AGENDA
MIDDLESEX-LONDON BOARD OF HEALTH

399 RIDOUT STREET NORTH
SIDE ENTRANCE (RECESSED DOOR)
Board of Health Boardroom

Thursday, 7:00 p.m.
2017 April 20

MISSION – MIDDLESEX-LONDON HEALTH UNIT

The mission of the Middlesex-London Health Unit is to promote and protect the health of our community.

MEMBERS OF THE BOARD OF HEALTH

Ms. Maureen Cassidy
Mr. Michael Clarke
Ms. Patricia Fulton
Mr. Jesse Helmer (Chair)
Mr. Trevor Hunter
Ms. Tino Kasi
Mr. Marcel Meyer
Mr. Ian Peer
Mr. Kurtis Smith
Ms. Joanne Vanderheyden (Vice-Chair)

SECRETARY-TREASURER

DISCLOSURE OF CONFLICTS OF INTEREST

APPROVAL OF AGENDA

APPROVAL OF MINUTES

Board of Health meeting, March 16, 2017.

DELEGATIONS

7:05 – 7:15 p.m. Mr. Trevor Hunter, Chair, Governance Committee, re: Item #1, Governance Committee meeting, April 20, 2017.

Receive: March 16, 2017 Governance Committee meeting minutes

7:15 - 7:25 p.m. Ms. Jennifer Proulx, Manager, Nurse-Family Partnership re: Item #2 The Canadian Nurse Family Partnership Education Project Update

Item #	Report Name and Number	Link to Additional Information	Delegation	Recommendation	Information	Brief Overview
Committee Reports						
1	Governance Committee (GC) MeetingApril 20, 2017 (Verbal Update)	Agenda: April 20, 2017 Minutes: March 16, 2017	x	x		To receive a verbal update from the April 20 Governance Committee Meeting.
Delegation and Recommendation Reports						
2	The Canadian Nurse Family Partnership Education (CaNE) Project Update (Report No. 019-17)		x		x	To provide an overview of the Canadian Nurse-Family Partnership Education Project.
3	Ontario Public Health Standards Modernization – Middlesex-London Health Unit Feedback (Report No. 020-17)	Appendix A		x		To approve feedback prepared by the Middlesex-London Health Unit to the Ministry of Health and Long-Term Care for consideration as they finalize the draft standards and begin implementation planning.
Information Reports						
4	Development and Implementation of a Strategy to Address HIV Epidemic and Related Issues in London (Report No. 021-17)	Appendix A			x	To receive an update on the development and implementation of strategies to address HIV and infectious diseases in persons who inject drugs.
5	Summary Information Report, April 2017 (Report No. 022-17)	Appendix A			x	To provide an update on Health Unit programs and services for April 2017.
6	Acting Medical Officer of Health / Acting Chief Executive Officer Activity Report, April 2017 (Report No. 023-17)				x	To provide an update on the activities of the Acting MOH / Acting CEO for April 2017.

OTHER BUSINESS

- Next Finance & Facilities Committee meeting: Thursday, May 4, 2017 @ 9:00 a.m.

    - The Finance & Facilities Committee will hold in-camera meetings on Thursday May 18 and Friday May 19 from 9:30 a.m. to 4:30 p.m. to discuss matters regarding a proposed or pending acquisition of land by the Middlesex-London Board of Health.
- Next Board of Health meeting: Thursday, May 18, 2017 @ 7:00 p.m.
- Next Governance Committee meeting: Thursday, June 15, 2017 @ 6:00 p.m.

CORRESPONDENCE

a) Date: 2017 February 27
Topic: Expert Panel on Public Health
From: Peterborough Public Health
To: The Honourable Dr. Eric Hoskins

Background:
Public Health Transformation is one of five goals under the Patients First Legislation. One of the major components of this transformation is the striking of an Expert Panel on Public Health which is chaired by Ontario's Medical Officer of Health, Dr. David Williams. This panel has been tasked with providing confidential recommendations directly to the Minister of Health and Long-Term Care. These recommendations would come without any consultation, validation or reporting to the public. This runs contrary to other panels that have been formed to enact the Patients First Legislation where panels provided public reports with recommendations and consultations. Peterborough Public Health is very concerned with the decision to keep this confidential.

Additionally, Peterborough Public Health expressed concern about funding and funding models being "out of scope" for the panel. Since the introduction of the public health funding formula there have been calls to evaluate the formula to assess whether it is meeting intended goals, what unforeseen consequences might be occurring and testing the validity of its underlying assumptions. Further, there were also comments regarding the future of the relationship with "obligated municipalities", support for the decision to not fund public health units through LHINs and the wish to understand how issues of funding will be addressed in the future.

Recommendation:
Receive.

b) Date: 2017 February 28
Topic: Opioid Use in Sudbury District
From: Sudbury & District Health Unit
To: The Honourable Dr. Eric Hoskins

Background:
The Sudbury District Health Unit passed a resolution which congratulates the Ontario Minister of Health and Long-Term Care and Chief Medical Officer on signing a joint statement of action committing to address the burden of opioid-related harms and the provincial opioid strategy. They requested that plans be developed with targets, deliverables and timelines that are communicated to stakeholders such as Board of Health. They further requested that the Federal Minister of Heath to communicate and promptly implement the federal opioid strategy.

Recommendation:
Endorse.

c) Date: 2017 March 09
Topic: Basic Income in Ontario
From: Huron County Board of Health
To: The Honourable Dr. Helena Jaczek, The Honourable Chris Ballard

Background:
In August 2016, Senator Hugh Segal provided a discussion paper to the Ontario government titled “Finding a Better Way: A Basic Income Pilot Project for Ontario”. This discussion paper outlined potential actions for organizing, planning, administering and designing a Basic Income Pilot for Ontario. The Huron County Health Unit drafted correspondence supporting the principle that everyone should have an income sufficient to meet basic needs and live with dignity and the Basic Income Guarantee Pilot. They also identify key policies and programs that should be complimentary to, rather than replaced by the Basic Income such as affordable child care, affordable housing, expanded health benefits and labour law reform.

The Middlesex-London Board of Health supported the investigation of a Basic Income Guarantee and sent correspondence regarding this matter to the Prime Minister of Canada, the Premier of Ontario and the Ontario Minister responsible for the Poverty Reduction Strategy.

Recommendation:
Receive.

d) Date: 2017 March 10
Topic: Response to the Standards for Public Health Programs and Services consultation document
From: Association of Local Public Health Agencies (alPHa)
To: All Board of Health Chairs, alPHa members

Background:
Modernization of the Ontario Public Health Standards is another component of the Patients First Public Health Transformation. The Ministry of Health and Long-Term Care addressed modernization at the Association of Local Public Health Agencies (alPHa) Winter Symposium on February 26, 2017. An Initial Analysis and Discussion was prepared by alPHa to be submitted to the Ministry. Key findings of this initial assessment included that there is now less content compared to previous Standards particularly in regard to health promotion requirements, that further details are required to assess the impact of the changes to boards of health. This report further details specific changes to the standards.

The Middlesex-London Health Unit has prepared a response for Board of Health feedback at the April board meeting. This response, once approved by the Board of Health will be forwarded to the Ministry of Health and Long-Term Care for their consideration.

Recommendation:
Receive.

e) Date: 2017 March 07
Topic: Opioid Addiction and Overdose
From: College of Physicians and Surgeons of Ontario
To: Dr. Christopher Mackie

Background:
At the November 2016 Middlesex-London Board of Health meeting, the Board passed a motion recommending the College of Physician and Surgeons of Ontario (CPSO) to advise their members that when prescribing opiates, patients should also be prescribed and counselled on use of naloxone to help prevent potentially fatal complications associated with opioid overdose.

A response from Dr. Rocco Gerace, Registrar, College of Physicians and Surgeons that they are currently investigating 80 physicians and their prescription practices and working with partners to promote appropriate prescription practices. They indicate naloxone may not be required by every patient and that access to those in need may be compromised if prescribed to those who do not require it. They suggest discussing the matter with the Chief Medical Officer of Health and they would be pleased to participate in such discussions.

Recommendation:
Receive.

f) Date: 2017 March 17
Topic: Public Health Programs and Services Consultation
From: Association of Local Public Health Agencies
To: Roselle Martino, Assistant Deputy Minister, Ministry of Health and Long-Term Care

Background:
See item (d) above.

Additional comments from alPHa included the difficulty of fully assessing the operational implications of the standards, the importance of examining capacity, resources and funding, the less prescriptive approach to health promotion and the lack of clarity on number of other issues.

Recommendation:
Receive.

g) Date: 2017 March 22
Topic: Expert Panel on Public Health and the Healthy Menu Choices Act
From: Leeds Grenville Lanark Board of Health
To: The Honourable Dr. Eric Hoskins

Background:
See item (a) above.

Additionally, the Leeds, Grenville and Lanark District Health Unit has asked the Ministry of Health and Long-Term Care how they intend to measure the success of the Healthy Menu Choices Act and who will be accountable for this.

Recommendation:
Receive.

h) Date: 2017 March 23
Topic: Tobacco Endgame
From: Scott Warnock, Board of Health Chair, Simcoe Muskoka District Health Unit.
To: The Honourable Dr. Eric Hoskins

Background:
The Simcoe Muskoka District Health Unit (SMDHU) passed a motion to support the federal government's proposal to have less than 5% of people using tobacco by 2035. This proposal includes approaches that were identified at the 2016 summit, A Tobacco End Game. SMDHU also included a motion to encourage alignment of the Smoke Free Ontario Strategy with federal plans. The tobacco end game approach includes enhance taxation, enhanced smoking cessation,

reduction in the production, supply and distribution of tobacco, litigation, and new funding streams for tobacco control.

Recommendation:
Receive.

i) Date: 2017 March 22
Topic: The Greater Access to Hepatitis C Treatment Act, 2016
From: Sylvia Jones, MPP Dufferin-Caledon
To: Chair Jesse Helmer

Background:
Sylvia Jones, MPP from Dufferin-Caledon introduced Bill 5, Greater Access to Hepatitis C to the Ontario Legislature. This legislation would provide treatment earlier than the current clinical criteria that demand an individual's liver is halfway to cirrhosis. The Bill passed first reading on September 13, 2016. The Member of Provincial Parliament provided an update on expanded access to four new drugs for patients with any disease severity or genotype. Previous correspondence relating to this item was received at the January 19th, 2017 Board of Health meeting.

Recommendation:
Receive.

j) Date: 2017 March 28
Topic: 2017 alPHa Fitness Challenge
From: Association of Local Public Health Agencies (alPHa)
To: all Health Unit staff

Background:
The Association of Local Public Health Agencies (alPHa) is sponsoring its annual employee fitness challenge on Thursday, May 11th. The challenge looks to have the entire staff participate in physical activity for at least 30 minutes that day.

Recommendation:
Receive.

k) Date: 2017 March 28
Topic: Low-Income Dental Program for Adults and Seniors
From: Porcupine Health Unit
To: The Honourable Dr. Eric Hoskins

Background:
The Porcupine Health Unit passed a resolution encouraging the Ministry of Health and Long-Term Care to expand public dental programs for those living on low incomes and that the resolution be forwarded to the Ministry of Health and Long-Term Care, the Chief Medical Officer of Health, alPHa, Ontario Boards of Health and the MPP for Timmins-James Bay.

Recommendation:
Receive.

Copies of all correspondence are available for perusal from the Secretary-Treasurer.

CONFIDENTIAL

The Board of Health will move in-camera to discuss matters regarding employee negotations, identifiable individuals and to consider confidential minutes from its March 16 meeting.

ADJOURNMENT

PUBLIC SESSION – MINUTES
MIDDLESEX-LONDON BOARD OF HEALTH
399 Ridout Street, London
Middlesex-London Board of Health Boardroom
Thursday, March 16, 2017 7:00 p.m.

MEMBERS PRESENT:
Mr. Michael Clarke
Mr. Jesse Helmer (Chair)
Mr. Trevor Hunter
Mr. Marcel Meyer
Mr. Ian Peer
Mr. Kurtis Smith

Regrets:
Ms. Maureen Cassidy
Ms. Tino Kasi
Ms. Patricia Fulton
Ms. Joanne Vanderheyden (Vice-Chair)

OTHERS PRESENT:
Ms. Laura Di Cesare, Secretary-Treasurer
Ms. Elizabeth Milne, Executive Assistant to the Board of Health and Communications (Recorder)
Mr. Jordan Banninga, Manager, Strategic Projects
Ms. Rhonda Brittan, Manager, Healthy Communities and Injury Prevention
Mr. Dan Flaherty, Communications Manager
Dr. Gayane Hovhannisyan, Acting Medical Officer of Health
Ms. Melissa Knowler, Public Health Nurse
Ms. Heather Lokko, Manager, Healthy Start
Mr. John Millson, Associate Director, Finance
Mr. Chimere Okoronkwo, Manager, Oral Health
Mr. Stephen Turner, Director, Environmental Health and Infectious Disease
Mr. Alex Tyml, Online Communications Coordinator
Ms. Suzanne Vandervoort, Director, Healthy Living

Chair Helmer called the meeting to order at 7:01 p.m.

Chair Helmer recognized and welcomed the Board's new Provincial Appointee, Dr. Michael Clarke.

DISCLOSURES OF CONFLICT(S) OF INTEREST

Chair Helmer inquired if there were any disclosures of pecuniary interest. None were declared.

APPROVAL OF AGENDA

It was moved by Mr. Peer, seconded by Mr. Meyer, *that the **AGENDA** for the March 16, 2017 Board of Health meeting be approved.*

Carried

APPROVAL OF MINUTES

It was moved by Mr. Hunter, seconded by Mr. Meyer, *that the **MINUTES** of the February 16, 2017 Board of Health meeting be approved.*

Carried

COMMITTEE REPORTS

1) Finance and Facilities Committee Meeting Update – March 2, 2017 (Report No. 010-17)

Mr. Peer provided a summary and update regarding reports reviewed at the March 2 Finance & Facilities Committee meeting.

Financial Controls Checklist (Report No. 009-17FFC)

It was moved by Mr. Peer, seconded by Mr. Meyer, *that the Board of Health receive Report No. 009-17FFC re: Financial Controls Checklist for information.*

Carried

Impact of Consent Process on Dental Screening Outcomes (Report No. 010-17FFC)

Mr. Peer explained why the committee had asked staff to put together a report on this, and discussed the dental consent form for screening and its use in schools.

Mr. Peer noted that the April 6 Finance & Facilities Committee meeting is cancelled.

It was moved by Mr. Peer, seconded by Mr. Hunter, *that the Board of Health:*

1) *Receive Report No. 010-17FFC comparing screening practices between school boards within the jurisdiction of the Health Unit and in Ontario for information; and*
2) *Direct staff to bring forward this report and the earlier report from 2007 to the next Finance & Facilities Committee meeting for review and input.*

Carried

Discussion ensued about the dental screening consent form, its use in schools and the directive that staff bring forward the earlier 2007 report at the May Finance & Facilities Committee meeting.

Chair Helmer asked whether the Board would like to forward this report to the Chair of the Thames Valley District School Board for further review and discussion on the consent process.

It was moved by Mr. Peer, seconded by Mr. Smith, *that the Board of Health forward Report No. 010-17FFC to the Chair of the Thames Valley District School Board for further discussion on the consent process.*

Carried

It was moved by Mr. Peer, seconded by Mr. Meyer, *that staff bring forward the report from 2007 for review and input to the Finance & Facilities Committee in May.*

Carried

It was moved by Mr. Peer, seconded by Mr. Meyer, *that the Minutes of the March 2 Finance & Facilities Committee meeting be received.*

Carried

2) Governance Committee Meeting, March 16, 2017 (Verbal Update)

2017 BOH Self-Assessment Results (Report No. 004-17GC)

Mr. Hunter summarized the discussion on this report and described the work soon to happen in regard to Board of Health development.

It was moved by Mr. Hunter, seconded by Mr. Peer, *that the Board of Health:*

1) *Receive Report No. 004-17GC re: Board of Health Self-Assessment Results for information; and*
2) *Consider the survey results and incorporate the feedback into Board development planning for 2017.*

Carried

Strategic Plan Update (Report No. 005-17GC)

Mr. Hunter introduced the report on the Strategic Plan Update. Ms. Di Cesare summarized the report's key highlights, noting that some items that have just been announced, such as the Ontario Public Health Standards modernization and the Value-for-Money Audit, which may require that staff amend or revise the scorecard later this year.

It was moved by Mr. Hunter, seconded by Mr. Smith, *that the Board of Health:*

1) *Receive Report No. 005-17 re: Strategic Plan Update for information; and*
2) *Approve the 2017 Middlesex-London Health Unit Balanced Scorecard.*

Carried

Chair Helmer flagged the e-agenda software for discussion.

Other Business:

Mr. Hunter summarized the discussion and reviewed the policy changes approved by the Governance Committee. Mr. Hunter noted that policy G-380 will be sent back to staff to review the language around disclosures of conflicts of interest.

It was moved by Mr. Hunter, seconded by Mr. Peer, *that the Board of Health approve policies G-270, G-280, G-290, G-300, G-350, G-370, G-470, G-480 and G-490.*

Carried

It was moved by Mr. Hunter, seconded by Mr. Smith, *that the Board of Health forward policies G-310, G-320, G-330, G-410 and G-420 to the Finance & Facilities Committee for review.*

Carried

Mr. Hunter summarized the discussion about posting the updated policies online once finalized to make them accessible to the public.

It was moved by Mr. Hunter, seconded by Mr. Peer, *that the Board of Health recommend that staff make the updated policies public on the Health Unit's website, once finalized and approved.*

Carried

It was moved by Mr. Hunter, seconded by Mr. Smith, *that the Board of Health receive the minutes of the January 19, 2017 Governance Committee meeting.*

Carried

The next Governance Committee meeting will be on April 20, 2017.

DELEGATION AND RECOMMENDATION REPORTS

3) Ontario Public Health Standards Modernization (Report No. 011-17)

Dr. Gayane Hovhannisyan introduced the report and provided a presentation to update the Board on the consultation and review process for the Ontario Public Health Standards (OPHS) modernization.

Discussion ensued about the following items:

- The potential impact of the OPHS modernization on staff and on the organization, and the tight timelines for the work and consultation.
- MLHU's capacity and ability to adapt to changes using existing public health resources and funding.
- Flexibility in providing or adjusting services, as required by the modernized standards.

- The possible impact of the modernized standards on the forty prioritized projects planned for 2017.

It was moved by Mr. Hunter, seconded by Mr. Peer, *that the Board of Health nominate Mr. Meyer to attend the Ministry of Health and Long-Term Care Standards Consultations on March 24, 2017, from 1 p.m. to 4 p.m.*

Carried

It was moved by Mr. Peer, seconded by Mr. Hunter, *that the Board of Health:*

1) *Receive Report No. 011-17 for information;*
2) *Direct Health Unit staff to prepare a written submission in response to the consultation document for Board of Health approval; and*
3) *Nominate Mr. Meyer to attend the Ministry of Health and Long-Term Care Standards Consultations on March 24, 2017, from 1 p.m. to 4 p.m.*

Carried

4) Vaccine Preventable Diseases (VPD) Program Review (Report No. 012-17)

Ms. Marlene Price provided a summary of work done by the Vaccine Preventable Diseases team.

Discussion ensued about the following items:

- Challenges and changes faced by the team, including changes to the Immunization of School Pupils Act (ISPA), providing additional vaccines and changes to Tuberculosis (TB) skin-testing procedures.
- Education sessions that will be provided to healthcare providers to update them on the changes to Tubersol/TB skin testing.
- The reasons for the withdrawal of service, following the Ministry review, which resulted in eliminating TB skin tests for students.
- Immunization exemptions on file, and how the numbers have changed over the years compared to five to ten years ago. Currently approximately three percent of students have an exemption on file.

It was moved by Mr. Hunter, seconded by Mr. Clarke, *that the Board of Health receive Report No. 012-17 re: Vaccine Preventable Diseases Program Review for information.*

Carried

5) The Legalization and Regulation of Cannabis in Canada (Report No. 013-17)

Dr. Hovhannisyan introduced Ms. Rhonda Brittan, Manager, Healthy Communities and Injury Prevention, and Ms. Melissa Knowler, Pubic Health Nurse, who answered questions about the report.

Mr. Peer summarized the meeting he attended with Parliamentary Secretary Bill Blair on February 28, 2017, to discuss cannabis legalization. Staff also attended this meeting to provide feedback and discussion.

Discussion ensued about the following items:

- Whether there will be a financial impact on the Health Unit when cannabis is legalized, and who will be responsible for cultivating, regulating and distributing the product.
- Likely the Health Unit will be involved in monitoring product sale and enforcement (sales, age limits, etc.). Costs are not likely to be embedded in the new legislation.
- Equitable distribution of the product and the importance of investing in treatment at the same time, given the lessons learned from the sale and distribution of tobacco and alcohol.
- Whether legalization will normalize the product and assist in regulation, and the impact on the illicit market.
- The controls each province will put in place to set age of use, and how the federal government arrived at setting the current age at eighteen.

Dr. Hovhannisyan summarized some of the discussion that the Health Unit brought to the meeting with Bill Blair, and noted that age of use, the negative impact on the brain and the impact that widespread availability and usage may have, including exposure to children and infants and during pregnancy.

It was moved by Mr. Hunter, seconded by Mr. Peer, *that the Board of Health:*

1) *Receive Report No. 013-17 re: The Legalization and Regulation of Cannabis in Canada for information; and*
2) *Direct staff to continue to work with partners at the local and provincial levels to advocate for and support the development and implementation of evidence-informed regulations.*

Carried

INFORMATION REPORTS

6) Summary Information Report, March 2017 (Report No. 014-17)

It was moved by Mr. Smith, seconded by Mr. Meyer, *that the Board of Health receive Report No. 014-17 re: Summary Information Report, March 2017 for information.*

Carried

7) Acting Medical Officer of Health / Acting Chief Executive Officer Activity Report, March 2017 (Report No. 015-17)

It was moved by Mr. Smith, seconded by Mr. Meyer, *that the Board of Health receive Report No. 015-17 re: Acting Medical Officer of Health / Acting Chief Executive Officer Activity Report, March 2017.*

Carried

CORRESPONDENCE

It was moved by Mr. Peer, seconded by Mr. Hunter, *that the Board of Health receive items a) through l).*

Carried

OTHER BUSINESS

Next meetings:

Chair Helmer noted the next Finance & Facilities Committee meeting on Thursday, April 6, will be cancelled.

- Next Governance Committee meeting: Thursday, April 20, 2017, 6:00 p.m.
- Next Board of Health meeting: Thursday April 20, 2017, 7:00 p.m.

Chair Helmer proposed a five-minute recess before moving into confidential session.

It was moved by Mr. Hunter, seconded by Mr. Meyer, *that the Board of Health take a five-minute recess before moving into confidential session.*

Carried

CONFIDENTIAL

At 8:43 p.m., Chair Helmer invited a motion, to move in-camera, to discuss matters regarding identifiable individuals; employee negotiations; and a proposed or pending acquisition of land by the Middlesex-London Board of Health; and to review the confidential minutes of the February 16 Board of Health meeting and the March 2 Finance & Facilities Committee meeting.

At 8:43 p.m., it was moved by Mr. Hunter, seconded by Mr. Clarke, *that the Board of Health move in-camera to discuss matters regarding identifiable individuals; employee negotiations; and a proposed or*

pending acquisition of land by the Middlesex-London Board of Health; and to review the confidential minutes of the February 16, 2017 Board of Health meeting and the March 2, 2017 Finance & Facilities Committee meeting.

Carried

At 8:43 p.m., all visitors and Health Unit staff, except for Ms. Laura Di Cesare, Dr. Gayane Hovhannisyan, Mr. John Millson, Ms. Heather Lokko, Mr. Stephen Turner, Ms. Suzanne Vandervoort, Mr. Jordan Banninga, Mr. Chimere Okoronkwo and Ms. Elizabeth Milne, left the meeting.

At 10:32 p.m., it was moved by Mr. Meyer, seconded by Mr. Peer, *that the Board of Health rise and return to public session.*

Carried

At 10:32 p.m., the Board of Health returned to public session.

ADJOURNMENT

At 10:32 p.m., it was moved by Mr. Smith, seconded by Mr. Hunter, *that the meeting be adjourned.*

Carried

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JESSE HELMER
Chair

LAURA DI CESARE
Secretary-Treasurer

PUBLIC SESSION – MINUTES
MIDDLESEX-LONDON BOARD OF HEALTH
Governance Committee
399 Ridout Street, London
Middlesex-London Board of Health Boardroom
Thursday, March 16, 2017 6:00 p.m.

Committee Members Present:	**Mr. Trevor Hunter (Chair)** Mr. Ian Peer Mr. Kurtis Smith Mr. Jesse Helmer
Regrets:	Ms. Maureen Cassidy
Others Present:	Mr. Marcel Meyer Ms. Elizabeth Milne, Executive Assistant to the Board of Health and Communications (Recorder) Mr. Jordan Banninga, Manager, Strategic Projects Ms. Laura Di Cesare, Director, Corporate Services

Chair Hunter called the meeting to order at 6:02 p.m.

DISCLOSURE OF CONFLICT(S) OF INTEREST

Chair Hunter inquired if there were any disclosures of conflict of interest to be declared. None were declared.

APPROVAL OF AGENDA

It was moved by Mr. Helmer, seconded by Mr. Smith, *that the AGENDA for the March 16, 2017 Governance Committee meeting be approved.*

Carried

APPROVAL OF MINUTES

It was moved by Mr. Peer, seconded by Mr. Smith, *that the MINUTES of the January 19, 2017 Governance Committee meeting be approved.*

Carried

NEW BUSINESS

4.1 2017 BOH Self-Assessment Results (Report No. 004-17GC)

Discussion ensued about the following items:

- The process used this year, including sending it out to be completed digitally and ranking items in question 19.
- Where efforts should be focused for Board development in the next year and how the committee will hone in and provide direction to staff for future Board education and development sessions such as regular education regarding the various programs and governing aspects such as policy or standards at each Board meeting.

It was moved by Mr. Peer, seconded by Mr. Helmer, *that the Governance Committee:*

1) *Recommend that the Board of Health receive Report No. 004-17GC re: Board of Health Self-Assessment Results for information; and*
2) *Consider the survey results and incorporate the feedback into Board development planning for 2017.*

Carried

4.2 Strategic Plan Update (Report No. 005-17GC)

Ms. Di Cesare provided a summary of the Strategic Plan Update and Balanced Scorecard, which included an update on projects that did not start in 2016 and those that will continue into 2017. Ms. Di Cesare advised that staff will endeavour to bring an update to the Committee semi-annually, versus at year end only. Ms. Di Cesare

also noted some recent announcements that may require some realignment of items identified on the 2017 scorecard. These challenges include the Ontario Pubic Health Standards Modernization work and the potential value for money audit which could impact and the work currently being done.

Discussion ensued about the following items:

- The feasibility of continuing to pursue the e-agenda software in the scorecard and the issues experienced in completing this item in 2016.

It was moved by Mr. Helmer, seconded by Mr. Smith, *that the Governance Committee:*

1. *The Governance Committee receive Report No. 005-17 re: Strategic Plan Update for information; and,*
2. *The Board of Health approve the 2017 Middlesex-London Health Unit Balanced Scorecard.*

Carried

OTHER BUSINESS

5.1 Policy Review (Continued)

Mr. Jordan Banninga, Manager, Strategic Projects provided a summary of and changes made to policies G-270, G-280, G-290, G-300, G-350, G-370, G-470, G-480, and G-490. Discussion ensued about the updates made to these policies, and that policy G-380 will be taken back to staff for a review of wording around declaration of conflict of interest and the possible removal of Appendix A to this policy.

It was moved by Mr. Helmer, seconded by Mr. Smith *that the Governance Committee recommend that the Board of Health approve policies G-270, G-280, G-290, G-300, G-350, G-370, G-470, G-480, and G-490.*

Carried

It was moved by Mr. Smith, seconded by Mr. Helmer, *that the Governance Committee forward policies G-310, G-320, G-330, G-410 and G-420 to the Finance and Facilities Committee to review and provide amendments.*

Carried

Discussion ensued about sharing the updated policy manual on the website, once finalized. The Committee agreed that it belongs in the public purview.

It was moved by Mr. Helmer, seconded by Mr. Smith *that the Governance Committee recommend the Board of Health consider putting the Governance Policy Manual on the Health Unit's website once finalized.*

Carried

Ms. Di Cesare thanked and recognized Mr. Banninga's efforts in preparing the Governance Reports for this evening's meeting.

The Governance Committee will review the remaining policies at its next meeting (G-120 and G-260). Any questions about the remaining policies for review will be forwarded to Mr. Banninga to clarify.

5.2 Next Meeting: Thursday, April 20, 2017

ADJOURNMENT

At 6:56 p.m. it was moved by Mr. Smith, seconded by Mr. Helmer, *that the meeting be adjourned.*

Carried

TREVOR HUNTER
Chair

LAURA DI CESARE
Secretary-Treasurer

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT
www.healthunit.com

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 019-17

TO: Chair and Members of the Board of Health

FROM: Dr. Gayane Hovhannisyan, Acting Medical Officer of Health
Laura Di Cesare, Acting Chief Executive Officer

DATE: 2017 April 20

THE CANADIAN NURSE-FAMILY PARTNERSHIP EDUCATION (CaNE) PROJECT UPDATE

Recommendation

It is recommended that Report No. 019-17 re: The Canadian Nurse-Family Partnership Education (CaNE) Project Update be received for information.

Key Points

- The Nurse Family Partnership® (NFP) is an evidence-based home visiting program targeting young, low-income, first-time mothers.
- The Canadian Nurse-Family Partnership Education (CaNE) project aims to develop, pilot and evaluate a Canadian model of education for NFP nurses and supervisors.
- CaNE pilot sites are recruiting clients to the NFP program after having completed the foundational NFP education requirements and are working with the CaNE research team on evaluation.

Background

The Nurse-Family Partnership® (NFP) is an intensive home visiting program for young, low-income, first-time mothers. The NFP has been evaluated in three randomized controlled trials (RCTs) in the USA, which have demonstrated positive effects on the outcomes of pregnancy, children's subsequent health and development, and parents' economic self-sufficiency. The NFP's strong evidentiary foundation has led to international implementation and evaluation. Steps are currently underway to adapt and evaluate the NFP to the Canadian context. From 2008 to 2012, the City of Hamilton Public Health Services and McMaster University collaborated on a pilot study to determine the feasibility and acceptability of delivering the NFP to Ontario families. Following the pilot study, an RCT to test the NFP's effectiveness in Canada commenced in British Columbia in 2013, with results expected in 2019.

The Canadian Nurse-Family Partnership Education (CaNE) Project

In 2015, the CaNE Project was launched to develop, pilot and evaluate a Canadian model of education for public health nurses and managers responsible for delivering the NFP, thus making it possible for additional health units to offer the NFP Program in Ontario. The CaNE Project is funded by a $351,000 grant from the Local Poverty Reduction Fund, as well as in-kind and moderate funding contributions from participating health units. The Ministry of Children and Youth Services approved the allocation of NFP nurses, managers and administrative staff from the Healthy Babies Healthy Children (HBHC) Program to implement the NFP for the duration of the project. The CaNE Project is a collaboration between the Middlesex-London Health Unit (MLHU), the City of Toronto (Public Health Division), the Regional Municipality of York (Public Health Branch), the City of Hamilton (Public Health Services), NFP International (University of Colorado) and McMaster University. The MLHU is the lead organization for the CaNE project, and, along with the City of Toronto (Public Health Division) and the Regional Municipality of York (Public Health Branch), is participating in the CaNE model of NFP education and will subsequently implement the NFP program. A provincial clinical lead was seconded from the City of Hamilton (Public Health Services) to develop and

coordinate the CaNE education (in collaboration with the NFP international consultant from the University of Colorado) and to provide NFP implementation support at the designated sites. McMaster University has been contracted as a third-party evaluator to complete an evaluation of the project.

Education, Evaluation and Implementation

NFP's success depends on preserving the integrity of the NFP model, which is achieved through public health nurses skilled in delivering the NFP home-visiting model. Public health nurses and managers from the three CaNE implementation sites completed approximately sixty hours of online education, followed by a full week of face-to-face training in January–February 2017. Managers completed an additional forty hours of online training, with four days of face-to-face education, in March 2017. Ongoing training and education continues, with job-shadowing opportunities for PHNs and managers with the NFP team in Hamilton and site-specific, team-based learning modules.

The CaNE evaluation will measure: 1) the feasibility and acceptability of education content and methods, as well as changes in knowledge and clinical practice, and 2) the extent to which the NFP program is delivered with fidelity to the eighteen required Canadian core model elements. The research team at McMaster University has recently received Research Ethics Board approval for the CaNE project evaluation, and are now working with participating health units to facilitate research ethics approval within their organizations.

MLHU's NFP team has been raising awareness about the NFP program among service providers, community partners and the public, building support for its implementation in the Middlesex-London community and promoting the NFP program referral process. CaNE implementation sites began recruiting clients to the NFP program at the end of February, 2017. In the first month of implementation, fifteen referrals have been made to the NFP program at MLHU, of which nine have consented to participate in it. Program data is being collected to guide clinical practice and supervision, assess and guide program implementation, enhance program quality and demonstrate program fidelity.

Provincial Advisory Committee

The Provincial Advisory Committee (PAC) was formed to facilitate collaboration, policy and practice consultation, and ongoing communication among the various stakeholders on relevant aspects of the CaNE project. The PAC membership includes representation from the Registered Nurses Association of Ontario, Public Health Ontario, the Ontario Ministry of Children and Youth Services, the British Columbia Ministry of Health, the Offord Centre for Child Studies, and all CaNE partners. The next PAC meeting is planned for September 2017, following a meeting in June 2017 involving stakeholders from B.C. and Ontario to discuss national governance of the NFP Program in Canada.

Next Steps

Through the collaborative efforts of a number of partners, significant progress has been made in moving the CaNE project forward. A final online education module will be developed for the third phase of NFP learning, and will be implemented later in 2017. NFP program recruitment will continue in Middlesex-London, with the goal of engaging eighty participants. Once internal research ethics approval is finalized at each participating health unit, evaluation will be launched and continue throughout the project's duration. Project reports will continue to be provided to our funders, as required. It is hoped that the evaluation results will complement efforts elsewhere in the country to determine the future of the NFP program in Canada.

This report was submitted by the Nurse-Family Partnership Team, Healthy Start.

Dr. Gayane Hovhannisyan, MD, PhD, FRCPC
Acting Medical Officer of Health

Laura Di Cesare, CHRE
Acting Chief Executive Officer

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 020-17

TO: Chair and Members of the Board of Health

FROM: Dr. Gayane Hovhannisyan, Acting Medical Officer of Health
Laura Di Cesare, Acting Chief Executive Officer

DATE: 2017 April 20

ONTARIO PUBLIC HEALTH STANDARDS MODERNIZATION – MIDDLESEX-LONDON HEALTH UNIT FEEDBACK

Recommendation

It is recommended that the Board of Health:

1) ***Receive Report No. 020-17 for information; and***
2) ***Approve and forward the feedback prepared by the Middlesex-London Health Unit (Appendix A) to the Ministry of Health and Long-Term Care for their consideration.***

Key Points

- The draft Standards for Public Health Programs and Services is a key document that establishes Ministry of Health and Long-Term Care (MOHLTC) policy direction regarding public health program and service delivery.
- Due to the potential impact on our current programs and services, extensive staff consultations were initiated to review and provide feedback regarding the positive developments, concerns, areas requiring clarification, potential challenges and program-specific changes.
- The Middlesex-London Health Unit's response will be forwarded to the MOHLTC for their consideration as they finalize the draft standards and begin implementation planning.

Background

As part of the Ontario Government's Patients First: Action Plan for Health Care, public health transformation was identified as one of five key policy goals. An essential component of this transformation is the modernization of the Ontario Public Health Standards (OPHS), which establish the minimum requirements for fundamental public health programs and services to be delivered by Ontario's thirty-six boards of health. This includes assessment and surveillance, health promotion and policy development, disease and injury prevention, and health protection.

MOHLTC released the draft Standards for Public Health Programs and Services in February 2017, coinciding with the Winter Symposium of the Association of Local Public Associations (alPHa).

Public health units and local boards of health have since sprung to action to review the draft Standards from the perspectives of:

- New program/service requirements;
- Opportunities for greater discretion or program changes;
- Areas with reduced expectations;
- Areas with enhanced expectations; and
- Other risks or feedback important for MOHLTC consideration.

Middlesex-London Health Unit Standards Review Process

The OPHS provide the foundation for how public health programs and services are conducted at the Health Unit. As such, it was imperative that all staff had the opportunity to review and provide feedback regarding the draft Standards.

At the beginning of March, the Senior Leadership Team (SLT) distributed the draft Standards consultation document, along with a feedback template, to each program manager. The SLT also used the March Town Hall meeting to discuss the draft Standards and share initial reflections with all staff. The managers, at team meetings, reviewed the draft Standards for potential impacts on their programs and services, and gathered additional comments from staff members. This team feedback was then collated by the directors in advance of the March 24 MOHLTC consultation in St. Thomas. At this session, SLT and Board of Health members were able to seek greater clarity regarding these potential impacts.

Further refinement to the MLHU feedback was considered by the SLT and used to formulate a response to be forwarded to the MOHLTC.

Middlesex-London Health Unit Response

Based on the feedback provided by Health Unit staff, information gathered at the MOHLTC consultation session and refinement from the SLT, the MLHU has formulated a response for the MOHLTC to consider as they finalize the draft Standards. This feedback (see Appendix A) outlines positive developments, concerns, areas that require further clarification, potential implementation challenges and specific comments pertaining to program and services areas in the draft Standards.

Next Steps

Additional feedback from the Board of Health will be consolidated into the response and provided to the MOHLTC as they continue to revise the Standards and begin implementation planning. The Health Unit will continue to engage with the MOHLTC whenever consultation opportunities are available. When the Standards are finalized, any anticipated program and service delivery changes, or other budget and planning considerations to result from the Standards modernization process, will be brought to the Board of Health.

This report was prepared by the Strategic Projects Team, Corporate Services Division.

Dr. Gayane Hovhannisyan, MD, PhD, FRCPC
Acting Chief Medical Officer of Health

Laura Di Cesare, CHRE
Acting Chief Executive Officer

Middlesex-London Health Unit Modernized Standards for Public Health Feedback

Positive Developments

The Standards Modernization represents a key opportunity to reflect upon current public health practices in Ontario. As such, the Middlesex-London Health Unit sees definitive areas in the draft Standards that will move public health forward.

Effective Public Health Practice
There is an enhanced emphasis on effective public health practice and evidence-informed decision-making with a focus on continuous quality improvement, client satisfaction, community engagement and priority populations. While there are potential organizational and resource implications to these enhancements, these components strongly align with the strategic directions of the Middlesex-London Health Unit and we feel they represent a positive shift in public health practice.

Emphasis on Health Equity
The inclusion of the Health Equity Standard, with an established definition of health inequity, and a mandate to work with indigenous communities formalizes to a greater degree the role that public health units play in addressing health equity.

Population Health Assessment
Using population health principles in health care planning at the local level is perceived as a positive policy direction. However, it will put significant pressure on the Health Unit if additional resources are not available to support this work.

Balance Between Standardization and Variability
Another positive development in the draft Standards is the balance between standardization of practice and the opportunity to meet local needs through variability and the development of programs of public health interventions. This is inter-related with comments regarding the balance between universal and targeted programming. This will require intentionality and good planning on the part of public health, but this is well within our current practice and something that we feel we are well positioned to do.

Concerns

While there are many positive developments, the Middlesex-London Unit does have some concerns in regards to the proposed changes to the Standards.

Reduced Emphasis on Clinical Programs and Services
The draft Standards do not have an explicit direction on whether or not health units should be providing clinical service delivery. While allowing for local flexibility is appreciated, it is unclear if the Ministry is planning to expand for example, access to confidential sexually transmitted infection services so these services are provided in the community.

There is also no mention of access to low-cost contraceptives in the draft Standards. The Middlesex-London Health Unit currently sees a large number of clients accessing our services for low-cost contraception and comprehensive pregnancy counselling which is an identified service gap in the community.

On another note, the draft Standards mention contraceptives and pregnancy counselling in the Infectious and Communicable Diseases Prevention and Control Standards. These are not related and pregnancy needs to be removed from this Standard and added to either an existing draft Standard or a new Standard needs to be created.

Annual Service Plans, Budget Submissions and Existing Budgetary Processes
While the Middlesex-London Health Unit strongly believes in financial accountability and good governance, we are concerned about the nature of the Annual Service Plan and Budget Submission expectations that may be imposed on health units. Will the Ministry use the annual service plans to approve funding, or will they simply be approved by the Ministry and used to drive improvement across the health system? Regardless of the intent, there are potential capacity issues at both health units and at the Ministry itself to review, approve and use the information provided in the submissions in a useful manner. If not aligned with current health unit practices, this could result in duplication of budgetary activities with both internal health unit and Ministry processes, or the need to significantly redevelop budget process to meet Ministry needs.

An additional budget process impact that will be felt with changes to the draft Standards is the impact on our decision-making process, Program Budgeting Marginal Analysis (PBMA). PBMA is a criteria-based decision-making framework that integrates the existing Standards into its scoring methodology.

Interoperability with Local Health Integration Networks
The role of public health in surveillance, assessment and the identification of local needs is an important role in the context of the larger health system. It is imperative that health units are properly connected with Local Health Integration Networks and are able to provide information, advice and/or decision-making through appropriate structures and processes. When health units identify local service gaps there must be mechanisms for this information to get considered in program and service delivery planning across the health system.

Areas Requiring Clarification

While we applaud the Ministry for taking on the large task modernizing the Standards, there is still much work to be done in terms of clarifying the intended outcomes that the Standards hope to achieve.

Working with Indigenous Communities and Community Partners
In regards to Indigenous communities, health units need a better understanding of the complexity of cross-jurisdictional collaborations (i.e. municipal/provincial/federal – section 50 agreements, memo of understanding) and how these concerns regarding jurisdictional issues that may have affected service delivery in the past can be addressed. It is also important that Indigenous leaders be involved in the development of Ministry expectations for public health, and in outlining the role that they would like health units to play within their communities; additional clarity on the involvement of Indigenous leaders in developing the proposed Standards would be helpful. The anticipated guidance document for health equity would be more useful if it included guidance for our work with Indigenous communities, as well as for our health equity work more broadly.

Health units are also directed to engage with other partners such as school boards, researchers, health practitioners and decision-makers. Comparable directives to these groups, particularly those accountable to the provincial government would be beneficial so that there is mutual effort in collaboration. This is seen as a very significant weakness in the existing Standards in terms of our ability to deliver on the intended outcomes. Also worth considering, would be enabling legislation which would require public health approach to policy-making. The Middlesex-London Health Unit currently engages with many of these stakeholders and actively endeavors to create strong relationships but there is, at times, a lack of reciprocity from the stakeholders.

The requirement for enhanced collaboration with various sectors, community partners, and with Indigenous communities could require a need for increased resources or reallocation from other areas of program and service delivery.

Mental Health Promotion
The inclusion of mental health promotion as an area of focus within public health is a positive development. However, greater clarity is needed regarding the scope of mental health promotion for public health practice. If it is not already being considered in implementation planning, the Ministry should consider providing a guidance document related to mental health promotion.

Developing Programs of Public Health Interventions
In developing a program of public health interventions, the expectations are unclear regarding how health units are to interpret the evidence of the effectiveness of the interventions. There may be challenges depending on the expectations from the Ministry in regards to new and novel interventions that don’t yet have robust evidence to support them. Support to review and summarize research evidence for interventions of interest to health units at the provincial level (MOHLTC, Public Health Ontario) could result in efficiency gain, as well as consistent interpretation of the evidence.

Clarity on the expectations for identifying and delivering services to priority populations would also be helpful. It is unclear if the health units should identify priority populations in the community and focus organizationally on these populations or whether priority populations should be identified separately for each public health program being delivered.

Accountability Agreement Indicators
With significant changes being presented in the draft Standards, the Middlesex-London Health Unit is interested in gaining clarity on whether or not there are expected changes to the Public Health Funding and Accountability Agreement Indictors. If there are expected changes, this would have implications for data collection and reporting mechanisms, and ensuring that the indicators are truly driving optimal public health performance. Of particular interest to us is the process that will be used to develop these indicators and the accountability mechanisms behind any future indicators.

Implementation Challenges

Change Management
Any change to the Standards that will result in a significant departure from the work that is currently being performed by the Middlesex-London Health Unit will carry with it change management implications. It is important that there is robust evidence and rationale justifying program and service delivery change and that there is comprehensive implementation planning. This would help to ensure that there are no unintended consequences to the elimination of particular programs and services. Change management carries with it significant resource implications in regards to staff time, training and the development of new policies and procedures. Implementing too many changes simultaneously may negatively impact organizational culture and the productivity of our workforce.

Human Resources Implications
The requirements associated with evidence-informed decision making and effective public health practice could pose significant capacity and resource implications to meet the intended outcomes of the draft Standards. This includes the need to provide training to existing staff, recruiting staff with new skills sets, and generally speaking, an increase to the compliment of staff who provide capacity in the foundational standards. Additionally, if there is a requirement to cease particular services there could be costs associated with downsizing in some areas in the event of skillsets that are not transferable.

There are opportunities to address these capacity gaps from a provincial level through the delivery or provision of training by Public Health Ontario, the Ministry of Health and Long-Term Care or other organizations. Examples of training to be considered include Indigenous Cultural Safety Training for the enhanced health equity requirements and evidence-informed public practice training from organizations such as the National Collaborating Centre for Methods and Tools.

Timelines and Additional Consultation
It is important that the Ministry carefully consider the expectations regarding the tight timelines for meeting the new Standards, ensuring that there is adequate direction for programs to continue to do their work and that health units don't experience significant disruption.

The timeline may not provide sufficient time to develop the comprehensive supports such as guidance documents and protocols which will be essential for operationalizing the Standards. We feel that health units should be actively engaged in the development of the guidance documents, protocols and accountability agreements if they are intended to deliver the best possible public health outcomes. Due to resource and capacity issues, we would recommend that the Ministry provide temporary secondments to facilitate involvement of experts at public health units assisting with the completion of this work.

Specific Comments / Questions

- Under the Principle of Need on page 10, *prevalence*, trends over time, and social impact (e.g. homelessness) should be considered as an addition to this definition. Incidence is only one of the variables we consider when assessing the need in the community.

- The process of identifying priority populations (footnote 3, page 13) only provides three ways to identify them. Does this rule out other options (e.g., community consultation)?

- How is Requirement 10 (Quality and Transparency) related to, and unique from, Requirement 2 (Program Planning, Evaluation and Evidence-Informed Decision-Making) and what additional expectations will there be in regards to quality improvement (committee, improvement plan, etc.)?

- In regards to Tuberculosis (TB), there is a marked absence of TB references under the Infectious Diseases Standard. Tuberculosis went from having its own Standard to being mentioned under only two requirements despite it being cited as a specific program outcome. Mentioning TB under some but not all requirements creates confusion. Please consider removing it or adding to all relevant requirements. There is a continued heavy dependence on the 2008 TB protocol in the field which is out of date and at present time the 2011 guidance document is still in draft. There is also no mention of Immigration Medical Surveillance or requirements for the provision of free TB medication (requirement #5 and #7 OPHS TB 2008). Will there be additional clarity in the protocols?

- In regards to the Chronic Disease and Injury Prevention, Wellness and Substance Misuse Standard, was there an intentional removal of specific reference to workplace as a setting for public health intervention? There is also no reference to how this Standard aligns with the Smoke-Free Ontario Strategy or a definition of what is meant by comprehensive tobacco control. Intimate partner violence is an important public health concern. Does the interpretation of 'violence' in the Chronic Disease Standard support our engagement on this issue if it is a priority area in our community?

- In regards to the School Health Standard, there is no mention of comprehensive school health or alignment with the Ontario Ministry of Education's Foundations for a Healthy School. Inclusion of vision screening in the draft Standards is unclear. Additional concern includes the omission of food literacy from the Health Eating definition.

- In regards to the Emergency Preparedness, Response and Recovery Standard, the forthcoming guidance document will be of critical importance to how this Standard is delivered. We believe that supplemental guidance is required on what role public health unit are expected to play in supporting a ready and resilient health system. There is also no mention of the need for Emergency Preparedness, Response and Recovery to make sure services are culturally safe and accessible (take beliefs, practices, language needs into consideration) when reaching out during or following an emergency (page 21).

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 021-17

TO: Chair and Members of the Board of Health

FROM: Dr. Gayane Hovhannisyan, Acting Medical Officer of Health
Laura Di Cesare, Acting Chief Executive Officer

DATE: 2017 April 20

DEVELOPMENT AND IMPLEMENTATION OF A STRATEGY TO ADDRESS HIV EPIDEMIC AND RELATED ISSUES IN LONDON

Recommendation

It is recommended that Report No. 021-17 re: Development and Implementation of a Strategy to Address HIV Epidemic and Related Issues in London be received for information.

Key Points

- Since February 2016, the Middlesex-London Health Unit (MLHU) has been investigating increases in new cases of HIV, Hepatitis C, invasive Group A Streptococcal Disease and infective endocarditis affecting the local persons who inject drugs (PWID).
- MLHU has been leading a stakeholder group to identify and address gaps or oversights in the community's response to the problem, as well as the development and implementation of a multi-pronged strategy to address the epidemic of HIV and other infectious diseases in this population.

HIV AND OTHER INFECTIOUS DISEASES IN PERSONS WHO INJECT DRUGS (PWID)

In June 2016, the Middlesex-London Health Unit (MLHU) declared a public health emergency related to increases in new cases of HIV, Hepatitis C, invasive Group A Streptococcal (iGAS) disease and infective endocarditis is persons who inject drugs (PWID). The investigation, which began in February 2016, determined the issues to be unique in terms of their magnitude and in comparison to other, similar regions in the province. Over the past year, more than fifty provincial and national experts and other stakeholders have been consulted, and a local HIV Leadership Team was created, with representation from St. Joseph's Infectious Diseases Care Program (IDCP), the London InterCommunity Health Centre (LIHC), the Regional HIV/AIDS Connection (RHAC), local infectious disease physicians and South West Local Integrated Health Network (SWLHIN).

Some of the strategies implemented are summarized here. The full report is attached as Appendix A.

Adaptation of the STOP HIV/AIDS Model

The STOP HIV/AIDS outreach model is aimed at steering people living with HIV, who are disconnected from care, into care. The model is based on interdisciplinary "pods," each containing an outreach nurse, an outreach worker and a social worker. Based on extensive consultations and review of evidence, the MLHU internally reallocated $270,000 toward adapting the STOP HIV/AIDS model to London, and hired an HIV lead/outreach team supervisor position, an outreach nurse and an outreach worker. The HIV lead/outreach position is filled, and we are currently in the process of recruiting an outreach nurse and an outreach worker.

Increased HIV Testing

A lack of point-of-care (POC) testing sites in London was identified as a gap in the community, particularly in areas of the city with large numbers of new HIV cases. To enhance the capacity for testing in the community

setting, all Sexual Health Public Health Nurses at MLHU have been trained to provide POC testing. LIHC and MLHU will continue to work collaboratively on targeted screening of PWID in the community.

Elgin Middlesex-Detention Centre (EMDC)

In a review of the fifty-eight HIV cases reported to the MLHU in 2016, eleven were diagnosed at the EMDC. Several meetings were held with EMDC, and with healthcare programs and services linked to EMDC, to identify gaps in services and opportunities for enhancement, such as increased testing, discharge planning and initiation of opioid replacement therapy.

Campaign to Increase Awareness Among PWID

With the increase in HIV and other infectious diseases among PWID, a health promotion campaign was developed to educate and promote harm reduction practices for this local population. RHAC and MLHU worked together to develop harm reduction messages and strategies to promote the use of clean injection equipment. Feedback collected from pilot testing with needle exchange clients indicated a preference for using stickers affixed to the needle exchange equipment kits handed out at the needle exchange sites.

Harm Reduction Services in London

RHAC's Counterpoint Needle Syringe Program (CNSP) is funded by the Middlesex London Health Unit (MLHU) and the AIDS Bureau, Ministry of Health and Long Term Care. The Ontario Harm Reduction Distribution Program (OHRDP) acknowledges CNSP as one of the largest needle exchange programs in Ontario. Currently, MLHU and RHAC are working together to enhance harm reduction services and increase the availability of supplies through small, fixed satellite sites, as well as by increasing service hours and availability of harm reduction supplies during the weekend.

Enhanced Surveillance

Recognizing that existing surveillance methods may not be collecting the necessary information to assess potential causes of increased HIV and other infectious diseases among PWID, enhanced surveillance methods are currently being developed and implemented.

Public Health Agency of Canada Grant

The alliance of stakeholders in London, which includes MLHU, has applied for this grant with a plan to leverage existing resources and work toward adapting the STOP HIV/AIDS model to a coordinated multi-agency response.

Advocacy for Provincial Support

The Board of Health Chair, Acting MOH and Acting CEO met with the Honourable Deb Matthews, Deputy Premier, in February 2017 to discuss the local context of, and issues arising from, substance use in our community. Upon a request for further information from the Deputy Premier, a proposal is being developed with strategies to respond to the growing HIV rate and related issues in London, and to identify areas for provincial support.

This report was submitted by the Sexual Health Team, Environmental Health and Infectious Disease Division and Foundational Standard Division.

Dr. Gayane Hovhannisyan, MD, PhD, FRCPC
Acting Medical Officer of Health

Laura Di Cesare, CHRE
Acting Chief Executive Officer

Appendix A to Report No. 021-17

Development and Implementation of a Strategy to Address HIV, Hepatitis C, invasive Group A Streptococcal Disease and Infective Endocarditis in Persons Who Inject Drugs in Middlesex-London, Ontario

April 20th, 2017

For information, please contact:

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Table of Contents

Introduction 3
- Rising HIV rates in London 3
- Hepatitis C, infective endocarditis and invasive Group A streptococcal infections in London ... 3
- Injection drug use in London, Ontario 3

Development and implementation of an HIV strategy for London 4
- Additional epidemiological analyses 4
- Initial stakeholder conversations 4
- Declaration of a public health emergency 4
- Deployment of a Field Epidemiologist from the Public Health Agency of Canada 4
- Convening of an HIV Leadership Team 5
- Environmental scan of public health units 5
- Continuing stakeholder engagement and activities 6
- Adaptation of the STOP HIV/AIDS model 6
- Increased HIV Testing 6
- Elgin Middlesex-Detention Centre 6
- Campaign to increase awareness among PWID 7
- Harm reduction services in London 7
- Supervised injection sites 7
- Enhanced surveillance 7
- Public Health Agency of Canada Grant 8
- Advocacy for provincial support 8

Appendix A: Epidemiologic summary of the HIV epidemic in Middlesex-London and Ontario 10

Appendix B: Epidemiologic Summary of Hepatitis C (HCV) and invasive Group A Streptococcal (iGAS) disease in Middlesex-London 11

Appendix C: Map of community services serving people who inject drugs in London, Ontario, 2016 .. 13

Appendix D: Interview Findings from Community Service Providers 14

Introduction

Rising HIV rates in London

In 2016, the Middlesex-London Health Unit (MLHU) saw a concerning rise in new HIV cases in London. A record high number of new HIV diagnoses (58 cases) were reported to the Health Unit that year, not explained by random variation or increases in HIV testing (see Appendix A). This represents the highest number of cases seen in one calendar year in Middlesex-London (M-L) since the 1980s. The majority of these cases resided in the City of London (54 out of 58), resulting in a city-specific rate of 14.1 cases per 100,000 in 2016, almost three times higher than the provincial average (see Appendix A). This increase in HIV rates in London is unique and is not comparable to anything seen in the rest of the province. In fact, HIV rates across the province have been declining over the past decade. The HIV rates in similar regions, such as Ottawa and Hamilton, were 5.8 per 100,000 and 3.7 per 100,000, respectively. Persons who inject drugs (PWID) have, at their highest, represented just under 10% of new cases of HIV in Ontario. In contrast, two thirds of new cases of HIV in M-L were attributed to PWID. Approximately one out of six were identified as being under-housed/homeless. Also, the majority of these cases were diagnosed in hospitals and were in more advanced stages of illness or have multiple comorbidities (e.g., mental health issues, infective endocarditis) at the time of diagnosis. During 2011-2016 (up to April, 2016) in M-L, a recent viral load test was performed on 97 cases out of 183 new cases during the same time period. Of the cases with viral load information, only 27% had an undetectable viral load on their most recent test.

Hepatitis C, infective endocarditis and invasive Group A streptococcal infections in London

Similar to HIV, Hepatitis C rates are higher in M-L compared to the rest of the province, but have been higher for several years. In 2016, there were 231 newly diagnosed cases of Hepatitis C (see Appendix B), with the rate for London being 57.3 per 100,000 (220 cases). Again, similar to HIV, the majority of these cases were in PWID. In contrast, the Hepatitis C rates in Toronto have been decreasing over the past decade, with 24.6 per 100,000 in 2015. In Toronto, approximately one third of cases reported injection drug use, whereas in M-L, over 60% reported this risk factor.

Further, an unusually high number of invasive Group A streptococcal (iGAS) cases were reported to MLHU in 2016, with 64 cases reported, compared to the five-year average of 25 between 2011-2015 (see Appendix B). Of the 64 cases reported in 2016, 30 (47%) were in PWID and 14 (22%) were identified as underhoused or homeless. The majority of cases occurred in London, resulting in a city-specific rate of 15.6 per 100,000 (60 cases). As of March 15, 2017, 28 cases have been reported for this calendar year.

Locally, infectious disease specialists have also observed alarming increases in infective endocarditis cases. London Health Sciences Centre has seen a 166% rise in first episodes and a 277% rise in total episodes of endocarditis associated with injection drug use, resulting in steep increases in hospital stays. In 2008, there were less than 200 total days of hospital stay due to injection drug use associated infective endocarditis, in comparison to approximately 2000 total days in 2015.

Injection drug use in London, Ontario

London has a large population of injection drug users, which is believed to be one of the largest in the country relative to the size of its population. While the exact size of the population of PWID remains

largely unknown, it has been estimated by local harm reduction professionals that there are approximately 6000 PWID in London (under 2% of the total population). The harm reduction program in London distributed over 2.7 million needles in 2015 and close to 3.0 million in 2016. By comparison, in 2015, Hamilton, which is similar in population-size as London, distributed just under one million needles, and Toronto distributed 2.6 million needles, albeit for a much larger population of 2.8 million. Both the 2012 I-Track survey and a recent survey of injection drug users in London reported very high rates of unstable housing and homelessness and unsafe injection practices (e.g. sharing needles, injecting in public places). One in five injection drug users surveyed recently reported being engaged in sex work and one in ten have been incarcerated. Drug use patterns are also unique with a high prevalence of crystal methamphetamine and prescription opioids (hydromorphone) injection. The recent Ontario Integrated Supervised Injection Site Feasibility Study (OISIS), which gathered data from local PWID, found 83.8% had injected crystal methamphetamine in the past 6 months, 88.4% had injected opioids, and 71.4% had injected both.

Development and implementation of an HIV strategy for London

Additional epidemiological analysis

Since only partial information is available though passive surveillance of reportable diseases at the local level, MLHU engaged with Public Health Ontario (PHO) Laboratories to request additional data. PHO provided MLHU with data related to the number of HIV tests performed in M-L, broken down by risk factor and test result. Further to this, in order to ensure the rise in new HIV cases was truly at the magnitude observed, MLHU submitted a special request with PHO to perform an assessment of the data quality. PHO undertook this special project and was able to identify where potential duplicate entries were in the provincial database. These duplicate entries were rare, however, and a rise in cases of HIV was still evident.

Initial stakeholder conversations

In March 2016, the MLHU coordinated a meeting between community agencies to advise them of the epidemiologic situation in M-L, and to discuss next steps. The stakeholders included providers from St. Joseph's Infectious Diseases Care Program (IDCP), the London InterCommunity Health Centre (LIHC), Regional HIV/AIDS Connection (RHAC), the Elgin Middlesex-Detention Centre (EMDC), local Infectious Disease physicians, representatives from academic and research communities, and the AIDS Bureau of the Ministry of Health and Long-Term Care.

Declaration of a public health emergency

In June 2016, MLHU declared a public health emergency due to the rise of HIV and other infections in PWID in London. The purpose of this was to alert local PWID communities, stakeholders who work with these communities, and other health care providers about the rapid increase in infectious disease in this population.

Deployment of a Field Epidemiologist from the Public Health Agency of Canada

Given the magnitude and scope of the emerging issue, a field epidemiologist was requested from the Public Health Agency of Canada (PHAC) to support the MLHU Epidemiologist and Data Analyst to:

1. Map the geographical distribution of cases of HIV and HCV in PWID to determine possible clusters.
2. Map harm reduction and addiction services in relation to HIV and HCV cases to identify service gaps (Appendix C).
3. Determine locations where used needles are discarded to discern high risk areas.
4. Conduct interviews with community service providers to explore the reasons behind the increased rate of infections. The PHAC Field Epidemiologist and an MLHU Program Evaluator engaged community service providers in M-L to conduct in-depth individual interviews in order to gain a better understanding of the potential causes of emerging infections in PWID (Appendix D).

Convening of an HIV Leadership Team

In August, 2016, a group of local health and community service leaders who work with PWID was convened. This group is comprised of representatives from RHAC, LIHC, IDCP, Addiction Service Thames Valley, and the Southwest Local Health Integration Network (SWLHIN). The purpose of this group is to work together towards developing and implementing an HIV strategy based on effective evidence-based strategies implemented in other regions. Enhanced surveillance, primary and secondary prevention, harm reduction, and HIV treatment (including "Treatment as Prevention" or "TasP") were identified as core pillars of this newly-formed strategy. It was recognized that any strategies adopted from other regions would need to take into account the local context and unique circumstances in London. Further, any adaptation of a strategy would need to take into account the services and assets currently available, working within the context of existing services, filling any potential gaps found. The group committed to collaborating with the newly-formed local Community Drug and Alcohol Strategy's Steering Committee, which was established based on Vancouver's four pillar model and which has been co-led by the MLHU since April 2016.

Environmental scan of public health units

In June, 2016, an environmental scan of five public health units in Ontario was conducted to obtain an overall understanding of their harm reduction outreach programs, including the populations they serve, their staffing roles, their modes of service delivery, the specific services provided and any evaluation outcomes. This summarized some basic information to see how other health units were serving PWID communities and allowed MLHU to generate potential ideas about how to adapt our services.

A second environmental scan was conducted with the same health units in November 2016. The purpose was to obtain additional information regarding satellite harm reduction services, including site locations, client location preferences, and benefits and challenges of working through satellite sites. Findings showed these health units have between 7 and 48 satellite sites, located in shelters, pharmacies, AIDS service organizations, mobile vans, community health centres, drop-in centres, a hospital, addiction treatment centre, and other local community-based organizations. Staff from these other health units indicated clients preferred accessing services from sites that are comfortable, convenient, non-judgmental, confidential and met clients where they were at. Benefits of satellite sites included increasing access points for clients, and integrating harm reduction approaches in multiple sites. Some of the challenges included keeping up with the demand for supplies and confidentiality concerns.

Continuing stakeholder engagement and activities

Over 50 provincial and national experts and other stakeholders have been consulted thus far. The scientific literature was reviewed to identify effective strategies to address HIV epidemics in PWID populations. The MLHU had multiple consultations with Pubic Health Departments in British Columbia and Saskatchewan to learn from their experiences with managing HIV outbreaks in PWID. We seconded the Manager of the MLHU's Sexual Health Clinic to Vancouver to learn about the Seek and Treat for Optimal Prevention of HIV/AIDS (STOP HIV/AIDS) model. We also consulted with the BC Centre for Disease Control (BC-CDC) and the Ontario HIV Treatment Network (OHTN) on developing enhanced surveillance to monitor HIV cases based on the cascade of care approach. We consulted with PHO Laboratories, the BC-CDC and the OHTN in exploring additional strategies in investigating the outbreak, such as HIV genotyping and incidence testing algorithms. We also consulted with the Chief Medical Officer's office. To research the outstanding questions that have arisen in our investigation we are in the process of organizing a meeting between local and national researchers.

Adaptation of the STOP HIV/AIDS model

Based on extensive consultations and review of evidence, the MLHU internally reallocated $270,000 towards the adaptation of the STOP HIV/AIDS model to London. This program aims to reduce HIV rates and increase the quality of life of people living with HIV. The reduction is achieved by preventing secondary transmission of HIV infections through a proactive public health approach to finding people living with HIV, promoting TasP, linking clients to HIV care and treatment programs, and supporting them to adhere to treatment. STOP HIV/AIDS aims to improve the experience of people living with HIV or AIDS in every health and social service interaction and significantly improve linkage and engagement across the full continuum of services in HIV prevention, testing and diagnosis, treatment, and care and support. The STOP HIV/AIDS team consists of interdisciplinary "pods" containing an outreach nurse, an outreach worker, and a social worker. The work is almost exclusively outreach based with a focus on connecting people who are disconnected from care into care. This means meeting clients wherever they are – in their homes, in parks, in streets and alleys, hotels, clinics, and community centres. The STOP HIV/AIDS team works closely with other services responsible for mental health, substance use and community health.

Increased HIV Testing

A lack of point-of-care (POC) testing sites in London was identified as a gap in the community, particularly in areas of the city with large numbers of new HIV cases. Increased targeted HIV testing for this population, connecting them with care, and enabling retention in care is based on STOP HIV/AIDS. To enhance the capacity for testing in the community setting, all Sexual Health Public Health Nurses at the MLHU were trained in Fall 2016 to provide POC testing. There are currently 11 sites where POC testing is available in London, with more sites to be available in 2017. LIHC and the MLHU will continue working collaboratively to target screening of PWID in the community.

Elgin Middlesex-Detention Centre

In review of the 58 HIV cases reported to the MLHU in 2016, 11 were diagnosed at the EMDC. Several meetings with key stakeholders providing health care programs and services linked to EMDC were held with representatives from the EMDC, MLHU, Infectious Disease team from St. Joseph's Health Care and

LIHC. Some areas identified for improvement in services at EMDC included better co-ordination of programs and services between different service providers, addressing the lack of capacity to initiate opioid maintenance therapy for inmates, increasing capacity for HIV testing, discharge planning for HIV clients and increasing communication between different stakeholders.

Campaign to increase awareness among PWID

With the increase in HIV and other infectious diseases in PWID, a health promotion campaign was developed to educate and promote harm reduction practices for this local population. RHAC and the MLHU worked together to develop harm reduction messages promoting the use of clean injection equipment at every use. Also, messaging was created to educate PWID on the warning signs of common medical conditions that can arise from injection drug use, including iGAS, which might require immediate medical assistance. Feedback collected from pilot testing with needle exchange clients indicated the preference for using stickers affixed to the needle exchange equipment kits handed out at the needle exchange sites. Different stickers and messages are used every week to increase awareness and promote safe injection practices.

Harm reduction services in London

RHAC's Counterpoint Needle Syringe Program (CNSP) is funded by the MLHU and the AIDS Bureau, Ministry of Health and Long Term Care. CNSP is acknowledged by the Ontario Harm Reduction Distribution Program (OHRDP) as one of the busiest needle exchange programs in Ontario. In the 2016 calendar year, CNSP was involved in 17,140 client interactions and distributed almost 3.0 million needles and syringes (from both fixed and mobile delivery programs) and over 6,000 sharps containers. Home delivery and outreach services performed almost 1,800 home deliveries in 2016, distributing almost 1 million of the total 3 million needles and syringes through this program. Currently, the MLHU and RHAC are working together to enhance harm reduction services and increase availability of supplies through small fixed satellite sites, as well as increasing service hours and availability of harm reduction supplies during the weekend.

Supervised injection sites

In 2016, a survey of local PWID and key stakeholders was conducted to determine the feasibility and willingness to use a supervised injection site and acceptability and feasibility of SIS from community stakeholders' perspectives. The study recruited 199 local PWID and interviewed 20 stakeholders. Study results found that 72% of participants had injected in public in the past 6 months and that 86% would use a supervised injection site. Further investigation and public input will be gathered to determine what a supervised injection site should look like for the London area, including whether there should be one central site or smaller satellite sites incorporated into the existing services to ensure accessibility.

Enhanced surveillance

Recognizing the limitations of passive surveillance systems in collecting the necessary information to assess potential causes of increased HIV infections and other infectious diseases in PWID, enhanced surveillance systems are currently being developed and implemented at MLHU. Enhanced surveillance questionnaires are incorporated in case management process and are directly aiming to determine factors

associated with increasing numbers of cases of HIV and iGAS. Each of these are administered separately and ask questions related to injection practices, needle sharing, as well as social and demographic factors such as current housing situation or Aboriginal background. In addition, MLHU is exploring implementation of cascade of care indicators for ongoing monitoring and evaluation of the HIV strategy.

Further to this, the MLHU had completed a preliminary agreement with the PHAC related to London being a site for their I-Track 4 enhanced surveillance. I-Track collects information from PWID related to drug use behaviour, sexual behaviour, HIV and hepatitis C testing and treatment, access to health services, and collects a finger-prick blood sample to test for HIV, Hepatitis C, and syphilis antibodies.

The MLHU is negotiating with the PHO laboratory to release the number of HIV positive test results, as well as number of HIV tests performed in M-L quarterly for the next two years to allow us monitoring of the impact of increase awareness and testing on HIV epidemic. Additionally, we are exploring the possibility of obtaining genotyping and drug resistance data to facilitate rapid initiation of HIV treatment.

Public Health Agency of Canada Grant

The Public Health Agency of Canada has merged its funding for community based organizations into the HIV and Hepatitis C Community Action Fund. The Community Action Fund will make available up to $26.4 million annually to support comprehensive responses to HIV, Hepatitis C, and related sexually transmitted and blood borne infections. Funding will be available for approved and eligible community-based programs on April 1, 2017. If successful in receiving grant funding, the alliance of stakeholders in London, including RHAC, LIHC and the MLHU, would leverage existing resources and work towards adapting the STOP HIV/AIDS model with a multi-agency coordinated response. Outreach workers will be able to further enhance client engagement, bridging clients into care and helping support client stability (e.g. housing, income).

Advocacy for provincial support

Board of Health Chair Jesse Helmer, Acting Medical Officer of Health Dr. Gayane Hovhannisyan and Acting Chief Executive Officer Laura Di Cesare met with the Deputy Premier of Ontario, Deb Matthews in February 2017 to discuss the local context and issues arising from substance use in London. At that meeting, the delegation was able to present data describing trends related to increasing number of cases of HIV, Hepatitis C, iGAS and infective endocarditis to the Deputy Premier. In response, Deputy Premier Matthews asked the MLHUto report back to her outlining strategies to respond to the growing rate of HIV in London and identify areas for provincial support.

Through a gap analysis, a review of the literature and other best practices in addressing similar outbreaks, and through consultation with the local HIV Leadership group, the MLHU has identified the immediate need to increase harm reduction services in the community. Additionally, while several successful programs exist in London, they are not sufficiently resourced to provide the level of service required to support the growing number of clients PWID and other marginalized populations living with HIV. Services must be augmented and coordinated quickly in order to provide comprehensive wrap-around care to an estimated 200 to 300 high-risk HIV clients with complex mental health and addiction issues. These services include: integrated community-based primary care and comprehensive addiction (counseling, withdrawal management, medical detox, opioid maintenance), mental health service and HIV

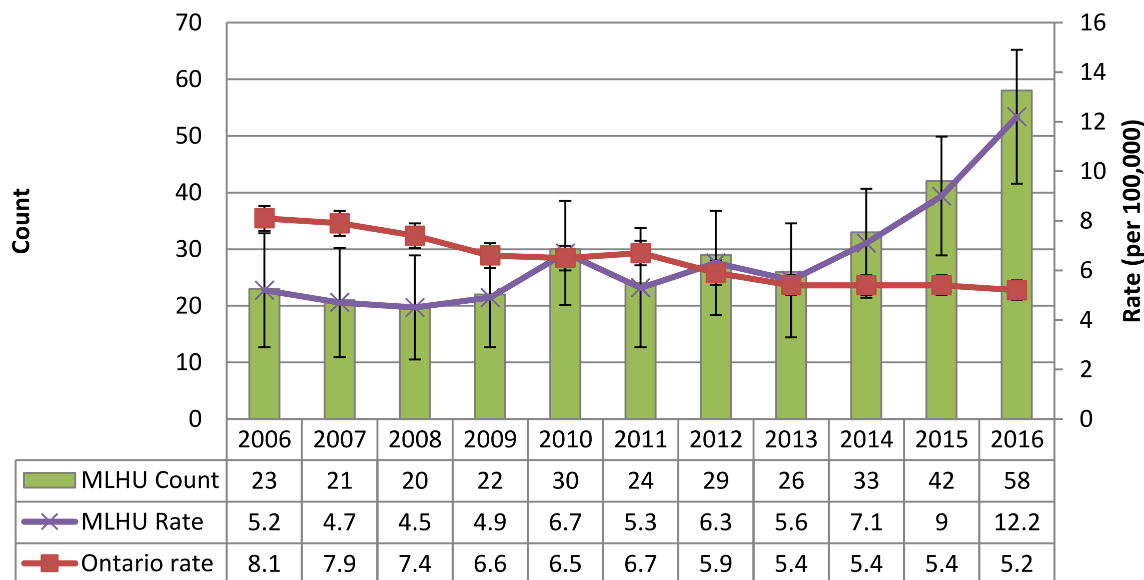
treatment programs, street-level outreach, and housing support. In Vancouver, where similar efforts are coordinated through the Dr. Peter Centre, cost estimates to provide these services are approximately $40 per patient per day. The MLHU requests that the provincial government provide sufficient funding to the community to enhance existing services, and to introduce new services that do not currently exist, such as comprehensive and coordinated addiction services and medical detox.

Several meetings were held between the Acting MOH with the office of the Chief Medical Officer of Health for Ontario to inform them about situation in London and to seek support. Currently internal discussions are being held at the Ministry of Health and Long-Term Care on how best support the MLHU in their endeavours to contain the epidemic and address the complex health issues in PWID in London.

Appendix A. Epidemiologic summary of the HIV epidemic in Middlesex-London and Ontario

The crude rate of reported HIV infection in M-L for 2016 was 12.2 per 100,000, with 58 cases reported as of December 31, 2016. This represents the highest number of cases seen in one calendar year in M-L since the 1980s. Prior to 2016, the crude rate of reported HIV infection in M-L had increased from 5.9 per 100,000 in 2005 to 9.0 per 100,000 in 2015, while the rate in the rest of the province has decreased (7.4 per 100,000 in 2005 to 5.5 per 100,000 in 2015; see Figure 1). It is estimated that four cases were from outside of London, residing in Middlesex County, whereas 54 were in the City of London, placing the crude rates of HIV in these two locations at 5.6 per 100,000 and 14.1 per 100,000, respectively. The largest proportional increase in HIV diagnoses in M-L residents in 2016 has been in 30-39 year olds, who, in 2016, represented half (50.0%) of new HIV cases. Additionally, of the 58 cases reported to MLHU, 37 (63.8%) were male, 20 (34.4%) female, and 1 (1.7%) unspecified. Injection drug use was the most frequent exposure category in 2016, reported by 39 (68.4%) of those with exposure classification listed (n=57). This is starkly different than the proportions in other, similar sized regions. Looking at a region that had, at one time, one of the largest HIV epidemics among persons who inject drugs, the most recently available data from Vancouver Coastal Health indicated that, in 2015, only 11 new cases of HIV were reported in this population (out of 128 new cases). M-L's rates of HIV are an outlier in terms of exposure categories. Persons who inject drugs in Ontario have, at their highest, represented just under 10% of new cases of HIV, in contrast to the two thirds of new cases in M-L.

Figure 1. Reported count and crude rate of new cases of HIV in Middlesex-London and Ontario, 2006-2016



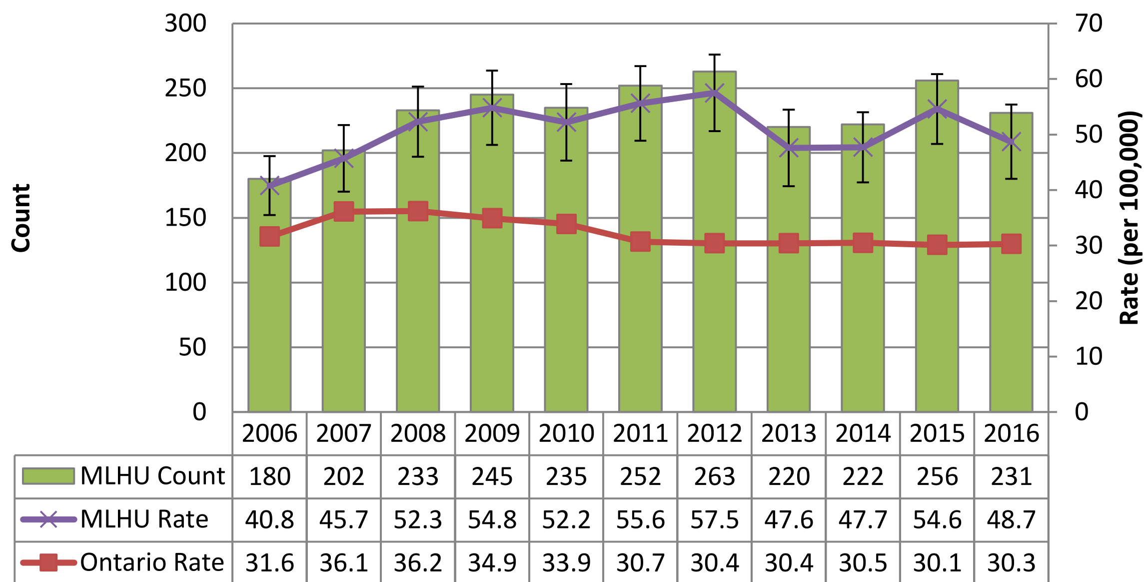
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
MLHU Count	23	21	20	22	30	24	29	26	33	42	58
MLHU Rate	5.2	4.7	4.5	4.9	6.7	5.3	6.3	5.6	7.1	9	12.2
Ontario rate	8.1	7.9	7.4	6.6	6.5	6.7	5.9	5.4	5.4	5.4	5.2

***Data source: PHO Query, January 31, 2017**
NOTE: Ontario rate excludes MLHU

Appendix B. Epidemiologic Summary of Hepatitis C (HCV) and invasive Group A Streptococcal (iGAS) disease in Middlesex-London

In 2016, 231 hepatitis C cases were reported to the MLHU, resulting in a crude rate of 48.7 per 100,000, a small decrease over the previous year. Prior to 2016, The crude rate of reported hepatitis C (HCV) infection in M-L has increased from 40.8 per 100,000 in 2006 to 54.6 per 100,000 in 2015. The rate in the rest of the province has remained steady and has consistently been lower than the rate in M-L (31.6 per 100,000 in 2006 to 30.3 per 100,000 in 2015; see Figure 4). Age trends in 2016 indicate an increase in the 20 to 29 year age category over the previous year, with 35.1% of infections in this group in 2016, compared with 29.0% the previous year (see Figure 5). Risk factors were identified for 82.7% (n=1968) of MLHU HCV cases from 2006-2015. Injection drug use was identified as a risk factor for 61.2% (n=1205) of HCV cases who lived in the MLHU area from 2006-2015. In 2016, of those with risk factor data gathered (n=182), 73.1% (n=133) of cases were attributed to injection drug use as a risk factor. Comparing to other regions, we see the MLHU region remains higher than most other regions in the province. In Toronto, for example, there have been decreasing crude rates of HCV over the past decade (37.3 per 100,000 in 2006 compared to 24.6 per 100,000 in 2015). "Injection Drug Use", in Toronto was identified as a risk factor in 37.7% (n=130) of the total of new cases with reported risk factor data (n=345).

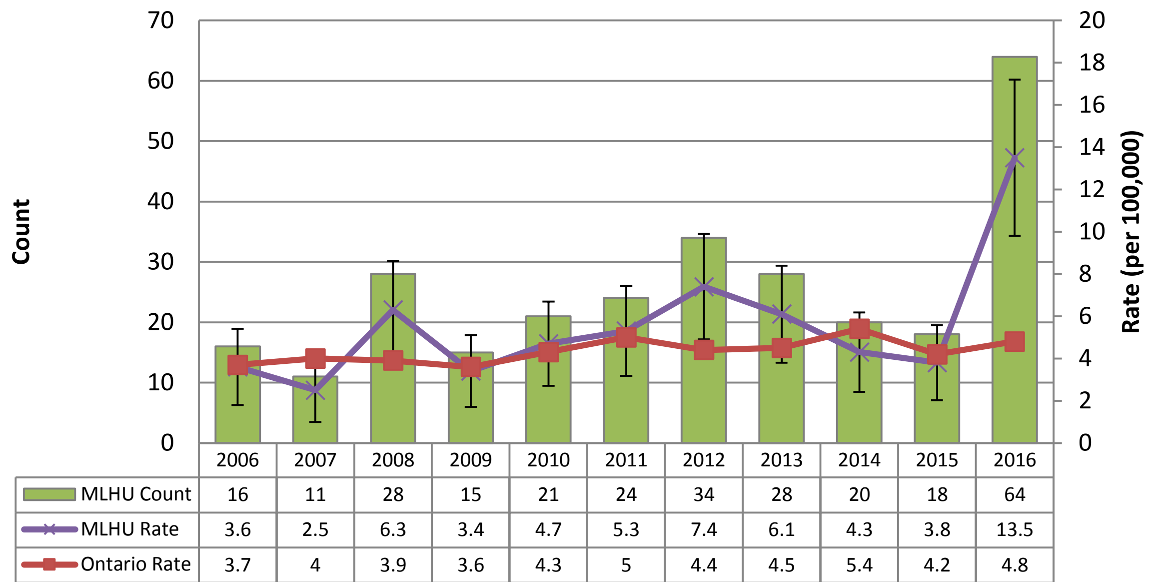
Figure 2. Reported count and crude rate of newly reported cases of Hepatitis C in Middlesex-London and Ontario, 2006-2016



	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
MLHU Count	180	202	233	245	235	252	263	220	222	256	231
MLHU Rate	40.8	45.7	52.3	54.8	52.2	55.6	57.5	47.6	47.7	54.6	48.7
Ontario Rate	31.6	36.1	36.2	34.9	33.9	30.7	30.4	30.4	30.5	30.1	30.3

***Data source: PHO Query, January 31, 2017**
NOTE: Ontario rate excludes MLHU

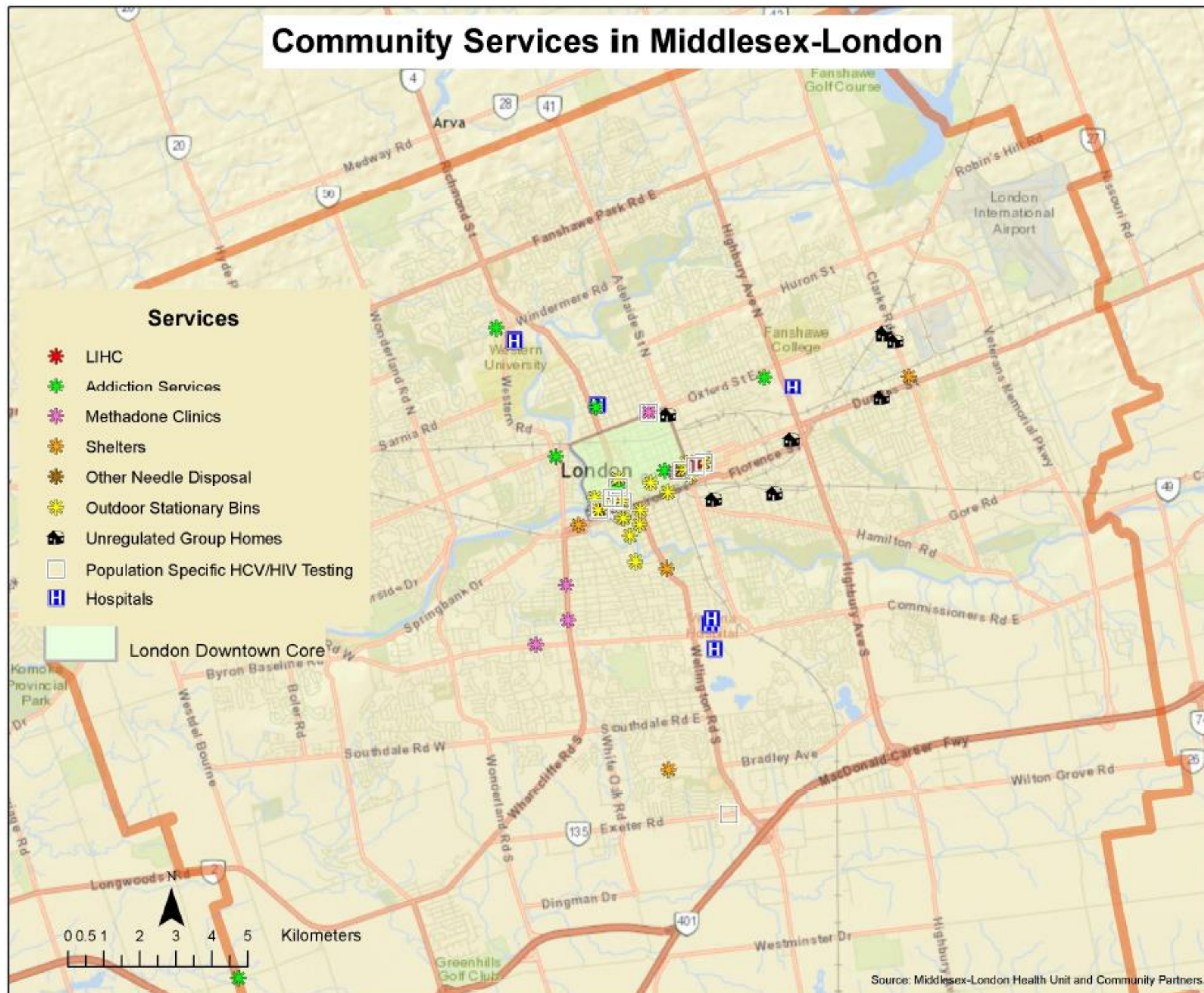
Figure 3. Reported count and crude rate of newly reported cases of invasive Group A Streptococcal (iGAS) Disease in Middlesex-London and Ontario, 2006-2016



	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
MLHU Count	16	11	28	15	21	24	34	28	20	18	64
MLHU Rate	3.6	2.5	6.3	3.4	4.7	5.3	7.4	6.1	4.3	3.8	13.5
Ontario Rate	3.7	4	3.9	3.6	4.3	5	4.4	4.5	5.4	4.2	4.8

***Data source: PHO Query, March 13, 2017**
NOTE: Ontario rate excludes MLHU

Appendix C: Map of community services serving people who inject drugs in London, Ontario, 2016



Appendix D: Interview Findings from Community Service Providers

Community service providers interviewed by the Field Epidemiologist and the Program Evaluator included those working in close contact with PWID: two infectious disease specialists, a family physician who works in addictions, the Director of Counterpoint Harm Reduction Services at the Regional HIV/AIDS Connection (RHAC), the Director of Client Services at London InterCommunity Health Centre (LIHC) and a case coordinator from London Cares. These service providers have an established rapport with PWID and can be considered gateways to the voices of PWID in the community.

The results of the thematic analysis showed four global themes: 1) increases in Infectious Diseases in PWID; 2) community strengths; 3) challenges to prevention and control; and 4) needs/opportunities for prevention and control. Under the global theme, increases in Infectious Diseases in PWID, the organizing themes that arose included: changes to drugs of choice, unsafe injection techniques, changes in injection equipment, lack of access to clean injection supplies and detection bias. The community strengths global theme consisted of the following organizing themes: commitment, collaboration and outreach. Within the global theme, challenges to prevention and control, the organizing themes that unfolded included: lack of understanding and buy-in from hospital, negative treatment of PWID, issues physicians face, conservative community, issues PWID encounter, and limits of epidemiology. From the global theme, needs/opportunities for prevention and control, the organizing themes included: harm reduction approaches, engaging health care institutions and practitioners, increasing education and awareness, and providing more funding and resources.

The interviews with community services providers generated hypotheses for further investigation into possible causes of emerging infections in PWID, such as Oxycontin being de-listed in 2012 and replaced with OxyNEO to prevent injecting or snorting. OxyNEO is rarely used by physicians in London, Hydromorph Contin is prescribed more frequently and ends up "on the street". Hydromorph Contin does not crush/dissolve well, which increases the damage to the circulatory system and heart valves. The increase in crystal methamphetamine use is another potential cause of infection as it is believed that cookers are used or shared more than once because of the residue. The interviews also provided valuable insight into potential prevention and control measures including, among others, a comprehensive community response, improving access to opioid replacement, and expanding outreach to include peer outreach and supervised injection sites.

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MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 022-17

TO: Chair and Members of the Board of Health

FROM: Dr. Gayane Hovhannisyan, Acting Medical Officer of Health
Laura Di Cesare, Acting Chief Executive Officer

DATE: 2017 April 20

SUMMARY INFORMATION REPORT FOR APRIL

Recommendation

It is recommended that Report No. 022-17 re: Summary Information Report for April 2017 be received for information.

Key Points

- Since April 2016, the Middlesex-London Health Unit (MLHU) has observed an increase in invasive Group A Streptococcal (iGAS) disease cases, largely among people who inject drugs (PWID) and people with precarious housing. A field epidemiologist from the Public Health Agency of Canada was deployed to support the investigation of this outbreak.
- The BOH directed MLHU staff to engage with key stakeholders to determine next steps related to implementation of Supervised Injection Services in London. Key stakeholders were consulted and a local leadership group is being formed, as well as an advisory committee.

Invasive Group A Streptococcal Disease Outbreak Investigation

Since April 2016, the Middlesex-London Health Unit (MLHU) has observed an increase in invasive Group A Streptococcal (iGAS) disease cases, largely (in over 40% of reported cases) among people who inject drugs (PWID) (see Appendix A). Also, many cases are associated with individuals who are homeless or have precarious housing (over 25%). As of March 31, 2017, thirty-one iGAS cases had been reported in 2017, exceeding the 2011–15 average of twenty-five cases per year. The MLHU requested a field epidemiologist from the Public Health Agency of Canada to support its team in investigating this outbreak. Dr. Catherine Dickson was mobilized to MLHU from March 6 to 31. During this time, she analyzed our iGAS data to better understand the risk factors that may be contributing to the iGAS increase, and worked with the hospital and public health labs to assess whether the observed infections were from a common iGAS strain. A field visit was made to the Salvation Army Centre of Hope, where the team noted open wounds among most residents.

As a part of this investigation, we created an enhanced surveillance questionnaire, reviewed literature for effective evidence, consulted with the Chief Medical Officer of Health (CMOH) office and contacted Toronto Public Health and the Alaska Division of Social Services to learn from their experiences with increased iGAS in similar populations. We have reached out to key stakeholders who work with PWID and under-housed populations to increase awareness of iGAS, and to provide information on how to access wound-care services for clients. We are engaging with Community Care Access Centres and London Intercommunity Centres to organize wound care in shelters, potentially combining this with GAS testing to determine colonization rates in this population.

Supervised injection Services (SIS): Next Steps

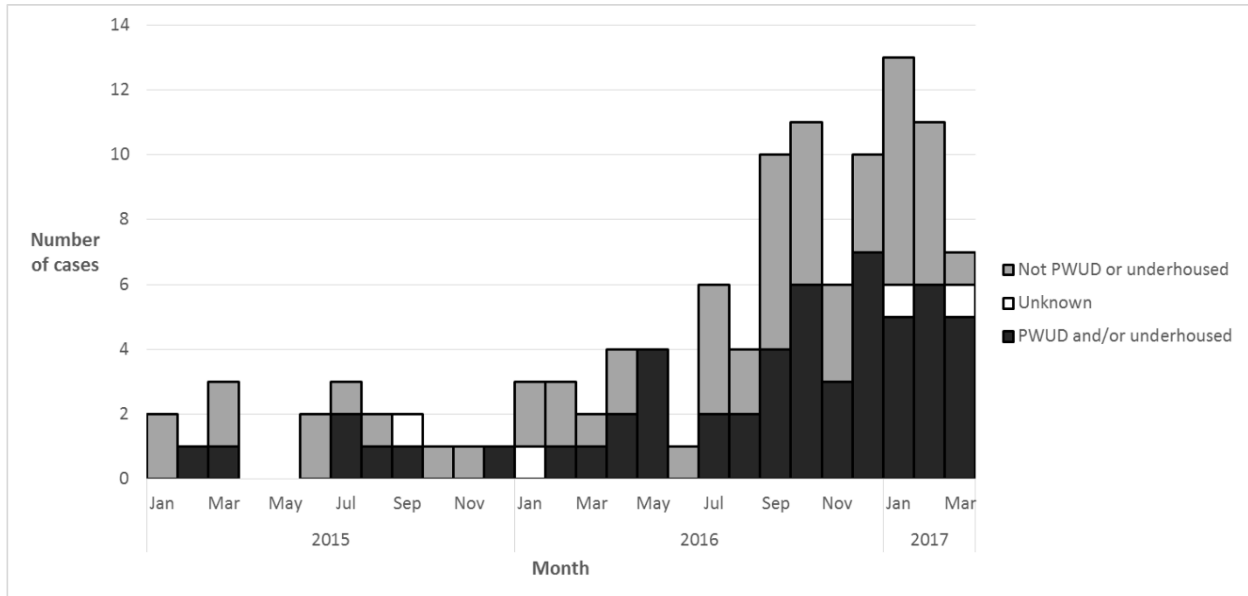
In 2016, a survey was conducted to determine feasibility and willingness among PWID to use a supervised injection site, and acceptability and feasibility of SIS from community stakeholders' perspectives. The study recruited 199 local PWID and interviewed twenty stakeholders. Study results found that 72% of participants had injected in public, while one in four reported a history of non-fatal overdose. Risks for infectious disease transmission were also evident, with 22% participants noting that they had borrowed and/or loaned used syringes in the previous six months. The majority of the participants (86%) expressed willingness to use a supervised injection site if available. The stakeholders were supportive of SIS in general; however, their opinions varied on the location and model of SIS.

Following direction from the Board of Health to explore next steps in assessing the feasibility of the integrated SIS model for London (see Supervised Injection Services Feasibility report, Report No. 005-17), initial meetings were held with key stakeholders, such as the Mayor's Office, the London Police Service, the Regional HIV/AIDS Connection (RHAC), the Ontario HIV/AIDS Treatment Network (OHTN) and the CMOH office. The MLHU also consulted with Ottawa Public Health and Toronto Public Health to learn from their experiences in implementing SIS in their jurisdictions. Agreement was reached on establishing a local leadership group with representation from the London Police Service, the Mayor's Office, RHAC and MLHU. In addition, an advisory group will be established with representatives from OHTN, the principal investigator of the SIS feasibility study and the Deputy CMOH of Ontario, to provide guidance on public and stakeholder consultations. Other stakeholders, including members of the business community and health and social services, will also be consulted extensively throughout the process. In addition, it was agreed that an external agency will be hired to conduct public consultations to allow for a transparent, unbiased process.

Dr. Gayane Hovhannisyan, MD, PhD, FRCPC
Acting Chief Medical Officer of Health

Laura Di Cesare, CHRE
Acting Chief Executive Officer

Figure 1: Monthly iGAS cases in Middlesex-London in PWUD and/or are underhoused and in people who are neither PWUD or underhoused, January 1, 2015 – March 30, 2017.



MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 023-17

TO: Chair and Members of the Board of Health

FROM: Dr. Gayane Hovhannisyan, Acting Medical Officer of Health
Laura Di Cesare, Acting Chief Executive Officer

DATE: 2017 April 20

ACTING MEDICAL OFFICER OF HEALTH / ACTING CHIEF EXECUTIVE OFFICER ACTIVITY REPORT – APRIL

Recommendation

It is recommended that Report No. 023-17 re: Acting Medical Officer of Health / Acting Chief Executive Officer Activity Report – April be received for information.

The following report lists the activities of the Acting Medical Officer of Health (Acting MOH) and Acting Chief Executive Officer (Acting CEO) for the period from March 6, 2017, to April 5, 2017.

The Acting MOH and Acting CEO participated in the March 9 All Staff Town Hall Meeting. The agenda included the following presentations:

- Ontario Public Health Standards Modernization – Dr. Gayane Hovhannisyan
- 2017 MLHU Budget – John Millson
- Auditor General Value for Money Audit – John Millson
- Strategic Plan Update – Laura Di Cesare
- Alternative Work Arrangements – Cynthia Bos
- MLHU Wear – Dan Flaherty
- Activity Based Workspace Pilot – Jordan Banninga
- Location Project Update – Jordan Banninga
- Community Drug and Alcohol Strategy – Rhonda Brittan
- Supervised Injection Services – Dr. Gayane Hovhannisyan

The Acting MOH and Acting CEO, along with Board members Jesse Helmer, Marcel Meyer and other senior leaders, attended the Ontario Public Health Standards – Standards Modernization Consultation held at the Elgin St. Thomas Public Health Unit. MLHU was one of nine health units invited to attend this session to provide feedback to the Ministry on the proposed changes to the Standards.

The Acting MOH / Acting CEO also attended the following events:

March 6 The Acting MOH and Acting CEO had an introductory meeting with Chris Steven, Executive Director of the Children's Aid Society of London and Middlesex.
The Acting MOH met with Brian Lester, Executive Director of the Regional HIV/AIDS Connection, regarding Safe Injection Services.

March 10 The Acting MOH attended the International Women's Day Breakfast.

March 13 The Acting MOH met with Neal Roberts, Chief of Middlesex-London Emergency Medical Services, regarding enhanced opioid surveillance.

March 15	The Acting MOH and Acting CEO attended a training session on Leading a Mentally Healthy Workplace.
March 23	The Acting MOH and Acting CEO attended a staff information session on Negotiating for Positive Outcomes.
March 24	The Acting MOH met with Chief John Pare of London Police Services. The Acting MOH met with staff at St. Joseph's Hospital to discuss drug strategies.
March 27	The Acting MOH and Acting CEO participated in the Value for Money teleconference held by the Office of the Auditor General of Ontario and chaired by Corinne Berinstein, Senior Audit Manager, Health Audit Services Team (HAST), Ontario Internal Audit Division – Treasury Board Secretariat (TBS).
March 30-31	The Acting MOH attended the Annual TOPHC Conference in Toronto, and facilitated a workshop there on Complex Issues Affecting People Who Inject Drugs The Acting MOH met with the CMOH regarding the iGAS outbreak and HIV epidemic in London.
April 1	The Acting CEO participated in the Annual London Abused Women's Centre (LAWC) 2017 CEO/Community Leader Challenge at Springbank Park.
April 3	The Acting MOH met with Mayor Matt Brown to discuss drug-related topics.

This report was submitted by the Office of the Medical Officer of Health.

Dr. Gayane Hovhannisyan, MD, PhD, FRCPC
Acting Medical Officer of Health

Laura Di Cesare, CHRE
Acting Chief Executive Officer