individuals, an organization, employer, or employee in Algoma. A Public Health Champion may include an individual or group who:

- Combatted isolation or stigma and worked to ensure that community members in all walks of life remained socially connected and cared for, enhancing community mental health and wellness.

  e.g. focused on the emotional and social wellbeing of long-term care home residents, people who live alone, people with substance use disorder, people accessing shelters, or prioritized supports or counselling for essential frontline workers.

- Supported health protection and infection prevention and control, and helped fellow community members stay healthy and safe.

e.g. went above and beyond expected public health measures to create a safe work environment; helped others with groceries and other essentials during the pandemic so that people who were ill or vulnerable could stay safely and comfortably at home;

- Helped spread credible information about the COVID-19 vaccine to help increase vaccine confidence and uptake in immunization.

  e.g. promoted key messages in their workplace or school, helped educate those who wanted more credible information on the vaccine, supported clinic staff with donations of food, or assisted with transportation ensuring people were able to get to and from a clinic safely.

Young Public Health Champion

A Young Public Health Champion may be an individual or group of individuals, or organization, of children, youth and/or young adults under 30 years old in Algoma.

Children, youth and young adults are powerful agents of change for building healthier communities now and in the future. Many young people have motivated community members and designed innovative solutions to improve health, safety, and wellbeing in Algoma. This year, we are awarding a Public Health Champion award to recognize the extraordinary efforts of a young person in Algoma who has demonstrated enthusiasm, optimism, and creativity in making Algoma a healthy place to live and grow for people of all ages and abilities, despite limits posed by public health measures related to COVID-19.

e.g., found ways to keep their class connected in the online learning environment, started a webpage to share healthy recipes or hosted a food drive for local resource centres, hosted free virtual fitness classes for community members to get active at home, safely cleaned up neighbourhoods, or shared strategies for home recycling and reducing our environmental impact;

Call for nominations end on January 28, 2022 @ 12 PM EST

Award winners will be presented at the *February 23, 2022* Board of Health virtual meeting.

Award Selection Nominations are evaluated by members of the Algoma Public Health Board of Health and Algoma Public Health staff.

How do I nominate?

Choose 1 of 3 options:

Option 1: Complete the **online form (/about-us/public-health-champion-s-young-public-health-champion-award/public-health-champion-nomination-form/)** and click 'submit'

Option 2: Download a **fillable PDF (/media/5126/phc_nomination-form_2021.pdf)**. Complete it and submit it electronically by emailing: **communications@algomapublichealth.com (mailto:communications@algomapublichealth.com)**

Option 3: Download a **nomination sheet (/media/5126/phc_nomination-form_2021.pdf)** (PDF) and mail it to:

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

To be eligible for nomination, the individual or group of individuals, organization, employer, or employee **must reside in the Algoma district**.

Current members of the Board of Health for Algoma Public Health and Algoma Public Health staff are not eligible.

Blind River (705) 356-2551 (tel:+17053562551)

Elliot Lake (705) 848-2314 (tel:+17058482314)

Sault Ste. Marie (705) 942-4646 (tel:+17059424646)

Wawa (705) 856-7208 (tel:+17058567205)

Public Health Resilience in Ontario

CLEARING THE BACKLOG, RESUMING ROUTINE PROGRAMS, AND MAINTAINING AN EFFECTIVE COVID-19 RESPONSE

Association of Local Public Health Agencies
January 2022

Since the beginning of the COVID-19 pandemic, Ontario's 34 local public health agencies (LPHAs) have been at the forefront of the ongoing response. They have prevented COVID-19 transmission, hospitalizations, and death through enactment and enforcement of public health measures, case and contact management, outbreak management, infection prevention and control, communication of credible advice to the public, coordination with local and provincial partners and leadership of the vaccination campaign.

These extraordinary efforts have come at the expense of nearly all the routine programs and services mandated by the Ontario Public Health Standards (OPHS) as their resources were redeployed almost exclusively to the pandemic response. This has resulted in a backlog of public health work that will have immediate and longer-term impacts on population health.

The purpose of this report is to demonstrate the need for additional investments in public health that will be required to clear the backlog, resume routine programs and services, and maintain an effective pandemic response. The content is adapted from an earlier and more detailed draft report that the Council of Ontario Medical Officers of Health (COMOH) submitted to the Chief Medical Officer of Health in early October. This was informed largely by a survey of all 34 public health units that gathered information about program deficits since 2020.

KEY FINDINGS: IMPACTS ON MANDATED PUBLIC HEALTH PROGRAMS AND SERVICES

Just like the widely reported "surgical backlog" in health care, a health promotion and protection backlog has accumulated since March 2020, which is certain to have a significant and measurable effect on the health of Ontarians for years to come.

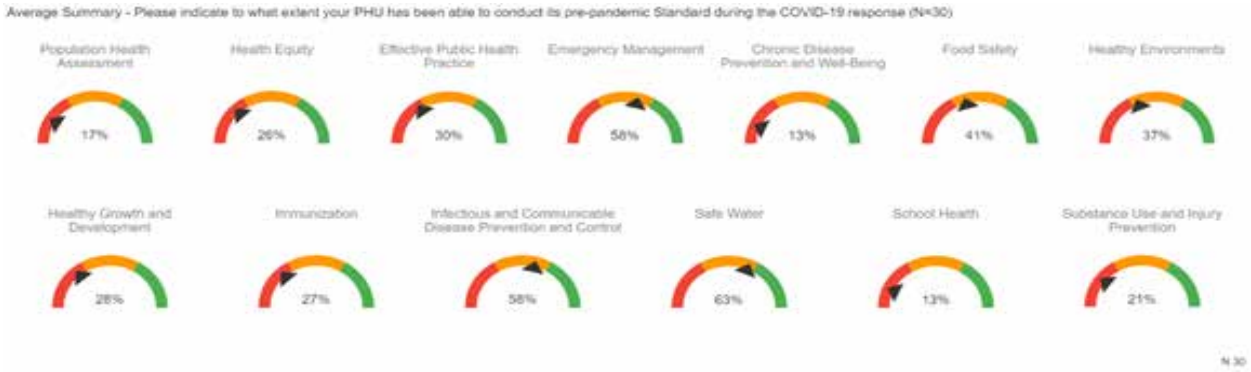
OPHS mandated public health programs and services have been significantly curtailed for nearly two years, with an average of 74% of 2020 LPHA resources and 78% (to date) of 2021 LPHA resources having been diverted to the COVID-19 response. This increase reflected a general upward trend as the pandemic evolved, and additional resources had to be secured to meet the demand throughout the province. Uncertainties about funding sources presented a challenge to managing extraordinary costs and allocating resources.

Health protection programs such as Safe Water, Infectious and Communicable Disease Prevention and Control, and Emergency Management Standards had the highest rates of completion, but most were response-driven and prioritized according to the level of risk, which in turn would focus primarily on COVID-19 related threats.

The Chronic Disease Prevention and Well-being and School Health Standards, which include injury prevention, healthy eating and physical activity, immunization, mental health, and substance use, had the lowest rates of completion. The population health impact of these deficits will be felt over a longer period and will almost certainly be magnified by the effects of the pandemic, which will in turn add to the cost of catching up on the OPHS mandates in these areas.

Specific concerns were expressed about the program backlogs related to children's health. Since the onset of the pandemic in March 2020, oral health screening in schools effectively ceased, and the Healthy Babies Healthy Children (HBHC) visits for vulnerable families and children were significantly reduced. Additionally, approximately 80% of the routine school immunization program was not completed during this time. Estimates indicate that this could account for a current backlog of up to 300,000 school-based vaccinations/year across the province.

Summary of PHUs self-reported completion of OPHS Standards in the context of the COVID-19 pandemic:



LESSONS LEARNED: PROCESS IMPROVEMENTS AND REINFORCEMENT OF PARTNERSHIPS AND COLLABORATION

The COVID-19 pandemic presented opportunities for public health to demonstrate its resilient and innovative capacity to meet local needs despite major resource challenges. Technological innovation, enhanced coordination with a wide range of partners, improvements to processes such as data analysis, reporting, surveillance, and communications, and the application of data to inform health equity approaches were highlighted. Each of these is expected to yield lasting benefits beyond the COVID-19 response.

RESTORING PUBLIC HEALTH'S WORK TO IMPROVE THE HEALTH OF ONTARIANS

LPHAs are beginning to develop recovery plans, which are aimed at resuming their vital and mandated programs and services under the OPHS while continuing to provide an effective ongoing response to COVID-19. These plans include ongoing assessments of program deficits that have resulted from the pandemic response and recommendations for a phased and priority-based approach to returning to full service while giving special attention to the public health needs of populations that have been disproportionally affected. Program areas that address mental health, substance use and harm reduction, child immunization catch-up, food safety inspection, and oral health were cited as priorities for the earliest stages of the recovery.

STRENGTHENING PUBLIC HEALTH FOR A MORE RESILIENT ONTARIO

Substantial recovery efforts will not be possible if the pandemic response continues to consume the bulk of local public health resources. While mitigation funding from the Province has been helpful, clearer and more timely assurances of funding for both routine and extraordinary public health activities will be required to inform budgets over multiple years. Additional and immediate investments will be required as maintaining COVID-19 response activities while resuming OPHS activities will not be feasible without additional resources. Recovery will also require addressing high levels of stress and burnout among public health staff to support their personal recovery.

RECOMMENDATIONS

Provincial support for an ongoing pandemic response: Maintain ongoing provincial investments in science, structures, and resources in support of the multi-sector effort required to effectively manage the COVID-19 pandemic.

- Ongoing provincial coordination of the response between sectors
- Maintenance and review of provincial guidelines and tools, commitment to effective communications, and central support for local public health implementation and adaptation of provincial guidance based on local community needs.
- Strengthening Public Health Ontario's capacity to provide scientific and technical advice to government, public health, health care, and related sectors

Provincial support for Local Public Health Agencies: Protect and promote the health of Ontarians through financial investments in PHUs that are clearly communicated and committed early in the fiscal year:

- Ongoing one-time COVID-19 funding for 2022 to support the COVID-19 response and ensure the ability to maintain required staffing level.
- One-time recovery funding to support recovery efforts, as outlined in this report, and to allow PHUs to address priority areas.
- Increase base funding, including but not limited to the addition of COVID-19 as a disease of public health significance beyond 2022.

Provincial support for evaluation and renewal: Continue to work with Ontario's public health stakeholders (Public Health Ontario, Office of the Chief Medical Officer of Health, Local Public Health Agencies) to develop the vision for a stronger responsive public health sector with the capacity to address population health needs through various partnerships into the future.

- Ensure that Ontario launches a comprehensive review and assessment of all aspects of the pandemic response to inform strategies for improvement.
- Ensure that public health stakeholders have the capacity and resources to participate fully in the review and in formulating recommendations.

PUBLIC HEALTH RESILIENCE IN ONTARIO

INTRODUCTION

Since the beginning of the pandemic, Ontario's 34 local public health agencies (LPHAs) have been at the forefront of the ongoing pandemic response. Led by dedicated local medical officers of health, boards of health, and a diverse and skilled workforce, these agencies have been instrumental in preventing COVID-19 transmission, hospitalizations, and death through enactment and enforcement of public health measures, case and contact management, infection prevention and control, communication of credible advice to the public, and leadership of the vaccination campaign. These activities have been crucial to preserving the capacity of Ontario's health care system as well as allowing for cautious and measured steps towards reopening the economy.

The unfortunate consequence of the extraordinary efforts required to limit the spread of COVID-19 and decrease its impact on the population at the local level is that LPHAs have had to suspend a significant proportion of the routine programs and services mandated by the Ontario Public Health Standards (OPHS) and redeploy their resources to the pandemic response.

This has resulted in a backlog of public health work that includes both quantifiable and less quantifiable impacts. Quantifiable impacts include services not performed, such as inspections, immunizations, disease investigations, and family visits to support early childhood development. Less quantifiable are the population health impacts of the reduction of public health programs and services, including health equity, active living and healthy eating, mental health, substance use including addressing the opioid epidemic, and poverty.

The purpose of this report is to summarize the backlog of public health programs and services created by the pandemic response, to outline the requirements for additional investments to support the resumption of these routine activities as the response continues, and to identify key secondary population health impacts of the pandemic that will require additional resources to tackle. Its content is derived almost exclusively from an earlier and more detailed report by the Council of Ontario Medical Officers of Health (COMOH) that was submitted to the Chief Medical Officer of Health in early October.

Information Sources

In the developmental stages of the COMOH report to the CMOH in the late summer of 2021, all 34 LPHAs in Ontario were invited to complete a 62-question survey designed to assess the proportion of resources reallocated to COVID-19 response and the consequent impact on OPHS programs and services requirements. It also asked for an outline of reasons for the program backlog and a ranking of public health topics for priority focus during the recovery stages. The survey also invited LPHAs to submit additional material related to recovery and priorities, which included recovery plans, reports,

presentation slide decks, and reports on indirect harms associated with the COVID-19 pandemic (the pandemic itself, and the public health measures).

Other sources of information also contributed to our understanding of the indirect impacts of the COVID-19 pandemic, the unintended consequences of public health measures used to slow COVID-19 transmission, and the effects of the curtailment of public health services on the health of the population. Discussions involving the Council of Ontario Medical Officers of Health and Ministry colleagues, various letters to the Ministry from Boards of Health on recovery, the Ontario Health dashboard for recovery topics, and public reports released by Public Health Ontario were invaluable to identifying priority population health issues that were aggravated by the pandemic. Mental health, substance use, healthy growth and development, chronic disease, health equity, income, violence/family violence, oral health, and racism emerged as the most significant.

KEY FINDINGS: IMPACTS ON MANDATED PUBLIC HEALTH PROGRAMS AND SERVICES

As noted in the Ontario Public Health Standards, the role of LPHAs is to "support and protect the physical and mental health and well-being, resiliency and social connectedness of the health unit population, with a focus on promoting the protective factors and addressing the risk factors associated with health outcomes", through the core functions of population health assessment and surveillance, health promotion and protection, disease prevention and emergency management.

Simply put, public health keeps people and communities healthy, saves lives and saves money. Public health programs and services prevent health problems from occurring in the first place and help prolong healthy lives, which reduces the need to draw on expensive and increasingly scarce resources of the health care system.

These routine public health supports to population health were significantly diminished throughout the pandemic. The survey data provided by LPHAs revealed that, on average, 74% of their 2020 resources and 78% (to date) of their 2021 resources were allocated to the COVID-19 response, with ranges of 20% to 100% in 2020 and 40% to 90% in 2021. A more fulsome analysis of what factors may have accounted for placement within these ranges was not completed, but the figures below demonstrate a general upward trend in resource diversion to the COVID-19 response between 2020 and 2021.

Figure 1. Public Health Unit reports of proportion of PHU resources allocated to COVID 19 response during the pandemic for 2020.

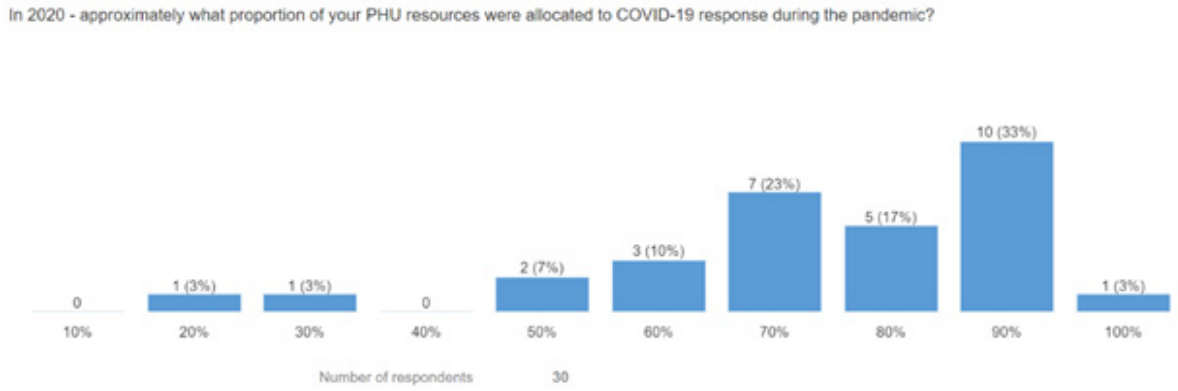
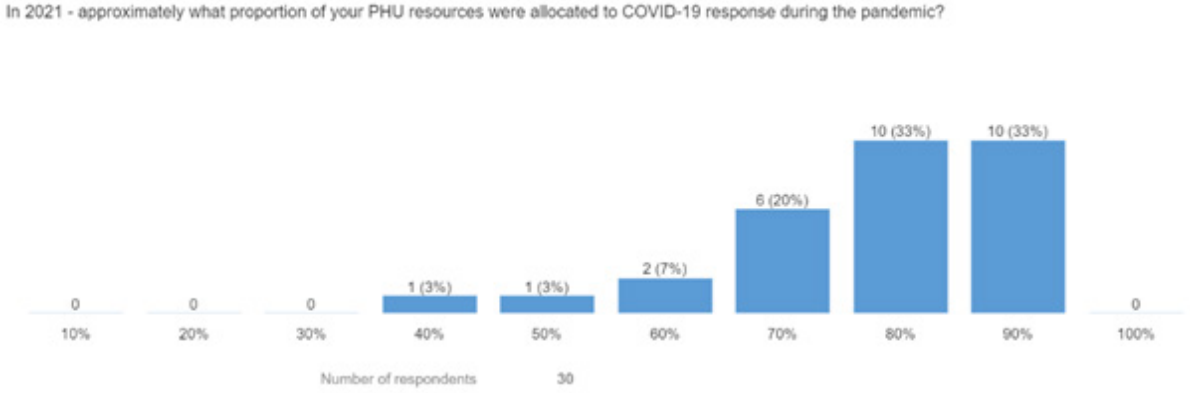


Figure 2. Public Health Unit reports of proportion of PHU resources allocated to COVID 19 response during the pandemic for 2021.



The increase in resource redeployment to COVID-19 responses from 2020 to 2021 reflects the rapidly evolving context of the pandemic, which placed a heavy workload on all LPHAs. When the pandemic began staff were faced with receiving and processing large and rapidly changing volumes of information, adapting guidance and public messaging to emerging science, and developing new processes to engage with community partners, decision makers and the public. As the pandemic evolved, response activities were modified according to the rise and fall of case counts, the emergence of more dangerous variants, and the rollout of an unprecedented and complex vaccination campaign.

In addition to redeployment of existing resources, all LPHAs that responded to the survey reported increasing their staff complement through temporary hiring to manage the demands. In addition to the added financial and administrative procedures, training and orientation of new staff added to the already burdensome load. A clear majority of the LPHAs reported having accessed the provincial workforce for case and contact management to assist with the response. Some also reported that the uncertainty related to funding impacted their ability to make timely decisions regarding the augmentation and allocation of resources to both urgent non-COVID-19 related activities along with the COVID-19 response.

Direct and indirect impacts on PHUs and public health programs and services

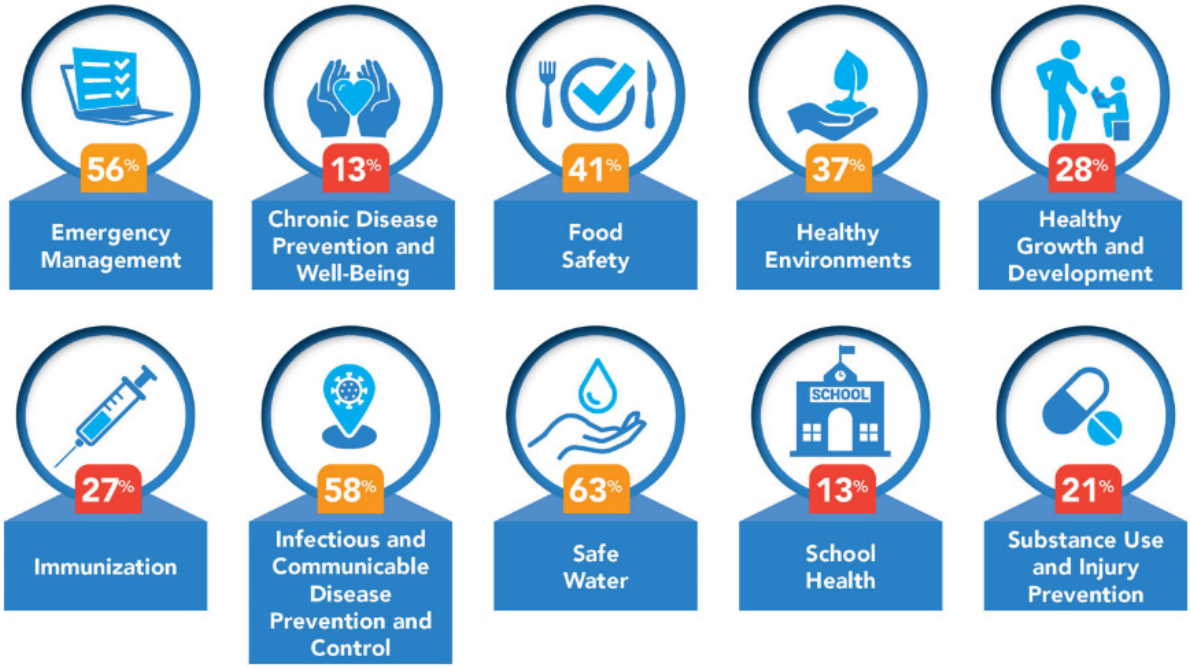
The redirection of resources to COVID-19 response efforts has led to a tremendous backlog of programs and services that will require equally tremendous commitment to resolve. Just like the widely reported “surgical backlog” in health care, the health promotion and protection backlog that has built up over nearly 2 years is certain to have a significant and measurable effect on the health of Ontarians for years to come. In the meantime, the pandemic itself has caused or magnified indirect harms to population health, including health inequities, impacts on mental health, increased substance use, and neglect of chronic diseases.

Specific questions were asked in our survey of LPHAs about the impact of the near-exclusive focus on COVID-19 response on their ability to carry out the full scope of the OPHS. The extent of completion of OPHS mandated activities ranged from 13% to 63%, and many respondents emphasized that most of the

work that was completed under each standard was linked in some way to the COVID-19 response. Non COVID-19 related activities overall were limited. Figures 9 and 10 below illustrate the average deficits for each OPHS Standard calculated from the survey data.

Figure 3: Summary of PHUs self-reported completion of OPHS Foundational Standards in the context of the COVID-19 pandemic

Figure 4: Summary of PHUs self-reported completion of OPHS mandated Program Standards in the context of the COVID-19 pandemic



Other Notable Findings from the Survey

- None of the OPHS requirements were completed to pre-pandemic levels due to the extensive redeployment of staff required to provide COVID-19 response activities including surveillance, case and contact investigation, outbreak and Infection Prevention and Control (IPAC) responses, enforcement, communications, vaccination and responding to public inquiries.
- The Safe Water, Infectious and Communicable Disease Prevention and Control, and Emergency Management Standards had the highest rates of completion but in many cases, the work was modified, response-driven and prioritized. Due to capacity constraints, many health units were required to triage their response to reportable diseases, IPAC complaints and inspections according to the level of risk.
- The Chronic Disease Prevention and Well-being and School Health Standards had the lowest rates of completion, a particular concern given the broad scope and far-reaching influence of each of these on overall population health. Injury prevention, healthy eating and physical activity, immunization, oral health, mental health, substance use, UV exposure, and violence and bullying are just some of the topics that LPHAs are required to address under these two Standards.

Service backlogs specifically related to children's health were also emphasized by respondents to the survey.

- Oral health screening in schools effectively ceased in March 2020 with the onset of the pandemic. Data from 16 LPHA respondents indicated that 2,602 children were screened in schools in the 2020-2021 school year, which is less than 1% of the 301,830 children who received oral health screening in the 2019-2020 school year.
- Healthy Babies Health Children (HBHC): overall, just over three quarters of public health agencies recommended or required the reduction of in-person home visits due to public health measures. In addition, many public health nurses from HBHC were redeployed to COVID-19 response activities creating waitlists and backlog of services for vulnerable families and children. Although many health agencies transitioned to virtual service delivery, when asked what percentage of HBHC families were receiving home visits using interactive video conferencing, 50% of public health agencies (17/34) reported <10% of their families were receiving video 'home visits'.
- School immunizations: 24 health agencies reported that approximately 80% of the school immunization program was not completed during the pandemic so far. Estimates provided by one health unit indicate that this would account for up to 300,000 school-based vaccinations/year that have not been administered across the province.

Overall, the program areas for which there is the greatest deficit are those in health promotion. These programs yield results over longer periods of time, and the effects of deficits in this area may not be immediately observed. Delays in addressing this backlog will magnify these effects, which include impacts on quality and quantity of life years and increased costs to the health care system.

Lessons Learned: process improvements and reinforcement of partnerships and collaboration

The COVID-19 pandemic presented many opportunities for public health to demonstrate its resilient and innovate nature through the enhancements to its traditional delivery of local public health programs and services to meet the local response needs. As reported in the survey and anecdotally through conversations amongst health units, new organizational processes were established, along with improved coordination of public health response among partners in health care and non-health care sectors. These enhancements could be further explored and considered during recovery for the effective and efficient operations of public health.

Improvements to processes because of the COVID-19 response were noted for the following activities by most respondents:

- data analysis, management, reporting, and visualization
- surveillance
- public and partner communications
- stakeholder engagement and collaboration
- public and partner education
- data driven health equity approaches
- emergency management

Some LPHAs noted that their processes for conducting case and contact management and IPAC management were supported by new technologies (e.g., PowerBI for enhanced data visualization, remote call centres, etc.) that will have lasting benefits beyond the COVID-19 response.

Support from the Office of the Chief Medical Officer of Health and Public Health Ontario were also identified as integral to the local response. The professional resources and tools including provincial guidelines, reference materials, legislation, emergency orders, and orders in council were essential to a coordinated public health response. Additional centralized human resources including the provincial workforce for case and contact investigation were also invaluable.

The importance of the existing network of local relationships among LPHAs, local health care providers, municipalities, social services, boards of education, and businesses was simultaneously demonstrated and enhanced during the COVID-19 response. Coordination of efforts to support public health measures, communicate information, implement assessment and testing strategies, and execute the mass vaccination campaign benefited significantly from local collaborative efforts, which will also be essential in the recovery phase.

RESTORING PUBLIC HEALTH'S WORK TO IMPROVE THE HEALTH OF ONTARIANS

The OPHS represents a broad range of often interrelated programs and services that address an equally broad range of population health determinants and outcomes. OPHS guidelines and protocols give LPHAs more detailed information to support their activities. These are Ministry mandated requirements and the basis of the related accountability and funding agreements.

LPHAs are beginning to develop recovery plans, which are aimed at resuming their vital and mandated programs and services under the OPHS while continuing to provide an effective ongoing response to COVID-19. These plans include assessments of program deficits that have resulted from the pandemic response and recommendations for a phased and priority-based approach to returning to full service

while giving special attention to the public health needs of populations that have been disproportionally affected.

This last point is noteworthy in its recognition that the pandemic and the response to it will have long lasting indirect health impacts on certain populations, which will put additional demands on LPHAs even within their OPHS mandate. Health equity has been identified as a foundational theme for recovery planning and will be a primary consideration in prioritizing activities. The core function of population health assessment will be critical here and given that this was one of the highest program standard deficits, it must be recognized that additional supports will be required to close this gap so that the other program gaps can be properly addressed.

LPHAs were also asked in the survey to rank program recovery priorities to address the public health backlog. The topics prioritized included mental health promotion, substance use and harm reduction including a focus on the opioid crisis, child immunization catch-up, food safety inspection, and oral health. Results are illustrated below in Figure 5.

The following specific priorities were identified for attention in the earliest stages of resuming routine activities:

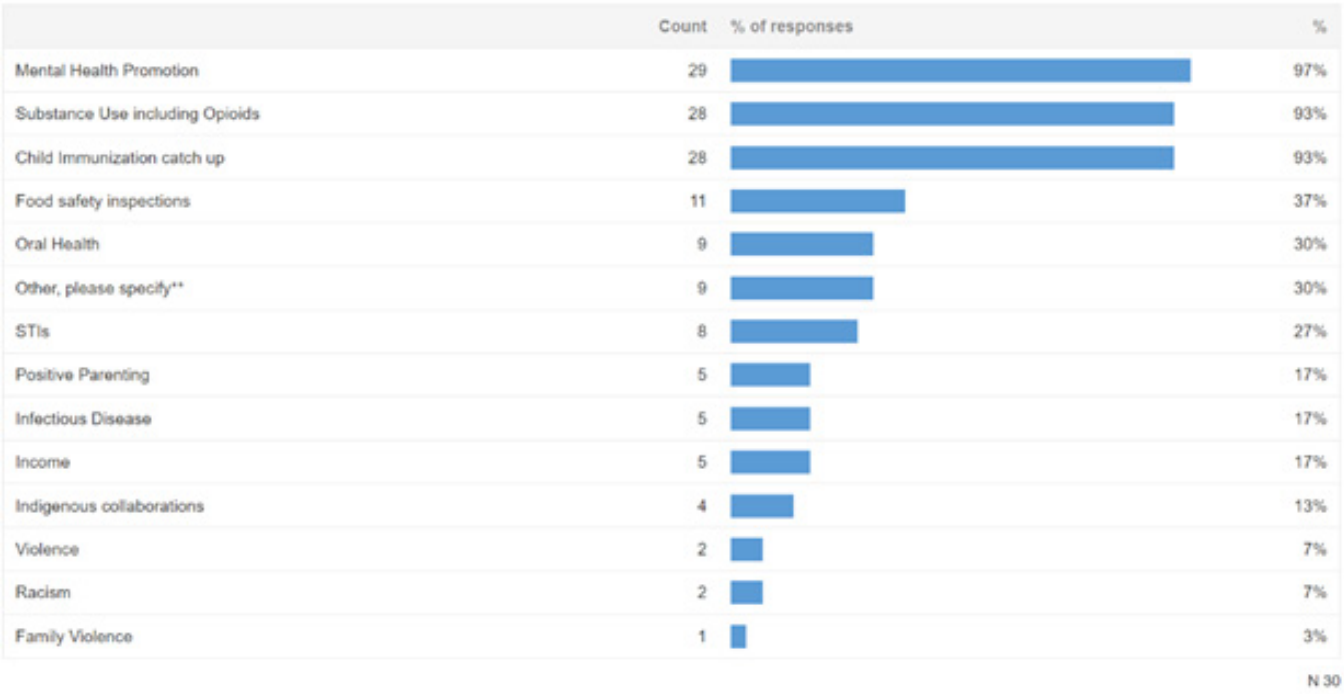
- Continue to provide a sustainable COVID-19 response to prevent transmission with a focus on protecting vulnerable populations.
- Offer school immunization catch-up to students who did not receive their full series of Grade 7 immunizations in the 2021/2022 school year.
- Reinstate/implement public health programs that support Mental Health Promotion as per the 2018 Ontario Public Health Standard Mental Health Promotion Guideline (2018) with special considerations for marginalized populations.
- Reinstate PHUs resources that support the prevention of substance use and local planning related to the opioid epidemic.

It is important to note that geographic and sociodemographic diversity is one of the features of Ontario's locally based public health system and this is recognized in the flexibility built in to the OPHS to allow for the tailoring of programs and services to address local needs and circumstances. It is therefore important to ensure that the relative ranking of priority areas for recovery does not preclude addressing the specific local needs of any given Board of Health.

This variation will also underlie differing states of readiness for and progress towards recovery, and the unpredictability of the future course of the pandemic will necessitate flexibility in planning. In any case, substantial recovery efforts will not be possible if the pandemic response continues to consume the bulk of local public health resources. Additional and immediate investments will be required.

Figure 5. Listing of priority topics and public health agencies responses

The following topics have been mentioned in various documents and communications as emerging population health priorities due to indirect impacts of the pandemic and public health measures. Other than Covid-19, please select the top 5 priorities in your catchment area. If your top 5 choices are not listed, please add them in the "Other, please specify" response field.



	Count	% of responses	%
Mental Health Promotion	29		97%
Substance Use including Opioids	28		93%
Child Immunization catch up	28		93%
Food safety inspections	11		37%
Oral Health	9		30%
Other, please specify**	9		30%
STIs	8		27%
Positive Parenting	5		17%
Infectious Disease	5		17%
Income	5		17%
Indigenous collaborations	4		13%
Violence	2		7%
Racism	2		7%
Family Violence	1		3%

N 30

STRENGTHENING PUBLIC HEALTH FOR A MORE RESILIENT ONTARIO

All respondent LPHAs indicated that they would need additional dedicated resources to support ongoing COVID-19 response and resumption of routine activities into 2022 and beyond. The pandemic response has clearly demonstrated that LPHAs cannot do both. While mitigation funding from the Province has been helpful, clearer and more timely assurances of funding for both routine and extraordinary public health activities will be required to inform budgets over multiple years.

If COVID-19 becomes endemic, we know that the requirement for additional human resources for case and contact investigation, outbreak management, and vaccination will become permanent. We also know that resources will be required to erase the program deficits outlined above. Both will be expenses on top of the typical funding for the basic public health mandate under the OPHS. A clear commitment by the Province to developing a process that ensures timely, predictable and sufficient funding to address each of these obligations would assist LPHAs in developing their budgets for 2022 and beyond. Recognizing that such funding would primarily be used for health human resources, recruitment and retention strategies may also need to be considered.

The demand for additional FTEs for Public Health Nurses, Public Health Inspectors, Immunizers, Contact Tracers, Epidemiologists/Data Analysts, Administrative/Program Assistants, and Management positions was significant and widespread during the pandemic. Some respondents also mentioned the need for Communications staff, Program Planners/Evaluators, and Health Promoters, and even mental health supports for their own staff. While the magnitude of these demands may diminish once the recovery phase begins, maintaining COVID-19 response activities while resuming OPHS activities will not be feasible without additional resources.

PHU recovery reports and frameworks also refer to staff experiencing high levels of stress and burnout and cite the importance of supporting public health staff through recovery. Strategies to support the recovery of the public health workforce are outlined in a report from PHO including recommendations for individuals, teams organizational and policy approaches including mental health supports and stigma reduction strategies. (Ontario Agency for Health Protection and Promotion (PHO), 2021).

Recommendations for supporting public health to improve the health of Ontarians

1. Provincial support for an ongoing pandemic response

Maintain ongoing provincial investments in science, structures, and resources in support of the multi-sector effort required to effectively manage the COVID-19 pandemic.

- Ongoing provincial coordination of the response between sectors (e.g. education, municipal, acute and long term care, public health, solicitor general, academic, etc.)
- Maintenance and review of provincial guidelines and tools, commitment to effective communications, and central support for local public health implementation and adaptation of provincial guidance based on local community needs.
- Strengthening Public Health Ontario's capacity to meet its mandate of providing scientific and technical advice to government, public health, health care, and related sectors

2. Provincial support for Local Public Health Agencies

Protect and promote the health of Ontarians through financial investments in PHUs that are clearly communicated and committed early in the fiscal year:

- Ongoing one-time COVID-19 funding for 2022 to support the COVID-19 response and ensure the ability to maintain required staffing level.
- One-time recovery funding to support recovery efforts, as outlined in this report, and to allow PHUs to address priority areas including public mental health promotion, public health opioid crisis response, and child and school immunization catch-up, other service backlogs including oral health screenings and inspections, and organizational needs related to human resources, infrastructure, and technology.
- Increase base funding, including but not limited to the addition of COVID-19 as a disease of public health significance beyond 2022.

3. Provincial support for evaluation and renewal

Continue to work with Ontario's public health stakeholders (Public Health Ontario, Office of the Chief Medical Officer of Health, Local Public Health Agencies) to develop the vision for a stronger responsive public health sector with the capacity to address population health needs through various partnerships into the future.

- Ensure that Ontario launches a comprehensive review and assessment of all aspects of the pandemic response to inform strategies for improvement.

- Ensure that public health stakeholders have the capacity and resources to participate fully in the review and in formulating recommendations.

CONCLUSION

The COVID-19 pandemic has clearly demonstrated the critical importance and proficiency of Ontario's public health system and the need to reinforce it. Lessons from past large scale infectious disease emergencies such as SARS and H1N1 helped to inform Ontario's and LPHAs' preparedness, but no sector was prepared for the scale, complexity, and duration of the response that this pandemic has required. As we have demonstrated here, the effectiveness of the local public health response has come at enormous cost, especially to the routine public health activities that are designed to protect and promote health at a population level every day.

It is anticipated that the need for ongoing COVID-19 response activities will continue for some time, and we can no longer ignore the suite of OPHS mandated activities that improve and protect the health and reduce health inequities well-being of the population of Ontario. COVID-19 programming will therefore need to be balanced with recovery efforts and integrated into existing OPHS accountabilities, and a strong commitment of provincial support, including the provision of sufficient, predictable and sustainable funding, will be required.

From: allhealthunits on behalf of Loretta Ryan
To: All Health Units
Cc: Board@lists.alphaweb.org
Subject: [allhealthunits] Information Break - January 2022
Date: Friday, January 21, 2022 3:01:03 PM
Attachments: image003.png
image004.png

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

January 21st, 2022

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

alPHa Report
Public Health Resilience in Ontario: Clearing the Backlog, Resuming Routine Programs, and Maintaining an Effective COVID-19 Response

The alPHa report on public health resilience highlights the need for the resumption of public health programs and services that were all but suspended during the pandemic response, clearing the backlog, and addressing the indirect public health impacts of the response measures. It is hoped that the content of will be of great value as we work together to advocate for a stable, sustainable, and resilient public health system in Ontario over the months and years to come. Read the full report and its executive summary.

alPHa Deputation and Submission to the Standing Committee on Finance and Economic Affairs Re: 2022 Ontario Budget

The Standing Committee on Finance and Economic Affairs has been holding hearings via videoconference to conduct Pre-Budget Consultations. alPHa was selected to present before the committee and Dr. Robert Kyle appeared on our behalf on January 19th. alPHa's deputation and submission recommend provincial supports for local public health agencies' ongoing pandemic response efforts, clearing the backlog of services not provided, and resumption of routine OPHS activities.

Winter Symposium and Section Meetings
Public Health Resilience **- Friday, February 25th, 2022**

alPHa is pleased to announce that registration is now open for the alPHa Winter Symposium: Public Health Resilience and the Section Meetings that are taking place on Friday, February 25, 2022.

We have an exciting line-up of speakers for this online event including the Hon. Christine Elliott (Deputy Premier and Minister of Health), Jamie McGarvey (President, AMO), Dr. Kieran Moore (Chief Medical Officer of Health), Colleen Geiger (President and CEO (acting), Public Health Ontario), Dr. Brian Schwartz (Vice President, Public Health Ontario), Dr. Christopher Simpson (Executive Vice-President, Medical, Ontario Health), Dr. Sara Allin (Associate Professor, DLSPH), and Dr. Charles Gardner (Chair, Council of Ontario Medical Officers of Health). alPHa's President, Dr. Paul Roumeliotis, is the Symposium Chair and members of alPHa's Board of Directors are moderating the sessions.

Registration information, the draft Symposium program, the draft agenda for the BOH Section meeting, and the event flyer can be accessed by going to the alPHa website and clicking on the Symposium Banner or by going to the event page. This webpage is also where updates are posted. The closing date to register is th

Friday, February 18 at 5 pm. Please note that you must be an alPHa member to participate in the Symposium or Section meetings.

alPHa would like to thank the University of Toronto's Dalla Lana School of Public Health and the Eastern Ontario Health Unit for their generous support.

We hope to see you online on Friday, February 25th!

COVID-19 Update

As part of the response to COVID-19, alPHa continues to represent the public health system and work with key stakeholders. To keep members up-to-date, alPHa shares Ministry of Health Situation Reports and COVID-19-related news. If you are not receiving these, please reach out to the contact person at your health unit who distributes information on behalf of alPHa.

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

alPHa Reports and Correspondence

Through policy analysis, collaboration, and advocacy, alPHa's members and staff act to promote public health policies that form a strong foundation for the improvement of health promotion and protection, disease prevention, and surveillance services in all of Ontario's communities. Reports and correspondence since the last Newsletter:

alPHa Report: PH Resilience 2022	2202-01-20
alPHa Report: PH Resilience 2022 Executive Summary	2202-01-20
alPHa Speaking Notes - Pre Budget, Jan 19, 2022	2022-01-19
alPHa Letter - 2022 Pre-Budget Submission	2022-01-19
alPHa Letter - Strengthening Response to Omicron	2022-01-04
alPHa Letter - Anniversary of 1st COVID-19 vaccine	2022-01-04

A complete online library is available here.

Boards of Health: Shared Resources

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

- Orientation Manual for Boards of Health
- Review of Board of Health Liability, 2018
- Legal Matters: Updates for Boards of Health
- Ontario Boards of Health by Region
- Governance Toolkit
- Risk Management for Health Units
- Healthy Rural Communities Toolkit
- The Ontario Public Health Standards
- Public Appointee Role and Governance Overview
- List of Health Units sorted by Municipality
- List of Municipalities sorted by Health Unit
- Map: Boards of Health Types
- NCCHPP Report: Profile of Ontario's Public Health System (2021) New!

PHO Resources

Omicron Resources

Fact Sheets

- How to Self-Monitor (updated)
- How to Self-Isolate (updated)
- Optimizing the Use of Masks Against COVID-19

Evidence Briefs

- SARS-CoV-2 Omicron Variant and Community Masking

COVID-19 Variant of Concern Omicron (B.1.1.529): Risk Assessment

Data and Surveillance

- Early Dynamics of Omicron in Ontario
- Early Estimates of Omicron Severity in Ontario based on a Matched Cohort Study

Check out PHO's Variants of Concern web page for the most up-to-date resources.

Upcoming PHO Events

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

- February 8 | PHO Rounds: Novel Disease Surveillance Tools for the Next Pandemic

Upcoming DLSPH Events, Courses and Webinars

The Dalla Lana School of Public Health hosts many public-health related events, from regular seminar series, featured guest speakers, and professional development opportunities. View all events by day, month, or type of event here. You can explore all past webinars here. Upcoming events include:

- January 24th - CVPD Webinar: Community Outreach and Engagement in the COVID-19 Vaccine Rollout
- January 26th - Advanced Artificial Intelligence and Healthcare: Is Consent Really in Jeopardy?
- January 31st - Race, Equity & Action Speaker Series – Antisemitism: Here and Now

News Releases

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

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

Take Care,

Loretta

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Public Health Resilience

2022 WINTER SYMPOSIUM

Association of Local Public Health Agencies

February 25, 2022

alPHa
Association of Local PUBLIC HEALTH Agencies

alPHa's Winter Symposium continues the conversation on the critical role of the province's Public Health System with discussions on key topics including the public health response to COVID-19 and the future of local public health in Ontario.

Participate in online plenary sessions with public health leaders in the morning, followed by BOH and COMOH Section meetings in the afternoon.

Registration is $229 plus HST. Information on how to register can be found here. The closing date to register is Friday, February 18, 2022.

Please note that you must be an alPHa member to participate in the Symposium or Section meetings.

Hosted by alPHa with generous support from:

Dalla Lana School of Public Health

EOHU Eastern Ontario Health Unit

BSEO Bureau de santé de l'est de l'Ontario

alPHa
Association of Local PUBLIC HEALTH Agencies

Public Health Resilience

alPHa Winter Symposium & Section Meetings

February 25, 2022

Draft Program as of January 18th

Note: Meeting is hosted via Zoom Webinar

8:30 am to 4:00 pm - All times are Eastern Time (ET)

Call to Order and Greetings from the alPHa President Dr. Paul Roumeliotis, President, alPHa **Land Acknowledgement** Trudy Sachowski, Vice-President, alPHa **Welcoming Remarks** Hon. Christine Elliott, Deputy Premier and Minister of Health Jamie McGarvey, President, Association of Municipalities of Ontario .	8:30 am to 8:35 am
Leveraging Comparative Research During the COVID-19 Pandemic to Support Health Policy Decisions Speaker: Dr. Sara Allin, Associate Professor of Health Policy at the Institute of Health Policy, Management and Evaluation, Moderator: Steven Rebellato, Affiliate Representative, alPHa Executive Dr. Allin will draw upon two recent global studies of policy responses to the COVID pandemic to identify promising practices and potential lessons for Canada. The first characterizes the scale and pace of coordinated policy responses in the Latin American and Caribbean region, and the second explores the key features of effective case and contact management in a selection of European and Asian countries. She will also reflect on the opportunities and challenges with conducting applied comparative policy research during the pandemic.	8:35 am to 9:05 am
Update from the Chief Medical Officer of Health Speaker: Dr. Kieran Moore, Chief Medical Officer of Health Moderator: Dr. Sudit Ranade, Vice-Chair, Council of Ontario Medical Officers of Health	9:05 am to 9:45 am
Public Health Ontario Update Speakers: Colleen Geiger, President and Chief Executive Officer (acting); Chief, Strategy and Stakeholder Relations, Research, Information and Knowledge, PHO Dr. Brian Schwartz, Vice President, PHO Moderator: Dr. Robert Kyle, Treasurer, alPHa Board	9:45 am to 10:15 am

Break	10:15 am to 10:30 am
Ontario Health Update Speaker: Dr. Christopher Simpson, Executive Vice-President, Medical, Ontario Health Moderator: Cynthia St. John, Affiliate Representative, alPHa	10:30 am to 11:00 am
alPHa Report – Public Health Resilience Speaker: Dr. Charles Gardener, Chair, Council of Ontario Medical Officers of Health Moderator: Dr. Paul Roumeliotis, President, alPHa It has been a long and very challenging pandemic for all of society, and indeed for local public health in Ontario. Public health units have been on the forefront of the response, redirecting the great majority of our resources and greatly reducing most of our routine program delivery for almost two years. As the pandemic continues, there is the need to maintain our resilience and to build up our capacity putting back in place these programs and services that are vitally important to the health of people in our communities. To map this out, a review has been done based on a survey in the late summer of 2021 identifying the public health program gaps and the resources and approaches needed to maintain and augment public health resilience as we continue in our response. Dr. Charles Gardner will present on the findings and the recommendations from this review.	11:00 am to 11:30 am
Lunch Break	11:30 am to 12:30 pm
The EQ Edge – *Leadership Success Through Resilience and Emotional Intelligence* Speaker: Tim Arnold, President, Leaders for Leaders Moderator: Carmen McGregor, Past-President, alPHa Emotional intelligence (EQ) is increasingly becoming one of the most important skills any individual can have to survive and thrive in an everchanging world. The research is clear; people with high emotional intelligence have higher job satisfaction, are more effective and more resilient employees, outperform and earn more than their colleagues, and live with higher confidence and happiness. Understand what emotional intelligence is, learn how to avoid being emotionally hijacked, and gain simple strategies that will develop your EQ.	12:30 pm to 1:30 pm
Section Meetings *Members of the BOH Section and COMOH meet separately in the afternoon. Board of Health members are asked to stay with the Zoom webinar platform. COMOH members will join a separate meeting. Agendas for these meetings are provided separately.*	1:30 pm to 4:00 pm

This event is hosted by alPHa with generous support from:

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Boards of Health Section Meeting
Friday, February 25, 2022
1:30 pm to 4:00 pm
Agenda

(Draft as of January 18, 2022)
BOH Section Chair: Wess Garrod
Note: Meeting is hosted via Zoom Webinar
All times are Eastern Time (ET)

1:30 pm **Call to Order**
Land Acknowledgement
Welcoming Remarks
Introductions

1:35 pm **alPHa Affiliates – On the Front Lines**

In addition to alPHa's Medical and Associate Medical Officers of Health and the Board of Health representatives, alPHa has on its Board senior public health managers in key public health disciplines – nursing, inspections, nutrition, dentistry, health promotion, epidemiology and business administration. Come and hear about the COVID-19 response and other key public health issues from the unique perspectives of these affiliate members.

Affiliate Representatives/Speakers:

Association of Supervisors of Public Health Inspectors of Ontario *(ASPHIO)/Affiliate Representative on alPHa Executive*	*Steven Rebellato*
Association of Ontario Public Health Business Administrators *(AOPHBA)*	*Cynthia St. John*
Association of Public Health Epidemiologists in Ontario *(APHEO)*	*Sarah Collier*
Ontario Association of Public Health Dentistry *(OAPHD)*	*Paul Sharma*
Health Promotion Ontario *(HPO)*	*Susan Stewart*
Ontario Association of Public Health Nursing Leaders *(OPHNL)*	*David Groulx*
Ontario Dietitians in Public Health *(ODPH)*	*Kerry Schubert-Mackey*

Moderator: Wess Garrod, BOH Section Chair

2:45 pm **Association of Municipalities of Ontario (AMO) Update**
Speaker: Monika Turner, Director of Policy, Association of Municipalities of Ontario

AMO works with Ontario's 444 municipalities to make municipal governments stronger and more effective. Come and hear the latest from AMO with regards to public health issues from a municipal perspective.

3:15 pm **Fit Cities Through Improvements to Our Human-Built Physical & Social Environments**
Speakers: Shanique Killingbeck, Partnership Coordinator at Faculty of Medicine & Dentistry, University of Alberta and Jodie Stearns, Postdoctoral Fellow, Faculty of Medicine & Dentistry, University of Alberta
Moderator: René Lapierre

The global COVID-19 pandemic has many thinking about the need for healthier and more sustainable communities. The concept of Fit Cities looks at how we can support human, environmental and economic fitness in municipalities, cities, and provinces through improvements to our human-built physical and social environments. They will examine how we can improve the human-built physical and social environments, achieve cross-sectoral partnerships, and increase global collaboration.

3:45 pm **alPHa Update / Section Business**
Speakers: *Wess Garrod, BOH Section Chair and Loretta Ryan, Executive Director, alPHa*

Approval of Minutes from November 19, 2021, BOH Section Meeting.

Section meeting ends at 4 pm.

This event is hosted by alPHa with generous support from:

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NOMA, FONOM, and NOSDA met jointly with government at ROMA to discuss the Mental Health, Addictions, and Homelessness Crisis in the North

For release: January 26, 2022

The Northwestern Ontario Municipal Association (NOMA), the Federation of Northern Ontario Municipalities (FONOM), and the Northern Ontario Service Deliverers Association (NOSDA) jointly discussed the crisis of Homelessness, Mental Health, and the Opioid Crisis with the Provincial Government yesterday at the ROMA Conference. NOMA President Wendy Landry, FONOM President Danny Whalen, and NOSDA Chair Michelle Boileau shared with the six Provincial Ministers, Associate Minister, and two Parliamentary Assistants the experiences in our communities. Danny Whalen commented, **"having the three organizations coming together today with over 20 individuals represented on the call shows just how important this is and the need to address these issues in the North."**

The three organizations shared with government a research paper written by the Northern Policy Institute titled "Solving the Homelessness, Mental Health and Addictions Crisis in the North". This paper provided 8 recommendations: provide long-term funding for capital repairs on community-housing units, amend the Health Protection and Promotion Act, 1990 to define a 'Northern Service Hub' and provide additional funding to these hubs, establish a joint taskforce to collect data and intelligence on the underlying and systematic retention issues of healthcare professionals in Northern Ontario, support new and existing 'Housing First' programs, support new and existing Indigenous culturally sensitive community-housing facilities, establish a 'Northern Mental Health and Addictions Centre of Excellence' to address the unique challenges of service and program delivery in Northern Ontario, contract a third-party operator for interfacility patient transfers to relieve the workload of paramedics, and establish mandated Mobile Crisis Intervention Teams in municipalities throughout Northern Ontario.

President Wendy Landry commented "**it is important to take an all of government approach, to manage and find made in the North solutions to the Mental Health and Addictions Crisis".** Michelle Boileau commented, *"*we want to work with this government to ensure the right resources are put in the right communities to reach people who need the resources where they live*"*, further *"***above all, we ask that this government recognize municipalities and NOSDA as a partner in our collective efforts to address the growing mental health and addiction challenges***."*

The three organizations shared personal experiences from their own communities to paint a picture of what the mental health, addicitons, and homelessness crisis looks like and how it is affecting people in every community across Northern Ontario. We are greatly appreciative of all the hard work and funding the government has given to help those in the North get the support they need but much more work is needed to ensure every person is receiving the best level of service regardless of where they live.

FONOM President
Danny Whalen
705-622-2479

NOMA President
Wendy Landry
807- 626-6686

NOSDA Chair
Michelle Boileau
705-465-5026

Executive Summary

Urgent action is required to address the homelessness, addiction, and mental health crisis in Northern Ontario. 2021 homeless enumeration data shows that Sault Ste. Marie, and the Districts of Kenora, Nipissing, and Cochrane have larger homeless populations than the five largest municipalities in Ontario. In fact, Thunder Bay and the District of Cochrane have more than double the homeless populations of Ottawa, Hamilton, and Waterloo, respectively. More astonishing is the growing number of people struggling with opioid addiction in Northern Ontario. Extreme spikes in opioid-related emergency department (ED) visits and deaths in most northern Public Health Units shows 2020 to be the most tragic and deadliest year yet of the opioid crisis. The growing number of people struggling with homelessness and addiction in Northern Ontario strongly indicates that there is also a mental health crisis amongst vulnerable populations. This paper also finds that the mental health crisis is not merely restricted to vulnerable populations in the North, but rather that Northern Ontarians in general are experiencing poorer mental health than Ontarians in the rest of the province.

As the homelessness, addiction and mental health crisis worsens in Northern Ontario, it is clear that current services and programs are not adequately meeting the needs of northern communities. As the ones 'on the ground', municipal governments face tremendous pressure from their tax-bases to solve homelessness, addiction, and mental health issues in their community but are restricted by tight budgets. A collaborative approach ought to be taken by the federal, provincial, and municipal governments in order to solve these issues. In particular, there is opportunity for the provincial government to support existing community-led services and programs which align with commitments already made by the provincial government in the 'Roadmap to wellness'. Provincial support for existing services and programs is an 'easy win' for all levels of government against the homelessness, addiction, and mental health crisis.

This paper identifies eight strategies governments can take to improve the homelessness, addiction, and mental health crisis in Northern Ontario. Those strategies are:

1. Provide long-term funding for capital repairs on community-housing units
2. Amend the *Health Protection and Promotion Act, 1990* to define a 'Northern Service Hub' and provide additional funding to these hubs
3. Establish a joint taskforce to collect data and intelligence on the underlying and systematic retention issues of healthcare professionals in Northern Ontario
4. Support new and existing 'Housing First' programs
5. Support new and existing Indigenous culturally sensitive community-housing facilities
6. Establish a 'Northern Mental Health and Addictions Centre of Excellence' to address the unique challenges of service and program delivery in Northern Ontario
7. Contract a third-party operator for interfacility patient transfers to relieve the workload of paramedics
8. Establish mandated Mobile Crisis Intervention Teams (MCIT) in municipalities throughout Northern Ontario

This paper provides evidence that these strategies are highly effective and economically viable ways to reduce the number of people struggling with homelessness, addiction, and mental health issues in Northern Ontario.

Solving the Homelessness, Addiction and Mental Health Crisis in the North

Introduction

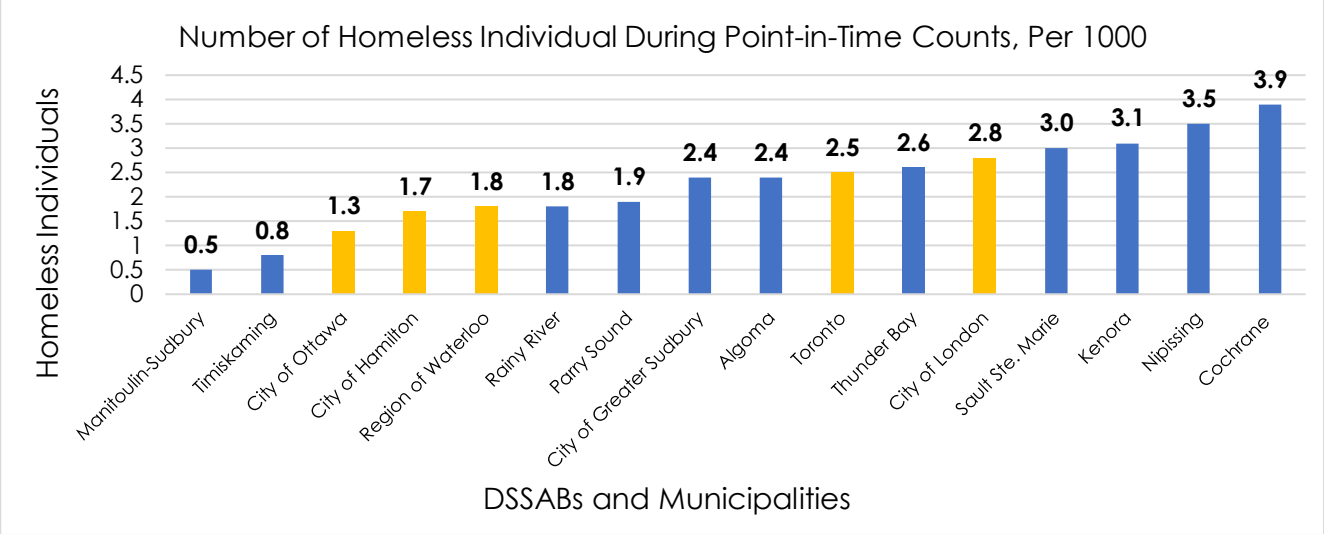
Northern Ontario is experiencing a homelessness, addiction, and mental health crisis. While these issues are not new in the North, significant gaps in health services around homelessness, addiction, and mental health have exacerbated the crisis. The growing number of Northerners suffering from homelessness, addiction, and mental health issues have ignited robust discussions at the provincial and municipal level around strategies to address service gaps. In 2019, the Association of Municipalities Ontario (AMO) published three detailed reports on homelessness, addiction, and mental health in Ontario, outlining recommendations for all levels of government. In March 2020, Ontario's provincial government published the *Roadmap to wellness*, introducing a new plan for the mental health and addiction service system (Government of Ontario, 2021c). Not long after, Ontario's Big City Mayors (OBCM) published a report calling on provincial and municipal governments to act boldly to address service gaps and vocalized their support for the *Roadmap to wellness* (OBCM, 2021). Later in 2021, Northern Ontario Municipal Association (NOMA), the Federation of Northern Ontario Municipalities (FONOM) and Northern Ontario Service Delivery Association (NOSDA) collaborated with municipal governments to draft a multi-ministry delegation package for mental health, addictions, and housing. This flurry of coordinated activity from municipal actors is indicative of the seriousness of the homelessness, addiction, and mental health crisis in the North.

This commentary seeks to further the coordinated efforts of municipal actors by offering timely data that supports highly effective strategies that governments can take to address this crisis. This commentary will start with an overview of the homelessness, addiction, and mental health crisis, followed by a brief explanation of the role and responsibilities of provincial and municipal governments. Roles and responsibilities of provincial and municipal governments will be discussed to provide context for the recommended strategies provided in the third section of this commentary.

The Homelessness, Mental Health and Addiction Crisis in the North

Section 19.1 of the *Housing Services Act, 2011* requires service managers – or District Social Service Administration Boards (DDSABs) in the North – to conduct detailed enumerations of their homeless populations every two years beginning in 2018. Homeless enumerations offer important insight on the characteristics and needs of homeless populations in specific communities and regions. Figure 1 shows that Sault Ste. Marie and the Districts of Kenora, Nipissing, and Cochrane[1] have higher homeless populations than the five largest municipalities in Ontario. With the largest homeless population in Northern Ontario, the District of Cochrane has more than double the homeless populations in Ottawa, Hamilton and the region of Waterloo.

Figure 1. Homeless Population per 1000 people, 2021[2]



Source: Author's calculations from 2021 enumeration reports from DSSABs and municipalities, and Statistics Canada census district population projections.

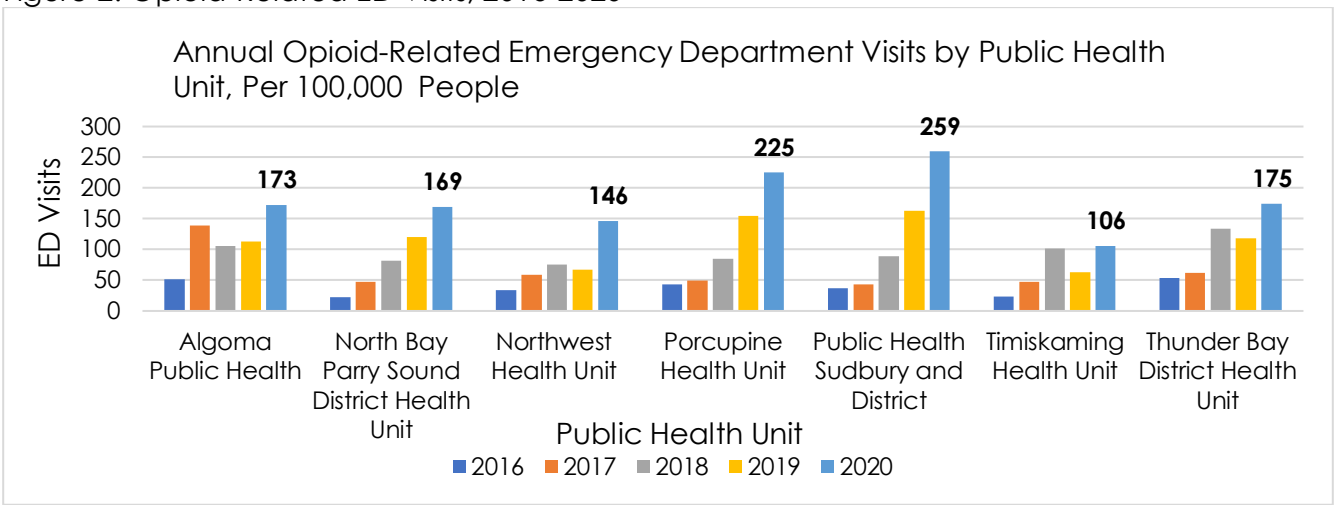
[1]Raw homeless enumeration data was provided by DSSABs and the City of Greater Sudbury. This data did not specify the communities in which homeless enumerations were conducted. Thus, it is assumed that homeless enumeration data represents entire DSSAB service areas. Where DSSAB service boundaries align with Census District boundaries – Cochrane, Kenora, Nipissing, Parry Sound, Rainy River, Thunder Bay and Timiskaming – DSSAB service areas will be referred to as 'the District of'. The service area of Sault Ste. Marie DSSAB will be referred to as simply 'Sault Ste. Marie'. The service area of Sudbury-Manitoulin DSSAB will be referred to as simply 'Sudbury-Manitoulin'. The service area of Algoma DSSAB will be referred to 'the District of Algoma', but notably and unlike the Census District of Algoma, this paper excludes the City of Sault Ste. Marie when referring to 'the District of Algoma'. As Greater Sudbury is a single-tier municipality with a Consolidated Municipal Service Manager, it is referred to as simply 'the City of Greater Sudbury'.

[2] Southern Ontario cities and regions included in Figure 1 were chosen based on available data from 2021 Enumeration Reports at the time of the publication of this paper. 2021 Homeless Enumeration data was unavailable for the district of Thunder Bay.

Moreover, Sault Ste. Marie and Thunder Bay DSSABs – the only two DSSABs that completed a point-in-time (PiT) count in a previous year[3] – reported an astonishing growth of homeless populations within their service area boundaries. Between 2016 and 2018, Sault Ste. Marie reported a 70 per cent increase in the city's homeless population, with a 58 per cent increase between 2018 and 2021 alone. In the District of Thunder Bay, the homeless population increased by 50 per cent between 2016 and 2018.

There is also a growing number of people struggling with addiction in Northern Ontario. As seen in Figures 2 and 3, 2020 was the most tragic and deadly year of the opioid crisis in the last five years. Between 2016 and 2020, opioid-related ED visits increased by an astonishing 695 per cent in the Porcupine Health Unit; 616 per cent in the North Bay Parry Sound District Health Unit; 522 per cent in the Public Health Sudbury and District, and 355 per cent in Thunder Bay District Health Unit (Public Health Ontario, 2021)[4]. At the lower end of the spectrum, all other northern Public Health Units still more than doubled their 2016 amounts in 2020[5].

Figure 2. Opioid-Related ED Visits, 2016-2020



Source: Public Health Ontario Interactive Opioid Tool, 2021.

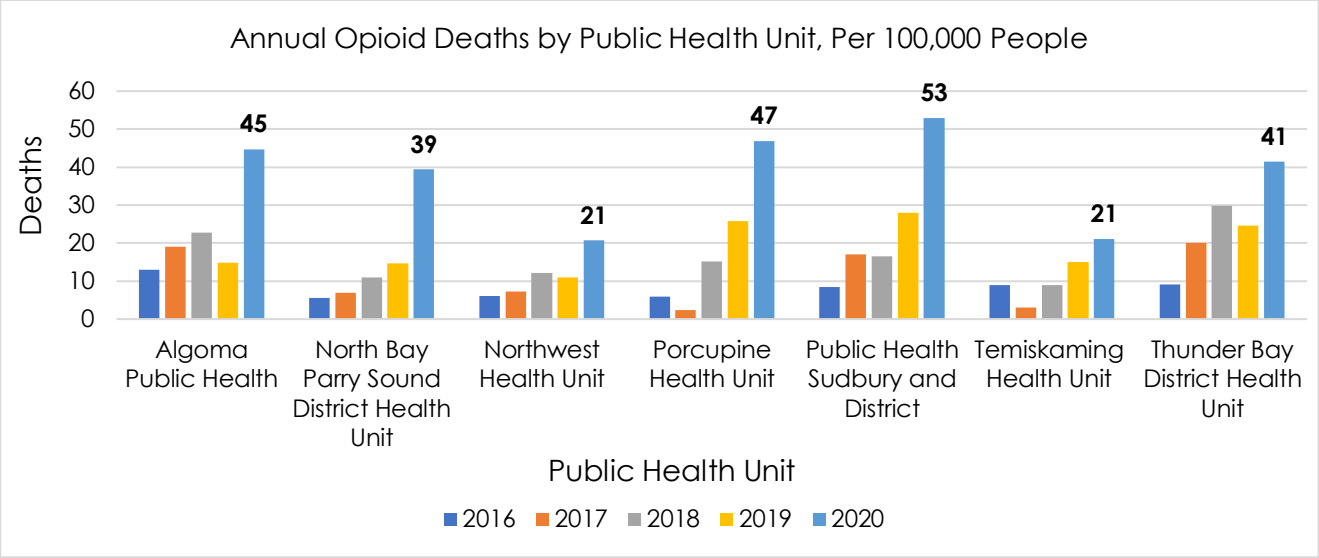
[3] Prior to 2020, municipalities could choose from three methods to conduct their homelessness enumerations: a PiT count, a period prevalence count, or a combination of the two. Due to the logistical challenges of conducting homelessness enumerations in large, sparsely populated districts, most DSSABs opted to conduct period prevalence counts or a combination of the two. According to Employment and Social Development Canada, "results from various communities show that period prevalence counts enumerate between 3 and 10 times as many people as point-in-time counts". Therefore, data collected by period prevalence counts in 2018 is inconsistent with data collected by PiT counts in 2021.

[4] N.B. Public Health Unit have custom service area boundaries that do not align geographically with DSSAB boundaries

[5] While Renfrew County and District Health Unit partially covers territory in Ontario's central, western and northern regions, it has been omitted from this commentary as the majority of the population within this public health unit is situated on territory outside of the political borders of Northern Ontario as defined by the Province of Ontario.

Corresponding with opioid-related ED visits, opioid-related deaths increased significantly in every northern Public Health Unit between 2015 to 2020. Importantly, Figure 3 shows an extreme spike in opioid-related deaths in 2020 compared to 2019. Opioid-related deaths increased by 200 per cent in Algoma Public Health Unit and 168 per cent in North Bay Parry Sound District Health Unit **in a single year.**

Figure 3. Opioid-Related Deaths, 2016-2020

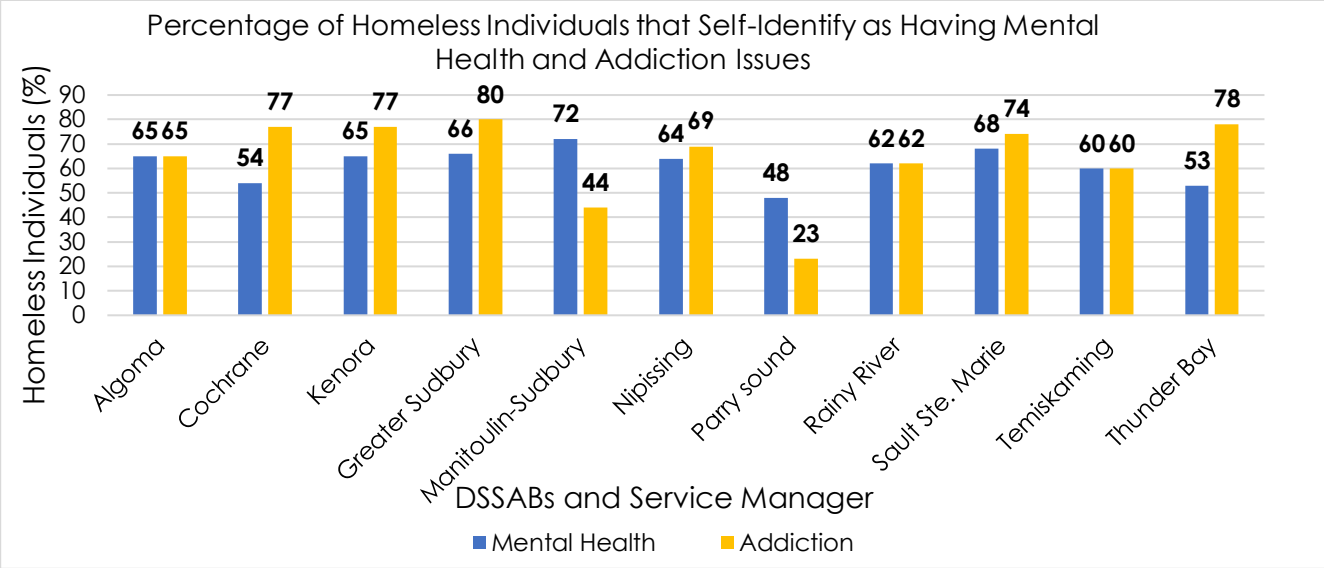


Source: Public Health Ontario Interactive Opioid Tool, 2021.

The growing number of people struggling with homelessness and addiction in Northern Ontario are strong indicators that there is also an ongoing mental health crisis. While mental health issues do not always lead to homelessness or addiction, or vice-versa, an abundance of research literature from organizations such as the Canadian Mental Health Association (CMHA) and the World Health Organization shows homelessness, addiction, and mental health to be interconnected, and part of a larger, multifaceted socio-economic issue. As such, homeless populations are disproportionally affected by mental health and addiction. Figure 4 shows that a staggering 72 per cent of homeless individuals in Manitoulin-Sudbury suffer from mental health issues, followed by 68 per cent in Sault Ste. Marie, and 66 per cent in the City of Greater Sudbury. In the City of Greater Sudbury, 80 per cent of the homeless population suffer from addiction, followed

by 78 per cent in the District of Thunder Bay, and 77 per cent in the Districts of Cochrane and Kenora.

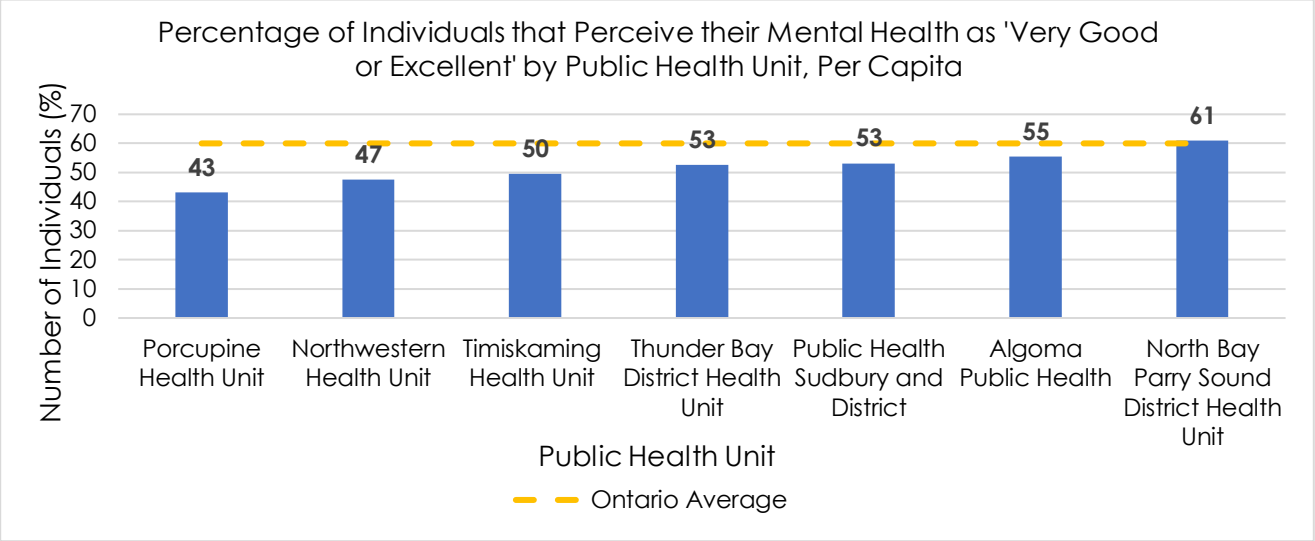
Figure 4. Homeless Individuals Struggling with Mental Health and Addiction Issues, 2021



Source: 2021 enumeration reports from DSSABs and City of Greater Sudbury.

Of course, it must be noted that mental health issues are not merely restricted to homeless individuals, but rather, affect the general population in Northern Ontario. CMHA found that Northern Ontarians self-reported higher rates of depression than the provincial average (CHMA 2009, 2), while Figure 5 shows that the number of Northern Ontarians who perceived their mental health as 'very good or excellent' is below the provincial average, except in North Bay Parry Sound District Health Unit. This data suggests there is a need from many community members in the North for mental health services and programs.

Figure 5. Perceived Mental Health of Individuals, 2017-2018



Source: Author's calculations from Statistics Canada health characteristics, two-year period estimates, and Census Profiles, Public Health Units, 2016 Census.

The Role and Responsibility of Government

The Constitution Act, 1867, as well as federal and provincial legislation and jurisprudence, define the role and responsibilities of all levels of governments regarding homelessness, addiction, and mental health issues. In terms of homelessness, the *Housing Services Act, 2011* states that the role of the provincial government is to provide general oversight and policy direction for "community-based planning and delivery of housing and homelessness services" (Government of Ontario, 2021b). More specifically, the provincial government is required to "assess current and future local housing needs, plan for local housing and homelessness services to address needs, and measure and report on progress" (Government of Ontario, 2021d). Furthermore, Article 92, Section 7 of the *Constitution Act, 1867* assigns the responsibility of public health to provincial governments. As homelessness, addiction and mental health **all** fall within the domain of public health, provincial governments are responsible for "developing and enforcing legislation, regulation, standards, policies and directories" to solve these issues (Public Health Ontario, 2020).

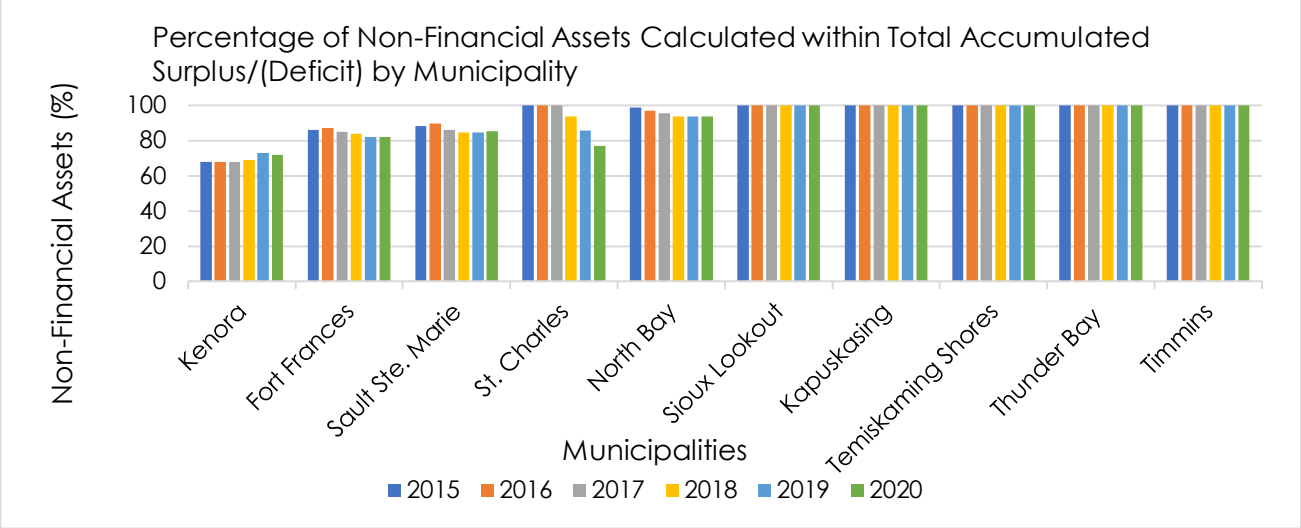
Municipal governments in Ontario play a unique role in community-housing – housing that is owned, operated and subsidized by non-profit organizations, municipal governments or DSSABs for low-income individuals or families (Government of Ontario, 2021a) – compared to the rest of the country. Since community-housing was downloaded from the province in 2001 and 2002, municipal governments act as local planning authorities, administrators of local community housing systems, and funders of housing benefits and rent (Government of Ontario, 2021d). In Northern Ontario, DSSABs – and Consolidated Service Manager in the City of Greater Sudbury – are responsible for the development of housing stock and the delivery of homelessness prevention programs (AMO 2019c, 10). DSSABs must outline their housing strategy in a ten-year housing and homelessness plan, and this plan must include strategies that address the housing needs of communities and that are in-line with provincial priorities (AMO 2019c, 11).

For health care and public health services, the role of municipal governments is as the employer for health services and funding partners to the provincial government (AMO 2019b, 15). Under the *Health Protection and Promotion Act, RSO, 1990*, provincial and municipal governments are required to cost-share the financial burden of health services, with the provincial government covering 75 per cent of service fees and municipal governments covering the remaining 25 per cent (AMO 2019b, 15). Municipal governments also support Public Health Units by providing a local lens to view policies and services (AMO 2019b, 15).

Despite well-defined roles of governments in Canada, as the ones 'on the ground', municipal governments face extraordinary pressure from their tax-bases to solve homelessness, addiction, and mental health issues in their community. Some municipalities have contributed additional funds to address homelessness, addiction, and mental health, but many more municipalities in Northern Ontario do not have the fiscal capacity to do so. Tight budgets leave little – or nothing – left-over for municipalities to spend on additional services and programs.

Figure 6 shows the percentage of non-financial assets accounted for within municipal budget surpluses. Where the percentage of non-financial or physical assets such as hospitals, schools, and community-housing are equal to 100, the municipality is experiencing a major cash deficit as 100 per cent of their surplus represents their physical assets rather than available cash funds. Importantly, Figure 6 shows that many municipalities in Northern Ontario do not have the available cash – despite budget surpluses on paper – to spend appropriately on homelessness, addiction, and mental health.

Figure 6. Percentage of Non-Financial Assets[6], 2015-2020



Source: Author's calculations of Net Financial Assets, end of year, total non-financial assets, and total accumulated surplus/(deficit) from municipal Financial Information Returns.

Budget shortfall is part of a complex economic issue for many municipalities in Northern Ontario. Rural and remote municipalities do not have the fiscal capacity to generate large amounts of municipal revenue due to small tax bases, nor do they benefit from the efficiency of scale. Furthermore, important factors such as population totals, population density, diminishing subsidies for rural areas and the number of service providers impact the cost-of-service delivery (Rizzuto 2020, 18).

[6] Municipalities represented in Figure 6 were chosen as a representative sample size to describe the general fiscal capacity of municipalities in Northern Ontario

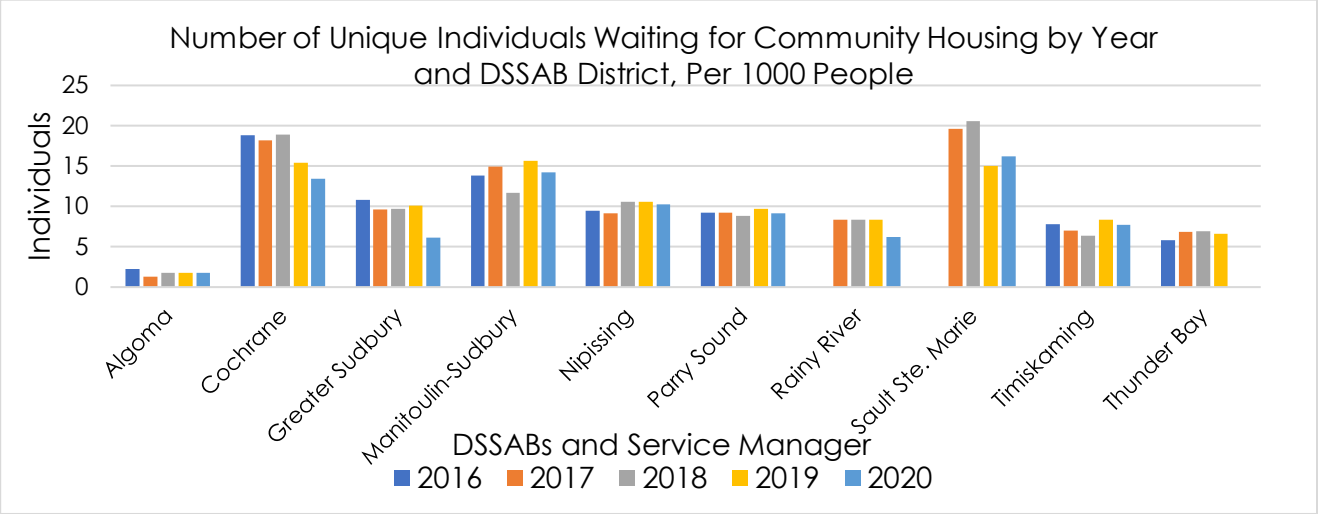
Service Gaps and Policy Strategies

The current – and worsening – homelessness, addiction, and mental health crisis in Northern Ontario indicates that existing policies, services, and programs do **not** meet the needs of northern communities. The following section identifies eight evidence-driven strategies that governments can take to improve the homelessness, addiction, and mental health crisis in Northern Ontario.

1. Community-Housing Waitlists

A shortage of community-housing has contributed to the growth of the homeless population in Northern Ontario (AMO 2019c, 5). Figure 7 shows long and stagnated waitlists for community-housing in the North.

Figure 7. Community-Housing Waitlist[7], 2016-2020



Source: Author's calculations from direct outreach to DSSABs and the City of Greater Sudbury, and Statistics Canada Census Division Population Projections for the corresponding years.

Much of the community-housing shortage can be attributed to the depletion of existing stock that is between 40 and 60 years old, and overdue for routine maintenance and repair (AMO 2019c, 23). As DSSABs struggle financially to keep up with the growing

[7] Community-housing waitlist data not available for the District of Kenora.

backlog of capital repairs, much needed community-housing units are left vacant despite the growing demand (AMO 2019c, 24).

The most time-effective and financially responsible way to address the shortage of community-housing in Northern Ontario is by maintaining and repairing the existing housing stock (AMO 2019c, 23). When the province downloaded community-housing to municipalities, however, the transfer was completed without a corresponding transfer of adequate reserve funds for current and projected future capital repairs (AMO 2019c, 24). While DSSABs do not have the fiscal capacity to properly address the backlog of capital repairs, federal and provincial governments do *and should*. Long-term funding for capital repair should be delivered from the federal and provincial governments to DSSABs to address this long-standing problem. Ideally, funding should span over a 10-year period so DSSABs can incorporate their strategy in their 10-year housing and homelessness plans, and provide an update on progress in their 5-year review report (AMO 2019c, 24).

2. Migration to Service Hubs

Service hubs in Northern Ontario face unique challenges in terms of their homeless population: the in-migration of people from surrounding rural and remote communities to access employment, education, and social and health services that do not exist in their community. Removed from their familiar environments and support systems, migrants often find themselves without the financial means to support themselves or return to their communities and, thus, become dependent on emergency shelters and other social services. This in-migration of vulnerable people applies pressure to "the housing stock, the homeless shelters, and the social services as a whole" in service hub communities (KDSB 2014, 8). The Districts of Kenora and Cochrane are particularly impacted by this migration trend as the District of Kenora includes 40 First Nations and a large unincorporated area, while the District of Cochrane includes seven First Nations, three unincorporated areas, and the only railway connection to the James Bay coast. In 2018, Thunder Bay DSSAB reported that 62 per cent of their homeless population within their service boundaries were migrants from surrounding areas (TBDSSAB 2018, 5).

Case Study: Sioux Lookout

Sioux Lookout, also known as "the Hub of the North", is a major service hub in the District of Kenora. Sioux Lookout Meno Ya Win Health Centre, a regional hospital and extended care facility, services the towns of Sioux Lookout, Pickle Lake, Savant Lake and 28 First Nations (Meno Ya Win Health Centre, 2021a). Collectively, Meno Ya Win provides health services for a population of 30,000, dispersed over 385,000 square kilometers (Meno Ya Win Health Centre, 2021b). Meno Ya Win and Sioux Lookout's Out of the Cold Emergency Shelter, both which services roughly the same area and communities, are significantly under-resourced for the population size they serve (Municipality of Sioux Lookout 2021, 20). Currently, the William "Bill" George Extended Care Unit operates with 20 beds, amounting to one bed per 1,500 people. In 2019, 768 unique individuals slept at the Out of the Cold Emergency Shelter – amounting to 15 per cent of Sioux Lookout's population – for a total of 5,000-person night stays annually (Municipality of Sioux Lookout 2021, 20). If this ratio was true for Toronto, it would mean 439,500 unique individuals stayed at an emergency shelter in one year, compared to the *actual* amount of 3,876 unique individuals (City of Toronto 2018, 7). Of course, it's not accurate to say 15 per cent of Sioux Lookout's population stayed at the emergency shelter, but rather it was mix of migrants from within the District of Kenora and residents of the town.

To ensure service hubs in Northern Ontario have adequate resources for their service area, an amendment could be made by the provincial government to the *Health Protection and Promotion Act, 1990*. This amendment should define a 'Northern Service Hub' and mandate the provincial government to provide additional support to these communities through reserve funds or the like.

3. Medical Professionals

According to a report from CMHA, titled 'Rural and Northern Community Issues in Mental Health', Northern Ontarians are disadvantage by "limited availability and access to primary health care, specialists, hospitals and community services and supports" (CMHA 2009, 3). In 2010, the publication date of this report, CMHA identified 34 northern

communities considered by the Ministry of Health and Long-Term Care (MOHLTC) to be 'an area of high physician need'. As of December 2021, this list has grown to **163** northern communities, encompassing the **entirety** of Northern Ontario (MOHLTC, 2021). The MOHLTC bases this list on a variety of compelling factors including "long-standing challenges in recruiting and retaining physicians, low health care provider-to-population ratios, travel time to reach service providers, and local demand for services" (CHMA 2009, 3). The scarcity of general physicians in the North acts as a major barrier to the establishment of necessary addiction and mental health services, such as medical detox centres and treatment facilities (Turner, 2021). Northerners struggling with addiction are often sent to treatment facilities in Thunder Bay, Winnipeg or Southern Ontario, separating them from their support systems and setting them up to fail (Turner, 2021).

The European Union faces many similar challenges to Northern Ontario and Canada when it comes to the shortage of health care workers. All member-states expressed serious concern around the sustainability and robustness of their health sectors due to demographic shifts, increased demand for services, an aging workforce, and recruitment and retention of health care workers (JAHWF 2016, 2). To enable strategic planning and informed decision making, the EU established the 'Joint Action Health Workforce Planning and Forecasting' (JAHWF). JAHWF is a three-year project mandated to collect intelligence and data of health sectors in the EU by "monitoring timely data, identifying mobility trends, estimating future skills and competencies that health workers will need, encouraging cooperation to find possible solution on expected shortages, and health workforce planning and forecasting on policy decision making" (Nordic Council of Ministries 2014, 36). By conducting research on the most advanced planning methodologies, JAHWF has enabled two pilot-programs in Italy and Portugal, and a feasibility study in Germany (Health Workforce EU, 2021). The Canadian Federation of Nurses Union have called on the federal government to lead a similar taskforce in Canada to investigate "new staffing models and other pilot projects", and address underlying and systematic retention issues (Yun, 2021).

Additionally, there is opportunity for government and others to support the work of the Northern Ontario School and their work around physician recruitment in Northern Ontario. The Physician Workforce Strategy has the goal of "linking human health resources to Northern Ontario's needs" (NOSM, n.d.). According to data collected in June 2021, 325 physicians are in demand across Northern Ontario – particularly for family physicians and rural generalists (NOSM, n.d.).

4. Housing-First Programs

'Housing First' is a multidisciplinary homelessness strategy that prioritizes the rapid placement of the most vulnerable individuals and families into housing with no preconditions (Gaetz, Scott and Gulliver 2013, 18). Since gaining popularity in the 1990s, Housing First is now described as a 'best practice' for ending homelessness in Canada, the United States and around the world (Homelessness Hub, 2021). In 2008, the federal government committed $110 million to conduct a four-year, five-city research project on Housing First – the world's most extensive study on Housing First programs at that time (Mental Health Commission of Canada 2014, 6). Each of the five cities – Vancouver, Winnipeg, Toronto, Montreal, and Moncton – focused on specific sub-populations such as individuals struggling with substance abuse in Vancouver and the urban Indigenous population in Winnipeg. Shockingly, the study found that 80 per cent of the 1,000 randomized participants remained housed after one year (Homelessness Hub, 2021). Moreover, a study published by Canadian Homelessness Research Network, the Homeless Hub, and the Government of Canada in 2013 that examined eight Housing First programs in Vancouver, Hamilton, Lethbridge, Victoria, Fredericton, Edmonton, and two in Calgary reported similar findings. The case study in Vancouver found no participants of the program were discharged to the streets within a four-year period (Gaetz, Scott and Gulliver 2013, 67), while the case study in Hamilton found 74 per cent of participants remained housed after six months and 90 per cent of this group remained housed after 12 months (Gaetz, Scott and Gulliver 2013, 80). The case study in Lethbridge revealed 90 per cent of participants remained housed within a 12-month period (Gaetz, Scott and Gulliver 2013, 95), while the case study in Victoria found 73 per cent of participants

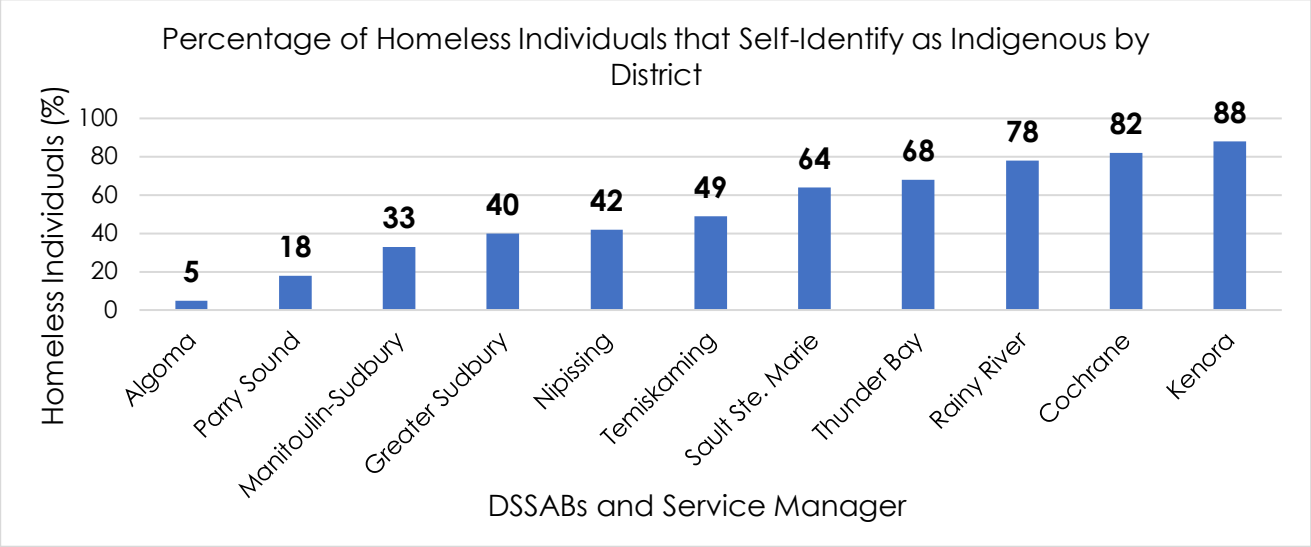
remained housed within a two-year period (Gaetz, Scott and Gulliver 2013,106). In Fredericton, 93.5 per cent of participants remained housed after 6 months, while 86 per cent of participants remained housed within a 3-year period (Gaetz, Scott and Gulliver 2013, 132). In Calgary, one case study found 92 per cent of participants within a 5-year period remained housed, while the other found 80 per cent of participants remained housed for at least 12 months (Gaetz, Scott and Gulliver 2013, 52).

In October 2020, the federal government launched the Rapid Housing Initiative (RHI) through Canada Housing and Mortgage Corporation (CMHC) to support Housing First programs. The federal government committed $1 billion in 2020 for 3,000 affordable housing units, with a second round of funding in the 2021-22 federal budget of $1.5 billion for a minimum of 4,500 affordable housing units. Seven First Nations in Northern Ontario have received $21 million collectively in funding from the RHI to build 85 new homes, but more communities can be supported. Moreover, RHI funding should support existing Housing First programs in the North, such as Housing Now, a new program established in 2020 by Cochrane DSSAB, in partnership with the Canadian Mental Health Association.

5. Culturally Sensitive Community-Housing

A significant proportion of the homeless population in Northern Ontario self-identify as Indigenous. Figure 8 shows Indigenous people account for over 60 per cent of the homeless population in four Northern Districts and in Sault Ste. Marie. In the District of Kenora, 88 per cent of the homeless population self-identify as Indigenous, followed by 82 per cent in the District of Cochrane, 78 per cent in the District of Rainy River, 68 per cent in the District of Thunder Bay, and 64 per cent in Sault Ste. Marie. Despite Indigenous people accounting for an overwhelming proportion of the homeless population in the North, there is limited culturally-sensitive services and programs to address their specific needs.

Figure 8. Homeless Individuals that Self-Identify as Indigenous, 2021



Source: 2021 Enumeration Reports from DSSABs and City of Greater Sudbury.

To tackle this problem, Kenora District Service Board (KDSB), Ontario Aboriginal Housing Services, North West Local Health Integration Network, Meno Ya Win Health Centre and Nishnawbe-Gamik Friendship Centre collaborated to lead a project that opened a 20-unit community-housing facility in Sioux Lookout. The facility offers culturally sensitive and easily accessible programs and services for Indigenous people (KDSB 2018, 21). This facility has reduced 911 calls to Ontario Provincial Police (OPP) in Sioux Lookout by 90 per cent (Helwig, 2021). A similar project is underway for a new 30-unit facility in the City of Kenora, while discussion between the District of Sault Ste. Marie Social Services Administration Board and OAHS have recently begun for another 30-unit facility in Sault Ste. Marie (Helwig, 2021).

These facilities align with the commitments made by the provincial government in the *Roadmap to wellness* to continue to work with Indigenous people and communities to co-developed services and programs that "enable Indigenous clients to access high-quality, culturally appropriate mental health, addictions and well-being services" (Government of Ontario, 2020c). They *also* align with the goals of the RHI. As such, supporting the existing facilities and the expansion of similar facilities across Northern

Ontario is an 'easy win' for the provincial and federal government in supporting Indigenous people struggling with homelessness, addiction, and mental health issues.

6. 'Northern' Mental Health and Addictions Centre of Excellence

In March 2020, the provincial government announced a new action plan to address mental health and addiction in Ontario with a more coordinated approach. The plan, outlined in the *Roadmap to wellness*, introduces the establishment of the 'Mental Health and Addictions Centre of Excellence'. As the "central point of accountability and oversight for mental health and addictions care" in Ontario, the Mental Health and Addiction Centre of Excellence will strive to **standardize** and monitor service delivery, report on performance, and provide support to health professionals (Government of Ontario, 2021c).

Northern Ontario, however, faces unique challenges compared to the rest of the province which must be considered by the provincial government before the establishment of a new standardized and centralized system of care for the province. While the *Roadmap to wellness* addresses many addiction and mental health issues in Northern Ontario, the implementation and delivery of these services must look different in the North for them to be effective. In recognition of the challenges of service delivery due to sparse populations within a large geographical region, there is robust support in Northern Ontario for the establishment of a '*Northern* Centre of Excellence for Mental Health and Addiction'. An engagement process conducted by the Centre for Rural and Northern Health Research and the Thunder Bay Drug Strategy, found that 95 per cent of the 216 participants from within six engagement areas – social services, education, peer, health care, policy and justice – and 65 Indigenous organizations, support the establishment of a 'Northern Centre of Excellence' (Lakehead University 2018, 4). As the *Roadmap to wellness* remains in the development phase, there is an opportunity for the provincial government now to consult with Northern decision makers and reassess the benefits to establishing a 'Northern Centre of Excellence'.

7. Inter-Facility Transportation

The opioid crisis is putting severe strain on municipal paramedic services. In the third quarter of 2021, Superior North EMS answered 187 opioid overdose calls – the highest amount ever recorded in the District of Thunder Bay (Public Health Ontario, 2021a). Similarly, the District of Cochrane is projected to surpass last year's total of 269 emergency medical services calls, with a total of 259 call recorded by the end of October 2021 (Porcupine Health Unit, 2021). To add to their workload, paramedics in Northern Ontario are uniquely required to assist in "non-urgent transfers of low-acuity patients between health facilities", often delaying their response time for emergency calls as resources are extremely limited (AMO 2019a, 6). Inter-facility transfers are a costly expense for municipal governments, and are avoided in other areas of the province through private contracts with private and non-profit operators that are funded by the province (AMO 2019a, 6)

To alleviate the workload of paramedics and solve a long-standing issue in the North, this commentary supports the recommendation made by AMO in their report, 'A Compendium of Municipal Health Activities and Recommendations', to include the provision of a third-party operator for inter-facility patient transfers in Northern Ontario provided and funded by the provincial government. Importantly, this commentary seconds the additional recommendation that only in situations where there is no alternative, should municipal paramedic services be used, and when this occurs, the cost should be reimbursed from the provincial government to municipalities from LHINs (AMO 2019a, 6).

8. Mobile Crisis Intervention Teams (MCIT)

Police officers are ill-equipped to handle an increasing number of service calls involving individuals experiencing mental health crises, resulting in a 'revolving door' phenomenon "where police have frequent contact with the same individuals who are often unable to access long-term, appropriate care" (Semple et al 2021, 3). These calls drain police resources due to their frequency and time-consuming nature as police

officers are typically required to remain in ED with individuals apprehended under the *Mental Health Act* until they have been seen by a physician (Semple et al 2021, 4).

The MCIT model, which pairs an experienced mental health professional with a police officer, has been implemented with tremendous evidence-based success in many cities across Ontario and Canada. MCIT models have proven to relieve pressure on police officers and provide better support to people in crisis. A study conducted on the Crisis Outreach and Support Team (COAST) by South Simcoe Police Service (SSPS) in partnership with CMHA and York Support Services Network found the implementation of COAST contributed to fewer apprehensions and significantly more resources provided to people in crisis (Semple et al 2021, 4). Moreover, the study found COAST provided significant economic benefits for SSPS. Reduced call times of patrol officers responding to mental health calls saved $47.43 **per call** and SSPS also saved on calls where COAST responded compared to patrol officers (Semple 2021, 14). A similar study conducted on the Joint Mobile Crisis Response Team Pilot Project (JMCRT) by Thunder Bay Police Services, Thunder Bay Regional Health Sciences Centre and CMHA also found a reduction in the number of apprehensions and less time spent by officers in ED. Since 2018, JMCRT has been successful in diverting 661 people from ED and 131 from police custody (Human Services & Justice Coordinating Committee, 2021).

As part of the $18.3 million commitment made by the provincial government in 2019 to support Ontario's first responders in the *Roadmap to wellness*, a pilot project for four new mobile mental health and addictions clinics were announced, with one set to open in Northern Ontario on Manitoulin Island. In June 2021, OBCM called on the federal government to establish "a consistent program to be mandated province-wide with the necessary funding" as a viable solution for solving the mental health crisis that has been "tried and tested" with success – a position supported by this paper (OBCM, 2021). Federal, provincial and municipal governments should work collaborative to introduce MCIT in communities across Northern Ontario.

Conclusion

It is clear that current efforts made by governments are not enough to address the worsening homelessness, addiction, and mental health crisis in Northern Ontario. Thus, all levels of government musts commit to new strategies for Northern Ontario. The strategies identified in this paper have been proven to be successful in reducing homeless populations and those struggling with addiction and mental health issues with evidence-based data. This data also shows the economic benefits of the suggested strategies. Importantly, the eight strategies align with commitments already made by the federal and provincial government, and therefore, should be supported whole-heartedly and without reservation.

Appendix A

Association of Municipalities of Ontario (AMO)

Canadian Mental Health Association (CHMA)

Canadian Mortgage and Housing Corporation (CMHC)

Crisis Outreach and Support Teams (COAST)

District Social Service Administration Board (DSSAB)

Emergency Department (ED)

Federation of Northern Ontario Municipal Association (FONOM)

Joint Action Health Workforce Planning and Forecasting (JAHWF)

Joint Mobile Crisis Response Team Pilot Project (JMCRT)

Kenora District Services Board (KDSB)

Ministry of Health and Long-Term Care (MOHLTC)

Mobile Crisis Intervention Teams (MCIT)

Northern Ontario Municipal Association (NOMA)

Northern Ontario School of Medicine (NOSM)

Northern Ontario Service Delivery Association (NOSDA)

Ontario's Big City Mayors (OBCM)

Ontario Provincial Police (OPP)

Point-in-Time (PiT) Counts

Rapid Housing Initiative (RHI)

South Simcoe Police Service (SSPS)

Thunder Bay District Social Service Administration Board (TBDSSAB)

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January 28, 2022

Association of Municipalities of Ontario (AMO)

Sent via email: policy@amo.on.ca

To whom it may concern:

Please be advised that the Council of the Corporation of the City of Brantford adopted the following resolution at its City Council meeting held on January 25, 2022:

12.5.2 Addressing the Revolving Door of Justice – Accountability for Sureties and Swift Justice – Resolution

WHEREAS the City of Brantford has experienced a substantial increase in criminal activity leaving residents fearful for their personal safety and losing confidence in the criminal justice system; and

WHEREAS the City of Brantford strives to create vibrant, safe, livable neighbourhoods in its community; and

WHEREAS concerns continue to be raised by businesses, the post-secondary institutions in the downtown area and their student bodies, neighbourhood associations, citizens and others; and

WHEREAS bringing matters related to criminal charges more expeditiously through the court system will create a greater deterrence to such behaviour, and therefore improve the safety and security of citizens in this community; and

WHEREAS each year a significant sum of surety money is forfeited further to breaches of the conditions of judicial interim release orders (“bail”); however, the necessary steps are not taken to collect this forfeited money, thus leaving a substantial financial resource unavailable;

NOW THEREFORE BE IT RESOLVED:

A. THAT Kevin Davis, Mayor of the City of Brantford, on behalf of the Council of The Corporation of the City of Brantford, correspond with the Honourable Prabmeet Sarkaria, President of the Treasury Board and the Honourable Doug Downie, Attorney General of Ontario, insisting that steps be taken immediately by the government to:

i. provide additional judicial resources dedicated to Brantford to allow for matters to move as expeditiously through the court system as possible; and

ii. provide such additional space and/or technological resources for the local court to ensure there is adequate space and technological resources to most efficiently address the significant local caseload and consequently decrease the time a matter takes to be fully resolved; and

iii. dedicate the required resources to collect the forfeited surety monies and reinvest that money back into the provincial judicial system; and

B. THAT the City Clerk BE DIRECTED to forward a copy of this resolution to the Association of Municipalities of Ontario (AMO), the Federation of Canadian Municipalities (FCM), Ontario Big City Mayors (OBCM) and the list of other Ontario Municipalities with a request that those municipalities pass similar resolutions; and

C. THAT the City Solicitor BE DIRECTED to send the letter referenced in Clause A to Brant County, the Six Nations of the Grand River and the Mississaugas of the Credit First Nation to determine if they are willing to be signatories to the letter.

I trust this information is of assistance.

Yours truly,

Tanya Daniels
City Clerk
tdaniels@brantford.ca

cc All Ontario municipalities
Ontario Big City Mayors (OBCM)
Federation of Canadian Municipalities (FCM)

January 28, 2022

Larry Brock, MP Brant
108 St. George Street, Suite #3
Brantford, ON N3R 1V6

Sent via email: larry.brock@parl.gc.ca

Will Bouma, MPP
96 Nelson Street
Suite 101
Brantford, ON N3T 2X1

Sent via email: will.bouma@pc.ola.org

To whom it may concern:

Please be advised that the Council of the Corporation of the City of Brantford adopted the following resolution at its City Council meeting held on January 25, 2022:

12.5.1 Closing the Revolving Door of Justice – Resolution

WHEREAS the City of Brantford has experienced a substantial increase in criminal activity leaving residents fearful for their personal safety and losing confidence in the criminal justice system; and

WHEREAS the increase in criminal activity is due in part to the failure of the justice system to hold in pre-trial custody many of the likely-to-reoffend individuals, including those who are in serious breach of prior bail conditions, a situation commonly referred to as the "revolving door of justice"; and

WHEREAS those involved in the justice system, from Justices of the Peace to those who have been arrested, acknowledge the "catch and release" bail system contributes to the increase in crime. One individual in particular, who plead guilty to several break and enter charges, together with breaches of probation and release order charges, advised the court during sentencing that he had been arrested 8 times in the previous year and felt that the system bore responsibility for failing to keep him in custody; and that being released repeatedly without the appropriate supports made it all but impossible for him to discontinue the criminal activity he engaged in; and

WHEREAS concerns continue to be raised by businesses, post-secondary institutions in the downtown area and their student bodies, neighbourhood associations, and citizens regarding the increased criminal activity; and

WHEREAS there is a pressing need for common sense bail reform that gives priority to the dignity and safety of victims over the wellbeing of criminals;

NOW THEREFORE BE IT RESOLVED:

A. THAT Kevin Davis, Mayor of the City of Brantford, on behalf of the Council of The Corporation of the City of Brantford, correspond with the Honourable David Lametti, Minister of Justice and Attorney General of Canada, insisting that steps be taken immediately by his government to strengthen the bail system, including:

    i. imposing more demanding and stringent surety and supervision requirements; and

    ii. imposing more substantive and effective consequences for continued breaches of a judicial interim release order (as known as “bail”) resulting in pre-trial incarceration, which changes are required to safeguard law abiding citizens and to restore the citizens faith in the criminal justice system; and

B. THAT the City Clerk BE DIRECTED to forward a copy of this resolution to Brant/Brantford MP Larry Brock and MPP Will Bouma; and

C. THAT the City Clerk BE DIRECTED to forward a copy of this resolution to the Brantford Police Services Board, Association of Municipalities of Ontario (AMO), the Federation of Canadian Municipalities (FCM) and the Ontario Big City Mayors (OBCM); and

D. THAT the City Clerk BE DIRECTED to forward a copy of this resolution to the heads of all Ontario Municipalities with a request that those municipalities consider adopting a similar resolution; and

E. THAT the City Solicitor BE DIRECTED to send the letter to be sent to the Honourable David Lametti to Brant County, the Six Nations of the Grand River and the Mississaugas of the Credit First Nation to determine if they are willing to be signatories to the letter.

I trust this information is of assistance.

Yours truly,

Tanya Daniels
City Clerk
tdaniels@brantford.ca

cc Brantford Police Services Board
Association of Municipalities of Ontario (AMO)
Federation of Canadian Municipalities (FCM)
Ontario Big City Mayors (OBCM)
Heads of all Ontario Municipalities

Township of Adjala-Tosorontio

7855 Sideroad 30
Alliston, ON L9R 1V1
P.: 705-434-5055
F.: 705-434-5051

January 25, 2022

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

sent via email: premier@ontario.ca

Re: Funding Support for Infrastructure Projects – Bridge/Culvert Replacements in Rural Municipalities

Dear Premier:

At the last regular Council meeting held January 12th, 2022, the following resolution was passed:

*"**RESOLVED** that the Council of the Corporation of the Township of Adjala-Tosorontio supports the requests from the Township of Adelaide-Metcalfe, the Township of Lake of Bays, the Township of Amaranth and Northumberland County for the Federal and Provincial Government to provide more funding to rural municipalities to support infrastructure projects related to major bridge and culvert replacements.*

***AND FURTHER THAT** this resolution be forwarded to the Premier of Ontario, Provincial Minister of Finance, Federal Finance Minister, AMO, and all Ontario municipalities."*

Sincerely,

Dianne Gould-Brown

Dianne Gould-Brown, CMO
Municipal Clerk

cc:
Hon. Peter Bethenfalvy, Ontario Minister of Finance minister.fin@ontario.ca
Hon. Chrystia Freeland, Federal Minister of Finance chrystia.freeland@fin.gc.ca
AMO amo@amo.on.ca
All Ontario Municipalities