AGENDA
MIDDLESEX-LONDON BOARD OF HEALTH

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

Thursday, 7:00 p.m.
2017 September 21

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, July 20, 2017.

DELEGATIONS

7:05 – 7:15 p.m.	Ms. Rhonda Brittan, Manager, Healthy Communities & Injury Prevention, re: October InMotion Community Challenge – Presentation
7:15 – 7:25 p.m.	Ms. Trish Fulton, Chair, Finance & Facilities Committee meeting re: Item #1 (Report No. 045-17)
7:25 – 7:35 p.m.	Mr. Trevor Hunter, Chair, Governance Committee re: Item # 2, September 21, 2017, Governance Committee meeting – Verbal Update.

Item #	Report Name and Number	Link to Additional Information	Delegation	Recommendation	Information	Brief Overview
Committee Reports						
1	Finance & Facilities Committee meeting, September 7, 2017 (Report No. 045-17)	Agenda: September 7, 2017 Minutes: September 7, 2017	x	x		To receive an update from the September 7, 2017 Finance & Facilities Committee (FFC) meeting.
2	Governance Committee meeting, September 21, 2017 Verbal Update	Agenda: September 21, 2017	x	x	x	To receive a verbal update from the September 21, 2017 Governance Committee (GC) meeting.
Delegation and Recommendation Reports						
3	Expert Panel on Public Health: Information Session Update (Report No. 050-17)	Appendix A		x	x	To provide an update on the expert panel on public health information session and request that the Board direct staff to work with local Municipalities on a joint submission to the current consultations.
Information Reports						
4	2017 Legislative and Regulatory Amendments Under the Immunization of School Pupils Act (Report No. 049-17)				x	To provide an update on changes to the Immunization of School Pupils Act regulations.
5	2016-2017 Influenza Season in Middlesex-London – Final Report (Report No. 046-17)	Appendix A			x	To provide an update on the 2016-2017 influenza season in Middlesex-London.
6	Summary Information Report, September 2017 (Report No. 047-17)				x	To provide an update on the Healthy Babies Healthy Children (HBHC) waitlist.
7	Medical Officer of Health / CEO Activity Report, September 2017 (Report No. 048-17)				x	To provide an update on the activities of MOH / CEO for September 2017.

OTHER BUSINESS

- Next Finance & Facilities Committee meeting: October 5, 2017 @ 9:00 a.m.
- Next Board of Health meeting: October 19, 2017 @ 7:00 p.m.
- Next Governance Committee meeting: October 19, 2017 @ 6:00 p.m.

CORRESPONDENCE

a) Date: 2017 July 6
Topic: The Revealing of Imperial Tobacco Canada Ltd's Anti-Contraband Campaign
From: North Bay Parry Sound District Health Unit
To: Minister Eric Hoskins

Background:

The North Bay Parry Sound District Health Unit (NBPSDHU) approved a motion that representatives of the of NBPSDHU would have no further meetings or discussions about any tobacco-related issues with representatives of the National Coalition Against Contraband Tobacco and the Ontario Convenience Stores Association who have worked on the behalf of Imperial Tobacco Canada.

Recommendation:

Receive.

b) Date: 2017 July 6
Topic: alPHa Conference Proceedings
From: Association of Local Public Health Agencies
To: All Health Units

Background:

The Association for Local Public Health Agencies (alPHa) held its annual conference in Chatham-Kent on June 11th through the 13th. Proceedings of the conference included: discussion of the health system transformation, weighing the legalization of cannabis, business meetings, resolution sessions, a change management session, understanding Program Based Marginal Analysis and discussion regarding an Age-Friendly Framework.

Recommendation:

Receive.

c) Date: 2017 July 21
Topic: Fluoride Varnish Programs for Children at Risk for Dental Caries
From: Association of Local Public Health Agencies
To: The Honourable Eric Hoskins

Background:

The Association for Local Public Health Agencies (alPHa) adopted a resolution that called on the Government of Ontario to provide funding through the Healthy Smiles Ontario Program for the implementation of school and community-based fluoride varnish for children at risk of dental caries.

Recommendation:

Endorse.

d) Date: 2017 July 25
Topic: Smoke-free Rental Housing
From: Minister Chris Ballard
To: Jesse Helmer

Background:

The Minister of Housing, Chris Ballard responded to the Chair of the Board thanking the Health Unit for its concerns regarding smoke-free rental housing and the standard lease. The government will be consulting on the details of the standard lease in coming months and will take the Health Unit's feedback under consideration.

Recommendation:

Receive.

e) Date: 2017 July 25
Topic: Preschool Speech Language Program
From: Minister Michael Coteau
To: Jesse Helmer

Background:

The Minister of Children and Youth Services, Michael Coteau responded to the Chair of the Board thanking the Health Unit for its ability to maintain service levels for the Preschool Speech and Language program. He has provided contact information for the Director of the Early Child Development Branch and encouraged us to explore and identify ways to maintain service levels.

Recommendation:

Receive.

f) Date: 2017 August 3
Topic: Public Funding for Dental Treatment Services for Low-income Adults
From: Peggy Sattler, MPP
To: Minister Eric Hoskins

Background:

Peggy Sattler, MPP for London West wrote correspondence to the Minister of Health and Long-Term Care regarding the lack of oral health programs for low-income adults and seniors. Ms. Sattler commented that the lack of support has resulted in the closure of the Middlesex-London Health Unit dental health clinic and has jeopardized the oral health of vulnerable London citizens.

Recommendation:

Receive.

g) Date: 2017 August 2
Topic: Expert Panel on Public Health Report
From: Association of Local Public Health Agencies
To: Chairs, Boards of Health, Medical Officers of Health, Senior Managers

Background:

The Association for Local Public Health Agencies (alPHa) shared materials concerning the Expert Panel on Public Health Report which includes: the full report and letters that were submitted during alPHa deliberations. Efforts are underway by alPHa to develop a process to gather members' feedback so as to make fully-informed contributions and sound advice on the behalf of constituents.

Recommendation:

Receive.

h) Date: 2017 July 18
Topic: Reporting of Viral Loads to Public Health Units
From: Canadian HIV/AIDS Legal Network
To: Dr. David Williams

Background:

The Canadian HIV/AIDS Legal Network wrote to Dr. David Williams, Chief Medical Officer, Ministry of Health and Long-Term Care in response to the decision to compel laboratories to report nominal HIV detectable viral loads to Public Health Units. The Legal Network strongly opposes the reporting of viral loads to Public Health Units and state that it is an unacceptable violation of patients' right to confidentiality of health information without evidence of its need of efficacy. They also note that it is unclear how Public Health Units plan to use the information provided. Lastly, they urge Public Health Ontario to reconsider the decision.

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 identifiable individuals, labour relations, a proposed or pending acquisition of land by the Middlesex-London Board of Health and to consider confidential minutes from its July 20, 2017 Board of Health meeting and September 7 Finance and Facilities Committee meeting.

ADJOURNMENT

PUBLIC SESSION – MINUTES
MIDDLESEX-LONDON BOARD OF HEALTH
399 Ridout Street, London
Middlesex-London Board of Health Boardroom
Thursday, July 20, 2017 7:00 p.m.

MEMBERS PRESENT:
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)

MEDIA
Chris Ensing, CBC London

OTHERS PRESENT:
Dr. Christopher Mackie, 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 & Injury Prevention
Ms. Laura Di Cesare, Director, Corporate Services
Ms. Shaya Dhinsa, Manager, Sexual Health
Ms. Bernadette Garrity, Public Health Nurse
Ms. Heather Lokko, Manager, Healthy Start
Mr. John Millson, Associate Director, Finance
Ms. Debbie Shugar, Manager, Screening Assessment & Intervention
Ms. Linda Stobo, Acting Manager, Oral Health & Manager, Chronic Disease & Tobacco Control
Mr. Stephen Turner, Director, Environmental Health & Infectious Disease
Mr. Alex Tyml, Online Communications Coordinator
Ms. Suzanne Vandervoort, Director, Healthy Living

Chair Helmer called the meeting to order at 7:00 p.m.

DISCLOSURES OF CONFLICT(S) OF INTEREST

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

APPROVAL OF AGENDA

Chair Helmer reviewed the proposed changes to the evening's Agenda which include:

1) The first matter of the evening now being a Confidential walk-on report regarding identifiable individuals, moved to the top of the agenda to accommodate a guest.
2) Dr. Mackie doing a presentation regarding the Public Health Integration Expert Panel Report

It was moved by Ms. Vanderheyden, seconded by Mr. Clarke, *that the **AGENDA** for the July 20, 2017 Board of Health meeting be approved, as amended.*

Carried

APPROVAL OF MINUTES

It was moved by Ms. Fulton seconded by Mr. Meyer, *that the **MINUTES** of the June 15, 2017 Board of Health meeting be approved.*

Carried

CONFIDENTIAL

At 7:02 p.m., it was moved by Ms. Vanderheyden, seconded by Ms. Fulton, *that the Board of Health move in-camera to discuss matters regarding identifiable individuals.*

Carried

Chair Helmer requested that all guests in attendance but the Board of Health, Ms. Elizabeth Milne, Dr. Mackie, Ms. Di Cesare, Ms. Vandervoort, Mr. Millson, Ms. Lokko, Mr. Turner, and Ms. Stobo leave the meeting.

At 8:21 p.m., it was moved by Mr. Peer, seconded by Ms. Vanderheyden, *that the Board of Health rise and return to public session.*

Carried

At 8:21 p.m. the Board of Health returned to public session.

It was moved by Ms. Cassidy, seconded by Ms. Vanderheyden, *that the Board of Health to take a five-minute recess.*

Carried

Chair Helmer called the meeting back to order at 8:28 pm.

DELEGATION AND RECOMMENDATION REPORTS

July Program Funding Update (Report No. 038-17)

Ms. Shaya Dhinsa, introduced the HIV Initiatives Update presentation which summarized current work being done, recent successes, current priorities and the Health Unit's latest funding request, which was send to Dr. Eric Hoskins, with the support of Deputy Premier Deb Matthews, to request Financial support to enhance outreach nursing capacity and harm reduction in the amount of $525,000.

It was moved by Ms. Cassidy, seconded by Mr. Hunter, *that the Board of Health to receive the presentation on HIV Initiatives Update.*

Carried

Discussion ensued about the following items:

- How the street-level outreach team can help to re-engage clients who no longer seek care.
- How consent may be a barrier to care and which could affect the work of the outreach team.
- How the resources have been reallocated through the PBMA process have assisted in addressing the HIV crisis, which allowed for more funding to work with clients at the street level.
- How the tracking of the strains of HIV can help to target public health interventions as part of the outreach work.

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

1) *Authorize the Chair to sign the amending agreement associated with the new $250,000 opioid response funding, pending staff review of the terms of this agreement; and*
2) *That Report No: 038-17 re: July Program Funding Update be received for information.*

Carried

Infant Hearing Program Amending Agreement (Report No. 041-17)

It was moved by Ms. Fulton, seconded by Mr. Meyer, that the Board of Health:

1) *Receive Report No. 041-17 Re: "Infant Hearing Program Increased Base Budget Funding;*
2) *Approve the revised Screening, Assessment, and Intervention Team budget; and*
3) *Authorize the Board Chair sign the Amending Agreement with the Ministry of Children and Youth Services.*

Carried

INFORMATION REPORTS

Q2 Financial Update & Factual Certificate (Report No. 042-17)

Chair Helmer advised that this report was brought directly to the Board since there is likely not be another Finance & Facilities Committee meeting until September.

It was moved by Ms. Fulton, seconded by Mr. Meyer, *that the Board of Health receive Report No. 042-17 re: "Q2 Financial Update & Factual Certificate" and appendices for information.*

Carried

Summary Information Report, July 2017 (Report No. 039-17)

It was moved by Mr. Peer seconded by Mr. Smith, *that the Board of Health receive Report No. 039-17 re: Summary Information Report for July 2017 for information.*

Carried

Medical Officer of Health Activity Report, July (Report No. 040-17)

Chair Helmer advised that Dr. Mackie also participated in a round table at Western with the federal Minister of Health regarding opioids and the Minister seemed to understand the problem very well. Chair Helmer also attended as an observer.

Mr. Hunter advised that he is proud to be serving as a Board member for an organization that tackles such important issues.

It was moved by Mr. Peer, seconded by Mr. Smith *that the Board of Health receive Report No. 040-17 re: Medical Officer of Health Activity Report – July for information.*

Carried

OTHER BUSINESS

It was moved by Ms. Cassidy, seconded by Ms. Kasi, *that the Board of Health cancel its August Finance and Facilities Committee meeting and Board of Health meeting*.

Carried

NEXT MEETINGS

As discussed previously, the August FFC and Board of Health meetings are not required.
Staff recommend cancellation of these meetings. If this is approved, future meetings are as follows:

- Next Finance & Facilities Committee meeting: September 7, 2017 @ 9:00 a.m.
- Next Board of Health meeting: September 21, 2017 @ 7:00 p.m.
- Next Governance Committee meeting: September 21, 2017 @ 6:00 p.m.

Presentation and Report regarding the Public Health Integration Expert Panel Report (Verbal)

Dr. Mackie introduced the proposal that came from the Minister's Expert Panel on Public Health earlier today, which recommends that Ontario establish 14 regional public health entities.

Discussion ensued about the following:

- How the Board of Health and reporting structure would look should the region be established into regional public health entities.
- That there is currently no commitment to implementing the proposal; the legislative barriers to cross before the implementation; and the next steps, which will include consultations with health units.
- That a regional set up may reduce the autonomy of Medical Officers of Health and Boards to advocate for their municipalities and work on behalf of their communities.
- That the discussion on this matter is far from over, with further information expected at the next Board of Health meeting in September, where the Board will further consider the proposal and its implications.

It was moved by Ms. Fulton seconded by Mr. Peer, *that the Board of Health receive the Report regarding the Public Health Integration Expert Panel.*

Carried

CORRESPONDENCE

It was moved by Mr. Ian Peer, seconded by Ms. Maureen Cassidy, *that the Board of Health receive items a), c), d) and f) through p).*

Carried

It was moved by Mr. Ian Peer, seconded by Ms. Maureen Cassidy, *that the Board of Health endorse item e)*

Carried

It was moved by Mr. Ian Peer, seconded by Ms. Maureen Cassidy, *that the Board of Health endorse item b).*

Carried

ADJOURNMENT

At 9:33 p.m., it was moved by Ms. Vanderheyden, seconded by Marcel, *that the meeting be adjourned.*

Carried

JESSE HELMER
Chair

CHRISTOPHER MACKIE
Secretary-Treasurer

PUBLIC MINUTES
FINANCE & FACILITIES COMMITTEE
MIDDLESEX-LONDON BOARD OF HEALTH
50 King Street, London
Middlesex-London Health Unit – Room 3A
2017 September 7, 9:00 a.m.

COMMITTEE MEMBERS PRESENT:
Ms. Trish Fulton
Mr. Jesse Helmer (9:11)
Mr. Marcel Meyer
Mr. Ian Peer
Ms. Joanne Vanderheyden

OTHERS PRESENT:
Ms. Lynn Guy, Executive Assistant to the Medical Officer of Health / CEO (Recorder)
Dr. Christopher Mackie, Secretary-Treasurer
Ms. Laura Di Cesare, Director, Corporate Services
Mr. John Millson, Associate Director, Finance
Ms. Tammy Beaudry, Accounting and Budget Analyst
Mr. Jordan Banninga, Manager Strategic Projects
Ms. Linda Stobo, Manager, Chronic Disease Prevention and Tobacco Control

At 9:01 a.m., Chair Fulton called the meeting to order.

DISCLOSURES OF CONFLICTS OF INTEREST

Chair Fulton inquired if there were any conflicts of interest. None were declared.

APPROVAL OF AGENDA

It was moved by Mr. Peer, seconded by Ms. Vanderheyden, *that the AGENDA for the September 7, 2017 Finance & Facilities Committee meeting be approved.*

Carried

APPROVAL OF MINUTES

It was moved by Mr. Meyer, seconded by Mr. Peer, *that the MINUTES of the June 8, 2017 Finance & Facilities Committee meeting be approved.*

Carried

NEW BUSINESS

4.1 Proposed 2018 PBMA Process, Criteria & Weighting (Report No. 029-17FFC)

As there were no changes to the process, criteria and weighting, Chair Fulton asked if the committee members were ready to approve the report.

It was moved by Mr. Peer, seconded by Mr. Meyer, *that the Finance & Facilities Committee receive and recommend that the Board of Health approve the 2018 PBMA criteria and weighting, which is proposed in Appendix A to Report No. 029-17FFC.*

Carried

4.2 Middlesex-London Health Unit – March 31 Draft Financial Statements (Report No. 030-17FFC)

Ms. Fulton asked Mr. Millson if there were any items that were of concern. Noting none, Mr. Millson asked if there were any questions. There were no questions.

It was moved by Mr. Peer, seconded by Ms. Vanderheyden, *that the Finance and Facilities Committee receive and recommend that the Board of Health approve the audited Consolidated Financial Statements for the Middlesex-London Health Unit, March 31, 2017, as appended to Report No. 030-17FFC.*

Carried

4.3 Canada Health Infoway Inc. Agreement (Report No. 031-17FFC)

Mr. Turner briefly reviewed the connectivity benefits of implementing Public Health Information Exchange (PHIX) and Immunization Connect Ontario (ICON) initiatives. He noted that PHIX will enable medical professionals to send immunization records and information for school-age clients to the Health Unit in a secure manner. He advised that the ICON will allow the public to access their immunization records. Discussion ensued regarding the potential issues that generally occur when implementing new processes.

It was moved by Mr. Helmer, seconded by Mr. Meyer, *that the Finance & Facilities Committee:*

1) *Receive Report No. 031-17FFC for information; and*
2) *Request that the Board of Health authorize the Chair to sign the funding agreement (Appendix A) between the Middlesex-London Health Unit and Canada Health Infoway Inc.*

Carried

4.4 Health Unit Contribution to London's Healthy Kids Community Challenge (HKCC) Sugary Drink Campaign (Report No. 032-17FFC)

Ms. Fulton asked if there were any questions. The Committee discussed how best to use the $30,000 to promote this campaign and reach as many residents as possible. It was noted that it is hard to compete with the large advertising budgets that the big name soft drink companies have but as more and more organizations begin to send out messaging, it will begin to make a positive impact.

It was moved by Mr. Meyer, seconded by Ms. Vanderheyden, *that the Finance & Facilities Committee receive Report No. 032-17FFC re: Health Unit Contribution to London's Health Kids Community Challenge (HKCC) Sugary Drink Campaign for information.*

Carried

OTHER BUSINESS

Next meeting: Thursday, October 5, 2017 at 9:00 a.m., Room 3A, 50 King Street, London

Ms. Vanderheyden thanked Linda Stobo and her Team for organizing the Smoke Free Movie night in Strathroy.

On behalf of the Board, Chair Fulton thanked Mr. Millson for his years of dedicated service and friendship.

CONFIDENTIAL

At 9.21 a.m., it was moved by Mr. Peer, seconded by Ms. Vanderheyden, *that the Finance & Facilities Committee move in-camera to discuss matters regarding labour relations and a proposed or pending acquisition of land by the Middlesex-London Board of Health.*

Carried

At 10:36 a.m., it was moved by Mr. Meyer, seconded by Mr. Peer, *that the Finance & Facilities Committee return to public session.*

Carried

At 10:37 a.m. the Finance and Facilities Committee returned to public session.

ADJOURNMENT

It was moved by Ms. Vanderheyden, seconded by Mr. Helmer, *that the Finance & Facilities Committee adjourn the meeting.*

Carried

At 11:00 a.m., Chair Fulton *adjourned the meeting*.

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TRISH FULTON
Chair, Finance & Facilities Committee

CHRISTOPHER MACKIE
Secretary-Treasurer

PUBLIC SESSION – MINUTES
MIDDLESEX-LONDON BOARD OF HEALTH
Governance Committee
399 Ridout Street, London
Middlesex-London Board of Health Boardroom
Thursday, June 15, 2017 6:00 p.m.

Committee Members Present:	**Mr. Trevor Hunter (Chair)** Mr. Ian Peer Mr. Kurtis Smith Ms. Maureen Cassidy Mr. Jesse Helmer
Others Present:	Ms. Joanne Vanderheyden, Board member Mr. Marcel Meyer, Board member Ms. Elizabeth Milne, Executive Assistant to the Board of Health and Communications (Recorder) Mr. Jordan Banninga, Manager, Strategic Projects Ms. Vanessa Bell, Manager, Privacy & Occupational Health & Safety Ms. Laura Di Cesare, Director, Corporate Services Mr. John Millson, Associate Director, Finance

Chair Hunter called the meeting to order at 6:01 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. Peer, seconded by Mr. Helmer, *that the AGENDA for the June 15, 2017 Governance Committee meeting be approved.*

Carried

APPROVAL OF MINUTES

It was moved by Mr. Helmer, seconded by Mr. Peer, *that the MINUTES of the April 20, 2017 Governance Committee meeting be approved.*

Carried

OTHER BUSINESS

Mr. Meyer arrived at 6:03 p.m.

4.1 Policy Review (Continued)

Mr. Jordan Banninga, Manager, Strategic Projects introduced the policies and Ms. Vanessa Bell reviewed the changes to policy G-100 regarding confidential information.

Mr. Smith arrived at 6:04 p.m.

Mr. Helmer thanked Ms. Bell for her summary of the revisions to policy G-100.

Mr. Banninga reviewed and provided a summary of changes made to the policies from the feedback and comments provided by the Finance & Facilities Committee (G-180, G-190, G-210, G-240, G-250, G-260, G-310, G-320, G-330, G-420).

Discussion ensued about the following items:

- Renaming the title of policy G-210 (Investing) and continuing consultation with the City and County regarding this policy.

  - The notion of investing and the framework in which the Health Unit is able to invest.
- Approving policy G-250, pending the following changes:
  - Update second paragraph to no longer reference the old policy.
  - Update language around intent; update should not to "shall not", making the use of "shall not" consistently throughout the policy.
  - Update Appendix A – sick leave reserve fund.
- Clarification in policy G-260 of who the Board of Health is accountable to.
- Clarification of funds versus gifts in policy G-330 and who these gifts or honorariums should be reported to.
  - Update language. Change honorarium to "Honoraria" throughout the policy.
- Clarification of policy G-420 as to when a rental car is to be used within a certain mileage limit, and the pre-approval required based on a case by case basis. The cost effectiveness of this requirement.
- Clarification of the use of MLHU versus "the health unit".
  - Apply consist use of MLHU to policies and board reports across the organization.

It was moved by Mr. Helmer, seconded by Ms. Cassidy, *that the Governance Committee recommend that the Board of Health approve G-100, G-180, G-190, G-210, G-240, G-250, G-260, G-310, G-320, G-330, G-420, pending final wording changes made by staff.*

Carried

4.2 Next Meeting: Thursday, September 21, 2017

ADJOURNMENT

At 6:42 p.m. it was moved by Mr. Smith, seconded by Ms. Cassidy, *that the meeting be adjourned.*

Carried

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TREVOR HUNTER
Chair

LAURA DI CESARE
Secretary-Treasurer

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 045-17

TO: Chair and Members of the Board of Health

FROM: Dr. Christopher Mackie, Medical Officer of Health / CEO

DATE: 2017 September 21

FINANCE AND FACILITIES COMMITTEE MEETING – September 7

The Finance and Facilities Committee met at 9:00 a.m. on Thursday, September 7, 2017.
A summary of the discussion can be found in the minutes.

The following reports were reviewed at the meeting and recommendations made:

Reports	Recommendations for Board of Health's Consideration and Information
Proposed 2018 PBMA Process, Criteria & Weighting **(Report No. 029-17FFC)**	It was moved by Mr. Peer, seconded by Mr. Meyer, *that the Finance & Facilities Committee recommend that the Board of Health approve the 2018 PBMA criteria and weighting that is proposed in Appendix A to Report No. 029-17FFC.* Carried
Middlesex-London Health Unit – March 31 Draft Financial Statements **(Report No. 030-17FFC)**	It was moved by Mr. Peer, seconded by Ms. Vanderheyden, *that the Finance & Facilities Committee recommend that the Board of Health approve the audited Consolidated Financial Statements for the Middlesex-London Health Unit, March 31st, 2017 Appendix A as appended to Report No. 030-17FFC.* Carried
Canada Health Infoway Inc. Agreement **(Report No. 031-17FFC)**	It was moved by Mr. Helmer, seconded by Mr. Meyer, *that the Finance & Facilities Committee:* *1) Receive Report No. 031-17FFC for information; and* *2) Request that the Board of Health authorize the Board Chair to sign the funding agreement (Appendix A) between the Middlesex-London Health Unit and Canada Health Infoway Inc.* Carried
Health Unit Contribution to London's Healthy Kids Community Challenge (HKCC) Sugary Drink Campaign **(Report No. 032-17 FFC)**	It was moved by Mr. Meyer, seconded by Ms. Vanderheyden, *that the Finance & Facilities Committee receive Report No. 032-17FFC re: Health Unit Contribution to London's Healthy Kids Community Challenge (HKCC) Sugary Drink Campaign for information.* Carried

The Finance and Facilities Committee moved in-camera to discuss matters regarding labour relations and a proposed or pending acquisition of land by the Middlesex-London Board of Health.

The next meeting will be Thursday October 5, 2017 at 9:00 a.m. in Room 3A, 50 King Street.

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

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health / CEO

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 050-17

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2017 September 21

EXPERT PANEL ON PUBLIC HEALTH: INFORMATION SESSION UPDATE

Recommendation

It is recommended that the Board of Health:

1. ***Receive Report No. 050-17 for information, and***
2. ***Direct staff to work with local municipalities on a joint submission to the current consultations.***

Key Points

- As part of the Patients First healthcare transformation project initiated in 2015, the Minister of Health and Long-Term Care established an Expert Panel on Public Health to develop recommendations on how to establish "strong public health within an integrated [health] system."
- The report, released in July of this year, recommends a new system of governance for public health which would dissolve the 36 existing Boards of Health, and establish new Boards that serve boundaries matching those of the 14 Local Health Integration networks (LHINs).
- Other significant changes recommended include separating the Medical Officer of Health (MOH) and Chief Executive Officer (CEO) roles in these new entities, and ensuring that Board of Health members have relevant skills and diverse backgrounds, including Indigenous and Francophone.
- Strengths and weaknesses of the new proposed model have been identified, and concern has been expressed about these changes by public health and municipal leaders locally and elsewhere.
- The City of London has inquired about preparing a joint submission to the current consultations on the Expert Panel's recommendations.

Background

When the Patients First Discussion Paper was first circulated in 2015, it included the establishment of an Expert Panel on Public Health to develop recommendations about how to establish "strong public health within an integrated [health] system." The panel's report became public in July of this year, and includes a number of recommendations that would significantly change the governance, boundaries, and administration of public health units in Ontario. The Expert Panel's report is attached as Appendix A to this report.

The Expert Panel was asked to consider how to ensure organizational structure and governance in public health, with the goals of: quality control (on dimensions such as accountability, transparency, and equity); and integration of public health within the health care system.

Highlights of the Expert Panel's recommendations include:

- Dissolving all current Boards of Health in Ontario and establishing new public health units with boundaries matching those of the 14 Local Health Integration Networks (LHINs);
- Separating the MOH and CEO roles in these new entities and having the MOH report to the CEO; and
- Establishing new criteria for Board of Health members, including representation from Indigenous and Francophone communities as well as other diverse groups.

Under the recommendations, local public health delivery areas would exist within each new LHIN-shaped public health unit, with the goal of ensuring a local presence and effective relationships with municipalities.

The public consultation period ends October 31 of this year.

Strengths

The Expert Panel's report identifies potential strengths of the proposed model, including allowing public health units to:

- Centralize administrative and specialized public health functions at the regional level;
- Be accountable for provincially-set public health standards;
- Collaborate with LHINs and other partners to plan and tailor health services in their regions;
- Establish local public health service delivery areas within regions, based on population and geography; and
- Locate public health programs and services in local communities to maintain local engagement.

Other strengths include the potential for some cost savings, addressing areas that lack capacity for key public health functions, and reducing the likelihood of breakdowns in crucial governance functions.

Weaknesses

Potential weaknesses of the proposed model have been identified by public health and municipal leaders locally and elsewhere, including:

- Loss of local autonomy and authority
- One-size-fits-all structure that may not meet local needs
- Unclear justification and inaccurate framing of the challenges faced by the current system
- Significant expenditure of human and financial capital in transition costs for uncertain gain
- Some boundaries that would encompass vastly different communities with vastly different needs, and others that would create artificial divisions within existing communities
- Focus on healthcare at the expense of partnerships with municipal and other partners
- Changes that are at variance with established best practices in organizational structure
- As much as $80 Million in increased annual costs in harmonized contracts

Next Steps

While there are real issues to be addressed in various parts of the public health system, addressing these using the Expert Panel's recommendations could result in some negative impacts. Other approaches may address existing challenges and be less risky.

The Board of Health has the opportunity to provide input as part of the public consultation process regarding the Expert Panel's recommendations. Both the Association of Municipalities of Ontario (AMO) and the Association of Local Public Health Agencies (alPHa) are currently developing their own responses to these recommendations. By working with the County of Middlesex and The City of London, the Health Unit may increase the impact of any submission.

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

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health / CEO

Public Health within an Integrated Health System

Report of the Minister's Expert Panel on Public Health

June 9, 2017

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I. About the Expert Panel

In January 2017, the Minister of Health and Long-Term Care established an Expert Panel on Public Health to provide advice on structural, organizational and governance changes for Ontario's public health sector within a transformed health system.

Mandate

As part of their recommendation, the Expert Panel was asked to consider:

1. The optimal organizational structure for public health in Ontario to:
   - ensure accountability, transparency and quality of population and public health programs and services
   - improve capacity and equity in public health units across Ontario
   - support integration with the broader health system and the Local Health Integration Networks (LHINs) – the organizations responsible for planning health services
   - leverage public health's expertise and leadership in population health-based planning, decision-making and resource allocation, as well as in addressing health equity and the social determinants of health.
2. How best to govern and staff the optimal organizational structure.

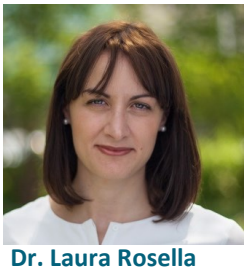
Membership

Members were chosen for their knowledge, expertise and perspectives and appointed by Order in Council. They were appointed as individuals and not as representatives of organizations or associations.

Dr. David Williams
Chief Medical Officer of Health, Ontario

Susan Fitzpatrick
Chief Executive Officer, Toronto Central Local Health Integration Network (LHIN)

Dr. Valerie Jaeger
Medical Officer of Health, Niagara Region Public Health



Dr. Laura Rosella
Canada Research Chair in Population Health Analytics, Assistant professor, Dalla Lana School of Public Health, UofT

Solomon Mamakwa
Health Advisor, Nishnawbe Aski Nation

Dr. Nicola J. Mercer
Medical Officer of Health and CEO, Wellington-Dufferin-Guelph Public Health

Gary McNamara
Mayor of the Town of Tecumseh, Chair of the Windsor Essex Health Unit

Carol Timmings
Director, Child Health and Development, Chief Nursing Officer, Toronto Public Health

Dr. Jeffrey Turnbull
Chief of Staff, The Ottawa Hospital, Chief - Clinical Quality, HQO

Desired Outcome: A Strong Public Health Sector within an Integrated Health System

It is the view of the Expert Panel that Ontario will benefit most from a highly skilled public health sector embedded and highly visible in communities across the province. Public health will continue to nurture strong relationships with municipal governments and other local organizations to positively influence the social determinants of health; and create safe, supportive, healthy environments. Its work will be overseen by boards that reflect the perspectives and diversity of local communities and municipalities and share and promote a strong commitment to public health.

The public health workforce in all parts of the province will have access to specialized public health knowledge and resources. Public health practitioners will share a commitment to evidence-based practice and achieving population health outcomes.

The work of public health will be guided by provincial policy and legislation, and supported by province-wide efforts to collect and analyze data on health status. Public health will continue to champion health equity, identifying groups within the population whose health is at risk and developing targeted universal programs so that all Ontarians have equal opportunity for good health outcomes. Public health will also ensure that Indigenous communities have an active voice.

At the same time, the public health sector will have the capacity to work much more effectively with the rest of the health system. Its understanding of local health needs will help identify health system priorities and shape health policy and services. Stronger relationships with other parts of the health system will make it easier to integrate health protection and promotion into all health services. Working with other parts of the heath system, public health will identify more effective ways to deliver population level interventions that will improve health and reduce health inequities.

Ontarians will recognize and value the work of public health and will access local public health programs and services within an integrated health system.

Goals of Patients First

- Effective integration of services and greater equity
- Timely access to, and better integration of, primary care
- More consistent and accessible home & community care
- Stronger links to population and public health
- Inclusion of Indigenous voices in health care planning

Principles Guiding the Panel's Work

To guide its work and deliberations, the Expert Panel developed the following principles:

- The strong independent public health voice and core public health functions will be preserved and leveraged to help reorient the health system.
- The local strengths of public health – including relationships with municipal and other community partners – will be maintained and enhanced to support integrated planning and service delivery.
- The federal government will continue to have responsibility for health services for Indigenous people in Ontario, including First Nations communities; however Ontario's public health sector also has a responsibility to protect and promote Indigenous health and to ensure Indigenous partners have an active voice.
- Being part of an integrated health system will create opportunities to enhance capacity and improve efficiency– some services may be delivered more effectively by or through other parts of the system.
- Form follows function: structural changes will be based on a clear understanding of the public health sector's role in an integrated health system.
- The organization and distribution of public health expertise, resources and services will reflect local needs and priorities.
- Boundary changes will be necessary to align public health with LHINs, and to support systems planning.

Process and Deliberations

To fulfill its mandate, the Expert Panel:

- reviewed background information, including past reports on Ontario's public health sector
- examined the functions of public health at the regional, local, and provincial levels
- reviewed the current organization of the health system
- discussed possible models and scenarios for reorganizing public health based on input received during consultation for Patients First, and various other submissions, letters, etc.
- looked at ways to align services and determine geographical boundaries
- reviewed the literature on various leadership roles and structures and models for governance
- discussed the potential implications for legislation, including the *Health Protection and Promotion Act* and the *Local Health System Integration Act*, and others.

II. The Opportunity

Public Health as Part of an Integrated Health System

As part of Patients First, all health programs and services – hospitals, home and community care, primary care and public health – are strengthening connections and working together to enhance Ontarians' health and well-being at all ages and stages of life.

Historically, public health and health care have operated as distinct systems. Public health largely focuses on the health of populations and providing upstream community-wide interventions, while health care services are designed to diagnose, treat, and improve individual health outcomes. A key goal of Patients First is to strengthen linkages and partnerships between the health care system and public health.

Close collaboration and formalized relationships between public health and LHINs will mean that:

- A population health approach will be integrated into local planning and service delivery across the continuum of health care
- health services will address and be responsive to population health needs and will seek to promote health and achieve health equity
- health promotion, health protection and health care will be more connected
- public health services and other health services will be better integrated

Preparing Public Health for its role in an Integrated Health System

To maximize its impact in the transformed system, public health must change and the health system must adapt to allow and support true integration.

Over the past year, three public health transformation initiatives have been focused on addressing key questions that will help public health be an effective partner in an integrated health system:

1. **What is the work of public health?**
   The **modernization of the Ontario public health standards** will provide a renewed framework for public health programs, services, and accountability in the 21st century.
2. **What is the role of public health in integrated planning?**
   The **public health work stream** is a collaboration between public health and LHINs working to provide guidance on formal engagement parameters for LHINs and public health across the province.
3. **How should public health be organized across the province to function effectively within an integrated system?**
   The **Expert Panel on Public Health** was asked to provide advice on what the structure and governance of public health should be to enhance its capacity to fulfill its health promotion and protection role and work effectively with partners within a transformed health system.

The Impact of Public Health within an Integrated System

What impact will the strengthened relationship between public health and LHINs have on all health system partners and on Ontarians?

Strong relationships outside the health system to protect and promote health.
Public health works with municipal governments, community organizations, schools, and local services outside the health system – to influence the social, environmental and structural factors that can lead to poor health. Public health can broker relationships between health care, social services, municipal governments, and other sectors to create healthier communities.

More focus on the social determinants of health and greater health equity.
Some Ontarians are at greater risk of poor health because of social determinants such as poverty, precarious housing, poor working conditions, and a lack of social support networks. Public health can embed a population health approach into health service planning and delivery to close these health gaps and enhance health equity.

More comprehensive targeted health interventions.
Although chronic diseases are among the most common and costly health problems facing Ontarians, they are also among the most preventable. Interventions targeting chronic disease risk factors can be successful in mitigating and preventing the burden of chronic diseases. Public health can identify high risk communities and offer targeted interventions that can prevent or delay the onset of these diseases and their complications.

Better care pathways and health outcomes.
A person's ability to follow a care pathway after surgery or treatment is affected by factors outside the health system. For example, if an individual is discharged from the hospital and returns to precarious housing and food security challenges, their recovery will be negatively impacted and they may have a higher likelihood of being re-admitted to the hospital than someone who has stable housing and access to healthy food. Public health can help the health system develop care pathways that take into account the social factors that affect health outcomes.

Greater recognition of the value of public health.
With public health as part of an integrated health system, Ontarians will better understand the importance of investing in health protection and promotion across the life course. They will see how public health benefits themselves, their families and their communities and, at the same time, helps contain health care costs and make the universal health care system more sustainable.

Improving access to care is one priority for the integrated system, but the vision of Patients First is much broader. It is also about promoting health, reducing health disparities and helping all Ontarians lead long healthy lives.

III. A Strong Public Health Sector in an Integrated System

The impetus for the Expert Panel's work is the government's Patients First Strategy. The key question for the Expert Panel was how to best organize public health to function effectively within an integrated system. However, the Expert Panel also viewed their task as an opportunity to strengthen the public health sector and support more efficient and effective operations.

Members worked to identify an optimal structure and governance model for public health in Ontario for the 21st century and beyond. In developing recommendations, the Expert Panel did not attempt to "retrofit" the current system.

1. The Optimal Organizational Structure for Public Health

Background

Ontario currently has 36 public health units. They range in size from 630 to 266,291 square kilometres. The smallest serves only 34,246 people dispersed over a geographic area as large as France, while the largest serves 2,771,770 people concentrated within 630 square kilometres. (See Appendix A: map showing current health unit areas and LHIN boundaries)

Public health units are responsible for delivering programs and services in accordance with standards established by the Ministry of Health and Long-Term Care. Public health units are responsible for identifying local health priorities and population needs and addressing those that fall within their mandate. Much of the work in public health is done in close collaboration with municipal partners. There is a cost-sharing relationship between the Ministry of Health and Long-Term Care and municipalities for delivery of public health programs and services.

Key strengths of the public health sector include its focus on health protection, health promotion, and health equity, its local presence, relationship with municipalities, its highly trained workforce, its collaborative relationships outside the health care system, and its in-depth understanding of and capacity to assess population-level health.

Challenges of the current structure – particularly felt in smaller health units – include a lack of critical mass and surge capacity and challenges recruiting and retaining key skilled public health personnel, which make it difficult to deliver equitable services across Ontario. A lack of mechanisms to coordinate across health units and lack of alignment with LHINs also make it challenging to collaborate, share resources and maximize effectiveness both within the public health sector and within the broader health system.

Criteria

The Expert Panel's goal was to recommend an organizational structure for public health that would:

- Maintain a strong independent public health sector within an integrated health system
- Relate effectively with the LHINs to influence health system planning
- Enhance public health's strong local presence and effective relationships with municipalities
- Ensure Ontarians continue to have access to public health programs and services in their communities
- Create public health organizations large enough to achieve critical mass and retain public health personnel and resources to efficiently operate services in all parts of the province
- Allow for clear definition of public health functions and roles at the provincial, regional and local levels, in order to make more effective use of public health expertise and resources
- Enhance public health practice and ensure more consistent implementation of the public health standards across the province
- Foster collaboration/coordination within the public health sector and with the rest of the health system.

Members of the Expert Panel agreed with findings and observations of a series of reviews over the past 20 years, which all determined that Ontario's public health sector would be stronger if:

* there were fewer health units with greater capacity
* there was a consistent governance model
* the sector was better connected to other parts of the health system.

Responsibilities and Functions

To ensure strong local programs and services, every effort should be made to locate the right mix of management and program staff in local communities. Depending on the size of the communities/populations they serve, local service delivery sites may have public health physicians, directors, managers/program leads, front-line staff and staff responsible for using local population health data to develop local initiatives that are reflective of community needs.

The optimal locations for regional and local public health activities should be determined within the region and based on the distribution of the population and geography. The regional public health entity could potentially look for opportunities to co-locate public health services with other health and/or municipal services, thereby increasing the potential for service integration.

Table 1 on pages 12 –15 outlines public health responsibilities and functions at provincial, regional and local levels.

Figure 1: Organizations Described at Each Level

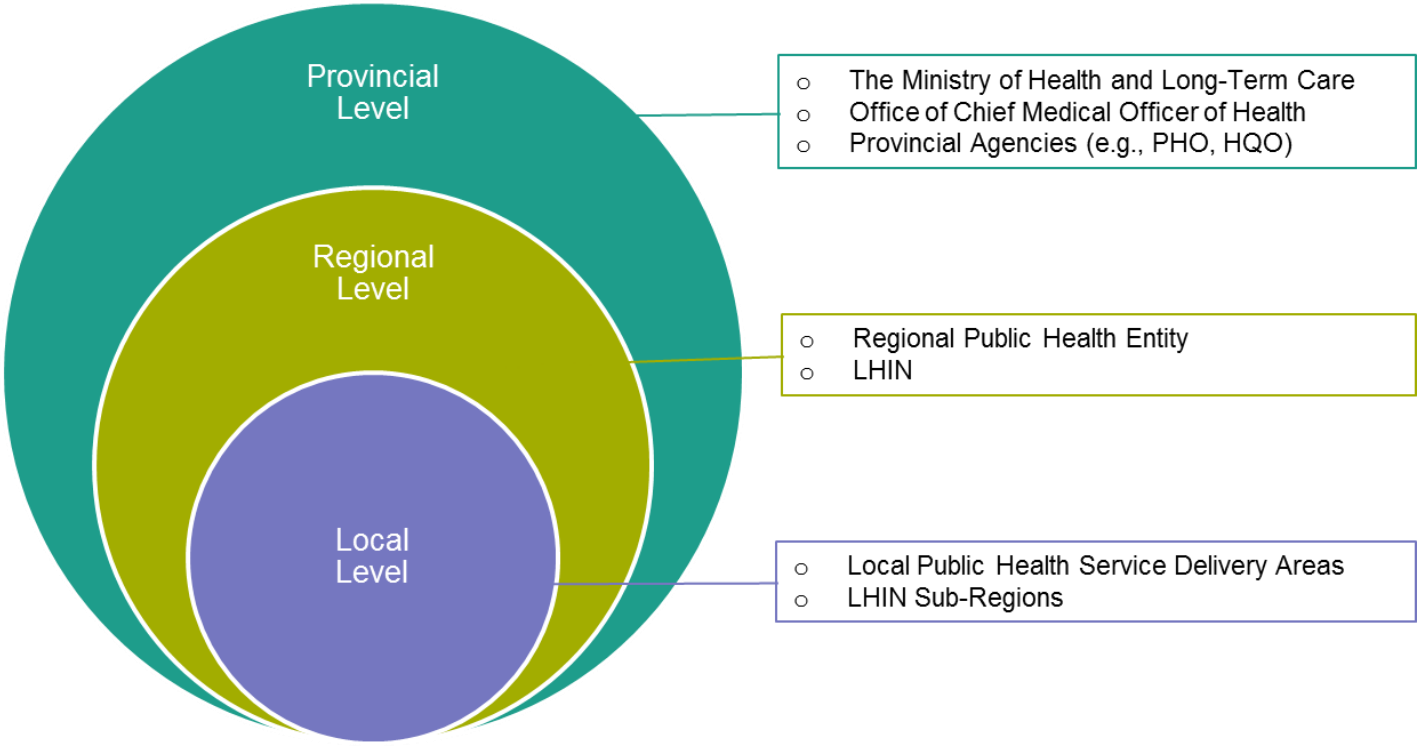


Table 1: Public Health Responsibilities and Functions

Category	Function	Regional	Local	Provincial	LHIN
Corporate Services	**Funding and Accountability**	• Accountability agreements with province • Performance management approach • Accountability for local public health entities	• Continuous quality improvement • Performance management initiatives	• Transfer payments • Overall provincial accountability with 14 regions	
	Human Resource Management	• Workforce strategy • Human resource policies and procedures	• Local oversight • Staff development	• 100% funded positions (e.g., social determinants of health nurses) • Medical Officer of Health/ Associate compensation	
	Administrative	• Risk management • Procurement • Service level agreements • Facilities planning and administration	• Local facilities management and input		
	Communications	• Strategic communication planning • Guidelines for use of relationships with media channels • Guidelines for public reporting	• Local issues management and correspondence with the media • Strategies for educating community partners and the public		
	Information tech-nology	• Corporate IT			

Table 1: Public Health Responsibilities and Functions (continued)

Category	Function	Regional	Local	Provincial	LHIN
Performance, Quality, and Analytics	**Surveillance and Monitoring**	• Collect and consolidate pertinent health-related data • Detect and notify of health events • Appropriate reporting of data to province, local offices, LHINs, etc.	• Apply surveillance data to guide public health policy and strategies • Document impact of an intervention or progress towards specified public health targets/goals • Investigation and confirmation of cases or outbreaks • Coordination and sharing of information with LHIN sub-regions	• Ongoing, systematic collection, analysis and interpretation of health-related data	• Receive surveillance information and assist with dissemination
	Information Management	• Responsible for common regional systems • Decision making • Data governance	• Systems designed to address local needs	• Centralized data systems • Data governance	• Potential integrated databases
	Performance and Evaluation	• Regional metrics and dashboards • Data repository • Inform /contribute to LHIN planning	• Local data collection and insights • Application of data in local planning and delivery • Program accountability • Quality of practice	• Provincial dashboards • Provincial level data • Coordination of data sharing with other jurisdictions and First Nations	• Coordination/ bridging work with public / population health data
	Research	• Set research priorities • Lead and/or participate in regional research projects • Review and incorporate research and evaluation findings into planning	• Conduct research projects • Help inform research proprieties • Partner with other organizations undertaking research • Stay up to date on latest studies • Ongoing program review and evaluation	• Set research priorities • Research grants	• Interpretation of population health research to inform planning

Table 1: Public Health Responsibilities and Functions (continued)

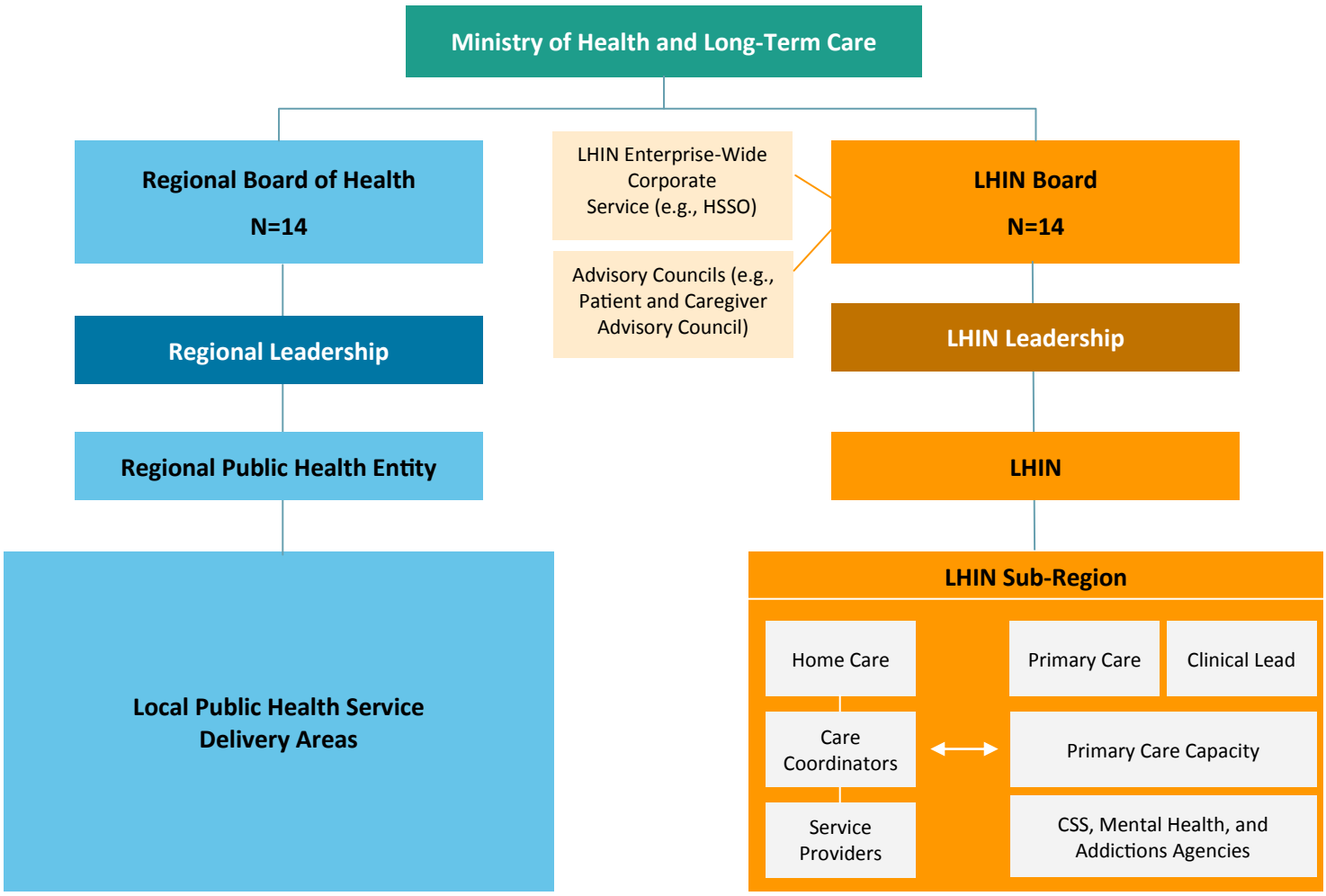
Category	Function	Regional	Local	Provincial	LHIN
Public Health Practice (Programs and Services)	**Planning**	• Annual service plan • Strategic plan • Health equity lens • Corporate planning • Resource allocation planning	• Operational plans • Implementation plans • Provide context, data, and costing inputs • Local perspective and considerations (including First Nations)	• Review and approve annual service plan • Mandate letters • Program and policy planning	• Regional input and alignment with other health services • Service planning
	Delivery	• Management of after-hours on-call system	• Implementation • Ongoing program and service delivery • Coordination of after-hours on-call system	• Provincial program implementation and oversight	• Coordinated delivery / optimization of services
	Coordination	• Work with leadership at all levels of government, throughout the public health organization, the 13 other regional MOHs, the LHIN, and across sectors • Functional integration and consistency with LHIN business plan	• Work with local leadership to execute public health services and delivery • Participation on local committees and in community meetings	• Chair provincial public health table with MOHs • Provide guidance and leadership on public health topics and issues	• Functional integration and consistency with public health business plan

Table 1: Public Health Responsibilities and Functions (continued)

Category	Function	Regional	Local	Provincial	LHIN
Strategic Engagement	**Health System**	• LHIN (cross-linkages) • Health regulatory colleges	• LHIN sub-regions (when applicable) • Primary care • Hospitals	• Public health accountability and reporting to province • Receive information/ direction/ mandates from province (when applicable)	• Information sharing • Inform planning at a LHIN and LHIN sub-region level • Consultation through LHIN committees (when applicable) • Routine collaboration between public health and LHIN leadership (at both regional and local/ LHIN sub-region levels) • Other health service providers e.g., hospitals, Community Health Centres and Family Health Teams
	Public Health System	• Chief Medical Officer of Health • Other MOHs and CNOs • Academic / research institutions • Public Health Ontario • Associations	• Regional public health • Other public health units • Academic / research institutions	• Regional MOHs (e.g., standing meetings)	• MOHs
	Governments	• Province	• Municipality	• Federal government • First Nations • Agencies	• Province
	Cross-Sector	• Leadership from all social deter-minants of health disciplines (e.g., environment, transportation, housing, children and youth services)	• Local community and social services • Education, transportation, housing, settlement, etc.	• Health in all policies approach	• Social services • Community and home care • Family services • Community and recreation services

Figure 2: Proposed End State — Public Health within an Integrated Health System

The Expert Panel recommends that Ontario establish 14 regional public health entities .



The proposed structure of 14 regional public health entities will allow public health to:

- **Centralize** administrative and specialized public health functions at the regional level
- **Be Accountable** for public health standards set provincially
- **Collaborate** with LHINs and other partners to plan and tailor health services in their regions
- **Establish** local public health service delivery areas within regions, based on population and geography
- **Locate** public health programs and services in local communities to maintain local engagement

The Expert Panel believes that having fewer regional public health entities will result in more frequent and effective interactions among regional medical officers of health and between regional medical officers of health and the province. At the same time, maintaining local public health delivery areas will ensure a strong local presence and effective relationships with municipalities.

For the proposed structure to succeed, it will be essential to establish strong working relationships, develop effective communication mechanisms and undertake shared projects and activities:

- within each regional public health entity
- between the regional public health entity and the municipalities in the region
- between the regional public health entity and the LHIN
- among the regional public health entities
- with the province.

2. Optimal Geographic Boundaries

Background

Ontario's existing 36 public health units are organized based mainly on municipal boundaries. The current configuration of health unit areas make it difficult to operate as a unified system with LHINs and other health system partners following LHIN boundaries.

The current organization of public health units has a negative impact on the capacity of smaller health units. Boundary changes are necessary to enhance public health capacity and effectiveness, and to help public health be more integrated with the rest of the health system. At the same time, it is important to maintain the strengths associated with public health's close relationship with municipalities.

Criteria

To determine the number of regional public health entities and their recommended geographic boundaries, the Expert Panel used the following criteria:

- create regional public health entities that would serve a large enough population to achieve critical mass to be able to operate efficiently and effectively and attract skilled staff
- support effective linkages with LHINs by aligning with LHIN boundaries
- respect municipal boundaries and relationships as much as possible
- whenever feasible, move existing health units in their entirety into the same regional health entity catchment area
- when it is not feasible to move entire existing health units together, divide health units based on municipal boundaries

Proposed Geographic Boundaries

The Expert Panel recommends that Ontario establish catchment areas for the 14 regional public health entities that are consistent with LHIN boundaries and respect existing municipal boundaries.

Figure 3: Proposed Boundaries Mapped Against Current Public Health Unit Boundaries

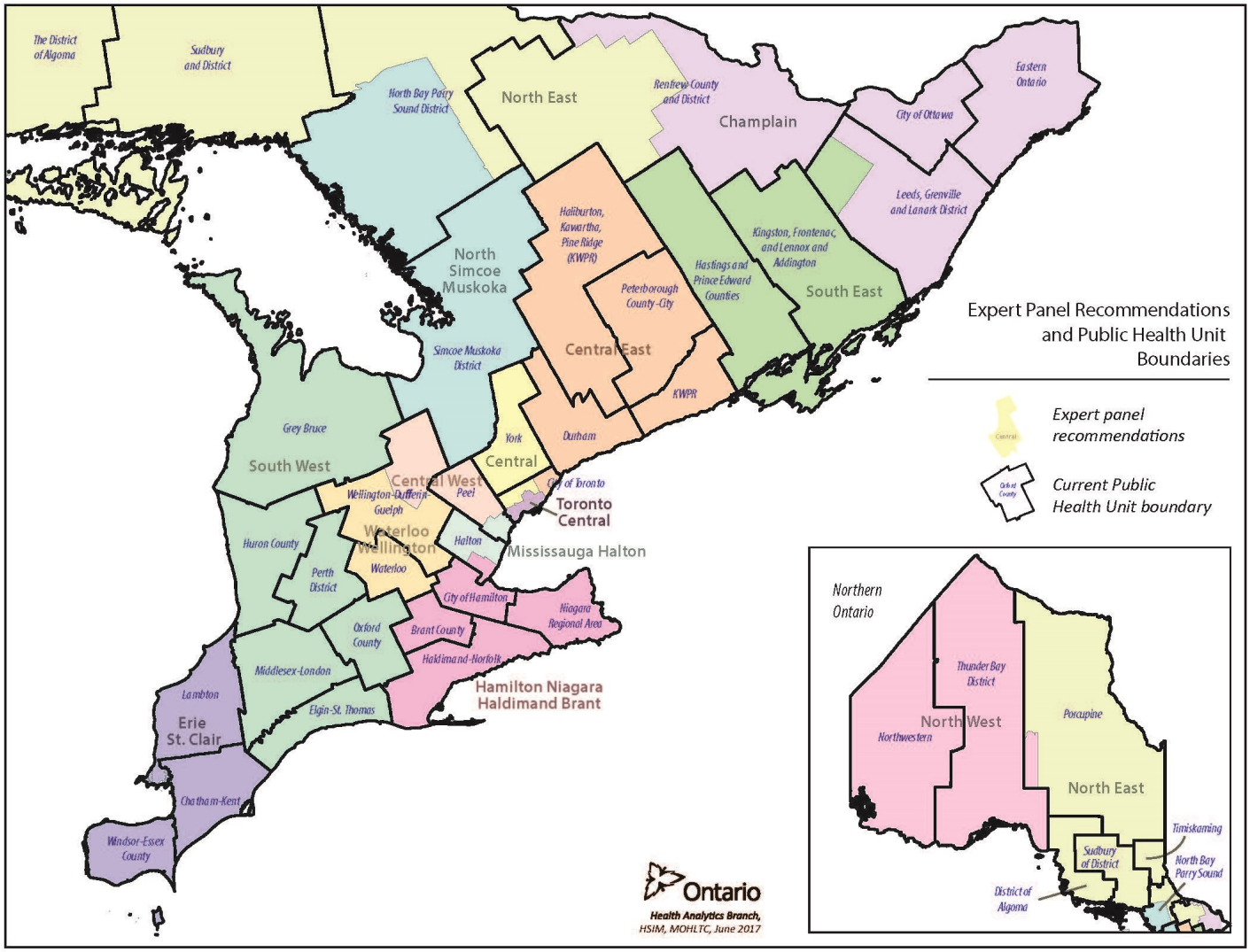
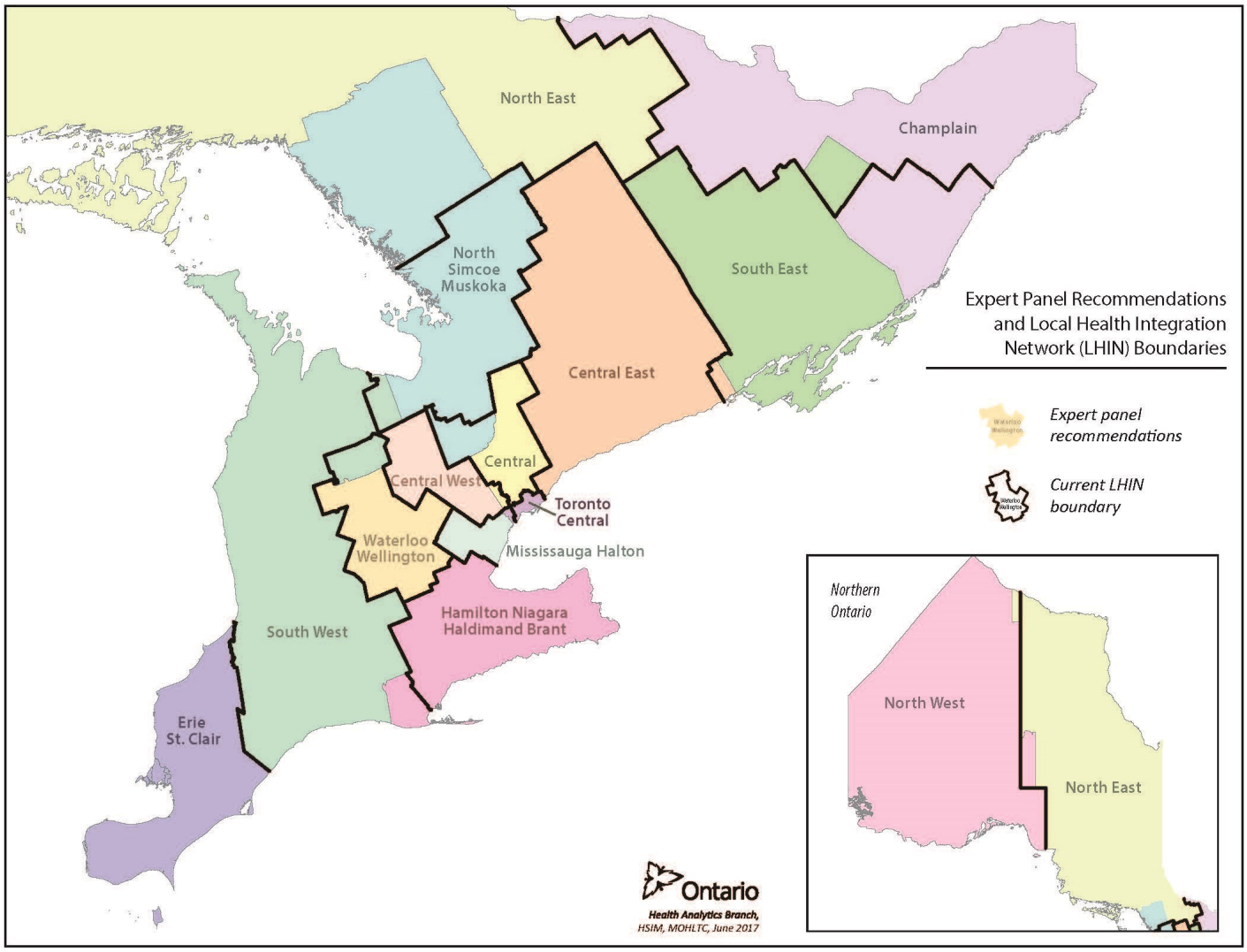


Figure 4: Proposed Boundaries Mapped Against Current LHIN Boundaries



With the recommended boundaries, the populations served by the regional public health agencies would range from about 0.25 million to 1.8 million.

3. Optimal Leadership Structure

Background

The proposed regional public health entities will be complex multi-million dollar organizations with staff spread across multiple local sites. The leadership structure and the quality and competence of public health leaders will be critical to the success of the proposed organizational structure.

Public health units of the future will require leaders with broad-based skills that encompass strong demonstrated organizational and business management, relationship management, strategic planning and performance management skills as well as extensive public health experience.

The literature indicates that, for large health organizations, a single leader as opposed to a joint leadership model is more effective – when the leader has the right mix of experience and competencies. It also indicates that it is essential for that single leader to have both content expertise – in this case, public health knowledge – and management expertise.

Criteria

The Expert Panel's goal was to propose a leadership structure that would:

- Reflect best practices in the leadership of health organizations
- Reinforce and capitalize on strong public health/clinical skills
- Be able to support geographically distributed programs and staff
- Maintain strong expertise and skills at both the regional and local levels
- Capture all the roles and functions of current leaders
- Operate efficiently and effectively

Proposed Leadership Structure

Figure 5: Proposed Leadership Considerations

Regional Public Health Entity	
CEO	• Direct report to the Board of Health
Regional Medical Officer of Health	• Public health physician • Ability to report directly to the Board of Health on matters of public health and safety
Senior Public Health Leadership	• E.g., nursing (Chief Nursing Officer), associate medical officers of health, other content-specific leaders, corporate management (e.g., Chief Administrative Officer, Chief Operating Officer, Chief Information Officer, etc.)

Local Public Health Service Delivery Areas	
Local Medical Officer of Health	• Local public health physician • Report to regional Medical Officer of Health • Number—variable, e.g., based on population and geography
Local Public Health Program and Service Management	• E.g., nursing leadership, public health inspection management, etc. • Program managers • Multi-disciplinary teams

Regional Public Health Entity—Functional Departments

Corporate Services

- Funding & Accountability
- Human Resource Management
- Administrative Services
- Communications
- Information Technology

Public Health Practice (Programs and Services)

- Planning
- Delivery
- Coordination

Performance, Quality, and Analytics

- Surveillance and Monitoring
- Information Management
- Performance and Evaluation
- Research

Strategic Engagement

- Strategic Planning and Integration

Engagement:

- LHINs
- Health System
- Public Health System
- Governments
- Cross-Sector
- Community

4. An Optimal Approach to Governance

Background

All public health units are governed by a board of health. While the *Health Protection and Promotion Act (HPPA)* requires that all health units be governed by a board of health, the legislation does not set out a specific model of governance. Currently, public health governance models vary considerably across the province (i.e., some are autonomous boards, others are part of the structure of the municipal or regional government). While variation is not necessarily a problem in and of itself, it can result in inequities.

A number of reviews and reports have highlighted challenges with current public health governance, including the wide variety of governance models, gaps in skills on some boards and challenges with both provincial and municipal appointments to the boards. Over time, this may affect public health's ability to work effectively with the LHIN boards, which have a consistent governance model.

Although the HPPA sets out a process for appointing members of the boards of health that reflect both the municipal and provincial responsibility for public health (i.e., some members are appointed by the municipalities and some by the Ministry of Health and Long-Term Care through orders in council), there are no specific requirements related to the skills or experience that board members should have. As a result, there are significant skill gaps on some boards of health.

In terms of appointing board members, boards of health experience high vacancy rates among provincial appointees. Vacant seats can make it difficult for boards to optimally function. Furthermore, there can be gaps in appointment of elected municipal officials as a result of elections.

Criteria

The Expert Panel's goal was to recommend a public health governance structure that would:

- Ensure greater consistency in governance of public health
- Maintain public health autonomy and independence
- Maintain a strong municipal voice and representation
- Relate effectively to LHIN boards
- Reflect best practices in governance
- Address issues related to board vacancies
- Reinforce the roles and responsibilities of board members
- Ensure accountability and effective oversight

Proposed Governance Model

The Expert Panel recommends that Ontario establish a consistent governance structure for regional boards of health in Ontario with the following features:

	Board of Health Governance Characteristics
Governance	Free-standing autonomous board
	Consideration for appropriate secretariat support for board operations
Appointees	Municipal members (formula for representation to be defined in Regulations – e.g., by population, by upper tier etc.)
	Provincial appointees (including OIC appointments for specific position(s) such as board chair, vice chair, finance – to be nominated by the board)
	Citizen members (municipal appointees)
	Other representatives (e.g., education, LHIN, social sector, etc.)
Size	Varied: 12-15 members
Indigenous Representation	Meaningful opportunity for representation to ensure Indigenous partners have an active voice (based on population demographics)
Francophone Representation	Representation for the Francophone community (based on population demographics)
Diversity and Inclusion	Boards should reflect the communities which they serve, including but not limited to inclusion of: • Gender and sexual orientation • Visible minorities • Lived experience • Diverse ages
Qualifications	Skills-based
	Experience
Appointment Process	Flexibility for combination of provincial and local appointments (for non-specific positions) to address varying capacity across province
Board Compensation	Apply consistent approach for board member compensation
	Consideration of equitable compensation across public boards (e.g., public health, LHINs, agencies, etc.)
Committees	Establishment of standing committees (e.g., good governance and nomination committees, finance and audit, HR, etc.) to be defined in Regulations
	Committees are responsive to community needs
Succession Planning and Implementation	Staggered transition/appointments for new board structures
	Tenure
	Targeted recruitment

Considerations for Proposed Regional Board of Health

The regional board of health should be small enough to be efficient but large enough to support strong standing committees (i.e., governance, finance/audit, quality). The literature shows that doing certain work in standing committees is more functional and effective than doing it as an entire board.

The goal is to attract highly skilled and competent individuals who will speak for the interests of public health to serve on the board. It is critical that:

- the board have the right mix of skills, competencies, and diverse perspectives
- all board members understand and accept their role
- the boards have a process to manage attendance and to remove people from the board who are not fulfilling their responsibilities.

Furthermore, when recruiting members to the regional board of health, the governance committee should look specifically for people who want to work on a team and share a commitment to improving the health of the population.

Because of past challenges with timing Order in Council (OIC) appointments, the Expert Panel recommends a smaller number of provincial appointees; however, to ensure accountability to the provincial government, those seats should be key positions (e.g., chair, vice-chair, chair of the finance/ audit committee). The governance committee should recommend the candidates for OIC appointments, and those candidates should be able to include elected municipal officials.

To address continuity of service challenges with municipal officials, the Expert Panel recommends that when an elected official appointed to the board of health is not re-elected, he or she continue to serve on the board of health until the municipality makes a new appointment. Municipalities should also be encouraged to appoint a mix of elected officials and members of the community to ensure diversity and continuity, and to reduce the challenges elected officials may experience balancing their municipal responsibilities with their responsibilities for public health.

IV. Implementation Considerations

The Expert Panel recognizes that if implemented, the recommendations will mean large organizational change for the sector. The Expert Panel was not asked to make specific recommendations about implementation, however, they have identified elements that should be considered in developing an implementation plan.

Legislation

The proposed health unit boundary changes and implementation of regional public health entities will have implications for public health and other related legislation. A detailed analysis will be required to determine how much of the proposed structure and governance model will require legislative amendments.

Funding

While public health funding was not within the scope of the Expert Panel's mandate, they have flagged that the current public health funding model may be a barrier to implementing the proposed structure.

Under the HPPA, municipalities have legislated authority for public health and provincial funding for public health is discretionary. Public health units receive an annual grant from the Ministry of Health and Long-Term Care– and the amount the province contributes has varied over the years.

The Ministry of Health and Long-Term Care provides funding for:

- up to 75% of ministry approved allocations

- 100% of certain programs, such as Healthy Smiles Ontario, the Infectious Disease Control Initiative, nursing initiatives and the Smoke-Free Ontario Strategy

- 100% of services in unorganized territories (i.e., areas without municipal organizations)

Municipalities provide funding for:

- at least 25% of ministry approved allocations (many provide more)

- other public health programs and services– beyond those provincially mandated

The ministry's contribution recognizes the challenges many municipalities – particularly smaller ones – face in funding public health services.

The proposed shift from local health units, whose costs are shared by local municipalities, to a regional public health entity will likely raise questions about the funding obligations of each municipality in the region.

As part of implementation planning, the ministry will need to re-visit funding constructs in order to implement the recommendations.

Transition Planning/Change Management

The proposed structure will have a significant impact on the 36 existing health units and boards of health. Although the transition may be more straightforward for the public health units that move in their entirety into a regional health entity than for those divided across two or more regional agencies, all will require assistance with change management. Given the complex nature of municipal government (i.e., upper tier, lower tier, independent), it may be helpful to engage consultants with a strong track record in change management to help with transition planning.

The transition from the current 36 local boards of health to a smaller number of regional boards of health will have particular implications for municipalities and municipal members. It is important that the new board structure recognize and protect municipal interests, while recognizing the potential for competition for municipal seats.

To ensure greater consistency across the province, it may be helpful to work with the Association of Ontario Municipalities to develop the criteria for municipal representation on the new regional boards.

Effective Linkages with LHINs and the Health System

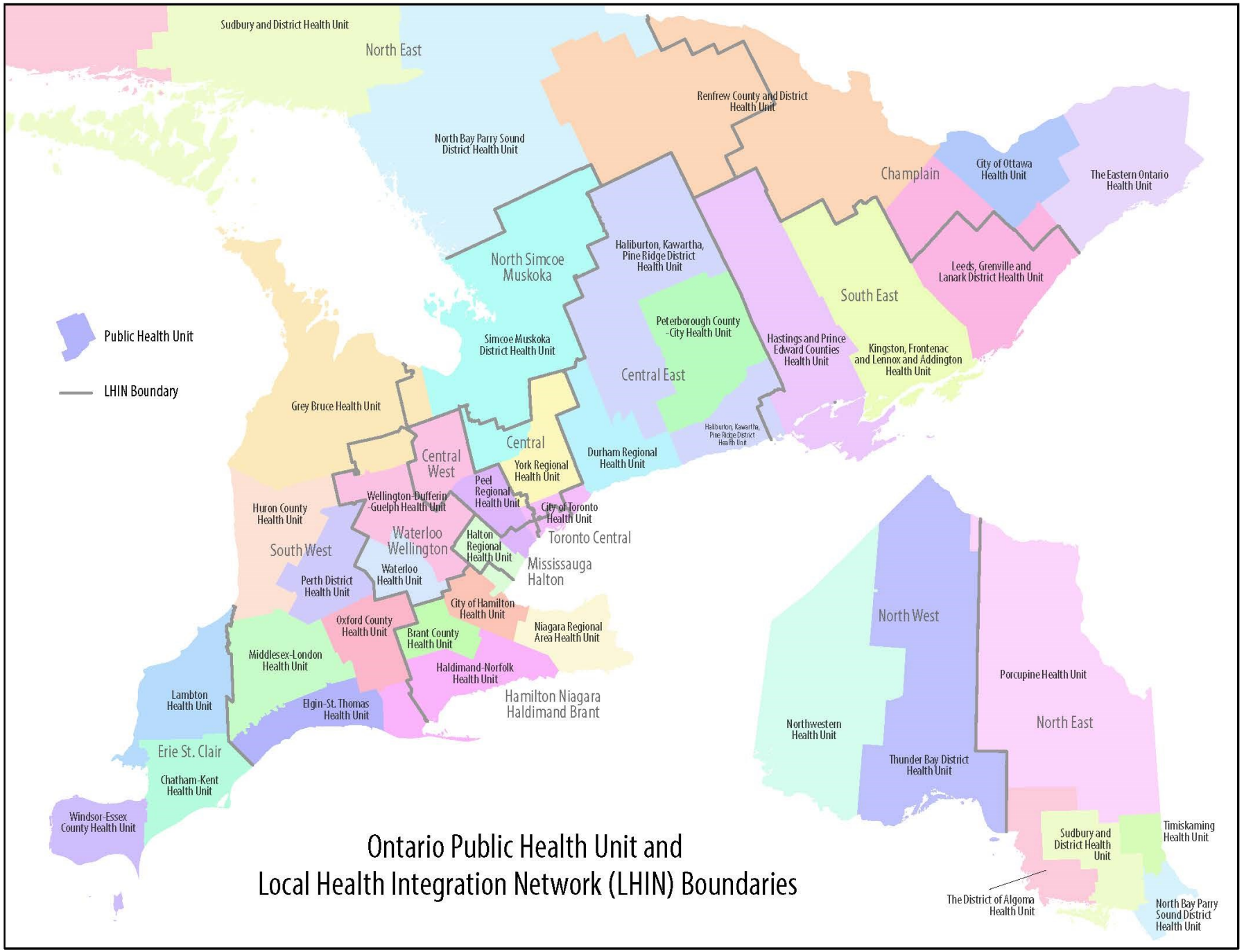
During its deliberations, the Expert Panel identified a number of strategies that, in its view, could enhance linkages with LHINs, such as:

- potential cross appointments (or ex-officio) to the regional Board of Health and the LHIN board
- regular meetings between the Regional Board of Health chair and the LHIN board chair
- regular meetings between public health and LHIN leadership as well as shared projects and activities.

Structured relationships will also be necessary with all health system partners including primary care, hospitals, and home and community care to develop stronger linkages between disease prevention, health promotion and care, maximize system efficiencies and support a fully integrated health system.

Appendix

Appendix A: Current LHIN and PHU Boundaries



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MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 049-17

TO: Chair and Members of the Board of Health

FROM: Dr Chris Mackie Medical Officer of Health

DATE: 2017 September, 21

2017 LEGISLATIVE AND REGULATORY AMENDMENTS UNDER THE IMMUNIZATION OF SCHOOL PUPILS ACT

Recommendation

It is recommended that Report No. 049-17 re: 2017 Legislative and Regulatory Amendments under the Immunization of School Pupils Act be received for information.

Key Points

- Starting September 1 2017, parents who request a non-medical vaccine exemption are required to complete an immunization education session at their local Public Health Unit in addition to submitting a valid affidavit (Statement of Conscience or Religious Belief form).
- Pending proclamation of approved legislation, Health Care Providers will be required to report vaccines administered to children and youth to their local Public Health Unit.

Background

Earlier this year, the Minister of Health and Long Term Care announced two amendments to the Immunization of School Pupils Act (ISPA) as part of Immunization 2020, a five-year strategy to improve the overall effectiveness and efficiency of Ontario's publicly funded immunization system:

- Parents and guardians considering not immunizing their children for non medical reasons would be required to participate in an education session delivered by their local public health in addition to submitting a valid affidavit (Statement of Conscience or Religious Belief form).
- Health care providers would be required to report any vaccines (regulated under ISPA) they administer to children and youth directly to their local public health unit.

The education component amendment was proclaimed on September 1, 2017. The amendment requiring health care providers to report vaccines administered has not yet been proclaimed.

Immunization Education Session

Public Health Units (PHUs) have been provided with an education module, transcript and supplementary fact sheets to assist in the planning and delivery of the immunization education session. The content of the immunization education session has been standardized across the province and addresses key topics on the risks and benefits of immunization, Immunization of School Pupils Act legislation and specific details on vaccine safety. Only one parent is required to complete the education session and only one education session is required per family.

Parents are responsible for:

- Completing an in-person immunization education session at their local Public Health Unit
- Completing the Statement of Conscience of Religious Belief Affidavit Form by swearing or affirming in front of a Commissioner for Taking Affidavits

- Submitting both the signed Statement of Conscience of Religious Belief Affidavit Form and Vaccine Education Certificate to their local Public Health Unit
- Maintaining a personal record of these documents

Public Health Units are responsible for:

- Delivering the immunization session to parents at the PHU
- Providing the Vaccine Education Certificate, signed and dated by the Medical Officer of Health (MOH) delegate to parents once they have completed the session
- Validating the documents submitted by parents
- Updating the information in the provincial immunization repository (creating an exemption record for the schoolchildren of parents who have made a valid request for a non-medical exemption)
- Ensuring that parents are aware of their responsibility to maintain a personal record of the exemption documents

Conclusion

The legislative and regulatory education amendments that came into force on September 1, 2917 are intended to strengthen the vaccine exemption process and help parents make an informed decision about their child's routine health care. The changes are based on actions outlined in the Immunization 2020: Modernizing Ontario's Publicly Funded Immunization Program. The other legislative amendments made to the ISPA regarding health care providers reporting of administered vaccines are expected to come into force at a future date.

This report was prepared by the Vaccine Preventable Diseases Team, Environmental Health Infectious Diseases Division.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 046-17

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2017 September, 21

2016-2017 INFLUENZA SEASON IN MIDDLESEX-LONDON - FINAL REPORT

Recommendation

It is recommended that Report No. 046-17 re: 2016-2017 Influenza Season in Middlesex-London– Final Report be received for information.

Key Points

- There were 480 laboratory-confirmed cases, 258 hospitalizations, 16 deaths and 40 confirmed facility influenza outbreaks during the 2016-17 Influenza Season; the number of laboratory confirmed influenza cases was slightly lower than in previous seasons
- The predominant strain during the 2016-2017 influenza season was influenza A (H3)
- The Health Unit will begin distributing influenza vaccine for the 2017-2018 flu season to Health Care Providers in early October.

Overview

This report provides the final analysis of the 2016-2017 influenza season (see Table 1 for comparison with previous years). In total, 480 laboratory-confirmed cases of influenza were reported to the Health Unit. It should be noted that many more people may have been infected with influenza but did not have laboratory testing performed and so were not reported to the Health Unit. A graph outlining when laboratory-confirmed cases occurred is shown in Appendix A (Figure 1).

Table 1: Influenza Cases, Middlesex-London, 2011-2012 through 2016-2017 Influenza Seasons

	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017
Laboratory-confirmed Cases	477	407	381	**489**	**480**
Hospitalizations	301	206	161	**197**	**258**
Deaths	26	17	14	**19**	**16**
Outbreaks	40	19	40	**12**	**40**

Cases ranged in age from 16 days to 103 years old. For cases whose ages were known, those aged 65 years and older accounted for 64% (308/480) of cases, followed by those aged 20-49 years, who accounted for 14% (65/480) of cases. There were 258 individuals with laboratory-confirmed influenza who were hospitalized representing 54% (258/480) of laboratory-confirmed cases. Those aged 65 years and older accounted for 72% (187/258) of hospitalized cases. There were 16 deaths reported among individuals with laboratory-confirmed influenza. The number of deaths was highest amongst those 65 years of age and older, representing 94% (15/16) of deaths among reported influenza cases.

Influenza Outbreaks

During the 2016-2017 season, 40 influenza outbreaks were declared in facilities, 22 in long-term care settings, 12 in retirement home settings, and 6 in hospital settings. Attack rates ranged from 4% to 82%. Duration of influenza outbreaks ranged from 7 to 34 days. Of the 40 outbreaks, influenza A was identified in

35 outbreaks and influenza B was identified in 6 outbreaks. Laboratory confirmed cases of influenza identified in facilities accounted for 23% (110/480) of cases. It should be noted that a number of cases associated with influenza outbreaks were identified but were not laboratory confirmed and are not included in this analysis. A graph outlining when outbreaks occurred is shown in Appendix A (Figure 2).

The rate of influenza by health unit within Ontario is shown in Appendix A (Figure 3). Median immunization coverage rates of staff at long term care homes and hospitals in the Health Unit and Ontario are shown in Appendix A (Figure 4).

Timing of the Season and Strain Typing

The influenza season typically occurs from October to April. The peak of the 2016-2017 influenza season was later than in previous years. As indicated in Figure 1 of Appendix A, the first confirmed influenza case was reported to the health unit on October 7, 2016 and had an onset of symptoms on October 4, 2016. Influenza activity did not intensify until late January. The last case was reported on May 24, 2017. Of the 480 laboratory-confirmed cases in Middlesex-London, 90% (432/480) were influenza A, 10% (48/480) were influenza B, and 0.2% (1/489) were co-infected with influenza A and B. Both influenza A and B peaked at the same time in mid-March. Of the influenza A cases identified 99% (112/113) were typed as influenza A (H3), >0.01% (1/113) were typed influenza A(H3) and influenza A(H1N1) pdm09 co-infection, and 76% (319/432) were not typed. Strain typing was conducted on 2 samples from Middlesex London. Two cases were strain typed A/Hong Kong/4801/2015-like.

Influenza Vaccine

The Health Unit distributed 112,400 doses of influenza vaccine to Health Care Providers in London and Middlesex County during the 2016-2017 influenza season. Distribution for the 2017-2018 season will begin in October. Those over 18 years of age are offered trivalent influenza vaccine which protects against three strains (two A and one B) of influenza viruses. Those aged 6 months through 17 years are offered the quadrivalent vaccine which offers protection against two Influenza A strains and two Influenza B stains, as the burden of illness caused by Influenza B strains is highest in this age group. The Health Unit will be offering influenza vaccine during its regularly scheduled Immunization Clinics.

Conclusion

The number of confirmed cases during the 2016-2017 influenza season was slightly lower than the previous season. Cases were reported from September 2016 to May 2017. Influenza A and B peaked in early January. The predominant strain of influenza identified was influenza A (H3). The Health Unit will continue to encourage yearly influenza vaccination to reduce the risk of influenza infection in the population for the 2017-2018 season.

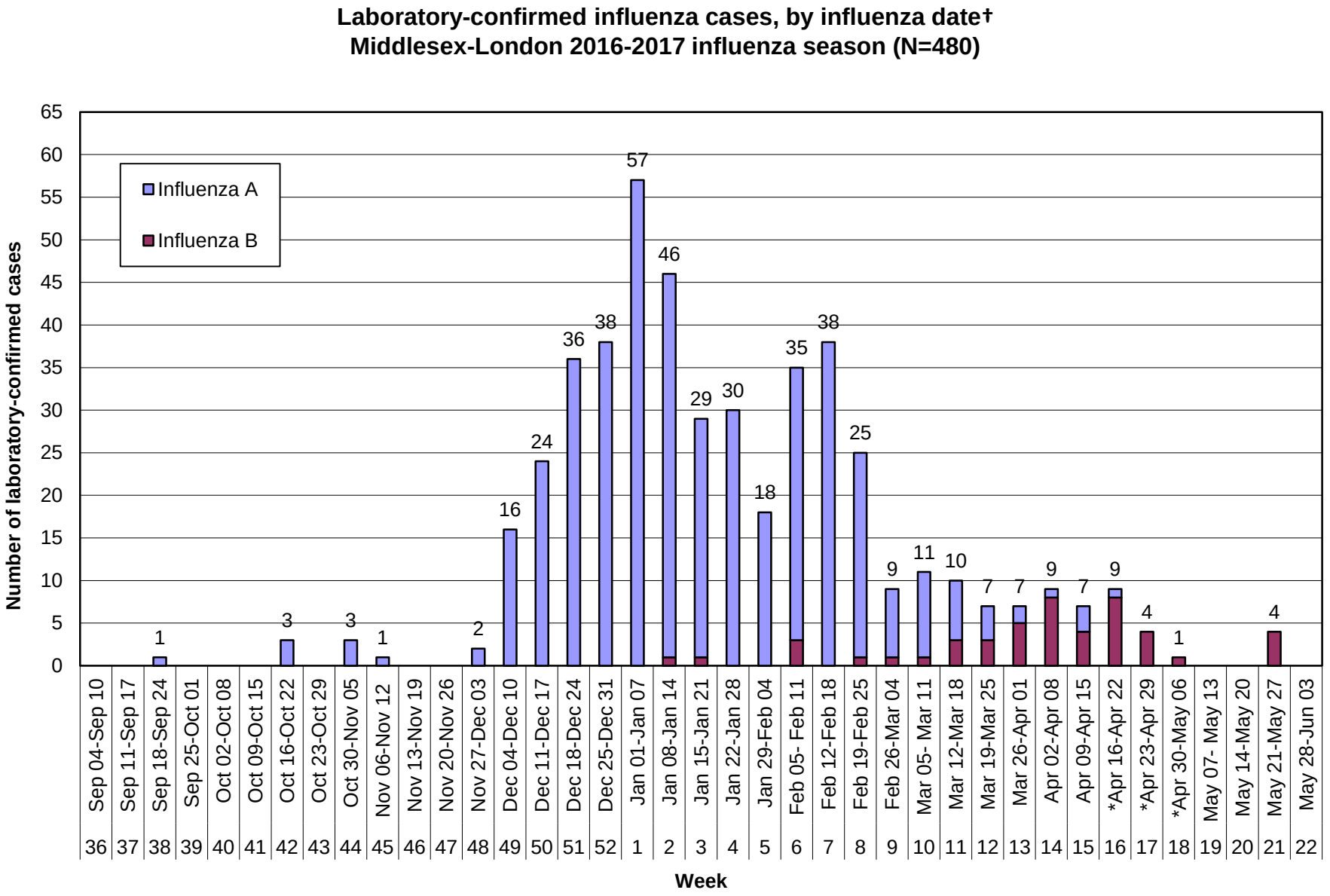
This report was prepared by Infection Disease Control and Vaccine Preventable Diseases Teams, Environmental Health and Infectious Diseases Division.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health and CEO

This report addresses the following requirement(s) of the Ontario Public Health Standards:
Infectious Diseases Prevention and Control and Vaccine Preventable Disease

Appendix A to Report No. 046-17

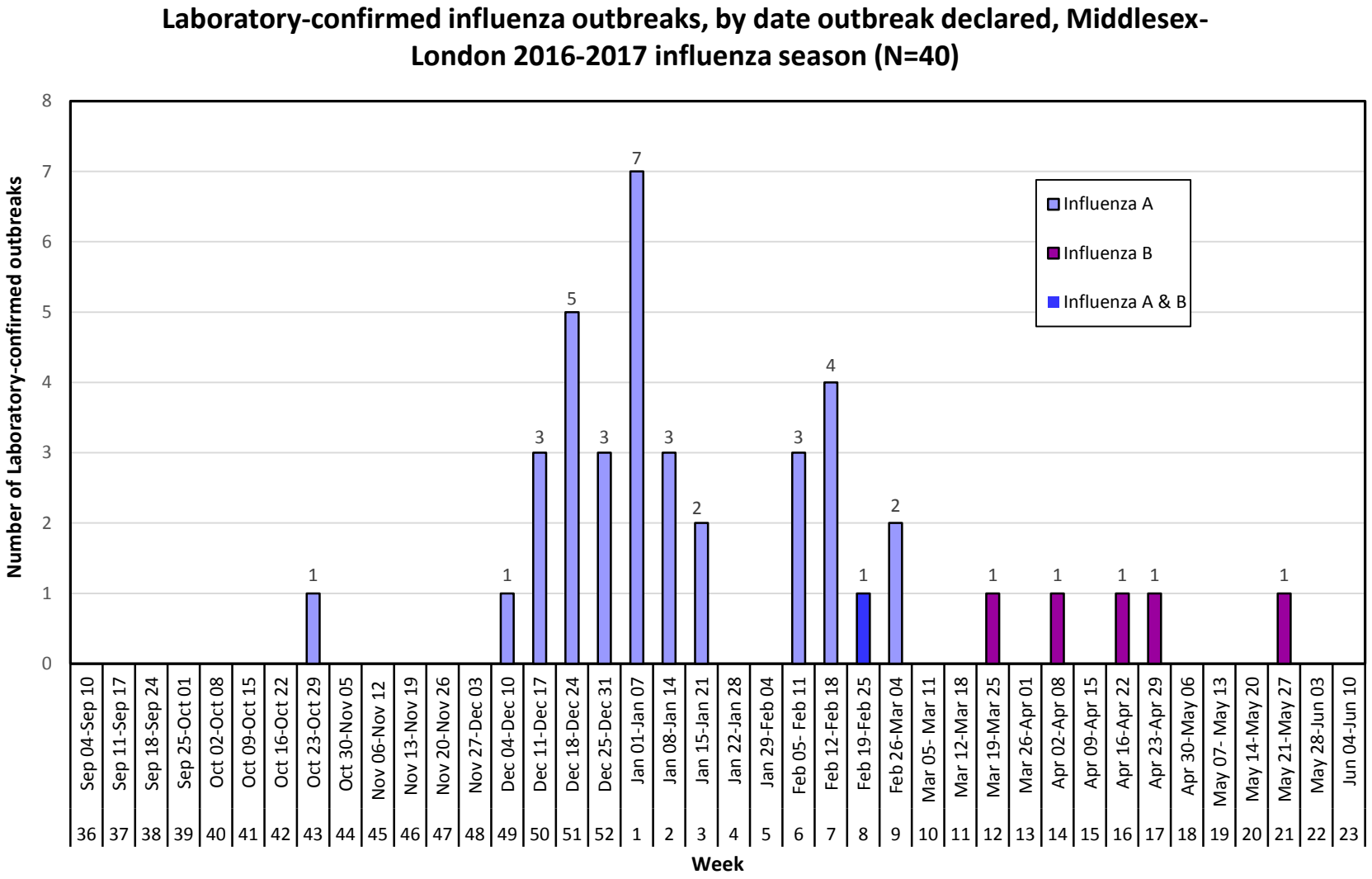
Figure 1



† Influenza date is the earliest of onset date, specimen collection date or reported date.

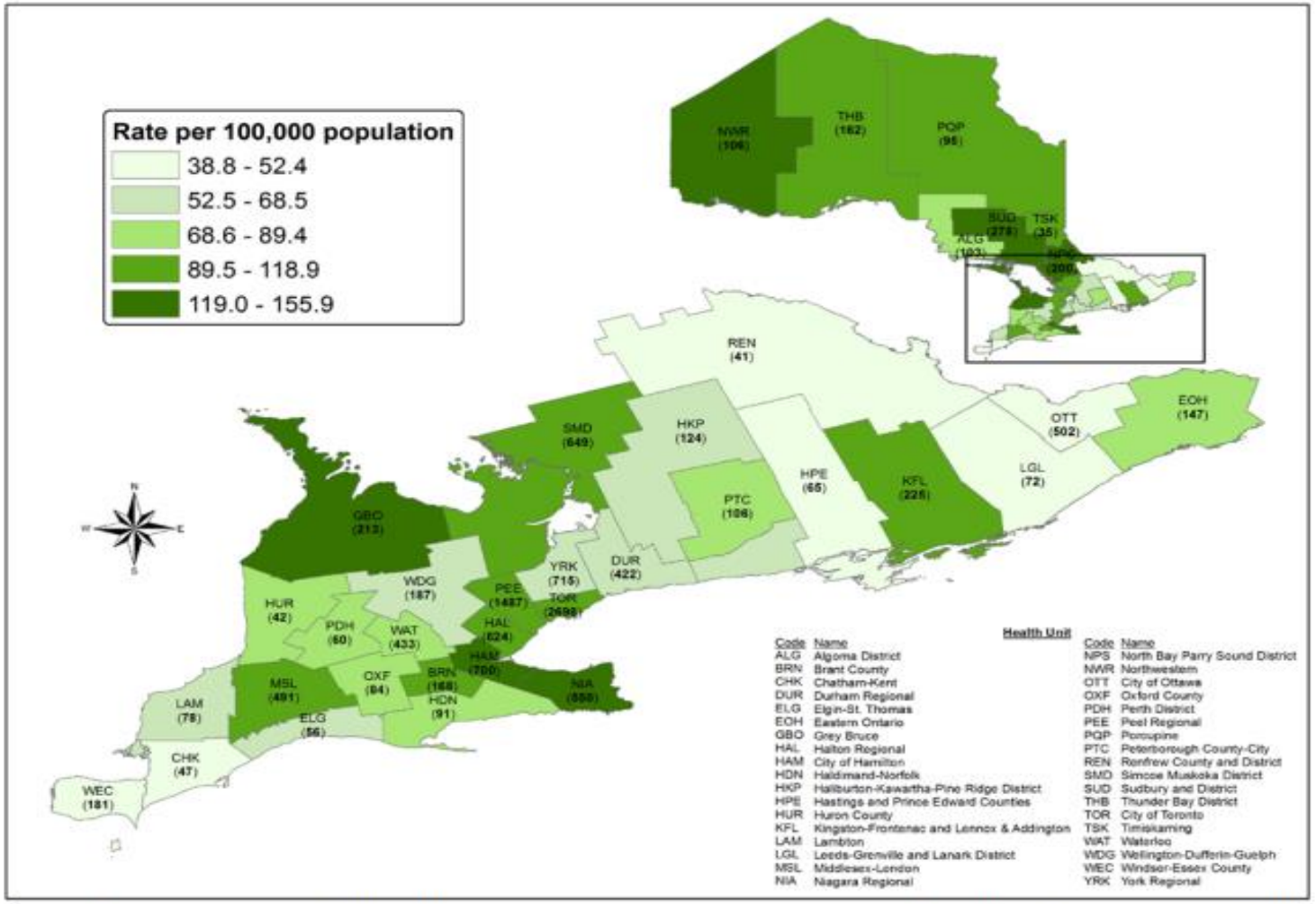
Appendix A to Report No. 046-17

Figure 2



Appendix A to Report No. 046-17

Figure 3. Rate of influenza per 100,000 population (and counts, in brackets), by health unit: Ontario, September 1, 2015 to August 31, 2016



Source: Ontario Ministry of Health and Long-Term Care (MOHLTC), integrated Public Health Information System (iPHIS) database, extracted by Public Health Ontario [2016/10/19]. Population Projections [2015-16], Ontario Ministry of Health and Long-Term Care, Health Analytics Branch, Date Received: [2015/03/13].

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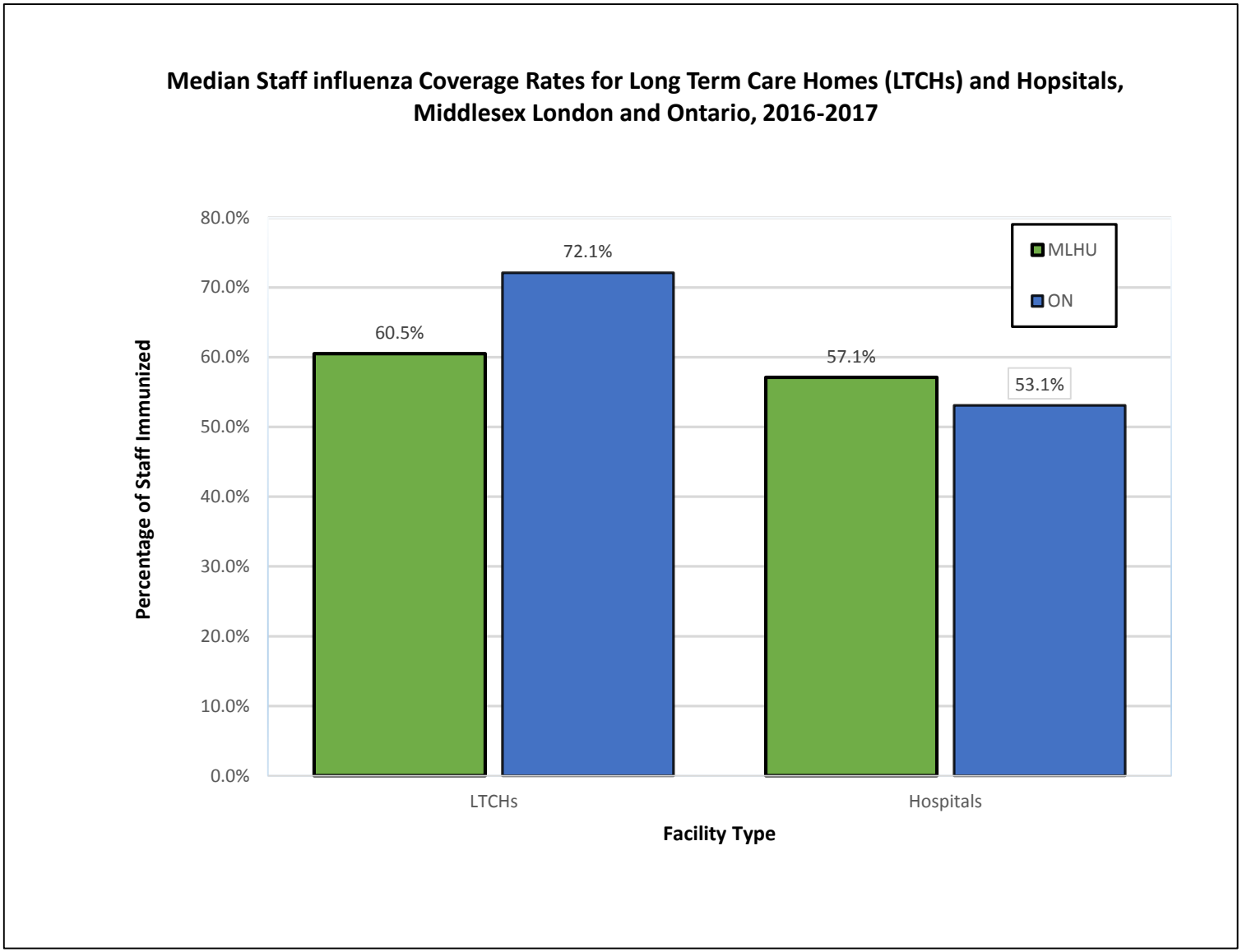
Appendix A to Report No. 046-17

Figure 4



MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 047-17

TO: Chair and Members of the Board of Health

FROM: Dr. Christopher Mackie, Medical Officer of Health / Chief Executive Officer

DATE: 2017 September 21

SUMMARY INFORMATION REPORT FOR SEPTEMBER

Recommendation

It is recommended that the Board of Health receive Report No. 047-17 re: Summary Information Report for September 2017, for information.

Key Points

- The Healthy Babies Healthy Children (HBHC) program waitlist, initiated on April 19, 2017 in consultation with the Ministry of Children and Youth Services (MCYS), has continued to increase; it is hoped that the status of the HBHC waitlist will improve over the coming weeks as outstanding staff positons are filled.

Healthy Babies Healthy Children (HBHC) Waitlist Update

The Best Beginnings Team provides high-risk home visiting services to pregnant women and families with children from birth until transition to school who are at risk for less-than-optimal growth and development. On April 19, 2017, in consultation with the Ministry of Children and Youth Services (MCYS), a waitlist for the HBHC program was implemented. Although the HBHC waitlist was initially quite small, with clients staying on the list for a short period of time (***see Board of Health Report 028-17***), waitlist has steadily increased and there are now 19 postpartum families, nine Prenatal and five Early Childhood families on the waitlist. Generally, postpartum families are being contacted in slightly over one week from the time the referral is received. Some Prenatal and Early Childhood clients have waited up to four weeks to obtain services. Prioritization processes are in place to ensure the most at-risk families receive services they require and the waitlist is reviewed daily. It is hoped that the status of the HBHC waitlist will improve over the coming weeks as outstanding staff positons are filled. We will continue to keep MCYS informed as necessary regarding the HBHC waitlist status.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health / CEO

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 048-17

TO: Chair and Members of the Board of Health

FROM: Dr. Christopher Mackie, Medical Officer of Health / CEO

DATE: 2017 September 21

MEDICAL OFFICER OF HEALTH ACTIVITY REPORT – SEPTEMBER

Recommendation

It is recommended that the Board of Health receive Report No. 048-17 re: Medical Officer of Health Activity Report – September for information.

The following report presents activities of the Medical Officer of Health for the period of July 10, 2017, to September 8, 2017.

July 11	The MOH was interviewed by Craig Needles at AM980 in regards to the Dental Clinic closure announcement.
July 13	The MOH met with Janette MacDonald, Downtown London to discuss Safe Injection Services (SIS). The MOH met with Roxanne Riddell, Community Impact Specialist at United Way of London & Middlesex to discuss the London for All initiative.
July 14	The MOH was interviewed by Al Coombs, CJBK in regards to the opioid crisis.
July 17	The MOH participated in the interview process to hire an Associate Medical Officer of Health. The MOH met with Linna Li, 3rd year PHPM resident at Queen's to discuss potentially completing a rotation at MLHU.
July 18	The MOH met with staff from the Southwest Ontario Aboriginal Health Access Centre (SOAHC) to discuss dental issues.
July 19	The MOH was interviewed by Jen Bieman of the London Free Press in regards to the Dental Clinic closure announcement.
July 20	The MOH attended an in studio interview at AM980 with Andrew Lawton in regards to mental health. The MOH attended the July Board of Health meeting.
July 21	The MOH attended the London for All Implementation Consultation session at Innovation Works.
July 24	The MOH and AMOH met with Western University staff to discuss the Masters in Public Health program.
July 31	The MOH participated in a teleconference regarding Indigenous Cultural Safety Leaders, Allies and Supporters Follow-Up Discussion (London).

The MOH was interviewed by London Free Press reporter Randy Richmond and reporter Kate Dubinski from CBC in regards to the opioid presentation at the Community and Protective Services meeting as well as an overview of the current drug situation.

August 2 The MOH was interviewed by Randy Richmond, London Free Press, in regards to drugs at the Elgin Middlesex Detention Centre (EMDC).

August 3 The MOH was interviewed by CBC Radio One Chris Ensign, X-FM Fanshawe Fiona Robertson, AM980 Leni Lamberink, CHRW Western Radio Richard Raycraft and the Western Gazette Grace To, in regards to fentanyl being found in other drugs.

August 4 The MOH was interviewed by Jim Knight of CTV News in regards to fentanyl being found in other drugs.

August 8 The MOH was interviewed by The London Free Press in regards to fentanyl being found in other drugs.

August 9 The MOH was interviewed by Kate Dubinski, CBC London in regards to concussions.
The MOH met with Michael Barrett, CEO South West LHIN to provide updates.
The MOH participated in an interview with AM980 News regarding fentanyl being found in other drugs.
The MOH was interviewed by CKNW Radio from British Columbia regarding the announcement made that fentanyl was found in marijuana.

August 10 The MOH met with staff from AT^LOHSA Native Family Healing Services Inc. to discuss the drug crisis
The MOH met with RHAC staff to discuss the Community Drug and Alcohol Strategy as well as Safe Injection Services.
The MOH provided Peter Devlin, President, Fanshawe College with an update of the MLHU location/relocation process.
The MOH had a phone discussion regarding the MLHU fentanyl announcement with Nick Boyce, Director at Ontario HIV and Substance Use Training Program.

August 14 The MOH met with Lisa Boyko, Community Engaged Learning Coordinator at Western University in regards to the drug course at Western.

August 16 The MOH met with Anne Armstrong from London Cares to discuss what is and can be done in regards to illegal drug issues.

August 17 The MOH met with Dr. Ken Wright, Schulich School of Medicine and Dentistry to discuss dental programs.

August 18 The MOH met with Chippewas of Thames Chief, Leslee White-Eye to discuss public health services.

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

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health / CEO