AGENDA
MIDDLESEX-LONDON BOARD OF HEALTH

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

Thursday, 7:00 p.m.
2017 October 19

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, September 21, 2017.

DELEGATIONS

7:05 – 7:15 p.m. Mr. Trevor Hunter, Chair, Governance Committee re: Item # 1, October 19, 2017, Governance Committee meeting – Verbal Update.

Item #	Report Name and Number	Link to Additional Information	Delegation	Recommendation	Information	Brief Overview
Committee Reports						
1	Governance Committee meeting, September 21, 2017 Verbal Update	Agenda: October 19, 2017	x	x	x	To receive a verbal update from the October 19, 2017 Governance Committee (GC) meeting.
Delegation and Recommendation Reports						
2	2018 Board of Health Budget – Financial Parameters (Report No. 052-17)			x		To provide an update on financial parameters required for 2018 budget planning.
3	Expert Panel on Public Health: Proposed Response and Process (Report No. 053-17)	Appendix A		x		To consider and approve a proposed response to the Report of the Minister's Expert Panel on Public Health
Information Reports						
4	Incident Management System (IMS) Activated to Enhance Reponse to Community Drug Crisis (Report No. 054-17)	Appendix A			x	To provide an update on the activation of the Health Unit's Incident Management System to enhance response to the community drug crisis.
5	Summary Information Report, October 2017 (Report No. 055-17)				x	To provide an update on the Locally Driven Collaborative Project (LDCP), Children Count.
6	Medical Officer of Health / CEO Activity Report, October 2017 (Report No. 056-17)				x	To provide an update on the activities of MOH / CEO for October 2017.

OTHER BUSINESS

- Next Finance & Facilities Committee meeting: November 2, 2017 @ 9:00 a.m.
- Next Board of Health meeting: November 16, 2017 @ 7:00 p.m.
- Next Governance Committee meeting: December 14, 2017 @ 6:00 p.m.

CORRESPONDENCE

a) Date: 2017 September 1 [received 2017 September 12]

Topic: Fair Workplaces, Better Jobs Act
From: Northwestern Health Unit (Board of Health and Medical Officer of Health)
To: Ontario Health Units

Background:

The Northwestern Health Unit (NWHU) passed a resolution commending the provincial government's actions to improve income levels and working conditions with the introduction of Bill 148: Fair Workplaces, Better Jobs Act, 2017. NWHU cites research that people with lower incomes have poorer physical and mental health and higher rates of mortality. The correspondence included a summary of Bill 148, its potential impact on the communities served by NWHU, and the rationale for supporting this bill.

Recommendation:

Receive.

b) Date: 2017 September 14 [received 2017 September 18]

Topic: Ontario's safe and sensible framework to manage federal legalization of cannabis
From: Peterborough Public Health
To: The Honourable Yasir Naqvi, Attorney General of Ontario

Background:

Peterborough Public Health (PPH) congratulated the Attorney General of Ontario on the release of plans for regulating legalized cannabis. PPH also advocated that the Province continue to use a public health approach and adopt measures such as plain packaging, prohibition of the production and sale of products that are attractive to youth, child-resistant packaging, and prohibition of cannabis advertisement.

Recommendation:

Receive.

c) Date: 2017 September 28
Topic: Report: "Access to Public Dental Programs in Ontario: An analysis based on interviews with Public Health Units
From: Ontario Oral Health Alliance
To: Medical Officers of Health; Chairs, Board of Health

Background:

The Ontario Oral Health Alliance released a report titled "Access to Public Dental Programs in Ontario: An Analysis based on interviews with Public Health Units." This report was initiated based on anecdotal information that access to dental care for low-income children and youth and people on social assistance was challenging due to the lack of dental suites. An informal telephone survey in 2016 with oral health staff at Ontario health units found that twelve out of thirty-five health units have dental suites, while others partner with community health centres, and most health units have local dentists who provide care to low-income children and youth and people on social assistance. Challenges relating to the current structure of Healthy Smiles Ontario, Ontario Works and the Ontario Disability Support Program were identified.

Recommendation:

Receive.

d) Date: 2017 September 8 [received 2017 September 27]

Topic: Smoke-free buildings
From: Ms. Margaret M. Rivard
To: Middlesex-London Board of Health

Background:

Ms. Rivard submitted correspondence to the Middlesex-London Health Unit regarding no-smoking prohibitions in her lease and the negative impact of smoking on health. This correspondence has been forwarded to the Chronic Disease Prevention and Tobacco Control team for follow-up.

Recommendation:

Receive.

e) Date: 2017 October 6
Topic: Opioid Strategy – Update on an Opioid Emergency Task Force and Investments
From: Roselle Martino, Assistant Deputy Minister, Ministry of Health and Long-Term Care
To: Medical Officers of Health

Background:

The Minister of Health and Long-Term Care announced the creation of a new Opioid Emergency Task Force to ensure those closest to the crisis are providing critical insight about what is happening on the ground, to support the province's coordinated response to the crisis and to address new challenges as they emerge. Additionally, the Ministry's Emergency Operations Centre has be to manage the crisis.

There have also been investments under the Opioid Strategy including $250,000 for the Middlesex-London Health Unit and Regional HIV / AIDS Connection for harm reduction programming and outreach workers.

Recommendation:

Receive.

CONFIDENTIAL

The Board of Health will move in-camera to discuss matters regarding identifiable individuals and labour relations and to consider confidential minutes from its September 20, 2017 Board of Health meeting.

ADJOURNMENT

PUBLIC SESSION – MINUTES
MIDDLESEX-LONDON BOARD OF HEALTH
399 Ridout Street, London
Middlesex-London Board of Health Boardroom
Thursday, September 21, 2017 7:00 p.m.

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

Regrets: Ms. Tino Kasi

OTHERS PRESENT:
Dr. Christopher Mackie, Secretary-Treasurer
Ms. Elizabeth Milne, Executive Assistant to the Board of Health and Communications (Recorder)
Ms. Mary Lou Albanese, Manager, Infectious Diseases
Mr. Chris Blain, Acting Online Communications Coordinator
Ms. Rhonda Brittan, Manager, Healthy Communities and Injury Prevention
Ms. Lisa Clayton, Human Resources Manager
Ms. Laura Di Cesare, Director, Corporate Services
Mr. Dan Flaherty, Communications Manager
Dr. Gayane Hovhannisyan, Associate Medical Officer of Health
Ms. Heather Lokko, Director, Healthy Start
Mr. John Millson, Senior Financial Business Administrator, City of London
Ms. Marlene Price, Manager, Vaccine Preventable Diseases
Mr. Stephen Turner, Director, Environmental Health and Infectious Disease
Ms. Linda Stobo, Manager, Chronic Disease and Tobacco Control
Ms. Suzanne Vandervoort, Director, Healthy Living

Chair Helmer called the meeting to order at 7:01 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

It was moved by Ms. Vanderheyden, seconded by Ms. Cassidy, *that the **AGENDA** for the September 21, 2017 Board of Health meeting be approved.*

Carried

APPROVAL OF MINUTES

It was moved by Mr. Peer, seconded by Mr. Hunter, *that the **MINUTES** of the July 20, 2017 Board of Health meeting be approved as amended.*

Carried

It was moved by Ms. Fulton, seconded by Ms. Vanderheyden, *that the Board of Health receive the September 7, 2017 Finance & Facilities Committee meeting minutes.*

Carried

DELEGATIONS AND RECOMMENDATION REPORTS

Ms. Rhonda Brittan presented to and invited the Board of Health to participate in the **in motion™** community challenge for the month of October.

It was moved by Ms. Vanderheyden, seconded by Mr. Peer, *that the Board of Health receive Ms. Brittan's presentation regarding the* in motion™ *community challenge.*

Carried

Finance & Facilities Committee meeting, September 7, 2017 (Report No. 045-17)

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

It was moved by Ms. Fulton, seconded by Mr. Meyer, *that the Board of Health approve the 2018 PBMA process, criteria and weighting as proposed in Report No. 029-17FFC, Appendix A.*

Carried

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

It was moved by Ms. Fulton, seconded by Ms. Cassidy, *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 (Appendix A).*

Carried

Chair Helmer noted that Mr. Millson is in attendance, thanked him for his advice and expertise over the years, and wished him the best of luck at the City of London going forward.

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

It was moved by Ms. Fulton, seconded by Mr. Clarke, *that the Board of Health:*
1) Receive Report No. 031-17FFC for information; and
2) 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)

Ms. Fulton noted that no motion was required for this report, as the Finance & Facilities Committee had received it for information.

Governance Committee meeting, September 21, 2017 – Verbal Update

It was moved by Mr. Hunter, seconded by Mr. Peer, *that the Board of Health receive the minutes of the June 15, 2017 Governance Committee meeting.*

Carried

Mr. Hunter noted that the Committee had reviewed several policies, all of which will be sent back to staff for further revisions and expert review.

The next meeting of the Committee will be Thursday October 19, 2017.

Expert Panel on Public Health: Information Session Update (Report No. 050-17)

Dr. Mackie introduced the report and provided context, requesting direction and feedback from the Board from a policy perspective.

Discussion ensued on the following items:

- That the Board take some time outside of the meeting cycle to further discuss the link between best practices in governance and the proposed new public health structure.
- The implications of the large proposed boundaries and how this could affect service delivery.
- Recognition of the intended objectives and outcomes of the Expert Panel report.
- The importance of providing comments and feedback that reflect the Health Unit's and municipal government's concerns while ensuring that the Board is engaged in the process constructively, working with, not against the Province to provide constructive feedback.
- Possible implementation timelines, and the earliest possible date for implementation.
- Where the proposed functions and responsibilities may fall, and the potential advantages or disadvantages of streamlining some of these functions and responsibilities.

Mr. Millson also noted that MLHU currently participates in a joint purchasing group, which helps with qualifying for discounted procurement. MLHU also led a joint procurement of contraceptives on behalf of all health units.

It was moved by Mr. Clarke, seconded by Ms. Cassidy, *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.*

Carried

INFORMATION REPORTS

2017 Legislative and Regulatory Amendments Under the Immunization of School Pupils Act (Report No. 049-17)

Discussion ensued on the following items:

- The conscientious objective form, legislative requirements and the suspension process for children who are not immunized.
- Options for parents to access vaccination records for their children to ensure compliance.
- That requests for exemptions have increased only slightly over the last eight years.
- Where the education sessions will be offered.

Ms. Marlene Price answered questions regarding parent education sessions, immunization records and the suspension process.

It was moved by Ms. Fulton, seconded by Ms. Vanderheyden, *that the Board of Health receive Report No. 049-17 re: 2017 Legislative and Regulatory Amendments under the Immunization of School Pupils Act for information.*

Carried

2016–17 Influenza Season in Middlesex-London – Final Report (Report No. 046-17)

Discussion ensued on estimating the impact that the influenza vaccine campaign may have had on the number of cases reported and the variability of influenza across the province.

It was moved by Ms. Cassidy, seconded by Mr. Meyer, *that the Board of Health receive Report No. 046-17 re: 2016-2017 Influenza Season in Middlesex-London – Final Report for information.*

Carried

Summary Information Report, September 2017 (Report No. 047-17)

It was moved by Mr. Clarke, seconded by Ms. Cassidy, *that the Board of Health receive Report No. 047-17 re: Summary Information Report for September 2017 for information.*

Carried

Medical Officer of Health / CEO Activity Report, September 2017 (Report No. 048-17)

It was moved by Ms. Cassidy, seconded by Mr. Peer, *that the Board of Health receive Report No. 048-17 re: Medical Officer of Health Activity Report, September 2017 for information.*

Carried

OTHER BUSINESS

Chair Helmer reviewed the next meeting dates for the Board of Health and its sub-committees:

- 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

It was moved by Mr. Hunter, seconded by Ms. Cassidy, *that the Board of Health receive items a), b) and d) through h).*

Carried

It was moved by Mr. Hunter, seconded by Ms. Cassidy, *that the Board of Health endorse item c).*

Carried

CONFIDENTIAL

At 7:56 p.m., it was moved by Ms. Cassidy, seconded by Mr. Hunter, *that the Board of Health move in-camera to discuss matters regarding identifiable individuals, labour relations, or a proposed or pending acquisition of land by the Middlesex-London Board of Health, and to consider confidential minutes of the July 20 Board of Health meeting and the September 7 Finance & Facilities Committee meeting.*

Carried

Chair Helmer requested that all in attendance except the Board of Health, Ms. Milne, Dr. Mackie, Ms. Di Cesare, Ms. Clayton, Ms. Albanese, Ms. Vandervoort, Mr. Millson, Ms. Lokko, Mr. Turner and Dr. Hovhannisyan leave the meeting.

At 8:30 p.m., it was moved by Ms. Cassidy, seconded by Ms. Fulton, *that the Board of Health rise and return to public session.*

Carried

At 8:30 p.m., the Board of Health returned to public session.

Dr. Mackie invited the Board of Health to "Save the Date" for MLHU's Annual Staff Appreciation Breakfast on Thursday, November 30, 2017, at 8:30 a.m.

Ms. Milne will send the invitation to Board members in October.

ADJOURNMENT

At 8:30 p.m., it was moved by Mr. Smith, seconded by Ms. Cassidy, *that the meeting be adjourned.*

Carried

JESSE HELMER	**CHRISTOPHER MACKIE**
Chair	**Secretary-Treasurer**

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 052-17

TO: Chair and Members of the Board of Health

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

DATE: 2017 October 19

2018 BOARD OF HEALTH BUDGET – FINANCIAL PARAMETERS

Recommendation

For 2018 planning purposes, it is recommended that the Board of Health approve:

1) ***An increase of 0% in provincial funding for Mandatory Programs;***
2) ***An increase of 0% in municipal funding for Mandatory Programs; and***
3) ***A grant increase of 0% for all other programs.***

Key Points

- On September 21, the Board of Health approved the 2018 process, criteria and weighting for Program Budgeting and Marginal Analysis (PBMA) proposals.
- Financial parameters are required in developing the operating budget.
- The province remains committed to funding public health units on a formula basis.
- The City of London's 2016–19 approved operating budgets include a 0% change in the level of funding for the MLHU. The County of Middlesex does not typically provide budget guidance.

Background

The Program Budgeting and Marginal Analysis (PBMA) process is a criteria-based budgeting process that facilitates allocation of resources based on maximizing service impact. At its September 21 meeting, the Board approved the process, criteria and weighting by which proposals will be reviewed as explained in Report No. 029-17FFC, re: "Proposed 2018 PBMA Process, Criteria and Weighting."

2018 Budget – Financial Parameters

Developing high-level planning parameters is an integral part of any budget development process. Such parameters help guide and inform planning and resource allocation decisions. Several factors are considered when recommending budget parameters, including the Health Unit's strategic direction, provincial funding guidance and municipal funding considerations.

Provincial Funding

As part of its 2017 planning process, the Board of Health approved a budget that included a 1.5% increase in provincial funding for Mandatory Programs. As of October 3, the Ministry of Health and Long-Term Care (MOHLTC) has not provided grant approvals for 2017; however, all health units have been strongly advised to expect a 0% increase in base funding for Mandatory Programs. In the event that further funding is available, it is expected that any Mandatory Funding Grants would be based on the funding model that was rolled out in 2015 (although this has not been confirmed). The Ministry has further indicated that health units should plan for no growth funding in 2018 given various factors, including the Province's objective to balance its annual budget by 2017–18.

For 100% provincially funded programs, such programs historically have not received annual increases. However, the Preschool Speech and Language Program received an increase of $336,059 in base funding

(from $1,482,315 to $1,818,374) in 2015–16, its first increase in more than seven years. For Ministry of Children and Youth Services programs, the granting process is different: the Minister approves a preliminary grant and then requests that public health units submit program budget and service outcomes based on the preliminary grant.

Municipal Funding

In 2016, the City of London approved a multi-year budget for 2016–19. Should there be no significant changes during this four-year period, business plans will be updated and City Council will be provided an annual progress update. The city's multi-year budget was approved on March 10, 2016, with a four-year average tax-levy target of between 2.2% and 2.9%. Included in the city's budget was a 0% change in their contribution to the Health Unit. This is consistent with the previous year's requests. The municipal level of contribution to the MLHU has remained more-or-less the same since 2005, aside from a $119,000 reduction in 2012. The County of Middlesex approves its budget in March each year, and has not historically provided budget target guidance in the past.

Conclusion

Developing high-level planning parameters is an integral part of any budget development process. Such parameters help to guide and inform planning and resource allocation decisions and to prioritize options for management when bringing forward recommendations to the Finance & Facilities Committee and the Board of Health. For the 2018 operating budget development process, it is recommended that the Board of Health approve 0% provincial and municipal grant increases for Mandatory Programs and a 0% grant increase for all other programs.

This report was prepared by the Corporate Services Division.

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

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 053-17

TO: Chair and Members of the Board of Health

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

DATE: 2017 October 19

EXPERT PANEL ON PUBLIC HEALTH: PROPOSED RESPONSE AND PROCESS

Recommendation

It is recommended that the Board of Health:

1) ***Receive Report No. 053-17;***
2) ***Approve Appendix A: Response to the Report of the Minister's Expert Panel on Public Health; and***
3) ***Direct staff to work with representatives of the City of London and the County of Middlesex to submit a joint cover letter that introduces the three organizations' separate responses to the Expert Panel and highlights common concerns.***

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."
- While the goals of Patients First are laudable, the recommendations of the Expert Panel would only partially achieve those goals, and would weaken the public health system.
- In addition, the recommendations reduce local integration and municipal autonomy, and are likely to increase both short-term and long-term costs.
- Alternative recommendations are already available that would achieve the goals of Patients First, maintain and strengthen the public health system, and avoid substantial cost increases.
- Deeper consultation would potentially identify better solutions to the issues currently faced by healthcare and public health in Ontario.

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 on how to establish "strong public health within an integrated [health] system." The panel's report became public in July of this year, and contains several recommendations that would significantly change the governance, boundaries and administration of public health units in Ontario. The Expert Panel report has been appended to previous MLHU reports, and is available here.

The Expert Panel was asked to consider how to enhance organizational structure and governance in public health in order to improve quality control (in terms of accountability, transparency and equity); and how to integrate public health with the healthcare system.

As previously described, the most significant changes recommended by the Expert Panel are:

- Dissolving all current Boards of Health in Ontario and establishing new public health units with boundaries matching those of the fourteen Local Health Integration Networks (LHINs);
- Separating the Medical Officer of Health (MOH) and CEO roles in these new entities, with the MOH reporting to the CEO, except for specific functions; and

- Establishing new criteria for Board of Health members, including representation from Indigenous and Francophone communities, as well as from other diverse groups.

Proposed Response and Process

Appendix A details the proposed MLHU response to the Expert Panel's report. As described in the proposed submission, several issues warrant further consideration before a decision is made. There are also alternative recommendations, like those of the Capacity Review Committee and the draft Report Back from the Public Health Work Stream (not publicly available), which would better achieve the goals of Patients First without incurring many of the risks posed by the Expert Panel's recommendations.

Health Unit, City of London and County of Middlesex staff have identified several shared interests and concerns regarding the Expert Panel's recommendations. While each organization will have a slightly different perspective on these issues, submitting our concerns together under the same cover letter will help to highlight our commonalities and strengthen our input. Pending Board, City and County approval of their respective submissions, our three organizations will also seek joint meetings with the relevant decision maker(s).

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

Appendix A to Report No. 053-17

Response to Report of Minister's Expert Panel on Public Health

Patients First: Strong Goals

The goals of Patients First: Action Plan for Health Care are laudable. Integration, equity, timely access, consistency and inclusion of Indigenous voices are goals that all healthcare and broader health system partners ought to share. In addition, there are important issues that need to be addressed to strengthen local public health in Ontario.

Further, there has been excellent work that is linked to the Patients First agenda in terms of revising public health program standards in Ontario. The proposed Ontario Standards for Public Health Programs and Services (OSPHPS) have the potential to raise the bar for public health unit performance and accountability.

Several issues are identified below. If the recommendations of the Expert Panel are implemented without revisions, they risk causing substantial harm to the public health system in Ontario. The issues below deserve further consideration before any decision is made about implementation.

Issue: Scale of Governance

There are some excellent recommendations related to governance in the Expert Panel report. For example, those that strengthen the composition of Boards by ensuring appropriate competencies and representation have the potential to improve public health governance across Ontario.

However, the recommended scale of governance raises deep concerns. While the Expert Panel does recommend locating public health services in local sub-LHIN regions, leadership and decision-making authority for organizational policy would rest at the scale of the LHINs.

Currently, the Medical Officer of Health, as the recognized leader of a public health unit, has the ability to connect with the community that he or she serves in a meaningful way. The leadership and decision-making authority that would be moved to a regional level are exactly the ingredients that allow for both successful partnership and adaptation to local needs. Such a change would substantially reduce the ability for local public health to build strong partnerships and meet communities' needs.

The boundary changes recommended by the Expert Panel would, in some cases, force public health agencies to serve regions with highly diverse needs under one policy regime, and, in other cases, divide

unified communities using boundaries that relate to healthcare referral patterns but do not correspond to health needs.

As a concrete example, the work currently being done by public health units to develop comprehensive responses to the Opioid Crisis is, quite appropriately, taking different forms in different parts of Ontario. In London, where there is a high concentration of people who inject drugs, supervised consumption facilities are being considered, and emergencies shelters are a primary site for distribution of naloxone kits. Conversely, other areas of this LHIN have, out of necessity, taken a much more distributed approach to harm reduction programing.

The change to the LHIN-wide Board of Health presents risks to a Board's ability to assist in adjusting to local needs, particularly in areas such as Southwest LHIN. Public health units rely on Board of Health members to help understand their communities' values, to build relationships with key partners, and to identify emerging issues. The Expert Panel's recommendations would reduce representation from most communities a one single member on a board of 12–15 people, making it much more difficult to remain in tune with communities.

Issue: Responsibility Without Authority

Matrix management, although useful in specific stages of product engineering, is generally fraught with challenges. For example, accountability and role clarity are substantially diminished.

Separating the Medical Officer of Health (MOH) and CEO roles into matrix management relationships with Boards of Health, as proposed by the Expert Panel, would eliminate the independence of the MOH and weaken their voice, even if MOHs retain the ability on paper to report to the Board of Health on certain matters. This would be a major loss in terms of the public's access to the unbiased public health advice that MOHs currently provide.

For the Medical Officer of Health, the proposed structure would represent "Responsibility Without Authority," which is described by some management experts as the single worst management strategy: generally ineffective and demoralizing for the employee.

Issue: Integration with Healthcare

Many public health units across Ontario are well connected with local healthcare agencies and providers. Examples in Middlesex-London include:

- The HIV Leadership Table, in which partners from public health, local hospitals, primary care and harm reduction are collaborating to address the HIV outbreak in London;
- The Healthcare Provider Outreach Program, in which public health nurses conduct door-to-door outreach with hundreds of primary care providers each year; and
- The Community Health Collaborative, which brings together anchor agencies across London and Middlesex to share data and analysis capability to provide a comprehensive view of health and

social indicators and ensure that health and social services are matched to the needs of neighbourhoods and communities.

Most healthcare agencies operate on a scale that is more closely aligned with the municipal boundaries that public health unit currently use, rather than with the LHIN-wide boundaries proposed by the Expert Panel. Moving to LHIN-wide Boards of Health would reduce the ability of public health to integrate with local healthcare partners. With the exception of the CCAC functions now being managed by the LHINs, there are very few region-level healthcare delivery agencies with which public health could integrate.

Issue: Costs

The Expert Panel's recommendations are a concern from both short-term and long-term cost perspectives. In the short-term perspective, the massive change management issues would require resourcing, and severance costs would likely be substantial. The change management issues at play, including the increasing risk of change fatigue, deserve special attention given the substantial changes that will be required to implement the new OSPHPS.

In the long-term perspective, the cost savings noted in the Expert Panel report are unlikely to materialize. The harmonization of union contracts across regions would likely increase overall costs by tens of millions of dollars annually. These costs are in part related to the fact that in general, the largest public health units in Ontario have the lowest pay rates. This is particularly true for nurses, who represent roughly half of the more than 8,000 local public health workers in Ontario. As an example, in LHIN 2, the largest public health unit pays nurses at a rate that is around the 50th percentile for health units, and a rate that is comparable with other similar health units, but this is the lowest hourly rate for nurses in health units the LHIN 2 region.

With a new level of senior management at the regional level and preservation of operations at the local level, the expert panel recommendations appear to create a new layer of management. Increased compensation required for management roles within more complex organizations would be an additional ongoing expense.

Another major cost issue is how to handle the roughly 25% of local public health budgets currently funded from municipal levies. Moving to a LHIN-wide governance model, where municipalities have far less input into public health decision-making, would imply uploading roughly $200 million to the provincial budget.

Issue: History of Collaboration

Public health has a long history of collaboration with municipalities. Some would argue that public health work, from the time of Dr. John Snow to the present, has been possible only by building upon insights and relationships that are inherently local.

The relationship between the City of London and the Middlesex-London Health Unit stretches back to 1885, when the first permanent Board of Health was established. Examples of successful collaboration are numerous. Recent examples include:

- Joint City and Health Unit leadership to establish a Child and Youth Network in London;
- A successful joint application to the Healthy Kids Community Challenge to promote healthy eating and physical activity;
- Collaboration to develop London for All, a comprehensive plan to address poverty in London; and
- A successful joint application to the Local Poverty Reduction Fund to bring the Nurse-Family Partnership, the worldwide gold-standard home-visiting outreach program, to Middlesex-London and three other Ontario public health units.

These successes were possible because of longstanding relationships and because of the similar scale of the City and Health Unit geography. Severing these relationships between municipalities and public health units by removing local leadership and decision-making would diminish the effectiveness of public health to meet the needs of Ontario communities.

In Summary: Opportunity for Deep Consultation

In the existing public health system, there are issues that need to be address. However, the recommendations of the Expert Panel would only partially achieve the goals of Patients First, and would weaken the public health system. In addition, the recommendations reduce local integration and municipal autonomy, and are likely to increase both short-term and long-term costs.

Alternatives exist that would go further toward achieving the Patients First objectives without the negative impacts that the Expert Panel's recommendations would entail. The challenges that have been faced in certain health units could be better addressed with the sort of targeted approach that has been successful in the child welfare sector. Recommendations of the Public Health Capacity Review Committee (2006) were developed in a robust way that included deeper consultation, and would largely address the issues identified here, and then some. Those outlined in the draft Report Back from the Public Health Work Stream, part of the Patients First initiative, would also achieve many of the needed changes without negatively the public health system.

Now is the time for deep consultation with municipalities, Boards of Health and others who would be affected by the Expert Panel's recommendations. The goals of Patients First are too important to rush. Reasonable alternatives should be carefully considered in order to avoid making changes that bring greater harm than they do benefit.

Appendix B to Report No. 053-17

BRIEFING NOTE

To: AMO Membership

Date: October 12, 2017

Subject: AMO's Response to the Expert Panel on Public Health

ISSUE: AMO does not support the recommendations of the Expert Panel on Public Health as outlined in the report, Public Health within an Integrated Health System, released on July 20, 2017. In the AMO President's correspondence, AMO demands that the government not change the public health system as recommended. The President's letter dated October 12, 2017 is included in this note in Appendix A.

SUMMARY OF AMO'S RESPONSE:

AMO does not support the recommendations of the Expert Panel on Public Health. We urge the Minister of Health and Long-Term Care and the provincial government not to adopt the recommendations given there is no clear evidence to justify such changes to the public health system. Integrating public health within the health care system would completely change and dilute over time the mandate of the local public health system.

ANALYSIS:

If the Expert Panel recommendations are implemented it will completely change the public health system and place it within the health care system. Neither the Expert Panel nor the Ministry have provided analysis on the implications of integrating from either a patient, program/service, or cost benefit analysis perspective. There is no solid empirical foundation provided to support the proposed change.

Many within the municipal sector are very opposed to integration of public health within the broader health care system for many reasons:

- Public Health will lose its local focus – even if there are local public health service delivery areas.
- The Public Health Units in Regional and Single-Tier municipal governments are fully integrated into the municipal system – regarding governance, as employees and linked to other parts of municipal services (i.e. planning, transit, housing, social services).
- There is a risk that integration will dilute the Public Health mandate and shift away from local population-based services toward clinical services to support the primary care system given those under resourced needs.

Creating coverage in larger geographic areas may help create critical mass, however, integration will be challenging in northern, rural and remote areas given smaller, spread out populations.

The recommendations concerning governance will weaken the local elected official voice by seeking to increase community members (LHINs, school boards) appointed to Boards of Health. The local elected official voice is important to reflect overall community need. The new model will only serve

to dilute municipal government involvement in Public Health. Being an elected official is a core competency. Elected officials bring a lens of value for money and the needs of the broader community.

It is suggested that the further that Public Health gets from the municipal core, the more the Province should be responsible for funding. Municipal governments may be less inclined to top up funding or contribute other in-kind municipal resources especially in the case of single-tier and regional governments where full integration of Public Health into the municipal system is the case. It may also be challenging to maintain close connections between local councils and Boards the larger and more regional they become. Municipal governments should have a strong role. It cannot be assumed that this will continue in a new model. This is a significant risk.

AMO's Health Task Force and the AMO Board carefully considered the matter of the Expert Panel's recommendations. AMO is opposed to the new proposed model for the reasons listed above. It is simply not clear that the benefits are worth the significant proposed disruption to the system. As well, it is also not clear the exact problem that the government is trying to address and, more broadly, what is the vision for the health care system. Until this is known and agreed to, as funding partners, it is challenging to respond to the need for change in Public Health.

In making its decision, the Board was guided by the following principles:

1. **Preserve the mandate of Public Health** – To make sure Public Health and its staff is not overwhelmed by the needs of health care services. Maintaining the distinctive role of Public Health to provide preventative and population-based health services that meet local needs, as a complimentary and equal partner to primary care's provision of clinical treatment services.

2. **Maintain the full range of current functions of Public Health** – To fulfill the mandate and desired public health outcomes ranging from disease prevention and health promotion to research and knowledge transfer. These are essential components to a well-functioning public health system.

3. **Enhance the capacity of Public Health** – To achieve better prevention and population health outcomes for local communities.

4. **Increase access to high quality health care informed by population health planning** – To guide primary care delivery that meets local needs.

5. **Achieve equity in health outcomes** – To benefit all individuals and regions of the Province in an equitable manner.

6. **Maintain local flexibility** – To ensure a One Size Doesn't Fit All model of standardization acknowledges the diversity of Ontario including areas of the Province (north-south, east-west, and rural-urban), and the diverse health need in different regions.

7. **Good public and fiscal policy** – To ensure change is driven by a clear public policy purpose and backed by evidence that any new arrangements will better suit that purpose. Change must be cost neutral for municipal governments.

8. **Facilitate greater partnerships and collaboration** – To maintain and strengthen linkages with the broader health care system but also with municipal and community services.

9. **Achieve good governance relationships** – To ensure that proper oversight models are in place that are appropriate for a public health organization, and for services, which are municipally funded.

10. **Support funding relationships** – To promote long-term sustainability with adequate resourcing and an appropriate direct relationship between Public Health and the Ministry of Health and Long-Term Care, rather than a new funding and oversight relationship with Local Health Integration Networks (LHINs).

11. **Accountable** – To establish clear accountability to both the public at the local level and to the Province.

12. **Transparent** – To build public confidence that models and structures achieve good outcomes at a reasonable cost.

BACKGROUND:

Public Health

Public health services, including both disease prevention and health promotion, are an essential part of Ontario's health services continuum. Municipal governments play a major role, often as the employer, and have significant responsibilities in delivering public health services. Ontarians are served by 36 local boards of health that are responsible for populations within their geographic borders. Most boards are autonomous entities while some have the local municipal council serving as the board of health. Among other requirements mandated by the Province, local boards of health are responsible for implementing the provincially mandated 2008 Ontario Public Health Standards.

Currently, public health services are cost shared as a 75% provincial and 25% municipal responsibility. In 1998, under the *Services Improvement Act*, municipalities became responsible for 100% funding of all public health units and services. This was quickly amended in 1999, when the 50/50 cost sharing arrangement between the municipal and the provincial governments was reintroduced. It stayed at this level throughout the 2000 Walkerton tragedy and the 2003 SARS outbreak.

In 2004, the provincial government launched Operational Health Protection to address long-standing public health system capacity issues that included phased-in increases to the provincial share of public health funding to 75% by 2007. Under the *Health Protection and Promotion Act*, 1990, the Province may provide grants to municipalities to assist with public health costs whereas municipal governments are legislatively responsible for public health funding. In 2006, the Capacity Review Committee's (CRC) report was released. CRC's recommendations on changes to governance and amalgamations of specific health units were not implemented by the Province.

In 2015, the last year data is available, municipal governments funded 38%, on average, of the public health costs for mandatory programs/Ontario Public Health Standards (source: 2015 FIR of conditional grants). So, municipal governments are paying above the required cost sharing amounts.

Expert Panel on Public Health

To review and envision a new role for Public Health with the context of the *Patients First Act* and the revised standards, the government convened an Expert Advisory Panel. Gary McNamara, Mayor of Tecumseh, was appointed to the panel by the Minister, as an individual, not as a municipal representative selected by AMO.

The work of the Expert Panel is important, as it has come up with recommendations to the government intended to redefine the role of Public Health for years to come. The Minister gave the panel a mandate to look at how public health could operate within an integrated health system. The panel tabled the report to the Minister in June 2017.

The key recommendation proposes an end state for Public Health within an Integrated Health System that would have Ontario establish 14 regional public health entities—that are consistent with the LHIN boundaries.

Other Expert Panel Report recommendations include:

Proposed Leadership Structure consisting of:

- Regional public health entity with a CEO that reports to the Board and a Regional Medical Officer of Health (MOH) who reports to the Board on matters of public health and safety.
- Under each regional entity would be a Local Public Health Service Delivery Area with a Local Medical Officer of Health (reporting to the Regional MOH), local public health programs and services.

Proposed Board of Health Governance would be freestanding autonomous boards:

- Appointees would be municipal members (with formula defined by regulation), provincial appointees, citizen members (municipal appointees), and other representatives (e.g. education, LHIN, social sector, etc.).
- varied member numbers of 12 – 15
- diversity and inclusion – board should reflect the communities they serve
- qualifications – skills-based and experience
- Board to have the right mix of skills, competencies, and diverse populations.
- "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 challenges elected officials may experience balancing their municipal responsibilities with their responsibilities for public health."

The Expert Panel was not asked to make specific recommendations on implementation; however, they did identify elements that should be considered in developing an implementation plan. These elements include:

Legislation

Funding – It was noted that "as part of implementation planning the Ministry will need to revisit funding constructs in order to implement the recommendations".

Transition Planning/Change Management – with wording that says:

- "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 recognizes and protects 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 Municipalities of Ontario to develop the criteria for municipal representation on the new regional boards."
- Effective linkages with LHINs and the Health System.

Appendix A

Association of Municipalities Ontario

Office of the President

Sent via e-mail: Eric.Hoskins@Ontario.ca

October 12, 2017

The Honourable Dr. Eric Hoskins
Minister of Health and Long-Term Care
Hepburn Block, 10th Floor
80 Grosvenor Street
Toronto, Ontario M7A 2C4

Dear Minister Hoskins:

After careful consideration by our Board of Directors and our Health Task Force, AMO does not support the recommendations of the Expert Panel on Public Health and urges you and the provincial government not to adopt them.

If the Expert Panel recommendations are implemented, it will completely change and dilute over time the mandate of the local public health system by integrating it with the health care system. There was no analysis provided by either the Expert Panel or the Ministry on the implications of this proposed integration from either a patient, program/service, or cost benefit analysis perspective. There was no clear demonstration of any benefits of such a change in the public health system.

Our many concerns on the Expert Panel recommendations include:

- Public health will lose its local and community focus. It is currently integrated within its communities with multiple local linkages with both public and private bodies and organizations.
- A large number of the current public health units are fully integrated within a municipal system that enables coordinated planning, policy and program work with and between municipal services such as land use planning, transit, parks, housing and social services. The health unit staff are also municipal employees.
- For the autonomous public health units, there are also strong and vibrant local linkages with their municipal governments and services that would be severed or at least damaged by moving to a regional public health structure.
- The proposed governance model will reduce the local leadership voice in decision-making.
- Ensuring critical mass for emergencies does not need to be addressed only structurally.
- Serving the populations in rural and northern Ontario is already challenging. Experience has shown that making an entity regional does not generally help such situations.
- Amalgamations are not for the faint of heart and they do not generally produce the expected outcomes or efficiencies.

Municipal governments are your funding partners in public health – not merely stakeholders. In 2015, the last year data is available, municipal governments funded 38%, on average, of the public health costs for mandatory programs. To act upon the Expert Panel's recommendations, would create significant fiscal churn and likely municipal reduction in our cost-sharing world.

Given the grave concerns of what would be lost by implementation of these recommendations without any evidence of benefit lead us to our decision not to support them. The significant municipal interest and stake in this matter cannot be understated. We are asking for your commitment not to adopt all or any of these recommendations.

We would appreciate an opportunity to discuss this with you soon.

Sincerely,

Lynn Dollin
AMO President

cc: The Honourable Kathleen Wynne, Premier
The Honourable Bill Mauro, Minister of Municipal Affairs
Dr. Robert Bell, Deputy Minister, Health and Long-Term Care
Sharon Lee Smith, Associate Deputy Minister, Health and Long-Term Care
Roselle Martino, Assistant Deputy Minister, Health and Long-Term Care

alPHa
Association of Local
PUBLIC HEALTH
Agencies

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alPHa's members are the public health units in Ontario.

alPHa Sections:

- Boards of Health Section
- Council of Ontario Medical Officers of Health (COMOH)

Affiliate Organizations:

- Association of Ontario Public Health Business Administrators
- Association of Public Health Epidemiologists in Ontario
- Association of Supervisors of Public Health Inspectors of Ontario
- Health Promotion Ontario
- Ontario Association of Public Health Dentistry
- Ontario Association of Public Health Nursing Leaders
- Ontario Society of Nutrition Professionals in Public Health

30 YEARS 1986-2016

October 17, 2017

The Honourable Dr. Eric Hoskins
Minister of Health and Long-Term Care
Hepburn Block, 10th Floor
80 Grosvenor Street
Toronto, Ontario M7A 2C4

Dear Minister Hoskins:

On July 20, 2017, you released the report of the Expert Panel (EP) on Public Health, Public Health within an Integrated Health System. This report fulfills part of the proposal introduced in your Patients First discussion paper [2015] "to appoint an Expert Panel to advise on opportunities to deepen the partnership between LHINs and local public health units, and how to further improve public health capacity and delivery" [p20]. We thank you, and the EP members, for the completion of this effort and for making the recommendations public for consultation in a timely manner.

The Association of Local Public Health Agencies (alPHa) is the non-profit organization that provides support to the 36 local public health agencies (boards of health and public health units) in Ontario to promote a strong, effective and efficient public health system in the province. alPHa brings together the senior leadership of local public health (LPH), including board of health members, medical and associate medical officers of health, and senior managers in each of the public health disciplines – nursing, inspection, nutrition, dentistry, health promotion, epidemiology and business administration.

As such, alPHa is the collective voice of the organizations and professional leadership that are subject to the EP recommendations. It is with this lens that we have reviewed the recommendations of the EP and have surveyed our member boards of health for input. While alPHa will provide comment from a system level perspective, we expect that the Association's sections, affiliates and member boards of health will provide feedback from their own perspectives.

Our members have been consistent and clear that the mandates of LPH and healthcare are and should remain separate and distinct. Irrespective of the influence of local circumstances, we are collectively concerned that the attempt to align these mandates to the degree recommended by the EP will be to the detriment of our ability to promote and protect health at the community level. We are not starting with a blank slate in Ontario. The LPH system has many strengths that we believe would be eroded by the EP proposals. We urge that the following overarching concerns be carefully considered as part of any analysis for potential implementation.

1. **System disruption.** The magnitude of the changes recommended is significant and careful feasibility studies need to be conducted to ensure that the benefits to the effectiveness of the LPH system outweigh the costs. The EP proposes an 'end state' for LPH that will require major disruption of every facet of the system, from governance to program delivery. With so many details yet to be mapped out and given the complexity of on-the-ground implementation, we cannot support the proposed changes. We are not convinced that the EP recommendations are the only or best way forward.

2. **Fit with the work of LPH.** Local public health distinguishes itself from the healthcare system (i.e., hospitals, home care, family physicians, medical specialists, etc.) in that LPH focuses on the primary prevention of illness and injury and the promotion of public policies that impact the health of the general population. A population health approach seeks to improve the health of the entire population and reduce health inequities among certain groups in the population. This helps individuals, groups, and communities to have a fair chance to reach their full health potential. This also prevents disadvantage by social, economic, or environmental conditions.

   The work of LPH is largely focused upstream, using a population health approach as articulated in the Ontario Public Health Standards. Upstream work includes working with healthcare and non-healthcare sectors to advocate, design, implement and evaluate policies and programs that prevent diseases and their risk factors and promote and protect health, before people become patients in the first place. Bringing the LPH population health lens to healthcare service planning and delivery will certainly have a positive impact on the health system, but, healthcare is a relatively minor factor in what makes populations healthy or unhealthy. Addressing the social determinants of health through a collaborative upstream approach yields a much greater return on investment and widespread gains in the health outcomes of Ontario's population. Health, rather than healthcare, is our mandate and it is difficult for us to see the benefit to the aims of LPH of closer alignment with the healthcare system to the degree recommended by the EP. Realigning the boundaries of public health units with those of LHINs places stronger emphasis on the relationship with healthcare than existing relationships that promote health and fall within municipal boundaries such as housing, employment, planning and school boards. We cannot support the goal of better integration with the healthcare system if it comes at the expense of the structures that support upstream work that is most effectively done in collaboration at the local level with sectors outside of healthcare.

3. **Meeting local needs.** Again, using a population health approach, much of the work of LPH is accomplished through partnerships with local governments, schools and other community stakeholders to develop healthy public policies, build community capacity to address health issues and promote environments that instill and habituate healthy behaviours. Local public health has a strong vision for the health of all Ontarians that encompasses providing the best opportunities for health considering the broad spectrum of what is known to cause the best conditions for health, i.e., the social determinants of health. From that perspective, alPHa has already expressed support, with caveats regarding LPH capacity, for the proposal in Patients First that recommends better integration of population health within the health system. We do

see value in formalizing working linkages between LHINs and LPH, as we believe that they will help to build on existing successful collaborations in addition to ensuring that population and public health priorities inform health planning, funding and delivery. We already know that a rigid or one-size-fits-all approach will not equitably meet the needs of Ontarians in all parts of the province and will not permit the public health system to leverage the diversity of systems, organizations and services in different parts of the province. This is one of the strengths of our system, and we recommend the identification and focused examination of areas of the province where needs are not being met through current structures, so that tailored strategies can be developed to enhance capacity.

4. **Local public health capacity.** LPH capacity for most public health units has been steadily eroding over years of no increases in Ministry-approved budgets. The implementation of the new Standards for Public Health Programs and Services, new Accountability Framework, and new requirements under the *Patients First Act, 2016* are expected to stretch LPH capacity even further, and we believe that it will not withstand the large-scale system disruption proposed by the EP. We note that, while more is being asked of LPH, the budgeted amount for the Population and Public Health Division that provides LPH with most of its funding decreased by .42 percent from the previous year in the 2017-18 budget that gave an overall increase of 3.62 percent to the Ministry of Health and Long-Term Care (MOHLTC).

Given the concerns that we have expressed about the massive systemic change proposed by the EP aimed at fostering LPH-LHIN collaboration, we would like to propose that the work of the Public Health Work Stream that was established to define the formal relationship between LHIN Chief Executive Officers (CEOs) and LPH Medical Officers of Health (MOH) under the *Patients First Act, 2016* be allowed to further develop as an alternative solution.

While the EP focused on a 'ideal' end state with little consideration of implementation challenges [implementation was not within the EP's mandate], the work of the Public Health Work Stream resulted in proposed frameworks for LPH and LHIN engagement that were developed considering the current structure and organization of both LPH and LHINs. The mandate of the Work Stream was to define the parameters for engagement and the set of actions required of LHIN CEOs and LPH MOHs to support local health planning and service delivery decision-making, including definition of specific processes and structures to be established. Upon completion of this work, the Population and Public Health Division surveyed MOHs regarding the recommendations presented in the *Report Back from the Public Health Work Stream*. At present, we are awaiting the publication of the survey results and an open and transparent discussion of the results with government representatives.

We suggest that the desired outcomes for a strong public health sector in an integrated health system stated in the EP Report may better be achieved through focusing on the frameworks proposed by the Work Stream as well as the results of research, such as the locally driven collaborative project, *Patients First – Public Health Units and LHINs working together for population health*.

In closing, we recommend that the initiatives underway including the new Standards for Public Health Programs and Services, new Accountability Framework, and findings of the Public Health Work Stream and other provincial and national actions in progress be implemented and evaluated before the EP recommendations are given further consideration.

We look forward to further consultation and transparent discussion of the way forward. alPHa will continue to provide comment as the work underway evolves and becomes public.

Yours truly,

Carmen McGregor,
President

Copy: Dr. Bob Bell, Deputy Minister
Sharon Lee Smith, Associate Deputy Minister
Roselle Martino, Assistant Deputy Minister,
Dr. David Williams, Chief Medical Officer of Health
Dr. Peter Donnelly, President and CEO, Public Health Ontario
Pat Vanini, Executive Director, AMO
Ulli S. Watkiss, City Clerk, City of Toronto
Giuliana Carbone, Deputy City Manager, City of Toronto
Boards of Health (Chair, Medical Officer of Health and CEO)

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 054-17

TO: Chair and Members of the Board of Health

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

DATE: 2017 October 19

INCIDENT MANAGEMENT SYSTEM (IMS) ACTIVATED TO ENCHANCE RESPONSE TO COMMUNITY DRUG CRISIS

Recommendation

It is recommended that the Board of Health receive Report No. 054-17 re: Incident Management System (IMS) to Enhance Response to Community Drug Crisis for information.

Key Points

- London has multiple overlapping drug-related crises, which require a range of layered responses.
- In 2015, 711 people died of an opioid overdose in Ontario, a 194% increase since 2003. In Middlesex-London, overdose deaths peaked in 2012, but there is reason to believe that they will increase again as fentanyl moves into the local drug market.
- HIV, Hepatitis C, and endocarditis are also causing significant illness in the region.
- The Medical Officer of Health activated the Incident Management System (IMS) to elevate and coordinate the MLHU response.

Background

In 2013, Middlesex-London EMS responded to 602 calls related to drug overdoses alone, or more than one overdose per day. Between 2008 and 2012, London Police Services responded to an average of 730 incidents per year related to drug possession, and an average of 230 calls per year related to trafficking, distribution and possession of controlled drugs and substances.

Between 2008 and 2012, the annual number of prescription-opioid-related deaths among Middlesex-London residents ranged from a low of 13 to a high of 41 in 2012. That year, the prescription-opioid-related death rate in Middlesex-London was 8.8 per 100,000 people, more than twice the provincial rate of 4.1 (see Report No. 032-14 re: The Impact of Prescription and Non-Prescription Drug Use). More recent data from 2015 and 2016 indicates that the rate of opioid-related deaths in Middlesex-London has been similar to that of Ontario (between 5 and 6 deaths per 100,000 people).

The local opioid market has historically been dominated by diverted prescription drugs. With the implementation of new prescribing guidelines in September, 2017, it is expected that the availability of prescription opioids will decrease, and more potent versions of illegally produced drugs such as fentanyl and carfentanil will become more common locally. This may lead to an increase in opioid overdoses and deaths.

In October 2016, the Minister of Health and Long-Term Care released a "Strategy to Prevent Opioid Addiction and Overdose" (Opioid Strategy), which includes ongoing work to: enhance data collection and surveillance; modernize prescription and dispensing practices; improve access to high-quality addiction treatment services; and enhance harm reduction services and supports. To support implementation of the Opioid Strategy's harm reduction pillar, on June 12, 2017, the Minister of Health and Long-Term Care announced that funding would be provided to boards of health to build on existing harm reduction programs and services, and to improve local opioid response capacity and initiatives.

Incident Management System Activated

The Medical Offer of Health activated the Health Unit's Incident Management System (IMS) as of September 11, 2017, to enhance the response to the community's drug crisis. IMS is a system of roles, accountability and processes to ensure order and efficiency in an emergency response. Throughout this process, the team has and continues to set and act upon priority action items and planning activities on a weekly basis.

The Harm Reduction Program enhancement consists of three areas of focus: to ensure the community has an overdose response plan in place; the dissemination of naloxone kits to those most at risk for overdose; and the implementation and/or enhancement of early-warning systems to ensure the timely identification of and responses to surges in opioid overdoses. As part of the work towards an application for federal exemption from drug laws that would allow for one or more supervised consumption facilities, community consultations will begin mid-October.

The Manager of Sexual Health has been seconded to the role of Operations Chief for the duration of the IMS activation period. The focus will be to continue to lead the sexual health files, such as supervised consumption facilities, harm reduction, naloxone distribution, the I-Track study and other responsibilities associated with drugs and opiates. In the interim, there will be an Acting Manager for Sexual Health, who will focus mainly on managing clinical services and sexual health promotion work. The team continues to work on this issue.

Appendix A provides a summary of what has been accomplished to date and some of the work that lies ahead.

Conclusion/Next Steps

The IMS group will continue to meet weekly for the next several months as the Health Unit responds to the local drug crisis and builds strategies to address the many associated challenges. These are issues that require our attention and focus in order to develop long-term responses that meet the needs of our community.

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

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

Appendix A to Report No. 054-17

Key Items Addressed to Enhance Response to the Community Drug Crisis

- A communications plan is being developed, one component of which is the creation of a distribution list of over 150 community partners who will receive updates about the MLHU's opioid overdose work.

- Public consultation on supervised consumption facilities are launching mid-October. Maria Sanchez-Keane, from the Centre for Organizational Effectiveness, will assist in the consultation process, which will include coordinating focus groups and a survey on supervised consumption facilities in order to seek a federal exemption, maximize engagement and allow for a transparent, unbiased process. The total cost of the consultations will be at most $30,000, of which $20,000 will be paid funded by the Ontario HIV Treatment Network, as explained in Report 026-17FFC. Additional costs for this work, including the external consultant's costs and room bookings (up to $15,000) have been referred to the Health Unit's Q3 variance process.

- MLHU has secured Ministry of Health and Long-Term Care (MOHLTC) funding for up to $250,000 to support planning, preparation and deployment activities for the Harm Reduction Program Enhancement. In the absence of additional inflationary funding for the Health Unit, this will mainly cover opioid-related work already being conducted.

- Policy supports are being developed for supervised consumption facilities. Public health units in Toronto and Ottawa, where successful applications have gone forward, are assisting by sharing policies and procedures to ensure that our federal exemption application meets all the requirements.

- On September 19, the MOHLTC established a provincial funding program for supervised injection services (SIS), subject to receipt of the appropriate federal exemption.

- On September 18, the Medical Officer of Health (MOH) gave a presentation to the London City Council's Strategic Priorities and Policy Committee (SPPC) on the opioid crisis in London. SPPC endorsed the creation of an Opioid Crisis Working Group under the leadership of the MOH. This group includes several key partners, such as London Police Services and the Local Health Integration Network (LHIN), as well as harm reduction agencies in the region.

- In August 2017, the MOHLTC expanded the naloxone program, with the Health Unit acting as a naloxone distribution hub for eligible community organizations, increasing dissemination of kits to those most at risk of opioid overdose. Since the end of August, thirteen presentations on naloxone have been given, 213 personnel have been trained and eighty-four kits have been distributed.

- Dr. Hovhannisyan is leading the opioid surveillance effort in cooperation with key MLHU staff, as well as EMS, police, hospitals, the MOHLTC and other health-sector partners.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 055-17

TO: Chair and Members of the Board of Health

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

DATE: 2017 October 19

SUMMARY INFORMATION REPORT FOR OCTOBER

Recommendation

It is recommended that the Board of Health receive Report No. 055-17 re: Summary Information Report for October 2017 for information.

Key Points

- The Middlesex-London Health Unit is participating in a Locally Driven Collaborative Project (LDCP) that will work collaboratively with school boards to develop the methodology for a new health module. As part of this project, MLHU will be reaching out to local school boards.

Children Count: Locally Driven Collaborative Project (LDCP)

MLHU is one of sixteen health units participating in a Locally Driven Collaborative Project (LDCP). Phase 1 of the project focused on determining gaps in health data for children and youth to better meet local needs, and ended with the release of the report "Children Count," in March 2017. An application for two years' extended PHO funding (January 2018 to January 2020) has been submitted. The project's Phase 2 is called "Children Count Pilot Study: Utilizing the school climate survey for coordinated health surveillance and planning for children and youth in Ontario." The research question and objectives are as follows:

Research Question

To determine the feasibility of utilizing the school climate survey to gather health data that will meet the needs of local public health and boards of education.

Objectives

Specific research objectives for this two-year LDCP will build on the recommendations of the "Children Count" report and the associated provincial task force:

- To work collaboratively with school boards to develop the methodology for a new health module, addressing healthy eating, physical activity and mental health for inclusion in the school climate survey (topics of priority were identified as needs in Phase 1 of the project);
- To pilot test and evaluate the applicability and feasibility of the partnership between public heath units and school boards in coordinated surveillance and assessment utilizing the school climate survey; and
- To develop a guide and/or toolkit for implementation of coordinated surveillance for health service planning using the school climate survey for child and youth health in Ontario.

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

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 056-17

TO: Chair and Members of the Board of Health

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

DATE: 2017 October 19

MEDICAL OFFICER OF HEALTH ACTIVITY REPORT, OCTOBER

Recommendation

It is recommended that the Board of Health receive Report No. 056-17 re: Medical Officer of Health Activity Report, October for information.

The following report presents activities of the Medical Officer of Health for the period of September 11, 2017, to October 6, 2017.

September 11	Activated the Incident Management System (IMS) Team re: drug crisis, and lead initial IMS meeting.
September 12	Participated in the COMOH Executive Committee teleconference Participated in the Extended Leadership Team meeting
September 13	Attended the Expert Panel on Public Health Report meeting in Toronto
September 14	Met with Board of Health Chair to review the September 21 Board agenda Met with City Councillor Michael van Holst to discuss drug-crisis issues Met with Dr. Ken Lee to discuss drug-crisis issues Met with City Councillor Anna Hopkins to discuss drug-crisis issues
September 15	Met with Michelle Baldwin, Pillar Nonprofit Network, to discuss drug-crisis issues Had a phone meeting with Sandra Datars-Bere, City of London Met with Angie Roth re: employment for high-risk youth
September 18	Had a phone meeting with Shmuel Farhi re: supervised consumption facilities Had a phone meeting with Mayor Brown re: Opioid Crisis Working Group Attended and participated in the SPPC meeting at City Hall
September 19	Had a phone meeting with City Councillor Josh Morgan re: drug-crisis issues Met with the IMS Team re: drug crisis
September 20	Was interviewed by Rita Ismail, CTV, re: Greenhouse Academy Had a phone meeting with Amardeep Thind, Western University, re: lecture for Master of Public Health students on the opioid crisis Met with Bill Rayburn, CAO, Middlesex County, re: Patients First transformation, and current lease at 50 King Participated in the Rogers TV Newsmakers series
September 21	Met with Mike Smith and Councillor Tanya Park re: Supervised Consumption Facilities

September 22 Participated in Sugar Sweetened Beverage Working Group teleconference
Met with Roxanne Riddell, United Way of London and Middlesex, re: "London For All"

September 26 Attended the Student Work Placement Event
Met with Susan Hall, City of London Advisory Committee on the Environment (ACE), re: participation in November 18 Resilient Cities Conference
Met with the IMS Team re: drug crisis

September 27 Met with staff to review PBMA disinvestment proposals
Was interviewed by Dale Carrothers, *London Free Press*, re: marijuana

September 28 Attended the YOU AGM and board meeting
Presented at the MLHU Planning and Evaluation Framework Workshop
Participated on the MOHLTC Provincial Funding Program for Supervised Injection Services Webinar
Participated in London Q&A with Craig Needles at Corus Studio
Was interviewed by Paul Wells, *Maclean's*, re: the opioid situation in London

September 29 Attended the alPHa 2017–18 board of directors meeting in Toronto

October 2 Had a phone meeting with Adam Thompson, City of London Intergovernmental Affairs, re: the city's submission to the Expert Panel on Public Health
Had a phone meeting with Scott McLeod, Central West LHIN, re: Report Back from the Public Health Work Stream
Met with the Opioid Crisis Working Group (OCWG)
Had a phone meeting with Michael Barrett, South West LHIN, re: debrief on OCWG meeting

October 3 Met with the IMS Team re: drug crisis

October 4 Had a phone meeting with Jeannette Eberhard, London Police Services Board, re: speaking at an upcoming meeting
Met with Linda Sibley, Addiction Services, re: operating supervised consumption facilities and public consultation
Spoke to Mayor Brown re: drug strategy

October 5 Met with Councillor Jesse Helmer, Rosanna Wilcox and Adam Thompson at City Hall to discuss the Expert Panel on Public Health
Participated on CJBK's "Ask The Experts" panel re: the *in motion*™ Community Challenge

October 6 Attended the Youth Opportunities Unlimited (YOU) executive committee meeting
Met with Peggy Sattler, MPP, re: drug-crisis issues
Gave lecture to MPH students, Western University
Met with Michael Corey, London Poverty Research Centre, re: current LPRC work

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

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Medical Officer of Health / CEO