AGENDA
MIDDLESEX-LONDON BOARD OF HEALTH

Thursday, January 24, 2019, 7:00 p.m.
399 RIDOUT STREET NORTH
SIDE ENTRANCE, (RECESSED DOOR)
MLHU Boardroom

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

Mr. John Brennan
Ms. Maureen Cassidy
Mr. Michael Clarke
Ms. Aina DeViet
Ms. Kelly Elliott
Ms. Trish Fulton
Ms. Tino Kasi
Mr. Ian Peer
Ms. Elizabeth Peloza
Mr. Matt Reid

SECRETARY-TREASURER

Dr. Christopher Mackie

DISCLOSURE OF CONFLICTS OF INTEREST

APPROVAL OF AGENDA

APPROVAL OF MINUTES

December 12, 2018 – Board of Health meeting

Receive: December 12, 2018 Relocation Advisory Committee meeting minutes
Receive: November 1, 2018 Finance and Facilities Committee meeting minutes

DELEGATIONS

7:30 – 7:35 Ms. Mary Lou Albanese, Manager, Infectious Disease, re: Infectious Disease Program Update

7:35 – 7:45 Ms. Shaya Dhinsa, Manager, Sexual Health and Ms. Marilyn Atkin, Program Lead, Community Outreach and Harm Reduction, re: Strategy to Address the HIV Outbreak and Related Issues in London: An Update (Report No. 004-19) and Program Update

7:45 – 7:50 Ms. Deb Shugar, Acting Manager, Screening Assessment & Intervention re: Screening Assessment and Intervention Program Update

7:50 – 7:55 Mr. Fatih Sekercioglu, Manager, Safe Water, Rabies & Vector-Borne Disease re: Safe Water, Rabies & Vector Borne Disease Program Update

Item #	Report Name and Number	Link to Additional Information	Delegation	Recommendation	Information	Brief Overview
Meeting Procedures						
1	Election of 2019 Board of Health Executive and other Procedures (Report No. 001-19)	Appendix A Appendix B Appendix C Appendix D Appendix E		x		To fulfill the requirements of the first Board of Health meeting of each year, e.g., election of Chair/Vice Chair and standing comittees for 2019.
Recommendation Reports						
2	Diversity and Inclusion Assessment (Report No. 002-19)			x		Approve negotiations with a contractor to conduct MLHU's diversity and inclusion assessment.
3	Location Project Update (Report No. 003-19)	Appendix A		x	x	To provide an update on the Health Unit's location project.
Information Reports						
4	Active Tuberculosis in a Shelter (Report No. 004-19)	Appendix A			x	To provide an update on the investigation and response to a case of active tuberculosis who had been living in the shelter system.
5	Strategy to Address the HIV Outbreak and Related Issues in London: An Update (Report No. 005-19)	Appendix A Appendix B Appendix C	x		x	To provide an update on the number of HIV cases and implemented strategies to increase access to harm reduction supplies and improve treatment pathways for at-risk and HIV positive clients.
6	Update on Transfer of Lead Agency responsibilities for tykeTALK, Infant Hearing and Blind/Low Vision Early Intervention Programs (Report No. 006-19)	Appendix A			x	To provide an update on the plan for Thames Valley Children's Centre to fully transition into the Lead Agency role for tykeTALK, Infant Hearing and Blind/Low Vision Early Intervention Programs by September 2019.
7	Summary Information Report for January (Report No. 007-19)	Appendix A Appendix B Appendix C			x	To provide an update on Health Unit programs and services for January 2019.
8	Medical Officer of Health/Chief Executive Officer Activity Report for January (Report No. 008-19)				x	To provide an update on the activities of the MOH/CEO.

OTHER BUSINESS

- New Board Members

- Confidentiality Attestation and Conflict of Interest Declaration:
  - G-100 Information, Privacy and Confidentiality
    - Appendix A, Privacy Statement
    - Appendix B, Annual Confidentiality Attestation
  - G-380 Conflicts of Interest and Declaration
    - Appendix A, Annual Declaration Form

- Next Finance and Facilities Committee Meeting: Thursday, February 7, 2019 @ 9:00 a.m.
- Next Board of Health Meeting: Thursday, February 21, 2019 @ 7:00 p.m.
- Next Governance Committee Meeting is scheduled for March 21, 2019.

CORRESPONDENCE

CONFIDENTIAL

The Board of Health will move in-camera to approve Confidential minutes from the December 12, 2018 Board of Health meeting.

ADJOURNMENT

CORRESPONDENCE – JANUARY 2019

a) Date: 2018 December 7
Topic: Support for Provincial Oral Health Program for Low-Income Adults and Seniors
From: Public Health Sudbury & Districts
To: Honourable Doug Ford

Background:
On December 7, 2018, Public Health Sudbury & Districts wrote to Premier Doug Ford expressing sincere appreciation for the provincial government's support of a provincial oral health program for low-income seniors. Public Health Sudbury & Districts identified a need to expand oral health programs to low-income adults, in addition to those in place or planned for children, youth, and seniors.

Recommendation: Receive.

b) Date: 2018 November 27
Topic: Healthy Babies Healthy Children Program Funding
From: Thunder Bay District Health Unit
To: Honourable Lisa MacLeod

Background:
On November 21, 2018, the Board of Health for Thunder Bay District Health Unit (TBDHU) wrote to Minister Lisa MacLeod regarding provincial funding allocations for the Health Babies, Healthy Children (HBHC) program. While TBDHU has made every effort to mitigate the outcome of an ongoing funding shortfall, it has become challenging to meet targets set out in HBHC service agreements. Without a funding level increase, services for high-risk families will be reduced. The TBDHU advocates for the Ministry of Children, Community and Social Services to fully fund the HBHC program, including staffing, operating, and administrative costs.

Recommendation: Receive.

c) Date: 2018 November 27
Topic: alPHa Board of Directors Meets with Minister of Health and Long-Term Care
From: Association of Local Public Health Agencies (alPHa)
To: All Board of Health members

Background:
On November 23, 2018, Minister Christine Elliott met with the Board of Directors of the Association of Local Public Health Agencies (alPHa). The Minister was provided with an overview of alPHa, the upstream importance of public health, and the key role that boards of health and public health units play in their respective communities. Minister Elliott acknowledged the importance of alPHa members being on the front lines of the public health system.

Recommendation: Receive.

d) Date: 2018 November 27
Topic: Results of the 2018 Nutritious Food Basket Survey for Wellington-Dufferin-Guelph Public Health
From: Wellington-Dufferin-Guelph Public Health
To: Honourable Lisa MacLeod

Background:
On November 27, 2018, Wellington-Dufferin-Guelph Public Health (WDGPH) notified Minister MacLeod of the release of its Nutritious Food Basket (NFB) survey and shared the survey results and findings as published in their Board of Health report of November 7, 2018. The NFB provides a standardized measurement for the cost of a "basket" of healthy foods that reflects Canadian nutrition recommendations and food purchasing patterns. It was evident through the results of the survey that households with limited incomes struggle to afford nutritious food. The findings also highlight the challenges faced by individuals on social assistance to avoid chronic diseases and mental illness.

Recommendation: Receive.

e) Date: 2018 November 21
Topic: Ontario's Basic Income Pilot
From: Thunder Bay District Health Unit
To: Premier Doug Ford, Honourable Lisa MacLeod

Background:
On November 21, 2018, the Board of Health for the Thunder Bay District Health Unit (TBDHU) wrote to Premier Ford and Minister MacLeod expressing concern over the termination of Ontario's Basic Income Pilot and the reduction of the scheduled increase to Ontario Works and the Ontario Disability Support Program. The TBDHU urges the provincial government to reconsider its decision, as significant resources have been invested in planning and implementing the project, and as these programs address issues of poverty as public health priorities. Thunder Bay had been designated as a pilot site for the Ontario Basic Income Pilot, and the Board of Health for TBDHU fully supports continuation of the pilot based on evidence of strong relationship between income and health.

Recommendation: Receive.

f) Date: 2018 December 05
Topic: Cannabis Retail Locations
From: KFL&A Public Health
To: Honourable Caroline Mulroney, Attorney General

Background:
On December 5, 2018, the Board of Health for KFL&A Public Health wrote to Minister Caroline Mulroney expressing concern about the regulations regarding the physical availability of cannabis. KFL&A Public Health urges the provincial government to strengthen these regulations by increasing the minimum distance requirement of 150 metres between cannabis retail locations and schools.

Recommendation: Receive.

g) Date: 2018 December 14
Topic: 2018 alPHa Board of Health Orientation Manual and Governance Toolkit
From: Association of Local Public Health Agencies (alPHa)
To: All Board of Health members

Background:
On December 14, 2018, the Association of Local Public Health Agencies (alPHa) released its updated *2018 Orientation Manual for Board of Health Members* and the companion document *Governance*

Toolkit for Ontario Boards of Health. The province's *Ontario Municipal Councillor's Guide 2018* is also available for Board of Health members new to municipal council.

Recommendation: Receive.

h) Date: 2018 December 19
Topic: Association of Local Public Health Agencies Update to Board of Health Members
From: Association of Local Public Health Agencies (alPHa)
To: Ontario Boards of Health

Background:
On December 19, 2018, the Association of Local Public Health Agencies (alPHa) provided an update that included welcoming new and returning board of health members and announced the release the Board of Health orientation documents referenced in Correspondence Item g) above. alPHa also extends an invitation to its upcoming 2019 Winter Symposium on February 21, 2019. Refer to Correspondence item h) in the December 12, 2018 Board of Health agenda. Additional updates were provided, which included information regarding public consultation on Bill 66 available on the alPHa website and about the November 23, 2018 meeting between the alPHa Board of Directors and Minister Christine Elliott.

Recommendation: Receive.

i) Date: 2018 December 19
Topic: Representation on the Middlesex-London Board of Health
From: Kathy Bunting, Clerk, County of Middlesex
To: Dr. Christopher Mackie, Medical Officer of Health, Middlesex-London Health Unit

Background:
Members from Middlesex County appointed to the Middlesex-London Board of Health were appointed for the term December 18, 2018, to November 30, 2022.

Recommendation: Receive.

j) Date: 2018 December 06
Topic: Appointments to the Middlesex-London Health Unit Board of Directors
From: Cathy Saunders, Clerk, City of London
To: Dr. Christopher Mackie, Medical Officer of Health, Middlesex-London Health Unit

Background:
Members from the City of London appointed to the Middlesex-London Board of Health were appointed for the term December 1, 2018, to November 15, 2022.

Recommendation: Receive.

k) Date: 2018 December 21
Topic: Sudbury and Districts Cost-Shared Operating Budget for 2019
From: Public Health Sudbury & Districts
To: Honourable Christine Elliott

Background:

On December 21, 2018, the Board of Health for Public Health Sudbury & Districts advised Minister Christine Elliott of its approved cost-shared operating budget for 2019. Although Public Health Sudbury & Districts is committed to balancing competing needs for fiscal restraint with the need for enhanced public health programming, the Board of Health is concerned over the increasing fiscal burden this places on constituent municipalities.

Recommendation: Receive.

l) Date: 2019 January 2
Topic: 2019–2022 Strategic Plan
From: Simcoe Muskoka District Health Unit
To: Ontario Boards of Health

Background:
On January 2, 2019, Simcoe Muskoka District Health Unit shared its 2019–2022 Strategic Plan, focusing on four priorities: relationships, public health standards, accountability, and governance.

Recommendation: Receive.

m) Date: 2019 November 13
Topic: Association of Local Public Health Agencies 2019 Winter Symposium
From: Association of Local Public Health Agencies (alPHa)
To: All Health Units

Background:
The Association of Local Public Health Agencies (alPHa) will hold its 2019 Winter Symposium on February 21, 2019, at the Chestnut Conference Centre, 89 Chestnut Street, in downtown Toronto. The one-day event will feature plenary speakers in the morning, followed by concurrent afternoon meetings for board of health members and medical officers of health and associate MOHs. An evening reception and lecture is planned at a location within walking distance of the morning/afternoon sessions.

Recommendation: Receive.

n) Date: 2019 January 02 [Received January 15]
Topic: Interim Supervised Consumption Site
From: Christine Elliott, Deputy Premier and Minister of Health and Long-Term Care
To: Chair, Middlesex-London Board of Health

Background:
On January 15, 2018 Minister Christine Elliott advised the Middlesex-London Health Unit's Board of Health that the Ministry of Health and Long-term Care is providing Regional HIV/AIDS Connection with up to $510,000 in one-time funding for the 2018-19 year to support the interim SCS at the 186 King Street facility. The Minister also identified that the exemption from the Minister of Health and Long-Term Care to operate an Overdose Prevention Site (OPS) is no longer required as it duplicates the temporary exemption from the federal Minister of Health, to operate an interim Supervised Consumption Service (SCS) at 186 King Street.

Recommendation: Receive.

PUBLIC SESSION – MINUTES
MIDDLESEX-LONDON BOARD OF HEALTH
399 Ridout Street, London
Middlesex-London Board of Health Boardroom
Wednesday, December 12, 2018 5:30 p.m.

MEMBERS PRESENT:	**Ms. Joanne Vanderheyden (Chair)** Ms. Trish Fulton (Vice-Chair) Mr. Marcel Meyer Mr. Ian Peer Mr. Kurtis Smith Ms. Tino Kasi Mr. Michael Clarke Ms. Elizabeth Peloza Mr. Matt Reid
REGRETS:	Ms. Maureen Cassidy
OTHERS PRESENT:	Dr. Christopher Mackie, Secretary-Treasurer Ms. Elizabeth Milne, Executive Assistant to the Board of Health and Communications Coordinator (Recorder) Ms. Laura Di Cesare, Director, Healthy Organization Mr. Dan Flaherty, Communications Manager Mr. Alex Tyml, Online Communications Coordinator Ms. Amanda Harvey, Project Coordinator Mr. Jeff Cameron, Stronghold Services Ms. Rachelle Wood, Policy Advisor Ms. Kendra Ramer, Manager, Strategic Projects Mr. Joe Belancic, Manager, Procurement and Operations Ms. Nicole Gauthier, Manager, Privacy and Risk Management Ms. Maureen Rowlands, Director, Healthy Living Ms. Misty Deming, Manager, Oral Health Mr. Stephen Turner, Director, Environmental Health and Infectious Disease Ms. Jenn Proulx, Manager, Nurse-Family Partnership

Chair Vanderheyden called the meeting to order at 5:32 p.m.

Chair Vanderheyden thanked Mr. Trevor Hunter and Mr. Jesse Helmer for their work and dedication on the Board of Health and welcomed the new City representatives, Ms. Elizabeth Peloza and Mr. Matt Reid, to the Board of Health.

DISCLOSURES OF CONFLICT(S) OF INTEREST

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

APPROVAL OF AGENDA

It was moved by Mr. Peer, seconded by Ms. Fulton, *that the **AGENDA** for the December 12, 2018 Board of Health meeting be approved.*

Carried

APPROVAL OF MINUTES

It was moved by Mr. Meyer, seconded by Mr. Smith, *that the **MINUTES** of the November 15, 2018 Board of Health meeting be approved.*

Carried

COMMITTEE REPORTS

Relocation Advisory Committee, December 12, 2018 – Verbal Update

Mr. Peer introduced and summarized the following reports considered by the Relocation Advisory Committee for information:

Design Consultation Summary (Report No. 004-18RAC)

It was moved by Mr. Clarke, seconded by Mr. Meyer, *that the Board of Health receive Report No. 004-18RAC re: "Design Consultation Summary" for information.*

Carried

Location Project – Demolition Update (Report No. 005-18RAC)

It was moved by Mr. Reid, seconded by Ms. Fulton, *that the Board of Health receive Report No. 005-18RAC re: "Location Project – Demolition Update" for information.*

Carried

Project Status Update – Verbal Update (received by the Relocation Advisory Committee for information)

It was moved by Mr. Peer, seconded by Mr. Reid, *that the **MINUTES** of the October 18, 2018 Relocation Advisory Committee meeting be received.*

Carried

RECOMMENDATION REPORTS

Electronic Client Record (ECR) – Project Update (Report No. 072-18)

Ms. Ramer and Mr. Belancic introduced the report, provided context, and answered questions.

Discussion ensued on the following items:

- The cost structure breakdown for the project, including an expected increase in costing if the Health Unit does not enter into an agreement before year end.
- How the negotiated pricing will increase throughout the five-year contract.
- MLHU's relationship with Ottawa in regard to the piggyback clause, and why the Health Unit entered into a single-source agreement with Intrahealth.
- Some reasons why contract negotiations may have fallen through with Ottawa.
- Whether Intrahealth might be willing to move the data into a new system as part of ending the contract in five years' time.

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

1. *Receive Report No. 072-18 re: "Electronic Client Record – Project Update"; and*
2. *Approve entering into a contract with Intrahealth Canada Limited for the purpose of implementing an Electronic Client Record solution.*

Carried

Enterprise Resource Planning – Human Capital Management Contract Award (Report No. 073-18)

Mr. Belancic introduced and provided context for this report, including a review of the public procurement process in response to the Health Unit's request for proposals as issued.

Discussion ensued on the following items:

- Why the proposal scores pertaining to each RFP were not included in the report, and why Ceridian, rather than other companies, was awarded the contract.
- How suppliers and vendors were reviewed as part of the public procurement process.
- Whether Ceridian is a Canadian company and where its offices and headquarters are located.

It was moved by Mr. Reid, seconded by Mr. Clarke, *that the Board of Health:*

1. *Receive Report No. 073-18 re: "Enterprise Resource Planning – Human Capital Management Contract Award" for information; and*
2. *Recommend the award of contract to Ceridian HCM Inc.*

Carried

Information Technology (IT) Capital Spending and Contract Award (Report No. 074-18)

Mr. Cameron and Mr. Belancic introduced the report and provided background on the IT capital spending contract award.

Ms. Peloza left the meeting at 6:00 p.m.

Discussion ensued about whether it might be possible for the Health Unit to work with Stronghold Services as part of this new contract.

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

1. *Receive Report No. 074-18 re: "IT Capital Computer Spending and Contract Award" for information;*
2. *Approve the strategy and purchases as outlined; and*
3. *Approve entering into a contract with Stronghold Services for the purchase of Information Technology equipment.*

Carried

Nurse-Family Partnership Ontario Clinical Lead (Report No. 075-18)

Ms. Lokko introduced the report and provided context.

Discussion ensued about MLHU being the license holder for the Ontario NFP, how this new role will function given current staff and structures at MLHU, and how it will be funded.

It was moved by Mr. Clarke, seconded by Mr. Meyer, *that the Board of Health:*

1. *Receive Report No. 075-18 re: "Nurse- Family Partnership" for information; and*
2. *Endorse Middlesex-London Health Unit (MLHU) as the hiring agency for the Ontario NFP Clinical Lead cost-shared position, within its role as the Ontario NFP license holder.*

Carried

INFORMATION REPORTS

Hepatitis A Outbreak – Update (Report No. 076-18)

Dr. Summers introduced the report and provided context. The report outlined the Hepatitis A outbreak that has been going on in our jurisdiction since October, together with the Health Unit's response.

Discussion ensued about the percentage of these cases that have equivalent morbidities, such as HIV.

It was moved by Mr. Reid, seconded by Mr. Peer, *that the Board of Health receive Report No. 076-18 re: "Hepatitis A Outbreak – Update" for information.*

Carried

Summary Information Report – December 2018 (Report No. 077-18)

It was moved by Mr. Meyer, seconded by Ms. Fulton, *that the Board of Health receive Report No. 077-18 re: "Summary Information Report – December 2018" for information.*

Carried

Medical Officer of Health/Chief Executive Officer Activity Report for December (Report No. 078-18)

It was moved by Mr. Clarke, seconded by Mr. Reid, *that the Board of Health receive Report No. 078-18 re: "Medical Officer of Health/Chief Executive Officer Activity Report for December" for information.*

Carried

CORRESPONDENCE

It was moved by Mr. Smith, seconded by Ms. Kasi, *that the Board of Health receive items a), through i).*

Carried

Discussion ensued about whether responses are received to letters that are sent out on behalf of the Board regarding various issues.

Dr. Mackie acknowledged the work of the three Middlesex County Board of Health members, Mr. Kurtis Smith, Ms. Joanne Vanderheyden, and Mr. Marcel Meyer, thanking them for their time, dedication, and contributions to the work of the Middlesex-London Health Unit and Board of Health.

OTHER BUSINESS

Chair Vanderheyden reviewed the next meeting dates for the Board of Health and its standing committees:

- Next Finance & Facilities Committee meeting: February 7, 2019 @ 9:00 a.m.
- Next Board of Health meeting: January 24, 2019 @ 7:00 p.m.
- Next Governance Committee meeting: March 21, 2019.

CONFIDENTIAL

At 6:17 p.m., it was moved by Ms. Fulton, seconded by Mr. Clarke, *that the Board of Health move in-camera to consider matters regarding employee negotiations, potential litigation, and identifiable individuals, and to approve the confidential minutes of the November 15, 2018 Board of Health meeting.*

Carried

At 6:39 p.m., it was moved by Mr. Peer, seconded by Mr. Smith, *that the Board of Health rise and return to public session.*

Carried

ADJOURNMENT

At 6:39 p.m., it was moved by Ms. Kasi, seconded by Mr. Meyer, *that the meeting be adjourned.*

Carried

JOANNE VANDERHEYDEN
Chair

CHRISTOPHER MACKIE
Secretary-Treasurer

PUBLIC SESSION – MINUTES
MIDDLESEX-LONDON BOARD OF HEALTH
RELOCATION ADVISORY COMMITTEE
399 Ridout Street, London
Middlesex County Building, MLHU Boardroom
Thursday, December 12, 2018, 4:30 p.m.

Committee Members Present:	**Mr. Ian Peer, Chair** Ms. Joanne Vanderheyden Mr. Michael Clarke Mr. Marcel Meyer
Others Present:	Mr. Matt Reid, Board Member Mr. Kurtis Smith, Board Member Dr. Christopher Mackie, Secretary-Treasurer Ms. Elizabeth Milne, Executive Assistant to the Board of Health and Communications Coordinator (Recorder) Ms. Laura Di Cesare, Director, Healthy Organization Mr. Joe Belancic, Manager, Procurement and Operations Ms. Kendra Ramer, Manager, Strategic Projects Ms. Amanda Harvey, Project Coordinator Mr. Jeff Cameron, Stronghold Services Mr. Brian Glasspoole, Manager, Finance Mr. Tom Bes, BES Consulting

Chair Peer called the meeting to order at 4:30 p.m.

Ms. Vanderheyden introduced Mr. Reid and welcomed him to the Board of Health.

DISCLOSURE OF CONFLICT(S) OF INTEREST

Chair Peer inquired if there were any disclosures of conflicts of interest to be declared. None were declared.

APPROVAL OF AGENDA

It was moved by Ms. Vanderheyden, seconded by Mr. Meyer, *that the **AGENDA** for the December 12, 2018 Relocation Advisory Committee meeting be approved, as amended.*

Carried

APPROVAL OF MINUTES

It was moved by Mr. Meyer, seconded by Mr. Clarke, *that the **MINUTES** of the October 18, 2018 Relocation Advisory Committee meeting be approved.*

Carried

NEW BUSINESS

Design Consultation Summary (Report No. 004-18RAC)

Ms. Di Cesare introduced the report. Mr. Belancic and Ms. Ramer answered questions and provided context.

Discussion ensued on the following items:

- Changes to the use of clinical space and how the consultations have made a difference to the preliminary floor plans.
- *Accessibility for Ontarians with Disabilities Act* requirements throughout the building.

- How to ensure dedicated space for making private and confidential calls in an open-concept space.
- Staff participation in the consultations.
- Whether the space is adequate for housing all staff and whether it will remain adequate if the workforce grows in coming years.
- How the current clinic schedule may be accommodated in the new space, and how much space will be required to run clinics going forward (i.e., whether waiting rooms are large enough to run multiple clinics, whether there is adequate space for the travel clinic to continue in the new location).

It was moved by Mr. Clarke, seconded by Ms. Vanderheyden, *that the Relocation Advisory Committee receive Report No. 004-18RAC re: "Design Consultation Summary" for information.*

Carried

Location Project – Demolition Update (Report No. 005-18RAC)

Mr. Belancic introduced and provided context for the report, which included the cost of removing a wall and changing the location of the elevator shaft, a secondary stair well, and certain costs associated with each.

Mr. Glasspoole arrived at 4:48 p.m. Mr. Smith arrived at 4:50 p.m.

Discussion ensued on the following items:

- That a zoning change is not required to continue with needle exchange at the new location.
- Providing an alternate access for needle exchange clients at Citi Plaza, and why it would be beneficial.
- If there are any safety risks associated with entrances and exits identified in the floor plan.

It was moved by Mr. Clarke, seconded by Mr. Meyer, *that the Relocation Advisory Committee recommend that the Board of Health receive Report No. 005-18RAC re: "Location Project – Demolition Update" for information.*

Carried

Project Status Update – Verbal Update and Presentation

Ms. Ramer introduced and provided context to this report, referencing the floor plan, highlighting some of the key themes identified by staff during the space needs consultations, and identifying next steps in space planning.

Discussion ensued about the stair well relocation and extension of elevator service into the basement.

It was moved by Ms. Vanderheyden, seconded by Mr. Meyer, that *the Relocation Advisory Committee receive the Project Status Update for information.*

Carried

OTHER BUSINESS

Chair Peer advised that the date of the next meeting will be determined in the new year.

ADJOURNMENT

At 5:31 p.m., it was moved by Mr. Meyer, seconded by Ms. Vanderheyden, *that the meeting be adjourned.*

Carried

_____
IAN PEER
Chair

_____
CHRISTOPHER MACKIE
Secretary-Treasurer

PUBLIC MINUTES
FINANCE & FACILITIES COMMITTEE
50 King Street, London
Middlesex-London Health Unit
Thursday, November 1, 2018, 9:00 a.m.

MEMBERS PRESENT: Ms. Trish Fulton (Chair)
Mr. Jesse Helmer
Ms. Tino Kasi
Mr. Marcel Meyer
Ms. Joanne Vanderheyden

REGRETS: Dr. Christopher Mackie, Secretary-Treasurer

OTHERS PRESENT: Mr. Michael Clarke, Board of Health
Ms. Maureen Cassidy, Board of Health
Ms. Laura Di Cesare, Director, Healthy Organization
Ms. Lynn Guy, Executive Assistant (Recorder)
Dr. Alexander Summers, Associate Medical Officer of Health
Mr. Brian Glasspoole, Manager, Finance
Mr. Joe Belancic, Manager, Procurement and Operations
Mr. Stephen Turner, Director, Environmental Health and Infectious Diseases
Ms. Maureen Rowlands, Director, Healthy Living
Ms. Heather Lokko, Director, Healthy Start
Ms. Brooke Clark, PHN

Chair Fulton called the meeting to order at 9:03 a.m.

DISCLOSURES OF CONFLICT(S) OF INTEREST

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

APPROVAL OF AGENDA

Chair Fulton noted that item 4.7 would be moved to earlier on the agenda, immediately following 4.1, to accommodate staff schedules. She also advised that at approximately 9:20 a.m., the Committee would take a short recess to allow attendees to attend the Middlesex-London Health Unit and Regional HIV/AIDS Connection announcement at 9:30 a.m. in the Middlesex County Building.

It was moved by Ms. Vanderheyden, seconded by Mr. Meyer, *that the amended **AGENDA** for the November 1, 2018 Finance & Facilities Committee meeting be approved.*

Carried

APPROVAL OF MINUTES

It was moved by Ms. Vanderheyden, seconded by Ms. Kasi, *that the **MINUTES** of the September 6, 2018 Finance & Facilities Committee meeting be approved.*

Carried

NEW BUSINESS

4.1 Q3 Financial Update and Factual Certificate (Report No. 038-18FFC)

Mr. Glasspoole introduced the report and provided additional context when necessary.

Discussion ensued on the following items:
• Limited revenue expected this year from oral health adult treatment.
• The technology budget, relating to a report reviewed by the FFC at its May 3 meeting.

It was moved by Ms. Kasi, seconded by Mr. Helmer, *that the Finance & Facilities Committee recommend that the Board of Health receive Report No. 038-18FFC re: "Q3 Financial Update and Factual Certificate" for information.*

Carried

It was moved by Ms. Kasi, seconded by Ms. Vanderheyden, *that the Finance & Facilities Committee recommend that the Board of Health approve the allocation of surplus to mitigate costs related to Relocation Project expenses and the Electronic Client Records project.*

Carried

4.2 Cyber Insurance (Report No. 039-18FFC)

Discussion ensued on the following items:
• Why the province isn't paying for all health units to be covered, and whether alPHa should be involved.
• Details on how the other two quotes compared to the one from Holman Insurance Brokers Ltd.

It was moved by Mr. Helmer, seconded by Ms. Vanderheyden, *that the Finance & Facilities Committee receive Report No. 039-18FFC re: "Cyber Insurance" for information.*

Carried

4.3 Location Project – Source of Financing (Report No. 040-18FFC)

Mr. Glasspoole noted that this was a fairly extensive process and highlighted some key points of the report. Ms. Di Cesare advised that the Province has been in contact and there is a meeting booked for next week.

Discussion ensued on the following items:
• Debt financing in general
• Clarification of the relationship between the Relocation Advisory Committee and the Finance & Facilities Committee.

It was moved by Mr. Meyer, seconded by Mr. Helmer, *that the Finance & Facilities Committee:*
1) *Receive Report No. 040-18FFC re: "Location Project – Source of Financing" for information; and*
2) *Recommend that the Board of Health approve the selection of the City of London as the lender for office fit-up.*

Carried

4.4 Enterprise Resource Planning – Financial System Update (Report No. 041-18FFC)

There was discussion about why the first round of requests for proposal (RFP) in 2017 yielded no bids. Mr. Belancic advised that it may have been the RFP's wording and/or the multiple requirements stipulated therein.

It was moved by Mr. Helmer, seconded by Mr. Meyer, *that the Finance & Facilities Committee receive Report No. 041-18FFC re: "Enterprise Resource Planning – Financial System Update" for information.*

Carried

4.5 Mobile Device Services Contract Extension (Report No. 042-18FFC)

There was a brief discussion about why this report is being called an "extension" when it appears to be a new contract. Mr. Belancic and Ms. Di Cesare provided additional context and noted that there will be cost savings, over the contract's two years, of approximately $31,000.

It was moved by Mr. Helmer, seconded by Mr. Meyer, *that the Finance & Facilities Committee receive Report No. 042-18FFC re: "Mobile Device Services Contract Extension" for information.*

Carried

4.6 Middlesex-London Health Unit Be Well Program Update (Report No. 043-18FFC)

It was moved by Mr. Meyer, seconded by Mr. Helmer, *that the Finance & Facilities Committee receive Report No. 043-18FFC re: "Middlesex-London Health Unit Be Well Program Update" for information.*

Carried

4.7 Proposed Resource Reallocation for the 2019 Budget (Report No. 044-18FFC)

Chair Fulton opened the floor to discussion, beginning with the subject of disinvestments.

Discussion ensued on the following disinvestment proposals:
• 1-001 reduction of staff for the Sexual Health Clinic. Mr. Turner assured the Committee that there should be no disruption to client services with the closure of the drop-in clinic. There will be a change in clinic hours, which will be communicated to clients.
• 1-004 Public Health Inspection Work. Mr. Turner noted that efficiencies have been found in the recommendations of the recent PHI review.
• Scoring was discussed briefly, including how the scores have changed since PBMA was introduced.

At 9:20 a.m., Chair Fulton asked for a motion to recess for the purpose of attending the MLHU/RHAC announcement. It was so moved by Mr. Meyer, seconded by Mr. Helmer.

Carried

At 9:57 a.m., Chair Fulton welcomed everyone back and asked for a motion to resume the meeting. It was so moved by Ms. Vanderheyden, seconded by Mr. Meyer. At this time, Ms. Cassidy joined the meeting and Chair Fulton provided her with an update on what had been covered on the agenda so far. Ms. Kasi did not return when the meeting reconvened.

Discussion ensued on the Electronic Client Records Investment Proposal. Mr. Turner noted that there is potential for bringing together public health, primary care, and acute care to allow for exchange of information across the healthcare system, but there are some logistical hurdles. The ECR that is noted here has the potential to allow health units to share data with each other. Mr. Clarke advised that Health Innovation funds are available, and that he will send the contact details to Mr. Turner for further exploration.

Discussion ensued on the following one-time investment proposals:
• 1-0024 Procurement Coordinator. Ms. Di Cesare provided additional details, noting that this position could be funded through savings and efficiencies in procurement process results, and that as such the recruitment process has begun.

• 1-0028 Vision Screening Coordinator. Ms. Rowlands advised that partnerships have been looked at and the Ivey Institute has offered free training. The Ministry has offered one-time funding for the purchase of equipment.

• 1-0035 Contract Epidemiologist. Dr. Summers noted that this extension is for the purpose of completing the Community Health Status Report. He mentioned that at this time he is not sure if a further extension will be required.

It was moved by Mr. Helmer, seconded by Ms. Kasi, *that the Finance & Facilities Committee approve Appendix A, PBMA Disinvestments totalling $390,727.*

Carried

It was moved by Mr. Helmer, seconded by Mr. Meyer, *that the Finance & Facilities Committee approve Appendix B, PBMA Investments totalling $397,526.*

Carried

It was moved by Ms. Vanderheyden, seconded by Mr. Helmer, *that the Finance & Facilities Committee approve Appendix C, PBMA One-Time Proposals totalling $140,784.*

Carried

It was moved by Mr. Meyer, seconded by Mr. Helmer, *that the Finance & Facilities Committee approve Appendix D, outlining proposals not currently recommended for inclusion totalling $631,732.*

Carried

4.8 Great-West Life Benefits Renewal Update (Report No. 045-18FFC)

It was moved by Mr. Helmer, seconded by Mr. Meyer, *that the Finance & Facilities Committee review and recommend that the Board of Health extend the current renewal period of the group insurance rates administered by Great-West Life as described in Report No. 045-18FFC re: "Great-West Life Benefits – Renewal Update."*

Carried

4.9 Enterprise Resource Planning – Human Capital Management Update (Report No. 046-18FFC)

Chair Fulton asked for Committee members to consider their questions vis a vis the potential need to go in camera.

Mr. Belancic advised that four bids have been received, which will be reviewed as soon as possible. In response to a question, Mr. Belancic noted that the contract would be for a minimum of five years and a maximum of ten, with an opt-out clause.

At 10:41 a.m., it was moved by Mr. Helmer, seconded by Mr. Meyer, *that the Finance & Facilities move in-camera to discuss matters regarding identifiable individuals.*

Carried

At 10:50 a.m., it was moved by Mr. Helmer, seconded by Mr. Meyer, *that the Finance & Facilities return to public session.*

Carried

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

1. *Receive Report No. 046-18FFC re: "Enterprise Resource Planning – Update" for information;*
2. *Recommend that the Board of Health approve the outsourcing of payroll services; and*
3. *Recommend that the Board of Health approve the implementation of a comprehensive Human Resource Capital Management System within the financial parameters identified herein.*

Carried

OTHER BUSINESS

Next meeting: December 6, 2018.

ADJOURNMENT

At 10:53 a.m., it was moved by Mr. Meyer, seconded by Mr. Helmer, *that the meeting be adjourned.*

Carried

At 10:53 a.m., Chair Fulton *adjourned the meeting*.

TRISH FULTON
Chair

LAURA DI CESARE
Director, Healthy Organization

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 001-19

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2019 January 24

ELECTION OF 2019 BOARD OF HEALTH EXECUTIVE AND OTHER PROCEDURES

Recommendations

It is recommended that the Board of Health:

1. ***Elect a Chair and a Vice-Chair for the current term;***
2. ***Appoint the Medical Officer of Health / Chief Executive Officer as Secretary-Treasurer for 2019;***
3. ***Recognize and appoint members to the Finance & Facilities Committee, the Governance Committee, and the Relocation Advisory Committee.***

Board Membership Update

The Board of Health consists of the following Members:

1. **Five (5) Provincial Appointees:** Ms. Trish Fulton, Mr. Ian Peer, Ms. Tino Kasi, Mr. Michael Clarke, (one Provincial vacancy)
2. **Three (3) City of London Appointees**: Ms. Maureen Cassidy, Ms. Elizabeth Peloza, and Mr. Matt Reid
3. **Three (3) Middlesex County Appointees:** Ms. Aina DeViet, Mr. John Brennan, and Ms. Kelly Elliott

The terms of Board of Health members can be found in Appendix A.

Procedures for the First Meeting of the Year

Bylaw No. 3 of the Board of Health regulates the proceedings of the Board. Section 18.0 of this Bylaw addresses Elections and the Appointment of Committees:

18.1 At the first meeting of each calendar year the Board shall elect by a majority vote a Chair, Vice- Chair, and Secretary-Treasurer for that year.

18.2 The Chair of the Board shall be selected for one year with a possible renewal of an additional year. The Chair shall rotate among the City, County and Provincial appointees.

18.3 The Vice-Chair and Secretary-Treasurer shall be elected for a one-year term.

18.4 The Secretary-Treasurer function is customarily performed by the Medical Officer of Health / Chief Executive Officer.

18.5 At the first meeting of each calendar year, the Board shall appoint the representative or representatives required to be appointed annually at the first meeting by the Board to other Boards, bodies, or commissions where appropriate.

18.6 The Board may appoint committees from time to time to consider such matters as specified by the Board (e.g., Finance and Facilities, Governance, etc.).

Election of Executive Officers

Chair: As per the current Bylaw No. 3, Section 18.2, as stated above, the Chair is elected for one year with a possible renewal of one additional year, and rotates among the three representative bodies. The Chair for 2018 was Ms. Joanne Vanderheyden, a Middlesex County appointee.

Vice-Chair: Bylaw No. 3, Section 18.3 stipulates that the Vice-Chair is elected for a one-year term. Ms. Trish Fulton, a Provincial appointee, was the 2018 Vice-Chair.

Secretary-Treasurer: Bylaw No. 3, Section 18.4 states that the Secretary-Treasurer function is customarily performed by the Medical Officer of Health / Chief Executive Officer.

Establishment of Standing Committees

In Section 1.3 (ii) of Board of Health Policy No. 1-010 (Structure and Responsibilities of the Board of Health), the Board determines whether it wishes to establish one or more Standing Committees at its first meeting of the year. In 2013, the Board of Health created the Finance & Facilities Committee, a standing committee that meets the first Thursday of each month and/or at the call of the Committee Chair. At its December 2013 meeting, the Board created the Governance Committee, a standing committee that has been meeting quarterly or at the call of the Committee Chair, immediately preceding the Board of Health meeting. At its September 2018 meeting, the Board created the Relocation Advisory Committee (RAC), which meets on an ad hoc basis or at the call of the Committee Chair, Mr. Ian Peer, who was appointed at the RAC's October 2018 meeting to serve until the committee ceases to exist.

1. Finance & Facilities Committee (Terms of Reference attached as Appendix B).

The membership of the Committee will consist of a total of five (5) voting members. The members will include the Chair and Vice-Chair of the Board of Health and in total, the membership will contain at least one Middlesex County Board Member, one City of London Board Member and two provincial Board Members.

2. Governance Committee (Terms of Reference attached as Appendix C)

The membership of the Committee will consist of a total of five (5) voting members. The members will include the Chair and Vice-Chair of the Board of Health and in total, at least one Middlesex County Board Member, one City of London Board Member and two provincial Board Members.

3. Ad Hoc Committee: Relocation Advisory Committee (The Terms of Reference attached as Appendix D)

The membership of the Committee will consist of a total of five (5) voting members. The members will include the Chair of the Board of Health and will contain at least one Middlesex County Board Member, one City of London Board Member and one provincial Board Member. Members will be selected notwithstanding their membership in any other standing committee. The Chair of the Relocation Advisory Committee (Mr. Ian Peer) was appointed at the first meeting and will serve until the committee ceases to exist. For clarity, all additional members of RAC, including the individual previously appointed (Mr. Michael Clarke), will be (re)appointed at the January Board of Health meeting.

All Board of Health members may attend the Finance & Facilities Committee, Governance Committee, and Relocation Advisory Committees meetings, but only Committee members can vote.

Meeting Schedule for 2019

The 2019 Proposed Meeting Schedule was sent electronically, on January 17, 2019, to all Board members for their review. This Schedule is attached as Appendix E for approval by the Board of Health.

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

This report addresses Bylaw #3 as outlined in the MLHU Administration Policy Manual.

MIDDLESEX-LONDON HEALTH UNIT

Middlesex London Board of Health

Appendix A to Report 001-19

Title	First Name	Last Name	Appointed By	First Appointed	Term Expires on
Ms.	Elizabeth	Peloza	City of London	December 1, 2018	November 15, 2022
Mr.	Matt	Reid	City of London (Citizen Appointee)	December 1, 2018	November 15, 2022
Ms.	Maureen	Cassidy	City of London	September 27, 2016	November 15, 2022
Mr.	John	Brennan	County of Middlesex	December 18, 2018	November 30, 2022
Ms.	Kelly	Elliott	County of Middlesex	December 18, 2018	November 30, 2022
Ms.	Aina	DeViet	County of Middlesex	December 18, 2018	November 30, 2022
Ms.	Tino	Kasi	Province of Ontario	November 2, 2016	November 1, 2019
Mr.	Ian	Peer	Province of Ontario	November 14, 2012	November 13, 2019
Ms.	Patricia	Fulton	Province of Ontario	January 9, 2013	January 8, 2020
Mr.	Michael	Clarke	Province of Ontario	March 1, 2017	February 29, 2020

Last updated 1/15/2019

MIDDLESEX-LONDON HEALTH UNIT
www.healthunit.com

Appendix C
Policy G-290

FINANCE & FACILITIES COMMITTEE
TERMS OF REFERENCE

PURPOSE

The committee serves to provide an advisory and monitoring role. The committee's role is to assist and advise the Board of Health, the Medical Officer of Health /Chief Executive Officer (MOH / CEO), and the Manager, Finance in the administration and risk management of matters related to the finances and facilities of the organization.

REPORTING RELATIONSHIP

The Finance & Facilities Committee is a committee reporting to the Board of Health of the Middlesex-London Health Unit. The Chair of the Finance & Facilities Committee, with the assistance of the Manager, Finance and the MOH / CEO, will make reports to the Board of Health as a whole following each of the meetings of the Finance & Facilities Committee.

MEMBERSHIP

The membership of the Committee will consist of a total of five (5) voting members. The members will include the Chair and Vice-Chair of the Board of Health and in total, the membership will contain at least one Middlesex County Board Member, one City of London Board Member and two provincial Board Members.

The Secretary-Treasurer will be an ex-officio non-voting member.

Staff support includes:

- Director, Corporate Services;
- Manager, Finance; and
- Executive Assistant to the Board of Health and Communications or the Executive Assistant to the Medical Officer of Health depending on availability.

Other Board of Health members are able to attend the Finance & Facilities Committee but are not able to vote.

CHAIR

The Finance & Facilities Committee will elect a Chair at the first meeting of the year to serve for a one or two-year term. The Chair of the Committee may be appointed for additional terms following the completion of an appointment to enhance continuity of the Committee.

TERM OF OFFICE

At the first Board of Health meeting of the year the Board will review the committee membership. At this time, if any new appointments are required, the position(s) will be filled by majority vote. The appointment will be for at least one year, and where possible, staggered terms will be maintained to ensure a balance of new and continuing members. A member may serve on the committee as long as he or she remains a Board of Health member.

DUTIES

The Committee will seek the assistance of and consult with the MOH / CEO, the Director, Corporate Services and the Manager, Finance for the purposes of making recommendations to the Board of Health on the following matters:

1. Reviewing detailed financial statements and analyses.
2. Reviewing the annual cost-shared and 100% funded program budgets, for the purposes of governing the finances of the Health Unit.
3. Reviewing the annual financial statements and auditor's report for approval by the Board.
4. Reviewing annually the types and amounts of insurance carried by the Health Unit.
5. Reviewing periodically administrative policies relating to the financial management of the organization, including but not limited to, procurement, investments, and signing authority.
6. Monitoring the Health Unit's physical assets and facilities.
7. Reviewing annually all service level agreements.
8. Reviewing all funding agreements.
9. Review governance-related financial policies.
10. Enquire into the financial risks faced by the organization, and the appropriateness of related controls to minimize their potential impact.

FREQUENCY OF MEETINGS

The Committee will meet monthly between Board of Health meetings, if a meeting is deemed to be not required it shall be cancelled at the call of the Chair of the Committee.

AGENDA & MINUTES

1. The Chair of the committee, with input from the Manager, Finance and the Medical Officer of Health & Chief Executive Officer (MOH / CEO), will prepare agendas for regular meetings of the committee.
2. Additional items may be added at the meeting if necessary.
3. The recorder is the Executive Assistant to the Board of Health and Communications.
4. Agenda & minutes will be made available at least 5 days prior to meetings.
5. Agenda & meeting minutes are provided to all Board of Health members.

BYLAWS:

As per Section 19.1 of Board of Health By-Law No. 3, the rules governing the proceedings of the Board shall be observed in the Committees insofar as applicable. This will include rules related to conducting of meetings; decision making; quorum and self-evaluation.

REVIEW

The terms of reference will be reviewed every 2 (two) years.

Implementation Date: June 20, 2013
Revision Date: April 7, 2016

MIDDLESEX-LONDON HEALTH UNIT
www.healthunit.com

Appendix A
Policy G-290

GOVERNANCE COMMITTEE

TERMS OF REFERENCE

PURPOSE

The committee serves to provide an advisory and monitoring role. The committee's role is to assist and advise the Board of Health, the Medical Officer of Health / Chief Executive Officer (MOH / CEO), and the Director, Healthy Organization in the administration and risk management of matters related to Board membership and recruitment, Board self-evaluation and governance policy.

REPORTING RELATIONSHIP

The Governance Committee is a committee reporting to the Board of Health of the Middlesex-London Health Unit. The Chair of the Governance Committee, with the assistance of the Director, Corporate Services and the MOH / CEO, will make reports to the Board of Health as a whole following each of the meetings of the Governance Committee.

MEMBERSHIP

The membership of the Committee will consist of a total of five (5) voting members. The members will include the Chair and Vice-Chair of the Board of Health and in total, the membership will contain at least one Middlesex County Board Member, one City of London Board Member and two provincial Board Members.

The Secretary-Treasurer will be an ex-officio non-voting member.

Staff support includes:

- Director, Healthy Organization;
- Executive Assistant to the Board of Health and Communications or the Executive Assistant to the Medical Officer of Health depending on availability; and
- Manager, Strategic Projects.

Other Board of Health members are able to attend the Governance Committee but are not able to vote.

CHAIR

The Governance Committee will elect a Chair at the first meeting of the year to serve for a one or two-year term. The Chair of the Committee may be appointed for additional terms following the completion of an appointment to enhance continuity of the Committee.

TERM OF OFFICE

At the first Board of Health meeting of the year the Board will review the committee membership. At this time, if any new appointments are required, the position(s) will be filled by majority vote. The appointment will be for at least one year, and where possible, staggered terms will be maintained to ensure a balance of new and continuing members. A member may serve on the committee as long as he or she remains a Board of Health member.

DUTIES

The Committee will seek the assistance of and consult with the MOH / CEO and the Director, Healthy Organization for the purposes of making recommendations to the Board of Health on the following matters:

1. Assist with the recruitment of suitable Board members.
2. Oversee Board member succession planning and make recommendations regarding recruitment of new Board members.
3. Provide advice regarding orientation and training of Board members.
4. Direct and oversee the assessment of the Board and Board committees and make recommendations to the Board regarding ways in which governance performance and contributions can be enhanced.
5. Oversee performance indicators that are reported to the Board and provide advice regarding the biennial Board retreat.
6. Compliance with the Board of Health Code of Conduct.
7. Performance evaluation of the MOH / CEO.
8. Governance policy and by-law review and development.
9. Compliance with the Organizational Standards.
10. Strategic Planning.
11. Review and make recommendations on the direction of the Privacy program.
12. Review and make recommendations on the direction of the Risk Management program.
13. Advise the Board on implications of significant developments in privacy legislation.
14. Review the annual privacy report.
15. Oversee the principles of the recruitment/retention strategy for employees.
16. Provide oversight related to occupational health and safety.

FREQUENCY OF MEETINGS

The Committee will meet quarterly or at the call of the Chair of the Committee.

AGENDA & MINUTES

1. The Chair of the committee, with input from the Director, Healthy Organization and the MOH / CEO, will prepare agendas for regular meetings of the committee.
2. Additional items may be added at the meeting if necessary.
3. The recorder is the Executive Assistant to the Board of Health.
4. Agenda & minutes will be made available at least 5 days prior to meetings.
5. Agenda & meeting minutes are provided to all Board of Health members.

BYLAWS:

As per Section 19.1 of Board of Health By-Law No. 3, the rules governing the proceedings of the Board shall be observed in the Committees insofar as applicable. This will include rules related to conducting of meetings; decision making; quorum and self-evaluation.

REVIEW

The terms of reference will be reviewed every 2 (two) years.

Implementation Date: June 20, 2013
Revision Date: April 21, 2016

RELOCATION ADVISORY AD HOC COMMITTEE

PURPOSE

The committee serves to provide an advisory and monitoring role. The committee's role is to assist and advise the Board of Health, the Medical Officer of Health / Chief Executive Officer (MOH / CEO), and the Director, Healthy Organization in the administration and risk management of matters related to the design, build, move and commissioning of the new location.

REPORTING RELATIONSHIP

The new Relocation Advisory Committee is an ad hoc committee reporting to the Board of Health of the Middlesex-London Health Unit. The Chair of the Relocation Advisory Committee, with the assistance of the Director, Healthy Organization and the MOH / CEO, will make reports to the Board of Health as a whole following each of the meetings.

MEMBERSHIP

The membership of the Committee will consist of a total of five (5) voting members. The members will include the Chair of the Board of Health and will contain at least one Middlesex County Board Member, one City of London Board Member and one provincial Board Member. Members will be selected notwithstanding their membership in any other standing committee.

The Secretary-Treasurer will be an ex-officio non-voting member.

Staff support include:

- Director, Healthy Organization;
- Executive Assistant to the Board of Health and Communications Coordinator or the Executive Assistant to the Medical Officer of Health depending on availability; and
- Manager, Strategic Projects
- Manager, Procurement and Operations

Other Board of Health members are invited to attend the Relocation Advisory Committee but do not hold voting rights.

CHAIR

The Relocation Advisory Committee will elect a Chair at the first meeting to serve until the committee ceases to exist.

DUTIES

The Committee will seek the assistance of and consult with the MOH / CEO and the Director, Healthy Organization for the purposes of providing oversight and making recommendations to the Board of Health on the following matters:

1. Reviewing proposals for the allocation of funds and resources in relation to the Location Project.
2. Monitoring the Health Unit's physical assets and facilities in relation to the Location Project.

RELOCATION ADVISORY AD HOC COMMITTEE

3. Reviewing all funding agreements related to the Location Project.
4. Reviewing governance-related policies impacted by the Location Project.
5. Enquiring into the financial and reputational risks faced by the organization related to the design, build, move and commissioning of the new facility and the appropriateness of related controls to minimize their potential impact.
6. Reviewing variances in overall project timelines greater than 1 month.
7. Reviewing negative variances in approved budgets of greater than 15%.
8. Receiving updates from Architect and Construction Project Manager.

FREQUENCY OF MEETINGS

The Committee will meet at the call of the Chair of the Committee.

AGENDA & MINUTES

1. The Chair of the committee, with input from the Director, Healthy Organization and the MOH / CEO, will prepare agendas for regular meetings of the committee.
2. Additional items may be added at the meeting if necessary.
3. The recorder is the Executive Assistant to the Board of Health and Communications Coordinator.
4. Agenda & minutes will be made available at least 5 days prior to meetings.
5. Agenda & meeting minutes are provided to all Board of Health members.

BYLAWS:

As per Section 19.1 of Board of Health By-Law No. 3, the rules governing the proceedings of the Board of Health shall be observed in the Committees insofar as applicable. This will include rules related to conducting of meetings; decision making; quorum and self-evaluation.

Implementation Date: October 1, 2018

2019 DRAFT Board of Health, Governance Committee and Finance & Facilities Committee Meeting Dates

2019 DRAFT Board of Health and Governance Committee Meeting Dates

Thurs. Jan. 24	Board of Health - 7:00 p.m.	
Thurs. Feb. 21	Board of Health - 7:00 p.m.	
Thurs. Mar. 21	Board of Health - 7:00 p.m.	*Governance Committee - 6:00 p.m.
Thurs. April 18	Board of Health - 7:00 p.m.	
Thurs. May 16	Board of Health - 7:00 p.m.	
Thurs. June 20	Board of Health - 7:00 p.m.	*Governance Committee - 6:00 p.m.
Thurs. July 18	Board of Health - 7:00 p.m.	
Thurs. Aug. 15	Board of Health - 7:00 p.m.	*This meeting is usually cancelled
Thurs. Sept. 19	Board of Health - 7:00 p.m.	*Governance Committee - 6:00 p.m.
Thurs. Oct. 17	Board of Health - 7:00 p.m.	
Thurs. Nov. 21	Board of Health - 7:00 p.m.	*Governance Committee - 6:00 p.m.
Thurs. Dec 12	Board of Health - 7:00 p.m.	

2019 DRAFT FFC Meeting Dates

Thurs. Feb 7	Finance and Facilities Committee - 9:00 a.m. - 12 noon
Thurs. Feb 14	Finance and Facilities Committee - 9:00 a.m. - 12 noon
Thurs. Mar 7	Finance and Facilities Committee - 9:00 a.m. - 12 noon
Thurs. Apr 4	Finance and Facilities Committee - 9:00 a.m. - 12 noon
Thurs. May 2	Finance and Facilities Committee - 9:00 a.m. - 12 noon
Thurs. June 6	Finance and Facilities Committee - 9:00 a.m. - 12 noon
Thurs. July 4	Finance and Facilities Committee - 9:00 a.m. - 12 noon
Thurs. Aug 1	*This meeting is usually cancelled
Thurs. Sept 5	Finance and Facilities Committee - 9:00 a.m. - 12 noon
Thurs. Oct 3	Finance and Facilities Committee - 9:00 a.m. - 12 noon
Thurs. Nov 7	Finance and Facilities Committee - 9:00 a.m. - 12 noon
Thurs. Dec 5	Finance and Facilities Committee - 9:00 a.m. - 12 noon

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 002-19

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2019 January 24

DIVERSITY AND INCLUSION ASSESSMENT

Recommendation

It is recommended that the Board of Health:

1) ***Receive Report No. 002-19 re "Diversity and Inclusion Assessment" for information;***
2) ***Approve entering into a contract with Turner Consulting Group for the purpose of MLHU's Diversity and Inclusion Assessment.***

Key Points

- Conducting a diversity and inclusion assessment in 2019 is one of MLHU's strategic priorities.
- Using established criteria, the internal Diversity and Inclusion Advisory Committee reviewed all applications submitted against the published Request for Proposals.
- A strong applicant has been recommended, with a proposed budget of $68,900. This is substantially more than was allocated.

Background

Health equity is a foundational value for MLHU, and is a focus in the current strategic plan; diversity and inclusion is a fundamental concept within health equity. Public health's mandate for health equity is primarily focused on clients, families, communities, populations, and systems. The senior leadership team recognizes the need to understand existing diversity in the organization, as well as employees' experience of inclusion within the workplace. Diversity strengthens a workplace, and inclusion ensures a positive work environment that maximizes outcomes.

Diversity and Inclusion Assessment

As a first step in the agency's Diversity and Inclusion Assessment, being led by the Health Equity Core Team in consultation with Human Resources and with input from an agency-wide advisory group, a Request for Proposals was published to identify an ideal third party to conduct an organizational diversity and inclusion assessment and to identify recommended areas for action. This project intends to:

- Assess the composition of the current workforce and how employees self-identify;
- Assess the need for revision and/or development of current and/or future policies and practices that foster an equity–oriented and inclusive workplace culture;
- Describe and understand the experiences and expectations of diverse groups within the workplace as it relates to inclusion, access, equity, engagement, and eliminating discriminatory practices; and
- Develop recommendations which will inform efforts to further create an equity-oriented and inclusive workplace culture that prevents and responds to the existence of discrimination and oppression to engage, encourage and support all employees to realize their full potential within the workplace.

Responses to the Published Request for Proposals

Seven proposals were received at the close of the RFP on December 20th. Two of the proposals were assessed as incomplete. The proposed work ranged from insufficiently meeting the scope as outlined in the RFP, to providing services beyond what was requested. Proposed budgets ranged from $19,040 to $91,000. A budget was not included in the RFP, however these budgets were all higher than what was allocated. Total scores received through the proposal evaluation process ranged from 176 to 341. Turner Consulting Group is recommended by the internal Diversity and Inclusion Advisory Group. They achieved the high score of 341, and provided a bid of $68,900. All committee members agreed that the applicant clearly demonstrated distinction and will offer good value.

The completed assessment and resulting recommendations will be brought forward to the Board for approval.

Conclusion / Next Steps

This inaugural diversity and inclusion assessment at MLHU is expected to strengthen the workplace and ensure a positive and inclusive workplace environment that maximizes outcomes. If this vendor is approved, staff will move forward with securing a contract, and the assessment process will be promptly initiated.

This report was prepared by the Office of the Chief Nursing Officer and the Healthy Organization Division.

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

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 003-19

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2019 January 24

RELOCATION PROJECT UPDATE

Recommendation

It is recommended that the Board of Health:

1) ***Receive Report No. 003-19 re: "Relocation Project Update"; and***
2) ***Recommend that the Board of Health authorize the Medical Officer of Health to provide notice to the current landlords to terminate leases at 50 King Street and 201 Queens Avenue once the date of completion of the future landlord's work is known.***

Key Points

- Lease agreements for properties at 50 King Street and 201 Queens Avenue include 12-month early termination clauses.
- An updated project plan (Appendix A) indicates the proposed move in date to Citi Plaza to occur in the first quarter of 2020.
- Authorizing the Medical Officer of Health to provide written notice to the property owners as soon as the end date of the landlord's work is known will allow the flexibility needed to adapt in this evolving situation.

Background

In 2016 the Middlesex-London Health Unit (MLHU) renewed its lease agreements with the property owners of 50 King Street and 201 Queens Avenue. The current lease agreements contain an early termination clause whereby the tenant (MLHU) is required to provide 12-months written notice to the landlord to terminate the lease. In preparation for the relocation to Citi Plaza, MLHU is required to provide written notice to both the Corporation of the County of Middlesex and the Richmond Block London Corporation of its intent to terminate the lease agreements.

Notice to the Landlord

In the lease agreement with Citi Plaza, the Health Unit was able to negotiate an 8-month fixturing period, which begins at the completion of the landlord's work. It would be the intention of the Health Unit to give notice when it has been confirmed that the landlord has 4 months left on their work schedule. On January 18, 2019, staff received an updated project plan (Appendix A) from Endri Poletti Architect (EPA) Inc. According to the detailed plans the expected move date to Citi Plaza occurs in the first quarter of 2020. In order to meet the terms of the lease agreements, MLHU proposes that property owners of 50 King Street and 201 Queens Avenue be provided written notice as soon as possible once the landlord confirms they have four months of work left.

Next Steps

It is recommended that the Board of Health authorize the Medical Officer of Health to give official notice to property owners at 50 King Street and 201 Queens Ave activating the 12-month exit clause requirement once the date of completion of the future landlord's work is known.

This report was prepared by the Healthy Organization Division.

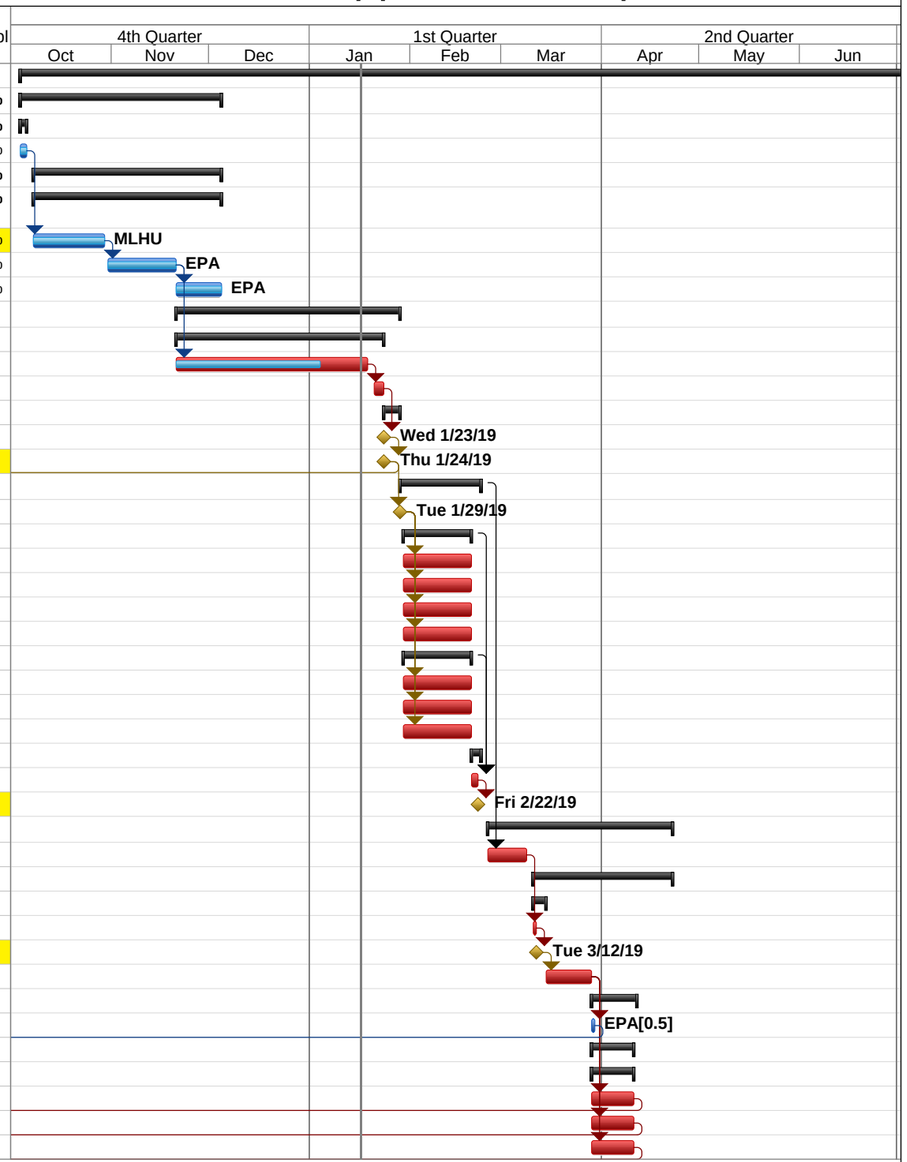
Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health / CEO

EPA
EMORE POLETTI ARCHITECTS INC.

MLHU Project Design Schedule

Appendix A Report 003-19

ID	Task Name	Duration	Start	Finish	Resource Names	Predecessors	% Compl
1	**MLHU - FIRST AND SECOND FLOOR**	**314 days**	**Thu 10/4/18**	**Thu 12/26/19**			**15%**
2	**PLANNING AND EVALUATION**	**44 days**	**Thu 10/4/18**	**Tue 12/4/18**			**100%**
3	**Analyze Clients Requirements**	**2 days**	**Thu 10/4/18**	**Fri 10/5/18**			**100%**
4	analysis of existing fuctional programing document	2 days	Thu 10/4/18	Fri 10/5/18			100%
5	**Functional Programming**	**42 days**	**Mon 10/8/18**	**Tue 12/4/18**			**100%**
6	**Analysis of Space Requirements & meeting with each department**	**42 days**	**Mon 10/8/18**	**Tue 12/4/18**			**100%**
7	Project Set Up - Data Gathering & Site Visits	16 days	Mon 10/8/18	Mon 10/29/18	MLHU	4	100%
8	Team Meetings	15 days	Wed 10/31/18	Tue 11/20/18	EPA	7	100%
9	Analysis of Space Requirements	10 days	Wed 11/21/18	Tue 12/4/18	EPA	8	100%
10	**PRELIMINARY DESIGN**	**42 days**	**Wed 11/21/18**	**Mon 1/28/19**			**60%**
11	**Prepare schematic design documents**	**39 days**	**Wed 11/21/18**	**Wed 1/23/19**			**65%**
12	Schematic Plans and Review w/ client	36 days	Wed 11/21/18	Fri 1/18/19	EPA	8	70%
13	Final Floor plans	3 days	Mon 1/21/19	Wed 1/23/19	EPA	12	0%
14	**Review**	**3 days**	**Wed 1/23/19**	**Mon 1/28/19**			**0%**
15	Submit Schematics to client for review	0 days	Wed 1/23/19	Wed 1/23/19	EPA	13	0%
16	Obtain written approval for design development	3 days	Thu 1/24/19	Mon 1/28/19	MLHU	15	0%
17	**DETAILED DESIGN DEVELOPMENT**	**19 days**	**Tue 1/29/19**	**Fri 2/22/19**			**0%**
18	Review Program w/ consultants	1 day	Tue 1/29/19	Tue 1/29/19	EPA	16	0%
19	**Detailed document development**	**15 days**	**Wed 1/30/19**	**Tue 2/19/19**			**0%**
20	Architectural	15 days	Wed 1/30/19	Tue 2/19/19	EPA[0.5]	18	0%
21	Mechanical	15 days	Wed 1/30/19	Tue 2/19/19	S+A[0.25]	18	0%
22	Electrical	15 days	Wed 1/30/19	Tue 2/19/19	S+A[0.25]	18	0%
23	Structural	15 days	Wed 1/30/19	Tue 2/19/19	DC BUCK	18	0%
24	**Develop Preliminary Specifications**	**15 days**	**Wed 1/30/19**	**Tue 2/19/19**			**0%**
25	Architectural	15 days	Wed 1/30/19	Tue 2/19/19	EPA[0.5]	18	0%
26	Mechanical	15 days	Wed 1/30/19	Tue 2/19/19	S+A[0.25]	18	0%
27	Electrical	15 days	Wed 1/30/19	Tue 2/19/19	S+A[0.25]	18	0%
28	**Review**	**3 days**	**Wed 2/20/19**	**Fri 2/22/19**			**0%**
29	Submit Schematics to client for review	2 days	Wed 2/20/19	Thu 2/21/19	EPA	19,24	0%
30	Obtain written approval for design development	1 day	Fri 2/22/19	Fri 2/22/19	MLHU	29	0%
31	**CONTRACT DOCUMENT PHASE**	**41 days**	**Mon 2/25/19**	**Mon 4/22/19**			**0%**
32	Contract documents	10 days	Mon 2/25/19	Fri 3/8/19	EPA[0.34],S+A[0.33],DC BUCK[0.33]	17	0%
33	**Quality Control - Establish review dates**	**31 days**	**Mon 3/11/19**	**Mon 4/22/19**			**0%**
34	**60% review with consultants**	**4 days**	**Mon 3/11/19**	**Thu 3/14/19**			**0%**
35	meeting with consultants	1 day	Mon 3/11/19	Mon 3/11/19	EPA	32	0%
36	Presentation to SLT - Obtain Design Approval	3 days	Tue 3/12/19	Thu 3/14/19	MLHU	35	0%
37	Implement 60% CD Review and Continue Development	10 days	Fri 3/15/19	Thu 3/28/19	EPA[0.34],S+A[0.33],DC BUCK[0.33]	36	0%
38	**90% review with consultants**	**10 days**	**Fri 3/29/19**	**Thu 4/11/19**			**0%**
39	Meeting with consultants (A,MEP AND SPECS & FINISHES)	1 day	Fri 3/29/19	Fri 3/29/19	EPA[0.5]	37	0%
40	**Specifications**	**9 days**	**Fri 3/29/19**	**Wed 4/10/19**			**0%**
41	**Prepare and assemble specification**	**9 days**	**Fri 3/29/19**	**Wed 4/10/19**			**0%**
42	Architectural	9 days	Fri 3/29/19	Wed 4/10/19	EPA[0.5]	37	0%
43	Mechanical	9 days	Fri 3/29/19	Wed 4/10/19	S+A[0.5]	37	0%
44	Electrical	9 days	Fri 3/29/19	Wed 4/10/19	S+A[0.5]	37	0%

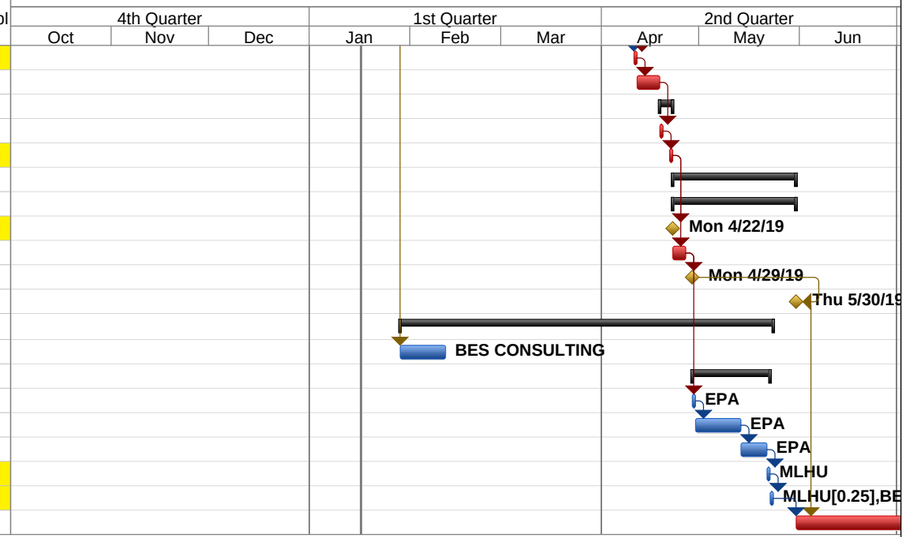


Project: 1715-2019-01-16-MLHU-Singu
Date: Thu 1/17/19

Task	External Tasks	Manual Task	Finish-only	Critical Split	
Split	External MileTask	Duration-only	Path Successor Milestone Task	Progress	
Milestone	Inactive Task	Manual Summary Rollup	Path Successor Summary Task	Split	
Summary	Inactive Milestone	Manual Summary	Path Successor Normal Task		
Project Summary	Inactive Summary	Start-only	Critical		

Appendix A Report No. 003-19

ID	Task Name	Duration	Start	Finish	Resource Names	Predecessors	% Compl
45	meeting with Owner	1 day	Thu 4/11/19	Thu 4/11/19	MLHU	39,42,43,44	0%
46	Implement 90% CD Review and Continue Development	5 days	Fri 4/12/19	Thu 4/18/19	EPA[0.34],S+A[0.33],DC BUCK[0.33]	45	0%
47	**100% review with consultants**	**2 days**	**Fri 4/19/19**	**Mon 4/22/19**			**0%**
48	meeting with consultants	1 day	Fri 4/19/19	Fri 4/19/19	EPA[0.34],S+A[0.33],DC BUCK[0.33]	46	0%
49	meeting with Owner	1 day	Mon 4/22/19	Mon 4/22/19	MLHU	48	0%
50	**PERMITTING PHASE**	**28 days**	**Mon 4/22/19**	**Thu 5/30/19**			**0%**
51	**Obtain client written authorization**	**28 days**	**Mon 4/22/19**	**Thu 5/30/19**			**0%**
52	MLHU - Client Authorization for Building Permit Submission	0 days	Mon 4/22/19	Mon 4/22/19	MLHU	49	0%
53	Prepare Material for Permit and Tender	4 days	Tue 4/23/19	Fri 4/26/19	EPA	49	0%
54	To submit drawings for building permit and get approval	24 days	Mon 4/29/19	Thu 5/30/19	EPA	53	0%
55	Building Permit Received	0 days	Thu 5/30/19	Thu 5/30/19	EPA	54FF	0%
56	**TENDERING PHASE**	**83 days**	**Tue 1/29/19**	**Thu 5/23/19**			**0%**
57	Pre- Qualification	10 days	Tue 1/29/19	Mon 2/11/19	BES CONSULTING	16	0%
58	**Distribution of Bidding and Proposal Documents**	**18 days**	**Mon 4/29/19**	**Wed 5/22/19**			**0%**
59	Distribute documents to GCs	1 day	Mon 4/29/19	Mon 4/29/19	EPA	53	0%
60	Bidding	10 days	Tue 4/30/19	Mon 5/13/19	EPA	59	0%
61	Bid and Proposal evaluation	6 days	Tue 5/14/19	Tue 5/21/19	EPA	60	0%
62	Contract sign GC	1 day	Wed 5/22/19	Wed 5/22/19	MLHU	61	0%
63	GC kick Off Meeting	1 day	Thu 5/23/19	Thu 5/23/19	MLHU[0.25],BES CONSULTING[0.25	62	0%
64	CONTRACT ADMINISTRATION	7.5 mons	Fri 5/31/19	Thu 12/26/19	BES CONSULTING[0.5],EPA[0.5]	63,55	0%



Project: 1715-2019-01-16-MLHU-Singu
Date: Thu 1/17/19

Task	External Tasks	Manual Task	Finish-only	Critical Split
Split	External MileTask	Duration-only	Path Successor Milestone Task	Progress
Milestone	Inactive Task	Manual Summary Rollup	Path Successor Summary Task	Split
Summary	Inactive Milestone	Manual Summary	Path Successor Normal Task	
Project Summary	Inactive Summary	Start-only	Critical	

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 004-19

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2019 January 24

ACTIVE TUBERCULOSIS IN A SHELTER

Recommendation

It is recommended that Report No. 004-19 re: "Active Tuberculosis in a Shelter" be received for information.

Key Points

- On December 13, 2018, MLHU received a report of a case of active pulmonary tuberculosis (TB) who had been living in the City of London shelter system since 2017. Early investigations determined that this individual was highly infectious, with a long period of communicability.
- In response, the IDC Team is currently completing a comprehensive contact investigation, supported by local and provincial partners.
- Individuals who are homeless and/or under-housed remain vulnerable to myriad communicable diseases, including tuberculosis, hepatitis A, and invasive Group A streptococcal disease.

Background

The Infectious Disease Control (IDC) Team monitors and responds to reports of active and latent tuberculosis (TB) in the community. TB infection is caused by the *Mycobacterium tuberculosis* bacteria complex. People with pulmonary and laryngeal TB can spread the bacteria through coughing, sneezing, or talking. The small bacteria can linger in the air for an extended period of time and be transmitted to others who share the same airspace.

Those who are exposed to the bacteria can develop latent infection (LTBI) or active disease. People with LTBI have no signs or symptoms and cannot spread TB to others. However, some people with LTBI may develop active TB and become infectious to others. People with active TB disease are sick and can develop respiratory disease, with symptoms such as cough, fever, chills, and night sweats. Although TB can also occur in other parts of the body, only respiratory TB can be spread from person to person.

The Middlesex-London region has had 7 to 18 active TB cases per year since 2015. These cases occur almost exclusively among newcomers to Canada who were exposed to TB in a different country.

Type	**2015**	**2016**	**2017**	**2018**
Active	18	8	7	12
Suspect	28	36	39	51

When a case of active respiratory TB is reported to the Middlesex-London Health Unit (MLHU), the IDC Team attempts to identify and screen all susceptible contacts for active and latent disease. Treatment with antibiotics is provided, and in this way the ongoing spread of tuberculosis in the community is controlled.

Case of TB in Shelter System

On December 13, 2018, the IDC Team received a report from the London Health Sciences Centre (LHSC) identifying a hospitalized individual with active pulmonary TB who had been living in the City of London shelter system since 2017. Early investigations determined that this individual was highly infectious, with a period of communicability from June 1 to December 13, 2018.

People who are under-housed or homeless are at higher risk of exposure to TB. Transmission of the bacteria occurs more easily in communal and congested living spaces, such as shelters. Additionally, poor nutrition and other stressors increase susceptibility. In such locations, it is more difficult to identify who exactly is at risk and, as a result, a more generalized approach must be taken to ensure comprehensive screening for disease. In this situation, all those who stayed in the shelter system during the period of communicability are considered to be at risk. Those who shared a sleeping space with the case are considered to be at higher risk and are of greatest priority for screening.

In collaboration with shelter staff and administrators, IDC staff initiated screening in December for both active and latent TB. Residents with symptoms consistent with potential active TB were asked to provide sputum samples and undergo a chest x-ray. All residents were eligible for screening. Traditional screening consists of a tuberculin skin test (TST). The TST is of limited use in this population because it requires the client to return for interpretation within 48–72 hours, and individuals in this population have had historically low rates of return. An alternative screening test is a blood test called an Interferon Gamma Release Assay (IGRA). This test is not publicly funded. Initially, only TSTs were available as a screening tool; however, as anticipated, only a small number of those screened (16 of 47) returned to have their results interpreted. Henceforth, LTBI screening will be completed using the IGRA blood test, in partnership with a local lab.

Next Steps

MLHU has communicated the situation to its provincial partners, including the Ministry of Health and Long-Term Care (MOHLTC) and Public Health Ontario (PHO). MLHU has requested and received approval from the Chief Medical Officer of Health to access rifapentine via the Drugs for an Urgent Public Health Need pathway. This newer TB medication, when administered with isoniazid, can be given once weekly for twelve weeks in treating LTBI. It is as effective as the standard nine-month daily treatment of monotherapy isoniazid, and results in a higher treatment completion rate.

Screening clinics will be held in the shelters throughout January 2019. All additional cases of active or latent TB will be referred to a local respirologist for assessment and treatment. Hepatitis A vaccine will also be offered at the screening clinics as part of the ongoing effort to address that.

This situation highlights the fact that individuals who are homeless and/or under-housed remain vulnerable to myriad communicable diseases, including tuberculosis, hepatitis A, and invasive Group A streptococcal disease.

This report was prepared by the Infectious Disease Team (Appendix A), the Environmental Health and Infectious Diseases Division, and the Associate Medical Officer of Health.

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

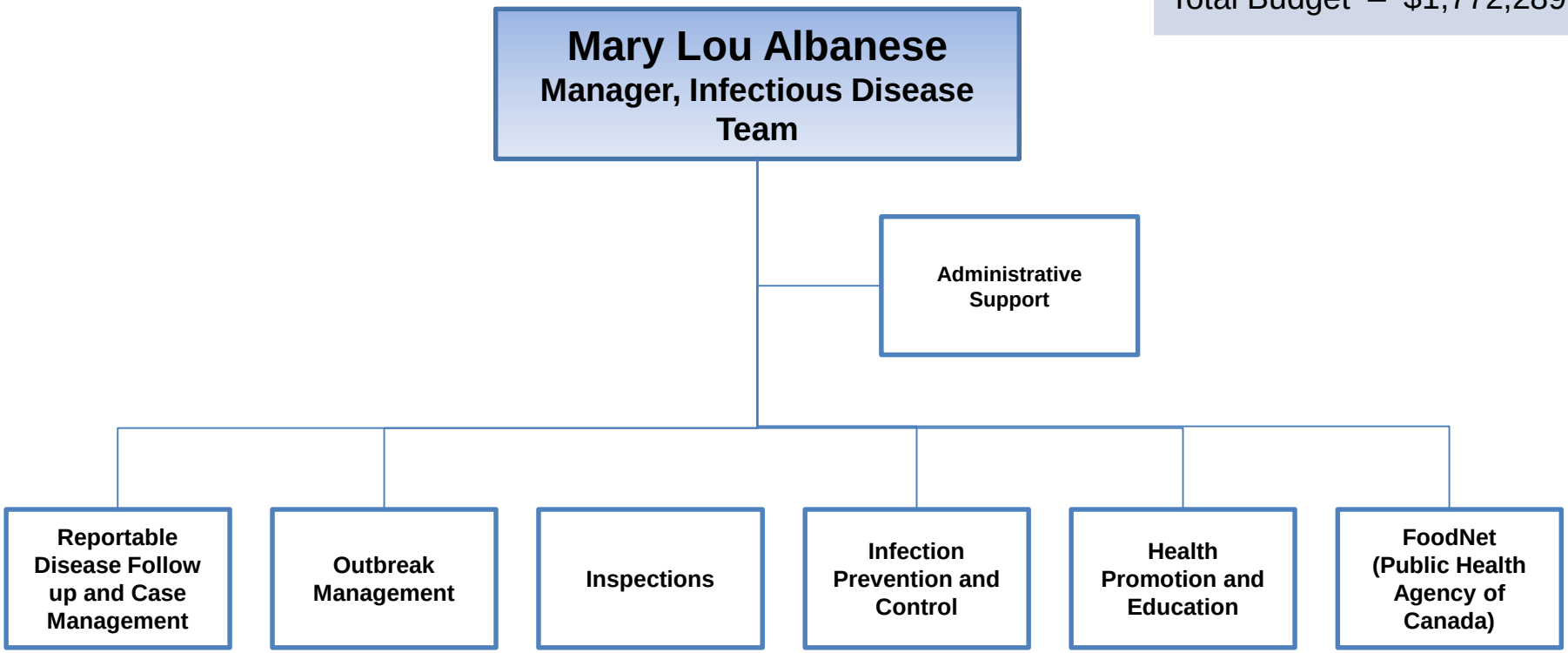
Environmental Health and Infectious Disease
Infectious Disease Control Team

Appendix A to Report No. 004-19

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

Total FTEs – 16.00 FTEs

Total Budget – $1,772,289



Program Highlights:

- There are 55 reportable diseases managed by team with PHI's primarily investigating enteric disease (salmonella, Ecoli, Giardia) and PHNs investigating diseases such as tuberculosis, vaccine preventable diseases, hepatitis A etc.
- Daily staff respond to questions that come in via intake line, email and by social media
- Facilities are inspected to prevent food borne illnesses e.g. Long term care kitchens and infectious diseases e.g. child care facilities and Personal Services Settings (hair, nail salons, barber shops, tattoo shops); vaccine fridges inspection to ensure cold chain is maintained and investigate reported breaches
- Work with retirement homes, long term care homes, child care facilities and school to prevent and manage outbreaks such as influenza. All staff respond to community wide outbreaks e.g. invasive Group A Strep., hepatitis A
- All complaints regarding the infection control practices of any location in Middlesex and London are investigated e.g. dental office, medical clinic, floatation tubs

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 005-19

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health /CEO

DATE: 2019 January 24

STRATEGY TO ADDRESS THE HIV OUTBREAK AND RELATED ISSUES IN LONDON: AN UPDATE

Recommendation

It is recommended that the Board of Health receive Report No. 005-19 re: "Strategy to Address the HIV Outbreak and Related Issues in London: An Update" for information.

Key Points

- The HIV Leadership Team has implemented recommendations to increase access to harm reduction supplies and to improve treatment pathways for at-risk and HIV-positive clients.
- Since the implementation of the Outreach Team in mid-2017 in response to increasing rates of HIV, the team's caseload has grown from approximately 25 clients to 124.
- There has been a marked reduction over the past two years in the number of newly diagnosed HIV cases and the proportion of cases reporting injection drug use as a risk factor.

Background

In June 2016, MLHU issued a public health alert related to rapidly increasing rates of HIV, hepatitis C, invasive Group A Streptococcal (iGAS) disease, and infective endocarditis among people who inject drugs (PWID). Prior to 2014, the Middlesex-London area identified an average of 25 new cases of HIV annually. However, by the end of 2016, the total number of new cases of HIV reported that year had climbed to 61—the highest number of new cases that Middlesex-London has seen in a single year (see Appendix A).

In response, local stakeholders and more than fifty provincial and national experts were consulted and a local HIV Leadership Team was established to identify and implement strategies to address the outbreaks. This team included representation from the St. Joseph's Health Care London Infectious Diseases Care Program, London InterCommunity Health Centre, Regional HIV/AIDS Connection, Elgin-Middlesex Detention Centre (EMDC), Ontario Aboriginal HIV/AIDS Strategy, Addiction Services of Thames Valley, local infectious disease physicians, and the South West Local Health Integration Network.

Implemented Strategy

Since its inception two years ago, the HIV Leadership Team and its member agencies have worked to develop and implement numerous strategies to reduce the rate of new HIV infections in the community. As the outbreak was primarily occurring among PWID, efforts focused on addressing the underlying risk factors associated with homelessness and unsafe injection practices. Successful models of care employed in Vancouver and Saskatchewan, where similar outbreaks had occurred, were studied and adapted for use in London-Middlesex. The keys to success in those models were the provision of wraparound care supports to clients, such as increased access to testing, harm reduction materials, and supervised consumption services, integration with primary care, support for mental health and addictions, coordination with housing and social services, and seamless transfers of care between support agencies. Locally, the agencies represented at the HIV Leadership Team table examined existing gaps in service and opportunities to better integrate service delivery between the service providers in London and Middlesex. From there, the group developed an extensive list of action items for implementation (see Appendix B). The bulk of these recommendations have now been implemented in part or in whole.

As of December 31, 2018, the number of newly diagnosed cases reported in 2018 had fallen to 29, representing a 52% decrease from the outbreak peak in 2016. As well, the number of cases reporting injection drug use as a risk factor has decreased from 74% of cases in 2016 to 52% of cases in 2018.

Some of the key initiatives believed to have contributed to this significant reduction in new cases include:

- enhanced collaboration in client support provided by the agencies involved in HIV care;
- implementation of HIV outreach programs, as well as use of assertive engagement models of care;
- establishment of the Temporary Overdose Prevention Site;
- increased access to harm reduction supplies and HIV testing;
- streamlined referrals into addiction treatment programs; and
- targeted public awareness campaigns promoting safer injection practices.

In June 2017, an adapted version of the successful Vancouver STOP HIV/AIDS outreach model was implemented at MLHU by reallocating internal resources through the PBMA budget process and securing a Public Health Agency of Canada grant. The MLHU Outreach Team is comprised of two outreach nurses, two outreach workers, and a program lead. The team works to seek, find, and link clients to ongoing care by supporting them in getting to and from appointments with HIV specialists. Since its implementation, the team's client portfolio has grown from approximately 25 clients to 124. This population can be difficult to engage due to issues with homelessness, substance use, and mental health. The Outreach Team also receives a large number of referrals from the St. Joseph's Infectious Diseases Care Program, as well as other community partners, and has been recognized for their ability to build trust with hard-to-reach populations.

The success of the Outreach Team comes from its collaboration with community organizations and the provision of numerous wraparound supports to clients. A community health and harm reduction team, comprised of partners who meet via teleconference as a weekly "huddle," allows all involved partners to discuss clients with shared consent. This huddle supports the client however necessary: e.g., locating a lost client, re-engaging with a client who has been challenging to support, providing practical support and resources for a client to access appointments, or assisting a client during discharge from hospital or EMDC.

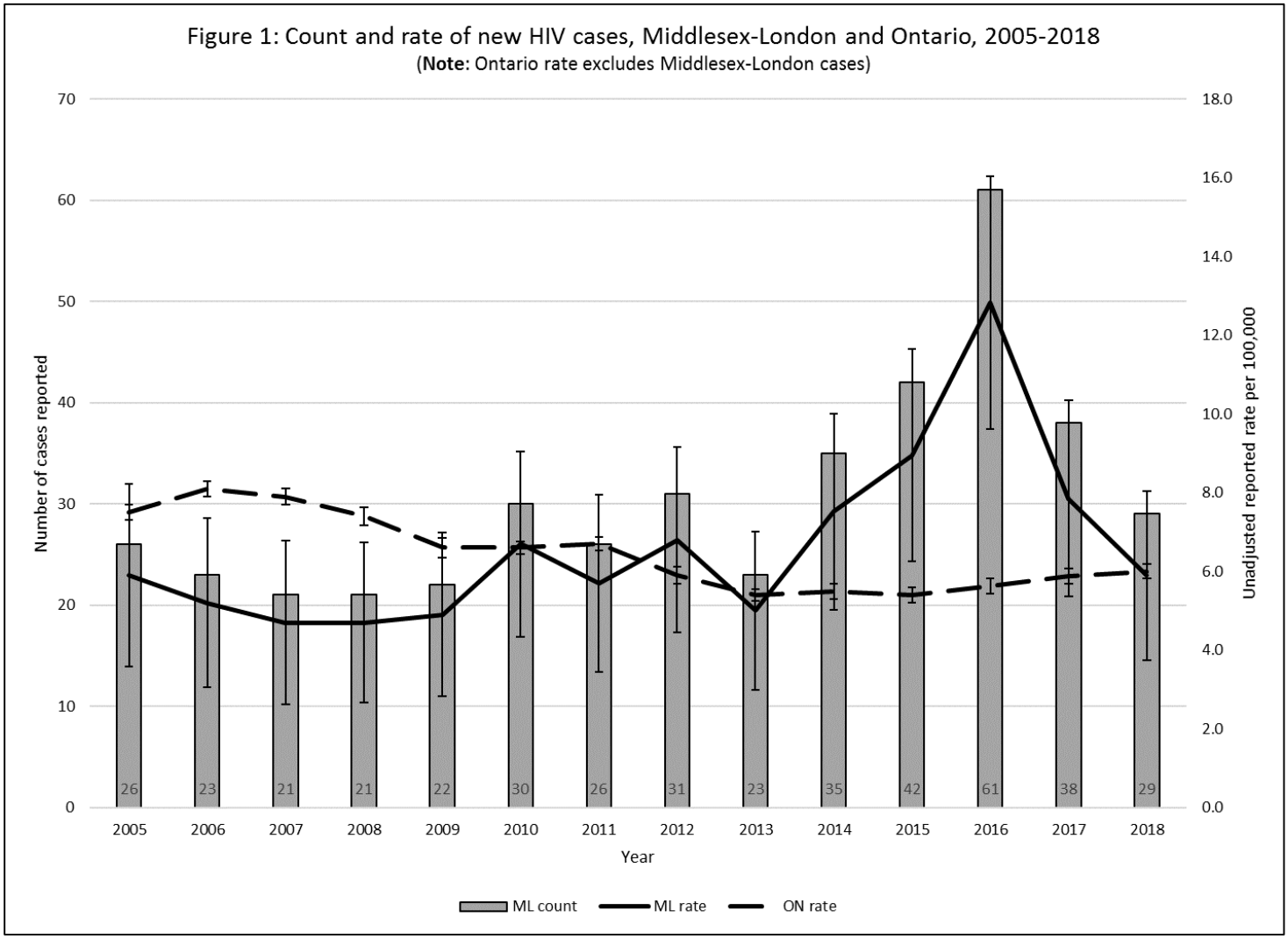
Conclusion / Next Steps

The marked reduction in the annual number of new HIV cases over the past two years is a very positive trend and has demonstrated the value of collaboration, education, and evidence-based intervention. However, the outbreak has also highlighted the significant health challenges faced by vulnerable populations, including the under-housed and homeless. While strong progress has been made with respect to HIV rates in this community, other infectious diseases, such as hepatitis A, invasive group A streptococcus, and tuberculosis, continue to pose serious health risks to residents of homeless shelters and PWID. The re-emergence in prevalence of sexual-activity-based risk factors, such as intercourse with Internet/anonymous partners and lack of condom use, underscores the need to maintain vigilance and provide robust education to the community about the risks of HIV.

The Health Unit and its partners in the HIV Leadership Team will continue to strive to achieve the UNAIDS 90-90-90 targets of having 90 percent of people living with HIV tested and aware of their status, 90 percent of people living with HIV undergoing treatment for their disease, and 90 percent of people living with HIV maintaining an undetectable viral load.

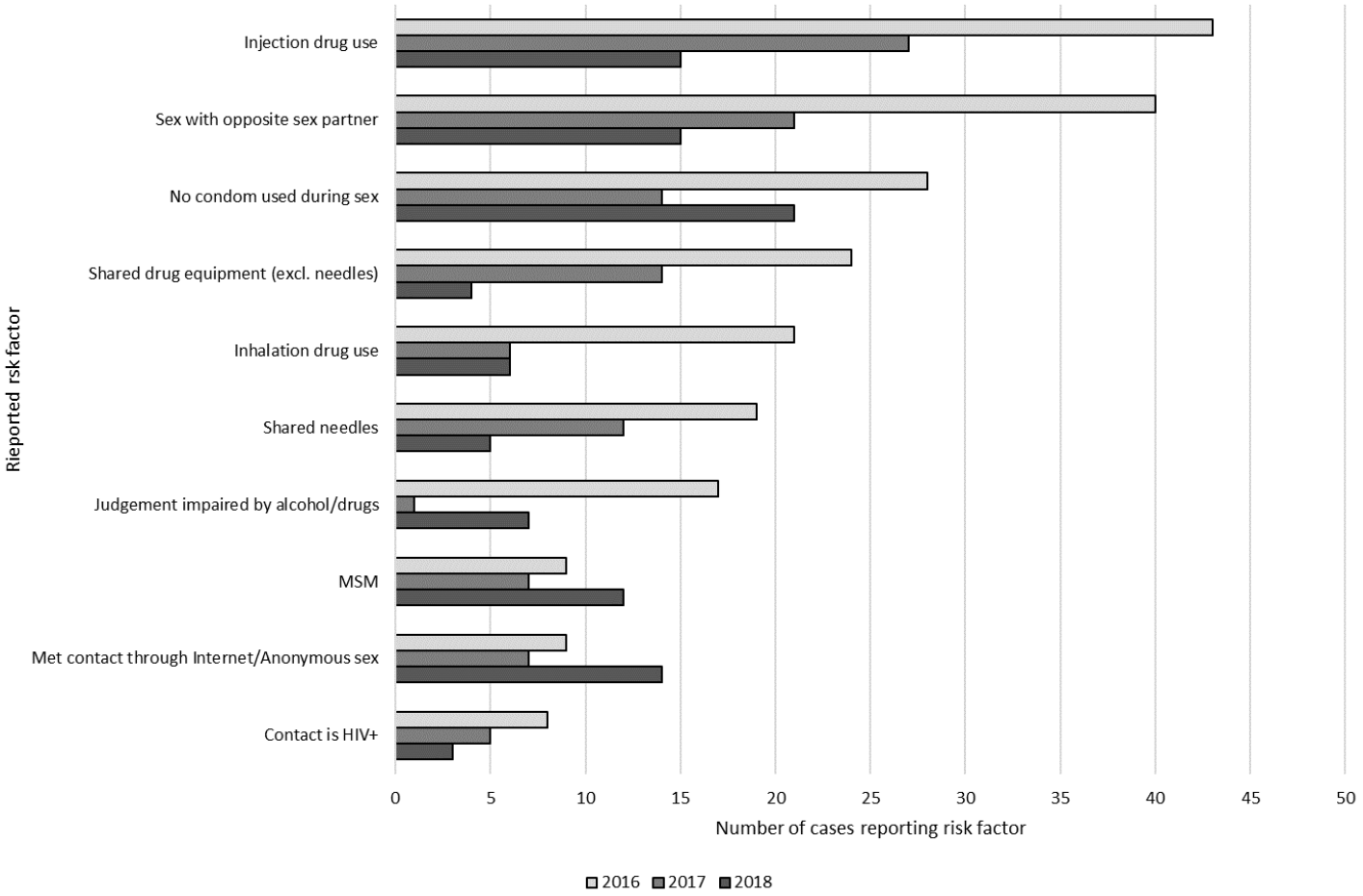
This report was submitted by the Sexual Health and Community Outreach and Harm Reduction Team (Appendix C), Environmental Health and Infectious Disease Division and the Associate Medical Officer of Health.

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



Data source: Public Health Ontario Infectious Disease Query, data extracted January 16, 2019. Data current as of January 9, 2019 at 7:00 a.m.

Figure 2: Count of new HIV cases by select reported risk factors, Middlesex-London, 2016-2018
(Note: Cases can report more than one risk factor)



Data source: MLHU iPHIS database, based on the CRN 2.0 data model, data extracted January 16, 2019.

HIV OUTBREAK COMMUNITY FORUM
Summary of Recommendations and Status

The status of each recommendation has been identified as follows:

- Engaging: Consulting with stakeholders
- Planning: Scope of work and timelines under development
- In Progress: Activities underway
- Complete: Complete and implemented

System Pathways:

Recommendation 1

Leverage existing resources to support clients to treatment.
Status: Complete

- Community Health and Harm Reduction Team (RHAC, LIHC, MLHU)

Recommendation 2

Development of specific order pathways when a PWID client enters hospital.
Status: In Progress

- PWID Pathways discussions at LHSC

Recommendation 3

Increase Outreach nursing
Status: Complete

- LIHC has requested funds from the LHIN for 2.0 FTE nursing to support MyCare Team
- MLHU has completed a proposal to increase outreach nursing within the London community (4 FTE)
- MLHU added 1.0 FTE Nursing to Outreach Team (Total of 2.0 FTE Nurses and 2.0 FTE Outreach Workers).
- Over 100 clients working with the Outreach Team
- SJHC has drafted an MOU with LIHC to provide IDCP nursing support to MyCare clinics

Recommendation 4

Discharge planning from hospital and EMDC
Status: Engaging/In Progress

- MLHU has been engaging with front line guards and social work staff at EMDC to be better notified of when discharge is happening.
- MLHU in discussion with client's lawyers/probation officer so we are aware of when a client could be released directly from the courthouse.

- Partnership between MLHU and IDCP ensuring to be at discharge planning meetings

Recommendation 5

Harm reduction services as a part of emergency clinic services within the hospitals emergency departments and medicine floors.
Status: Engaging

- Naloxone being distributed in LHSC hospitals through pharmacy to any clients.

Harm Reduction:

*Capacity Development

Recommendation 1

Development of a health care provider training module on cultural sensitivity towards Harm Reduction, stigma, barriers to accessing care and spiritual/holistic care.
Status: Engaging

Recommendation 2

Develop a role for the academic flex medical centres to provide access to primary care for the PWID population.
Status: Engaging

*Clinical Services

Recommendation 1

Continued work around Safe Consumption Facilities
Status: Complete / Ongoing

- Opioid Working Group
- IMS Working Group
- City Counsel presentation and support
- Exemption application process (Complete by January 2018)

Recommendation 2

Identify opportunities for harm reduction distribution in hospital
Status: Engaging

- Naloxone being distributed in LHSC hospitals through pharmacy to any clients.

Recommendation 3

Suboxone support in hospitals
Status: In progress

Recommendation 4

Expansion of harm reduction supplies to include other services (Pharmacies, SOAHAC, etc.)
Status: In progress

- Increased distribution of Naloxone
- Use of strategic partners to assist in distribution of kits
- Pharmacies beginning distribution of harm reduction supplies

Recommendation 5

Adopt the assertive engagement model as an important/valid option to support clients and develop a common understanding of what that means.
Status: Complete

- MLHU Outreach Team
- Community Huddle

Testing

Recommendation 1

Increase testing within hospital and EMDC
Status: Engaging / In Progress

- MLHU in discussions with LHSC and SJHC around process and feasibility of testing within the emergency department and at Parkwood Hospital
- MLHU in discussions with EMDC around feasibility for Rapid Point of Care (POC) testing to be offered within EMDC.

Recommendation 2

Explore alternatives to current HIV testing models
Status: In Progress

- Options Clinic is coordinating POC testing within multiple settings in London

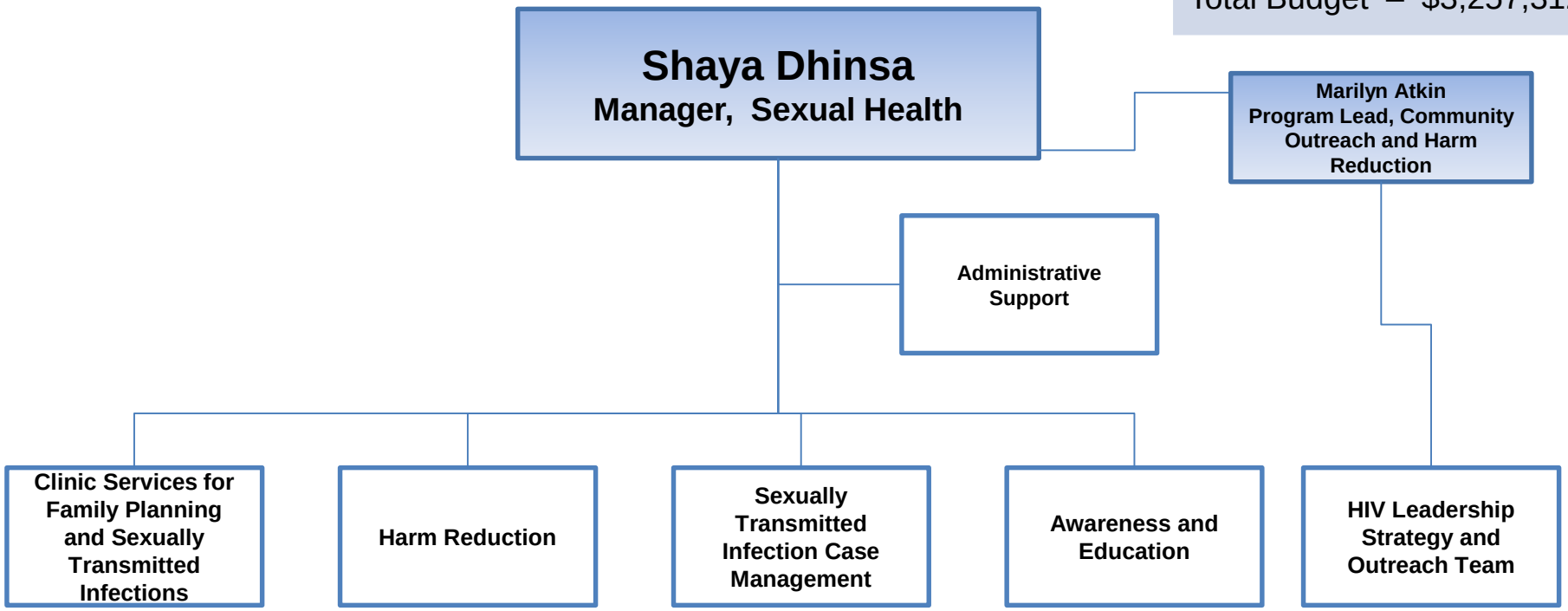
Environmental Health and Infectious Disease
The Clinic & Sexual Health Promotion

Appendix C to Report No. 005-19

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

Total FTEs – 21.74 FTEs

Total Budget – $3,257,312



Program Highlights:

- Implement Priority Populations in Sexual Health Clinic to align with Ontario Public Health Standards and ensure clients who need access to Sexual Health Services receive it
- "Get It On Chlamydia Campaign" formal launch Feb 2019 during Sexual Health Awareness Week to encourage people to use condoms and get tested to decrease rates of Chlamydia
- HIV Leadership – the outreach team and leadership team provide harm reduction interventions to reduce the harms associated with drug use and to prevent the spread of infectious diseases i.e. Temporary Overdose Prevention Site
- As part of a multi-prong approach to decreasing HIV & Hepatitis C rates, continue to work with RHAC and City of London with the Needle Recovery coordinated plan. Collate data from "Cook Your Wash Campaign" and develop promotional materials

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 006-19

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2019 January 24

UPDATE ON TRANSFER OF LEAD AGENCY RESPONSIBILITIES FOR tykeTALK, INFANT HEARING, AND BLIND/LOW VISION EARLY INTERVENTION PROGRAMS

Recommendation

It is recommended that the Board of Health receive Report No. 006-19 re: "Update on Transfer of Lead Agency Responsibilities for tykeTALK, Infant Hearing, and Blind/Low Vision Early Intervention Programs" for information.

Key Points

- While the plan for the Thames Valley Children's Centre to fully transition into the Lead Agency role by September 2019 remains in place, changes to Infant Hearing screening will occur in March 2019.
- Healthy Babies Healthy Children (HBHC) screening will continue to be provided by MLHU Public Health Nurses; however, hearing screening will be provided through a contract with an existing service provider agency.

Background

In April 2018, the Board of Health approved MLHU to move forward with discussions to transition Lead Agency responsibilities for early intervention programs to the Thames Valley Children's Centre (TVCC). The transfer of the Lead Agency role has been approved by the Ministry of Children, Community, and Social Services. It was agreed that full transition of the Lead Agency role will take place in September 2019. All existing service provider contracts will be taken over by TVCC. In the interim, a manager position was added to MLHU's existing service provider contract with TVCC to oversee daily program operations and manage the transition. Communication regarding the upcoming changes between TVCC, MLHU, contracted service providers, community partners, and the public took place during the summer of 2018.

Update

Two full-time Public Health Nurses currently provide combined Infant Hearing and Healthy Babies Healthy Children screening services at the London Health Sciences Centre (LHSC). After further discussion, it has been determined that changes to screening will occur earlier than originally planned. As of March 2019, Infant Hearing Program (IHP) screening at LHSC will be provided Monday to Friday by an existing service provider agency contracted with MLHU. Babies born on the weekend will be referred to local community IHP clinics for hearing screening. HBHC screening will be provided Monday to Saturday by two 0.6 FTE Public Health Nurses. It is anticipated that this HBHC screening model will be more effective than the current model, in which full-time PHNs provide service Monday to Friday and two additional part-time (approximately 0.3 FTE) PHNs provide services on weekends and holiday Mondays.

Conclusion

Plans to transition the tykeTALK, Infant Hearing, and Blind/Low Vision early intervention programs' Lead Agency role to TVCC are well underway. Staff will keep the Board of Health apprised of any significant changes as they arise. Throughout the transition, access to tykeTALK, IHP, and BLV services will be

seamless for families. That the separation of HBHC and IHP screenings is occurring earlier than originally planned is not expected to have any negative implications for screening services provided to families giving birth at LHSC. TVCC remains a committed and proactive partner in transition planning.

This report was prepared by the Screening Assessment Intervention Team (Appendix A), and Healthy Start Division.

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

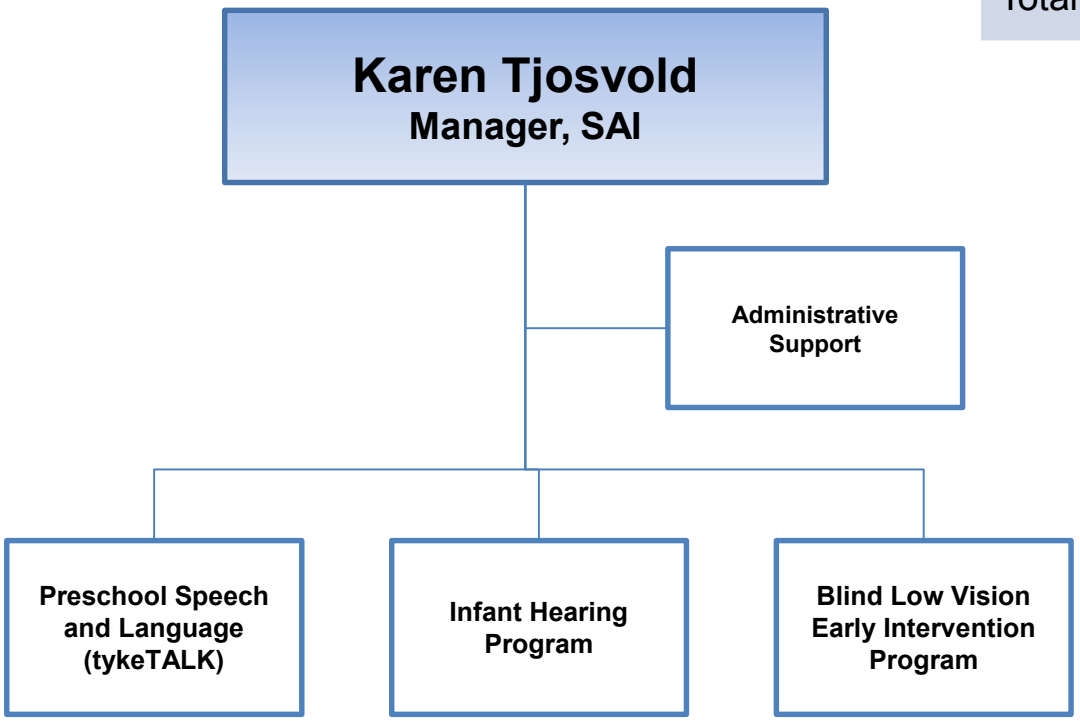
Healthy Start
Screening Assessment and Intervention

Appendix A to Report No. 006-19

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

Total FTEs – 4.40 FTEs

Total Budget – $3,191,771



Program Highlights:

- Contract with MCYS provide these early identification and early intervention programs - lead agency role shifting to Thames Valley Children's Centre in September 2019
- Program administration located at MLHU - direct services contracted to local service providers
- Provide speech and language therapy to about 2000 children per year
- Infant Hearing Program screens 10,000 newborns per year, with new bloodspot screen being fully implemented in 2019
- Approximately 30-35 babies are identified with permanent hearing loss per year and provided with supports and services through specially trained audiologists and speech language pathologists

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 007-19

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2019 January 24

SUMMARY INFORMATION REPORT – JANUARY 2019

Recommendation

It is recommended that Report No. 007-19 re: "Summary Information Report – January 2019" be received for information.

Key Points

- Middlesex-London Community Drug and Alcohol Strategy partners prepared and submitted input to the Government of Canada's Consultation on Strengthening Canada's Drugs and Substances Strategy.
- Middlesex-London Health Unit staff submitted to the consultation for Bill 66 indicating concerns that this legislation could have negative impacts on human health.

Consultation on Strengthening Canada's Drugs and Substances Strategy

Canada has had successive drug strategies in place since 1987, which have aimed to balance public health and public safety objectives via the key pillars of prevention, treatment, enforcement, and, at times, harm reduction. In 2006, under the National Anti-Drug Strategy (NADS), the harm reduction pillar was removed. The NADS was replaced in December 2016 with the Canadian Drugs and Substances Strategy (CDSS), which takes a four-pillar approach. The goal of the CDSS is to protect the health and safety of all Canadians by minimizing harms from substance use for individuals, families, and communities. In September 2018, the Government of Canada released a background document and opened a public "consultation on strengthening Canada's approach to substance use issues" to obtain input to further strengthen the federal government's health-focused approach to substance-use issues (including alcohol and other drugs, as well as the problematic use of prescription drugs) via the CDSS. A submission of input, attached as Appendix A, was prepared and submitted on December 4, 2018, by partners of the Middlesex-London Community Drug and Alcohol Strategy.

Bill 66

The Clean Water Act was enacted as a follow up to the Walkerton Inquiry Report. It enhanced the safety of drinking water in Ontario in a number of ways, including protection of source water. Bill 66 would amend the Planning Act to allow municipalities to pass "open-for-business" planning by-laws which could allow developers to bypass the Clean Water Act and several other pieces of environmental protection legislation. The bill would also repeal the Toxics Reduction Act, which requires large industries to track, report, and reduce their toxic emissions. Middlesex-London Health Unit staff submitted to the consultation for Bill 66 indicating concerns that this legislation could have negative impacts on human health (Appendix C). The Association of Local Public Health Agencies (alPHa) and others submitted similar concerns.
This update was prepared by the Safe Water, Rabies & Vector-Borne Disease team, Environmental Health & Infectious Disease Division (Appendix B).

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

Strengthening Canada's Approach to Substance Use Issues: Input to the Canadian Drugs and Substances Strategy (CDSS)

Consultation input from Middlesex-London Community Drug and Alcohol Strategy

December 4, 2018

Middlesex –London Community Drug and Alcohol Strategy

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The Middlesex-London Community Drug and Alcohol Strategy

The Middlesex-London Community Drug and Alcohol Strategy (CDAS) is a locally developed long-term strategy for preventing and addressing substance use-related harms in London and Middlesex County in Ontario, Canada.

Based on a four pillar framework of prevention, treatment, harm reduction and enforcement it is the result of the expertise of over 50 local partners representing health, education, social services, law enforcement, the non-profit sector, the private sector, municipal government, and people with lived experience, as well as the diverse voices of hundreds of citizens who are invested in the health and wellness of Middlesex-London. The vision of the CDAS is a caring, inclusive, and safe community that works collaboratively to reduce and eliminate the harms associated with drugs and alcohol.

Members of the CDAS Implementation Steering Committee, including representatives of the Middlesex-London Health Unit, Addiction Services of Thames Valley, London Police Service, Regional HIV/AIDS Connection, and Canadian Mental Health Association - Middlesex have reviewed the Background Document: Public Consultation on Strengthening Canada's Approach to Substance Use Issues published September 5th, 2018 as well as the Consultation's areas for discussion, and provides the following input for consideration.

The Middlesex-London Community Drug and Alcohol Strategy and its partners thank the Government of Canada for holding this consultation and its continued commitment to sustain and strengthen an evidence based Canadian Drugs and Substances Strategy (CDSS).

Question 1

What sorts of circumstances do you see within your networks, communities or in society that you think contribute to problematic substance use?

Inequalities related to the determinants of health – in particular, poverty and access to safe and affordable housing. People who are unstably housed or homeless are some of the most underserved and vulnerable populations in Canada. Because of this, coupled with higher rates of mental health issues, feelings of shame, fear, hunger, pain, and the stresses of living on the streets, a much higher proportion of people who are homeless experience addictions and harms of substance use.

Marketing practices and social norms related to legal substances. Using alcohol as an example, alcohol is legal and widely consumed yet with clear evidence of health and social harms. A public health approach balances the legality of a substance with evidence based regulations related to marketing, pricing, availability of the product, and education to the consumer; for example, in the form of product warning labels. Nonetheless, there has been continued growth in the aggressive promotion of alcohol products and a clear move away from harm-reducing public policy, such as those related to pricing, marketing and availability.

Stigma significantly contributes to problematic substance use. It is a causal factor in problematic substance use and a barrier to seeking help, receiving support and recovery. Local focus groups of both Indigenous people and youth identifying as LGBTQ2+ identified additive stigma as well as racism as significant barriers. We know that the impacts of stigma and marginalization on people who use substances only serve to intensify negative consequences of substance use.

Question 2

Have you seen or experienced programs, practices or models at the local or regional level that could be expanded, or implemented more broadly, to improve circumstances or social determinants of health that influence substance use?

There are programs and models that could be expanded and implemented more broadly. We recommend the following as examples:

Increase awareness and support funding for evidence based upstream initiatives, e.g. Icelandic Model. In Ontario, Waterloo Region and Lanark County are working toward adoption and implementation of such a model.

> "Planet Youth Lanark County is not a program. It is a new approach to identify and establish long term, community-driven strategies that promote positive social and environmental change. Some of the steps taken in Iceland and other countries that have proven successful include: removing barriers to positive activities and pursuits for youth, bringing awareness to the public about the benefits of increased family time, improving lines of communication between schools, parents, community organizations and youth." http://planetyouthlanark.ca/.

Support low-cost accessible recreation opportunities e.g. ACT-i-pass. The ACT-i-Pass is a card that allows all grade 5 students that live or attend school in the city of London the opportunity to access

FREE recreation programs throughout their ENTIRE school year. http://inmotion4life.ca/activity-excercise/acti-pass

Continue to focus on housing as a key to prevention through Housing First initiatives. A local model of success is London Cares Homeless Response Services. London Cares Homeless Response Services is a Housing First intervention aimed at individuals experiencing chronic and persistent homelessness based on a highly collaborative community-based approach. https://londoncares.ca.

Interventions that support families e.g. Nurse-Family Partnership ® (NFP). This is an evidence-based home-visiting program for first-time parents and their children. The NFP pairs expecting mothers with a Public Health Nurse to receive ongoing home visits throughout pregnancy, infancy and toddlerhood (until age 2). The program supports developing parenting skills, building a strong network of support for the mother baby, supporting a safe and nurturing environment for family and baby. https://www.healthunit.com/nurse-family-partnership https://nfpcanada.mcmaster.ca/

* In addition to the above examples and areas of focus, the Government of Canada can further support substance use prevention by **ensuring strong legislation and regulations at the federal level** that supports/ensures implementation at the provincial and local levels maintains the intent of federal policy. For example, the *Cannabis Act* aims to: keep cannabis out of the hands of youth, keep profits out of the pockets of criminals, and protect public health and safety by allowing adults access to legal cannabis

Question 3

What needs to change to make sure that opioid medications are being provided and used appropriately, based on the needs of each patient?

Continue to promote the 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain to provide updated guidance to physicians on appropriate prescribing practices.

Ensure education regarding pain management and opioid prescribing guidelines is included in medical training and training for other prescribing health care providers e.g. dentists, nurses.

Require provincial opioid monitoring systems be put in place across Canada and support the interconnectedness of these systems.

Enhance focus on patient education regarding opioids.

In addition to focus on opioids, support programs and policies that increase physician knowledge of and population access to alternate forms of pain management, including non-pharmaceutical e.g. mindfulness, physiotherapy, and other forms of pain management.

Support training opportunities for health and other professionals about risk and protective factors for addiction, as well as harm reduction and injection drug use.

Question 4

How can we make sure that those who require prescription opioids to manage their pain have access to them, without judgement or discrimination?

Continued and increased healthcare provider education: 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain to provide updated guidance to physicians on appropriate prescribing practices.

Ensure opioid prescribing control and monitoring systems do not result in unintended consequences such as creating an increased demand for access to illicit opioids.

Support programs and policies that increase physician knowledge of and population access to alternate forms of pain management, including non-pharmaceutical e.g. mindfulness, physiotherapy, other.

Ensure equitable access to pain management including pain clinics.

Provide opportunities for community members and organizations to learn about substance use, harm reduction, addictions and stigma around drug use.

Provide opportunities for healthcare professionals to learn about substance use, harm reduction, addictions and stigma around drug use.

Question 5

Which kinds of messages would work best to help Canadians understand the serious harms that can result from stigma around substance use?

Factual information about substances that counters a "blame the user" mentality: Provide opportunities for community members and organizations to learn about substance use, harm reduction, and addictions including the risk and protective factors for problematic substance use.

Stories: Share positive messaging and continue to help people tell their personal stories in a non-stigmatizing way. A local example of this is Addiction Services of Thames Valley *Possible Campaign* http://adstv.on.ca/itspossible/

Language: Work towards shifting language to reduce stigma (e.g., overdose to poisoning).

Role of Media: Continue to challenge media to not perpetuate stigma in both imaging and language.

Question 6

How can we best act to reduce stigma across the country? (you may select more than one answer)

√ Information campaigns by governments

√ Information campaigns by non-governmental organizations, celebrities, social media influencers, etc.

√ Engagement with people who use drugs to help them share their stories and experiences with stigma with the public Other(s)

Question 7

What would you recommend to improve substance use treatment services in Canada?

Reduce system barriers and create greater access to treatment and recovery services.

Explore and support new models of treatment to meet community need e.g. "daytox", Indigenous models of care, low-threshold treatment and service options.

Expand the use of models that integrate mental health support, harm reduction and connection to a range of substance treatment options. E.g. Rapid Access Addiction Medicine (RAAM) Clinics. RAAM Clinics have been implemented in several communities in Ontario. In London, the clinic team includes a physician, nurse practitioners and addictions and mental health counsellors.

Funding for a continuum of treatment and care for individuals using substances for example pre-treatment beds/stabilization housing between withdrawal and treatment or other recovery programming.

Support concrete strategies that enable access e.g. childcare, transportation.

Close the gap between short term programs and longer term residential program wait times.

Address stigma.

The general public and those who live with or have family members that live with addiction are often not aware of the range of treatment options. Increasing public awareness and understanding regarding the continuum of treatment as outlined in the consultation document is an important step in increasing access.:

- Providing services quickly, once a person is ready to undertake treatment
- Providing a full range of services which include early intervention and outreach, management of withdrawal symptoms, inpatient and outpatient services, and long-term care and support
- Tailoring treatment to an individual's needs (physical, mental, social, spiritual, etc.)
- Getting extra help and support, such as from family, friends and one's community
- Providing culturally-appropriate supports (e.g. for Indigenous peoples)
- Additional, non-medical, supports known as "wraparound" services (e.g., stable housing, education, training, employment, and child care)

Question 8

What obstacles or barriers do people face when they want to access treatment in Canada?

Barriers to accessing treatment include: transportation and availability of services – notably in rural areas; access to culturally appropriate an culturally sensitive services that are trauma informed; access to

a broad enough continuum of services; lack of service integration and interconnectedness – including interconnectedness of addiction and mental health services; access to child care, financial barriers; stigma; awareness of treatment options and others.

Question 9

The federal government has been focussed on removing regulatory barriers to effective treatment. For example, we have recently made it easier for treatment providers to prescribe medications such as methadone for people with opioid use disorder.

Are there other regulatory barriers to treatment that the federal government should look at, in order to help increase access to evidence-based treatment in Canada?

Ensuring access to opioid maintenance services is particularly challenging for Indigenous people both in reserve communities and in urban and other settings. Tailored programing with staff working in an Indigenous governance models and reflecting the different cultural practices of the variety of Indigenous people living in these communities should be available wherever Indigenous people live. Use of Suboxone as a treatment modality can facilitate treatment over longer distances, and help keep Indigenous people connected with their culture.

Access to diacetylmorphine (prescription heroin) has been heavily regulated and used more for treatment of pain than as a treatment option for people with dependency on other opiates that can be lethal. Dispensing practices that are limited to hospitals also have created barriers for people who cannot attend the hospital multiple times a day. The removal of these barriers increases treatment options for drug dependent people.

In addition, access to more drug checking programs at Supervised Consumption Sites can assist those using drugs to titrate their doses if the potency is very high. Regulations and cost are a barrier to more programs.

Question 10

In addition to current harm reduction initiatives – such as supervised consumption sites, needle exchange programs – what other harm reduction services should governments consider implementing in Canada?

Continue to reduce barriers for communities to implement supervised consumption sites.

Managed alcohol programs (MAPs) are an important tool to reduce alcohol related harms in a very marginalized high needs population. A proposal to implement a MAP locally in London, ON has not been successful related to provincial funding. Other barriers include stigma related to providing alcohol to alcohol dependent people (people ask "shouldn't they just stop or be made to stop?"), as well as finding a location that does not invoke "NIMBYism". Locally it has been identified by stakeholders that being co-located with stabilization beds and programs or withdrawal management could be a good connection.

Canada's Low Risk Alcohol Drinking Guidelines (LRADG) containing information for people to reduce harms from alcohol were released in 2011, yet many Canadians are unaware of these guidelines and

continue to drink at levels exceeding them. Recently released Low Risk Cannabis Use Guidelines (LRCUG) also contain important information to reduce harms from cannabis. Federal education campaigns are recommended to increase public awareness of both LRADG and LRCUG.

Implement policy that mandates standard labels on all alcohol products including number of standard drinks in a container, health warnings and nutritional information.

Implement Needle Syringe Programming and a broader harm reduction approach within corrections facilities across Canada. Programs that ensure access to sterile injecting equipment are an important component of a comprehensive approach to reducing the vulnerability of prisoners to HIV/HCV and other blood bourn illnesses.

Question 11

Many harm reduction tools focus on opioid use disorder (e.g., naloxone). How can the federal government develop harm reduction tools to address a broader range of substances, such as stimulant drugs (e.g., methamphetamines, cocaine)?

Implement policies that enable substitution of pharmaceutical grade medications as replacements for illicit substances such as crystal methamphetamine.

Drug checking services allow people to know what is in their substance and have the potential to save lives. We commend the Government of Canada in piloting drug checking and investment in developing this technology. Expanded access of drug checking is needed as an important harm reduction tool to reduce harms and save lives.

Question 12

How can we better bring public health and law enforcement together to explore ways to reduce the cycle of involvement for people who use substances with the criminal justice system?

Community Drug Strategies bring diverse community service providers together to work on projects collectively, otherwise these professionals would not normally interact or work together, such as public health and law enforcement.

Access to Drug Treatment Court is a critical component of the continuum of addiction treatment in Canada. Federal funding should be matched by provincial funding and be made available for more courts that create diversion from jail sentences and address criminogenic thinking and behaviours. Drug Treatment Courts should be fully funded and supported as best practice throughout the country.

Drug treatment courts create opportunities for behaviour modification that can last a lifetime and save lives and money and reintegrate families. Pro-social behaviours are introduced to participants through rewards and sanctions, close monitoring and reporting in an addiction treatment and justice partnership. Outcomes for the investment in Drug Treatment Courts are positive and show that diversion programs rooted in addiction treatment can successfully change behaviours long-term.

Consider **other pre-court diversion opportunities** i.e. immediate release to treatment or harm reduction facility for those who meet criteria (low risk and are willing to participate in treatment, health care, etc.) Opportunities to intervene early in the criminogenic lifestyle can be created through **Problem-Solving Courts** that link those with legal and drug use problems to the services that can help them before they need diversion from longer sentences.

Drug Treatment Programs and Drug Treatment Courts create a partnership of supports for individuals and link justice and treatment and other supports to help individuals with criminal backgrounds move away from crime fuelled by addiction and into pro-social activities and productive lifestyles.

Question 13

What further steps can the federal government take to better address current regulation and enforcement priorities, such as addressing organized drug crime and the dangerous illegal drugs like fentanyl being brought into Canada?

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1. In 2017, Bill C-37 received Royal Assent to amend the Controlled Drugs and Substances Act. This Bill provided valuable tools to better equip law enforcement to disrupt opioid importation and production. One tool critical in disrupting the opioid crisis was regulating pill presses and encapsulators, thereby making it more difficult for drug dealers to mass produce counterfeit pills. Unfortunately, Bill C-37 did not go far enough to deter the importation of pill presses for illicit purposes. Specifically:

   • Lack of comprehensive vetting of persons and businesses importing pill presses and encapsulators

   • No requirement for importers to articulate intended use

   • No controls over domestic sales or resale of imported pill presses

   • CBSA not provided with full range of powers under s.46 of the CDSA to arrest and charge for illegal importation of pill presses

   Counterfeit pills containing fentanyl and its analogs continue to make their way to the illicit drug markets across Canada. Enforcement action on drug labs demonstrate that pill presses, encapsulators, stamps and dyes are widely used in the production of these counterfeit pills. Tightening up the regulations will assist law enforcement with disrupting the distribution of illicit counterfeit fentanyl pills.

2. Cross-border access to data is one of the most pressing and concerning issues for law enforcement worldwide, particularly in the areas of organized crime. Currently, criminal investigations are limited and hindered by the jurisdictional rules surrounding where the data is stored. This is an open invitation to criminals to hide their activity by storing information in another jurisdiction. In addition, current procedures present challenges in terms of the voluntary collaboration of service providers, cooperation between law enforcement agencies, the implementation of certain investigative techniques, and the effective implementation of international mutual legal assistance in criminal matters. Initiatives are underway internationally to counter this situation, including the drafting of a 2nd Protocol to the Budapest Convention on Cybercrime. The United States adopted the CLOUD Act in 2018, enabling easier access to user

data abroad. They were able to do this by reciprocal agreements that respected international comity and yet still protected users' privacy. Canada must support these initiatives and I would request that the Government of Canada actively consult with the CACP in pursuing similar access from Canada. Canadian law enforcement often relies on the Mutual Legal Assistance Treaty (MLAT) in Criminal Matters Act, to access information stored outside Canada or held by service providers located outside Canada. Pursuing information through MLAT can take as many as 22 months which is not effective for investigation or timely presentation of evidence in court.

Question 14

Recognizing Indigenous rights and self-determination, how can all governments work together to address the high rates of problematic substance use faced by some Indigenous communities?

Indigenous persons within Canada have a lengthy and complex history with colonization with extreme inequities in all aspects of life, including culturally unsafe healthcare, inadequate education systems, sub-standard housing, and mental and physical abuse experiences. Commitment to Reconciliation across all levels of government, reducing and eliminating inequities and addressing systemic barriers to wellness is imperative to preventing and addressing substance use related issues.

"Health and well-being must be pursued in the context of the community in which First Nations people live and remain connected throughout their lives" *Honouring our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada*.

Indigenous persons and communities are the experts in their own lives and the needs of their communities. Preventing and addressing substance use issues should focus on strengths and supporting (e.g. through funding) Indigenous models of care.

Work alongside Indigenous communities to identify and address Indigenous-specific determinants of health, such as colonization and cultural continuity, that contribute to problematic substance use.

Utilize culturally appropriate models of social determinants of health (e.g. Indigenous-informed model by the National Collaborating Centre for Aboriginal Health)

Question 15

What can we learn from Indigenous approaches to problematic substance use, such as using holistic approaches, that may help inform activities under the CDSS?

Holistic and cultural focused approaches address wellness as a whole and include elements of physical, mental, emotional, and spiritual health versus the focus on disease. Causal factors in problematic substance use are complex and interrelated. Activities supported by the Government of Canada under the CDSS should focus on interconnected and long term strategies that consider the whole person and address the complexity of substance use, e.g. wrap around treatment programs that have cultural, spiritual and mental health elements embedded.

An example of a holistic healing model is the First Nations Mental Wellness Continuum Framework designed by the Thunderbird Partnership Foundation. https://thunderbirdpf.org/first-nations-mental-wellness-continuum-framework/. It is a national framework that addresses mental wellness among First Nations in Canada. It identifies ways to enhance service coordination among various systems and supports culturally safe delivery of services. The Thunderbird Partnership Foundation is an essential resource and a leader in holistic healing and wellness related to substance use and addiction within the First Peoples communities of Canada.

Question 16

How can governments, and the health, social, and law enforcement sectors design more effective substance use policies and programs for at-risk populations?

Work in purposeful partnership with diverse populations to enhance access to culturally safe prevention, treatment, harm reduction and enforcement related programs and services.

Include populations that have been identified as at higher risk in the development and implementation of programs, policies and services. Provide financial remuneration for this work.

Create and enable (including funding) new Peer training programs (e.g. peer support workers, Peer support and mutual aid) that are specific to people who have lived experience with addiction.

Ground policies and programs and anchor funding for these programs in principles that are inclusive. For example, some of the guiding principles that ground the Middlesex-London Community Drug and Alcohol Strategy locally include: Community strength based; Non-stigmatizing; Hopeful; Responsive to barriers; Culturally safe, Equity focused; Reconciliation aware.

Support and mandate culturally safe and trauma-informed care training to agencies and organizations and embed policies and practices to ensure services are culturally safe.

Implement programs that interconnect addiction, mental health, housing, and other supports using interdisciplinary wrap-around models.

Question 17

What are effective policies and programs to help improve access to prevention, treatment, and harm reduction services for at-risk populations?

There are known risk factors that may influence the likelihood of someone using substances and developing a substance use disorder. Because of inequities influenced by the social determinants of health, certain groups are more at-risk for problematic substance use and disproportionate harm. At risk populations include, but are not limited to, people who are unstably housed or homeless; lesbian, gay, bisexual, transgender, queer or questioning (LGBTQ2+) youth; Indigenous populations; populations in correctional facilities; people with histories of trauma; people living with mental illness.

Policies and programs that address poverty, homelessness, housing and other social determinants of health including Indigenous determinants of health:

- Access and availability of efficient, attainable, scattered and diverse housing stock.
- Financial support/basic income programs at rates that reflect cost of living.
- Financial support for medical expenses and treatments not covered by health benefits (e.g., transportation to health related appointments).
- Expanded supportive housing approaches and Housing First programs to assist people experiencing chronic and persistent homelessness to secure permanent housing with support.
- Work alongside Indigenous communities to identify and address Indigenous-specific determinants of health, such as colonization and cultural continuity, that contribute to problematic substance use.

Programs that ensure information is communicated using accessible and targeted language to reflect the needs of diverse populations.

Programs and polices that address and eliminate stigma:

- Provide opportunities for community members and organizations to learn about substance use, harm reduction, addictions and stigma around drug use.
- Provide opportunities for healthcare professionals to learn about substance use, harm reduction, addictions and stigma around drug use.

Question 18

What urgent gaps related to substance use (in terms of data, surveillance, and/or research) need to be addressed in Canada?

Data/surveillance:

As outlined in the consultation background document, there are significant limitations in access to comprehensive and systematically organized data including emergency room visits, poisonings, coroner reports, overdoses, prescribing rates, crime rates, incarceration rates, impaired driving rates, and use of treatment and harm reduction facilities, notably, disaggregated across social and economic characteristics.

We are pleased that the Government of Canada is working towards developing and implementing a Canadian Drugs Observatory that would provide systematic and sustained data collection in Canada and urge continued focus related to this.

Research:

Evidence based reform of current drug laws and policy: In order to effectively prevent and address substance related harms, we urge the Canadian government to place focus on researching evidence of the benefits of changing legislation related to criminalizing possession of substances.

Question 19

How can we use research tools to better identify emerging substance use issues as early as possible?

Emerging substance issues often are first noticed on the front line level, before they are identified by traditional surveillance and reporting systems. Federal support to develop novel data collection systems and implement these systems at the provincial and local levels would be a step in identifying issues sooner.

Require provincial opioid monitoring systems be put in place across Canada and support the interconnectedness of these systems.

Question 20

We look forward to continuing to work together as a country to address substance use issues from a health perspective. If you have any additional comments or ideas on potential next steps in the CDSS, please include them below.

We commend and thank the Government of Canada for its commitment to a public health focused and evidence based four pillar approach to addressing substance use in Canada. Please find additional comments below.

The Government of Canada should play a strong role in continuing to build evidence and implement policies that support, enable and compel implementation of timely evidence based action at the provincial and municipal levels.

Urgent and growing attention to safe affordable housing as a key determinant of health should be a foundation of the four pillar CDSS.

The Government of Canada should continue to invest in the Substance Use and Addictions Program (SUAP) to fund and support evidence-informed and innovative initiatives across health promotion, prevention, harm reduction, treatment and rehabilitation - targeting a broad range of legal and illegal substances including opioids, alcohol, cannabis and prescription drugs.

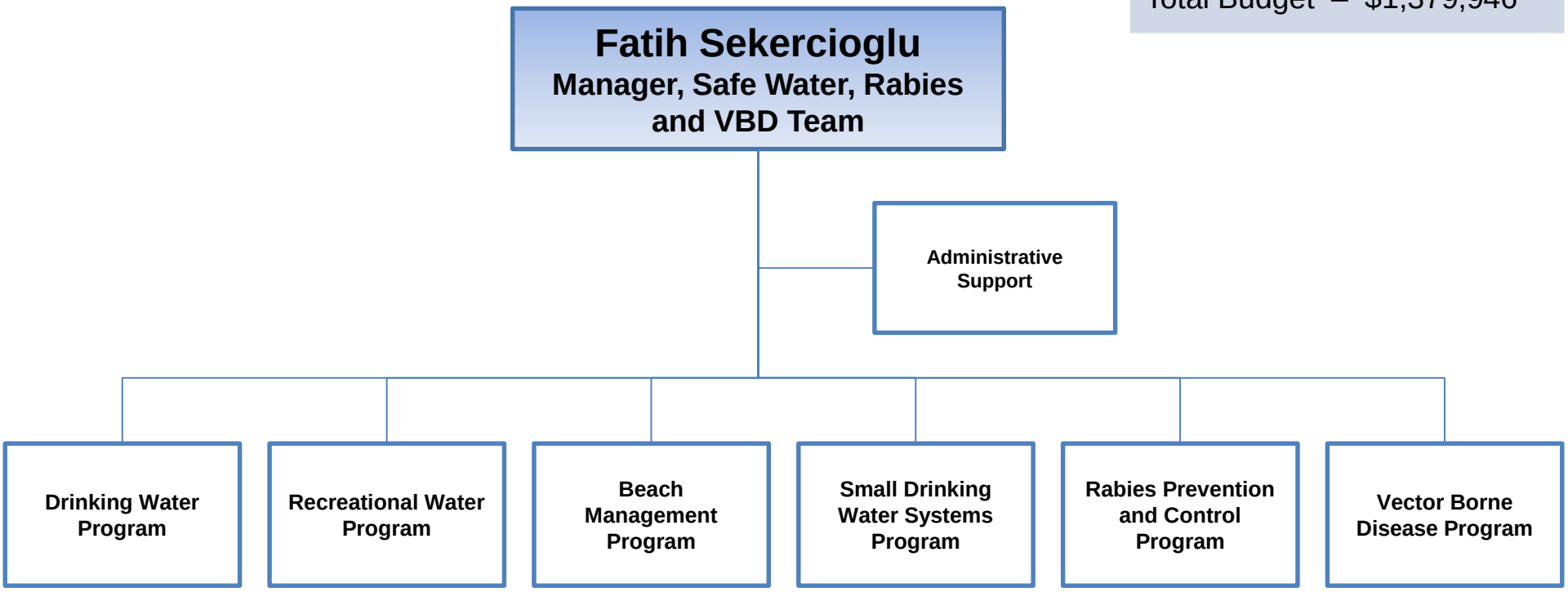
Environmental Health and Infectious Disease
Safe Water, Rabies and Vector Borne Disease Team

Appendix B to Report No. 007-19

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

Total FTEs – 14.00 FTEs

Total Budget – $1,379,946



Program Highlights:

- Enhanced Private Well Water Program
- Continued partnership with the FoodNet program
- Small Drinking Water Systems owner/operator training and dissemination of the newly developed operator's guide
- Evidenced-informed standing water sites surveillance & treatment program (to monitor and control WNV activity)
- Low-cost rabies clinics

MIDDLESEX-LONDON HEALTH UNIT

To: Michael Helfinger, Senior Policy Advisor
Ministry of Economic Development, Job Creation and Trade

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

Subject: Response to consultation on Bill 66, Restoring Ontario's Competitiveness Act, 2018 from the Middlesex-London Health Unit

Date: January 17, 2019

Summary

The Middlesex-London Health Unit (MLHU) is appreciative of the opportunity to provide input regarding *Bill 66, Restoring Ontario's Competitiveness Act, 2018.* The MLHU's mandate includes the promotion and protection of the health of the people who live in London and Middlesex County.

Any business requires healthy employees. As such, an open-for-business approach should ensure adequate protections for the basic necessities of human health. Clean drinking water is such a basic necessity. Indeed, achieving a clean drinking water supply has been perhaps the greatest public health achievement in history.

The proposed amendments found in Schedule 10 would allow municipalities to create bylaws that could put drinking water at risk of contamination. As such, the Middlesex-London Health Unit recommends that this schedule be removed from the legislation.

Schedule 10

The *Clean Water Act* and other relevant legislative documents have been enacted after the Walkerton tragedy in 2000 as a response to strengthen the water safety net in the province. Schedule 10 amends the *Planning Act* to add a new section 34.1, which allows local municipalities to pass open-for-business planning by-laws. These by-laws involve the exercise of a municipality's powers under section 34 of the Act and allow municipalities to impose one or more specified conditions. The "open-for-business" zoning by-laws do not have to comply with prescribed provisions in the *Clean Water Act, Greenbelt Act, 2005, Great Lakes Protection Act, Lake Simcoe Protection Act, 2008, Oak Ridges Moraine Conservation Act, 2001, Resource Recovery and Circular Economy Act, 2016* and other provincial statutes.

The Walkerton Inquiry Report authored by Justice Dennis O'Connor considered lack of multi-barrier approach a fundamental gap in ensuring the safety of drinking water. Protection of source water is the first and most important step of the multi-barrier approach in the provision of safe drinking water. Allowing large-scale industrial developments in vulnerable areas that may threaten groundwater or surface water resources diminishes the safety net for drinking water sources.

Section 39 of the *Clean Water Act* currently requires all *Planning Act* decisions to conform to policies in approved source protection plans that address significant drinking water threats prescribed by the *Clean Water Act* such as landfills, sewage systems, and the storage or handling of fuel, fertilizers, manure, pesticides, road salt, organic solvents and other substances on lands near wells or surface water intake pipes used by municipal drinking water systems. To ensure the protection of drinking water sources, this provision should remain applicable to all municipal planning and zoning decisions.

Risk to Residents of Neighbouring Municipalities

An important consideration with regards to requiring municipalities adhere to a provincial standard or Act is that the effects of actions taken by a municipality are not necessarily limited to the municipality that takes the action. When a municipality allows for an activity that has impact on a water system, it would likely be a downstream municipality that would suffer the impact which emphasizes the importance of adhering to provincial standards.

Recommendation:

The MLHU recommends that Schedule 10 be withdrawn and that the Government of Ontario continue the protection of source water to safeguard the health and safety of the people of Ontario.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 008-19

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2019 January 24

MEDICAL OFFICER OF HEALTH ACTIVITY REPORT FOR JANUARY

Recommendation

It is recommended that the Board of Health receive Report No. 008-19 re: "Medical Officer of Health Activity Report for January" for information.

The following report presents activities of the Medical Officer of Health (MOH) for the period of November 26, 2018, to January 11, 2019.

November 26	Met with Steve Cordes, Executive Director, Youth Opportunities Unlimited (YOU) to review the YOU Board agenda
November 27	Participated in the Public Health Ontario (PHO) Grand Rounds: Highlights from the 2017 Vaccine Safety Report teleconference and webinar
November 29	Attended the Annual Middlesex-London Health Unit Staff Day event at the Western Fair District Attended the YOU Reception at the YOU Made It Café Attended a meeting of the Urban League on Mental Health
December 3	Met with staff from the London and Middlesex Housing Corporation to discuss Consumption and Treatment Services (CTS) Participated in teleconference, hosted by the Urban Public Health Network (UPHN) and presented by the Health Canada Controlled Substances Directorate, on Supervised Consumption Facility (SCF) policy updates Interviewed by Megan Stacey, *London Free Press*, about CTS Attended City of London 2018 inaugural Council meeting and reception
December 5	Chaired teleconference of the Council of Ontario Medical Officers of Health (COMOH) Executive Committee Introductory meeting with Ron Holliday, retired MD, to discuss the opioid crisis and mental health
December 6	Participated in teleconference with presenters on a "return on investment" workshop being developed for The Ontario Public Health Conference (TOPHC) Participated in teleconferce on "public health economics" hosted by Brian Schwartz, Vice-President, Public Health Science, Public Health Ontario Attended the National Day of Remembrance at Victoria Park
December 10	Met with Laura Cole, Partner at Your Latitude, to discuss staff training Attended Planning and Environment Committee meeting, London City Hall
December 11	Attended London Chamber of Commerce networking event

Met with Linda Kasi, Registered Nurse, Parkwood Institute, to discuss managing illicit substances in an inpatient setting

December 12 Met with Michael Meagher, Senior Advisor, Mayor's Office, City of London, to discuss the state of the City's health
Attended Relocation Advisory Committee and Board of Health meetings
Attended Board of Health annual dinner

December 13 Interviewed by Craig Needles, AM980, about hospitalizations in relation to opioid usage
Met with key partners in regard to the proposed 241 Simcoe Street CTS
Attended Middlesex County inaugural Council meeting and dinner

December 14 Interviewed by Camille Ross, CTV, on the opioid crisis
Chaired COMOH Executive Committee teleconference
Attended the combined Organizational Structure and Location (OSL) Social Drop-In and MLHU Year End Celebration event in the 50 King St. Lunch Room

December 17 Met with Josh Monk, Western University student representative, London Youth Advisory Council
Met with Endri Poletti, architect, to review draft floor plans for the CitiPlaza location

December 19 Chaired meeting of Medical Officers of Health in Toronto

December 20 Participated in multiple teleconferences in regard to the mobile CTS
Interviewed by Jen Bieman, *London Free Press*, about funding for the Temporary Overdose Prevention Site (TOPS)
Attended the Youth Opportunities Unlimited (YOU) Board social

January 2 Phone call with George Pasut, Public Health Ontario, to discuss Locally Driven Collaborative Projects (LDCPs)

January 3 Phone call with Kelly Scherr, City of London, to discuss water quality

January 7 Monthly one-on-one phone call with Brian Schwartz, Public Health Ontario
Phone meeting with TOPHC Workgroup members to discuss their workshop

January 8 Chaired monthly conference call with COMOH Executive Committee
Phone call with Lynne Livingstone, City of London, to discuss Naloxone

January 9 Phone call with Clint Shingler, Director, Health System Emergency Management Branch Office of the Chief Medical Officer of Health, Public Health Ministry of Health and Long-Term Care (MOHLTC), regarding a traveller returning from the Democratic Republic of the Congo

January 11 Participated in alPHa Executive Committee monthly conference call

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

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