

Board of Health Meeting

Agenda Package

Wednesday, December 17, 2025
10:00 a.m.
221 Portsmouth Avenue, Kingston

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Board of Health Agenda

Wednesday, December 17, 2025

10:00 a.m.

221 Portsmouth Avenue, Kingston

1. **Call to order**

2. **Land acknowledgement**

Southeast Public Health 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 and 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 December 17, 2025, as amended:

- Deputation Requests
 - Current position: Item 9.1 under New Business.
 - Amended position: moved to immediately follow *Disclosure of Pecuniary Interest and/or Conflict of Interest* and renumbered as Item 7, with sub-items 7.1–7.4.
- Rural Services Delivery Strategy Presentation and Branch Office Report
 - Current position: Item 8 (after Committee Reports).
 - Amended position: moved to immediately follow *Deputation Requests*, remaining as Item 8, with Committee Reports to follow (renumbered Item 9).

Notes:

- All subsequent agenda items will be renumbered sequentially.
- This amendment affects only the order of items, in accordance with By-Law No. 1, and does not alter the content of any agenda item.

5. **Approval of previous meeting minutes**

[Schedule 5](#)

MOTION: THAT the Board of Health approve the minutes of the meeting held on November 26, 2025, as circulated.

6. **Disclosure of pecuniary interest and/or conflict of interest, and the general nature thereof when the item arises**

7. Committee reports

7.1. Governance Committee Update (Mayor R. Jones)

[Schedule 7.1](#)

7.1.1. BOH Self-Evaluation Results Summary

[Schedule 7.1.1](#)

7.1.2. Amendment Listing

[Schedule 7.1.2](#)

7.1.3. By-Law No. 1

[Schedule 7.1.3](#)

MOTION: THAT the Board of Health approve the BOH Self-Evaluation Results Summary, Amendment Listing, and By-Law No. 1, as circulated.

8. Staff presentations/reports (Dr. P. Oglaza)

8.1. Rural Services Delivery Strategy Presentation

[Schedule 8.1](#)

MOTION: THAT the Board of Health receive the Rural Strategy Presentation and endorse, in principle, the direction outlined therein.

8.2. Branch Office Report

[Schedule 8.2](#)

MOTION: THAT the Board of Health receive the Branch Office Report and endorse **Option ___** as outlined in the report, as follows:

Option 1: Endorse staff recommendation to close branch office locations in Almonte, Cloyne, Gananoque, Napanee, Perth, Kemptville, and Trenton by March 1, 2026, provided that continued access to public health services is maintained. In June 2026 present BOH an evaluation report assessing the implemented change in the service delivery model.

Option 2: Continue to have branch offices and revisit the decision in June 2026 following a review of an updated report on the rural strategy implementation and use of the branch offices.

Option 3: Keep branch offices and find savings and efficiencies elsewhere to balance 2027 budget and beyond.

9. New business

9.1. Deputation Requests

9.1.1. United Counties of Leeds and Grenville (Warden Corrina Smith-Gatcke)

[Schedule 9.1.1](#)

9.1.2. Prince Edward Family Health Team (Mr. Barinder Gill, Executive Director)

[Schedule 9.1.2](#)

9.1.3. Prince Edward County (Councillor Kate MacNaughton)

[Schedule 9.1.3](#)

9.1.4. Kemptville District Hospital (Mr. Frank Vassallo, President & CEO)

[Schedule 9.1.4](#)

9.2. Merger Updates

[Schedule 9.2](#)

MOTION: THAT the Board of Health receive the merger update report, as circulated.

10. **Information items**

[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.

Board of Health Minutes

Open Session

Date: Wednesday, November 26, 2025

Time: 10:00 a.m.

Location: Kingston Office and via MS Teams

In-person: Mr. Stephen Bird, Councillor Conny Glenn, Councillor Judy Greenwood-Speers, Mayor Robin Jones, Councillor Sean Kelly, Councillor Anne-Marie Koiner, Councillor Michael Kotsovos, Councillor Peter McKenna, Mayor Jan O'Neill, Ms. Barbara Proctor, Councillor Bill Roberts, Warden Nathan Townend.

Virtual: Dr. Jeffrey Allin, Reeve Richard Kidd, Ms. Melanie Paradis.

Regrets: Councillor Jeff McLaren, Dr. David Pattenden, Mr. Chris Seeley.

Officer: Dr. Piotr Oglaza

1. **Call to order**

The meeting was called to order by Chair J. O'Neill at 10:00 a.m.

2. **Land acknowledgement**

Spoken by Chair J. O'Neill.

3. **Roll call**

Conducted by Recorder K. Thompson.

4. **Approval of the agenda**

MOTION: It was MOVED by Mayor R. Jones and SECONDED by M. Paradis THAT the Board of Health approve the agenda for November 26, 2025, with Information Item 9.1 – Leased Office Locations reordered as Item 7.

CARRIED

Amendment (Not Carried): A motion to add a closed session regarding Section 239(2) of the Municipal Act (personal matters about an identifiable individual, including Board employees) was **DEFEATED**.

5. **Approval of previous meeting minutes**

MOTION: It was MOVED by Councillor P. McKenna and SECONDED by Warden N. Townend THAT the Board of Health approve the minutes of the meeting held on October 22, 2025, as circulated.

CARRIED

- **Clarification:** Harmonization Funding distribution (Appendix 4) was explained by Dr. P. Oglaza; municipalities will determine allocation.
- **Appreciation:** Board acknowledged Finance staff for their work.

6. **Disclosure of pecuniary interest and/or conflict of interest, and the general nature thereof when the item arises**

No conflicts or pecuniary interests declared.

7. **Leased Office Locations**

This item was moved up on the agenda from Information Item 9.1 to follow the approval of the minutes.

At its April 23, 2025 meeting, the Board of Health requested a review of Southeast Public Health (SEPH) office locations, service usage, and occupancy costs to identify opportunities to reduce costs, increase capacity, and improve organizational performance. The assessment identified underutilized offices incurring operational costs that exceeded service output, highlighting the need to optimize resources while maintaining accessible, high-quality public health services, particularly in rural communities.

Board members expressed concerns regarding the communication and consultation process preceding the announcement of office closures. Members emphasized the importance of:

- Transparency and maintaining public trust;
- Establishing clear evaluation criteria for decision-making;
- Minimizing impacts on staff and service delivery;
- Ensuring ongoing access to public health services, particularly in rural areas.

While acknowledging that closures may be necessary for financial sustainability, members stressed the need to step back and review criteria and impacts before any decisions are finalized.

MOTION: It was MOVED by Mayor R. Jones and SECONDED by Councillor B. Roberts THAT the Medical Officer of Health/Chief Executive Officer reconsider closing leased offices at this time;

AND THAT a staff report outlining the criteria used in assessing office closures, along with further discussion on this matter, be brought forward to the December 17, 2025, Board of Health meeting.

CARRIED

Follow-Up Staff Report:

The staff report will include:

- Evaluation criteria for office closures
- Financial implications

- Accessibility and service delivery considerations
- Timeline for revisiting decisions
- Board input on priorities and policy

The report will inform discussion at the December meeting and ensure that any future decisions regarding leased office locations are transparent, evidence-based, and responsive to community needs.

8. Committee reports

8.1. Finance Committee Update

Councillor A. Koiner reported that the Finance Committee reviewed the 2024 financial statements for the Dental Treatment Assistance Fund (DTAF) and the Charitable Organization Trust Fund. The Committee recommended that it assume trustee responsibilities, together with designated staff, as the most effective approach for oversight and administration of these funds. It was agreed that the Finance Committee, as appointed by the Board under its terms of reference, would provide consistent oversight.

MOTION: It was MOVED by Warden N. Townend and SECONDED by Councillor P. McKenna THAT the Board of Health approve that, going forward, oversight of the Dental Treatment Assistance Fund and the Charitable Organization Trust Fund be provided by the Finance Committee and agency officers, and that both Finance Committee members and agency officers be appointed as Trustees.

CARRIED

8.2. Governance Committee Update

8.2.1. BOH Deputation Request Policy & Form

8.2.2. MOH Evaluation Policy

Mayor R. Jones reported on the Governance Committee review of the BOH Deputation Request Policy & Form and the MOH Evaluation Policy. The Committee recommended approval to ensure accountability, transparency, and effective governance.

MOTION: It was MOVED by Mayor R. Jones and SECONDED by Councillor B. Roberts THAT the Board of Health approve the BOH Deputation Request Policy and Form and the MOH Evaluation Policy.

CARRIED

8.2.3. ALIGN Interviews

The Board was provided with information regarding the upcoming ALIGN Governance Training interviews. Board members were encouraged to submit their preferred interview dates and times directly to Ms. Angela Freeman. These 30–60 minute sessions are

intended to gather information to tailor governance training to the needs of the newly merged Board. Feedback will inform the design and delivery of future governance training.

9. **New business**

9.1. **Cloyne Branch Office**

The Board of Health discussed the proposed sale of the Southeast Public Health branch office located at 14209 Highway 41 in Cloyne, Ontario. Staff provided context from a comprehensive operational review, noting that the Cloyne office is underutilized and that changes in community needs and service delivery have reduced demand for in-person clinical services. Public health programs and services are increasingly offered digitally, virtually, and through community partnerships, including:

- Home visiting programs (Healthy Babies, Healthy Children; Nurse Family Partnership)
- Prenatal and parenting programs (online and in-person)
- School-based immunization clinics (e.g., Hepatitis B, HPV, Meningococcal)
- Virtual sexual health testing
- Dental screening in schools
- Mobile immunization and dental clinics in partner locations
- School health supports and educator resources
- Environmental health inspections and services
- Communicable disease case and contact management
- Harm reduction resources in partner locations
- Health promotion communications via website and social media

Staff advised that all permanent Cloyne office employees will be reassigned to the Kingston office and that the closure will save approximately \$15,500 annually in building, operational and maintenance costs. The closure will not impact the delivery of programs or public health services in the area.

Board members discussed the process for declaring the property surplus and obtaining consent from the majority of the municipalities under section 52(4) of the Health Protection and Promotion Act. Members also emphasized the importance of local consultation and public communication.

Following discussion, a motion to defer consideration of the sale until the review of the leased office locations is complete was recommended to ensure alignment with other ongoing operational decisions and municipal

consultations.

Staff confirmed that deferral would allow additional municipal consultation, and that no substantial financial implications were anticipated due to the delay. The Board acknowledged the operational benefits and cost savings of the Cloyne office closure while supporting further due diligence before approving the sale.

Original Motion (for reference):

MOTION: THAT the Board of Health supports the staff recommendation regarding the property sale of Southeast Public Health's branch office located at 14209 Highway 41 in Cloyne, Ontario;

AND THAT the Board of Health declare the property as surplus;

AND FURTHER THAT the Board of Health obtain the consent to sell the property from councils of municipalities represented on the Board of Health.

DEFERRED

Substitute Motion:

MOTION: It was MOVED by Reeve R. Kidd and SECONDED by Warden N. Townend THAT the Board of Health defer consideration of the sale of the Southeast Public Health branch office at 14209 Highway 41, Cloyne, Ontario, until the report on the leased office locations has been received.

CARRIED

9.2. Merger Updates

The Board of Health received the merger update report. During discussion, a member noted progress on branding but raised concerns about remaining outdated signage in the community and requested timelines for completion. The member also observed that the latest Change Readiness Assessment shows improvement in most areas but that the sustainment score remains low, indicating the need for a clearer plan and supporting measures.

MOTION: It was MOVED by Councillor C. Glenn and SECONDED by Councillor A. Koiner THAT the Board of Health receive the merger update report, as circulated.

CARRIED

9.3. 2026 Meeting Schedule

MOTION: It was MOVED by Mayor R. Jones and SECONDED by Councillor P. McKenna THAT the Board of Health approve the 2026 meeting schedule, as circulated.

CARRIED

10. Information items

The Board received the information items, with item 9.1 addressed earlier.

Discussion included gender-based violence (GBV) prevention, domestic violence awareness, equity-focused public health initiatives, and community partnerships. Members were informed that Southeast Public Health, in collaboration with Thunder Bay District Public Health Unit and Lakehead University, has developed a new framework to guide local efforts in preventing GBV and promoting health equity, with awareness activities underway including presentations, media releases, and outreach to community partners.

Questions regarding the process for issuing a Board of Health update to the media, particularly in relation to Item 7 – Leased Office Closures, were clarified to ensure the communication is timely.

MOTION: It was MOVED by Councillor C. Glenn and SECONDED by Councillor A. Koiner THAT the Board of Health receive the information items 9.2 to 9.6, as circulated.

CARRIED

11. Adjournment

MOTION: It was MOVED by Warden N. Townend and SECONDED by Councillor C. Glenn THAT the Board of Health meeting be adjourned at 11:16 a.m.

CARRIED

Memo

To: Board of Health Members
From: Dr. Piotr Oglaza, Medical Officer of Health/CEO
Reviewed by: Governance Committee Chair
Date: December 17, 2025
Re: Governance Committee Update for the Board of Health

Issue:

The Governance Committee has reviewed the BOH Self-Evaluation results and has prepared a summary for the Board's review and approval. (Appendix #1) Also being recommended for approval are the Amendment Listing and updates to By-Law No. 1 (Appendix #2).

Background:

As outlined in the Governance Committee's terms of reference, the Committee's responsibilities include:

- Conduct a Board self-evaluation and make recommendations for improvement on Board effectiveness and engagement every two years.
- Review of Board policies, by-laws and Committee terms of reference every two years to ensure appropriate structures and procedures are in place and make recommendations to the Board for approval.

Current Status:

The Governance Committee met on December 9, 2025 to review the BOH Self-Evaluation summary and recommend changes to By-Law No. 1. It is being recommended that the regular Board of Health meeting commence at 10:30 a.m., with the closed session beginning at 10:00 a.m.

Rationale:

- A BOH Self-Evaluation is conducted to identify the Board's strengths and identify areas for growth.
- Review of Board By-Laws is done to improve operational efficiency and transparency.

Supporting Documents:

Attached for review and approval are:
Appendix #1 BOH Self-Evaluation Summary
Appendix #2 Amendment Listing
Appendix #3 By-Law No. 1

Recommendation:

THAT the Board of Health approve the BOH Self-Evaluation Summary, Amendment Listing and By-Law No. 1 as circulated.

BOH Self-Evaluation Results Summary

The results of the BOH Self-Evaluation were generally positive with good feedback on elements previously identified as not yet completed. Some responses stated disagree given some elements have not yet been completed for the organization. By and large the Board has awareness of their role and responsibilities and there have been requests for some resources in a format that is user friendly.

Governance Committee members reviewed the BOH self-evaluation results and identified the following areas for follow-up:

Board Roles and Responsibilities

The Board is adequately prepared to oversee an emergency situation.

In the Ontario Public Health Standards' Public Health Accountability Framework, Boards of Health must ensure that the administration monitors and responds to emerging issues and potential threats to the organization, from both internal and external sources, in a timely and effective manner. In accordance with the agency's Risk Intelligence Policy, developed by the SEPH Board of Health on June 25, 2025, an Annual Risk Report is prepared by staff and all significant risks facing the Health Unit shall be assessed and appropriate mitigation strategies identified (prevention, early detection, recovery/corrective) and reviewed annually by the Board of Health.

SEPH will develop an emergency response plan as part of its operations, which guides its actions during a public health emergency.

Board Decision-Making

The Board has appropriate input into the development of the agenda.

According to By-law No. 1 an agenda shall be drafted by the Secretary-Treasurer in consultation with and approved by the Chair of the Board. Both the Finance and Governance Committee's bring forward items to add to the Board agenda for approval.

The Board uses sound decision-making processes.

The Board follows Roberts' Rules of Order which guides decision-making through a structured process that ensures fairness and efficiency. Members propose formal motions which are then debated and voted on.

Meetings

Meetings are structured so there is sufficient time for discussion of decision items.

The agendas are structured to identify items for information and those that require a decision/motion. Given there are some topics that require more discussion than others the following recommendations were made: putting a time restriction on discussion items, adhering to the one speaker one time rule, or deferring the item to another meeting.

Board Relations

Board members assist in developing and maintaining positive relations with key stakeholders.

For clarity, key stakeholders are identified as member municipalities. Board members advise municipal councils on public health issues and act as a link between public health and municipalities.

Board members are active in promoting a positive image of the agency in the community.

It is important for board members to participate in community events, keep connected with stakeholders, and provide updates on health information that is within public health's scope. Key messages will be developed for board members on public health's role to ensure consistent messaging. These key messages will be added to the Board of Health Orientation Binder.

Planning and Priorities

The Board is familiar with the organization's annual budget planning process and is clear with its role.

The Board of Health's role in the annual budget planning process is strategic oversight and ensuring sufficient resources are available for programs and services under the OPHS. As outlined in the OPHS, the Board of Health shall submit an Annual Service Plan and Budget Submission to include all programs and services delivered by the Board of Health and program costing for ministry-funded programs. It is important to speak about the budget using clear language with straightforward terms and concepts and a standardized SEPH Memo template has been developed for the Board to ensure consistent messaging.

The Board ensures the agency's strategic plan is being implemented.

The Board ensures the agency's strategic plan is considered when making Board decisions.

The amalgamation/merger of the three health unit's is being considered as the strategic plan for 2025-2026. A memo regarding the timeline for the strategic plan will go to the Board in the interim.

Organization Mission, Values and Strategic Plan

Governance Committee members are recommending that all questions in this category (1-10) be discussed further and that the strategic plan, mission and vision be added to a future Board agenda.

Category – Community Engagement

The role of the organization is well known in our community.

With the new branding of SEPH, subsequent media releases and ongoing engagement by staff in the community, the role of the organization is growing and is a work in progress. Strategic priorities will be part of future strategic planning discussions.

Our community is aware of the programs and services provided by the organization.

Much work is underway to promote awareness of our programs and services such as ongoing media releases to municipal stakeholders, regular local radio interviews providing updates on programming, TV interviews on salient issues, newspaper ads in local papers, the launch of our new SEPH website, and regular interaction with municipal partners.

Board members are well equipped to speak publicly about the role of Public Health and the programs and services it provides.

A key messages document outlining the role of public health is being developed to ensure consistent messaging. The Medical Officer of Health/CEO is available to provide additional support when needed.

Engagement with municipalities is a priority and the organization currently engages with municipalities in a satisfactory way.

The development of key messages for board members to give at Council meetings is being recommended as one strategy of engagement as part of normal routine or when required.

Additional Comments

Advocacy for value of the role of Public Health in communities.

- Public health funding is a preventative investment that saves money by reducing the need for acute care

Consultation with community regarding funding.

- Members of the SEPH finance team and the Medical Officer of Health/CEO are working with municipalities regarding municipal levy contributions and present to municipal councils when requested.

POLICY/BY-LAW/TERMS OF REFERENCE AMENDMENT LIST FOR THE BOARD OF HEALTH			
Meeting	Document	Amendment	BOH Meeting
March 25, 2025 Governance	Governance Committee Terms of Reference and Finance Committee Terms of Reference	Addition of Vice Chair to the Governance and Finance Committees Terms of Reference (Appendix #1 and #2)	June 25, 2025
Executive Assistants Recommendation	By-law No. 1 – Conduct of the Affairs	<ul style="list-style-type: none"> • Page 10 – numbering • Page 13 – Item 32 changed signed minutes to approved minutes • Page 13 – Item 34 changed to reflect agenda items – order of Closed Session moved to after Information Items • Page 19 and 20 – Update titles to reflect type of vacancy (Appendix #3) 	June 25, 2025
July 8, 2025 Governance	By-law No. 1 – Conduct of the Affairs	<ul style="list-style-type: none"> • Page 12 Section 31 - An item must be ruled time sensitive by the Chair and must receive 2/3 majority consent by the members present to introduce additional business. 	December 17, 2025
September 9, 2025 Governance	By-law No. 1 – Conduct of the Affairs	<ul style="list-style-type: none"> • Page 14 Section 34 - Addition of Notice of Motion and Announcements as standing agenda items. 	December 17, 2025
October 7, 2025	By-law No. 1 – Name change from SEHU to SEPH	<ul style="list-style-type: none"> • Name change from South East Health Unit (legal name) to Southeast Public Health (operational name) throughout document 	December 17, 2025
December 9, 2025	By-law No. 1 – Closed session to be held from 10:00 a.m. – 10:30 a.m. with open session to follow.	<ul style="list-style-type: none"> • Page 13 Section 34 – Move closed session to beginning of meeting. 	December 17, 2025

**BOARD OF HEALTH
FOR SOUTHEAST PUBLIC HEALTH**

BY-LAW NO. 1 – CONDUCT OF THE AFFAIRS

A by-law relating generally to the conduct of the affairs of the Board of Health for the **SOUTHEAST HEALTH UNIT PUBLIC HEALTH** including, but not limited to, the calling and proceedings at meetings.

BE IT ENACTED as a by-Law of the Board of Health for ~~South-East~~Southeast Health-UnitPublic Health as follows:

1. Interpretation

In this by-law and all other by-laws of the Board of Health for ~~the~~ ~~South-East~~ Public Health Unit, unless the context otherwise specifies or requires:

- a) “Act” means the *Health Protection and Promotion Act*, R.S.O. 1990, c. H.7, as amended;
- b) “Agency” means ~~the~~ ~~South-e~~East Public Health-Unit;
- c) “Agreement” means the agreement between the County of Addington, the City of Belleville, the City of Brockville, the County of Frontenac, the Town of Gananoque, the United Counties of Leeds and Grenville, the County of Hastings, the City of Kingston, the County of Lanark, the County of Lennox, the Town of Prescott, the City of Quinte West, the Corporation of the County of Prince Edward, and the Town of Smiths Falls and the Board of Health under the Act;
- d) “Board” means the Board of Health for ~~the~~ ~~South-E~~east Public Health-Unit.
- e) “By-law” means the by-laws of the Board of Health for ~~the~~ ~~South-E~~east Public Health Unit in force and effect;
- f) “Chair” means the Chair of the Board elected under this by-law or any person presiding at the meetings of the Board and shall include a Presiding Officer;
- g) “Committee” means a Committee of the Board, but does not include the Committee of a Whole;
- h) “Committee of a Whole” means all the members present at a meeting of the Board sitting in Committee;
- i) “Council” means the Council of any Municipality or County which is a party to the Agreement;
- j) “Meeting” means a meeting of the Board;
- k) “Member” means a member of the Board;
- l) “Municipal Act” means the *Municipal Act*, 2001, S.O. 2001, c. 25, as amended;
- m) “Regulations” means the regulations made under the Act, as from time to time amended, and every regulation that may be substituted therefore and, in the case of such substitution, any references in the by-laws of the Board of Health for ~~the~~

~~South East~~Southeast Public Health ~~Unit~~ to provisions of the regulations shall be read as references to the substituted provisions therefore in the new regulations;

- n) "Secretary-Treasurer" means the Medical Officer of Health or their designate;
- o) All terms which are contained in the by-laws, and which are defined in the Act or the regulations, shall have the meanings respectively given to such terms in the Act or the regulations;
- p) Words importing the singular number only shall include the plural and vice versa and words importing a specific gender shall include all other genders;
- q) The headings used in the by-laws are inserted for reference purposes only and are not to be considered or taken into account in construing the terms or provisions thereof or to be deemed in any way to clarify, modify or explain the effect of any such terms or provisions; and
- r) The *Corporations Information Act* does not apply to the Board of Health. Except as prescribed, the *Not-for-Profit Corporations Act, 2010* does not apply to the Board of Health.

2. Designation of Head

As required by the *Municipal Freedom of Information and Protection of Privacy Act*, R.S.O. 1990, C. M.56 ("MFIPPA"), as amended, the Board thereby designates the Chair of the Board as the Head of ~~South-e~~East ~~Public Health Unit~~ for the purposes of the MFIPPA. The Chair of the Board shall provide for all other institutional requirements regarding access and privacy as set out in the *Municipal Freedom of Information and Protection of Privacy Act* and the *Personal Health Information and Protection Act* ("PHIPA").

MEMBERSHIP

3. Duty of Board of Health

Every board of health shall oversee, provide or ensure the provision of the health programs and services required by the Act and the regulations made thereunder, including but not limited to the Ontario Public Health Standards published from time to time to the persons who reside in the health unit served by the Board, and shall perform such other functions as are required by or under the Act or any other applicable legislation.

4. Numbers

The membership of the Board shall be as follows:

- i. One (1) member to be appointed by the Municipal Council of the City of Belleville;
- ii. Two (2) members to be appointed jointly by the Municipal Councils; of the City of Brockville, and Towns of Gananoque, Prescott and Smiths Falls;
- iii. One (1) member to be appointed by the Frontenac County;
- iv. One (1) member to be appointed by the Municipal Council of the County of Hastings;
- v. Two (2) members to be appointed by the Municipal Council of the City of Kingston;

- vi. One (1) member to be appointed by the Municipal Council of the County of Lanark;
- vii. One (1) member to be appointed by the Municipal Council of the United Counties of Leeds and Grenville;
- viii. One (1) member to be appointed by the Municipal Council of the County of Lennox and Addington;
- ix. One (1) member to be appointed by the Municipal Council of The Corporation of the County of Prince Edward;
- x. One (1) member to be appointed by the Municipal Council of the City of Quinte West;
- xi. The Lieutenant Governor in Council can appoint one less than the total number of municipal appointees as provided for in the Act.

5. Ex-Officio Members

The Medical Officer of Health/Chief Executive Officer (“MOH/CEO”) is an ex-officio member of the Board.

6. Secretary-Treasurer

The MOH/CEO shall be duly appointed as Secretary-Treasurer of the Board.

ATTENDANCE FOR THE BOARD OF HEALTH MEETINGS

7. Attendance

Members are required to attend all Board meetings. The MOH/CEO or designate, shall attend all meetings of the Board except on matters that relate to their remuneration or the performance of their respective duties.

8. Directors

Senior staff of ~~the South-East~~ [Public Health Unit](#) shall be present at regular Board meetings, as required, to discuss agenda items related to their area(s) of responsibility.

9. Recording Secretary

The Executive Assistant to the MOH/CEO shall be the Recording Secretary of Board meetings.

10. Unexcused Absences

Unexcused absences of a member from three (3) consecutive Board meetings in a calendar year shall mean that the appointing Municipal Council shall be so notified, in writing, by the Chair of the Board of the said absences and of the Board's request that the appointing Municipal Council review the member's appointment, and a copy of the letter sent to the absentee Board member.

11. Leave of Absence

The Board may, upon receipt of a written request, extend to any Board member a leave of absence for a definitive period of time. During any Board approved leave of absence, paragraph 10, “Unexcused Absences”, shall not apply.

BOARD MEMBERS

12. Remuneration - Expenses

The remuneration of Board members shall be in accordance with the Act. The Board shall pay the reasonable and actual expenses of each member of the Board in accordance with the Act and the policies of ~~the South-eEast~~ Public Health Unit.

13. Term of Office

The term of office of a municipal member of the Board continues during the pleasure of the Council that appointed the municipal member, unless ended sooner, ends with the ending of the term of office of the Council.

The term of office of a provincial appointee of the Board continues for the duration of the appointment as outlined by the Lieutenant Governor’s appointment notification.

14. Disqualification

The seat of a municipal member of the Board becomes vacant for the same reasons that the seat of a member of council becomes vacant under subsection 259(1) of the *Municipal Act*, 2001, as amended. Regardless of whether the member is municipally appointed or appointed by the Lieutenant Governor, no person whose services are employed by the Board is qualified to be a member of the Board.

15. Vacancy

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

16. Oath of Confidentiality

Every member of the Board is required to sign an Oath of Confidentiality agreeing to uphold the privacy of all confidential information, including but not limited to personal information and personal health information, that may come to their attention in the course of their being a member of the Board, whether or not such information arises inside or outside of meetings of the Board, arises in Closed Session, and regardless of what form the personal information and/or personal health information is received by the Board member.

MEETINGS OF THE BOARD

17. First Meetings of the Year

The Board shall hold its first meeting of the year not later than the last day of January.

18. Number of Meetings

Regular meetings of the Board shall be held at least eight (8) times annually on such a day, hour and place as the Board shall determine.

19. Notice for Ordinary Meetings

Members of the Board will be notified within seventy-two (72) hours of any ordinary meetings by email and board portal.

20. Special Meetings

Special meetings may be called by the Chair or, in their absence, the Vice Chair at any time that is deemed advisable and necessary or by a majority vote at any regular meeting at which quorum is present. The Secretary-Treasurer may call a meeting of the Board upon being petitioned, in writing, by a majority of the members to do so.

21. Notice for Special Meetings

Members of the Board will be notified within twenty-four (24) hours of any special meetings by email and board portal.

22. Omission of Notice

The accidental omission to give notice of any meeting of the Board to, or the non-receipt of any notice by, any person shall not invalidate any resolution passed or any proceeding taken at such meeting.

23. Adjournment

Any meeting of the Board may be adjourned from time to time by the Chair of the meeting, with the consent of the majority of those attending the meeting, to a fixed time and place. Notice of any adjourned meeting of the Board is not required to be given if the time and place of the adjourned meeting is announced at the original meeting. Any adjourned meeting shall be duly constituted if held in accordance with the terms of the adjournment and a quorum is present. The members who formed a quorum at the original meeting are not required to form the quorum at the adjourned meeting. If there is no quorum present at the adjourned meeting, the original meeting shall be deemed to have terminated forthwith after its adjournment. Any business may be brought before or dealt with at any adjourned meeting which might have been brought before or dealt with at the original meeting in accordance with the notice calling the same.

24. Quorum

Fifty (50%) per cent plus one (1) of the members of the Board fixed under section 4, hereof, shall form a quorum for the transaction of business and, notwithstanding any vacancy among the Board members, a quorum of Board members may exercise all the powers of the Board. No business shall be transacted at a meeting of the Board unless a quorum of the Board members is present.

The appointed hour having been struck and a quorum being present, the Chair shall call the meeting to order. If, fifteen minutes after the appointed hour have elapsed and the

Chair or the Vice Chair, as the case may be, has not yet appeared and a quorum is present, the members may appoint one of themselves or the Secretary-Treasurer to chair the meeting until the arrival of the Chair or Vice Chair. If thirty (30) minutes after the appointed hour, a quorum is not present, then the meeting shall stand adjourned until the next regular meeting, an adjourned meeting, or a newly scheduled meeting. The Recording Secretary shall record the names of all members present and not present at the meeting.

25. Electronic Participation

Members of the Board may participate by means of such telephonic, electronic or other communication facilities as permits all persons participating in the meeting to communicate with each other simultaneously and instantaneously, and a Board member participating in such meeting by such means is deemed for the purpose of the Municipal Act to be present at that meeting, counted in quorum and in voting. [MA 238(3.1)]

26. Voting

Questions arising at any meeting of the Board members shall be decided by a majority vote evidenced by a show of hands. The Chair and each Board member present, where not otherwise disqualified from voting, shall vote on all questions.

In the case of a tie vote, the vote will be lost.

27. Recorded Vote

Any member may request a recorded vote and each member present, and not disqualified from voting by virtue of any legislation or declared conflict of interest, must then announce their vote.

To abstain or fail to vote under such circumstances is deemed to be a negative vote. When a recorded vote is requested, the names of those voted for and those who voted against the question shall be called and entered upon the minutes in alphabetical order. Votes will be counted by the Treasurer-Secretary and (1) scrutineer. When a question is put and “carried” without a dissent or a call for a recorded vote, then the matter will be deemed to be carried unanimously by those present.

DECLARATION OF PECUNIARY INTEREST; CONFLICT OF INTEREST

28. Declaration of Pecuniary Interest

Where a Board member, either on their own behalf or while acting for, by, with or through another, has any pecuniary interest direct or indirect in any matter and is present at a meeting of the Board at which the matter is the subject of consideration, the member,

- a) shall, prior to any consideration of the matter at the meeting disclose the interest and the general nature thereof;

- b) shall not be present or take part in the discussion of, or vote on any question in respect of the matter; and
- c) shall not attempt in any way, whether before, during or after the meeting, to influence the voting on any such question.

Where the meeting referred to above is not open to the public, in addition to complying with the requirements set forth above, the member shall forthwith leave the meeting or the part of the meeting during which the matter is under consideration.

Where the interest of a member has not been disclosed as required by reason of the absence from the meeting referred to therein, the member shall disclose the interest and otherwise comply with the requirements first set forth above at the first meeting of the Board attended by the member thereafter.

Every declaration of interest and the general nature thereof made by a Board member shall, where the meeting is open to the public, be recorded in the minutes of the meeting by the Recording Secretary. Where the meeting is not open to the public, every declaration of interest made by a Board member, but not the general nature of that interest shall be recorded in the minutes of the next meeting that is open to the public.

29. Registry

The Board shall establish and maintain a registry in which it shall keep a copy of each statement filed and a copy of each declaration recorded pursuant to section 28. Access to the registry shall be available for public inspection in the manner and during the time that the Board may determine.

BOARD PACKAGES, AGENDA, MINUTES, AND REPORTS

30. Board Packages

The agenda, minutes of the previous meeting, and written reports are to be sent to Board members via electronic means 72 hours in advance of the scheduled meeting. The agenda and notice of the meeting are to be posted on ~~the~~ [Southeast Public Health's Unit's](#) website approximately one week prior to the meeting. Written reports will be made available to the public 48 hours ahead of the scheduled meeting, where possible, or at or after the Board meeting where such advance provision is not reasonably practicable.

31. Agendas

For all regular and special Board meetings, an agenda shall be drafted by the Secretary-Treasurer in consultation with and approved by the Chair of the Board. If for any reason copies of the agenda shall not have reached members before the meeting, the member(s) will advise of such and the agenda shall be provided by the Secretary-Treasurer at the opening of the meeting.

Any member wishing to introduce business additional to that set out in the agenda must make the request during the "Approval of Agenda" portion of the agenda, it must be ruled time sensitive by the Chair and must receive 2/3 majority consent and must receive unanimous consent by the members present to introduce additional business. If unanimousthis

consent is not obtained, the member may give notice of motion to discuss the business at the next regularly scheduled meeting of the Board. The motion must be seconded.

32. Minutes

The Recording Secretary records the minutes of the meeting and submits them to the Secretary-Treasurer for review. The minutes of the previous meeting shall be circulated to the Board approximately one week prior to the next regularly scheduled meeting. At the regularly scheduled meeting, a motion will be entertained to have the minutes approved and adopted as circulated or in the case of corrections, approved and adopted as amended with the amendments specifically stated.

If the minutes of the previous Board meeting were not circulated in advance, the Secretary- Treasurer shall read them, but no motion or discussion shall be allowed on the minutes except in regard to their accuracy. Any minutes that were not circulated in advance but read by the Secretary-Treasurer in accordance with this provision shall be placed on the agenda of the next meeting of the Board for the purposes of a motion for the adoption of such minutes, either as read or in the case of corrections, approved and adopted as amended with the amendments specifically stated.

After the confirmation and adoption of the minutes, they shall be signed by the Chair. The official approved minutes of the Board shall be posted by the Recording Secretary on the South e-East Public Health's Unit's website.

33. Reports

The MOH/CEO's report and any other specific reports noted on the Agenda are to be provided in writing to the Board 72 hours prior to the meeting. In some circumstances, a revised report, verbal report, or additional report may be forthcoming on a matter where the timing of such does not coincide with the preparation of the Board packages.

ORDER OF BUSINESS FOR REGULAR MEETINGS

34. Agenda

The agenda items shall include but not be limited to:

- a) Call to Order;
- b) Land Acknowledgement;
- c) Roll Call;
- d) Approval of Agenda - amendments or corrections of, adoption of;
- e) Approval of Minutes - amendments or corrections of, adoption of;
- f) Pecuniary Interest and/or Conflict of Interest, and the general nature thereof when the item arises;
- g) Closed Session – motion to go into Closed Session including a reason for the closed session in accordance with the Municipal Act; [MA239(2)]
- f)h) Rising and Reporting of Closed Session;
- g)j) Committee Reports;

- h)j) Staff Reports/Presentations;
- i)k) New Business;
- j)l) Information Items;
- m) Notice of Motion;
- k)n) Announcements;
- l) ~~Closed Session—motion to go into Closed Session, including a reason for the closed session in accordance with the Municipal Act;—{MA239(2)}~~
- m)o) Rising and Reporting of Closed Session; and
- n)p) Adjournment.

ORDER OF BUSINESS FOR SPECIAL MEETINGS

35. Drafting the Agenda

An agenda shall be drafted by the Secretary-Treasurer in consultation with and approved by the Chair of the Board.

36. Copies of the Agenda

If for any reason, copies of the agenda shall not have reached members before the meeting, the member(s) will advise of such and the agenda shall be provided by the Secretary-Treasurer at the opening of the meeting.

37. Additional Business

The agenda shall not contain business other than those subjects for which the special meeting was called.

38. Agenda

The agenda items shall include but not be limited to:

- a) Call to Order;
- b) Agenda - adoption of;
- c) pecuniary interest and/or conflict of interest, and the general nature thereof when the item arises;
- d) Business item for which the special meeting was called; and
- e) Adjournment.

39. Closed Session

Should the item of business for which the special meeting was called be a matter for Closed Session, a motion to go into Closed Session and a motion to rise and report from closed session will also be included on the agenda, including the reason for the closed session in accordance with this by-law.

BOARD OF HEALTH MEETINGS: PROCEDURES

40. Invitation of a Non-Board Member

Any person that wishes to address the Board, who is not a Board member, shall not be allowed to address the Board except upon invitation of the Chair and the Board members. Speakers will be allowed up to 5 minutes to speak to the Board.

41. Board Member

No member shall be allowed to speak more than once upon any question before the meeting unless expressly permitted to do so by the Chair, except the mover of the original motion who shall have the right to reply when all members choosing to speak shall have spoken. An amendment being moved, seconded, and put by the Chair, any member, even though she/he has spoken on the original motion, may speak again on the amendment. No member shall speak for more than five minutes at one time.

Members wishing to raise points of order or explanation must first obtain the permission of the Chair and must raise the matter immediately following from when the alleged breach occurred. A member wishing to explain a material part of their speech which may have been misconstrued or misunderstood may be granted their privilege by the Chair, providing that, in so doing, they do not introduce any new matter. Any member may formally second any motion of amendment and reserve their speech until a later period in the debate.

42. Selection of Speakers

Every member, before speaking, shall ask permission to speak and address the Chair as "Chair". The Chair, if the request is in order, shall grant permission to speak and address the member or staff by their first and/or last name. When more than one member is recognized to speak, the first to be recognized shall be given precedence, the decision resting with the Chair. Thereafter, the members shall be called upon by the Chair to speak in the order in which they were recognized.

43. Interruption

If any member interrupts the speaker, or uses abusive language, or causes disturbance or refuses to obey the Chair when called to order, they shall be named by the Chair. They shall thereupon be expelled from the meeting and shall not be allowed to enter again until an apology satisfactory to the Board has been given. No member shall leave the meeting before its adjournment without the permission of the Chair.

44. Conduct During Board Meetings

At all times all members of the Board shall use temperate language and conduct themselves in an appropriate manner. If, at any time, intemperate or insulting language is used against the Chair or the Board or any of its members or staff, the offending member shall respectfully apologize and retract their statement.

45. Order and Procedure

All members shall abide by the Chair's decision or that of the Board regarding matters of order and procedure. If any member continues to abuse their position in the Board meeting, after being named by the Chair, the Chair shall have the power to have them removed from the Board meeting until the meeting is over or until the member apologizes in full to the Chair and the members.

MOTIONS AND AMENDMENTS

46. Original Motion and Amendments

The first proposition on any particular subject shall be known as the original motion and all succeeding propositions on that subject shall be called amendments.

47. Amendments

The main question may be amended only once after which the original amendment shall be voted upon and, if carried, shall stand instead of the original motion, and if lost, the main question will be recalled. A further amendment may then be put and voted upon.

Every amendment submitted shall be in writing and shall be decided or withdrawn before the main question is put to the vote.

48. Procedures

Every motion or amendment must be moved and seconded by members actually present at the meeting before it can be discussed, debated or put from the Chair and wherever possible should be set forth in writing. When a motion is seconded, it shall be read by the Chair or Recording Secretary before a debate. When a question is under debate, no motion shall be received unless to refer it to committee, to amend it, to postpone it, to adjourn it, or to move the previous question.

49. Withdrawals or Additions

After a motion is read by the Chair or Recording Secretary, it shall be deemed in the possession of the Board, but may, with the permission of the Board, be withdrawn at any time before discussion or amendment. Any motion properly moved and seconded must be presented to the Board.

50. Reconsidering - Rescinding

No motion to reconsider a resolution entered upon the minutes shall be received or put unless a notice of intention to introduce such a rescinding motion shall have been made in writing at the previous meeting.

ADJOURNMENTS

51. Adjournments

A motion to adjourn the Board meeting or adjourn the debate shall always be in order, but, if it is defeated, then no second motion to the same effect shall be made.

CLOSED SESSION

52. Closed Sessions

A Closed Session is defined as a private session where only Board members and invited staff and professional advisors such as legal counsel are present and excludes all others, including the public and the media.

The Board may resolve to go into Closed Session if the subject matter to be considered

falls within one or more of the following categories provided for in the *Municipal Act*, 2001, as amended: [MA 239(2)]

- a) the security of the property of the Board or the Agency;
- b) personal matters about an identifiable individual, including Board employees;
- c) a proposed or pending acquisition or disposition of land by the Board or the Agency;
- d) labour relations or employee negotiations;
- e) litigation or potential litigation, including matters before administrative tribunals, affecting the Board or the Agency;
- f) advice that is subject to solicitor-client privilege, including communications necessary for that purpose;
- g) a matter in respect of which a council, board, committee or other body may hold a closed meeting under an act other than the *Municipal Act*;
- h) information explicitly supplied in confidence to the Board or the Agency by Canada, a province or territory or a Crown agency of any of them;
- i) a trade secret or scientific, technical, commercial, financial or labour relations information, supplied in confidence to the Board or the Agency, which, if disclosed, could reasonably be expected to prejudice significantly the competitive position or interfere significantly with the contractual or other negotiations of a person, group of persons, or organization;
- j) a trade secret or scientific, technical, commercial, or financial information that belongs to the Board or the Agency and has monetary value or potential monetary value; or
- k) a position, plan, procedure, criteria, or instruction to be applied to any negotiations carried on or to be carried on by or on behalf of the Board or the Agency.

The Board shall resolve to go into Closed Session if the subject matter to be considered falls within one or more of the following categories provided for in the *Municipal Act*, 2001, as amended: [MA 239(3)]

- a) a request under the *Municipal Freedom of Information and Protection of Privacy Act*, if the Board is the head of an institution for the purposes of that Act; or
- b) an ongoing investigation respecting the Board or the Agency by the Ombudsman appointed under the *Ombudsman Act*, an Ombudsman referred to in subsection 223.13 (1) of the *Municipal Act*, 2001, or the investigator referred to in subsection 239.2 (1) of the *Municipal Act*, 2001.

53. Procedural Votes

Only procedural votes or those related to the giving of advice and direction to staff can take place in Closed Session. Speakers will be allowed up to 5 minutes to speak to the Board.

54. Procedure

When a decision to go into Closed Session is made, the Board shall state, by resolution,

the following:

- a) The fact of the holding of a Closed Session;
- b) The general nature of the matter to be considered at the Closed Session; and
- c) That all matters to be considered are to be held as strictly confidential, the content of which matters, discussions, documents or related information is not to be disclosed to any persons, media, or other organizations. [MA239(4)]

55. Rules

Rules of the Board shall be observed in the Closed Session meeting, except those limiting the number of times a member may speak.

56. Quorum Voting

The rules for quorum and voting shall be the same for the Closed Session as for the Open session. Votes will be counted by the Treasurer-Secretary and (1) scrutineer.

57. Questions of Order

Questions of order arising in the Closed Session shall be decided by the Chair.

58. Agenda

A written agenda shall be prepared by the Secretary-Treasurer for every Closed Session meeting and approved by the Board Chair.

59. Completion of the Closed Session

The Board shall rise with a report upon completion of the Closed Session.

60. Order of Business

The order of business for closed session meetings shall be:

- a) Pecuniary Interest and/or Conflict of Interest, and the general nature thereof when the item arises;
- b) Report from the Chief Executive Officer or Board Standing and/or Ad hoc Committee Chair regarding item(s) on the Closed Session Agenda; and
- c) Business: unfinished, new, or arising for correspondence received listed under one of the categories of subject matter to be discussed under which a meeting may be closed.

61. Absence of the Chair or Vice Chair

In the absence of the Chair, Vice Chair, or whoever has been designated to chair the meeting of the Closed Session, one of the other members shall be elected to preside until the arrival of the designated Chair.

62. Confidential Minutes

Minutes of the Closed Session shall be recorded by the Recording Secretary and, after approval by the Board and upon signature by the Board Chair, shall be maintained by the Secretary-Treasurer in a manner to protect the confidentiality of information contained

therein.

63. Breach of the Rules

If a member disregards the rules of the Board or a decision of the Chair of a Closed Session on questions of order or practice or upon the interpretation of the rules set out, and persists in such conduct after having been called to order by the said Chair, the Chair shall forthwith put the question with no amendment, adjournment, or debate, “that the member shall be ordered to leave their seat for the duration of the meeting”.

If, following such vote by the members, the member apologizes, they may, by a further vote of the members, be permitted to retake their seat.

64. Breach of Confidentiality

If a member of the Board disregards the rules of the Board respecting the requirement to maintain the confidentiality of matters and related information arising in a Closed Session, or disregards their own Oath of Confidentiality respecting the security of personal information and/or personal health information, the Board may call for the member to resign as a member of the Board.

OFFICERS

65. Chief Executive Officer

The MOH/CEO will chair the first Board meeting of the year until a Chair has been elected.

66. Election and Removal of the Chair and Vice Chair

Any member of the Board may serve as an officer of the Board. The Chair and Vice Chair shall be elected at the first meeting of the Board each year. Nominations for Chair and Vice Chair will be solicited at the first meeting and a majority vote will determine the election result. If more than one nomination is received for each Officer position, a secret ballot will be conducted. The ballots will be distributed by the Recording Secretary and counted by the Secretary-Treasurer. All officers shall serve for a term of one calendar year or until their successors are elected.

67. Chair and Vice Chair Vacancy

Any Chair or Vice Chair vacancy shall be filled by a special election held at the next meeting following announcement of the vacancy.

68. Appointment of the Medical Officer of Health

The Board shall appoint a full-time Medical Officer of Health and may appoint one or more Associate Medical Officers of Health of the Board. Where the office of Medical Officer of Health of the Board is vacant or the Medical Officer of Health is absent or unable to act, and there is no Associate Medical Officer of Health of the Board or the Associate Medical Officer of Health is absent or unable to act, the Board shall forthwith appoint a physician as Acting Medical Officer of Health, which Acting Medical Officer of Health shall perform the duties and have the authority to exercise the powers of the Medical Officer of Health of the Board.

The Medical Officer of Health is the only employee of the Board and reports to the Board.

69. Eligibility for Appointments

A Medical Officer of Health or an Associate Medical Officer of Health or Acting Medical Officer of Health (where applicable) must have the following credentials,

- a) They are a physician
- b) They possess the qualifications and requirements prescribed by the regulations to the Act for the position; and
- c) The Minister approves the proposed appointment. [HPPA, Part VI, S.64]

70. Medical Officer of Health Vacancy

If the position of Medical Officer of Health of the Board becomes vacant, the Board and the Minister, acting in concert, shall work expeditiously towards filling the position with a full-time Medical Officer of Health.

71. Dismissal of Medical Officer of Health

A decision by the Board to dismiss the Medical Officer of Health or an Associate Medical Officer of Health from office is not effective unless,

- a) the decision is carried by the vote of two-thirds of the members of the Board; and
- b) the Minister consents in writing to the dismissal.

A decision by the Board to dismiss the Acting Medical Officer of Health shall be effective by ordinary resolution.

72. Dismissal of Chief Executive Officer

A decision of the Board to dismiss the Chief Executive Officer is not effective unless the decision is carried by the vote of two-thirds of the members of the Board.

73. Notice of Attendance

The Board shall not vote on the dismissal of the Medical Officer of Health, an Associate Medical Officer of Health, or the Chief Executive Officer unless the Board has given to the Medical Officer of Health, Associate Medical Officer of Health, or Chief Executive Officer,

- a) reasonable written notice of the time, place and purpose of the meeting at which the dismissal is to be considered;
- b) a written statement of the reason for the proposal to dismiss the Medical Officer of Health, Associate Medical Officer of Health, or the Chief Executive Officer; and
- c) an opportunity to attend and to make representations to the Board at the meeting.

74. Duties of Officers

- a) The Chair Shall:
 - i. Preside at all meetings of the Board;
 - ii. Preserve order and proper conduct during meetings;
 - iii. Keep a speakers list recognizing members who wish to speak on a matter;
 - iv. Issue a final ruling on any question of order and/or procedure unless challenged by way of a motion or appeal by not less than two members, and thereafter a majority of the members present shall vote in support of such

- challenge;
 - v. Inform the members when it is the opinion of the Chair that a motion is contrary to the rules and privileges of the Board; and
 - vi. Remind members of their obligations of confidentiality with respect to matters and information arising in Closed Session.
- b) The Vice Chair Shall:
- i. Preside in the absence of the Chair; and
 - ii. Carry out the duties of the Chair as noted.
- c) The MOH/CEO shall:
- i. Be responsible for and shall report to the Board on issues relating to the protection and the promotion of the public's health.
 - ii. Be responsible for the day-to-day operations, policies, and directives, program and service delivery, matters of human resources and finances of the South East Health Unit, and
 - iii. for keeping the Board apprised of such matters.

COMMITTEES

75. Committees

The Board may establish, by resolution, standing committees of the Board as it deems necessary. Special ad hoc committees may also be established, and the members appointed for a specific purpose for a specific period of time. Such committees shall be deemed to be discharged when their purpose has been achieved or when the specific period of time has lapsed. Electronic participation in such meetings is allowable, including being counted in quorum and voting, subject to any policies in respect of same adopted by the Board from time to time.

RULES OF ORDER

76. Robert's Rules of Order

The rules contained in the current edition of Robert's Rules of Order Newly Revised shall govern the Board in all cases to which they are applicable and in which they are not inconsistent with these by-laws and any special rules of order the Board may adopt.

AFFILIATION

77. Affiliation

~~The South-eEast Public Health Unit~~ may hold membership in various agencies (i.e. Ontario Public Health Association, Association of Local Public Health Agencies, Ontario Hospital Association, Canadian Public Health Association, etc.) as needed and at the discretion of the MOH/CEO. The Board may be entitled to representation at meetings of various membership organizations. Should voting be required at such meetings, proxy representations with authority to vote shall be appointed and authorized by the Board whenever necessary.

ENACTED this 17th day of December, 2025.

Jan O'Neill
Chair, Board of Health

Piotr Oglaza
Medical Officer of Health and CEO



**Southeast
Public Health**

Schedule 8.1

Rural Services Delivery Strategy

Dr. Piotr Oglaza, MD, CPHI (C), MPH, FRCPC

Medical Officer of Health/Chief Executive Officer

December 17, 2025

A promise of the merger



A more robust
complement of
rural services



Consistent staffing with a
dedicated presence within
rural communities



A more comprehensive
suite of services
addressing historic
service gaps in rural
communities



With an increased presence in these communities, the new organization would benefit from the intimate knowledge of the challenges and barriers that we can then, help to address, in collaboration with rural partners or foster new partnerships.



Rural Services Delivery Strategy

Guiding principles:



Serving people,
not places



Evidence-based
programs and
services



Maximizing
resource
impacts



Health equity

Components of rural framework:

Work with community
partners

Focus on outreach
and mobile services

Leverage technology
and innovation

Serving people, not places

- Outreach model in KFLA that provides services where people already are:
 - Meal programs
 - Shelters
 - Drop-in programs
 - Congregate living settings



Evidence-based programs and services

- Employing catch-up clinics in LGL to ensure that all students are up-to-date on routine immunizations
- Using data-driven approach to pinpoint the best location to host vaccine clinics in schools
- Using a tried-and-tested outreach model
- Approach led to KFLA having some the highest ISPA compliance in the province



Maximizing resource impacts



Technology:

Harmonizing electronic documentation tools such as Hedgehog and EMR



Cross training staff:

Staff redeployment to address backlog, ensure compliance, and overall community safety



Quality

improvement:

Training in Improving and Driving Excellence across sectors (IDEAS)

Health equity



Use existing health equity measures to plan clinics and services

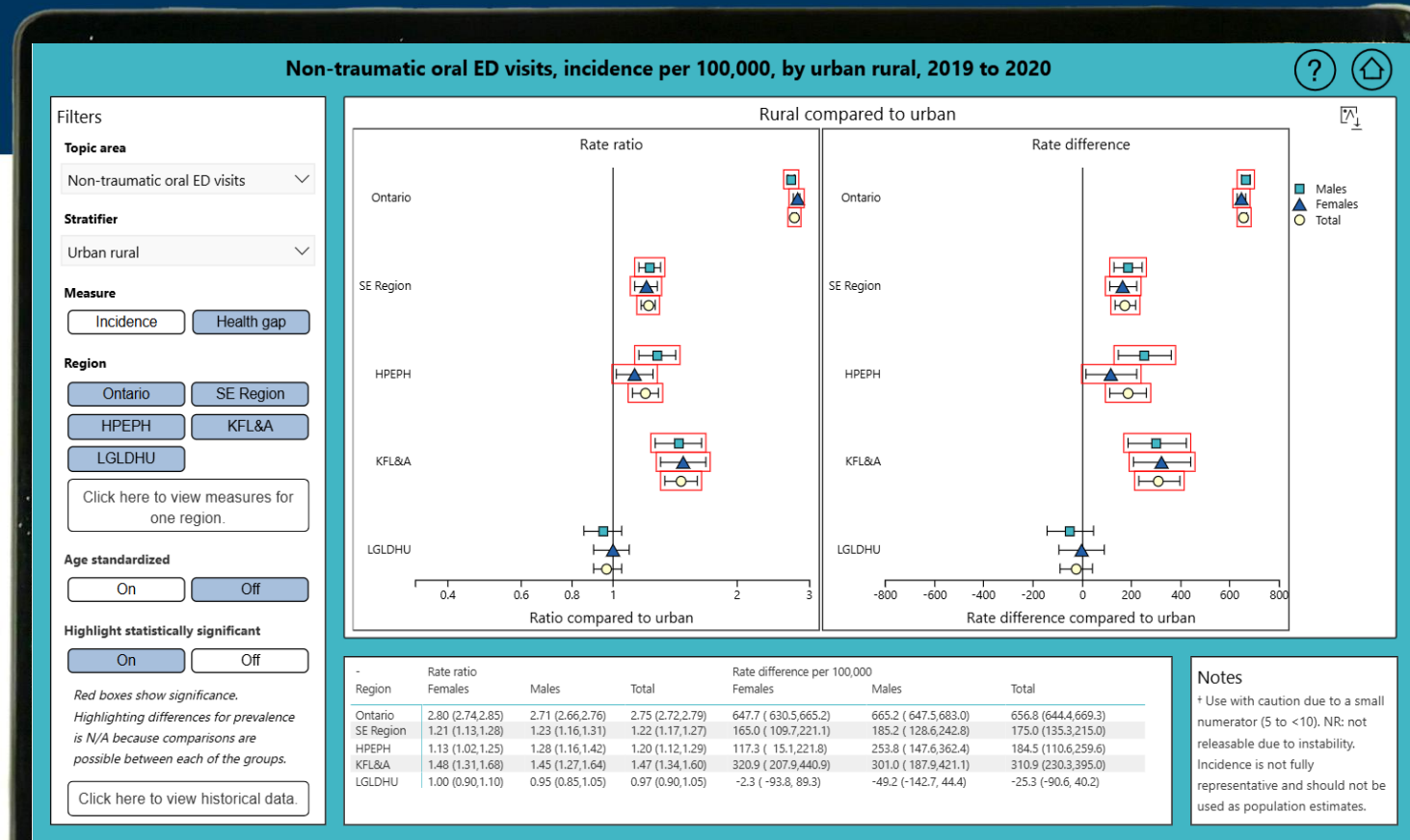


Ensure everyone has access to services by removing barriers



Upstream action and equitable access to quality services

Using technology to address health equity gaps our community



Using algorithms to find optimal delivery spaces

- Site suitability analysis: Finds the optimal place for services using GIS process (vaccine fridge, clinic location, etc.)
- Weighs criteria such as:
 - Demographics
 - Population Density
 - Distance To Roads
 - Land Use
 - Health Equity
 - Drive time



Work with community partners

- To reduce transportation barriers, we work with:
 - Community health teams
 - Schools
 - Hospitals
 - Other partners
- Quick test STI clinic models in community settings
- Early years and joint programming with partners



Focus on outreach and mobile services



Home visiting
(HBHC/NFP)



Immunization
community clinics



Mobile
services



Existing outreach programs at Southeast Public Health



-  Healthy Babies, Healthy Children programs
-  Nurse Family Partnership home visiting programs
-  Online and in-person prenatal classes and parenting programs
-  Immunization clinics
-  Virtual testing for sexual health services
-  Dental health services
-  Mobile immunization and dental
-  School health supports for educators
-  Public health inspector services
-  Communicable disease case and contact management
-  Harm reduction resources
-  Health protection and health promotion communications
-  Surveillance dashboards

Focus on outreach: Mobile vans

- One mobile van, currently used in KFLA to provide immunization and outreach to hard-to-reach populations
- Two mobile vans, currently used in KFLA, Leeds and Grenville, and Lanark counties to distribute harm reduction supplies, safer drug use education, safer disposal of sharps education, as well as Naloxone training and distribution
- 25 outreach sites in KFLA alone



Focus on outreach: Mobile STI testing and case follow up

Office	Number of STI testing visits
HPE Mobile	85
KFLA Mobile	248
Almonte	80
Bancroft	47
Belleville	1,107
Brockville	435
Carleton Place	54
Gananoque	28
Kemptville	118
Kingston	1,090
Perth	31
Picton	56
Smiths Falls	281
Trenton	253

-  Mobile
-  Proposed closures
-  Remaining offices and outreach sites



Focus on outreach: Supporting staff



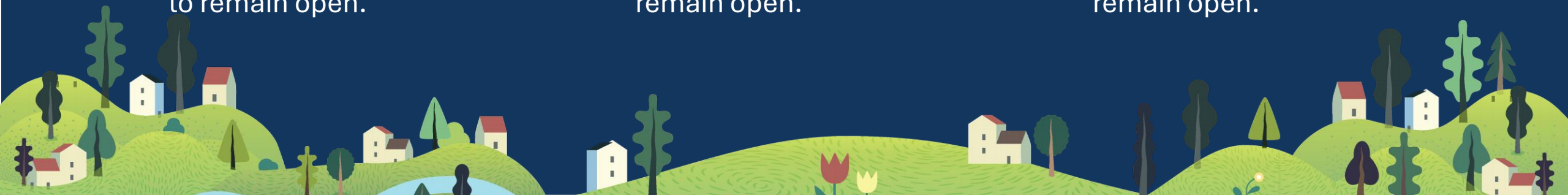
48% (N=268k)
of the SEPH population lives within a 15-minute drive of one of the offices proposed to remain open.



85% (N=472k)
of the SEPH population lives within a 30-minute drive of one of the offices proposed to remain open.



92% (N=513k)
of the SEPH population lives within a 45-minute drive of the offices proposed to remain open.



Focus on outreach: Mobile dental unit



Focus on outreach: Presence within the community

- Office locations do not equal presence or optimal service delivery in the community
- Many existing services are already outreach-based
- Coordination of this outreach model is often done from one of our four owned offices
 - Belleville
 - Brockville
 - Kingston
 - Smiths Falls



Leveraging technology and innovation



SPRITE Project



GetaKit
STI testing



HIV PreP Clinics



Prenatal
Bump to Baby
program

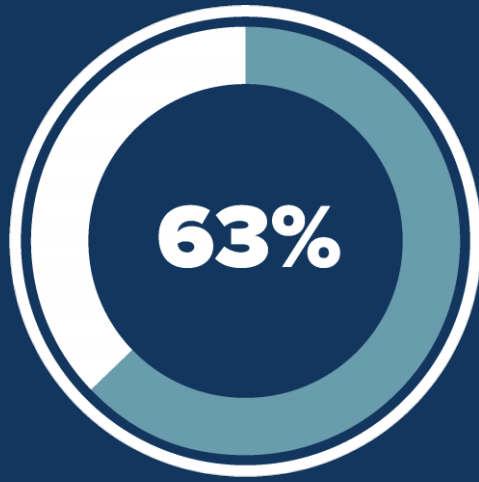
Leveraging innovation: SPRITE

- 1,644 POCT administered
- 500+ Outreach events
- 89 true positives
- 44 new infections/reinfections (requiring treatment)
- 35 treated at POC (80%)

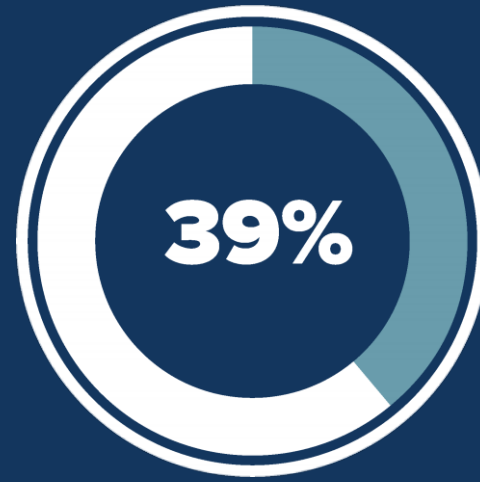


Leveraging innovation: SPRITE

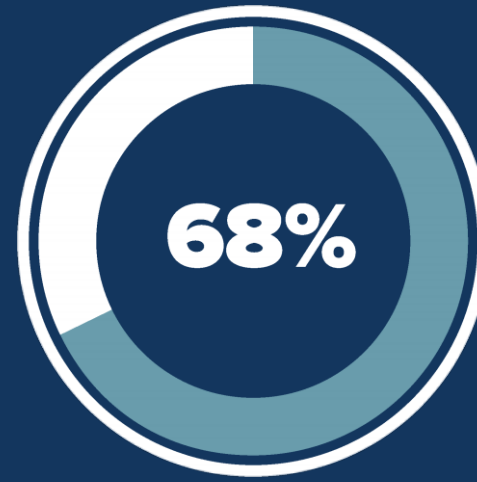
Are we reaching the population?



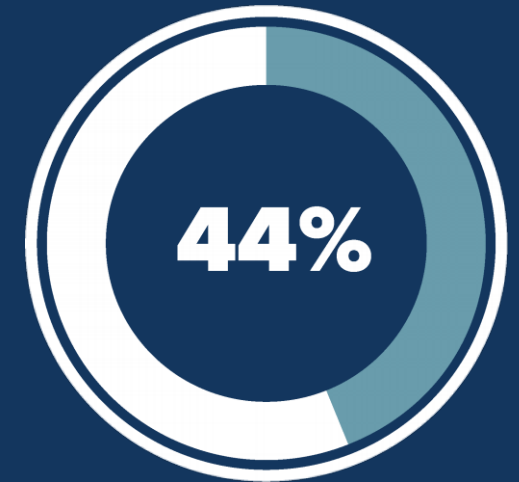
were under-housed or experiencing homelessness
(un(der)housed)



reported having at least one sexual risk factor
(multiple sexual partners, anonymous sexual partners, sexwork (current))

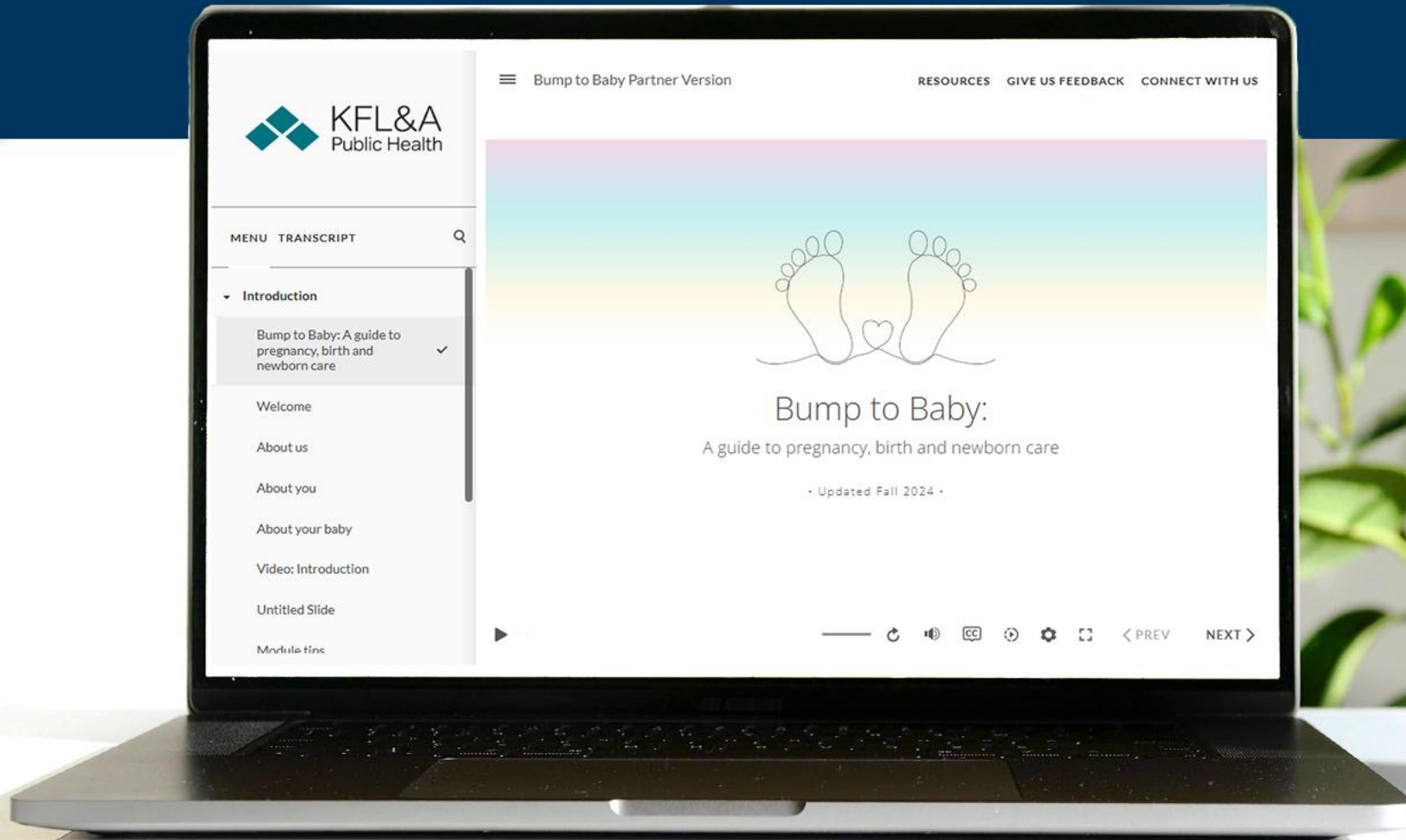


reported illicit substance use
34% reported crystal meth use,
31% fentanyl,
32% crack and/or cocaine



reported using more than one type of illicit drug

Leveraging technology: Bump to Baby



Rural Services Delivery Strategy:

Protecting our communities, maximizing our resources

Different
delivery

Targeted
service

Optimal population
protection



Working better with our communities

- Each community has different needs
- Committed to working with our communities to ensure that service delivery is effective for the needs of each population
- Our goal is the same, deliver impactful public health services in the most efficient way possible, to ensure long-term sustainability of services across the region and the health of our communities



Thank you



Southeast Public Health Report: Branch Office Assessment

Background:

Rural service delivery was a core pillar of the merger business case.

The goal in the business case was to offer:

- A more robust complement of rural services
- Consistent staffing with dedicated presence within rural communities
- A more comprehensive suite of services addressing historic service gaps in rural communities

It has always been an understanding that, through our merger, these were the underlying goals of what Southeast Public Health's rural strategy would be.

Conversations around branch offices began while looking at the feasibility of keeping our Gananoque office open, discussions that began prior to the merger within the legacy agency of Leeds, Grenville and Lanark (LGL) District Health Unit. Our Gananoque office has been closed to client services since the summer due to staffing shortage.

The results of the initial evaluation of Gananoque showed that the office was being underutilized, which then led to a comprehensive and methodical evaluation of all branch locations, with the goal of ensuring robust, consistent and comprehensive rural services across our new region.

This assessment was guided by a defined set of criteria, including:

- **Cost Analysis:** Review of all expenditures associated with each location, including lease obligations, cleaning services, and utility costs; staffing.
- **Accessibility and Service Delivery:** Consideration of travel distance, geographic access, and the ability of each location to support effective service delivery.
- **Service Demand and Utilization:** Examination of client usage patterns, service volumes, and demand trends at each site.
- **Operational Efficiency:** Evaluation of overall cost-effectiveness, and resource optimization across offices.

As you will see in the tables below, the assessment found that clinics at many of the branch office locations were not operating at full capacity, not achieving maximum productivity, and failing to make the best use of time and resources, and still requiring those who most need the services to travel instead of taking services to hard-to-reach populations.

It also found that we were spending funds on:

- Full year leases, with locations open one to three days per week.
- Leasing larger office areas than needed.
- Leasing office space for staff that do not require to be in the location to do their work
- Offering services in spaces not configured for public health services.

With our agency facing increasing financial pressure where funding has not kept pace with inflation and the rising cost of delivering public health services, based on current trends, we projected a funding shortfall of approximately \$15.6 million by 2030. In response, the Board has directed staff to identify \$5 million in cost savings while ensuring we continue to meet our mandate to protect and promote the health of our communities.

To achieve both our promise to rural communities to provide optimal public health services, while ensuring that we are spending public funds in the most efficient and effective ways possible, our comprehensive assessment of our operations in branch offices identified opportunities for greater efficiency, improved service delivery, and better alignment of resources with community needs.

Our communities, technologies, and service expectations have evolved significantly in recent years, requiring us to reassess how, where, and by what means we deliver public health programs.

This report presents the detailed criteria used in the review of our outer offices, the findings of that assessment, and recommendations, which are based on the agency's next steps, to harmonize programs and services and to further refine a rural strategy that ensures residents, regardless of their location or proximity to an agency office, receive core mandated public health services.

Current state:

Number and Location of Offices

Southeast Public Health (SEPH) has thirteen offices located over 19,942 km² geographical area serving approximately 595,000 residents. There are five owned office buildings located in Belleville, Brockville, Cloyne, Kingston, and Smiths Falls and eight leased office buildings located in Almonte, Bancroft, Gananoque, Kemptville, Napanee, Perth, Picton, and Trenton. Of these thirteen offices, seven are along the 401 corridor.

Staffing of Offices

We have approximately 406 staff who work from one of the owned offices in Belleville, Brockville, Kingston, and Smiths Falls and about 25 staff that are assigned to one of the eight leased offices and the owned office in Cloyne. Recent organizational restructuring to integrate our three agencies into one unified agency has resulted in fewer management positions, broader spans of control, and team oversight that now extends across former legacy boundaries. As a result, many managers have direct reports situated in multiple office locations. Unifying our agency has created operational challenges, including reduced opportunities for in-person connection, greater travel demands on staff, and increased difficulty building relationships with new team members.

Financial Pressures

The voluntary public health merger is meant to strengthen the overall public health system by increasing capacity, improving organizational performance, and creating fewer, larger, and more efficient and resilient public health entities. We have received three years of provincial funding which began on April 1, 2024, and will continue to March 31, 2027, to support our agency's merger transition. These one-time funds have provided short term relief but will not address the underlying issues that have caused long term financial instability at the legacy agencies. This funding context has required staff to consider the following cost saving considerations:

- Proactive planning to maintain organizational stability. By implementing changes incrementally, the agency can adapt more effectively to ongoing funding pressures. We are not waiting until post-merger funding to achieve all cost savings from underutilized resources, operational overhead, vendor and contract harmonization, etc. as this would create significant disruption and will destabilize the agency.
- We are also operating within an environment of significant unknowns, including the forthcoming Ontario Public Health Standards and a revised provincial public health funding model—both of which will directly affect future service delivery expectations and funding levels. Beginning our planning and change initiatives now positions the organization to adapt more effectively once these provincial directions become clear, reduces the risk of reactive decision-making, and ensures we have the flexibility to respond proactively to whatever new requirements or funding structures emerge.
- Since April 2025, significant efforts have been made in finding operational efficiencies, including the consolidation of leadership and corporate services positions, leading to over \$2 million in savings.
- To ensure continued delivery of public health services, changes to staffing has been minimized, and we have prioritized retaining our valued frontline staff and are leveraging new technology innovative service delivery, and integrating our services with community partners,

Assessment:

A comprehensive and methodical assessment was undertaken to determine whether the tangible and intangible benefits of the agency's branch offices outweigh the total operational and maintenance costs. This assessment was guided by a defined set of criteria, including:

- Cost Analysis: Review of all expenditures associated with each location, including lease obligations, cleaning services, and utility costs; staffing.

- **Accessibility and Service Delivery:** Consideration of travel distance, geographic access, and the ability of each location to support effective service delivery.
- **Service Demand and Utilization:** Examination of client usage patterns, service volumes, and demand trends at each site.
- **Operational Efficiency:** Evaluation of overall cost-effectiveness, and resource optimization across offices.

This structured approach ensures that decisions regarding office operations are data-driven, objective, and aligned with organizational sustainability and service delivery needs.

Cost

The objective of the financial analysis is to ensure the agency has sufficient funding to support current operations and immediate needs, while also assessing the long-term financial sustainability of the organization.

This analysis does not include detailed cost information for the four office buildings owned in Belleville, Brockville, Kingston, and Smiths Falls. These locations collectively accommodate all staff and have the capacity to support additional employees through available workstations and office space.

Figure 1 provides an overview of the annual occupancy costs for branch offices, including lease payments and, where applicable, maintenance, cleaning, and utility expenses, along with the number of days each location is operational. The chart also outlines the associated staffing costs for administrative personnel required to be onsite when offices are open to the public, as well as the maintenance costs for the owned office in Cloyne. The total costs are provided as aggregated totals for occupancy overhead, staffing, and merger transition of IT infrastructure (e.g., networking for phone and IT systems). The total cost to keep the eight branch offices open with one staff present during hours of operation is over \$543,600 per year (estimated costs for 2026).

Figure 1: Annual occupancy costs for branch offices

Branch Offices	Hours of Operation	Costs/Space
Almonte 79 Spring Street Ownership in the name of Almonte General Hospital	Tuesday and Thursday 9:00 a.m. – 4:00 p.m. (Two Mondays/month for clinics) Require: 0.5 FTE Admin Staff	Lease fees Parking fees for staff and clients <u>Facility space:</u> <ul style="list-style-type: none"> • Not Infection Prevention and Control (IPAC) compliant due to carpet

<p>Bancroft 1P Manor Lane</p> <p>Ownership in the name of The Corporation of the County of Hastings</p>	<p>Tuesday and Thursday 8:30 a.m. – 4:30 p.m. (Mon, Wed, Fri by appointment only)</p> <p>Require: 0.5 FTE Admin Staff</p>	<p>Lease fees</p> <p>SEPH sublet to healthcare professional</p>
<p>Cloyne 14209 Hwy 41</p> <p>Ownership in the name of Southeast Public Health (formerly KFL&A Public Health)</p>	<p>Monday – Friday 8:30 a.m. – 4:30 p.m.</p> <p>Require: 1.0 FTE Admin Staff and 0.2 FTE Maintenance Staff</p>	<p>Maintenance fees</p> <p><u>Facility space:</u></p> <ul style="list-style-type: none"> • Configuration of office space is not conducive to clinics • Not IPAC compliant due to carpet • Free use of space for food bank
<p>Gananoque 375 William Street South</p> <p>Ownership in the name of The Corporation of the United Counties of Leeds and Grenville</p>	<p>Tuesday and Wednesday 8:00 a.m. – 4:00 p.m.</p> <p>Require: 0.4 FTE Admin Staff</p>	<p>Lease fees</p> <p><u>Facility space:</u></p> <ul style="list-style-type: none"> • Closed to client services since May 2025 • Inability to staff office with current staff • Addressing backlog of core PH work in LGL, including Gananoque
<p>Kemptville 80 Shaver Crescent</p> <p>Ownership in the name of The Corporation of Municipality of North Grenville</p>	<p>Monday – Thursday 8:30 a.m. – 4:30 p.m.</p> <p>Require: 0.8 FTE Admin Staff</p>	<p>Lease fees</p> <p><u>Facility space:</u></p> <ul style="list-style-type: none"> • Shared utility bills with campus
<p>Napanee 99 Advance Avenue</p>	<p>Monday – Friday 8:30 a.m. – 4:30 p.m.</p>	<p>Lease fees</p>

Ownership in the name of The Corporation of the Town of Greater Napanee	Require: 1.0 FTE Admin Staff	
Perth 14 Isabella Street Ownership in the name of 2781935 Ontario Inc.	Monday 10:30 a.m. – 4:00 p.m.	Lease fees <u>Facility space:</u> <ul style="list-style-type: none"> Optional clinic space in community (no staff regularly on site)
Picton 35 Bridge Street In the name of CASA-DEA Finance Limited	Monday to Friday 8:30 a.m. – 4:30 p.m.	Lease fees – N/A; through a partnership with Prince Edward Family Health Team this office has become an outreach site. <u>Facility space:</u> <ul style="list-style-type: none"> PEFHT provides reception services Shared clinic space (no staff regularly on site)
Trenton 499 Dundas Street West In the name of Trenton Dundas Inc.	Monday to Wednesday 8:30 a.m. – 4:30 p.m. Require: 0.6 FTE Admin Staff	Lease fees <u>Facility space:</u> <ul style="list-style-type: none"> Staff travel from Belleville office when there is a clinic Not IPAC compliant due to carpet
Total building costs:	\$261,600 (excludes Bancroft and Picton)	
Total staffing costs:	\$282,000 (excludes Bancroft)	
Total costs:	\$543,600 (excludes Bancroft and Picton)	
Costs to harmonize IT infrastructure:	\$75,000 (estimate one time fee 2026, from voluntary merger funding)	

Accessibility and service delivery

An environmental scan of the local public health agencies in Ontario (found in Appendix A) shows most agencies have approximately three offices, except for Northeastern Public Health, which has 13 offices covering 288,000 km² (about 14 times area of Southeast region) and Northwestern Health Unit, which has 12 offices covering 173,828 km² (about 8 times area of Southeast region).

The current distribution of the agency's thirteen offices reflects historical legacy boundaries. As a result, several locations are no longer centrally positioned to serve the full geography of the southeast region. In many cases, offices are clustered along the Highway 401 corridor or are situated near former catchment borders, limiting regional accessibility and connectivity. The Service Location Map (Appendix B) illustrates the distances and spatial relationships among branch offices in the region.

Key observations from the location review include:

- **Proximity to Owned Offices Along the 401 Corridor:**
Three leased offices (Trenton, Napanee, and Gananoque) are located within 50 km of one of the organization's owned offices in Belleville, Kingston, or Brockville.
- **Proximity to Smiths Falls:**
Three leased offices (Perth, Almonte, and Kemptville) are within 50 km of the organization's owned office in Smiths Falls.
- **Additional Proximity Within the Belleville Catchment:**
One leased office (Trenton) and one outreach site (Picton) fall within 50 km of the Belleville-owned office.

Our agency's geographical area is extensive, encompassing urban centres and rural communities; however, an analysis using the branch offices in Kingston, Belleville, Brockville, Smiths Falls and Bancroft offices. Overall, the results are:

- 48% (N=268k) of the SEPH population lives within a 15-minute drive of one of our owned offices.
- 85% (N=472k) of the SEPH population lives within a 30-minute drive of one of our owned offices.
- 92% (N=513k) of the SEPH population lives within a 45-minute drive of one of our owned offices.

With this analysis there are a few assumptions made:

- The mapped dataset used for the analysis cannot account for the bridges to Prince Edward County. As such, we have assumed that the entire population of Prince Edward County lives within 30 minutes of the Belleville office. Through a partnership with Prince Edward Family Health Team we will also have access to the Picton office as it will be an outreach site. In some, cases this will be shorter and in others longer.

- Likewise, the ferries to the Frontenac Islands cannot be captured and this population has been assumed to live within 45 minutes of the Kingston office.

Figure 2: Count and Percentage of Total SEPH Population within a 15-minute drive of an owned office

Count & Percentage of Total SEPH Population Within a 15-Minute Drive Time of an Owned SEPH Office

Office Name	Population Count (#)	Population Percentage (%)
Kingston Office	137,481	24.6%
Belleville Office	67,964	12.2%
Brockville Office	33,307	6.0%
Smiths Falls Office	21,550	3.9%
Bancroft Office	6,733	1.2%
Grand Total	267,035	47.8%

A ‘suitable’ drive time for healthcare delivery is highly contextual and varies significantly based on the type of service (e.g., emergency versus preventive healthcare) and geographical area. The benchmark used by primary care is a 30-minute drive time, not a single, universal national standard but rather a commonly adopted metric used by various institutions. (Reference: [Drive time to cardiac rehabilitation: at what point does it affect utilization?](#))

Service demand and utilization

Correspondingly, office-based service demand has declined. Reduced foot traffic and lower clinic attendance have led most leased offices to scale back hours of operation and decrease or discontinue in-person clinics. This trend may also reflect the success of broader provincial initiatives, including expanded attachment to primary care providers and an increased scope of practice for pharmacies (e.g., vaccinations and health checks).

Further, there have been significant shifts in community needs since the establishment of these outer offices. Increasingly, clients are accessing public health information and services through digital and virtual channels. Examples include use of the agency’s website and social media platforms, virtual clinic booking, consultations and screening tools, and online learning modules and resources. These digital tools offer clients more convenient and immediate access to information, care, and education, while enabling greater autonomy in managing their health.

In Figure 3, the types of clinics offered at the eight leased offices are outlined. These clinics include immunization, infant feeding, sexual health, and preschool speech and language (PSL) as well as

the clinic volumes (including clinic volume ratio of number of clients per clinic hour using 2024 data).

Also outlined in Figure 3 are the staff positions at each office. Many of these positions are not required to complete work in this region where the branch office is located and have requested assignment to one of these offices based on their proximity to their home. The staff who provide services in the rural areas are not necessarily assigned to a branch office (i.e., staff travel from the main office to the branch offices in KFLA and HPE to facilitate clinics as there are many other opportunities for community outreach and clinics from the main office in other communities beyond ones that have a branch office).

Figure 3: Assessment of clinic usage by leased location

Office Location Number of Staff	Staff Positions	Clinic volumes (including clinic volume ratio of number of clients per clinic hour)
Almonte 6.5 FTE	Public Health Nurses <ul style="list-style-type: none"> • 1 FTE Health Promotion • 1.5 FTE Early Years – Healthy Babies Healthy Children (HBHC) • 2 FTE Infectious Disease Prevention Public Health Nurse Coordinator <ul style="list-style-type: none"> • 1 FTE Infectious Disease Prevention Administrative Assistant 1 FTE Infectious Disease Prevention	Clinic volume: <ul style="list-style-type: none"> ○ Immunization 533 clients in 39 clinic hours; Ratio = 13.15 clients/hour ○ Infant feeding 218 clients in 288 clinic hours; Ratio = 0.76 clients/hour ○ Sexual health 198 clients in 240 clinic hours; Ratio = 0.83 clients/hour
Bancroft 5.0 FTE	Public Health Nurses <ul style="list-style-type: none"> • 1 FTE Early Years – HBHC 	Clinic volume:

	<ul style="list-style-type: none"> • 1 FTE Health Promotion (Schools) • 1 FTE Sexual Health/Harm Reduction <p>Public Health Inspector</p> <ul style="list-style-type: none"> • 1 FTE Environment Health <p>Program Assistant/Family Home Visit</p> <ul style="list-style-type: none"> • 1 FTE Office Services/Early Years -HBHC 	<ul style="list-style-type: none"> ○ Immunization 184 clients in 60 clinic hours; Ratio = 3.07 clients/hour ○ Sexual health 86 clients in 288 clinic hours; Ratio = 0.30 clients/hour
<p>Gananoque</p> <p>2.0 FTE</p>	<p>Public Health Nurses</p> <ul style="list-style-type: none"> • 1 FTE Infectious Disease Prevention <p>Speech Language Pathologist</p> <ul style="list-style-type: none"> • 1 FTE Preschool Speech and Language Program 	<p>Clinic volume:</p> <ul style="list-style-type: none"> ○ Immunization 103 clients in 24 clinic hours; Ratio = 4.29 clients/hour ○ PSL appointments 164 clients in 1008 clinic hours; Ratio = 0.16 clients/hour ○ Sexual health 79 clients in 216 clinic hours; Ratio = 0.37 clients/hour
<p>Kemptville</p> <p>6.0 FTE</p>	<p>Public Health Nurses</p> <ul style="list-style-type: none"> • 3 FTE Health Promotion • 1 FTE Sexual Health 	<p>Clinic volume:</p> <ul style="list-style-type: none"> ○ Immunization 306 clients in 39 clinic hours; Ratio = 7.85 clients/hour ○ Infant feeding 109 clients in 240 clinic hours; Ratio = 0.45 clients/hour ○ PSL 145 clients in 1008 clinic hours; Ratio = 0.14 clients/hour

	<p>Speech Language Pathologist</p> <ul style="list-style-type: none"> • 1 FTE Preschool Speech and Language Program <p>Administrative Assistant</p> <ul style="list-style-type: none"> • 1 FTE Logistics, Inventory, and Data Management <p>Program Manager (retired September 30, 2025) – not replaced.</p> <p>1 FTE Health Promotion</p>	<ul style="list-style-type: none"> ○ Sexual health 237 clients in 240 clinic hours; Ratio = 0.99 clients/hour
<p>Napanee</p> <p>4.8 FTE</p>	<p>Public Health Nurses</p> <ul style="list-style-type: none"> • 0.8 FTE Early Years - HBHC <p>Public Health Dietitian</p> <ul style="list-style-type: none"> • 1 FTE Early Years - Canada Prenatal Nutrition Program <p>Public Health Inspector</p> <ul style="list-style-type: none"> • 2 FTE Environment Health <p>Program Assistant</p>	<p>Clinic volume:</p> <ul style="list-style-type: none"> ○ Immunization 274 clients in 66 clinic hours; Ratio = 4.15 clients/hour

	<ul style="list-style-type: none"> • 1 FTE Environment Health 	
Perth 0 FTE		Clinic volume: <ul style="list-style-type: none"> ○ Sexual health 70 clients in 288 clinic hours; Ratio = 0.24 clients/hour
Picton 2.0 FTE	Public Health Inspector <ul style="list-style-type: none"> • 2 FTE Environment Health 	Clinic volume: <ul style="list-style-type: none"> ○ Immunization 244 clients in 60 clinic hours; Ratio = 3.73 clients/hour ○ Sexual health 98 clients in 144 clinic hours; Ratio = 0.68 clients/hour
Trenton 1.6 FTE	Public Health Nurses <ul style="list-style-type: none"> • 1 FTE Early Years - HBHC Program Assistant <ul style="list-style-type: none"> • 0.6 FTE Office Services 	Clinic volume: <ul style="list-style-type: none"> ○ Immunization 1223 clients in 240 clinic hours; Ratio = 5.10 clients/hour ○ Infant feeding 72 clients in 240 clinic hours; Ratio = 0.30 clients/hour ○ Sexual health 358 clients in 288 clinic hours; Ratio = 1.24 clients/hour
Cloyne 1.2 FTE	Program Assistant <ul style="list-style-type: none"> • 1.0 FTE Office Services • 0.2 FTE Maintenance II 	No clinics.

While typical appointment times may vary for the services provided, the clinic volume for sexual health, infant feeding and preschool speech and language clinics indicate they are not operating at their full capacity, not achieving maximum productivity, and failing to make the best use of time and resources resulting in high per-client healthcare staffing costs. The clinic volume for immunization clinics, although offered less frequently across the region, are still experiencing poor attendance at branch offices. The agency may have to overstaff (i.e., hire more staff than is required in the agency) to cover gaps in absenteeism, cancel clinics last minute due to no

appointments, etc. This results in inefficient staff allocation and impacts the entire agency's productivity and operational costs.

Aside from the underutilization of clinics, based on the staff assigned to branch offices we are paying for office space that is not needed or fully utilized. Many of these staff members can perform their duties from a location other than the leased office, as their roles do not require them to be physically present at that specific site. This is due to the nature of the work that involves a blend of community-based and virtual or office- and home-based work.

Even though foot traffic has decreased at branch offices, we recognize that there are still community residents, outside of the clinics, who access our branch offices. Our administrative staff provide support via telephone, respond to inquiries, book appointments and meetings, and link individuals to other service agencies. The branch office locations also offer self-serve and pre-arranged services (e.g., pick up resources for well water sampling, vaccine order pick-up, harm reduction kits, and health education resources and kits, etc.).

Closing branch offices would require consideration of these administrative, self-serve and pre-arranged services and alternate arrangements made to continue to support them (and potentially expand access to areas that have not had branch office locations too).

Operational efficiency

Chipping away at unnecessary operational overhead costs is a more sustainable and strategic approach to financial health than operating in a persistent deficit. A prolonged deficit position often necessitates operational cuts later, which can be more severe and unplanned (e.g., layoffs or service quality reduction).

There are other ways to deliver public health services outside of depending on our branch office locations. The use of the Social Determinant of Health/health equity dashboard (created by Knowledge Management team) has assisted the KFL&A immunization team since 2019 to determine where clients who need public health services reside. This has shifted their delivery model (i.e., away from static clinic locations, staff setting up clinics where there is identified need, divested in owned real estate, integrating services more with partners). The dashboard was shared with other legacy agencies, HPEPH shifted their delivery model; staff were working from the main office rather than branch offices to increase collaboration amongst team members and to do more outreach.

The following program statistics indicate, even with less staff, the delivery model based on a rural outreach strategy rather than a static branch office location will improve the delivery of core public health services in southeast region.

Figure 4: Infection Prevention and Control Inspection Compliance

	LGL Area	KFL&A Area	HPE Area
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	All-risk total	High/Moderate Risk	All-risk Total	High/Moderate Risk	All-risk total	High/Moderate Risk
Food Safety						
# premises	96	86	268	139	99	66
#inspections required annually		247	238	482	353	
# facilities meeting annual target YTD		36	34	186	118	63 *For 2025 a decision was made by HPE to not conduct food safety inspections in 33 low and ultra-low risk premises due to capacity limitations. These premises were before and after school care settings.
% facilities meeting annual target YTD		62%	78%	74%	93%	63% 96%
Childcare IPAC Inspections						
# premises		45	NA	54	NA	31 NA
#inspections required annually		45		54		31
# facilities meeting annual target YTD		32		53		31
% facilities meeting annual target YTD		71%		98%		100%
Personal Service Settings						
# premises		294	116	354	108	263
#inspections required annually		294	116	354	108	263 *202 facilities offer non-invasive personal services (the EH

					team, NOT the IPAC team, are responsible for completion of these inspections)	
# facilities meeting annual target YTD	124	69	232	84	253	58
% facilities meeting annual target YTD	42%	60%	66%* *Note: this includes premises that are due every other year skewing data lower than actual	78%	96%	95%

Harmonizing programming across SEPH

One of the Ministry of Health’s intention with voluntary mergers has been to address long-standing issues in Ontario’s public health sector, such as organizational performance inconsistencies. The program harmonization of services across the southeast region has identified inconsistencies in how legacy agencies were meeting standards, including legal requirements and the enforcement of the Immunization of School Pupils Act (ISPA), Child Care and Early Years Act, compliance with entry of Lyme disease reporting, and timely follow up of sexual health lab reports. Additional support is being put in place now to address lower ISPA coverage rates and additional mechanisms will be added as teams continue to harmonize their programs to ensure compliance with enforcement legislation.

When the voluntary business case was prepared, we all recognized the need for change on how we deliver core public health services and committed to a rural strategy for the delivery of public health services.

We remain committed to ensuring that rural residents continue to receive all core, mandated public health services. The role and necessity of branch offices has changed, much of what is done at these offices can be delivered in alternative ways, especially clinics. Based on the data, clinics were underutilized at the branch offices, and we don’t know if those who truly needed our services were even being served in these numbers. We continue to evolve and learn better ways to deliver our services, using health equity dashboards will help us determine the best clinic locations and improve access to core public health services. The closure of branch offices reflects a shift in *how* services are delivered—not a reduction in the level or quality of service provided.

Rural Services Delivery Strategy

As we continue to develop our rural strategy, the following guiding principles and components will shape our approach.

Guiding Principle:

- **Serving people, not places:** Focusing on client needs rather than physical office locations.
- **Evidence-based programs and services:** Ensuring all services reflect the best available data and public health practice.
- **Maximize Resource Impacts:** Using resources for the greatest possible outcome or value, while minimizing waste, cost, and negative side effects.
- **Health equity:** Focusing our programs and services on equity-deserving populations who have been systemically disadvantaged by the social determinants of health, such as income, education, housing, race, gender, religion, etc.

Components:

- Work with community partners
- Focus on outreach and mobile services
- Leverage technology and innovation

The purpose of the Rural Services Delivery Strategy is to improve health outcomes in rural areas by addressing unique challenges like geographic barriers and social determinants of health. It will support easier access for those most in need to receive core public health programs and services.

Summary

The assessment findings from the review of the following criteria, including the cost analysis, accessibility and service delivery, service demand and utilization, and operational efficiency indicates branch offices are underutilized and not operating at full capacity, failing to make the best use of time and resources (costing approximately \$550,000 annually to keep these offices open), and may not be providing optimal service delivery for hard to reach and vulnerable populations.

With over 85 percent of the southeast region's population within a 30-minute drive to a larger owned office and our Bancroft office, we have a strategic opportunity to decrease costs and close the following branch offices (i.e., Almonte, Cloyne, Gananoque, Napanee, Perth, Kemptville, and Trenton). This will provide additional resources, through staffing and services, to support the implementation of the rural strategy. This strategy holds at its centre a delivery model that has been proven to reach more clients by bringing targeted services to where people need them most, instead of making them come to a static location.

Decreasing branch office locations across the region will not decrease services. It will allow us to focus our service delivery and target those most in need in our communities. It will unify our agency and by supporting staff and team collaboration, while integrating our services more with community partners.

We have an opportunity to cut operational overhead costs and maximize resources. By focusing our resources on evidence-based approaches, leveraging technology and innovation, we will be able to position ourselves as a leader in public health to best serve our community and to strategically position our agency as a leader in public health. All this while ensuring the long-term financial health and stability of our new agency.

We must also always consider the long-term financial health and stability of our new agency. Municipalities are aware of the financial constraints that we are facing, and we have heard their concerns about where public funds are being invested. It is our duty to maximize resources so that they have the highest impact possible. We will work with individual municipalities to ensure optimal service delivery based on the local needs of their communities.

We are committed to continuing to find operational efficiencies, while working with individual municipalities to ensure optimal service delivery based on the local needs and to bridge health equity gaps in our communities. By decreasing overhead costs through redesigning the agency's office footprint and closing the branch offices, it will support us to deliver on the promises first made in the merger business case to ensure a robust, consistent approach to deliver a comprehensive rural strategy.

Considering the above factors, Southeast Public Health stands by the original recommendation to close the majority of our branch offices.

Options for consideration

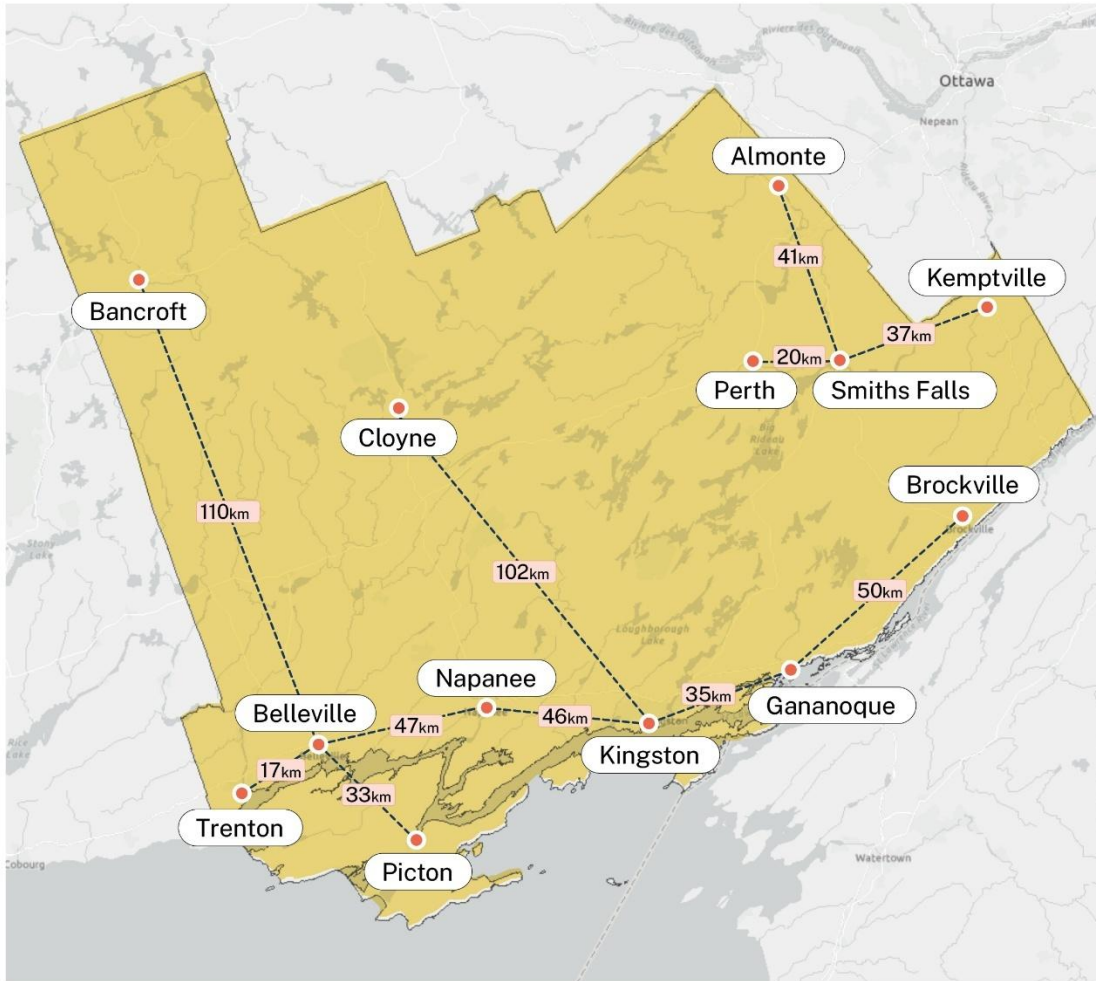
- 1) Endorse staff recommendation to close branch office locations in Almonte, Cloyne, Gananoque, Napanee, Perth, Kemptville, and Trenton by March 1, 2026, provided that continued access to public health services is maintained. In June 2026 present BOH an evaluation report assessing the implemented change in the service delivery model.**
- 2) Continue to have branch offices and revisit the decision in June 2026 following a review of an updated report on the rural strategy implementation and use of the branch offices.**
- 3) Keep branch offices and find savings and efficiencies elsewhere to balance 2027 budget and beyond.**

Appendix A: Number of Offices at each Local Public Health Unit:

1. Algoma Public Health – 4
2. Chatham-Kent Health Unit – 3
3. City of Hamilton Public Health & Social Services – 1
4. Durham Region Health Department – 1
5. Eastern Ontario Health Unit – 6
6. Grand Erie Health Unit – 4
7. Grey Bruce Health Unit – 1
8. Lakelands Public Health – 4
9. Halton Region Health Department – 1
10. Huron Perth Public Health – 4
11. Lambton Public Health – 2
12. Middlesex-London Health Unit – 2
13. Niagara Region Public Health Department – 5
14. North Bay Parry Sound District Health Unit – 2
15. Northeastern Health Unit – 13 (280,146 km²)
16. Northwestern Health Unit – 12 (173,828 km²)
17. Ottawa Public Health – 1
18. Peel Public Health – 3
19. Region of Waterloo Public Health – 1
20. Renfrew County and District Health Unit – 1
21. Simcoe Muskoka District Health Unit – 7
22. Southwestern Public Health - 3
23. Sudbury and District Health Unit – 5
24. Thunder Bay District Health Unit – 6
25. Toronto Public Health – 3
26. Wellington-Dufferin-Guelph Health Unit – 3
27. Windsor-Essex County Health Unit – 2
28. York Region Public Health Services – 1
29. Southeast Public Health – 13 (19,942 km²)

Appendix B: Service Location Map

Southeast Public Health Service Location Map



Smiths Falls to Kemptville	37 km
Smiths Falls to Perth	20 km
Smiths Falls to Almonte	41 km
Brockville to Gananoque	50 km
Kingston to Gananoque	35 km
Kingston to Cloyne	102 km
Kingston to Napanee	46 km
Napanee to Belleville	47 km
Belleville to Picton	33 km
Belleville to Trenton	17 km
Belleville to Bancroft	110 km

Board of Health Deputation Request Form

First Name:	Warden Corinna	Last Name:	Smith-Gatcke
Street Address:	25 Central Avenue, Suite 100		
City/Town:	Brockville, ON	Postal Code:	K6V 4N6
Phone:	██████████	Alternate Phone:	██████████
Email:	██████████ (Staff Contact: Bruce Enloe, EA to Mayor Peckford)		
Municipality you live in	United Counties of Leeds and Grenville		
Date you wish to present: (Check the website for dates)	2025-12-17		
<p>Brief statement of the subject matter you wish to discuss</p> <p>We wish to address the Board’s December 17, 2025 agenda item on the proposed criteria for closing Southeast Public Health Unit satellite offices in rural communities, including Kemptville and other locations. Our delegation will outline the anticipated impacts of these closures on equitable access to public health services for rural and small-urban residents, including seniors, families, and those without reliable transportation, and will share the concerns and experiences we are hearing from our municipalities.</p>			
<p>What action are you requesting of the Board</p> <p>We are requesting that the Board of Health:</p> <ol style="list-style-type: none"> 1. Pause any decisions to close satellite public health offices until a full equity and access analysis has been completed and shared publicly. 2. Re-examine the proposed criteria for closures through a rural-urban equity lens, to ensure rural communities are not disproportionately impacted. 3. Commit to meaningful consultation with affected municipalities, hospitals, and community partners before finalizing any service realignment, including in-person and mobile models. 4. Provide clear, transparent rationale and data supporting any proposed changes to service locations, including the impacts on distance travelled, transportation barriers, and continuity of care for residents. 			
<p>Overview of your delegation (names of speaker and individuals attending the meeting, name of organization, etc.)</p> <p>Warden Corinna Smith-Gatcke will serve as the single spokesperson, representing the United Counties of Leeds and Grenville and multiple lower-tier municipalities within Southeast Public Health’s catchment area.</p> <p>The delegation represents the Counties and local municipalities, including North Grenville and Edwardsburgh-Cardinal, whose residents rely directly on Southeast Public Health’s satellite offices for timely, local access to core public health services. Together, we speak for ~100k residents across rural Eastern Ontario who would be materially affected by the closure of these sites.</p>			



Signature (by entering your full name below, this will serve as your signature)

Submitted via email on December 1, 2025, by Bruce Enloe, Executive Assistant, on behalf of:

- Warden Corinna Smith-Gatcke, United Counties of Leeds and Grenville (Spokesperson)
- Mayor Nancy Peckford, North Grenville
- Mayor Tory Deschamps, Edwardsburgh-Cardinal

See below for more information regarding speaking at and attending Board meetings.

November 2025

Ensuring Accessible and Equitable Public Health Services Across Leeds & Grenville

Delegation to the Southeast Public Health Board
December 17, 2025

Warden Corrina Smith-Gatcke
with Mayors Nancy Peckford and Tory Deschamps



“As the Mayor of one of the fastest-growing communities in Eastern Ontario, I can say confidently that we need more and closer public health options - not fewer and further away. With limited health care capacity in our largely rural region, local public health services are essential to ensuring residents can have access to basic preventative care.”

— *Mayor Nancy Peckford, North Grenville*



Purpose of Delegation

- ▶ Respond to the proposed closure of eight satellite public health offices.
- ▶ Present a coordinated municipal perspective on behalf of Leeds & Grenville municipalities.
- ▶ Highlight access, equity, and rural-urban considerations.
- ▶ Express support for the Board's motion to pause closures pending further review.
- ▶ Advocate for transparent, evidence-based service planning.

Who We Represent

- ▶ The United Counties of Leeds & Grenville (UCLG) is comprised of **10 lower tier municipalities and collaborates with the 3 single tier municipalities through a Joint Services Agreement.**
- ▶ UCLG Residents heavily rely on local public health services.
- ▶ Reduced access to preventative public health care and harm reduction services **will impact a region with over 105,000 residents, and growing**
- ▶ Equitable, practical public health delivery is an imperative.



Leeds & Grenville: A Rural Region with Unique Access

- ▶ The geographic size of the United Counties is **3,300 square kilometres**
- ▶ **We are physically larger than the City of Ottawa & comprised of various townships, villages and hamlets.**
- ▶ Public health satellite offices **have increased access to preventative health care in nearly every community** where long travel distances for health care services is already quite common.
- ▶ Public health units have supported countless seniors, youth, and low-income residents **across the region.**
- ▶ Eg. Kemptville PH office serves Grenville County, ie. Edwardsburg-Cardinal, Augusta, Merrickville-Wolford and others



Some of the Essential Services Delivered Through Satellite Offices

- ▶ Breastfeeding & early-years supports
- ▶ Vaccination & immunization programs
- ▶ Speech & language services
- ▶ Smoking/tobacco cessation
- ▶ Disease prevention & surveillance
- ▶ Health promotion in schools
- ▶ Environmental health inspections
- ▶ Rural well-water bacteriological testing
- ▶ Sexual health clinics
- ▶ Among other services!



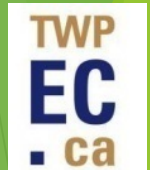
Observed Service Reductions in Recent Months:

- ▶ Reduced access to sexual health clinics in North Grenville.
- ▶ Reduced public health presence in schools.
- ▶ Less predictable vaccine clinic availability.
- ▶ **Limited communication** with municipalities and partners.
- ▶ Lower utilization likely reflects **awareness gaps**, not lack of need.

In regards to the merger and potential closure:

“Residents immediately expressed concerns about travelling much farther for basic services. Our region covers an enormous rural area, and decisions must reflect rural realities. The merger raised rural–urban divide concerns from the beginning.”

— *Mayor Tory DesChamps, Edwardsburg-Cardinal*



Impact of Satellite Closures

- ▶ Residents will have Travel distances of **60–80 km** for routine services
- ▶ **To be clear, there is NO public transportation to Brockville or Smith Falls from North Grenville.**
- ▶ There are **NO private taxis or ride shares** in North Grenville and limited options throughout Grenville County.
- ▶ North Grenville is seeing a population surge in seniors and families, and expected to exceed City of Brockville's population within a decade
- ▶ There is **very little FREE COMMUNITY space** for remote public health clinics and service delivery in our municipalities
- ▶ **Office closures mean increased risk of lower vaccination and early-intervention uptake, and** reduced harm-reduction access.
- ▶ **Inevitably, there will be greater pressures** on primary care and emergency departments.



North Grenville's Growth Will Drive Higher Service Needs

- ▶ 2021 population: **18,000 (closer to approx. 19,500 in 2025)**
- ▶ Projected 2046 population for North Grenville is 30,800 - according to the *Medium-growth scenario* undertaken by **North Grenville's Population Housing and Employment Forecast conducted in Dec 2023**
- ▶ This growth Represents **30–75 percent growth** over 25 years
- ▶ **A minimum of 4,905 new homes** - THIS is **196 homes per year in North Grenville** with hundreds of new homes in neighbouring communities. A 45 percent increase over past trends
- ▶ Undoubtedly, there will be **an increasing demand** for accessible public health services in our County

A rapidly growing population with limited primary care capacity requires *more* local access to public health - not less



Our Requests to the SEPH Board

1. Maintain satellite offices, including the Kemptville Office which is the only office in Grenville County
2. Conduct a full rural-equity and access analysis.
3. Examine any future potential offices closures through a rural access lens.
4. Engage municipal leaders, health partners, and schools immediately to identify partnership opportunities.
5. Share evidence used to support any potential argument to close the office and change service levels.

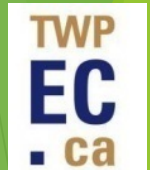


Closing Message:

Public health mergers must not reduce access for rural communities.

Local presence matters.

Leeds & Grenville is committed to collaboration and practical solutions that protect equitable access to care.



Board of Health Deputation Request Form

First Name:	Barinder	Last Name:	Gill
Street Address:	Prince Edward Family Health Team (PEFHT), 35 Bridge St., Suite 1 and 2		
City/Town:	Picton, ON	Postal Code:	K0K 2T0
Phone:	██████████	Alternate Phone:	
Email:	██████████		
Municipality you live in	Prince Edward County		
Date you wish to present: (Check the website for dates)	2025-12-17		
<p>Brief statement of the subject matter you wish to discuss</p> <p>The Prince Edward Family Health Team wishes to express our concern regarding the recently announced South East Public Health rural office closures and the potential reduction or modification of programs and services in Prince Edward County.</p> <p>Public health plays an essential role in the wellbeing of our community. Its close connection to primary care is especially vital in a rural context, where residents already face barriers related to geography, transportation, and access. Any reduction in local public-health presence risks widening those gaps.</p> <p>At the same time, we recognize the pressures facing Southeast Public Health, and we are committed to working constructively together. Regardless of the model or location, PEFHT strongly supports maintaining public-health programs and services within Prince Edward County. Immunizations, sexual health services, maternal-child supports, school health, environmental health, and health-promotion activities are critical components of a healthy population and directly complement the work of our primary-care teams.</p>			
<p>What action are you requesting of the Board</p> <p>Information Only</p>			
<p>Overview of your delegation (names of speaker and individuals attending the meeting, name of organization, etc.)</p> <p>Barinder Gill, Executive Director, PEFHT</p>			
<p>Signature (by entering your full name below, this will serve as your signature)</p>			
<p>Submitted via email on December 2, 2025, by Barinder Gill, Executive Director, PEFHT</p>			

See below for more information regarding speaking at and attending Board meetings.

The Importance of Public Health in Rural Communities

PRINCE EDWARD COUNTY

DEPUTATION TO THE SOUTHEAST PUBLIC HEALTH – BOARD OF PUBLIC HEALTH

WEDNESDAY DECEMBER 17, 2025

BARINDER GILL, EXECUTIVE DIRECTOR – PRINCE EDWARD FAMILY HEALTH TEAM

DR. SARAH LE BLANC – FAMILY PHYSICIAN – PRINCE EDWARD FAMILY HEALTH TEAM



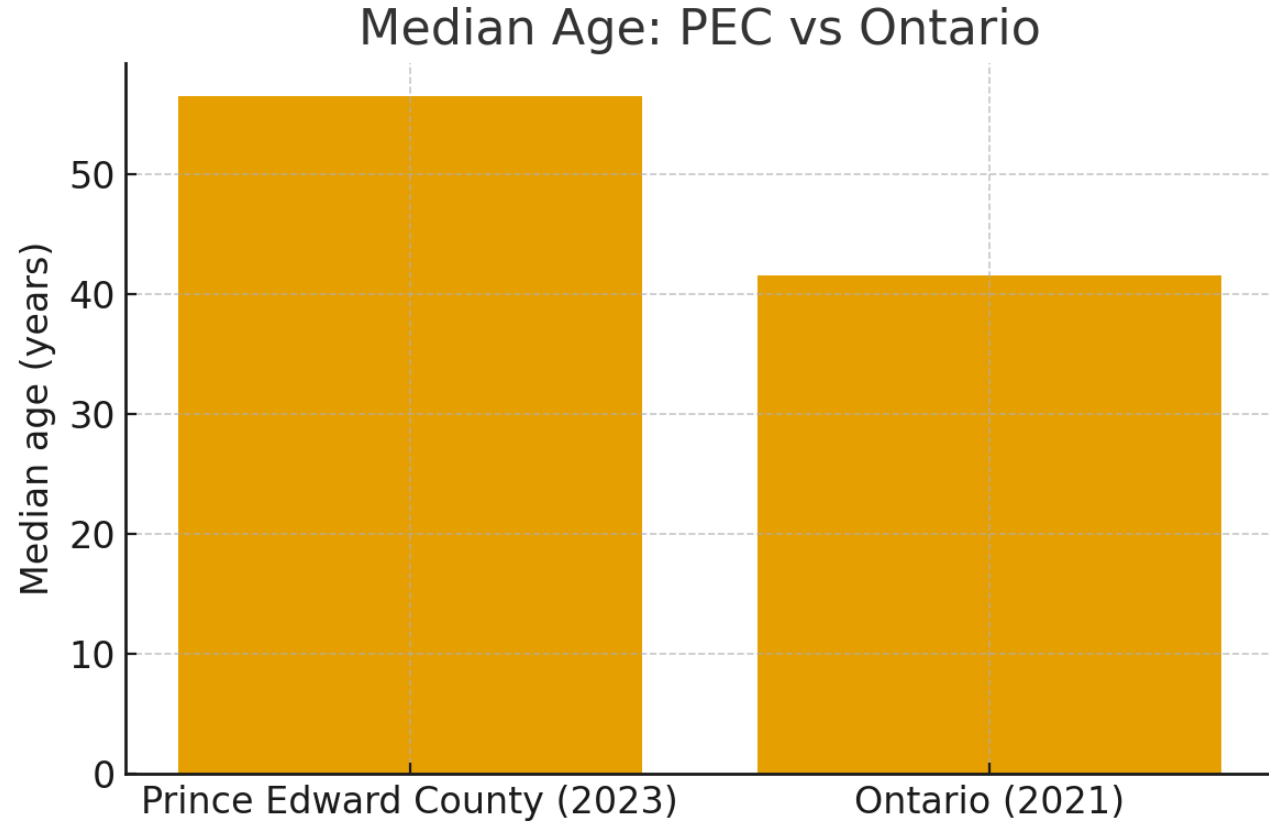
P R I N C E E D W A R D
FAMILY HEALTH TEAM

Your partner for best health

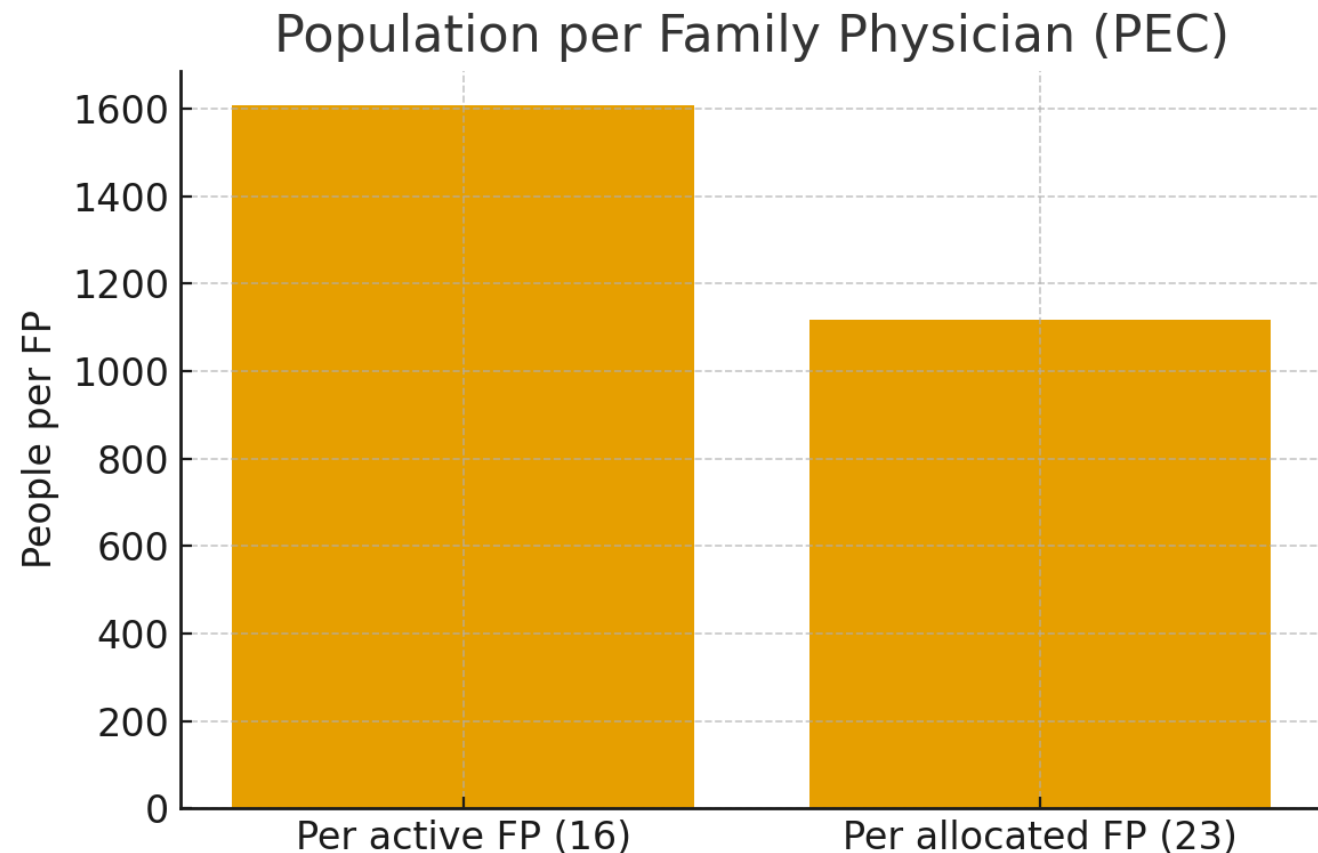
Prince Edward County — Key Facts

- Population (2021): 25,704. (Statistics Canada)
- Median age (2023): 56.5 — among the oldest communities in Ontario. (The County Foundation - VitalSigns)
- PEFHT clinical capacity: PEFHT reports 17 practicing County family physicians (allocation for 23).
- Health Care Connect waiting list (Dec 2022): ~1,675 people without a family doctor (local reporting).
- Teenage pregnancy rates in Hastings & Prince Edward counties have historically been higher than the Ontario average (HPE Teenage Pregnancy Report).

Median Age Comparison



Population per Family Physician



Teenage Pregnancy and Youth Supports

- Hastings & Prince Edward counties have historically had higher teenage pregnancy rates than Ontario averages (data 2005-2014).
- School-based programs, sexual health clinics, and confidential services are key prevention strategies.
- Reductions to local public health presence can reduce access to these vital services and increase risk for vulnerable youth.

Recent Public Health Office Changes

- Southeast Public Health / SEPH announced relinquishing leases for several rural offices including Picton (announced Nov 21, 2025).
- Operational consolidations may increase travel times for residents, reduce local visibility, and erode trusted relationships.
- Even with assurances of continued service, physical presence matters for access and community trust.

Recommendations — Local Actions

- Preserve at least core local public health presence in PEC to maintain visibility, trust and confidence in public health.
- Formalize partnership (in progress) between PEFHT and SEPH for shared outreach clinics and immunization delivery.
- Prioritize school-based sexual health and youth outreach programs to address higher teen pregnancy rates.
- Maintain investments and resource allocations in targeted prevention (immunizations, harm reduction, chronic disease screening) to reduce downstream primary care load.
- Monitor metrics: number of residents without family physicians, immunization coverage, teen pregnancy rates, and wait times for services and consider such metrics in future decision-making.

Board of Health Deputation Request Form

First Name:	Councillor Kate	Last Name:	MacNaughton
Street Address:	Shire Hall, 332 Picton Main St.		
City/Town:	Picton, ON	Postal Code:	K0K 2T0
Phone:	██████████	Alternate Phone:	
Email:	██		
Municipality you live in	Prince Edward County		
Date you wish to present: (Check the website for dates)	2025-12-17		
<p>Brief statement of the subject matter you wish to discuss</p> <p>I wish to thank the board for pausing the closure of local sites, and to speak about the importance of those local services in rural areas and the critical value of an ongoing public health presence in Prince Edward County. I will also talk about the value of in-school services.</p>			
<p>What action are you requesting of the Board</p> <p>I will be seeking assurance that in-school public health services will be maintained and I will be requesting the board commit to considering strong local provision alternatives that maintain a consistent, accessible presence in rural communities; and ensure there is a practical plan for local delivery before any satellite locations are closed; and to commit to continuation or improvement of the local services Prince Edward Currently receives.</p>			
<p>Overview of your delegation (names of speaker and individuals attending the meeting, name of organization, etc.)</p> <p>I am speaking both as a citizen and also in my role as a councillor for Prince Edward County.</p>			
<p>Signature (by entering your full name below, this will serve as your signature)</p>			
<p>Submitted via email on December 4, 2025, by Cllr. Kate MacNaughton, Prince Edward County</p>			

See below for more information regarding speaking at and attending Board meetings.

Board of Health Deputation Request Form

First Name:	Frank	Last Name:	Vassallo
Street Address:	2675 Concession Road, P.O. Box 2007		
City/Town:	Kemptville, ON	Postal Code:	K0G 1J0
Phone:	██████████	Alternate Phone:	
Email:	██████████		
Municipality you live in	North Grenville		
Date you wish to present: (Check the website for dates)	2025-12-17		
<p>Brief statement of the subject matter you wish to discuss</p> <p>I wish to discuss the rationale and corresponding data related to the proposed closure of the Kemptville Health Unit and the plan for the continuation of Public Health Services in our region</p>			
<p>What action are you requesting of the Board</p> <p>Aside from the info as requested above, I would like to discuss options for the continuation of Public Health Services in our region that may be new and innovative and partnership oriented.</p>			
<p>Overview of your delegation (names of speaker and individuals attending the meeting, name of organization, etc.)</p> <p>Frank J. Vassallo, President and CEO, Kemptville District Hospital Katie Hogue, VP, Clinical Services and Nursing/CNE, Kemptville District Hospital</p>			
<p>Signature (by entering your full name below, this will serve as your signature)</p>			
<p>Submitted via email on December 4, 2025, by Frank J. Vassallo and Katie Hogue.</p>			

See below for more information regarding speaking at and attending Board meetings.

Delegation Note

Date: December 11, 2025

Subject: Closure of the Kemptville Site of the South East Health Unit – Impacts on Local Health Care Delivery

Delegation Presented by: Kemptville District Hospital (KDH), on behalf of primary care partners across North Grenville

Delegation Narrative

Thank you for the opportunity to speak today on behalf of Kemptville District Hospital and our primary care partners across North Grenville. We are here to express deep concern regarding the announced closure of the Kemptville office of the South East Health Unit—a decision with far-reaching implications for our growing community, our health system, and our most vulnerable residents.

Following the public announcement, KDH leadership met in person with Medical Officers of Health Dr. Oglaza and Dr. Li at the Kingston Public Health Unit. We appreciated their willingness to hear our concerns, and we were encouraged by their candid acknowledgment that communication and engagement could—and should—have been stronger. While there were clearly missed opportunities in how this decision was discussed and communicated, the meeting ended on a constructive note, with a shared commitment to additional engagement, clearer planning, and more transparency related to service transitions.

However, despite this positive step, significant information gaps remain. Before any restructuring of this scale can move forward, our community needs a clear understanding of what services are currently delivered in Kemptville, what services may already have been reduced prior to this announcement, and whether declining utilization reflects actual need or simply limited visibility—what we have described as unconscious demarketing. We also need clarity around where each program is proposed to transition, how residents will be informed, and what supports will be in place for those who cannot easily travel.

Given these unknowns, it is essential that the Health Unit develop both a **Plan A** and a **Plan B** for each service. Rural communities cannot rely on assumptions about clinician availability, travel feasibility, or the ability of local providers to absorb additional responsibilities. Continuity of care depends on having well-defined, realistic options that safeguard access even when service models shift.

Many of the services provided locally by the Health Unit are foundational to public health and upstream prevention. These include immunizations, prenatal and maternal-infant health, breastfeeding support, naloxone distribution, rabies assessment, communicable disease management, environmental health inspections, harm reduction programs, and sexual health services. These are not peripheral programs—they are core components of the broader health system and essential to protecting community health.

One urgent concern is the shift toward sexual health services being offered **only on request**. For teens and young adults, who often require confidential and timely access to STI testing or contraception, this model introduces significant barriers. We risk situations where a young person delays care because they

are hesitant to “request” it, cannot travel, or fear the loss of anonymity. As a result, they may turn to the emergency department or face preventable long-term health consequences. These are real risks, and they reflect the importance of locally available, walk-in, youth-friendly clinical services.

The closure also has predictable impacts on the rest of our health system. Without accessible public health programming, KDH’s Emergency Department will see more preventable visits; primary care and community paramedicine—already operating at full capacity—will be asked to absorb additional responsibilities; and residents with the least ability to travel will disproportionately bear the burden of service loss.

Yet, even amid these concerns, we also see opportunity. There is real potential to re-envision how public health services are delivered in North Grenville—through integration with the Nurse Practitioner-Led Clinic (when funded), local FHOs, community paramedicine outreach, school-based programs, and municipal partnerships. These models could actually enhance reach and streamline care. But they cannot be designed or implemented without transparency, accurate data, and meaningful co-planning from the outset.

For these reasons, we respectfully request that the South East Public Health Unit provide:

1. The full rationale and supporting data used in the decision-making process.
2. Disclosure of any services previously reduced and the communication history associated with those reductions.
3. A clear, comprehensive chart outlining all current services, staffing roles, and proposed transitions.
4. A defined Plan A and Plan B for each service to ensure continuity and equitable access.
5. Formal consultation with KDH, primary care leaders, municipal leadership, and community paramedicine before any changes move forward.

While our recent engagement with the Medical Officers of Health was constructive, significant gaps remain in the evidence, planning, and transparency surrounding this decision. The closure of the Kemptville Health Unit site poses substantial risks to emergency preparedness, rural health equity, and continuity of care for one of Ontario’s fastest-growing communities. We urge the Health Unit to work with us—to share data openly, to revisit decisions that have system-wide implications, and to design a path forward that protects and strengthens public health services rather than diminishes them.

In closing, we need to reflect upon the phenomenal manner in which Public Health collaborated, planned, and delivered services with its many partners during the pandemic. We must continue to work together as all of us are stronger than one of us!

Thank you for your attention to this critical matter. We welcome the opportunity to continue this dialogue and support collaborative solutions that meet the needs of our residents.

Memo

To: Board of Health Members
From: Susan Stewart, Director, Merger Office
Date: December 17, 2025
Re: **Merger Updates**

Branding and Marketing

The project team continues to work on the new Southeast Public Health (SEPH) website. Collaboration with the selected vendor is ongoing, with a current focus on harmonizing navigation menus and planning content migration. SEPH managers are being engaged to identify website features that would support their programs and services. The website is live at www.southeastph.ca, with updates to its visual design underway. The project team and vendor are on track to deliver the final product by March 31, 2026. Signs for the Belleville, Kingston, Brockville and Smith Falls offices were ordered in October with an estimated timeline of six to eight weeks for delivery. As of drafting this memo, it has been seven weeks since ordering the signs, which have not yet been delivered.

Benefit Provider

As of December 1, 2025, Southeast Public Health transitioned to a new benefit provider. The provider has offered support to staff for accessing their portal. In collaboration with the Human Resources team, the provider is delivering information sessions to orient staff to the new plan.

All Staff Day

The inaugural in-person All Staff Day was held on December 2, 2025. The event opened with Dr. Kieran Moore, Chief Medical Officer of Health, as a keynote speaker, followed by long-service award presentations celebrating colleagues.

The afternoon focused on building relationships within new teams and featured another keynote speaker, Tim Arnold, a leadership development and teambuilding expert. His presentation focused on embracing connection through complexity.

The event was captured by Shannon Loomer, a visual artist from VisualTalks, who illustrated the essence of the day's discussions in real time.

We thank Mayor Jan O’Neill, Chair of the Southeast Board of Health, who participated in this event by thanking staff at the start of the long-term service awards. We would also like to thank all Board of Health members who were able to attend this event.

Staff feedback on the event is being collected through a survey.

Enterprise Resource Planning System

Implementation teams have been struck for both Dayforce (Human Resources/Payroll) and Sparkrock (Accounting/Finance) systems. The Dayforce Team is currently working with our implementation partner to scope the project, set up data templates and transfer data. Implementation will not occur until after payroll transition, into June 2026.

Sparkrock training for all finance staff is happening in November/December, with a 'soft finance' go-live date set for January and general staff training starting in February.

Policy and Procedure Harmonization

A policy review process has been established. The first cycle, harmonizing over 25 policies, is complete. Policies are being shared with staff and implemented across the organization. Cycle Two is scheduled for January–March 2026.

Medical Directives

Medical Directives are formal documents that outline specific tasks, procedures and clinical activities that healthcare professionals are authorized to perform without the need for direct physician assessment at the time of implementation. The Office of the Chief Nursing Officer (OCNO) is working on harmonizing medical directives. To date, seventeen medical directives have been harmonized and shared with staff.

A look back to 2025 – Completed Merger Projects

As 2025 comes to an end, the Merger Office would like to take a moment to review the significant progress made on major merger projects completed in 2025 and to thank all of the staff involved in these projects:

- Vendor selection for Enterprise Resource Planning for Human Resources, Payroll and Finance
- Assessment of all properties
- Migration of contracts, memorandums of understanding, agreements (on-going).
- Non-unionized wage, benefit and terms and conditions of employment harmonization (pending approval)
- New benefit provider selected and transition of all staff to new provider
- New Employee and Family Assistance Program provider selected for Southeast Public Health
- Harmonized short-term disability provider and adjudication process
- Senior level (Medical Officer of Health, Deputy Medical Officers of Health, and directors) organizational structure established
- Management level organizational structure established
- Assignment of staff to new teams
- Organizational transition so that we are working within the “new” team structure

- Public Sector Labour Relations Transition Act (PSLRTA) process initiated
- Organizational training plan needs assessment conducted
- Training for managers and staff on change management and dealing with change
- Crucial conversations training offered to all leadership
- Project management training for the Merger Office and the Executive Committee
- Tenancy migration to Microsoft 365 with common southeastph.ca e-mail addresses, supported by training on new Microsoft 365 tools
- Implementation of Hedgehog system for Environmental Health
- Electronic Medical Record (EMR) vendor selection
- Program and policy harmonization process and tools developed
- Program harmonization initiated across all portfolios
- Policy review cycle designed and implemented
- Harmonization of medical directives initiated
- Merger communication tools for all staff developed and implemented including:
 - Merger Memo
 - Message from the Merger Office (for timely messages)
 - Merger Hub
 - Merger Road Map
- New branding and logo launched
- New website launched (will undergo further development)
- New Southeast Public Health social media accounts launched
- Change management tools and processes implemented, including:
 - Change readiness assessment survey (quarterly)
 - Change management advisory group implemented
 - Culture building events held
 - Townhalls, Coffee Chats, and All Staff Day
 - “Navigating the New Team Landscape” module launched to all staff
 - Legacy events to recognize and honour all of the legacy public health units and the strengths that they brought to the newly merged Southeast Public Health

This memo is for the information of the Board.

Information Items

Board of Health Meeting – December 17, 2025

1. aPHa – [Holiday Greetings](#) – dated December 12, 2025.
2. aPHa – [Winter Symposium and Workshops](#) (Registration mid-January) – dated December 12, 2025.
3. Middlesex-London Health Unit – Board of Health Resolution: [Monitoring Food Affordability and Implications for Public Policy and Action](#) – dated December 11, 2025.
4. Municipality of Mississippi Mills – Correspondence from Mayor C. Lowry: [Concern Regarding Closure of Almonte Health Unit Office](#) – dated December 11, 2025.
5. Windsor-Essex County Health Unit – Board of Health Resolution: [Adverse Childhood Experiences \(ACEs\)](#) – dated November 20, 2025.
6. aPHa – [2026 Budget Consultations](#) – dated December 3, 2025.
7. Windsor-Essex County Health Unit – Board of Health Resolution: [Prevention and Response to Radon Exposures](#) – dated November 20, 2025.
8. Windsor-Essex County Health Unit – Board of Health Resolution: [School Food Programs](#) – dated November 20, 2025.



WISHING YOU A WONDERFUL HOLIDAY SEASON

We would like to extend our warmest wishes to
each and every one of you.
Here's to a safe and fun holiday season, filled with
warmth, happiness, and good health!

From the alPHa staff:
Loretta, Gord, Melanie, and Lynne

Please note:

*alPHa's office will close at noon on Wednesday, December 24th
2025 and will reopen on Monday, January 5th 2026.*



**Association of Local
Public Health
Agencies**

**Winter Symposium
and Workshops**

**February 11-13,
2026**

**Co-hosted by
alPHa**

Association of Local
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**Region of Waterloo
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Schedule 10.2

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Local public health plays a critical role in promoting healthy communities. This event will provide Members with engaging online workshops and in-depth plenary sessions with prominent public health leaders on the importance of Ontario's local public health system.

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Registration will be available mid-January and further information will be shared in alPHa's newsletter, *InfoBreak*, by email and on the website.

The Winter Symposium is generously supported by:



MIDDLESEX-LONDON BOARD OF HEALTH

REPORT NO. 83-25

TO: Chair and Members of the Board of Health

FROM: Dr. Alexander Summers, Medical Officer of Health
Emily Williams, Chief Executive Officer

DATE: 2025 December 11

MONITORING FOOD AFFORDABILITY AND IMPLICATIONS FOR PUBLIC POLICY AND ACTION (2025)

Recommendation

It is recommended that the Board of Health:

- 1) Receive Report No. 83-25 re: "Monitoring Food Affordability and Implications for Public Policy and Action (2025)" for information;
 - 2) Direct staff to draft a resolution for the 2026 Association of Local Public Health Associations (alPHA) Annual General Meeting recommending the Government of Ontario increase the Ontario Works earned income exemption to match the Ontario Disability Support Program earned income exemption; and
 - 3) Direct staff to forward Report No. 83-25 re: "Monitoring Food Affordability and Implications for Public Policy and Action (2025)" to Ontario Boards of Health, the City of London, Middlesex County, and appropriate community agencies.
-

Report Highlights

- In 2024, 1 in 3 households in Middlesex-London were food insecure. This is a statistically significant increase from 2023.
- Local food affordability monitoring is a requirement of the [Ontario Public Health Standards](#).
- The 2025 Ontario Nutritious Food Basket results demonstrate decreased food affordability and inadequate incomes to afford basic needs for many Middlesex-London residents.
- Food insecurity has a pervasive impact on health; and there is a need for income-based solutions.

Background

Food insecurity, defined as inadequate or insecure access to food due to financial constraints, is a key social determinant of health¹. For children and adults, food insecurity is a strong predictor of poor health and is associated with an increased risk of a wide range of physical and mental health challenges, including chronic conditions, non-communicable diseases, infections, depression, anxiety, and stress¹⁻³. Poor diet quality costs Ontario an estimated \$5.6 billion

annually in direct healthcare and indirect costs (e.g., lost productively due to disability and premature mortality)⁴.

As a result of systemic and structural inequities, racism, and colonization, food insecurity disproportionately affects certain populations^{1,3,5}. Higher rates of food insecurity are found among Indigenous People, Black people, recent immigrants, female lone parent led households, low-income households, and other marginalized populations¹. Although households whose main income is from social assistance have the highest rate of food insecurity, 58.6% of food insecure households in Ontario rely on wages, salaries, or self-employment as their main income¹.

Routine monitoring of food affordability helps generate evidence-based recommendations for collective public health action to address food insecurity which is often tied to income inadequacy. The [Ontario Public Health Standards](#) require monitoring local food affordability as mandated in the [Population Health Assessment and Surveillance Protocol, 2018](#).

The Ontario Nutritious Food Basket (ONFB) is a survey tool that measures the cost of eating as represented by current national nutrition recommendations and average food purchasing patterns. The Ontario Dietitians in Public Health (ODPH), in collaboration with Public Health Ontario (PHO), develop, test, and update tools for monitoring food affordability for Ontario public health units. The costing tool uses a hybrid model of in-store and online data collection.

Local Food Insecurity

The rate of food insecurity in Middlesex-London has significantly increased in recent years ([Appendix B](#)). In 2024, 1 in 3 households (31.3%) in Middlesex-London were food insecure⁶. This is a statistically significant increase from 2023 (1 in 4 households, 25.1%) and 2022 (1 in 6 households, 17.5%)⁶. Middlesex-London Health Unit is the only Ontario public health unit with a statistically significant higher food insecurity rate in 2024 than Ontario.

In 2024, an estimated 194,000 residents lived in food insecure households in Middlesex-London^{6,7}. This is an increase of approximately 54,000 residents from 2023 (estimated 140,000 residents)^{6,7}. However, food insecurity data are not available below the health unit level, limiting the ability to stratify prevalence estimates between the City of London and Middlesex County.

The prevalence of food insecurity across Canada suggest that food insecurity may be lower in rural areas (i.e., Middlesex County) than urban areas (i.e., City of London)⁸. However, food insecurity is still a concern for Middlesex County as evidenced by the number of meal programs and food banks in Middlesex County⁹. In addition, food bank usage underrepresents the actual rate of food insecurity, as many people who are food insecure do not access food banks¹⁰.

Food insecurity is measured by the Household Food Security Survey Module (HFSSM) and classified as food secure, marginally food insecure, moderately food insecure, or severely food insecure ([Appendix C](#)). In recent years, moderate and severe food insecurity have increased disproportionately compared to marginal food insecurity ([Appendix C](#))⁶. Ontario data provides an estimate for the increases at the local level, as Middlesex-London data is only available as the dichotomous variable of food secure or food insecure.

Local Food Affordability

Local food and average rental costs from May 2025 are compared to a variety of household and income scenarios, including households receiving social assistance, minimum wage earners, and median incomes ([Appendix D](#), [Appendix E](#)). The scenarios include food and rent only and

are not inclusive of other needs (i.e., utilities, Internet, phone, transportation, household operations and supplies, personal care items, clothing, etc.). The household scenarios highlight that incomes and social assistance rates are not keeping pace with the increased cost of living. Comparing the monthly funds remaining after rent and food costs in 2025 to 2024 for various household scenarios illustrates that specific scenarios are falling further behind each year and provides evidence for the impact of income-based policy changes on food affordability (e.g., Ontario Disability Support program rate increases are indexed to inflation, while Ontario Works rate increases are not indexed to inflation).

A key indicator of food insecurity is the average monthly cost of a nutritious diet as a proportion of household income. Households with low incomes spend up to 47% of their after-tax income on food, whereas households with adequate incomes (family of 4) only spend approximately 12% of their after-tax income.

Monitoring food affordability data and methodology details, including other cost adjustments required to compare the 2024 and 2025 scenarios, are included in [Appendix D](#).

Public Health Action

Annually, the Health Unit monitors and reports on local food affordability, the impact of health inequities due to food insecurity, effective strategies to reduce these inequities, and shares this information with the municipalities, the public, and community partners.

Ontario's [Poverty Reduction Act, 2009](#) requires the provincial government to develop a new poverty reduction strategy every five years. The current strategy, [Building a Strong Foundation for Success: Reducing Poverty in Ontario \(2020-2025\)](#), is soon to expire. MLHU submitted a response to the recent Ontario Poverty Reduction Strategy (OPRS) consultation including recommendations from the [food insecurity municipal primer \(Appendix F\)](#).

The food insecurity municipal primer includes a recommendation to work with the provincial government to advance income-based policies and income support programs (e.g., increase the amount of income exempt from reduction of Ontario Works (OW) benefits to better support those working toward leaving the OW program) (Report No. 48-25). The current OW earned income exemption of \$200 per month, with benefits reduced by 50 cents for every additional dollar earned, has not increased since 2013¹¹. In 2023, the provincial government increased the Ontario Disability Support Program (ODSP) earned income exemption from \$200 to \$1,000 per month, with benefits reduced by 75 cents for every additional dollar earned¹².

Earlier this year, the Board of Health received a [verbal delegation](#) from the London Food Bank (LFB) about their partnership with the Health Unit and the current state of food insecurity in Middlesex-London. [Feed Ontario](#), of which LFB is a member, advocates for solutions to end food insecurity and poverty in Ontario, including increasing the OW income exemption to align with the ODSP income exemption¹³.

It is recommended that the Board of Health direct staff to draft a resolution for the 2026 Association of Local Public Health Agencies (aLPHa) Annual General Meeting recommending the Government of Ontario increase the OW earned income exemption to match the ODSP earned income exemption (i.e., increase from \$200 to \$1000 per month, with benefits reduced by 75 cents for every additional dollar earned).

Living wages help to protect individuals against food insecurity. A living wage is the hourly wage a full-time worker needs to earn to afford basic expenses and participate in community life. In

Middlesex-London, the 2025 living wage is \$21.05 per hour¹⁴ as compared to the Ontario minimum wage of \$17.60. Local food costs, as estimated using the ONFB, are shared with the Ontario Living Wage Network and used to calculate our regional living wage. The Health Unit re-certified as a living wage employer in 2025.

Next Steps

Continued work is needed to address food insecurity and its significant health and well-being implications. MLHU will continue to highlight the need for upstream income-based solutions and programs that address both food affordability and access.

Affordable housing is critical to ensuring households can afford other necessities, such as food. Policy recommendations and actions that can be taken by municipalities and housing providers are included in “The Built, Natural, and Social Environments Framework: Housing” ([Report No. 82-25](#)).

This report was written by the Municipal and Community Health Promotion Team of the Family and Community Health Division and the Population Health Assessment and Surveillance Team of the Public Health Foundations Division.

References are affixed as [Appendix A](#).



Alexander Summers, MD, MPH, CCFP, FRCPC
Medical Officer of Health



Emily Williams, BScN, RN, MBA, CHE
Chief Executive Officer

This report refers to the following principle(s) set out in Policy G-490, Appendix A:

- The Population Health Assessment and Surveillance Protocol, 2018; and the Chronic Disease Prevention and Well-Being and Healthy Growth and Development standards, as outlined in the [Ontario Public Health Standards: Requirements for Programs, Services and Accountability](#).
- The following goal or direction from the [Middlesex-London Health Unit's Strategic Plan](#):
 - Our public health programs are effective, grounded in evidence and equity

This topic has been reviewed to be in alignment with goals under the Middlesex-London Health Unit's [Anti-Black Racism Plan](#) and [Taking Action for Reconciliation](#), specifically recommendations:

Anti-Black Racism Plan Recommendation #37: Lead and/or actively participate in healthy public policy initiatives focused on mitigating and addressing, at an upstream level, the negative and inequitable impacts of the social determinants of health which are priority for local ACB communities and ensure the policy approaches take an anti-Black racism lens.

Taking Action for Reconciliation Supportive Environments: Establish and implement policies to sustain a supportive environment, as required, related to the identified recommendations.

FOOD INSECURITY

MIDDLESEX-LONDON 2025



Food insecurity negatively impacts physical, mental, and social health ¹

Food insecurity is the inadequate or insecure access to food due to a lack of money ¹



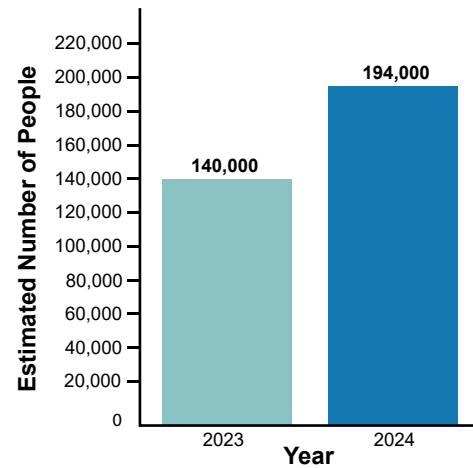
2024

1 in 3 Middlesex-London households were food insecure ²

2023

1 in 4 Middlesex-London households were food insecure ²

Middlesex-London Residents Living in a Food Insecure Household ^{2, 3}



How much money is left each month after paying for food and rent? ⁴



Income Source	Single Person		Family of 4		
	OW ^a	ODSP ^b	OW ^a	Minimum Wage ^c	Median Income ^d
Food (% of Monthly Income Needed)	47%	27%	40%	23%	12%
Rent (% of Monthly Income Needed)	116%	67%	63%	37%	19%
What's Left?	-\$558	\$84	-\$79	\$2,020	\$6,792

^a Ontario Works ^b Ontario Disability Support Program ^c As of May 2025 ^d Statistics Canada, 2025.

Households still need to pay for all other expenses, including childcare, utilities, Internet, phone, tenant insurance, transportation, personal care, clothing, school supplies, gifts, recreation, out of pocket medical and dental costs, education, and savings.

Solutions are needed that help people afford the costs of living



- Adequate social assistance benefits
- Jobs that pay a living wage
- A basic income guarantee
- Affordable housing, public transit, and childcare
- Reduced income tax for low-income households
- Free tax filing support

References
 1. Tarasuk V, Li T, Fafard St-Germain AA. (2022). Household food insecurity in Canada, 2021. Toronto: Research to identify policy options to reduce food insecurity (PROOF). Retrieved from <https://proof.utoronto.ca/>
 2. Ontario Agency for Health Protection and Promotion (Public Health Ontario). (2025). Snapshots Data File for Household Food Insecurity (2019 to 2023 (annual, 2-year combined, 3-year combined)). Retrieved from <https://www.publichealthontario.ca/en/Data-and-Analysis/Health-Equity/Household-Food-Insecurity>
 3. Ministry of Finance (MOF). (2024). Ontario population projections, 2023-2051. Toronto ON: MOF.
 4. Middlesex-London Health Unit (December 2025). Monitoring food affordability and implications for public policy and action (2025).



OFFICE OF THE MAYOR

Municipality of Mississippi Mills
3131 Old Perth Rd · Almonte ON · K0A 1A0

Phone: 613-256-2064

Fax: 613-256-4887

E-mail: clowry@mississippimills.ca

December 11, 2025

Jan O'Neill
Chair, Southeast Board of Health

Subject: Concern Regarding Closure of Almonte Health Unit Office

Dear Chair O'Neill and the Southeast Health Board,

I am writing to express my strong objection to the proposed closure of the Almonte Health Unit Office. This decision appears to have been made without transparency or meaningful consultation, and it may have serious, long-lasting consequences for the residents of Mississippi Mills.

Mississippi Mills is one of Eastern Ontario's fastest-growing municipalities. Between 2016 and 2021, our urban centre of Almonte saw a dramatic 21% increase in population. By 2028, Almonte's population is projected to increase to 8,030 people—a 59% increase since 2016. Over the next 5–15 years, Almonte's population will more than double to 11,047 residents—representing 119% growth.

Our community is experiencing enormous growth, and with it, increasing demand for accessible health care services. This growth makes consideration of health service provision not only timely but essential. Closing the Almonte office without a clear, viable plan for alternative, local service delivery disregards the needs of the community today and in the future. The cart isn't just before the horse—it's halfway down the hill, gathering speed, and no one seems to be steering.

I fully support the modernization of service delivery; however, it must be implemented with care, transparency, and a commitment to equity. Rural parity in health planning is non-negotiable—modernization cannot come at the expense of access for rural communities. Residents in rural areas deserve equitable levels of service to those in urban centres; any plan that disadvantages rural populations is unacceptable.

Currently, the Almonte office provides critical services, including:

- Free testing and treatment for sexually transmitted infections
- Emergency contraception (Plan B)
- Free or low-cost birth control

- Pregnancy testing and options counseling
- Naloxone kits
- Free condoms
- Immunizations for eligible individuals (HPV, Hepatitis A and B, MPOX)
- Healthy Babies Healthy Children program

Of note, these services disproportionately affect women. Limiting access creates barriers to timely advice, guidance, and essential care such as emergency contraception. There is ample evidence that barriers to services enabling women to control their reproductive health have long-lasting impacts on their future well-being. These impacts include increased rates of unintended pregnancies, which can disrupt education and economic stability; delayed treatment for conditions like STIs, leading to chronic health issues; and heightened mental health challenges such as stress and anxiety. Access to these services is not only a matter of convenience—it is a cornerstone of fundamental health care and personal agency for women. Safeguarding the access to these services is vital to preserving women’s control over their reproductive health and overall well-being.

In addition, if these services become centralized, the hardship for all Mississippi Mills residents will be significant:

- Transportation barriers: Many residents do not have access to reliable transportation – a critical social determinant of health. Traveling 50–75 km to Smiths Falls or beyond is not feasible for those without a vehicle or who rely on limited rural transit options.
- Financial strain: Increased travel costs for low-income families and individuals seeking essential health services will create inequities.
- Time and accessibility: Parents with young children, seniors, and those with mobility challenges will face major obstacles in accessing care.
- Privacy concerns: Sensitive services such as STI testing or pregnancy counseling become harder to access discreetly when travel is required.
- Impact on maternal and child health: Are we expecting new mothers to access breastfeeding support an hour away, or from a mobile clinic? Neither are practical nor reasonable alternatives.

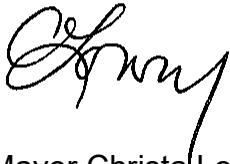
A further complication that has not been considered: Mississippi Mills has very limited rental or community space availability. It means that relocating services within our municipality is not a simple solution. Without a clear plan, the closure of the Almonte office will leave a gap that will not easily be filled.

Rural communities deserve fair access to public health service, and any modernization plan must ensure that no resident is left behind due to geography. I urge the Board to halt any closure plans until a comprehensive, transparent strategy for rural service delivery is developed in collaboration with other rural healthcare providers, and an

opportunity for meaningful community consultation is provided. Equity must be at the heart of this decision.

Thank you for your attention to this matter. I look forward to your response, and to working together to ensure fair access to public health services for all our residents

Sincerely,

A handwritten signature in black ink, appearing to read 'Christa Lowry', written in a cursive style.

Mayor Christa Lowry
Municipality of Mississippi Mills

CC: Warden Richard Kidd, Lanark County Representative



Windsor-Essex County Health Unit Board of Health

RECOMMENDATION/RESOLUTION REPORT – Adverse Childhood Experiences (ACEs) Local Policy Advancement

2025-11-20

ISSUE

Early adversities or Adverse Childhood Experiences (ACEs) are stressful or traumatic events occurring before the age of 18 that can trigger extreme or prolonged stress response, potentially leading to serious health issues later in life. These experiences may include physical, sexual, or emotional abuse; physical and emotional neglect; and household dysfunction such as parental separation, exposure to domestic violence, or substance use issues.

Locally, rising indications of youth mental health challenges, family stress, and community violence point to ongoing exposure to adversity among children and youth in Windsor and Essex County (WEC). Despite the well documented health and social costs of ACEs, prevention and trauma informed response are not yet fully integrated across community systems such as education, housing, health care and social services.

The issue is compounded by other broader systematic and individual traumas, including colonialism, racism, housing instability, children from low-income households, newcomers, and Indigenous communities. These individuals face a greater likelihood of exposure to ACEs with few accessible protective supports. Without coordinated, upstream policy action, ACEs will continue to drive intergenerational cycles of trauma, health inequity and system strain.

Preventing ACEs is increasingly recognized as an upstream public health strategy to reduce substance use, prevent chronic diseases and mental health issues, improve overall health, and address health inequities faced by families. A trauma-informed care approach is a foundational strategy in addressing ACEs. A trauma-informed approach acknowledges the widespread nature of trauma especially among children, youth and families and its effects on health. It involves adapting organizational policies and to foster resilience, prevent re-traumatization and promote safe, supportive environments for both clients and staff.

BACKGROUND

In May 2025, [the WECHU presented a board information report](#) outlining the significance of ACEs in our region. The presentation focused on what ACEs are, their health implications, populations most at risk, protective factors and key WECHU activities planned for 2025 which included:

- **Staff Capacity Building** – The WECHU has developed e-learning training modules on ACEs and trauma-informed care for all staff. Completion of this training will be mandatory throughout the organization and integrated into staff orientation, and annual refresher courses. In addition, the WECHU will share the e-learning modules with other community organizations and health care providers, encouraging the adoption of training within their own organization to build capacity and understanding of ACEs with their employees.
- **Policy Development/Implementation** – A corporate policy has been developed to guide implementation and integration of trauma-informed principles into daily WECHU operations. This policy ensures consistent application of training across WECHU programs and services. The WECHU will share this policy with other

community partners and health care providers to encourage adoption of similar policies to develop consistent, community wide application of ACEs and trauma informed care principles with clients.

- **Community Collaboration** – As a key priority, the WECHU is working with key community organizations to establish a working committee to address ACEs and trauma from a regional perspective. An initial meeting was held in June 2025 with interest from several local groups to work and collaborate on future initiatives focused on ACEs and trauma informed care.
- **Regional Communication Strategy**- The WECHU is developing communication messages about ACES including tips for parents and families to create positive experiences, and targeted messaging for priority populations introducing the concept of positive and adverse childhood experiences (PACES). Rollout of messaging is planned for early December 2025.

PROPOSED MOTION

WHEREAS Adverse Childhood Experiences (ACEs) are linked to a range of negative health and social outcomes across the lifespan, including chronic disease, mental illness, substance use disorders, and premature mortality; and

WHEREAS Adverse Childhood Experiences (ACEs) contribute to significant health inequities that disproportionately affect children and families facing poverty, racism, housing/food instability, and other systemic barriers; and

WHEREAS national data indicates that 61.6% of the population has experienced at least one Adverse Childhood Experiences (ACEs) in their lifetime and locally 19.3% of respondents had experienced at least one childhood maltreatment incident in Windsor-Essex County (Dawdy et. al., 2025)

WHEREAS the Windsor-Essex County Board of Health can endorse comprehensive policy recommendations that will help to address various health sectors in the region by focusing on the prevention and mitigation of Adverse Childhood Experiences (ACEs) and trauma; and

WHEREAS public health has a legislative mandate to promote health equity, prevent illness, and address the social determinants of health through multi-sectoral collaboration and policy advocacy.

NOW THEREFORE BE IT RESOLVED that the Windsor-Essex County Board of Health supports engaging local community partners to co-develop strategies that reduce exposure to Adverse Childhood Experiences (ACEs) and trauma and strengthen protective factors across the region by encouraging adoption of WECHU's training resources and policy within partner organizations;

AND FURTHER THAT the Windsor-Essex County Board of Health will support local collaboration with health care providers through the sharing of resources, research/data, best practices and recommends health care providers adopt WECHU's training resources and policies on Adverse Childhood Experiences (ACEs) and trauma informed principles within their own professional development and practices;

AND FURTHER THAT the Windsor-Essex County Board of Health calls on municipal, provincial, and federal partners to implement policies and funding that prevent ACEs by addressing poverty, housing insecurity, food access, and family supports;

AND FURTHER THAT, that the Windsor-Essex County Health Unit calls on the provincial government to ensure sustained provincial investment (i.e., funding, training and enhancement of programs and services focused on ACEs) in upstream initiatives that support at risk children, youth and families and help prevent or mitigate adverse childhood experiences, trauma and associated health issues and behaviours.

Key References:

Center for Health Care Strategies (2018). Brief: Laying the Groundwork for Trauma-Informed Care. Retrieved from https://www.chcs.org/media/Laying-the-Groundwork-for-TIC_012418.pdf

Dawdy, J., Dunford, K. and Magalhaes Boateng, K. (2025). Ontario Early Adversity and Resilience Framework. Public Health Ontario Adverse Childhood Experiences and Resilience Community of Practice

Madigan, S., (2023). Adverse childhood experiences: a meta-analysis of prevalence and moderators among half a million adults in 206 studies. *World Psychiatry* 2023; 22:463–471

From: allhealthunits <allhealthunits-bounces@lists.alphaweb.org> on behalf of alPHa communications <communications@alphaweb.org>
Sent: Wednesday, December 3, 2025 1:01 PM
To: 'allhealthunits@lists.alphaweb.org'
Cc: Board
Subject: [allhealthunits] 2026 Budget Consultations

This sender is trusted.

Dear alPHa Members,

The Ontario government has launched the [online portal](#) for input from people and businesses to inform the *2026 Budget*. As always, there is a variety of ways to submit, and these are outlined below.

alPHa will be providing a written submission. We invite Members' contributions to this undertaking, and we strongly encourage individual submissions to ensure the breadth of local public health contexts in Ontario is covered.

How to Participate

alPHa invites input from its Members to inform our submission on your behalf. To contribute, please send an e-mail to loretta@alphaweb.org by December 31, 2025.

To contribute directly on behalf of your public health unit, please visit www.ontario.ca/budgetconsultations, where you will find four options. The deadline for all submissions is January 30, 2026:

1. *Online survey* (3 -5 mins, multiple choice, no open-ended questions).
[Take the survey](#)
2. *Written submission*
Submit your "Top Three" suggestions for the *2026 Budget* and/or upload a document.
[Submit your proposal](#)
3. *Mail / e-mail (alPHa recommends uploading written documents via the portal as well)*
The Honourable Peter Bethlenfalvy
Minister of Finance
c/o Communications Services Branch
Frost Building North, 3rd Floor
95 Grosvenor Street
Toronto, Ontario
M7A 1Z1
Minister.fin@ontario.ca (cc MOFconsultations@ontario.ca)

In-Person Consultation

Email: MOFconsultations@ontario.ca for more information on consultations in your area.

We hope you find this information useful.

Take Care,

Loretta

Loretta Ryan, CAE, RPP

Chief Executive Officer

Association of Local Public Health Agencies (alPHa)

PO Box 73510, RPO Wychwood

Toronto, ON M6C 4A7

Tel: 416-595-0006 x 222

Cell: 647-325-9594

loretta@alphaweb.org

www.alphaweb.org



Windsor-Essex County Health Unit Board of Health

RECOMMENDATION/RESOLUTION REPORT – Prevention and Response to Radon Exposures in WEC

2025-11-20

BACKGROUND

Radon is an invisible, odorless, and tasteless radioactive gas that results from the natural decay of uranium in soil and rock. It can enter homes and buildings through cracks, or openings in the foundation, and when the gas accumulates in enclosed spaces, it can become a health risk. As radon decays, it releases radioactive particles that can attach to dust and other substances, which can damage the cells lining the lungs when inhaled. Prolonged exposure to radon can increase the risk of lung cancer. For non-smokers, radon exposure is the primary cause of lung cancer and for people who smoke the risk of is even higher. In fact, the Government of Canada (2025) estimates that radon exposure is responsible for 16% of lung cancers in Canada, resulting in more than 3,000 deaths each year¹. Exposure to radon poses significant health risks, especially to vulnerable populations like children, seniors, and individuals with pre-existing lung conditions. Children are particularly susceptible, as early exposure increases their lifetime risk of lung cancer.

Health Canada has set the Canadian guideline for indoor radon levels in the home at 200 Becquerels per cubic metre (Bq/m³). A recent 2024 [Cross-Canada Survey of Radon Exposure in the Residential Buildings of Urban and Rural Communities](#) was published and found that the central region (Ontario and Quebec) of Canada has approximately 1 in 6 residential homes with an average radon level at or exceeding 200 Bq/m³. The only way to know what the radon level is in a home or building, is to test for it. Corrective actions should be taken within one year if radon level results are at or greater than 200 Bq/m³. Effective techniques to reduce indoor radon levels include sealing cracks or gaps in the house or the building foundation, sealing sump-pump holes, and increasing ventilation. However, if these techniques do not reduce radon levels below 200 Bq/m³, a more extensive radon mitigation system must be installed by a certified radon professional. According to Health Canada, the expense of radon mitigation typically ranges from \$2000 to \$4000 which can present a significant financial burden for low-income households.

In [February 2019](#), the WECHU Board of Health passed a resolution that outlined a number of progressive public health initiatives aimed at lowering community risks and exposures related to radon. The key actions included promoting municipal and public policy updates on testing and mitigation, along with strengthening provincial building code requirements for new constructions of homes. Since this resolution, WEC municipalities have adopted a radon rough-in requirement for all new residential construction through by-laws (2020). The Ontario Building Code further strengthened these measures by mandating a rough-in for a subfloor depressurization system in all new homes and buildings in January 2025.

The WECHU continues to promote radon awareness through educational campaigns to the community, every November during Radon Action Month, to encourage residents to test their homes.

In 2022, the WECHU provided consultation to the Essex County Library, and its branches, to implement a Radon Monitor Lending Program that offers Essex County residents the opportunity for short term borrowing of radon devices to test their homes. The program was initially funded by a grant and launched with 20 short-term radon testing devices for library cardholders. The program has continued and expanded to 54 devices. From 2022 to 2024, the devices were circulated 4,094 times. While the Essex County Library has successfully added this resource to their services, other community serving organizations throughout the community hold important opportunities to offer similar types of free access to testing devices for the public. Free access to testing is of particular benefit to low-income households in high priority neighbourhoods. A more comprehensive, community based, barrier free access approach could expand reach and access.

Municipalities are in a unique position to take a leadership role in helping communities take action to prevent and identify radon concerns by developing and implementing radon policy frameworks. Many WEC residents live and work in spaces that lack modern radon mitigation systems, and the high cost of remediation is a major barrier for residents in low-income households. By implementing testing and mitigation policies in public spaces, municipal housing, and subsidized living facilities, municipalities can not only reduce exposure but also encourage other local organizations and businesses to adopt their own comprehensive radon policies.

PROPOSED MOTION

Whereas, the 2025 Government of Canada data shows that long-term radon exposure is the leading cause of lung cancer after smoking, and can be attributed to 3000 lung cancer deaths per year in Canada; and

Whereas, the 2024 Cross Canada Study indicates that the central region (Ontario and Quebec) of Canada has approximately 1 in 6 residential homes with average radon levels at or exceeding 200 Bq/m³, and

Whereas, testing is the only accurate way to know a home or building's radon level, and

Whereas, radon mitigation can present a significant financial challenge for many low-income homeowners in the WEC region, and

Now therefore be it resolved that the Windsor-Essex County Board of Health recommends local municipalities adopt radon policy frameworks that includes radon testing in municipally owned indoor spaces, including municipally supported congregate living sites, and implement mitigation strategies when high radon levels are detected; and

FURTHER THAT, the Windsor-Essex County Board of Health recommend local municipalities adopt a free and accessible short-term radon monitoring device lending program, in a variety of public spaces, for residents to test their homes for radon barrier free; and

FURTHER THAT, the Windsor-Essex County Board of Health continues to recommend that local municipalities explore opportunities for subsidy programs, specifically for those living in high priority neighbourhoods and low-income households, to reduce the cost of radon remediation in homes where radon is detected.



Windsor-Essex County Health Unit Board of Health

RECOMMENDATION/RESOLUTION REPORT – Windsor and Essex County School Food Programs

2025-11-20

BACKGROUND

Across Ontario, and particularly in Windsor and Essex County (WEC), inadequate nutrition among children and youth remains a significant public health challenge requiring coordinated policy action. Between 2023 and 2024, 25.7% of people in Windsor-Essex were living in a food-insecure households. Further, in 2023, 12.9% of children 1 to 17 years old in WEC lived in food-insecure households. Low-income households tend to have competing demands for scarce resources and spend less money on food compared to higher-income counterparts, making access to food out of reach for many families. Poor nutrition has serious consequences, including short-term impacts on students' academic success, mental well-being, overall growth and development, and causes increased rates of costly nutrition-related illnesses over time.

Families are struggling, which is why a comprehensive, evidence informed, community-based school food strategy is vital for our community. While school food programs are not a replacement for robust income security measures to directly [address household food insecurity](#), they are a key component of a comprehensive social support system: they reduce children's hunger during school hours, relieve pressure from household budgets, and improve the diets of children and youth across socio-economic backgrounds.

The Ontario Student Nutrition Program (OSNP) is a government-supported initiative that provides nutritious food, such as breakfasts, lunches, and snacks, to school-age children and youth to help them learn, develop healthy eating habits, and feel a sense of belonging at school. The universal program is delivered during school hours, through a network of schools and community partners, relying on volunteers to provide meals and support students' physical, social, and academic development. This program operates under a cost-shared funding model comprising two primary sources:

- **OSNP Grant:** Start-up funding that consolidates all OSNP-administered contributions, including federal, provincial, regional, and locally raised funds.
- **School-Generated Funds:** Schools are responsible for supplementing their programs through local fundraising efforts to ensure adequate financial and material resources.

This model presents an inherent challenge, as schools with the highest levels of need often lack the fundraising capacity to sustain their programs at the required level. Further, current decision making about which schools receive what amount of funding is done largely in isolation of local collaboration with local public health units. In addition, local not-for-profits have been conducting school lunch pilot projects which operate at the same time as OSNP programs. Rather than filling gaps in service (afterschool, weekends and holidays), these programs are duplicating services. There is also limited, if any, funding from local municipal governments to support school food programs, leaving this sustainable funding source as an unused resource.

On October 10, 2025, the federal government announced that they will be introducing legislation to make the National School Food Program permanent. On that same day, the Ontario government announcement an additional \$5 million of funding for this school year. These commitments to school food are welcomed, and very promising, but require a local perspective that is not the current practice.

The Windsor-Essex Food Strategy, endorsed by the Board of Health in June 2024, provides a framework of actions that can support neighbourhood focused initiatives that centre around schools identified by the WECHU, in consultation with the local school boards. The Windsor-Essex Food Policy Council can support these coordinated approaches, as we utilize school food programs to transform the local food system and provide significant opportunities to elevate the health, economy, and the food environment for all.

PROPOSED MOTION

Whereas, food insecurity affects approximately 1 in 4 households in WEC; and

Whereas, the current model for Ontario Student Nutrition Program funds does not include a locally driven, evidence-informed strategy, and does not prioritize recommendations and insight of local schools, boards and the WECHU; and

Whereas, opportunities for funding food programs outside of OSNP in schools are sporadic, time-limited, disconnected from risk-based food strategies, and not driven by local evidence of food insecurity needs in our school communities;

Whereas, the Windsor-Essex Food Policy Council network of local food system representatives can work to implement food strategy recommendations at the neighbourhood level;

Whereas, the WECHU, the Greater Essex County District School Board and the Windsor Catholic District School Board have prioritized a coordinated approach to addressing food insecurity in schools;

Now therefore be it resolved that the Windsor-Essex County Board of Health calls on the provincial government to review the current funding algorithm used in programs like the Ontario Student Nutrition Program, to ensure that local evidence informed strategy is upheld, led through insights of the local public health unit and school boards;

FURTHER THAT, local not-for-profit and community service organizations working to support food security strategies, focus on programming in high priority communities, specifically outside of school settings, with a key goal of addressing larger community-based food needs;

FURTHER THAT, local not-for-profit and community service organizations working to support food security strategies, focus on programming in high priority communities, for students and families during periods when school food programs are inaccessible (during non-school months and breaks, evenings, and weekends);

FURTHER THAT, local school boards, in consultation with the WECHU, be given the lead role in decision making and allocation of funding (new and current) for school-based food programs, to ensure a more coordinated and evidence informed local approach, reducing duplication of efforts, and utilizing existing key local data and school informed insights;

FURTHER THAT, the Windsor-Essex Food Policy Council prioritize the creation of evidence informed programs that improve physical access to foods in neighbourhoods surrounding the highest needs schools;

FURTHER THAT, the Windsor-Essex County Board recommends that local municipalities dedicate funding to sustainable food programming in schools, guided by evidence need at the recommendation of local public health and school boards.