South East Health Unit

formerly

HASTINGS PRINCE EDWARD Public Health

KFL&A Public Health

Leeds, Grenville & Lanark District HEALTH UNIT

BOARD OF HEALTH MEETING

AGENDA PACKAGE

WEDNESDAY, May 28, 2025

at 10:00 a.m.

179 North Park Street, Belleville

ZOOM Sign-In Information

https://ca01web.zoom.us/j/66564253262?pwd=atESTQEGxppqH2d9Mbepiiq0RCg91c.1

Meeting ID: 665 6425 3262
Passcode: 539659

Dial by your location
• +1 647 558 0588 Canada
• +1 647 374 4685 Canada

To ensure a quorum we ask that you please RSVP to clovell@hpepha.ca or 613-966-5500 Ext. 231.

Hastings Prince Edward Public Health
179 North Park St.
Belleville, Ontario K8P 4P1
613-966-5500 | 1-800-267-2803
Fax: 613-966-9418

Kingston, Frontenac and Lennox & Addington Public Health
221 Portsmouth Ave.
Kingston, Ontario K7M 1V5
613-549-1232 | 1-800-267-7875
Fax: 613-549-7896

Leeds, Grenville & Lanark District Health Unit
458 Laurier Blvd.
Brockville, Ontario K6V 7A3
613-345-5685 | 1-800-660-5853
Fax: 613-345-2879

BOARD OF HEALTH AGENDA

Wednesday, May 28, 2025 – Belleville Office

1. **CALL TO ORDER**
2. **LAND ACKNOWLEDGEMENT**
   South East Health Unit is located on the traditional territory of Indigenous peoples dating back countless generations. We would like to show our respect for their contributions and recognize the role of treaty making in what is now Ontario. Hundreds of years after the first treaties were signed, they are still relevant today.
3. **ROLL CALL**
4. **APPROVAL OF THE AGENDA**
   MOTION: THAT the Board of Health approve the agenda for May 28, 2025 as it has been circulated.
5. **APPROVAL OF THE MINUTES OF PREVIOUS MEETING** Schedule 5
   MOTION: THAT the Board of Health approve the minutes of the meeting held on April 23, 2025 as circulated.
6. **DISCLOSURE OF PECUNIARY INTEREST**
7. **COMMITTEE REPORTS**
   7.1 ***Governance Committee Update*** – Mayor Robin Jones
   - 7.1.1 **alPHa Board of Health Training** Schedule 7.1.1

     MOTION: THAT the Board of Health approve the recommended date of June 25, 2025 to be used as a training session for the Board by the Association of Local Public Health Agencies as facilitators.
   - 7.1.2 **South East Health Unit Operating Name** Schedule 7.1.2

     MOTION: THAT the Board of Health approve the recommendation to adopt the operational names of the new Health Unit as: Southeast Public Health (SEPH) and Santé publique du Sud-Est (SPSE).
8. **STAFF REPORTS**
   8.1 **Innovation and Revenue Generation** Schedule 8.1
   Presented by Dr. Hugh Guan, Associate Medical Officer of Health and Director

8.2 **SPRITE in Action**: Advancing Syphilis Testing and Treatment through Community Engagement Schedule 8.2
Presented by Stephanie Vance, Public Health Nurse

8.3 **Measles Update** Schedule 8.3
Presented by Dr. Ethan Toumishey, Deputy Medical Officer of Health-West

MOTION: THAT the Board of Health accept all staff reports as presented.

9. NEW BUSINESS

9.1 **alPHa Resolutions Package** Schedule 9.1

MOTION: THAT the Board of Health show its support for the resolutions put forth to be voted on at the alPHa AGM by having attendee Board members vote for the resolutions as set out below and as circulated.

9.2 **Merger Updates and Change Readiness** Schedule 9.2

MOTION: THAT the Board of Health receive the merger update report and the Change Readiness Assessment report as circulated.

10. INFORMATION ITEMS (see website) Schedule 10

MOTION: THAT the Board of Health receive the information items as circulated.

11. ADJOURNMENT

MOTION: THAT this Board of Health meeting be adjourned.

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BOARD OF HEALTH OPEN SESSION MINUTES

Wednesday, April 23, 2025 Kingston 10:00 a.m.

Minutes of the meeting of the South East Health Unit held at 221 Portsmouth Avenue, Kingston, ON, through in-person and MS Teams attendance.

In attendance:

In-Person:	Mayor Jan O'Neill, Mr. Stephen Bird, Councillor Conny Glenn, Councillor Judy Greenwood-Speers, Councillor Sean Kelly, Councillor Anne-Marie Koiner, Councillor Jeff McLaren, Ms. Barbara Proctor, Councillor Bill Roberts (10:05 a.m.), Mr. Chris Seeley, Warden Nathan Townend.
Virtual:	Dr. Jeffrey Allin, Mayor Robin Jones (10:18 a.m.), Reeve Richard Kidd, Councillor Michael Kotsovos, Ms. Melanie Paradis.
Regrets:	Councillor Peter McKenna, Dr. David Pattenden
Officer:	Dr. Piotr Oglaza

1. **CALL TO ORDER** – Meeting was called to order at 10:02 a.m. by Chair O'Neill.

2. **LAND ACKNOWLEDGEMENT** – Spoken by Chair O'Neill.

3. **ROLL CALL** – Conducted by Recorder, K. Thompson.

4. **APPROVAL OF THE AGENDA**

   It was MOVED by Warden N. Townend and seconded by Mr. S. Bird THAT the Board of Health approve the agenda for April 23, 2025, as circulated.

   CARRIED

5. **APPROVAL OF THE MINUTES OF PREVIOUS MEETING**

   It was MOVED by Councillor S. Kelly and seconded by Councillor A. Koiner THAT the Board of Health approve the minutes of the meeting held on March 26, 2025, as circulated.

   CARRIED

6. **DISCLOSURE OF PECUNIARY INTEREST** – Mr. S. Bird and Ms. B. Proctor declared a conflict of interest with Item 7.1.2: *Board Members' Remuneration and Expenses Policy*, confirming their decision out of an abundance of caution following clarification that the matter pertained to setting stipend amounts within a legislated maximum.

7. COMMITTEE REPORT

7.1 *Governance Committee Update*

Warden N. Townend provided an update on behalf of the Governance Committee. He reported that the Committee held a productive meeting on April 8, 2025, during which members reviewed and finalized a list of secondary policies identified by the South East Transition Team's By-law Review Subcommittee. Each item was considered individually, which also served to orient newer members who had not participated in the subcommittee's earlier work. The Committee anticipates that most policies and by-laws will be returned from legal counsel for review, after which they will be brought forward to the Board for consideration. It was confirmed that the Committee's review process is now well underway.

*7.1.1 **alPHa Conference and Symposium Attendance***

It was MOVED by Councillor B. Roberts and seconded by Ms. B. Proctor THAT the Board of Health approve attendance at alPHa conferences and symposiums based on board members' expressed interest.

CARRIED

*7.1.2 **Board Members' Remuneration and Expenses Policy***

In response to a question, it was confirmed that if a municipality within the Board of Health's jurisdiction were to establish a higher stipend amount in the future, any adjustment to the Board's stipend would not occur automatically. Such a change would require review by the Governance Committee and formal approval by the Board through a separate motion.

It was MOVED by Councillor B. Roberts and seconded by Ms. M. Paradis THAT the Board of Health approve the recommended amount of per diem remuneration and approve the associated *Board Members' Remuneration and Expenses Policy*, as circulated.

CARRIED

*7.1.3 **Board Member Oath of Conduct and Confidentiality Policy***

It was MOVED by Councillor S. Kelly and seconded by Mr. S. Bird THAT the Board of Health approve the Board Member Oath of Conduct and Confidentiality Policy;

AND THAT once approved all members review and sign the Oath of Conduct and Confidentiality to show their agreement and understanding of its contents, as circulated.

CARRIED

*7.1.4 **Policy / By-law / Terms of Reference Amendment List***

It was MOVED by Warden N. Townend and seconded by Ms. B. Proctor THAT the Board of Health, through the Governance Committee, keep a running amendment list to track requested changes to policies, by-laws and terms of reference;

AND THAT these changes be presented to the Board of Health for approval twice a year in June and November after first being reviewed by the Governance Committee.

CARRIED

*7.1.5 **Board Chair as Ex-Officio Member***

It was confirmed for information that the Board Chair, as an ex-officio member, is a voting member of the Governance and Finance Committee. The clarification was acknowledged before proceeding.

*7.2 **Finance Committee Update***

Councillor A. Koiner, Finance Committee Chair, provided an update on the meeting held April 16, 2025. The Committee reviewed the draft fourth-quarter 2024 report for Leeds, Grenville and Lanark District Health Unit, which showed a year-end deficit of $1.4 million, partially offset by a transfer of $871,000 from reserves. A Workplace Safety and Insurance Board (WSIB) rebate is still pending, which may positively impact the final figures. The Committee also reviewed the category breakdowns and allocations from the legacy agencies to the merged entity, discussing strategies to address the deficit, particularly focusing on structural deficiencies in base funding and municipal contributions. The Committee expressed satisfaction with the oversight provided on the financial statements.

For the South East Health Unit, the first-quarter results indicated a surplus of $373,000, largely attributed to merger-related funding. The Committee clarified that this figure may be adjusted as additional changes are made and category definitions are finalized. High office operations and communications expenses were noted, primarily due to merger activities, but the overall financial situation was viewed positively.

The Committee reviewed the Annual Service Plan briefing note, which highlighted a base funding request of $48 million. The increased demand for dental care services was also noted, along with discussions on opportunities for student practicums in public health inspection as part of workforce development initiatives.

The 2024/2025 Year One Merger Budget and accomplishments were also reviewed. The Committee expressed appreciation for staff efforts in successfully merging the three legacy organizations. It was noted that most

of the $10 million in merger funding has been spent, primarily on building occupancy costs and three major mortgages, which will contribute to the organization's long-term stability. The Committee expressed confidence in the financial position and progress to date.

It was MOVED by Councillor A. Koiner and seconded by Warden N. Townend THAT the Board of Health receive the Finance Committee update and financial reports as circulated herein.

CARRIED

8. NEW BUSINESS

8.1 Public Health Funding Projections

Dr. P. Oglaza introduced J. Wickson, Finance Manager, who presented long-term funding projections for the South East Health Unit. The projections were based on reasonable and conservative assumptions and were intended to provide a high-level overview of the financial trajectory for the merged organization. He noted that while the model required assumptions that are not yet Board decisions, it was intended as a planning tool to support informed discussion. Dr. P. Oglaza reminded members of the adage, "All models are wrong, but some are useful," and encouraged the Board to consider the broader strategic context.

J. Wickson outlined a projected deficit of $15.6 million by 2030, primarily due to limited increases in provincial funding and rising operational costs. Expenses are expected to grow by 4 percent annually, compounded by a 1 percent annual population growth rate. He noted that merger transition funding is expected to mitigate some financial pressure through 2026. However, significant funding challenges are projected to emerge once this transitional support concludes. It was also emphasized that, had the three legacy health units not merged and had transitional funding not been available, these financial pressures would have been experienced earlier.

The Committee discussed the implications of harmonizing provincial funding levels across the legacy health unit jurisdictions. J. Wickson explained that adopting the highest provincial funding rate across all jurisdictions could improve the financial position by up to $2 million annually; however, a substantial structural deficit would still remain.

Board members discussed the need for reform of the provincial public health funding formula. There was consensus on the strategic advantages of the merged entity, including increased operational flexibility and a stronger, unified voice for advocacy. Members supported engaging local Members of Provincial Parliament (MPPs) to strengthen advocacy efforts and reinforce the case for funding reform.

Looking forward, the Committee agreed on the need for continued strategic planning, refined financial modelling, and stronger data to

support funding requests. Members also highlighted the value of positioning public health as a critical investment in the broader healthcare system, rather than solely as a cost driver, in future communications and advocacy.

It was MOVED by Councillor C. Glenn and seconded by Councillor Sean Kelly THAT the Board of Health demonstrate its support for long-term, sustainable provincial public health funding by requesting participation in the Ministry of Health's policy review of the public health funding methodology.

CARRIED

8.2 **Merger Updates**

Dr. P. Oglaza introduced S. Stewart, Director of the Merger Office, to provide an update on progress toward full integration. S. Stewart highlighted key developments, including the establishment of a temporary Merger Hub, designed to service as a centralized internal resource for staff. The Hub provides access to frequently asked questions, leadership updates, merger-related memos, and staff highlights. It is intended to support communication and coordination until a unified IT infrastructure is implemented across the organization.

S. Stewart noted that the Merger Office is developing a flexible change management plan with a focus on communication, change readiness, organizational culture, and staff training. As part of this plan, a "Merger Map" has been created to guide employees through the transition, complemented by regular updates to ensure transparency and staff engagement.

In response to a question about Board access to the Merger Hub, S. Stewart explained that the site is currently accessible only to internal users. She committed to consulting with IT staff to explore possible access solutions for Board members.

Broader merger-related initiatives underway include staff engagement events, leadership training, branding and visual identity development, compensation harmonization for non-union roles, early-stage planning for a new website incorporating AI-supported content analysis, and work toward a consolidated Microsoft 365 environment.

The Board also discussed collaboration with other newly merged health units. Chair J. O'Neill shared that she had recently met with the Chair of the merged Haliburton Kawartha Northumberland Peterborough Health Unit to discuss shared challenges and best practices, with plans to reconnect following the submission of quarterly reports to the Ministry of Health. Dr. P. Oglaza added that Medical Officers of Health from merged entities meet regularly to exchange information and approaches to

operational issues. Although there is no shared repository among health units, resources are shared informally via email where appropriate. He further noted that while most merged units remain focused on operational integration, this Board has begun to turn its attention to longer-term strategic considerations, including financial sustainability.

Board members expressed appreciation for the work of the Merger Office and emphasized the importance of continued strategic planning to address both integration and funding challenges over the long term.

9. ADJOURNMENT

A board member commended the agency's effective response to a recent measles incident involving schools in Belleville and the surrounding area. The investigative efforts of the team were described as highly effective and brought reassurance to students, families, and the broader community. The member noted this as a strong example of Public Health work at its best.

Reflecting on a prior Board discussion regarding public health priorities over the next two to four years, the member emphasized the growing challenges faced by vulnerable populations, including those experiencing homelessness, mental health issues, substance use, and food insecurity. It was noted that these challenges have become increasingly visible and have significant economic impacts at the municipal level.

In this context, a request was made for a report outlining how Public Health is currently collaborating with communities across the region to support vulnerable populations. The intent is to strengthen the Board's understanding of local approaches, share best practices across jurisdictions, and explore opportunities for leadership in this area at the provincial level.

Dr. P. Oglaza acknowledged that regional integration efforts remain underway following the recent merger but indicated a preliminary report could be developed. They noted this would likely reflect differing strategies across the former health units. It was also emphasized that any expansion of focus on vulnerable populations must be carefully balanced with available resources and the organization's mandated responsibilities.

It was moved by Mr. C. Seeley and seconded by Warden N. Townend THAT this Board of Health meeting be adjourned at 11:25 a.m.

CARRIED

Jan O'Neill, Board Chair
South East Health Unit

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Board of Health Briefing Note

To:	South East Health Unit Board of Health
Prepared by:	Board of Health Governance Committee
Approved by:	Dr. Piotr Oglaza, Medical Officer of Health and CEO
Date:	Wednesday, May 28, 2025
Subject:	**SEHU Board of Health Training**
Nature of Board Engagement	☐ For Information ☒ **Strategic Discussion** ☒ **Board approval and motion required** ☐ Compliance with Accountability Framework ☐ Compliance with Program Standards
Action Required:	**MOTION:** To approve the afternoon of Wednesday, June 25, 2025 to be used as a training session for the board by the Association of Local Public Health Agencies (alPHa) as facilitators.
Background and Current Status:	One of the roles of the Governance Committee is to organize orientation, continuing education and training for Board members to enable the Board to fulfill its mandate effectively. Planning for a Board Retreat is underway with a confirmed date yet to be determined. alPHa provides a training course for Boards of Health that focuses on Governance and the Social Determinants of Health. Attached is an overview of the learning objectives and costing for review. (Appendix #1) Dr. Oglaza has been in contact with Loretta Ryan from alPHa who would be available to provide this training to the Board on June 25, 2025.
Recommendation:	The Governance Committee recommends to the Board moving forward with the alPHa training to take place after the June 25, 2025 Board meeting.

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Board of Health Briefing Note

To:	South East Health Unit Board of Health
Prepared by:	Veronica Montgomery, Communications Manager on behalf of the branding and marketing project team
Approved by:	Dr. Piotr Oglaza, Medical Officer of Health and CEO
Date:	Wednesday, May 28, 2025
Subject:	**South East Health Unit's Operating Name**
Nature of Board Engagement:	☐ For Information ☒ **Strategic Discussion** ☒ **Board approval and motion required** ☐ Compliance with Accountability Framework ☐ Compliance with Program Standards
Action Required:	**MOTION:** THAT the Board of Health approve the recommendation from the Governance Committee and adopt the operational names as: Southeast Public Health (SEPH) and Santé publique du Sud-Est (SPSE).
Background and Current Status:	In 2024, the Tri-Board Merger Committee selected the legal name South East Health Unit (SEHU) for the merged entity comprised of Hastings Prince Edward Public Health; Kingston, Frontenac and Lennox & Addington Public Health; and the Leeds, Grenville and Lanark District Health Unit. It was understood that the work of selecting the operating, public-facing name would include staff as part of a robust rebranding project. As outlined in previous merger updates to the BOH, the project team has been working with the Executive Committee and a branding and marketing consultant to establish a new brand identity for SEHU. In February 2025, a survey to all SEHU staff was distributed to gather input as to how they wanted to be seen and represented by the new brand identity. The response rate was more than 50 percent. Results included: • Sixty-four percent of staff who responded preferred a geographical name over a creative name. • Eighty-four percent of staff who responded voted to have "public health" included in the name, as opposed to "health unit". • "Knowledgeable, reliable, trustworthy" was the highest ranked quality to associate with the brand identity. • "Community" was the most used word to describe SEHU to the public.

	The phrase “health unit” is derived from a naming convention related to the legal jurisdictions of the Health Protection and Promotion Act. Over time, and especially since the COVID-19 pandemic, the term “public health” has become more recognizable and referenced by members of the public and media. Following the January 2025 voluntary mergers, 18 of 29 (62 percent) public health agencies in Ontario use the term “public health” in their operational name. In 2012, the Leeds, Grenville and Lanark District Health Unit Board of Health considered rebranding to incorporate “public health” in their operating name; however, it was not adopted due to associated costs, timing and brand recognition. With this information, as well as the insights shared during engagement sessions with key internal groups, it is recommended that the public-facing name be **Southeast Public Health**, with the initials **SEPH**. En Français, nous sommes **Santé publique du Sud-Est** (**SPSE**). The proposed operational name is representative of our agency's expanded region. The initials SEPH are a nod to the initials for the southeast direction on a compass and emphasize our commitment to the new geographic area we proudly serve. Confirming the operational, public-facing name will allow staff to finalize the domain name, email address, social media handles, logo and more. The next step in this branding process will be a vote for all staff and BOH members on their preferred logo and tagline.
Recommendation:	The Governance Committee recommends the endorsement of the public-facing names Southeast Public Health (SEPH) and Santé publique du Sud-Est (SPSE).

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Board of Health Briefing Note

To:	South East Health Unit Board of Health
Prepared by:	Dr. Hugh Guan, Associate Medical Officer of Health and Director
Approved by:	Dr. Piotr Oglaza, Medical Officer of Health and CEO
Date:	Wednesday, May 28, 2025
Subject:	**Innovation and Revenue Generation**
Nature of Board Engagement	☒ **For Information** ☒ **Strategic Discussion** ☐ Board approval and motion required ☐ Compliance with Accountability Framework ☐ Compliance with Program Standards
Action Required:	No action required.
Background and Current Status	The April 23, 2025 Board of Health meeting had a presentation on public health funding projections and led to a discussion of various strategies to address projected deficits. Members expressed interest in opportunities on the revenue side of funding projections. This briefing note and associated presentation present a snapshot of activities within the Knowledge Management portfolio, which is a revenue centre for the South East Health Unit (SEHU). The team engages in various external contracts and partnerships that act as cost-recovery for the agency while advancing the work of public health internally and across the province. The activities include professional services consultancy, data science and surveillance products, and research projects. Over the 2024-2025 year, initiatives within the portfolio in conjunction with various program teams led to $500,000-$800,000 in direct cost-recovery to SEHU or over $1.2 million in funding to wider public health sphere activities. Opportunities in existing areas of work are continually explored with continuous lead generation and development. Strategically, the portfolio leverages the critical mass of expertise and experience within SEHU staff, the reputation of SEHU as an innovator, and existing partnerships. With the wider public sector facing funding challenges, SEHU is positioned well to capitalize on the need to find synergies in capacity and expertise.

Schedule 8.1

Innovating Revenue

Dr. T. Hugh Guan MD MSc FRCPC
Associate Medical Officer of Health
Director, Knowledge Management

May 28, 2025

South East Health Unit

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Context

Function: Research and Development

Skilled team

- Epidemiologists
- Research associates
- Foundational Standards Specialists
- Librarians
- Nurses

Skillsets

- Quantitative analytics
- Qualitative methodologies
- Facilitation
- Program evaluation
- GIS
- AI and machine learning
- Clinical procedures

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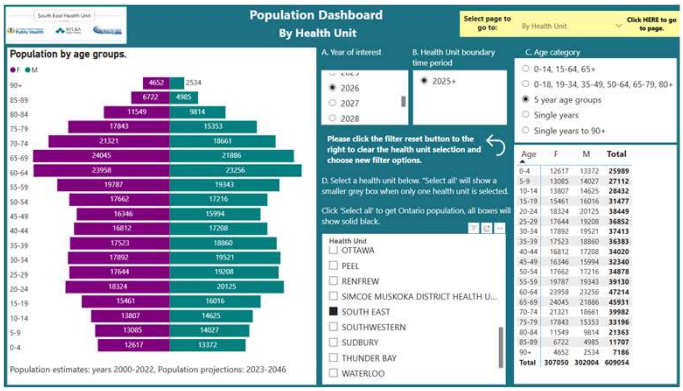
Areas of work – Professional services

Support contracts to other public health agencies

- Epidemiologic services
- Creation of business intelligence tools (dashboarding)

2024 to 2025

- $100,000 to $200,000 in contracts



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Areas of work – Data science & surveillance

Acute Care Enhanced Surveillance system

- Provincial syndromic surveillance system
- 100 percent funding from Ministry of Health
- Research grants

2024 to 2025

- $200,000 to $300,000 in funding

aces ACUTE CARE ENHANCED SURVEILLANCE

South East Health Unit

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Schedule 8.1

Areas of Work - Research

Various research and quality improvement grants

- Syphilis point-of-care tests
- HIV pre-exposure prophylaxis
- Vaccination processes

2024 to 2025

- $700,000 to $800,000 in research grants to public health activities
- $200,000 to $300,000 in direct cost-recovery

South East Health Unit

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Strategy

Leveraging South East Health Unit expertise and data to find win-win solutions

- Internal strengths: critical mass of skilled, experienced staff; leading provincial systems; existing relationships
- External opportunities: public health sector funding challenges; reputation; health digital transformation

Bridging research to practice gap

Being Brazen

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Board of Health Briefing Note

To:	South East Health Unit Board of Health
Prepared by:	Dr. Hugh Guan, Associate Medical Officer of Health and Director Presented by: Stephanie Vance, Public Health Nurse
Approved by:	Dr. Piotr Oglaza, Medical Officer of Health and CEO
Date:	Wednesday, May 28, 2025
Subject:	**SPRITE in Action: Advancing Syphilis Testing and Treatment Through Community Engagement**
Nature of Board Engagement	☒ **For Information** ☐ Strategic Discussion ☐ Board approval and motion required ☐ Compliance with Accountability Framework ☐ Compliance with Program Standards
Action Required:	No action required.
Background and Current Status	Syphilis, a curable sexually transmitted infection, which has been increasing dramatically in Ontario, especially in public health units (PHUs) serving smaller-urban areas. People, especially women, those who are un(der)housed, street-involved, work in the sex trade, or use injection drugs are known to be disproportionately affected by syphilis. Housing instability, stigma, discrimination within the healthcare system, and substance use (particularly opioids and crystal methamphetamines) and co-infections all lead to limited access to care, resulting in delayed diagnosis and treatment. If left untreated, syphilis can cause serious health outcomes including neurological, cardiovascular, and musculoskeletal complications. The Syphilis Point-of-Care Rapid Testing and Immediate Treatment Evaluation (SPRITE) study addresses the alarming rise in syphilis rates in Ontario by delivering a flexible point-of-care testing and treatment outreach nursing model to these underserved groups who are at greatest risk. Point-of-care testing allows for public health nurses to screen and immediately treat people for syphilis during public health outreach activities, meeting people where they are at, and removing the problem of losing people to follow-up that can arise with the traditional serology testing method. SPRITE is a province-wide initiative, which includes a total of seven public health units (PHUs), including legacy health units; Hastings Prince Edward Public Health; Kingston, Frontenac, and Lennox & Addington Public Health; and Leeds, Grenville, Lanark District Health Unit. It aims to evaluate implementation of the rapid 'test and treat' model using the INSTI® Multiplex HIV-1/HIV-2/Syphilis

	Antibody Test, coupled with flexible community-based nursing outreach to settings that are accessible to underserved populations. These settings can include supervised consumption sites, shelters, mobile units, and other community-based organizations serving these groups. The evaluation uses both qualitative and quantitative data collection. Between June 23, 2023 and March 31, 2025 a total of 1,221 valid tests were conducted, more than 380 outreach events have been held, and 30 people identified as infectious have been immediately treated. Key findings indicate that the rapid test and treat nursing outreach model helps to improve healthcare access for underserved populations, ensuring infection identification, timely treatment, community engagement and trust-building. Current findings have been shared with community partners, academics, the larger medical community and partners in public health. The study represents a significant advancement in public health efforts to combat syphilis in Ontario, providing valuable insights and informing future practices and policies. The SPRITE study is in operation until the Fall of 2025, with efforts being made to secure funding for an extension and expansion of the project.

Schedule 8.2

Responding to syphilis with a rapid 'test and treat' outreach nursing model of care

Stephanie Vance, PHN

Clinical Services, Sexual Health & Harm Reduction
South East Health Unit

May 28, 2025

South East Health Unit

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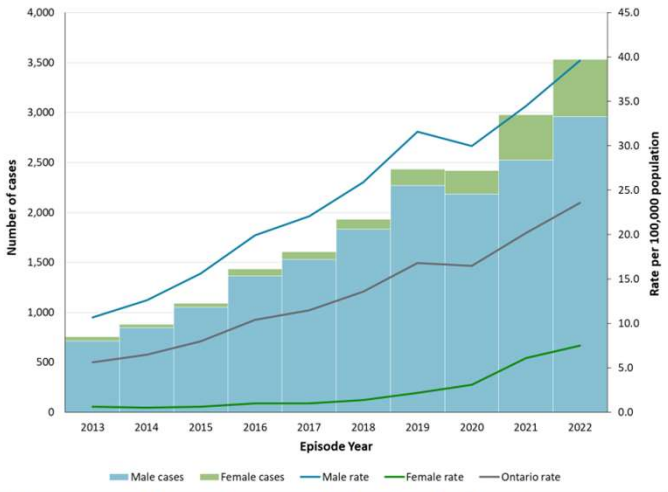
Infectious syphilis

Figure 1. Infectious syphilis cases and rate (per 100,000 population) by year and sex*: Ontario, 2013-2022



Data source: Cases: Integrated Public Health Information System (iPHIS) [database]. Population Estimates: Statistics Canada.

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Schedule 8.2

Syphilis Point-of-Care Rapid testing and Immediate Treatment Evaluation (SPRITE) Study

Goal: implement flexible nursing outreach models using the syphilis/HIV INSTI® Point-of-Care Test (POCT) across Ontario

Outreach to underserved groups in the community

Partnership between Queen's University, three legacy public health units (now merged as the South East Health Unit) and four others across the province

South East Health Unit

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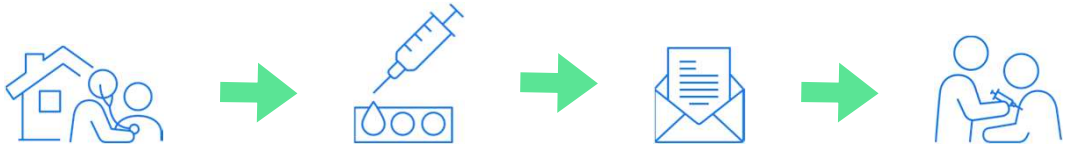
Low barrier testing for syphilis (and HIV)



POC testing in non-traditional clinic settings

Conducting confirmatory serology

Fast results

Same-interaction treatment

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Schedule 8.2

Flexible outreach

- Pre-planned events called blitzes, or pop-up testing events
- Visits to congregate settings or shelters
- Visits to community service hubs (e.g., consumption treatment sites, food banks, social services, mental health and addictions)
- Primary care clinics
- Public health unit
- Walk-abouts in the community to encampments or other sites

South East Health Unit

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Our impact to date (March 2025)*

1,221 Point-of-care tests were completed

380+ Outreach events hosted

36 Of individuals tested were identified as infectious**

30 Of these individuals were treated immediately**

*Since June 2023. Please note, these results are preliminary and for monitoring purposes
**Based on true positives

South East Health Unit

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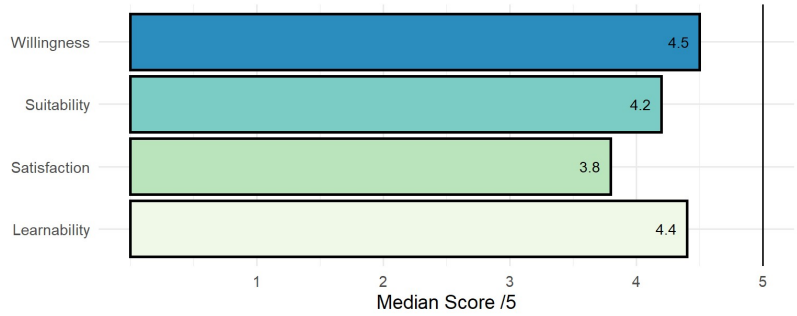
Schedule 8.2

What do public health nurses think?

Figure 2. Median subdomain scores (out of five) for the health care provider POCT implementer survey (N=26), SPRITE, 2023-2024.



High overall feasibility and acceptability

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What do public health nurses think?

- 100 percent are willing to consistently offer and perform the syphilis/HIV POCT
- 100 percent feel the POCT should continue while providing outreach services.

"Excellent tool to engage clients in STBBI screening. The quick result is enough to engage clients to accept POCT screening, allowing the opportunity to discuss other STBBI screening and public health services they could benefit from during that encounter. Anecdotally, the availability of the POCT has increased the number of individuals engaging [public health nurse's] for STBBI testing during outreach encounters."

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Schedule 8.2

Key takeaways

POCT coupled with the outreach model:

- removes barriers
- identifies and treats new infections and reinfections
- promotes open discussion
- furthers engagement with underserved population

Research questions that are underway

- Does this model of care break the chain of transmission and reduce incidence at the population level? (Mackrell L, PhD student at Queen's)
- How do regional differences in the incidence and prevalence of syphilis affect POCT performance? (Baleh T, MD Public Health Resident at Queen's)

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Acknowledgements

This work was supported by the Locally Driven Collaborative Projects (LDCP) grant (2023-2024 and 2024-2025) program from Public Health Ontario (PHO) and the Canadian Institutes of Health Research (CIHR) through a 2023 Catalyst Grant (SR8 190795), 2024 Operating Grant (AS1-192619), and Knowledge Mobilization Grant (EKS 193138) granted to NPA, Sahar Saeed, Queen's University. Please see www.spritestudy.ca for more information.

The views of the presenters do not necessarily represent those of PHO or CIHR.

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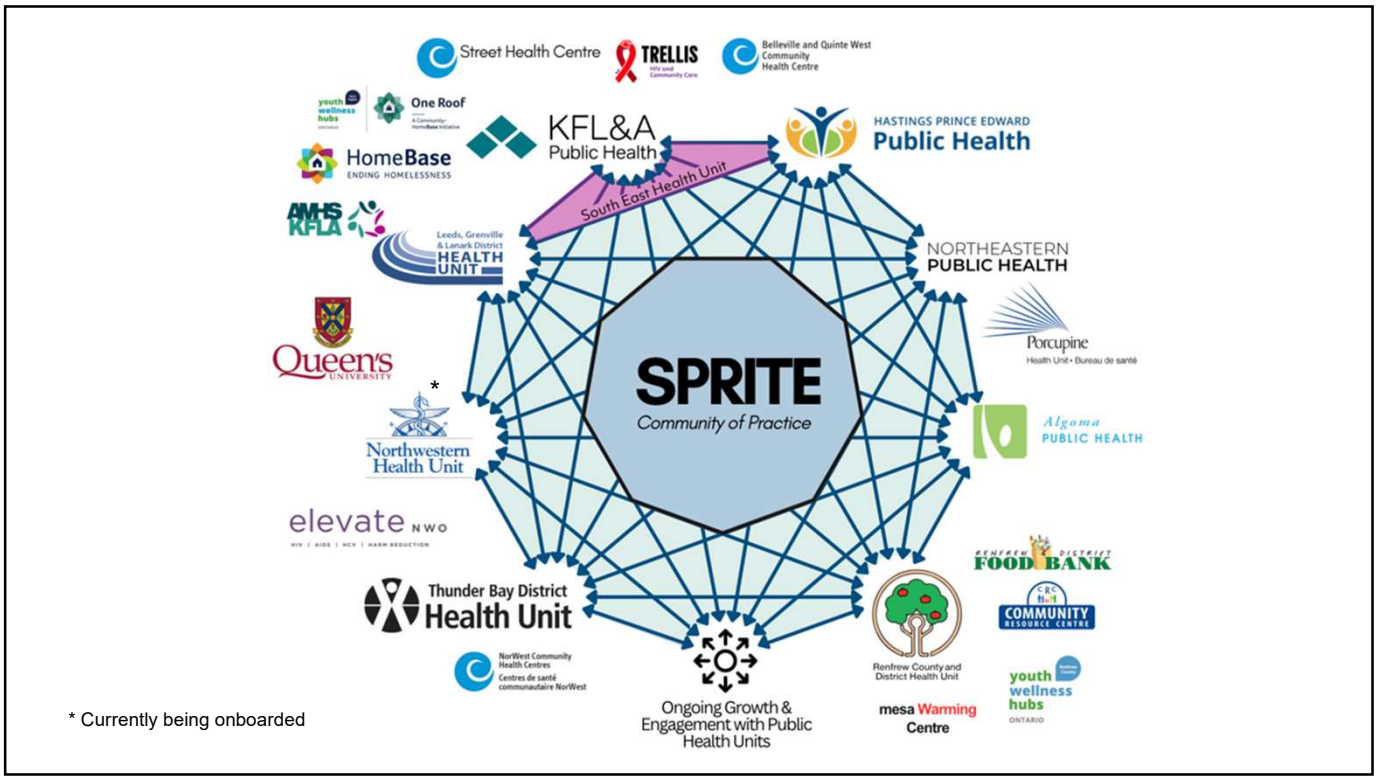
Schedule 8.2



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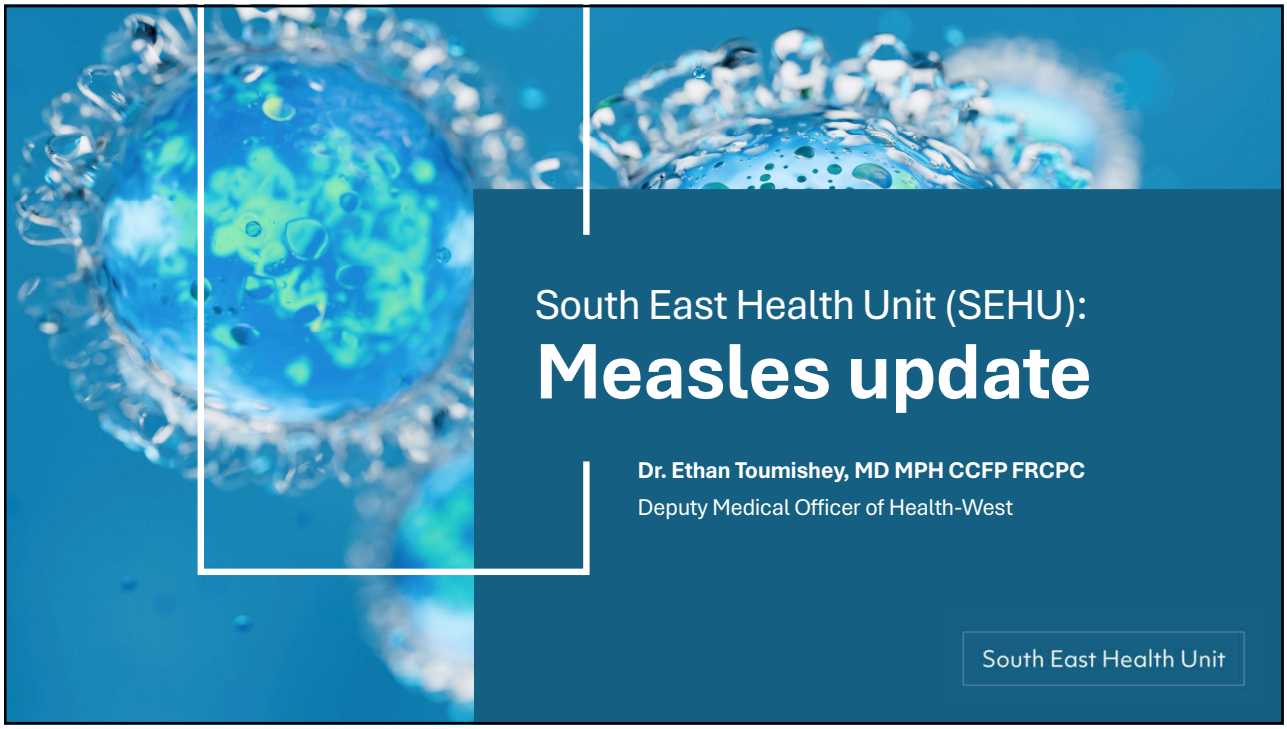
Board of Health Briefing Note

To:	South East Health Unit Board of Health
Prepared by:	Dr. Ethan Toumishey, Deputy Medical Officer of Health
Approved by:	Dr. Piotr Oglaza, Medical Officer of Health and CEO
Date:	Wednesday, May 28, 2025
Subject:	**Measles Update**
Nature of Board Engagement	☒ **For Information** ☐ Strategic Discussion ☐ Board approval and motion required ☐ Compliance with Accountability Framework ☐ Compliance with Program Standards
Action Required:	No action required.
Background and Current Status	Measles is a highly contagious vaccine preventable respiratory virus. Beginning in 2024, Ontario saw more cases of measles. Presently, Ontario is part of a pan-Canadian measles outbreak with activity occurring in Ontario and several other provinces. Across Ontario as of May 15, 2025, there are 1,622 cases of measles. Locally in South East Health Unit (SEHU), there have been 80 cases as part of this outbreak. However as of May 15, 2025, the region has not had another measles case for over 3 weeks meaning that there is unlikely to be ongoing community transmission in the area. Immunization coverage for measles is high across the region ranging up to 98.0% measles vaccination coverage amongst 4 to 17-year-olds in the legacy Kingston, Frontenac, and Lennox & Addington area, which may in part explain the low measles activity locally. Vaccination efforts have been ongoing across the region. Longer term efforts by the provincial government such as the funding and implementation of a provincial immunization registry, as recommended by the Ontario Immunization Advisory Committee, could further strengthen the immunization program in SEHU.

Schedule 8.3



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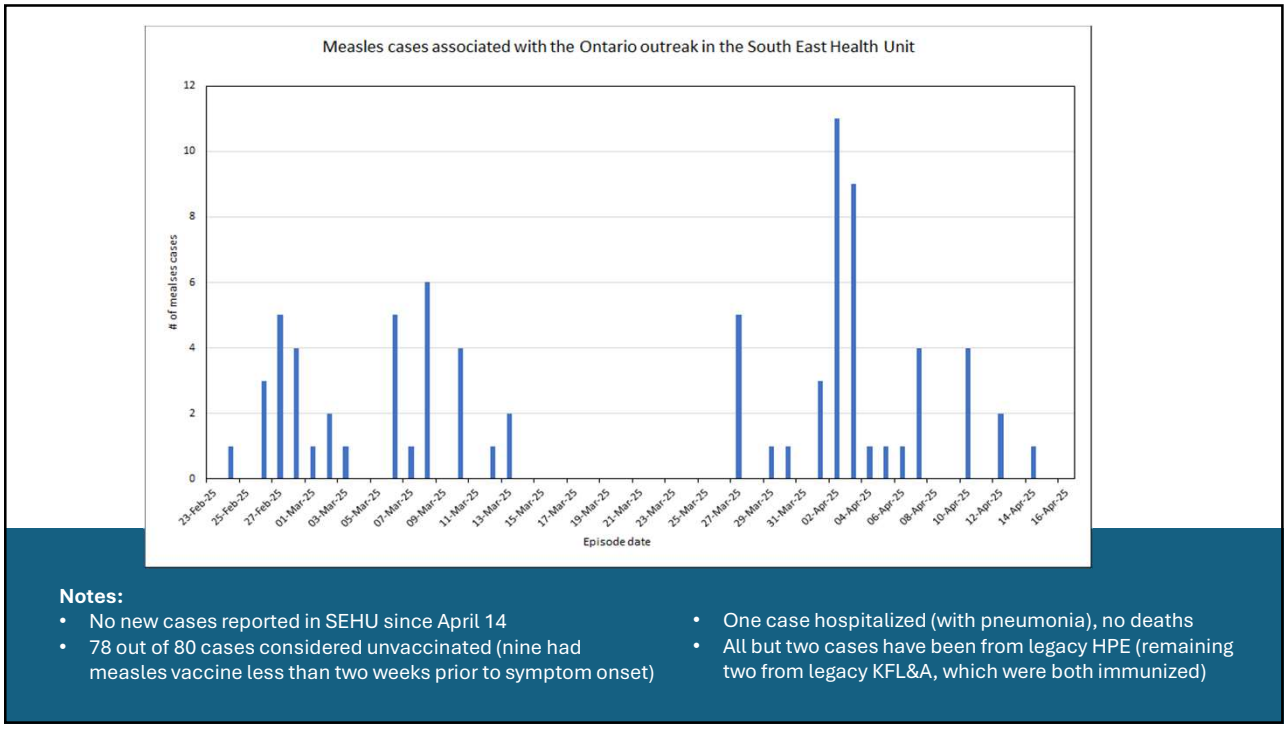

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Schedule 8.3

Characteristics of measles cases in SEHU region

Total cases to date = 80
(cases born in or after 1970 = 79)

Average age = 16.6
(range 0 – 65, median 12)

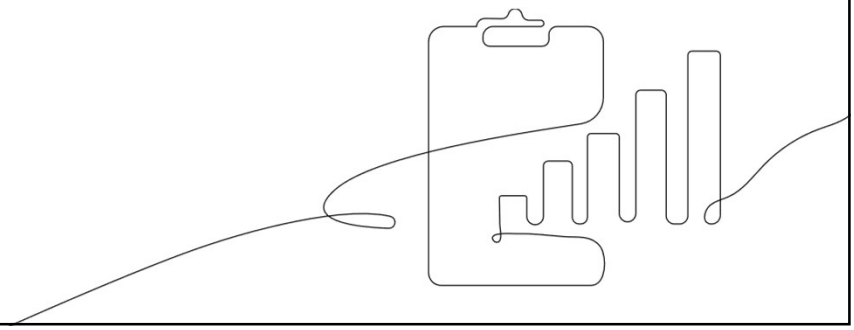
Male cases = 42
(average age = 16.1)

Female cases = 38
(average age = 17.1)

Age breakdown
<1 = 5
1-4 = 13
5-9 = 16
10-19 = 17
20-29 = 15
30-39 = 9
40+ = 5

Symptoms (most common)
Fever, rash, runny nose, cough

Legacy HPE acquisition exposures
- Wedding only = 42
- Household/Parent = 14
- Estate sale only = 10
- Unknown = 7
- Estate sale and wedding = 5



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Characteristics of measles cases in Ontario (Oct. 28, 2024 – May 13, 2025)

Total cases to date =
1,622 (cases born in or after 1970 = 1,594)

Age breakdown
- <1 = 97 (6.0 percent)
- 1-4 = 301 (18.6 percent)
- 5-9 = 401 (24.7 percent)
- 10-19 = 438 (27 percent)
- 20-39 = 292 (18 percent)
- 40+ = 85 (5.2 percent)
- Unknown = 8 (0.5 percent)

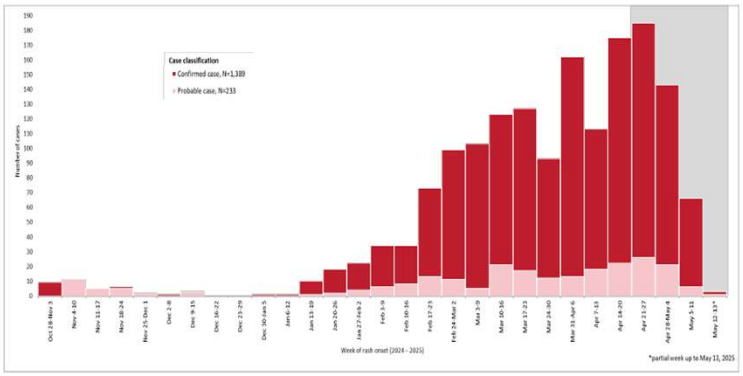
Immunization Status
- Unimmunized = 1428 (88 percent)
- 1 dose = 19 (1.2 percent)
- 2 or more doses = 66 (4.1 percent)
- Unknown/no proof of immunization = 109 (6.7 percent)

The highest rates of outbreak cases continue to be in southwestern Ontario

Gender
- Male cases = 826
- Female cases = 794
- Unknown = 2

Hospitalizations
= 119 (7.3 percent)
- ICU = 9
- Deaths = 0

Figure 1: Number of Measles Outbreak Cases by Week of Rash Onset and Case Classification: Ontario, October 28, 2024 – May 13, 2025



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Board of Health Briefing Note

To:	South East Health Unit Board of Health
Prepared by:	Dr. Piotr Oglaza, Medical Officer of Health and CEO
Date:	Wednesday, May 28, 2025
Subject:	**Association of Local Public Health Agencies (alPHa) Annual General Meeting (AGM) Resolutions for Consideration**
Nature of Board Engagement	☐ For Information ☒ **Strategic Discussion** ☒ **Board approval and motion required** ☐ Compliance with Accountability Framework ☐ Compliance with Program Standards
Action Required:	**MOTION:** THAT the Board of Health show its support for the resolutions put forth to be voted on at the alPHa AGM by having attendee Board members vote for the resolutions as set out below and as circulated.
Background	Each year the Association of Local Public Health Agencies (alPHa) has an Annual General Meeting (AGM) and Conference to which members of Boards of Health and Medical Officers of Health from all Ontario Health Units are encouraged to attend. As part of the AGM, resolutions are presented for voting on which have been put forth by member Health Units. Below and attached are the resolutions that have been put forth for consideration this year. The number of votes a health unit has is dependent on the population base that it represents. As a new and bigger population-based health unit (over 400,000), South East Health Unit has seven votes at this year's meeting.
Integrating the Ontario Early Adversity and Resilience Framework into Public Health Practice to Improve Population Health Outcomes	**alPHa Resolution A25-01** NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies endorses the Ontario Early Adversity and Resilience Framework as a comprehensive resource for public health practice in Ontario. AND FURTHER that alPHa write a letter to the Chief Medical Officer of Health (CMOH) recommending that the Ontario Early Adversity and Resilience Framework be referenced within the upcoming version of the Ontario Public Health Standards as a key resource for implementing the related standards, including health equity, comprehensive health promotion, and substance use prevention.

	AND FURTHER that alPHa write a letter to the Minister of Health, the Minister of Children, Community and Social services, and the Associate Minister of Mental Health and Addictions, with a copy to the CMOH, sharing this Framework as a potential foundational document across sectors that are working to prevent early adversity and promote resilience, and to help illustrate the role of local public health in this work.
Indigenous Representation on Boards of Health	**alPHa Resolution A25-02** NOW THEREFORE BE IT RESOLVED THAT the Association of Local Public Health Agencies call upon the Government of Ontario to ensure Indigenous representation on all local Boards of Health. AND FURTHER THAT Indigenous representatives be verifiably Indigenous, grounded in community, with lived experience, from the territory in which they will represent on a Board of Health. AND FURTHER THAT the Minister of Health and local Boards of Health be so advised.

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Resolutions for Consideration
2025

Resolutions Session
2025 Annual General Meeting
Thursday, June 19, 2025

Resolution #	Title	Sponsor	Page
A25-01	Integrating the Ontario Early Adversity and Resilience Framework into Public Health Practice to Improve Population Health Outcomes	Boards of Health for the Simcoe Muskoka District Health Unit, Durham Region Health Department, and Haliburton Kawartha Northumberland Peterborough Health Unit	3
A25-02	Indigenous Representation on Boards of Health	Board of Health for Public Health Sudbury & Districts	11

alPHa RESOLUTION A25-01

TITLE: **Integrating the Ontario Early Adversity and Resilience Framework into Public Health Practice to Improve Population Health Outcomes**

SPONSOR: **Boards of Health for the Simcoe Muskoka District Health Unit, Durham Region Health Department, and Haliburton Kawartha Northumberland Peterborough Health Unit**

WHEREAS Early life adversity is common; approximately 60% of the population has experienced at least one adverse childhood event, and 12–16% have experienced four or more. (Madigan et al., 2023; Joshi, 2021).

WHEREAS Not all children have an equal opportunity to thrive, and some can face increased adversity due to systemic inequities, like poverty.

WHEREAS Exposure to early life adversity, without the benefit of safe, stable, nurturing relationships and environments, can result in prolonged toxic stress, disrupting normal growth and development and leading to long-term impacts on physical and mental health. (Center on the Developing Child, Harvard University, 2021).

WHEREAS Early life adversity is preventable, and resilience can be fostered through investments in protective factors at the individual, family, and community levels.

WHEREAS Preventing adverse childhood experiences has been shown to significantly reduce chronic health conditions and risk factors.

WHEREAS Public Health, in collaboration with community partners, plays a vital role in leading and fostering efforts to address early life adversity and promote resilience.

WHEREAS The Public Health Ontario Adverse Childhood Experiences & Resilience Community of Practice has adapted a framework from Fraser Health Population and Public Health (2022) to develop the Ontario Early Adversity and Resilience Framework, to provide Public Health Units, municipal and provincial governments, and community partners in Ontario with tools to collaboratively prevent and address early adverse childhood events and increase resiliency within their communities.

WHEREAS Past alPHa resolutions have supported the development of early childhood resilience by promoting positive environments for children, such as A19-8, Promoting Resilience through Early Childhood Development Programming, A11-8, Public Health Supporting Early Learning and Care, and A19-9, Public Health Support for Accessible, Affordable, Quality Licensed Child Care.

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies endorses the Ontario Early Adversity and Resilience Framework as a comprehensive resource for public health practice in Ontario.

AND FURTHER that alPHa write a letter to the Chief Medical Officer of Health (CMOH) recommending that the Ontario Early Adversity and Resilience Framework be referenced within the upcoming version of the Ontario Public Health Standards as a key resource for implementing the related standards, including health equity, comprehensive health promotion, and substance use prevention.

AND FURTHER that alPHa write a letter to the Minister of Health, the Minister of Children, Community and Social services, and the Associate Minister of Mental Health and Addictions, with a copy to the CMOH, sharing this Framework as a potential foundational document across sectors that are working to prevent early adversity and promote resilience, and to help illustrate the role of local public health in this work.

Backgrounder

The Ontario Early Adversity and Resilience (OEAR) Framework was developed through collaboration within the Public Health Ontario Adverse Childhood Experiences and Resilience Community of Practice (ACER CoP). This group brings together public health practitioners from various program areas, including Healthy Growth and Development, Child and Family Health, Healthy Babies Healthy Children, Chronic Disease and Injury Prevention, and other program areas involved in work related to ACEs or resilience, along with community partners involved in regional ACEs and resilience coalitions. By facilitating knowledge exchange, supporting the development of best practices, and coordinating research and interventions, the ACER CoP works to strengthen public health capacity, advocate for evidence-based policies, and advance a standardized provincial strategy to address ACEs and resilience in Ontario.

Adapted from *Fraser Health's Population and Public Health: A Health Promotion Strategy to Prevent Adverse Childhood Experiences and Foster Resilient Children, Families, and Communities (2022-2027)*, the Ontario Early Adversity and Resilience framework provides a structured approach to addressing early life adversity. It serves as a resource for communities and decision-makers by promoting evidence-based strategies at all socio-ecological levels, simplifying complex concepts to enhance understanding, and fostering a shared language around adversity and resilience. Additionally, it encourages collective responsibility through cross-sector collaboration and strengthens the impact of initiatives aimed at reducing adversity and building community resilience (Dawdy et al., 2025).

The OEAR framework is built on four focus areas, five pathways to change, and ten guiding principles that work together to address ACEs and foster resilience in a comprehensive and integrated manner. The four focus areas—socially connected, equitable, and inclusive communities; social-emotional development and resilience; reproductive health and rights; and responsive and culturally safe parenting/caregiving—target essential aspects of children's development and well-being. The five pathways to change—shifting social norms, integrating upstream strategies, influencing public policy, lessening harm, and utilizing data—provide a strategic approach to implementing effective interventions within these focus areas. Underpinning this framework, the ten guiding principles ensure that all interventions are grounded in core values such as equity, cultural safety, collaboration, and evidence-based practices. This alignment creates a cohesive and impactful approach to enhancing child health outcomes and building resilient communities (Dawdy et al., 2025).

Adverse Childhood Experiences represent a significant Public Health threat and should be considered an important primordial cause of chronic disease. In 1998, a groundbreaking study by Felitti et al., was published exploring the relationship between childhood experience of traumatic events to adult health risk behaviour and chronic disease. Findings demonstrated that a single adverse childhood event raises the odds of poor adult health outcomes by a marginal amount, with each additional ACE experienced representing a proportionate increase. Study after study completed since, has shown a consistent, graded or dose-response relationship between the number of ACEs experienced in childhood and the increased likelihood of poor adult health outcomes. ACEs are widespread and their cost to individuals,

families, communities, and society is substantial. Calls for action to address ACEs have been growing around the world. Frameworks, such as the Fraser Health and Ontario Early Adversity and Resilience framework, have been developed to mitigate and potentially eliminate the impact of toxic stress from early life adversity. Efforts to address chronic diseases are incomplete if the impact ACEs have on later adult health outcomes is not taken into consideration.

Felitti and colleagues, 1998, defined ACEs as exposure to one or more categories of childhood maltreatment (physical, emotional, or sexual abuse, and neglect) or family challenges such as separation or divorce, incarceration, caregiver mental illness, substance abuse, or domestic violence occurring within the first 18 years of life. They are now well established and can be divided into two main categories:

- Harms that affect children directly (physical abuse, sexual abuse, emotional abuse, physical neglect, and emotional neglect)
- Household challenges that increase children's exposure to trauma in their living environment (intimate partner violence, substance abuse, mental illness, incarceration of a family member and parental separation/divorce). (Hughes et al., 2017)

It is now recognized that many other negative experiences in childhood have the potential to contribute to poor health outcomes. Accordingly, ACEs research has expanded to explore the impact of structural violence, historical/intergenerational trauma (i.e., disconnecting certain cultures from their families, relationships, and cultural practices) and adversities external to the family environment such as war, climate events, being a victim of crime, economic disadvantage, homelessness, discrimination, peer victimization, low birth weight, and child disability. Research indicates that all sources of early adversity have similar impacts on later health outcomes. In fact, "the predictive value of ACE models improves when other adversities such as peer victimization and low family income are included in ACE questionnaires" (Asmussen et al., 2020; Carsley & Oei, 2020; Asmussen et al., 2020).

The number of ACEs experienced by an individual represents their score. Higher ACE scores are associated with increased risk of chronic illness and a shortened life span. Cubbin, Kim & Panisch (2019) found the likelihood for development of one or more chronic diseases increased by ten percent with every additional ACE reported by the individual. Research shows that individuals with at least four ACEs have an increased risk of all negative health outcomes (Neves et al., 2021). ACEs are strongly associated with such health endangering behaviours as sexual risk-taking, smoking, inactivity, alcohol abuse, problematic drug use and violence (both interpersonal and self-directed, including suicide) (Neves et al., 2021 & Novais et al., 2021). They have also been linked to many persistent chronic health conditions including poor mental health, heart disease, chronic lower respiratory disease, obesity, cancer, and diabetes, as well as premature mortality (Grummit et al., 2021 & Novais et al., 2021)). Additionally, ACE factors have been linked to specific "pathologies, namely, hypercholesterolemia, stroke, high blood pressure, diabetes, rheumatoid arthritis, neoplasia, depression, and anxiety disorder" (Novais et al., 2021, p. 9).

Approximately half to two-thirds of participants in population-based studies report having experienced at least one ACE (Carsley & Oei, 2020). A cross-sectional analysis of the Canadian Longitudinal Study on Aging among individuals 45 to 85 years found that ACEs are highly prevalent across all demographic groups (Joshi et al., 2021). Although ACEs are experienced universally, it is important to understand that their long-term impact may be different depending on the influence social determinants of health play on the child and family. Indeed, research has shown that childhood maltreatment and family dysfunction rarely happen in the absence of other adversities. Multiple circumstances involving the

child, family, community, and society work together to increase or decrease the risk of poor adult outcomes for children who have experienced ACEs (Asmussen et al., 2020).

ACEs can lead to toxic stress, which has a profound impact on development. Some forms of stress are considered a normal and essential part of healthy development such as positive stress (e.g., the first day of school). More intense stress responses can be characterized as tolerable stress (e.g., loss of a loved one) when it is time-limited and buffered by supportive relationships with adults who help the child adapt. However, severe or prolonged stress without adequate support can lead to chronic activation of the stress response system, leading to elevated levels of stress hormones (toxic stress) and disruption of healthy brain development, causing wear and tear on vital systems like the cardiovascular and immune responses (Center on the Developing Child, Harvard University, 2021). Persistent exposure to toxic stress, whether from ongoing occurrences or various triggers, can severely impact an individual's physical and mental well-being over the long term. Sensitive and responsive caregiving is crucial in regulating stress hormones and building resilience into adulthood.

Exposure to toxic stress from early life adversity incurs significant costs for individuals, communities, and society. If unaddressed, it can impair academic performance, hinder work productivity, damage relationships, increase the risk of suicide and violence, and reduce life expectancy (Prevention Institute, 2017). At the community level, this stress erodes cohesion, promotes harmful norms, and amplifies individual trauma, leading to lower academic achievement, reduced economic productivity, and poorer health outcomes (Prevention Institute, 2017). The financial burden on society is also immense. In Europe and North America, the annual costs of ACEs are estimated at $581 billion (US) and $748 billion (US), respectively, with over 75% of these costs attributed to individuals with two or more ACEs (Bellis et al., 2019). According to Hughes et al. (2021), these costs account for between 1.1% and 6.0% of European countries' GDPs. A 10% reduction in ACE prevalence could result in annual savings of $105 billion and 3 million Disability-adjusted Life Years (DALYs), underscoring the economic benefits of investing in safe, nurturing childhoods to alleviate pressures on healthcare systems (Bellis et al., 2019).

While some individuals exposed to childhood adversity may develop chronic health issues or engage in health-endangering behaviors, others demonstrate greater resilience, maintaining positive mental health despite experiencing toxic stress. Resilience is the ability to adapt, recover, and thrive in the face of adversity. It is not a fixed trait, but a dynamic process influenced by both genetic factors and environmental conditions. This variation highlights the complex interplay between biology and environment in shaping responses to adversity. Resilience can be developed and strengthened over time through safe, stable, and nurturing relationships, social support, and access to resources. Evidence-based approaches exist to enhance resilience at both individual and community levels, helping to prevent and mitigate the effects of early life adversity while promoting long-term well-being. (Alberta Family Wellness, 2015)

At the individual level, resilience is strengthened when protective factors—such as biological, emotional, cognitive, and social supports—are reinforced through daily interactions and targeted interventions. Examples of these strategies include strengthening economic supports for families, promoting social norms that protect against violence and adversity, ensuring children have a strong start in life, teaching stress management and problem-solving skills, connecting youth with caring adults and structured activities, and providing timely interventions to reduce both immediate and long-term harm. These approaches aim to shift norms, environments, and behaviours in ways that not only mitigate the impact of toxic stress but also prevent it from being experienced in the first place. (Shern et al., 2014; Centers for Disease Control and Prevention, 2019)

At the community level, collective resilience is fostered through opportunities for stable, trusting relationships; participation in group activities such as sports or clubs; and accessible, supportive public services. However, some communities have fewer resources—whether in economic opportunities, access to green spaces that support mental well-being, or the presence of positive role models within social networks. These areas are often characterized by neglect, substandard housing, and high levels of individual, family, and community violence. Addressing trauma at a community level requires coordinated efforts across policy, programs, and legal frameworks. Healing through culturally relevant practices and the development of trusting relationships is essential. Participatory frameworks, which empower communities to advocate for their needs, are most effective when supported by a multisectoral collective of agencies working together to determine how best to provide necessary supports (Ellis & Dietz, 2017; Pinderhughes, Davis & Williams, 2015).

ACEs are increasingly recognized as a significant determinant of public health, emphasizing the vital role public health units can play in prevention. Addressing early life adversity through primordial prevention—an upstream approach that reduces risk factors before they lead to poor health outcomes—can help lower substance use, reduce chronic disease, and improve overall population health. With their focus on prevention and broad population-level impact, public health units are well-positioned to lead these efforts. They can convene partners to plan, prioritize, and implement strategies that prevent and mitigate early adversity, ultimately strengthening community well-being (Carsley et al., 2022; Centers for Disease Control and Prevention, 2019).

Addressing adverse childhood experiences is not just a public health priority—it is an essential strategy for building healthier, more resilient communities. Investing in early prevention and mitigation strategies will not only improve individual health outcomes but also reduce societal costs and strengthen population health for future generations.

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alPHa RESOLUTION A25-02

TITLE: **Indigenous Representation on Boards of Health**

SPONSOR: **Board of Health for Public Health Sudbury & Districts**

WHEREAS 22% of all Indigenous Peoples in Canada reside in Ontario. Indigenous people disproportionately experience "poorer reported physical and mental health status, and a higher prevalence of chronic conditions (e.g. asthma and diabetes) as well as disabilities compared to non-Indigenous people" [i,ii]. In addition, "the life expectancy of First Nations people, Métis and Inuit has been shown to be consistently and significantly lower than that of the non-Indigenous population."[iii] These poorer health outcomes are a direct result of the Canadian government's genocidal policies, which have had and continue to have a reverberating impact on today's systems; and

WHEREAS the Association of Local Public Health Agencies and Boards of Health play a crucial role in addressing the health disparities faced by the Indigenous population as per the Ontario Public Health Standards, *Relationships with Indigenous Communities Guideline*, 2018; and

WHEREAS Indigenous peoples have the inherent right to self-determination, which includes the right to actively participate in decisions that affect their health and well-being; and

WHEREAS meaningful Indigenous representation in decision-making processes is essential to ensuring that public health policies and programs adequately reflect the needs, priorities, and self-determined aspirations of Indigenous peoples; and

WHEREAS the Truth and Reconciliation Call to Action 23, which calls upon all levels of government to "Increase the number of [Indigenous] professionals working in the health-care field;"[iv] and

WHEREAS the Ontario Public Health Standards advises "Selection of board of health members based on skills, knowledge, competencies and representatives of the community, where boards of health are able to recommend the recruitment of members to the appointing body;"[v]

NOW THEREFORE BE IT RESOLVED THAT the Association of Local Public Health Agencies call upon the Government of Ontario to ensure Indigenous representation on all local Boards of Health.

AND FURTHER THAT Indigenous representatives be verifiably Indigenous, grounded in community, with lived experience, from the territory in which they will represent on a Board of Health.

AND FURTHER THAT the Minister of Health and local Boards of Health be so advised.

[i] Hahmann T., & Kumar, M. (2022). *Unmet health care needs during the pandemic and resulting impacts among First Nations people living off reserve, Métis and Inuit*. *StatCan COVID-19: Data to Insights for a Better Canada*. (45-28-0001). Ottawa, Canada: Statistics Canada. https://www150.statcan.gc.ca/n1/pub/45-28-0001/2022001/article/00008-eng.htm

[ii] Hahmann, T., Badets, N., & Hughes, J. (2019). *Indigenous people with disabilities in Canada: First Nations people living off reserve, Métis and Inuit aged 15 years and older*. (89-653-X2019005). Ottawa, Canada: Statistics Canada. https://www150.statcan.gc.ca/n1/pub/89-653-x/89-653-x2019005-eng.htm

[iii] Yangzom, K., Masoud, H., & Hahmann, T. (2023). Primary health care access among First Nations people living off reserve, Métis and Inuit, 2017 to 2020. Ottawa, Canada: Statistics Canada. https://www150.statcan.gc.ca/n1/en/pub/41-20-0002/412000022023005-eng.pdf?st=cahhYO9r

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

[v] Ontario Ministry of Health. *Ontario Public Health Standards: Requirements for Programs and Services*. 2021. Accessed March 27, 2025. https://files.ontario.ca/moh-ontario-public-health-standards-en-2021.pdf.

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Schedule 9.1

alPHa
Association of Local PUBLIC HEALTH Agencies

Allocation of Votes: alPHa Resolutions Revised 2025		
Health Unit	**Population**	**Voting Delegates**
TORONTO*	2,794,356	**20**
POPULATION 1,000,000 and OVER **		**8**
Ottawa	1,017,449	
Peel	1,451,022	
York	1,173,334	
POPULATION OVER 400,000		**7**
Durham	696,992	
Halton	596,637	
Hamilton	569,353	
Middlesex-London	500,563	
Niagara	477,941	
Simcoe-Muskoka	599,843	
South East****	558,292	
Waterloo	587,165	
Windsor Essex***	422,860	
POPULATION 300,001 – 400,000		**6**
Haliburton-Kawartha-Northumberland-Peterborough****	336,864	
Wellington-Dufferin-Guelph	307,283	
POPULATION 200,000 – 300,000		**5**
Eastern Ontario	210,276	
Grand Erie****	261,643	
Southwestern***	216,533	
Sudbury***	202,431	
POPULATION UNDER 200,000		**4**
Algoma	112,764	
Chatham-Kent	104,316	
Grey Bruce	174,301	
Huron Perth	142,931	
Lambton	128,154	
North Bay-Parry Sound	129,362	
Northeastern****	113,582	
Northwestern	77,338	
Renfrew	107,522	
Thunder Bay	152,885	

* total number of votes for Toronto endorsed by membership at 1998 Annual Conference
**new allocation category of population >1M endorsed by membership at 2023 Annual Conference
*** denotes health units that have moved into a different allocation category based on latest census data
****denotes new post-merger health units as of January 1, 2025
Health Unit population statistics taken from: Statistics Canada – 2021 Census Profiles – Sorted by Health Region

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Board of Health Briefing Note

To:	South East Health Unit Board of Health
Prepared by:	Susan Stewart, Director, Merger Office
Approved by:	Dr. Piotr Oglaza, Medical Officer of Health and CEO
Date:	Wednesday, May 28, 2025
Subject:	**Merger Update**
Nature of Board Engagement	☒ **For Information** ☐ Strategic Discussion ☐ Board approval and motion required ☐ Compliance with Accountability Framework ☐ Compliance with Program Standards
Action Required:	No action required.
Branding and Marketing	• The Executive and Operations Committees have worked with the branding and marketing project team, our Graphic Designers, and Scott Thornley and Company (STC) -- the consultants supporting the project -- to select potential options for South East Health Unit's (SEHU) brand identity. • The Board of Health and staff are invited to complete a survey that presents two options for our brand identity, including the inspiration behind each design, examples of how it may be applied, and the logo.
Organizational Culture	• On April 25, all senior leaders and managers for SEHU met for a Leadership Development Day to learn how to better support staff and to begin work on building a cohesive management team. Managers are also being asked about other supports they need to help them lead their teams. • Part of creating a new organization is establishing shared values and a desired culture. The Executive and Operations Committees worked with a consultant to draft a document outlining the values and elements of a shared culture. Input will be sought across the organization. Staff's thoughts and input will be collected during planned organizational events in May/June. • We are working to establish events to build a unified culture. These include events at the Smiths Falls, Brockville, Kingston and Belleville offices for the Executive Committee to meet and talk with staff. The focus will be on showcasing the strengths of each legacy organization. A Town Hall is planned for June 23 for all staff. This is an important opportunity for staff to ask questions directly to the leadership team. We are also planning an in-person event for all staff this fall.

	• We have created a Staff Engagement Project team who has completed a review of legacy events, training, and communications for all three legacy agencies. Next steps include validating, assessing and making recommendations for the South East Health Unit.
Finance	• We are working to harmonize our payroll work periods, payroll dates, and payroll systems. This is a necessary step to ensure consistency, efficiency, and compliance across our new organization. The timeline for this transition will be February or March of 2026. • Work is underway to finalize criteria for a Human Resources and Payroll system. Finance and Human Resources are collaborating on this.
Information Technology	• Legacy Leeds, Grenville and Lanark District Health Unit staff are now on Microsoft Teams. This allows all staff within the SEHU to be able to communicate more efficiently. • The timeline to have all SEHU staff on the same Microsoft platform (with common email addresses) is later in 2025.

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Board of Health Briefing Note

To:	South East Health Unit Board of Health
Prepared by:	Susan Stewart, Director, Merger Office
Approved by:	Dr. Piotr Oglaza, Medical Officer of Health and CEO
Date:	Wednesday, May 28, 2025
Subject:	**Change Readiness Assessment Results**
Nature of Board Engagement	☒ **For Information** ☐ Strategic Discussion ☐ Board approval and motion required ☐ Compliance with Accountability Framework ☐ Compliance with Program Standards
Action Required:	No action required.
Background and Current Status	Change can be challenging. Effective change management ensures a smooth transition by identifying key areas of support and addressing organizational concerns. As part of our commitment to a successful public health merger, a Change Readiness Assessment will be completed by staff each quarter. The Change Readiness Assessment measures five key dimensions critical to successful change in a public health merger: commitment, clarity, culture, capacity, and sustainment. The results of this survey will be used to assess how we, as an organization, can support everyone in the merger implementation journey. The baseline Change Readiness Survey was completed at the end of March. During the two-week time period that the survey was open, 140 staff completed the assessment (response rate = 30%). The results indicate that overall readiness score is moderate (3.4/5) and the lowest scores are in the sustainment dimension. The baseline results are in line with what was expected, given the current point in the merger and work that is underway to define the current state. The results of the Change Readiness Assessment have been shared with South East Health Unit leadership and will be shared with all staff. The Merger Office is drafting an action plan in collaboration with leadership to address the baseline results and ensure activities are in place to improve change readiness scores. The action plan will be shared with staff. The Change Readiness Assessment will be repeated at the end of June.

Schedule 9.2

Report on Baseline South East Health Unit Change Readiness Assessment Results

Background

As part of our commitment to a successful public health merger, SEHU has adopted a Change Readiness Assessment to identify key areas of support and concern related to change management. The Change Readiness Assessment measures five key dimensions critical to successful change in a public health merger: commitment, clarity, culture, capacity, and sustainment. The Change Readiness Assessment will be completed quarterly by all staff.

Methods

An invitation to complete the first Change Readiness Assessment was sent to all SEHU staff at the end of March in a Merger Memo newsletter with follow-up reminders sent at each legacy organization using existing channels. The survey was open for two weeks. Medallia (an online survey tool) was used for staff to complete the Change Readiness Assessment. Quantitative data were summarized by Knowledge Management staff at SEHU, and Sense & Nous provided support for thematic analysis of qualitative data.

Results

A total of 140 staff completed the assessment (response rate = 30%). Results are provided below for all SEHU staff across each dimension.

The results indicate that the overall readiness score is moderate (3.4/5) and the lowest scores are in the sustainment dimension.

Dimension	Description	Average Score (out of 5)
Commitment	visibly committed senior leaders, a clear vision	3.6
Clarity	clear reasons for merging, process for decision-making, accessible communication channels	3.6
Culture	well-defined principles for the merger, staff feel accountable to contribute to successful merger, SEHU will provide improved public health services to communities	3.6
Capacity	staff can acquire competencies for effective merged operations, access to appropriate infrastructure, feeling of being appropriately supported	3.5
Sustainment	policies and protocols in place, follow-up to address any shortfall, clear plan to track merger's impact	2.9

Themes from Qualitative Data

Staff also shared comments that provide additional insight into change readiness and can be used to inform the Action Plan. Main themes identified in the qualitative data were:

- Specific actions all levels of staff can take to demonstrate commitment to the merger (clear vision, well-defined organizational structure, communication, involvement, collaboration)
- Additional information or communication to clarify merger purpose and process (clear goals, decision-making transparency, organizational structure, communications)
- Suggestions to create a cohesive culture (relationship-building and collaboration, culture-building, shared values, training, unified branding, team charters)
- Additional resources that could support staff and teams to adapt to the merged environment (technology, file sharing, meeting space, support available when new tools are introduced)
- Suggestions to ensure the merger benefits for the community and staff are fully realized and sustained over the long term (definition of success, continued investments)

Discussion and Recommendations

The baseline results are in line with what was expected, given the current point in the merger and uncertainty for staff while the organizational structure continues to be developed.

Repeating the Change Readiness Assessment each quarter will allow leadership to monitor readiness scores and trends, and to identify where more initiatives are required.

The Merger Office is working collaboratively with leadership to review the baseline results and develop an action plan to work towards an improved state of change readiness. The action plan will be shared with staff.

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Listing of Information Items
Board of Health Meeting – May 28, 2025

1. Sudbury & Districts Public Health – Letter to Sylvia Jones and Kamal Khera re Support for a provincial immunization registry dated March 21, 2025
2. Sudbury & Districts Public Health – Letter to Sylvia Jones and Kamal Khera re endorsement of the Walport Report, and for continued focus on public health emergency and pandemic preparedness dated March 21, 2025
3. Windsor-Essex County Health Unit – Recommendation/Resolution Report – Intimate partner/gender based violence dated December 5, 2024
4. Community Foundation for Kingston & Area – Email to Kingston, Frontenac and Lennox and Addington Public Health re community grants program award re Dental treatment assistance fund dated May 6, 2025
5. Association of Local Public Health Agencies (alPHa) – InfoBreak for April 2025
6. Association of Local Public Health Agencies (alPHa) – InfoBreak for May 2025

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179 North Park St.
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221 Portsmouth Ave.
Kingston, Ontario K7M 1V5
613-549-1232 | 1-800-267-7875
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Leeds, Grenville & Lanark District Health Unit
458 Laurier Blvd.
Brockville, Ontario K6V 7A3
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