BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT
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AGENDA
MIDDLESEX-LONDON BOARD OF HEALTH

Thursday, April 18, 2019, 7:00 p.m.
399 Ridout Street North, London, Ontario
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

Ms. Trish Fulton (Chair)
Ms. Maureen Cassidy (Vice-Chair)
Mr. John Brennan
Mr. Michael Clarke
Ms. Aina DeViet
Ms. Kelly Elliott
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

MINUTES

Approve: March 21, 2019 - Board of Health meeting

Item #	Delegation	Recommendation	Information	Report Name and Number	Link to Additional Information	Overview and Lead
Reports and Agenda Items						
1			**x**	Public Health Inspector Enforcement Actions – Q1 2019 (Report No. 027-19)		To provide an update on Public Health Inspector enforcement activities for the first quarter of 2019. Lead: David Pavletic, Manager, Food Safety and Healthy Environments
2	**x**		**x**	Program update: Food Safety and Healthy Environments	Food Safety and Healthy Environments Program Template	Lead: David Pavletic, Manager, Food Safety and Healthy Environments
3	**x**		**x**	Program update: Southwest Tobacco Control Area Network (SWTCAN)	SWTCAN Program Template	Lead: Donna Kosmack, Manager, SWTCAN
4	**x**		**x**	Program update: Finance	Finance Program Template	Lead: Brian Glasspoole, Manager, Finance
5	**x**		**x**	Program update: Communications	Communications Program Template	Lead: Dan Flaherty, Manager, Communications
6			**x**	2018 Annual Report (Report No. 028-19)	Appendix A 2018 Annual Report	To provide an update on the Health Unit's activities and achievements in 2018. Lead: Dan Flaherty, Manager, Communications
7	**x**		**x**	Program update: Procurement and Operations	Procurement and Operations Program Template	Lead: Joe Belancic, Manager, Procurement and Operataions
8		**x**		Location Project – Project Plan and General Contractor Pre-Qualification April 2019 (Report No. 030-19)	Appendix A Appendix B Appendix C	To provide a project plan update and request approval of a contractor for fit-up at Citi Plaza. Lead: Lead: Joe Belancic, Manager, Procurement and Operataions
9		**x**		Impact of 2019 Provincial Budget (Report No. 031-19)		To provide an update on the impact of the 2019 provincial budget on the Middlesex-London Health Unit. Lead: Dr. Christopher Mackie

10			**x**	Medical Officer of Health/ CEO Activity Report for April (Report No. 029-19)		To provide an update on the activities of the MOH/CEO for April. Lead: Dr. Christopher Mackie
Correspondence						
11			**x**	April 2019 Correspondence		To receive correspondence items a) though i) and k). To endorse item j) Private Members' Bill re: Inspection of Clinics.

OTHER BUSINESS

- Next Finance and Facilities Committee Meeting: Thursday, May 2, 2019 @ 9:00 a.m.
- Next Board of Health Meeting: Thursday, May 16, 2019 @ 7:00 p.m.
- Next Governance Committee Meeting is scheduled for Thursday, June 20, 2019 @ 6:00 p.m.

CONFIDENTIAL

The Board of Health will move in-camera to consider matters regarding identifiable individuals, information (e.g., a trade secret or scientific, technical, commercial, or financial) that belongs to the Middlesex-London Health Unit and has monetary value and confidential minutes from the March 21, 2019 Board of Health meeting.

ADJOURNMENT

PUBLIC SESSION – MINUTES
MIDDLESEX-LONDON BOARD OF HEALTH

Thursday, March 21, 2019, 7:00 p.m.
399 Ridout Street North, London, Ontario
Side Entrance (recessed door)
MLHU Boardroom

MEMBERS PRESENT:	Ms. Trish Fulton (Chair) Ms. Maureen Cassidy (Vice-Chair) Ms. Aina DeViet Mr. Ian Peer Ms. Elizabeth Peloza Mr. Matt Reid Mr. John Brennan
REGRETS:	Ms. Tino Kasi Ms. Kelly Elliott Mr. Michael Clarke
OTHERS PRESENT:	Dr. Christopher Mackie, Secretary-Treasurer Ms. Elizabeth Milne, Executive Assistant to the Board of Health and Communications Coordinator (Recorder) Mr. Jordan Banninga, Manager, Program Planning and Evaluation Mr. Joe Belancic, Manager, Procurement and Operations Ms. Cynthia Bos, HR Manager Ms. Laura Di Cesare, Director, Healthy Organization Mr. Dan Flaherty, Communications Manager Ms. Nicole Gauthier, Manager, Privacy, Risk and Governance Ms. Donna Kosmack, Manager, Southwest Tobacco Control Area Network Ms. Melissa Knowler, Public Health Nurse Ms. Ellen Lakusiak, Dietitian Ms. Heather Lokko, Director, Healthy Start Ms. Kendra Ramer, Manager, Strategic Projects Ms. Maureen Rowlands, Director, Healthy Living Ms. Linda Stobo, Manager, Chronic Disease Prevention and Tobacco Control Mr. Alex Tyml, Online Communications Coordinator Mr. Stephen Turner, Director, Environmental Health and Infectious Diseases

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

DISCLOSURE OF CONFLICT OF INTEREST

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

APPROVAL OF AGENDA

It was moved by Ms. Peloza, seconded by Mr. Peer, *that the **AGENDA** for the March 21, 2019 Board of Health meeting be approved.*

Carried

MINUTES

It was moved by Ms. DeViet, seconded by Mr. Reid, *that the **MINUTES** of the February 21, 2019 Special Meeting of the Board of Health be approved.*

Carried

It was moved by Ms. DeViet, seconded by Mr. Reid, *that the **MINUTES** of the February 21, 2019 Board of Health be approved.*

Carried

It was moved by Mr. Peer, seconded by Ms. Peloza, *that the **MINUTES** of the November 15, 2018 Governance Committee meeting be received.*

Carried

It was moved by Mr. Peer, seconded by Mr. Reid, *that the **MINUTES** of the March 7, 2019 Finance & Facilities Committee meeting be received.*

Carried

Ms. Rowlands and Mr. Turner arrived at 7:03 p.m.

March 7, 2019 Finance & Facilities Committee (FFC) Meeting Update (Report No. 020-19)

Mr. Matt Reid, Chair, Finance & Facilities Committee, introduced and reviewed the reports considered at the March 7 FFC meeting.

2018 Board of Health Remuneration (Report No. 010-19FFC)

It was moved by Mr. Reid, seconded by Ms. DeViet, *that the Board of Health receive Report No. 010-19FFC re: "2018 Board of Health Remuneration" for information.*

Carried

By-Law and Policy Review (Report No. 011-19FFC)

Mr. Reid reported that the report had been received by the Finance & Facilities Committee for information.

Q4 Financial Update and Factual Certificate (Report No. 012-19FFC)

It was moved by Mr. Reid, seconded by Ms. Peloza, *that the Board of Health approve Report No. 012-19FFC re: "Q4 Financial Update and Factual Certificate."*

Carried

2018 Vendor/Visa Payments (Report No. 013-19FFC)

Mr. Reid reported that the report had been received by the Finance & Facilities Committee for information.

Public Sector Salary Disclosure Act – 2018 Record of Employees' Salaries and Benefits (Report No. 014-19FFC)

Mr. Reid noted this has already been sent to the Ministry before coming to the board due to deadlines.

It was moved by Mr. Reid, seconded by Mr. Peer, *that the Board of Health receive Report No. 014-19FFC re: "Public Sector Salary Disclosure Act – 2018 Record of Employee's Salaries and Benefits" for information.*

Carried

Mr. Reid noted that the April 4, 2019 Finance & Facilities committee meeting will be cancelled. Dr. Mackie advised that the next meeting will be held on May 2.

Chair Fulton welcomed Ms. DeViet as the new Chair of the Governance Committee for 2019.

March 21, 2019 Governance Committee meeting – Verbal Update

Ms. DeViet introduced the following reports reviewed at the Governance Committee meeting at 6:00 p.m.

Q1 2019 Activity Report – Strategic Projects (Report No. 001-19GC)

It was moved by Ms. DeViet, seconded by Mr. Reid, *that the Board of Health receive Report No. 001-19GC re: "Q1 2019 Activity Report – Strategic Projects" for information.*

Carried

2017 Year-end Performance on Accountability Indicators (Report No. 002-19GC)

It was moved by Ms. DeViet, seconded by Ms. Peloza, *that the Board of Health receive Report No. 002-19GC re: "2017 Year-end Performance on Accountability Indicators" for information.*

Carried

Governance Policy Review and Development (Report No. 003-19GC)

Ms. DeViet noted the amount of work by staff that went into reviewing these policies. She also outlined the plan for policy review going forward, considering that policies are required to be reviewed every two years per the requirements of the Ontario Public Health Standards.

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

1) *Approve the governance by-laws and policies appended to this report; and*
2) *Approve development of the new governance policies outlined within this report.*

Carried

Governance Committee Reporting Calendar (Report No. 004-19GC)

It was moved by Ms. DeViet, seconded by Ms. Cassidy, *that the Board of Health approve the 2019 Governance Committee Reporting Calendar.*

Carried

2019 Board Development (Report No. 005-19GC)

Ms. DeViet noted that there is a plan to carry out board development activities in June, which will be scheduled based on Board members' availabilities.

It was moved by Ms. DeViet, seconded by Ms. Peloza, *that the Board of Health approve the "Leading Through Transition/Change Management" session delivered by Your Latitude as a 2019 Board development opportunity.*

Carried

Board of Health Self-Assessment (Report No. 006-19GC)

It was moved by Ms. DeViet, seconded by Ms. Peloza, *that the Board of Health:*

1) *Approve the Board of Health Self-Assessment Tool appended to this report; and*
2) *Approve initiation of the Board of Health self-assessment process for 2019.*

Carried

Ms. DeViet noted that the next Governance Committee meeting will be held on June 20.

Chair Fulton introduced the program updates for the evening and provided context for the program update process (which aligns with the Annual Service Plan) to give board members an overview of the comprehensive work that takes place at MLHU.

Program Update: Privacy, Risk, and Governance

Ms. Di Cesare introduced Ms. Gauthier and the Privacy, Risk, and Governance program within the Healthy Organization Division.

Ms. Gauthier provided a summary of key initiatives and focus of work, which include employee education and policy development for the privacy, risk, and governance portfolio.

Program Update: Human Resources

Ms. Bos introduced and provided an overview of the Human Resources program within the Healthy Organization Division and some of the highlights and initiatives planned for 2019, which include outsourcing of payroll services, the Diversity and Inclusion Project, and implementation of a new Enterprise Resource Planning tool.

Program Update: Strategic Projects

Ms. Ramer introduced the Strategic Projects team within the Healthy Organization Division and reviewed some of the main functions of this team, which provides internal support for project lifecycles within the organization.

Program Update: Oral Health

Ms. Rowlands introduced Ms. Golding, Manager, Oral Health, Healthy Living Division. Ms. Golding provided an overview of the Oral Health program, which includes school dental screenings, clinical services, and the fluoride varnish program, which is applied after the dental screening takes place in schools.

Discussion ensued on the following items:

- The fluoride varnish program in schools and the criteria upon which the program is based.
- How schools are categorized for the fluoride varnish program.
- The percentage of kids that are being missed under the program criteria.
- The percentage of families enrolled in the Healthy Smiles Program versus those that actually access services once enrolled.

London Community Dental Alliance Update (Report No. 021-19)

It was moved by Ms. Cassidy, seconded by Ms. DeViet, *that the Board of Health receive Report No. 021-19 re: "London Community Dental Alliance Update" for information.*

Carried

Board of Health Representation on the Food Policy Council (Report No. 022-19)

Chair Fulton reviewed the requirements and responsibilities of the voting position on the Middlesex-London Food Policy Council as outlined in the report.

Chair Fulton advised the Board that Mr. John Brennan has agreed to let his name stand should the Board wish to nominate him for the position on the Food Policy Council.
It was moved by Ms. Peloza, seconded by Mr. Brennan, *that the Board of Health receive Report No. 022-19 re: "Board of Health Representation on the Food Policy Council" for information.*

Carried

It was moved by Mr. Reid, seconded by Ms. Cassidy, *that the Board of Health appoint Mr. John Brennan to the Middlesex-London Food Policy Council as a voting member.*

Carried

Chair Fulton thanked Mr. Brennan for agreeing to put his name forward and participate on the Middlesex-London Food Policy Council.

Association of Local Public Health Agencies (alPHa) Resolution: Preventing Mental Illness Through Early Childhood Development Programming (Report No. 023-19)

Dr. Mackie introduced the report and provided context for the alPHa Resolution process.

Ms. Lokko provided context for this report and advised the Board that three additional health units will be co-sponsoring this resolution.

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

1) *Receive Report No. 023-19 re: "Association of Local Public Health Agencies (alPHa) Resolution: Preventing Mental Illness Through Early Childhood Development Programming" for information; and*
2) *Co-sponsor the proposed resolution for the 2019 alPHa Annual General Meeting.*

Carried

Summary Information Report for March (Report No. 024-19)

It was moved by Ms. Cassidy, seconded by Ms. DeViet, *that the Board of Health receive Report No. 024-19 re: "Summary Information Report – March 2019" for information.*

Carried

Medical Officer of Health/CEO Activity Report for March (Report No. 025-19)

It was moved by Mr. Peer, seconded by Ms. DeViet, *that the Board of Health receive Report No. 025-19 re: "Medical Officer of Health Activity Report for March" for information.*

Carried

Health Canada Seeking Feedback on Measures to Limit Vaping Product Advertising (Report No. 026-19)

Discussion ensued on the prevalence of vaping advertising.

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

1) *Receive Report No. 026-19 re: "Health Canada Seeking Feedback on Measures to Limit Vaping Product Advertising";*
2) *Submit a letter to the Tobacco Control Directorate of Health Canada, attached as Appendix A, expressing its support and recommendations for strengthened measures to limit vapour product advertising; and*
3) *Endorse and submit the letter, attached as Appendix B, that was prepared by the Southwest Tobacco Control Area Network on behalf of the eight public health units in southwestern Ontario, for its submission to Tobacco Control Directorate of Health Canada.*

Carried

Ms. Rowlands recognized Ms. Stobo for her work in this area.

CORRESPONDENCE

It was moved by Mr. Peer, seconded by Ms. Cassidy, *that the Board of Health receive correspondence items a), through o).*

Carried

Dr. Mackie introduced and provided context for correspondence item p), which came via The Council of Medical Officers of Health (COMOH), and which seeks to ensure that science drives policy rather than an enforcement approach that can drive persons with HIV underground and discourage testing. This resolution brings a message of respect and inclusion, which, if communicated this way, can help to increase testing rates and decrease transmission rates.

It was moved by Ms. Cassidy, seconded by Ms. Peloza, *that the Board of Health endorse item p) re: Undetectable=Untransmittable.*

Carried

OTHER BUSINESS

Chair Fulton reviewed the next meeting dates:

- The next Finance & Facilities Committee meeting on Thursday, April 4, has been cancelled.
- The next Board of Health meeting is scheduled for Thursday, April 18 @ 7:00 p.m.
- The next Governance Committee meeting is scheduled for Thursday, June 20 @ 6:00 p.m.

CONFIDENTIAL

At 7:59 p.m., it was moved by Ms. DeViet, seconded by Mr. Reid, *that the Board of Health move in-camera to consider matters regarding identifiable individuals and approve Confidential minutes from its November 15, 2018 Governance Committee meeting and February 21, 2019 Board of Health meeting.*

Carried

At 7:59 p.m., everyone left the meeting except the Board of Health, Dr. Mackie, Ms. Milne, Ms. Di Cesare, Ms. Rowlands, Ms. Lokko, and Mr. Turner.

At 8:27 p.m., it was moved by Ms. DeViet, seconded by Mr. Reid, *that the Board of Health rise and return to public session.*

Carried

ADJOURNMENT

At 8:27 p.m., it was moved by Mr. Reid, seconded by Ms. Peloza, *that the meeting be adjourned.*

Carried

TRISH FULTON
Chair

CHRISTOPHER MACKIE
Secretary-Treasurer

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO.027-19

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2019 April 18

PUBLIC HEALTH INSPECTOR ENFORCEMENT ACTIONS – Q1 2019

Recommendation

It is recommended that the Board of Health receive Report No. 027-19 re: "Public Health Inspector Enforcement Actions" for information.

Key Points

- Public Health Inspectors (PHIs) on the Food Safety and Healthy Environments (FS&HE) team, the Safe Water, Rabies and Vector-Borne Disease (SWRVBD) team, and the Infectious Disease Control (IDC) team conduct inspections at a variety of facilities in the City of London and Middlesex County. Operators of facilities are required to achieve regulatory compliance
- Enforcement actions, such as the issuance of Provincial Offence Notices and Closure Orders, may be taken when other public health interventions have proven ineffective in achieving regulatory compliance.

Background

Public Health Inspectors (PHI) work to protect the public via delivery of compliance inspections at facilities within the City of London and Middlesex County. Regulatory compliance is usually obtained through inspection work that incorporates aspects of on-site education and awareness. In some instances, assisted compliance interventions are delivered to operators who may require additional support to achieve compliance, but have demonstrated the willingness to strive toward compliance. Such interventions may include the provision of food handler training materials in other languages or additional supports through practical, hands-on instruction. In instances where significant infractions exist and are not corrected at the time of the inspection, PHIs conduct follow up re-inspections in order to ensure that compliance has been attained.

Enforcement actions may be taken when recurring infractions continue to happen despite intervention measures advised by the inspector, and when sustained compliance does not appear likely on the part of the operator. PHIs may issue a Provincial Offence Notice (Part I or Part III) in such instances, as warranted. Regulations made under the authority of the *Health Protection and Promotion Act*, R.S.O. 1990, c. H.7 provide a schedule of set fines with corresponding short-form wording. In some circumstances, PHIs may need to implement a progressive enforcement approach that eventually results in a Part III Summons to appear in court.

When a PHI identifies a significant health hazard at a premises during an inspection, the PHI may take several actions under the authority of the *Health Protection and Promotion Act*, R.S.O. 1990, c. H.7, including the ordering of the premises to close and cease operation. In 99% of cases, infractions can be resolved at the time of inspection. For significant infractions that cannot be resolved immediately, a Closure Order is issued under Section 13 of the *Act*. Such an order remains in effect until the operator is able to eliminate the health hazard and demonstrate safe operation. An order under this section may also include, but is not limited to:

- requiring the vacating of premises;
- requiring the owner or occupier of premises to close the premises or a specific part of the premises;
- requiring the placarding of premises to give notice of an order requiring the closure of the premises;
- requiring the doing of work, specified in the order, in, on, or about the premises specified in the order;
- requiring the removal of anything that the order states is a health hazard from the premises or the environs of the premises specified in the order;
- requiring the cleaning or disinfecting, or both, of the premises or the thing specified in the order;
- requiring the destruction of the matter or thing specified in the order;
- prohibiting or regulating the manufacturing, processing, preparation, storage, handling, display, transportation, sale, or offering for sale or distribution of any food or thing; and
- prohibiting or regulating the use of any premises or thing.

Until recently, infractions in personal service settings (PSS) required enforcement under Section 13, as there was no corresponding schedule of fines under the regulation for these environments. This issue has since been rectified and has helped inspectors provide an added layer to progressive enforcement options. MLHU now discloses all enforcement actions on the MLHU inspection site: https://inspections.healthunit.com/Portal/Enforcements.

Reported Actions

Inspection Type	Regular	Follow-up	Non-Critical Infractions	Critical Infractions	Enforcement Actions
Child Care	58	2	11	0	0
Institutional Food	87	1	11	4	0
Food Safety	717	72	835	428	3
Infection Control	1	0	0	0	0
Personal Service Settings	71	4	15	3	0
Recreational Water	114	14	134	1	7
Drinking Water	5	0	0	0	0

Next Steps

Enforcement actions shall be taken when interventions aimed at assisting compliance and educating operators have proven ineffective, and when operators have demonstrated an unwillingness to change unsafe behaviours. Additionally, actions may be taken to eliminate health hazards through the issuance of Closure Orders. PHIs work with operators to create safe and healthy environments. It is the goal of MLHU to establish good working relationships with operators and to achieve the common desire of having a safe and healthy environment.

This report was prepared by Environmental Health and Infectious Disease Division.

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

Environmental Health and Infectious Disease
Food Safety and Healthy Environments

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Total FTEs – 17.00 FTEs

Total Budget – $1,727,958

2019-04-18-BOH-Program-update

David Pavletic
Manager, Food Safety and Healthy Environments

- **Surveillance and Inspection**
- **Management and Response**
- **Awareness, Education and Training**
- **Reporting and Disclosure**

Program Highlights:

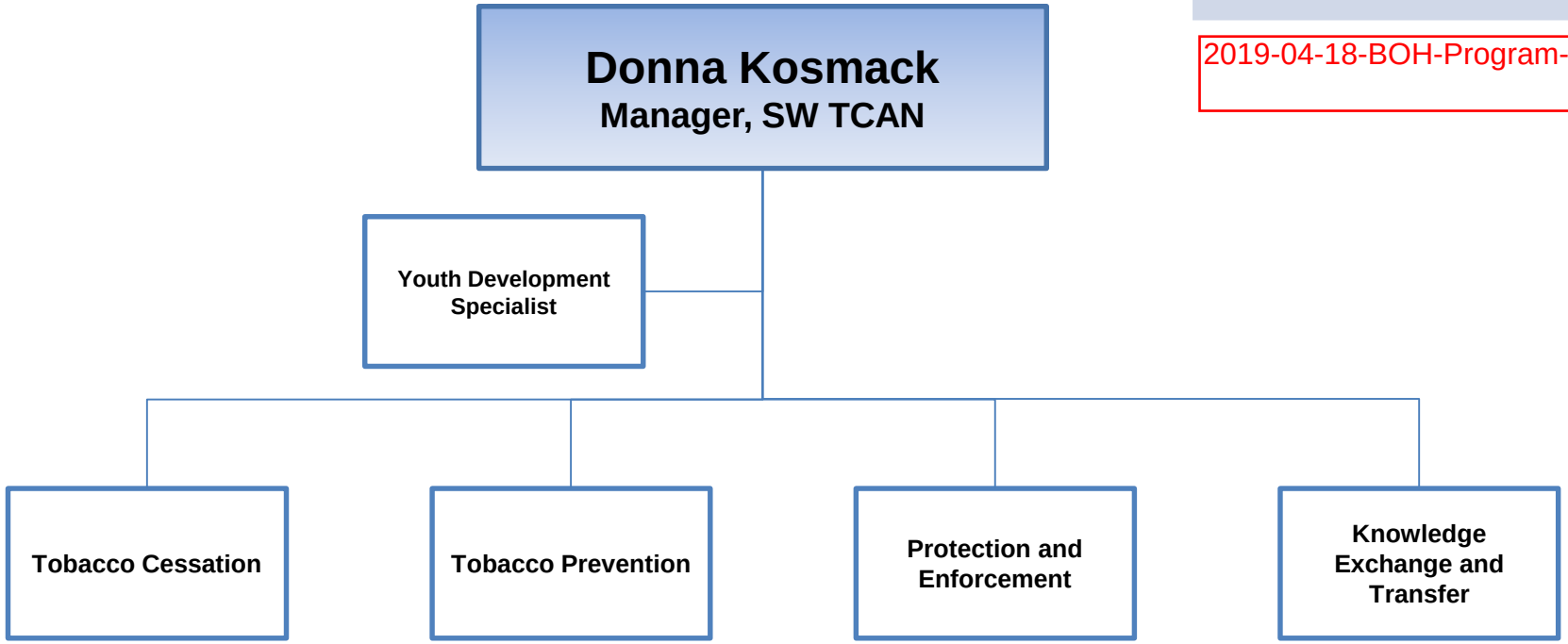
- Establish a comprehensive, risk-based, housing inspection program with increased focus on Vulnerable Occupancies
- Build on the work from the MLHU Vulnerability Assessment to deliver interventions aimed at addressing the impacts from climate change through vulnerability planning
- Risk assess and research new emerging food preparation processes with a focus on high risk foods
- Revamp existing Disclosure site, to incorporate other program area inspections and implement new Hedgehog software program for PHIs

Healthy Living
Southwest Tobacco Control Area Network

Total FTEs – 2.40 FTEs

Total Budget – $436,500

2019-04-18-BOH-Program-update

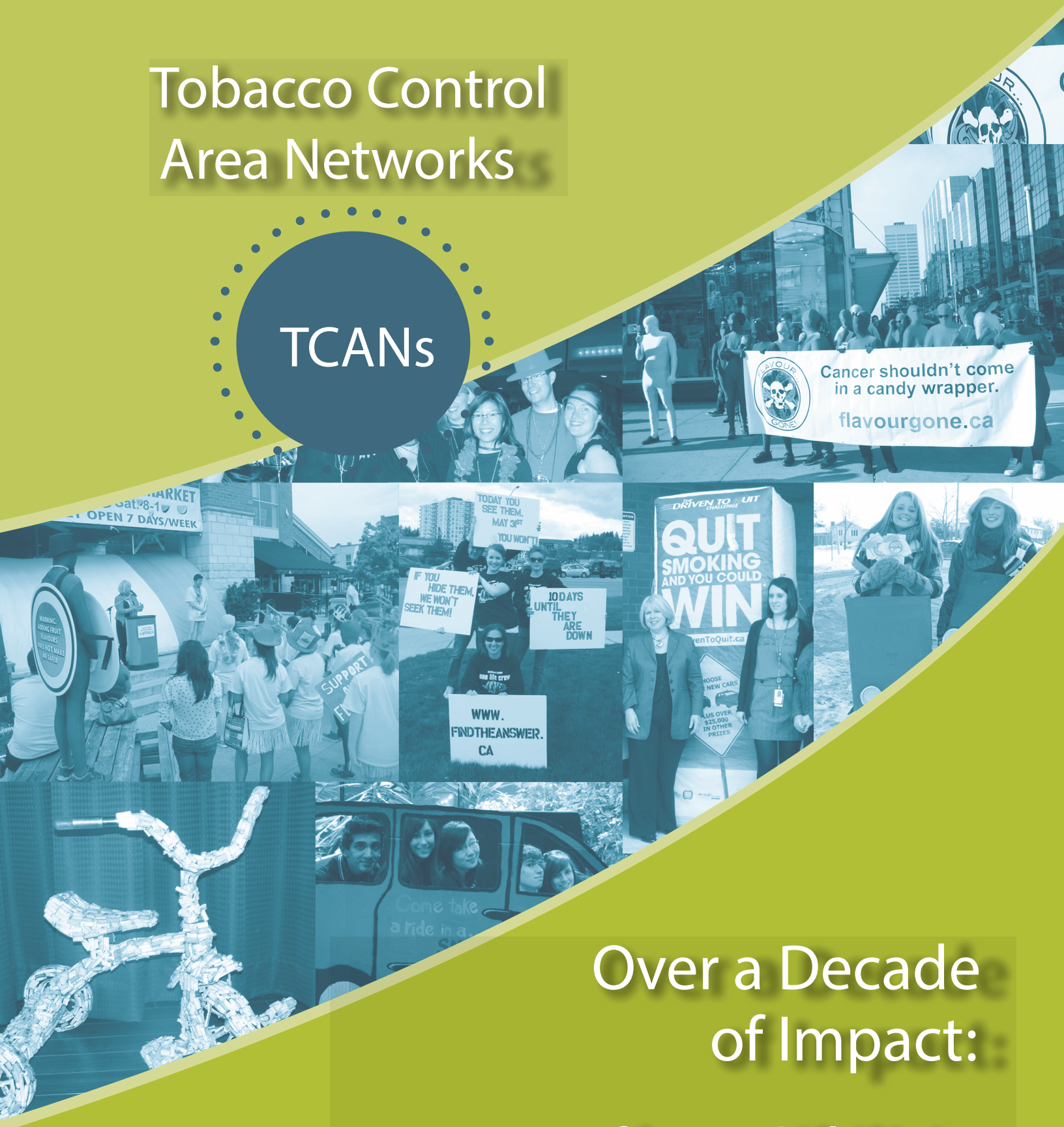


Program Highlights:

- Working to reduce smoking rates among young adult males by working with provincial partners to promote provincial contest and by implementing an innovative prevention campaign
- In conjunction with other TCAN partners the youth social identities project, Uprise, continues to be implemented across Ontario
- Increase awareness and public support for smoke-free movies; the TCAN plays a leadership role as the co-chair of the Ontario Coalition for Smoke-Free Movies
- Increase access to smoke-free multi-unit housing; the TCAN plays a leadership role as the co-chair of the Ontario Coalition for Smoke-Free Multi-Unit Housing
- Support health care providers to practice brief contact interventions with their clients/patients
- Provides a leadership role to ensure coordination and collaboration between public health units as well as other Smoke Free Ontario partners

Tobacco Control Area Networks

TCANs



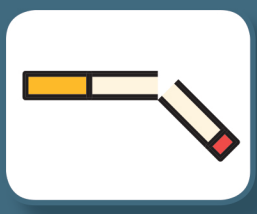
Over a Decade of Impact:

A Future of Possibilities

This document highlights the purpose, functions, and impact of Tobacco Control Area Networks (TCANs). It will help individuals who are new to tobacco control in Ontario understand how TCANS contribute to the overall goals of the Smoke-Free Ontario Strategy.

"The TCANs and tobacco control community as a whole have come a very long way and made many gains in the last decade. However, contrary to popular opinion, tobacco control is not done. There are still many individuals who need support to quit, people who need protection from second-hand smoke and young people we need to keep tobacco-free".

Donna Kosmack, Southwest TCAN Coordinator



36 Ontarians Die Every Day From Tobacco - Related Disease*

In 2015,

17.5%

Of Ontarians Aged 12 Or Older, Smoked Either Daily Or Occasionally+

$2.2 BILLION In Direct Health Care Costs*

$5.3 BILLION In Indirect Costs*

+ Canadian Community Health Survey, 2015.

* Evidence to Guide Action: Comprehensive Tobacco Control in Ontario, 2010.

Ontario's 40-YEAR Tobacco Control Journey

Ontario Is On A Journey To Make The Province Tobacco-Free*

Over the past 40 years, this journey has required the vision and commitment from multiple stakeholders to prevent young people from starting to use tobacco, to protect people from exposure to second-hand smoke, and to reduce tobacco use. While tremendous gains have been made in each of these areas, the journey is not complete. With the emergence of new products, such as e-cigarettes, there is the ever present need to continue efforts and not erode the great gains made so far.

1970

- National Non-Smoking Week (NNSW) begins

1980

- Smoking and Health in Ontario: A Need for Balance Task Force On Smoking
- Introduction of Mandatory Programs and Services Guidelines for public health

1990

- Chief Medical Officer of Health Report: Tobacco and Your Health
- Ontario Tobacco Strategy
- *Tobacco Control Act Enacted*
- Chief Medical Officer of Health Report: Sounding the Alarm
- Expert Panel Report: Actions will speak louder than words

2000

- Smoke-Free Ontario Strategy
- *Smoke-Free Ontario Act*
- Retail Display Bans
- Smoking in cars with kids under 16 illegal

2010+

- Smoking in outdoor public spaces illegal
- Flavoured tobacco banned
- Hospitals grounds smoke-free
- *Electronic Cigarette Act* for sale and supply to minors
- Menthol added to flavor ban.

*the term 'tobacco-free' and any use of the word tobacco (as in tobacco products) is meant to refer to commercial production, distribution, sale, and consumption. The term does not refer to the sacred use of tobacco as pratised among First Nations people.

The Smoke-Free Ontario Strategy

Since 2005 the Smoke-Free Ontario Strategy (SFOS), which is under the jurisdiction of the Ministry of Health and Long-Term Care (MOHLTC), has led the province's comprehensive efforts to address tobacco control. Based upon internationally-accepted best practices for tobacco control from the Center for Disease Control (CDC) in the United States, the Strategy employs programs, policies, laws, and public education in 3 areas:

CESSATION

Help Smokers Quit

PROTECTION

Protect People From Exposure To Second-Hand Smoke

PREVENTION

Encourage Young People To Never Start Smoking

TCANs are core to the implementation of the Smoke-Free Ontario Strategy.

What Are TCANs?

TCANs are 7 geographically distinct locations that exist across Ontario.

TCANs

1. One Public Health Unit is the "Coordinating" location

2. Comprised of a team including the TCAN Coordinator, Youth Development Specialist (YDS) and Program Assistant

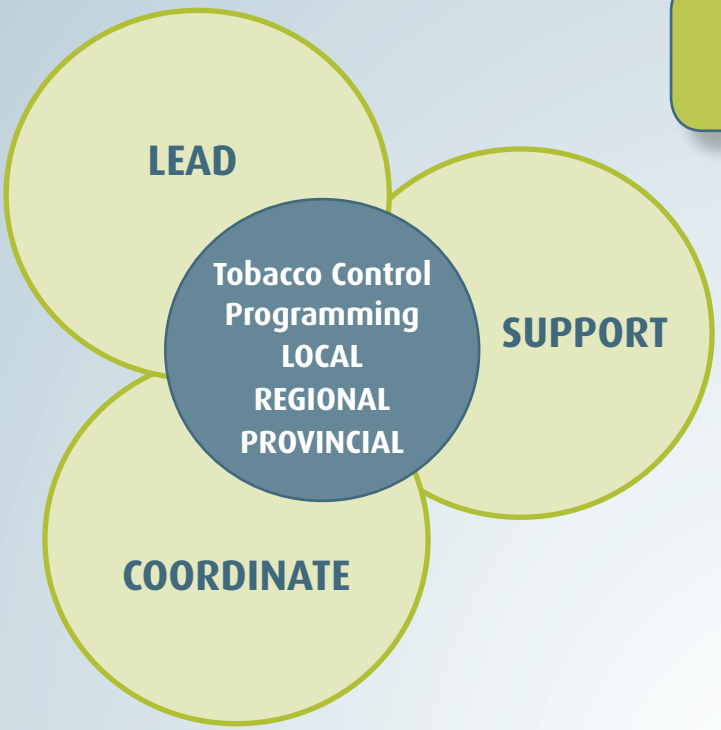
3. Have a Steering Committee with decision making responsibility

4. Sub-committees for Enforcement, Prevention, and Cessation

"TCANs have provided support for great successes in tobacco control over the last ten years. The issue of tobacco use is far from over, but we are transitioning to an end game scenario; aiming for less than 5% tobacco use by the year 2035. To meet this lofty goal, new Tobacco Control Strategies are coming from MOHLTC and Health Canada, and TCANs are primed to be catalysts for change."

Andrea Kruz, TCAN Coordinator, TCAN-East

What Is The Purpose Of TCANs?



LIAISON

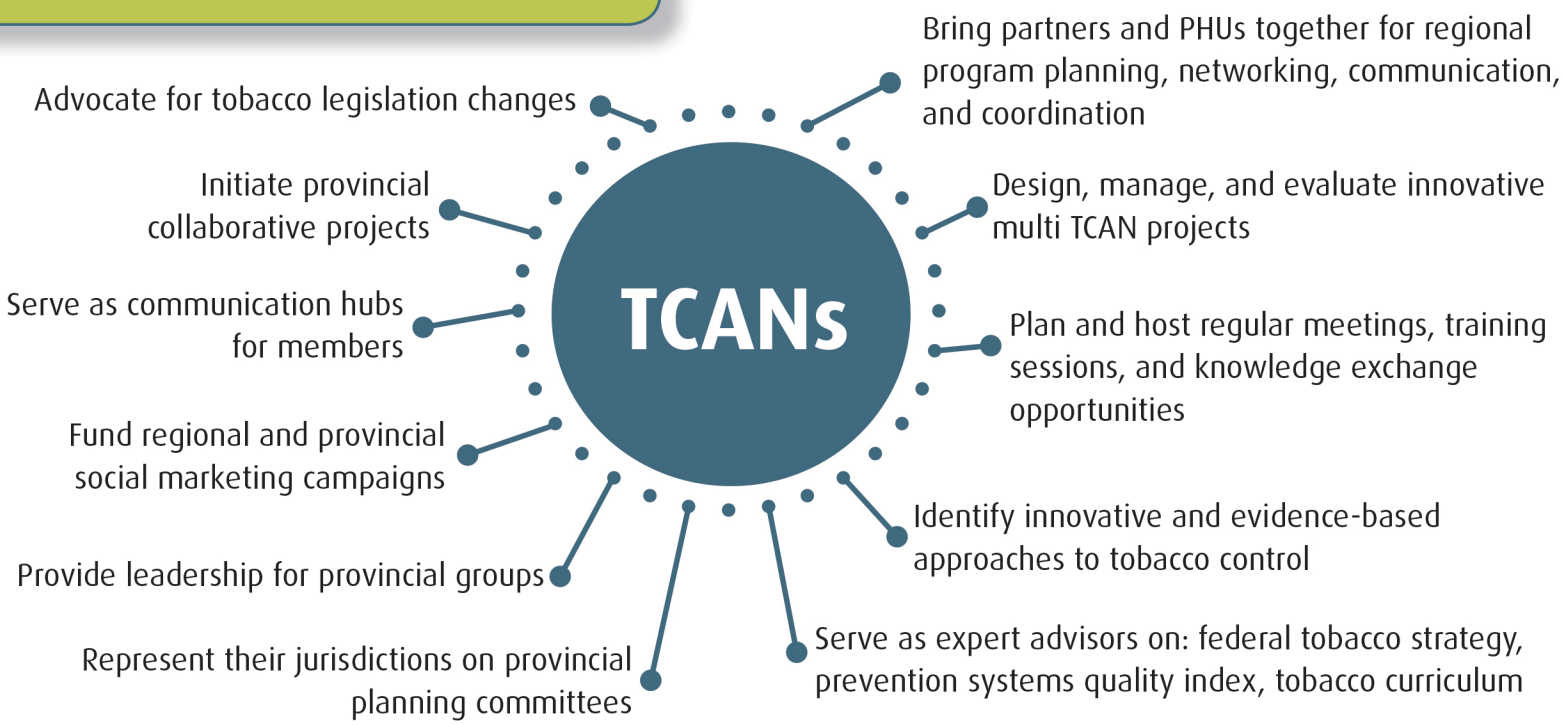
Between TCAN Members And The MOHLTC

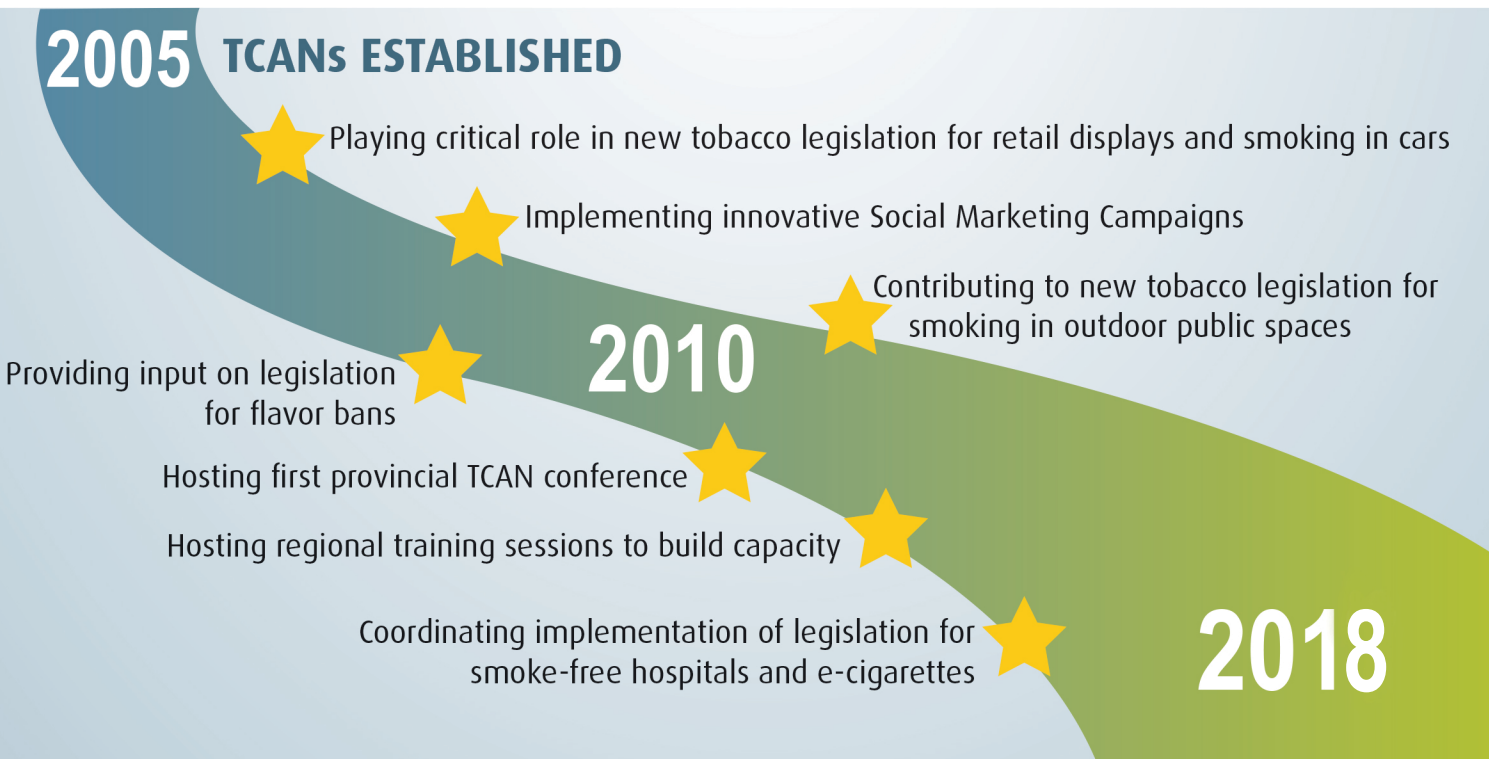
TRUSTED VOICE

Who Funds TCANs?

The Coordinating Public Health Unit (CPHU) receives funding from the MOHLTC. The funds are used for staff, coordination, and collaboration activities. The funding is separate from the local PHU's regular tobacco budget.

What Do TCANs Do?





"Tobacco use is a public health crisis. By working together, SHL, TCANs and individual PHUs have a larger reach and greater impact. Together we can educate more partners on how to help their clients quit smoking and assist more smokers to make more quit attempts and to access evidence-based supports that can help them quit for good."

Elizabeth Harvey, Senior Manager, Partnerships and Promotion, Smokers' Helpline, Canadian Cancer Society

What Impact Are TCANs Making?

Smoke-Free Vehicles

Encourage Quit Attempts

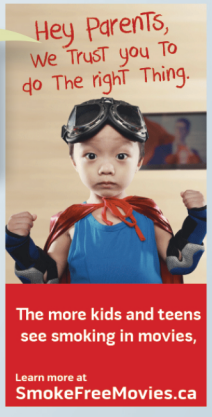
Federal Flavour Bans

Smoke-Free Outdoor Spaces

Smoke-Free Campuses

E-Cigarettes Legislation

No Smoking In 'Under 18A' Movies



ONTARIO COALITION FOR SMOKE FREE MOVIES

Power Wall Education and Enforcement

Prevent Uptake Of Tobacco Products

Reduce Tobacco Use Among The 'Alternative Peer' Crowd

Because of TCANs...

- **There is a clear and strong voice** representing the diverse tobacco-related needs and challenges across the province.
- The goals for tobacco control in Ontario have a **sophisticated network for implementation at the local and regional levels** – on the ground, where it counts.
- There is continuity and **strong institutional memory** – over 50% of TCAN staff has been part of the Strategy since its launch.
- There are **economies of scale** for resources such as advertising, printing, and social marketing campaigns.
- There is a **thriving network** of individuals and organizations that are working collaboratively to **systematically reduce** the devastating effects of tobacco on people in Ontario.
- Communities **learn from** and with **each other**.

"Being connected with colleagues from other PHUs via the TCAN was invaluable, especially when I first started working in public health. They helped provide context to the work, inspired me by sharing information about their approaches, and helped me to think critically about the work that I was planning and completing."

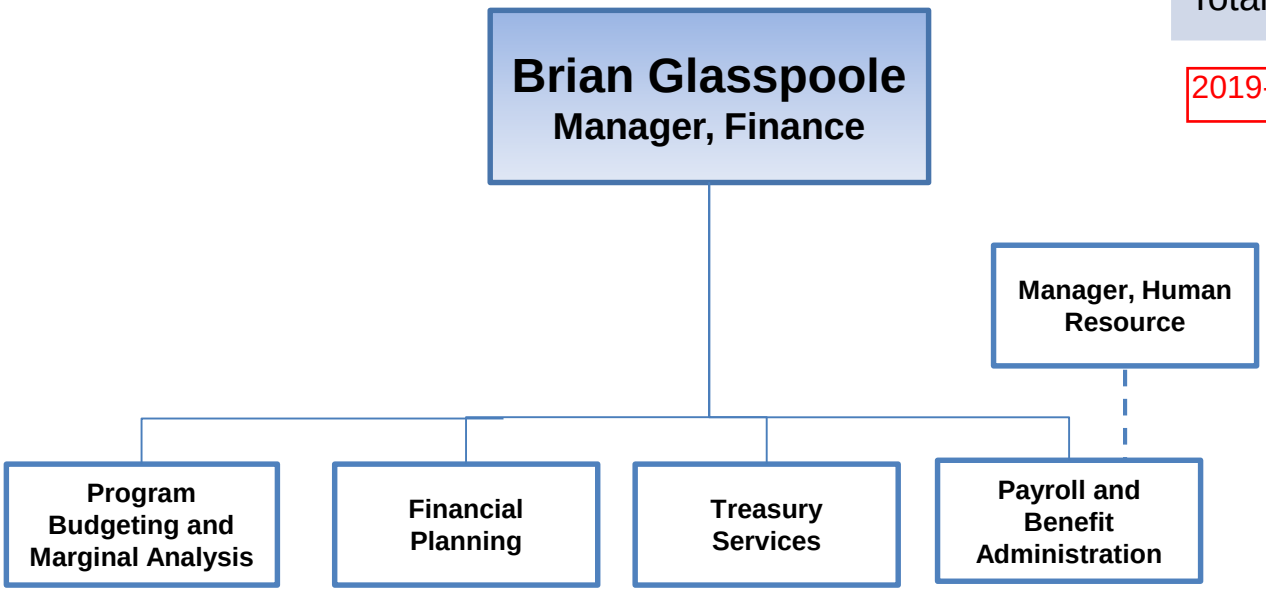
Leigh Ann Darling Health Promoter,
Tobacco Prevention Elgin St. Thomas Public Health

Healthy Organization
Finance

Total FTEs – 5.00 FTEs

Total Budget – $455,506

2019-04-18-BOH-Program-update



Program Highlights:

- Upgrading financial systems to improve efficiencies and financial controls
- Work with Senior Leadership / Board of Health to ensure sustainable program funding and responsible financial management
- Financial policy development/review to ensure the safe guarding of assets, transparent decisions and practices
- Provide financial analysis and support for Health Unit projects such as: program reviews; office location decisions and contract negotiations

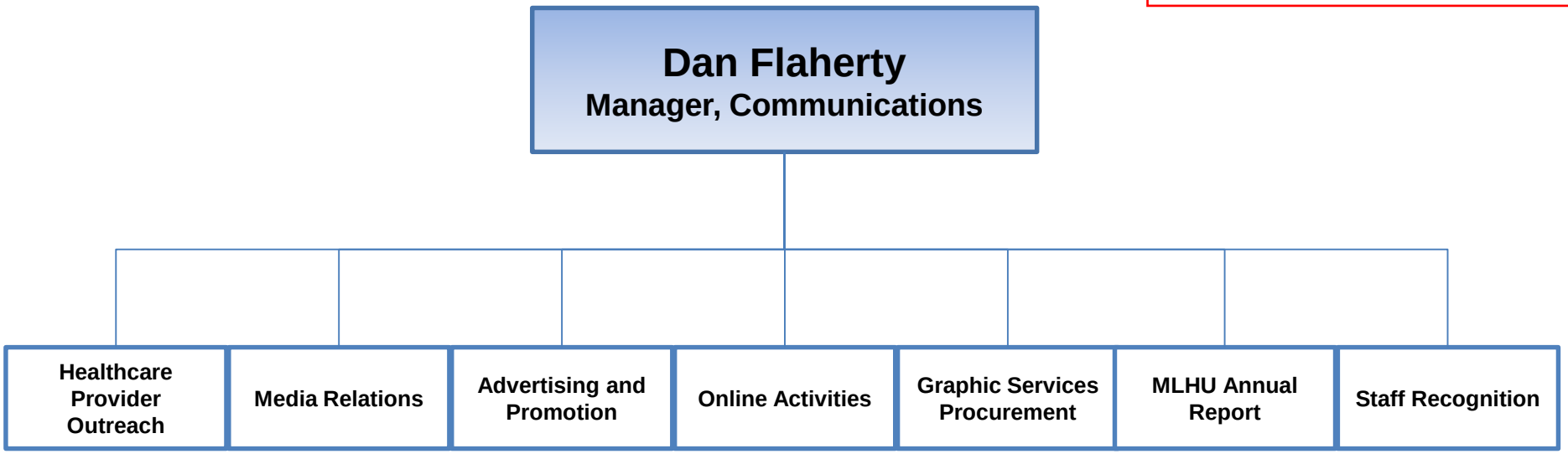
Office of the Medical Officer of Health
Communications

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

Total FTEs – 5.20 FTEs

Total Budget – $531,685

2019-04-18-BOH-Program-update



Highlights:

- MLHU Annual Report
- Implementation of New Corporate Branding and Graphics Standards
- Continued development of Healthcare Provider Outreach Program
- Enhancement of the MLHU's online presence – expansion of new social media platforms, campaigns (through website and social media), audience engagement (contests, etc.), generating audience impressions
- Building capacity for enhanced public-facing communication across MLHU

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 028-19

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2019 April 18

2018 MIDDLESEX-LONDON HEALTH UNIT ANNUAL REPORT

Recommendation

It is recommended that Report No. 028-19 re "2018 Middlesex-London Health Unit Annual Report" be received for information.

Key Points

- As part of the Ontario Public Health Organizations Standards, health units are required to produce an annual financial and performance report to the communities they serve.
- The Middlesex-London Health Unit's Annual Report for 2018 outlines its mission and role and highlights the activities and achievements of the programs and services provided through its five Divisions over the course of the year. The 2018 Annual Report is attached as Appendix A.

Background

Each year, Ontario health units produce an annual financial and performance report to the communities they serve. This public reporting of the Health Unit's activities aims to ensure transparency and accountability to the community and stakeholders.

The Middlesex-London Health Unit's 2018 Annual Report (Appendix A) provides a summary of activities, achievements and information about the Health Unit's Divisions and the work undertaken by teams over the course of the year. The report provides information on programs and services, as well as the planning and advocacy work that spans infectious disease / outbreak prevention and response, environmental health, chronic disease prevention, support for young families and child development. The financial reporting included in the 2018 Annual Report provides a helpful breakdown of the Middlesex-London Health Unit's funding, and how those funds are distributed among cost-shared and 100%-funded programs and services.

Next Steps

The 2018 Annual Report can be found on the health unit's website and will be shared widely with other health units, community partners and stakeholders.

This report was prepared by Communications, Office of the Medical Officer of Health.

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

Appendix A to Report No. 028-19

MLHU

annual report 2018

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

A note from the Medical Officer of Health and CEO

This year has been a time of renewed focus on supporting those in our community with the greatest needs.

As the drug crisis intensified in London and Middlesex, we looked at those who struggle with addiction, homelessness, and other crushing burdens through a new lens. With data from only three quarters of the year available at the time of writing this note, it's already clear that we had more deaths due to opioid poisoning in 2018 than ever before. This shifts addiction from being a chronic disease to being acutely fatal.

Ontario's first legally-sanctioned temporary overdose prevention site, or TOPS as it came to be known, became a success. The service not only led to the creation of new and meaningful relationships but both saved and changed hundreds of lives. Over 80 potentially fatal opioid poisonings were reversed, and in the first 150 days of operation, staff at TOPS referred 150 people to addiction treatment. Dozens more were referred to housing, social services, and other healthcare services.

We also continued to build connection and understanding with our local First Nations through our reconciliation efforts. We invested in improving relationships through staff training and also through a new partnership with the Southwest Ontario Aboriginal Health Access Centre. This innovative partnership provides oral health care for local Indigenous people, and preventive services to local children and youth who wouldn't otherwise have access to dental care.

For the staff of the Middlesex-London Health Unit, 2018 was a year when we lived our vision of helping people to reach their potential in new and meaningful ways. As we strive to bring kindness, compassion and love to our work, each interaction is part of our broader mission to promote and protect the health of our community.

On the following pages of this report you'll learn much more about the work of our staff and our teams. Our work spans infectious disease and outbreak prevention and response, environmental health, chronic disease prevention, and support for young families and child development. The Middlesex-London Health Unit is a crucial part of protecting and promoting your health, and we are proud to serve the people of London and Middlesex.

Sincerely,

Dr. Christopher Mackie
Medical Officer of Health / Chief Executive Officer
Middlesex-London Health Unit

Board Chair Greetings

As chair of the Board of Health, I'm pleased to share with you the progress made in 2018, as we continue to offer quality public health services throughout Middlesex County and the City of London.

The Middlesex-London Board of Health is tasked with the responsibility and authority to plan, manage, deliver, monitor and evaluate public health services in the region. The Board does this in a variety of ways, including providing oversight, ensuring the organization's accountability by monitoring and evaluating its performance, and interacting and communicating with its stakeholders and partners, and public we serve.

It can be daunting when the decisions you make touch the lives of the residents you represent each and every day. Having Board of Health members with diverse perspectives and backgrounds, representing the unique needs of our communities, is invaluable to helping the organization identify and respond to community needs.

In 2018, we completed a health needs scan of Middlesex County, which included a survey. We also held meetings with local municipal councils to identify any gaps in service and determined how best to serve the needs of our rural residents, and residents of our small urban centres.

The work of public health is constantly evolving to address rapidly growing demands in an ever-changing environment. Over the last several years we have seen evidence of this in the opioid crisis and concerns about addiction; the importance of mental health promotion; the societal impacts of poverty; the importance of achieving health equity; and ensuring we are there to meet the needs of our entire population.

The Board of Health and Health Unit staff members are committed to an ongoing process to work alongside our Indigenous community partners and communities to develop respectful and productive relationships that ultimately lead to better health outcomes.

In closing, I would like to express my sincere thanks to the members of our hard-working, engaged and committed Board of Health and to our dedicated, extremely knowledgeable staff for their many contributions over the past year. I am very grateful to all of them for their service, leadership and guidance.

When we come together as a team committed to the wellbeing of our communities, positive outcomes happen.

Sincerely,

Joanne Vanderheyden
Chair Middlesex-London Board of Health

Back row left to right: Michael Clarke, Tino Kasi, Kurtis Smith, Marcel Meyer, Trevor Hunter, Ian Peer
Front row left to right: Trish Fulton, Dr. Chris Mackie, Joanne Vanderheyden, Jesse Helmer, Maureen Cassidy

REPRODUCTIVE HEALTH TEAM

The Reproductive Health Team works alongside individuals and families from across London and Middlesex County, encouraging them during pregnancy and helping them to be as prepared and as healthy as possible leading up to the birth of a child.

Grow Towers Making a Difference

Through the Smart Start for Babies program, the team continued to encourage the consumption of fresh vegetables and herbs in early 2018, by purchasing a third aeroponic tower garden, this time to support the Prenatal Immigrant Program. The tower is located at, and maintained by, the South London Neighbourhood Resource Centre. Tower gardens are designed to grow a variety of vegetables, herbs and flowers indoors, in a minimum amount of space. Among the produce harvested from the grow towers are gourmet lettuce, romaine lettuce, spinach, arugula, bok choy, kale, basil, cilantro, chives, parsley and thyme.

The tower garden at the South London Neighbourhood Resource Centre joins other grow towers already in use at the Health Unit's 50 King Street offices and at the Argyle Family Centre in East London.

Healthy Start

National Breastfeeding Week

As an early kick-off to National Breastfeeding Week (NBW), the team held its annual Breastfeeding Challenge on the morning of Saturday, September 29th. To celebrate the NBW theme of *Breastfeeding – Foundation of Life,* MLHU staff aimed to have as many breastfed children as possible from across the region together at the same time.

In addition to the Breastfeeding Challenge, the team also welcomed guest speaker Dr. Emma Allen-Vercoe, from the University of Guelph, as part of National Breastfeeding Week. Dr. Allen-Vercoe spoke about her studies in the area of the microbiome that exists within the human gut and how these trillions of microbes are vital for overall health. She also presented the reasons why this community of microbes is especially important and how aspects of modern living can have a negative effect on this biome, with potential health detriments.

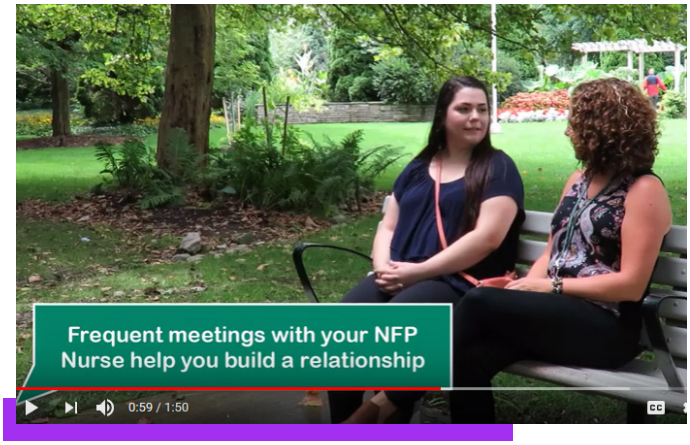
The presentation was live-streamed to the Internet through the Health Unit's Facebook page.

BEST BEGINNINGS TEAM

The Best Beginnings Team provides programs and services that support healthy child development while building parenting skills with families facing challenges who have infants and young children. The team provides these services through the Healthy Babies Healthy Children (HBHC) program and the Nurse Family Partnership®.

The HBHC program is for families expecting the birth of a child, as well as for families with children, from the time they are born until they start school. Public Health Nurses and Family Home Visitors offer home visits to support families through various challenges they may face. Visiting families in their homes provides the opportunity for HBHC staff and families to develop a relationship and by working together, to build skills that strengthen family resilience. The HBHC program celebrated its 20th anniversary in 2018.

The Nurse-Family Partnership® is an intensive home visiting program for young, low-income, first-time mothers. Public Health Nurses develop a strong relationship with young women, beginning early in their pregnancy, that continues until the child's second birthday.



Nurse-Family Partnership®:
In 2018, the *Nurse Family Partnership®* developed a short video to promote the program. Featuring a young mother who shares her experiences working with MLHU staff, the video has helped to increase awareness of the program and the positive benefits it can provide for young families. Since it began, the *Nurse-Family Partnership®* has received 109 referrals for services.

As the program continued to encourage young women and their children, 2018 also marked the end of the *Canadian Nurse-Family Partnership Education* pilot program. The goal of the program was to develop, pilot, and evaluate a Canadian model of education for Nurse-Family Partnership® nurses and program supervisors. Results of the evaluation will be shared early in 2019 and will be used to shape *Nurse-Family Partnership®* education across the country.

EARLY YEARS TEAM

The Early Years Team uses a variety of strategies to provide services to families with young children. The team's goal is to improve a child's physical, emotional, and social health and development from when they are born until they start school. Health Unit staff provide direct client services and referrals to other agencies and service providers in London and Middlesex County, as they support families and caregivers across the region. The team's areas of focus include breastfeeding, growth and development, mental health promotion, positive parenting, infant care, and child safety.

In January of 2018, the Early Years Team launched a new program called *Precious Moments*. Created in partnership with the South London Neighbourhood Resource Centre, *Precious Moments* offers community-based support for Arabic-speaking women who are new to Canada and who have a baby under the age of six months. It focuses on infant health and overall maternal mental wellness. The program is a great example of the valuable partnerships the Health Unit has with other community agencies.

FOOD SAFETY AND HEALTHY ENVIRONMENTS TEAM

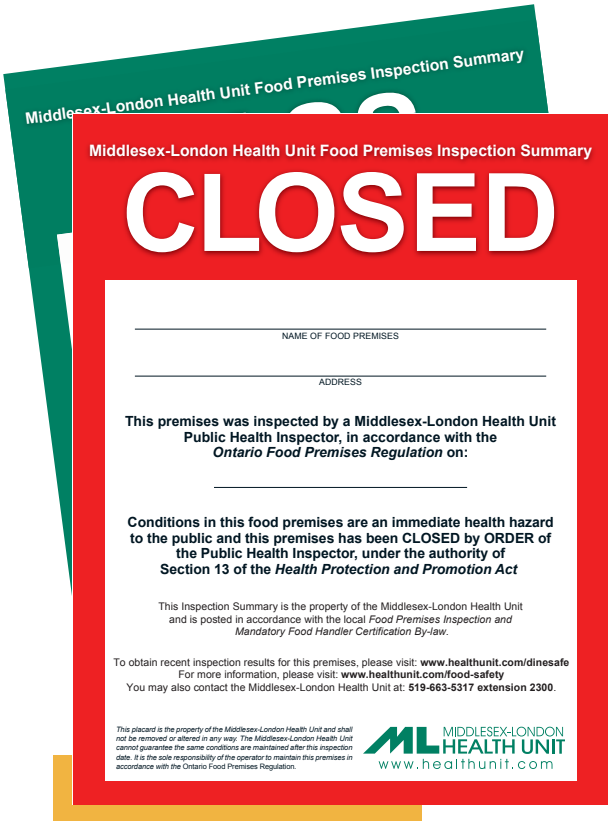
In addition to conducting inspections at all premises that sell food in London and Middlesex County, the Food Safety and Healthy Environments Team also monitors local forecasts for potential extreme weather events, as part of its efforts related to climate change.

Extreme temperature notifications

In the summer, extreme temperature notifications are issued based on forecast highs and lows as well as humidex values, in addition to the length of time when those conditions will persist. When the Environment Canada forecast calls for daytime highs of 31° Celsius or more combined with lows of no less than 20° Celsius and / or a Humidex of 40 or higher, the Health Unit notifies the community of an extreme heat event. The Health Unit will issue a *Heat Alert* when conditions are expected to last for a day, *Heat Warnings* are issued when these conditions last for two consecutive days, and *Extended Heat Warnings* are issued when hot and hazy weather continues for three consecutive days, or more.

During winter months, the Team will issue *Cold Weather Alerts* when the forecast calls for the mercury to dip to –15° Celsius or colder, when windchill values are forecast to reach –20, or when Environment Canada issues a *Cold Alert* or *Cold Warning* of its own.

A very cold start to 2018 led to the Health Unit issuing five *Cold Weather Alerts*, including one which started on January 2nd and lasted six days. Between May 28th and September 24th, the Team also issued six *Heat Warnings*. Extreme temperature notifications are shared widely with school boards, private schools, child care centres, local municipalities and others. These notices are shared so that administrators and decision makers can make decisions that help reduce potential harms related to extreme heat or extreme cold.



Dine Safe – Inspection Disclosure System

As the Team's name would suggest, the Food Safety and Healthy Environments Team also conducts inspections of businesses that sell food to members of the public. This includes restaurants, grocery stores, convenience stores, gas stations and more. Public Health Inspectors with this team visit food premises and consider 46 criteria set out in the *Health Protection and Promotion Act,* which allow inspectors to determine if an establishment is being operated in a safe and sanitary way. Through the *DineSafe* program, inspection results are displayed on a coloured sign at each food premise indicating the Public Health Inspectors' findings during their last inspection:

- Green – Pass: The establishment was found to be in substantial compliance with the Ontario Food Premises Regulation;
- Yellow - Conditional Pass: The establishment was found to have significant non-compliance with specific areas of the Ontario Food Premises Regulation;
- Red – Closed: Conditions in the establishment pose an immediate health hazard to the public and the premises has been closed by order of the Public Health Inspector, under the authority of Section 13 of the Health Protection and Promotion Act.

The team completed 3,279 food premises inspections and 325 re-inspections in 2018. The team also acted upon 1,260 food safety complaints and 1,395 health hazard complaints in addition to responding to numerous service requests. During 2018, the team also issued 3,447 Food Handler Training Certificates to those who completed the training.

VACCINE PREVENTABLE DISEASES TEAM

As its name would suggest, the Vaccine Preventable Diseases (VPD) Team spends much of its time working to reduce or eliminate the incidence of vaccine preventable diseases in London and Middlesex County. The team uses a multi-disciplinary approach to achieve this goal. First, team members lead immunization clinics in schools, as well as in community and clinic settings. They also review and update students' immunization records as required under the *Immunization of School Pupils Act*. Finally, they provide educational opportunities and consult with local healthcare providers, as well as local residents about vaccines and immunizations. In addition, the team oversees the distribution of publicly-funded vaccines to healthcare providers, and inspects the refrigerators where these are stored. The team also investigates cases of vaccine-related reportable diseases.

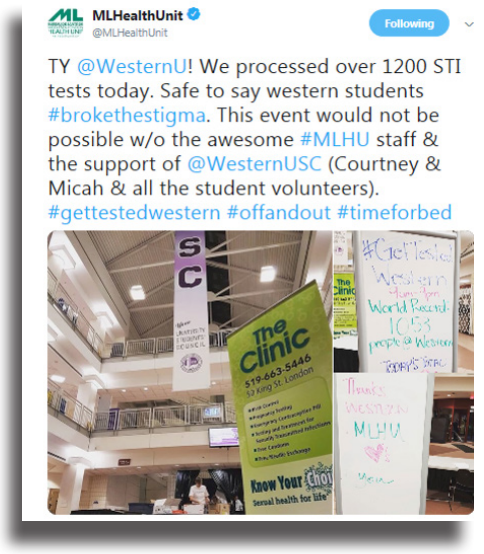
Immunization Program

In 2018, the VPD Team began to adjust its efforts with a new focus on priority populations, in an effort to better meet the needs of people who require immunizations, but who don't have a family physician. The Team also adjusted its clinical services to make sure that children under the age of 18, who require the vaccinations set out in the *Ontario Child Care and Early Years Act* as well as the *Immunization of School Pupils Act* received the immunizations they needed.

Another important initiative introduced in 2018 was the *Immunization Connect Ontario*, or ICON, system, which allows parents to enter and update their children's immunization information online. Once entered by parents, the information is reviewed by VPD staff and incorporated into the individual immunization records the Health Unit maintains as part of its legislative responsibilities. Over the course of the year, staff members entered 24,682 individual vaccinations, updating the records of 3,597 individuals. There were also 7,272 yellow immunization record cards downloaded from ICON in that time.

SEXUAL HEALTH PROMOTION TEAM

Staff members working with the Health Unit's Sexual Health Promotion Team were busy in 2018. The team played a key role in the response to the opioid crisis and operations at London's Temporary Overdose Prevention Site (TOPS). It also continued to build relationships and provide important services to under-housed and street-level populations through the Outreach Team, while getting involved in the annual *Get Tested Western!* event. Staff from Western University and the Sexual Health Promotion Team joined forces for the 4th edition of the event at Western's University Community Centre. While they had set a new world record in 2017, testing 1,053 people for a sexually-transmitted infection in just 12 hours, staff and volunteers were amazed at the turnout in 2018. Incredibly, by the end of the twelfth hour, more than 1,200 people had been screened, setting a new benchmark for STI testing in one day.



OUTREACH TEAM

In October, the Health Unit's Outreach Team was honoured for its important and compassionate work, when it was awarded St. Joseph's Health Care's *Community Partner of Distinction Award*, which recognizes partnership and collaboration. In presenting the award, St. Joseph's described the team as an exemplary community partner and a kind, caring and compassionate group that goes above and beyond to support its patients. The Outreach Team works collaboratively to locate patients, provide transportation to clinic appointments and even attends the appointments with patients. The team often connects with patients through social media, email, text messages and always demonstrates a heightened level of care and understanding.

INFECTIOUS DISEASE CONTROL TEAM

There is a list of 70 Diseases of Public Health Significance within the text of the *Health Protection and Promotion Act*. Healthcare providers who become aware of, or diagnose, a case of one of these diseases must report it to their local public health unit. It is this list of 70 diseases that forms the backbone of the work undertaken by the members of the Infectious Disease Control (IDC) Team. Along with local partners, the team works diligently to detect, follow-up and control any incidences of these illnesses that may occur in the community. In addition to working with individuals who may have become ill, the team also conducts inspections in institutional settings including childcare centres, long-term care homes, hospitals and others, for food handling and/or infection control practices. While conducting these inspections, staff also conduct cold-chain inspections to verify that any vaccines held at these institutions are handled properly and are maintained at the proper temperatures.

World Hepatitis Day

In late July, and as part of the global effort to raise awareness about hepatitis testing, prevention and treatment, the Team marked *World Hepatitis Day* with a special event at London's Covent Garden Market. The team provided snacks, giveaways and challenged community members' trivia skills as it discussed viral hepatitis, testing and the supports available in our community.

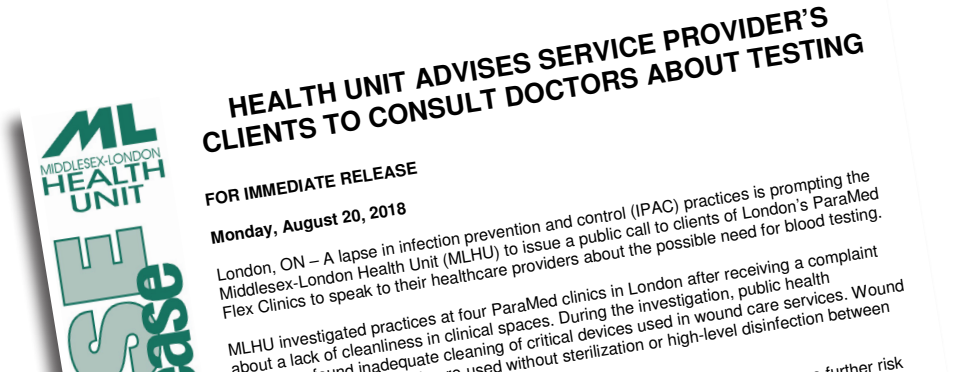
Flex Clinic Investigation

In August, the IDC Team became aware of a lapse in infection prevention and control practices at a London "flex" clinic. The discovery of inadequate practices led to a call for clients to speak to their healthcare providers about the possible need for blood testing. The number of clients who were advised through letters sent to their homes exceeded 10,000. Thankfully no cases of blood-borne infections associated with the situation were identified.

Hepatitis A Outbreak

With the fall of 2018 came an unexpected hepatitis A outbreak that demonstrated some of the health inequities that exist among local residents from different socio-economic levels. For several months, members of the IDC Team observed a growing number of hepatitis A cases, mostly among under-housed or homeless Londoners, and also among those who inject drugs. Where staff would only expect to see about three cases of hepatitis A per year, most of which would be travel-related, there had been 16 non travel-related cases by mid-October. The team continued to manage this hepatitis outbreak through the end of 2018, with on-going work continuing into 2019.

members of the IDC Team observed a growing number of hepatitis A cases.


MIDDLESEX-LONDON HEALTH UNIT

HEALTH UNIT ADVISES SERVICE PROVIDER'S CLIENTS TO CONSULT DOCTORS ABOUT TESTING

FOR IMMEDIATE RELEASE

Monday, August 20, 2018

London, ON – A lapse in infection prevention and control (IPAC) practices is prompting the Middlesex-London Health Unit (MLHU) to issue a public call to clients of London's ParaMed Flex Clinics to speak to their healthcare providers about the possible need for blood testing.

MLHU investigated practices at four ParaMed clinics in London after receiving a complaint about a lack of cleanliness in clinical spaces. During the investigation, public health found inadequate cleaning of critical devices used in wound care services. Wound

SAFE WATER, RABIES AND VECTOR-BORNE DISEASES TEAM

Glencoe Watermain Break

A summertime water main break in Glencoe led to a *Boil Water Advisory* being issued for the village on July 30th. Staff members with the Safe Water program responded to the incident, which led to a loss of pressure in the distribution system, creating the potential for contaminated water to enter the water supply, rendering it unsafe to drink. To supplement water being boiled in local residences, the Municipality of Southwest Middlesex also acted quickly and provided bottled water to residents while remedial work was being completed. Repairs to the system, as well as the roadway where the water main break occurred, were completed within a few days and the Boil Water Advisory was lifted on August 1st.

West Nile Virus

The summer is also when the majority of the Vector-Borne Disease program's work is done. As sunny days and warmer weather draw people out of their homes, it's also when we need to protect ourselves from mosquitoes. On July 31st, the Health Unit issued a release advising that one of its mosquito traps contained insects that had tested positive for West Nile Virus (WNV). The trap, located near Springbank Drive and Wharncliffe Road, may have been the first, but it was not the last found to contain WNV-positive mosquitoes, during the summer of 2018.

A month later, the Health Unit provided an update, reporting that there had been a human case of WNV and an additional six mosquito traps containing bugs that tested positive for the disease. Even though the end of summer was around the corner, it was clear that the mosquitoes were still biting. While the Health Unit went on to report that the infected individual showed no symptoms of the virus, their diagnosis, combined with finding more West Nile Virus-positive mosquitoes was significant. The half dozen traps were located in areas that cover wide parts of London, as well as central and western Middlesex County, suggesting mosquito populations capable of spreading West Nile Virus were established across a wide area.

Key Statistics from the Safe Water, Rabies and Vector-Borne Diseases Team

Recreational Water:

- A total of 696 recreational water facility inspections were conducted by Public Health Inspectors

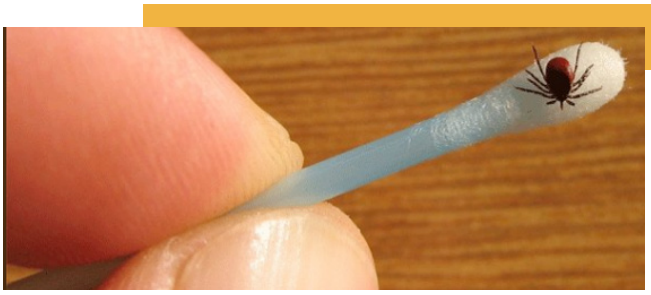
Drinking Water:

- Enhanced Private Well Water Program: 289 phone calls to notify and discuss adverse water test results
- Training manual for Small Drinking Water Systems (SDWS) owners and operators was developed. Small Drinking Water Systems (SDWS) owner/operator training sessions will start early 2019.
- 243 adverse water quality incidents reported to the MLHU, which were followed-up promptly.

Rabies Prevention and Control: Investigation of 950 animal biting incidents; responded to within 24 hours; 99 clients received Post Exposure Prophylaxis. Four bats tested positive for rabies.

Vector-Borne Disease: 301 tick submissions, 13 WNV positive mosquito pools, 110,821 larval treatments to catch basins located on public property, continued to monitor for the presence of mosquitoes capable of carrying the Zika Virus in Middlesex-London with new sentinel traps. No Zika vector mosquitoes were identified.

110,821 larval treatments



950 animal biting incidents

Opioids Response 2018

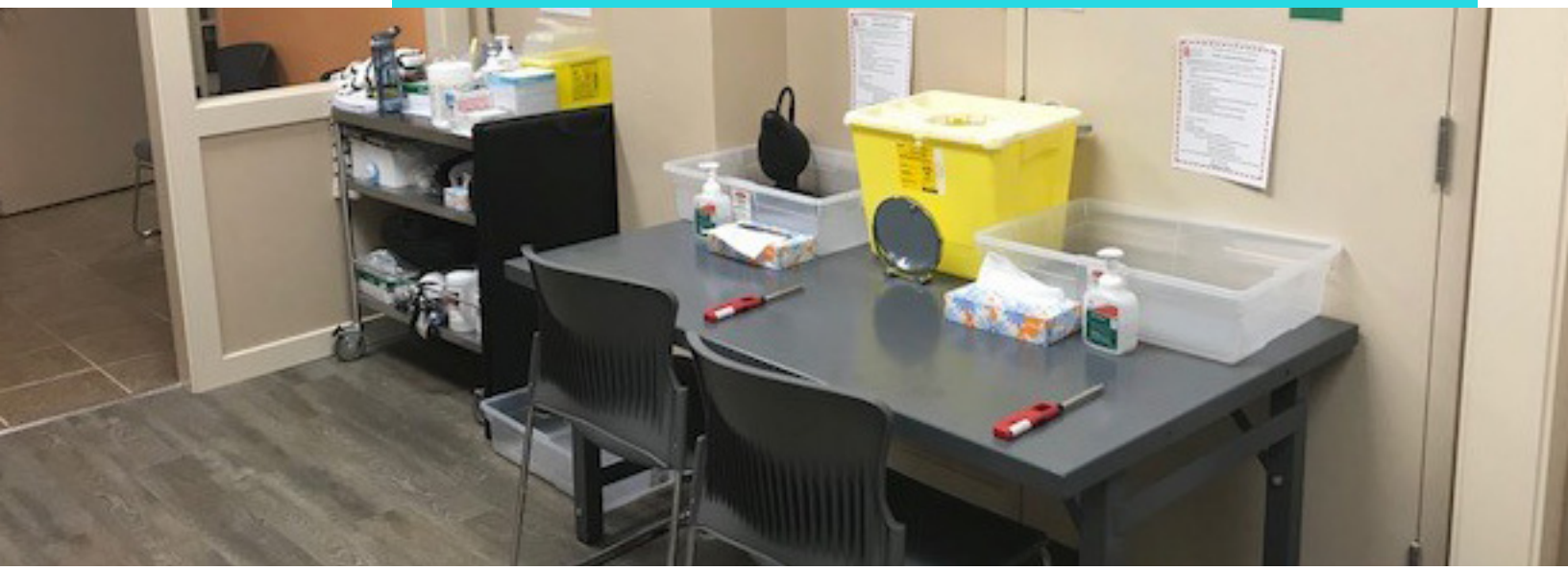
One of the biggest challenges of 2018 was also one of its greatest opportunities. For several years, the Middlesex-London Health Unit had been facing a growing crisis brought on by multiple and overlapping drug-related issues. As Health Unit staff reviewed the data and consulted with partners, an image emerged of the damage done by opioid drugs and a rising number of HIV cases associated with injection drug use. These were reaping a devastating toll among some of the most marginalized people in our community.

"The misuse of opioid drugs has claimed thousands of lives across the country over the last decade, including nearly 400 deaths in our community alone. In contrast to the decline in the provincial HIV infection rate, the rate in our community is climbing due to injection drug use," said Dr. Chris Mackie, Medical Officer of Health and CEO at the Middlesex-London Health Unit in early December of 2017.

There were no easy answers or apparent solutions to the opioid crisis. What was obvious was the need for an urgent and novel response.

TOPS – London's Temporary Overdose Prevention Site

By the late fall of 2017, the Health Unit and its partners, including Regional HIV / AIDS Connection (RHAC), were seeking input about the establishment of permanent Supervised Consumption Facilities (SCF) in London. They gathered input, ideas and feedback through a series of community consultations, an online survey and four focus groups that included 56 participants representing the Indigenous community, peers and professionals. While work on the plan to establish permanent Supervised Consumption Sites was already underway, a provincial decision opened the door to the rapid response that was needed in London's downtown core.



On December 6th, the Ministry of Health and Long-Term Care announced Ontario was facing a public health emergency due to the opioid crisis and moved to allow for the creation of temporary overdose prevention sites. These sites would aim to prevent deaths by allowing drugs to be consumed in a safer and supervised environment. A key condition necessary for the creation of these facilities came when the Government of Canada allowed provinces facing the opioid crisis to seek exemptions under federal law, making drug consumption at temporary overdose prevention sites legal. Within days, the MLHU and its partners began working towards establishing a legally-sanctioned, temporary overdose prevention site in downtown London.

With much of the information necessary to apply for a temporary overdose prevention site in London already in place, including data gathered from public meetings, the online survey and focus groups, the search for a site was underway. Key findings from the consultation process were instrumental in the planning phase including the importance of access to integrated services linking to wraparound support, treatment and rehabilitation in a proposed facility.

As the drug crisis intensified in London and Middlesex, the Health Unit and its partners looked at those struggling with addiction, homelessness, and other crushing burdens, through a new lens.

"This is a life and death matter, and I am pleased with the provincial announcement to support immediate opening of Overdose Prevention Sites," said Sonja Burke, Director of Counterpoint Harm Reduction Services at RHAC. "It's a definitive statement that every life is valuable and harm reduction is a critical part of the addictions continuum."

On January 12th, the Middlesex-London Health Unit, RHAC and their partners, including the Southwestern Ontario Aboriginal Health Access Centre, London CAReS; Addictions Services of Thames Valley, London Intercommunity Health Centre and the Canadian Mental Health Association submitted the first application for a temporary overdose prevention site in Ontario.

"This is a life and death matter, and I am pleased with the provincial announcement to support immediate opening of Overdose Prevention Sites,"

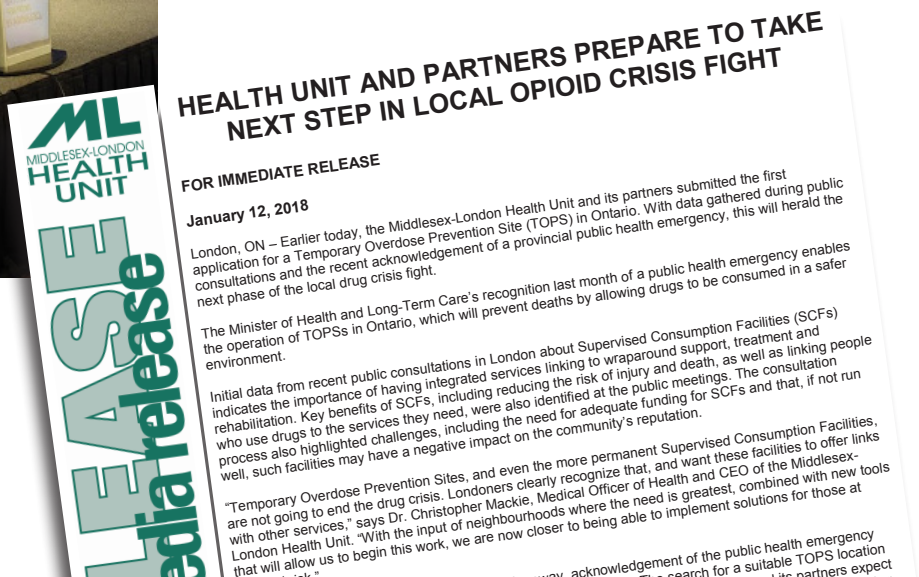
Within a week, the Ministry of Health and Long-Term Care had approved the application and provided one-time funding in the amount of $130,700. The facility would be located at 186 King Street, in space shared with RHAC and the Counterpoint Needle and Syringe Program, creating a needed service in a location already familiar to people who use injection drugs.

London's Temporary Overdose Prevention Site, or TOPS as it came to be known, opened its doors on Monday, February 12th, and quickly began to make a mark in the fight against opioids and the toll they were taking on the community.

From just four clients the first day, to 44 two weeks later, clients were gaining confidence and trust in the facility and its staff. The London Police Service also reported that they had not seen any changes in the level of activity in the area near the facility since TOPS had opened.

By the end of 2018, the service had not only led to the creation of new and meaningful relationships but it had both saved and changed hundreds of lives. Over 80 potentially fatal opioid poisonings were reversed, and in the first 150 days of operation alone, staff at TOPS referred 150 people to addiction treatment. Dozens more were referred to housing, social services, and other healthcare services.

The important life-saving and life-changing work done at TOPS was recognized at the 2018 Pillar Community Innovation Awards, when the partners who created and continue to operate the facility, received the award for Community Collaboration.


ML MIDDLESEX-LONDON HEALTH UNIT

Media release

HEALTH UNIT AND PARTNERS PREPARE TO TAKE NEXT STEP IN LOCAL OPIOID CRISIS FIGHT

FOR IMMEDIATE RELEASE

January 12, 2018

London, ON – Earlier today, the Middlesex-London Health Unit and its partners submitted the first application for a Temporary Overdose Prevention Site (TOPS) in Ontario. With data gathered during public consultations and the recent acknowledgement of a provincial public health emergency, this will herald the next phase of the local drug crisis fight.

The Minister of Health and Long-Term Care's recognition last month of a public health emergency enables the operation of TOPSs in Ontario, which will prevent deaths by allowing drugs to be consumed in a safer environment.

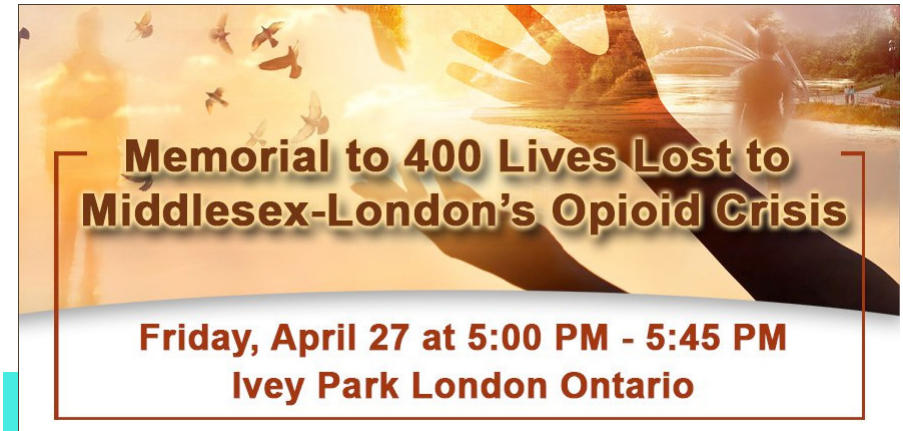
Initial data from recent public consultations in London about Supervised Consumption Facilities (SCFs) indicates the importance of having integrated services linking to wraparound support, treatment and rehabilitation. Key benefits of SCFs, including reducing the risk of injury and death, as well as linking people who use drugs to the services they need, were also identified at the public meetings. The consultation process also highlighted challenges, including the need for adequate funding for SCFs and that, if not run well, such facilities may have a negative impact on the community's reputation.

"Temporary Overdose Prevention Sites, and even the more permanent Supervised Consumption Facilities, are not going to end the drug crisis. Londoners clearly recognize that, and want these facilities to offer links with other services," says Dr. Christopher Mackie, Medical Officer of Health and CEO of the Middlesex-London Health Unit. "With the input of neighbourhoods where the need is greatest, combined with new tools that will allow us to begin this work, we are now closer to being able to implement solutions for those at

...acknowledgement of the public health emergency ... search for a suitable TOPS location ... partners expect

Riverside Memorial to More Than 400 Lives Lost
April 25, 2018

Against the backdrop of an overcast afternoon on the banks of the Thames River, a large group of people gathered to remember the lives lost to the opioid crisis over the last decade in London. Representatives from local organizations and agencies involved on the frontlines of the crisis joined politicians, those who have lost loved ones and, in some cases, those who have struggled with addiction themselves, in a moving memorial on April 25th. The memorial included music, spoken tributes and an original poem from London Poet Laureate Tom Cull, in tribute to those who have become casualties in the battle against opioids.



The lessons learned from waging battle against these powerful drugs are reminders of the pain and suffering endured not only by those who lost their lives due to drug poisoning, but also among their loved ones and their community.

Dangerous Forms of Opioid Drugs Arrive

In mid-summer, new data about the presence of fentanyl in London, including a spike in the number of opioid-related deaths in the last quarter of 2017, caught the attention of local agencies and organizations on the front lines of the opioid crisis. Information from multiple datasets and a recent warning by London Police that new forms of fentanyl may have arrived in the region, prompted heightened concern from the Health Unit and its partners. The information that had been gathered over the previous months was painting a troubling picture.

While naloxone kits were becoming more widely available, not only through the MLHU, but also through local pharmacies for people who use opioids, and for the friends and family of those who use, the London Police Service also began carrying the potentially lifesaving tools.

"I am deeply concerned about the increase in deaths as the data is showing and, anecdotally, what appears to be an increase in fentanyl-related overdoses that our officers are responding to," London Police Chief John Pare stated in early June. "Starting this week, Naloxone kits are being distributed to all of our officers so they will be able to provide immediate assistance if exposed to fentanyl or to provide immediate assistance to someone who has overdosed."

"Several data sources are showing what appears to be a steadily increasing presence of fentanyl in our community,"

Naloxone is a drug that can reverse an opioid-related overdose, potentially saving a life and making it possible to receive urgent medical care.

"Several data sources are showing what appears to be a steadily increasing presence of fentanyl in our community," said Dr. Chris Mackie, Medical Officer of Health and CEO at the Middlesex-London Health Unit. "What this information tells us is that there is likely more of this substance on our streets and that it is being made available in new and different forms that we haven't seen before."

The potential that fentanyl could be mixed with other drugs without users being aware of it also raised alarm bells, further underscoring the need for those who use these substances to exercise caution to prevent opioid-related poisonings, injuries and overdoses.

As the world marked International Overdose Awareness Day on August 31st, the Health Unit issued a news release indicating that the potential arrival of new and highly toxic forms of opioids to our region was cause for concern.

For several weeks, MLHU staff had been receiving information about an increasing number of opioid-related overdoses and RHAC had issued a community warning the previous week, noting there had been 13 overdoses at TOPS between August 1st and 23rd and an additional six on August 31st alone.

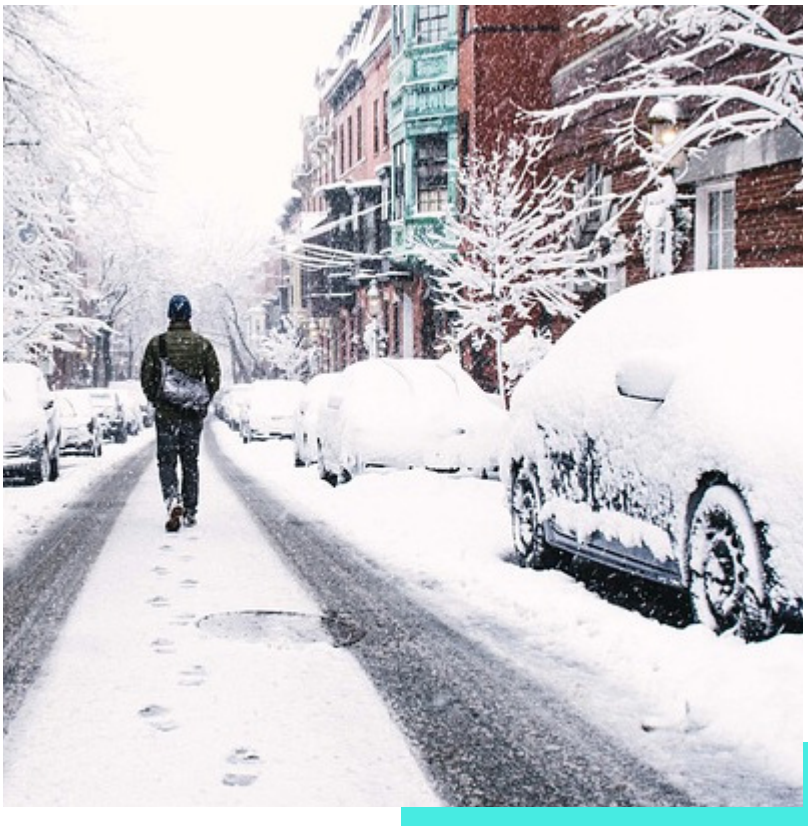
In all of these cases, the overdoses were reversed due to the intervention of staff members as well as the use of oxygen and naloxone. In all but one case, the drug used was fentanyl.

The number of opioid poisonings in the month of August stood in stark contrast with the eight overdoses that occurred, and were reversed, at TOPS between mid-February and August 1st.

Data gathered by the Heath Unit as part of its surveillance of the local opioid crisis indicated the number of opioid-poisonings was increasing, raising concerns that those who inject drugs were being exposed to a new threat.

Working Towards Permanent Consumption and Treatment Services

While the work done at TOPS was showing that positive change can come when a compassionate approach is used, the Health Unit and RHAC also continued to work closely to make permanent Supervised Consumption Facilities a reality in London.



In mid-January, the Health Unit released a report on the public consultations about SCFs that had been held in November of 2017. The data was gathered from 334 people who took part in nine consultations held in November; as well as the more than 2,000 responses to an online survey and four focus groups that included 56 participants representing the Indigenous community, peers and professionals.

Among the findings was that the majority of participants in the consultation process wanted to support people struggling with opioid addiction. The report showed that 90% of respondents identified decreases in drug-related deaths and injuries, and a reduced risk of infectious diseases like hepatitis C and HIV/AIDS, as key benefits of establishing an SCF in London. Consistent with the compassionate tone that would come to characterize the local response to the opioid crisis, only one percent of survey respondents felt SCFs would be of no benefit.

"We've known for some time that people who are facing addictions want and need access to supervised consumption facilities. Now we have data from the community that will help guide the development of these facilities," said Shaya Dhinsa, Manager of Sexual Health with the Middlesex-London Health Unit.

The report's recommendations included a call for multiple and/or mobile SCFs in the city, and an appeal to respect neighbourhood needs and concerns. What became evident was that the crisis was being felt widely across the city and that it was important to create an integrated service model to link some of the most vulnerable people in the community to the support, treatment and rehabilitation they need.

Armed with evidence demonstrating such a facility would be used, and a consultation process showing a strong desire to support those addicted to opioid drugs, the Health Unit and RHAC submitted an application to Health Canada in mid-March, for an SCF in the city of London.

By the end of April, the partners had identified two potential sites for permanent SCFs, one in a residential apartment building located at 241 Simcoe Street and the other in a retail location at 446 York Street, near London's downtown core. In addition to the two physical locations being proposed, the Health Unit and RHAC also applied for a federal exemption to allow for a mobile SCF. The plan would be to have the vehicle make stops at specific locations identified in the community consultation report.

After holding several meetings with residents and business owners whose properties were in proximity to the two proposed SCF sites, MLHU and RHAC received letters of support from the provincial government. The letters detailed capital and operational funding commitments, and a letter of support from the Health Minister for the establishment of the proposed SCFs, which are required as part of the Health Canada application process.

In a similar way to how TOPS operates, the proposed SCF sites would provide a place for those who have obtained drugs to consume them under the supervision and care of trained medical professionals and skilled harm reduction workers. The facilities would also include after-care areas, where clients could interact with staff from community agencies and organizations that provide support and services, including counselling, treatment and housing.

"While this is an important step in the process, we value the community's input and feedback," said Dr. Mackie. "We've already started the conversation and look forward to the discussions that will follow in the coming weeks and months."

Among the next steps were obtaining federal approval for the proposed sites, as well as municipal zoning and building permits.

"While this is an important step in the process, we value the community's input and feedback,"

In late October, MLHU and RHAC were notified that the Federal Government had approved the applications for the proposed sites of two permanent SCFs, now known as Consumption and Treatment Facilities (CTS), at 241 Simcoe Street and 446 York Street in London. In addition, the partners were also notified that Health Canada had approved TOPS as an interim site until the location on York Street was operational, and received correspondence from the Province that the temporary site could continue to operate through the end of the year.

"This is great news and we look forward to working closely with the Provincial Government on this new approach to providing vital services and support to those who are struggling to overcome powerful drug addictions," Dr. Mackie said at the time.

"The interactions and relationships forged with our clients have allowed us to build a rapport with people who are often ignored. These decisions show that their lives matter," said RHAC Executive Director Brian Lester.

By the end of 2018, plans to establish permanent CTS locations in London were still being finalized. It is hoped that once operational, these facilities will continue to show the kind of successes seen at TOPS, where lives are not only being saved, but are being changed for the better.

The overdoses that have been reversed, the relationships that have been forged and the referrals to treatment and services have shown that supervised consumption is a harm reduction strategy that can play a key role in addressing the challenges of the opioid crisis.

CHRONIC DISEASE AND TOBACCO CONTROL

Smoke is Smoke Campaign

In January of 2018, the Chronic Disease Prevention and Tobacco Control team rolled out its new Smoke is Smoke campaign during National Non-Smoking Week. The campaign's simple message is that all smoke is harmful, whether it comes from tobacco, cannabis or from a Hookah pipe. The campaign returned in March to coincide with the Cannabis Municipal Knowledge Exchange Forum held at London's Lamplighter Inn, then again in October to promote this important message at Health Fairs at Western University and Fanshawe College.

Cannabis: Know the Law. Know the Facts

The legalization of non-medicinal cannabis was something the Middlesex-London Health Unit paid close attention to in 2018. On March 28th, MLHU hosted a Cannabis Municipal Knowledge Exchange Forum, which brought together municipal staff and elected officials from across London and Middlesex County, as well as local police services, fire prevention officers and delegates from neighbouring health units. Presentations by staff from the Ministry of the Attorney General's Ontario Cannabis Legalization Secretariat, the Association of Municipalities of Ontario and the Middlesex-London Health Unit, provided delegates with updates on the government's plan to legalize cannabis.

In September, the Healthy Communities and Injury Prevention Team also held a Cannabis and the Workplace workshop, which drew on the expertise of the Workplace and Substance Misuse Prevention programs. Experts from the fields of law, medicine, occupational health and safety, and policy development shared their knowledge about cannabis education and policy with the 170 workplace representatives from across southwestern Ontario who were in attendance.

Shortly after non-medicinal cannabis became legal in Canada on October 17th, the Health Unit launched its *You Need to Know* campaign, which aims to help London and Middlesex County residents better understand the regulations and potential health risks associated with cannabis use. Accompanied by the www.YouNeedToKnow.ca website, the campaign uses clear graphics that highlight key parts of the legislation, while underscoring potential negative health effects and risks associated with cannabis use. The website also provides links to credible research, online resources, and strategies to help lower the potential risks associated with cannabis use.

Tobacco, Vaping and Cannabis Enforcement – by the Numbers:

- 856 workplace inspections
- 189 bar, restaurant and outdoor special event inspections
- 1122 tobacco retailer inspections
- 532 e-cigarette (vapour products) retailer inspections

Dog Days in the Park

Summertime means getting out and enjoying the sunshine and warm temperatures. Definitely not the time you'd want to be inhaling second-hand smoke. The Health Unit's *One Life One You* youth advocacy group took part in several Dog Days in the Park in London. These events highlighted the Smoke-Free Ontario Act as well as the City of London's outdoor smoking bylaw. The teens interacted with off-leash dog park users at the Greenway and Stoney Creek dog parks, and brought attention to the burden that tobacco litter and second-hand smoke place on our outdoor spaces. The Dog Days in the Park events serve as a reminder that "a smoke-free park is a healthier park."

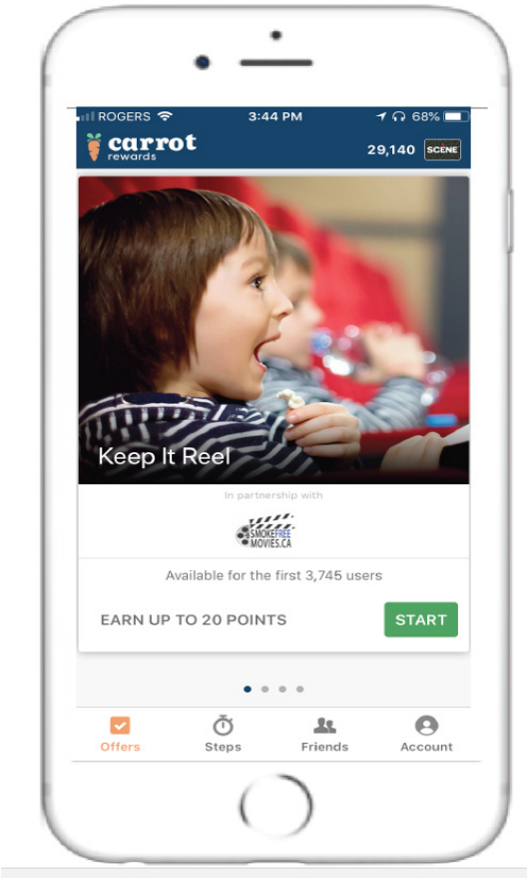
Smoke-Free Ontario Act, 2017

The *Smoke-Free Ontario Act, 2017*, came into force on October 17th, coinciding with the legalization of cannabis in Canada. With the enactment of the updated legislation, the smoking and vaping of cannabis are now regulated under the same provincial legislation as tobacco. The use of e-cigarettes to vape any substance, and the smoking and vaping of cannabis, are prohibited in the same places where tobacco use is already banned. The Smoke-Free Ontario Act, 2017 also regulates the sale, supply and promotion of tobacco and vapour products.

1-Day Stand

The *1-day Stand* is an initiative led by *Leave the Pack Behind* and public health partners, supporting Ontario post-secondary institutions to assist them with the implementation of clean air and smoke-free policies. A *1-Day Stand* event, planned by Health Unit staff, students from Western University's Masters of Public Health class and the University's Smoke-Free Policy Committee, was held at Western on March 21st. By the summer of 2019, Western's campus will be 100% smoke- and vapour-free. The Health Unit also worked with the University to offer stop smoking programs for faculty and staff; services for students are available through Student Health Services.

TOBACCO CONTROL AREA NETWORK



The Southwest Tobacco Control Area Network, or TCAN, used the Carrot app to educate users about smoke-free movies and encouraged people to take action by writing their local MPP, requesting that films that show tobacco use be restricted to adult audiences in Ontario. The campaign also ran in Eastern Ontario and saw almost 44-thousand people complete the Carrot survey, while more than 2,000 sent letters to their elected members of Provincial Parliament.

almost **44,000** completed the survey

The Southwest TCAN joined five other TCANs in the effort to change social norms among the "alternative" youth crowd and to shift their peer crowd values away from tobacco use. Over the course of 2018, TCAN staff participated in seven events where there were a combined 8,345 youth in attendance. Of those in attendance, 401 youth registered to be part of the Southwest TCAN's email distribution list and 227 youth registered to work with the TCAN at future events.

Social Media:
8,411,559 views/engagements on our social media ads/posts which exceeded the goal by 43%.

HEALTHY COMMUNITIES AND INJURY PREVENTION

Harvest Bucks

The Harvest Bucks Program continued for a seventh year in 2018, distributing nearly $190,000 in vegetable and fruit vouchers that can be exchanged for produce at local farmers' markets and other small community grocers. Vouchers are distributed through community and emergency food programs, in addition to other food literacy and social service programs. The effort is intended to increase local access to, and consumption of, vegetables and fruit, while promoting community connectedness through the farmers' market experience.

Helmets on Kids

In June, the Helmets on Kids Committee, released a new video highlighting the proper use of helmets, whether you're riding a bike, using rollerblades, or on a skateboard. Over the course of 2018, more than 900 local children received new helmets, at no charge, through the Committee's efforts and ongoing partnership with the Ontario Trial Lawyers Association.

Community Drug and Alcohol Strategy (CDAS)

It can be said that 2018 was the year when London and Middlesex County brought a collaborative focus to addressing the multiple and overlapping challenges gripping the community, including opioids, crystal meth, alcohol and others. After many months of focused work, 2018 marked the release of the *Middlesex-London Community Drug and Alcohol Strategy – A Foundation for Action*. The partnership leading the development of this strategy included representatives from the health, education and social services sectors, as well as from law enforcement, the private sector, municipal government and people with lived experience. Extensive community input was key in helping to shape the Strategy. Early in 2018, the Community Drug and Alcohol Strategy (CDAS) Steering Committee, hosted a series of drop-in information and feedback sessions, which provided an opportunity for members of the public to learn more and share thoughts that will shape the final strategy for the community. Additionally, focus group sessions were held with people who have lived experience of injection drug use, youth who identify as LGBTQ2+, and members fo the Indigenous community.

On October 16th, the *Middlesex-London Community Drug & Alcohol Strategy – A Foundation For Action* was released publicly at a news conference held at London's Goodwill Centre. Leading up to the release of the report, and as work on the strategy continued, it became apparent that people across the City of London and Middlesex County face challenges each day that are associated with the use of drugs and alcohol. These challenges can, and often do, have devastating negative effects on health, relationships, safety and overall community wellness.
The Strategy consists of 23 recommendations with 98 associated actions, and sets a long-term comprehensive plan to prevent and address local substance-related harms. Work to implement the recommendations of the *Middlesex-London Community Drug & Alcohol Strategy – A Foundation For Action* is underway and will continue through 2019 and beyond.

Tony the Streetwise Cat & Active and Safe Routes to School

Tony the Streetwise Cat was back at work in April and May of 2018, raising awareness about pedestrian crossovers in London. The animated Lego cat was part of a social media campaign that also included an enforcement component that saw the London Police Service conduct an education and enforcement blitz about pedestrian crossovers. The animated YouTube videos featuring Tony the Streetwise Cat amassed more than 42,600 views during the campaign.

Not only was he a presence on YouTube, but Tony the Street-Wise Cat also visited Stoneybrook Public School in the spring to teach students how to use pedestrian crossovers. Members of the London-Middlesex Road Safety Committee, and *Active and Safe Routes to School*, joined Tony to teach children at Stoneybrook about the importance of walking to school and how to use pedestrian crossovers safely.

In October, the *Active and Safe Routes to School* program celebrated iWalk month, where students were encouraged to track their method of travel to and from school. Posters, social media messages and a Climate Change and Active School Travel Toolkit were created to help promote the campaign.

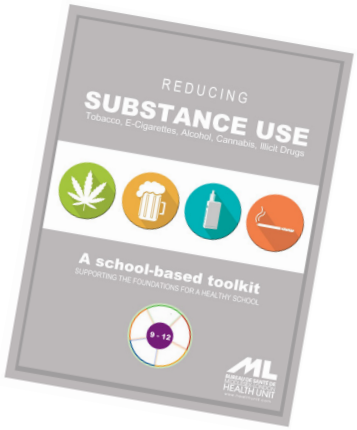
SCHOOL HEALTH (CHILD HEALTH & YOUNG ADULT TEAMS)

Improving Food Environments in Schools

Staff with the Child Health and Young Adult Teams work diligently with school board partners to promote healthy nutrition environments in schools. In 2018, #Food4Thought, a new healthy eating program co-created by school board and health unit staff, was launched. The program is a six-week student voice initiative, designed to improve food literacy and students' sense of belonging to their school. In addition, staff advocate for school-level policies for healthy snack celebrations and healthy rewards.

Substance Use Prevention for Children and Youth

As the need for local resources related to drug use and the legalization of non-medicinal cannabis began to emerge, the Child Health and Young Adult Teams partnered with local school boards to provide educators, parents, and students with strategies and resources to reduce substance use among children and youth. To help address this need, the new *Reducing Substance Use Toolkit for Secondary Schools* was created. The toolkit contains strategies to support curriculum, teaching, & learning; social and physical environments; school & classroom leadership; student engagement; and home, school & community partnerships.



Situational Supports

Public Health Nurses working in secondary schools conduct one-on-one situational supports with students in schools. Over the course of the 2018-2019 school year, nurses responded to 2,280 face-to-face student requests and/or concerns about health-related matters. The top three topics were health matters related to physical well-being, sexual health and mental well-being. Testing and education related to sexually-transmitted infections (STI) was a new service added for students this year.

ORAL HEALTH TEAM

Partnership with Southwestern Ontario Aboriginal Health Access Centre

In April, 2018, the Middlesex-London Health Unit and the Southwest Ontario Aboriginal Health Access Centre (SOAHAC) announced a partnership that would provide new dental treatment options for Indigenous community members across the region. On April 5th, the dental clinic space at 50 King Street became space that would be shared between MLHU and SOAHAC. Through the Healthy Smiles Ontario program, the Health Unit would provide preventive oral health services to youth under the age of 17 who are from qualifying families, while SOAHAC would provide culturally-safe dental treatment services to its clients.

The creation of the partnership was a solution to a challenge that had faced SOAHAC's Board of Directors for years. For more than a decade and a half, the Board had been seeking ways of addressing the pressing oral health needs of local Indigenous communities. The partnership dovetails well with the MLHU's efforts to respond to the Truth and Reconciliation Commission's Calls to Action. The collaboration is a demonstration of the Health Unit's commitment to working with, and seeking direction from, local First Nations and Indigenous-led organizations.

Oral Health Month

In April, the Health Unit also marked *Oral Health Month*. The Oral Health Team took part in the province-wide effort to *Brush Up on The Facts: Keep Kids Teeth Healthy*. The awareness campaign, the first in 15 years, was a collaboration between the Ontario Association of Public Health Dentistry and the 35 Public Health Units across the province. The campaign was aimed at parents and caregivers of young children, and emphasized the importance of oral health in children's overall growth and development. The campaign proved to be a success, as increased web traffic made its way to the Health Unit's website and social media channels.

Fluoride Varnish and Dental Screening Programs

The Health Unit's Fluoride Varnish Application Program continued to provide services at 18 elementary schools and 13 daycares across the region in 2018. Over the course of the year, 1,251 children received 2,279 fluoride varnish applications as part of the program.

During the 2017-2018 school year, staff were able to screen 16,038 students in 130 elementary schools to assess their teeth; of all these students, 1,776, or roughly 11%, children were found to have urgent dental needs.

16,038 students in **130** elementary schools

The Oral Health Team also provided preventive services and screening at the 50 King Street Dental Clinic in 2018.

- 594 were screened for urgent dental needs
- 1,203 children received preventive services such as cleaning, dental sealants and fluoride varnish
- 240 adults received preventive services through the Smile Clean Program

Healthcare Provider Outreach Program

Raising awareness about public health programs and services, providing timely updates, and bringing attention to emerging issues, are some of the key functions of the Middlesex-London Health Unit's Healthcare Provider Outreach program. The Healthcare Provider Outreach team provides a mechanism for program staff to communicate with a wide range of health professionals in the City of London and Middlesex County. Through resource binders highlighting programs and services, to dedicated content on the MLHU website, annual face to face visits, and monthly eNewsletters, Healthcare Provider Outreach staff have become valued collaborators for local healthcare professionals. The team also organizes and provides several educational opportunities for healthcare providers across the region each year.

In addition to reaching out to local healthcare providers, and working with program staff to develop engaging content, the team is also part of a provincial community of practice. The insights and experiences that have enhanced the Healthcare Provider Outreach program locally are helping to shape how other health units collaborate and communicate with physicians, nurses and other health professionals across Ontario.

2018 Healthcare Provider Outreach Highlights

23,184 resources distributed as part of MLHU binders
296 visits to Healthcare Provider offices
49 internal consultations
1,286 receive each electronic newsletter
284 resource binders distributed
51 external consultations

Finance Report

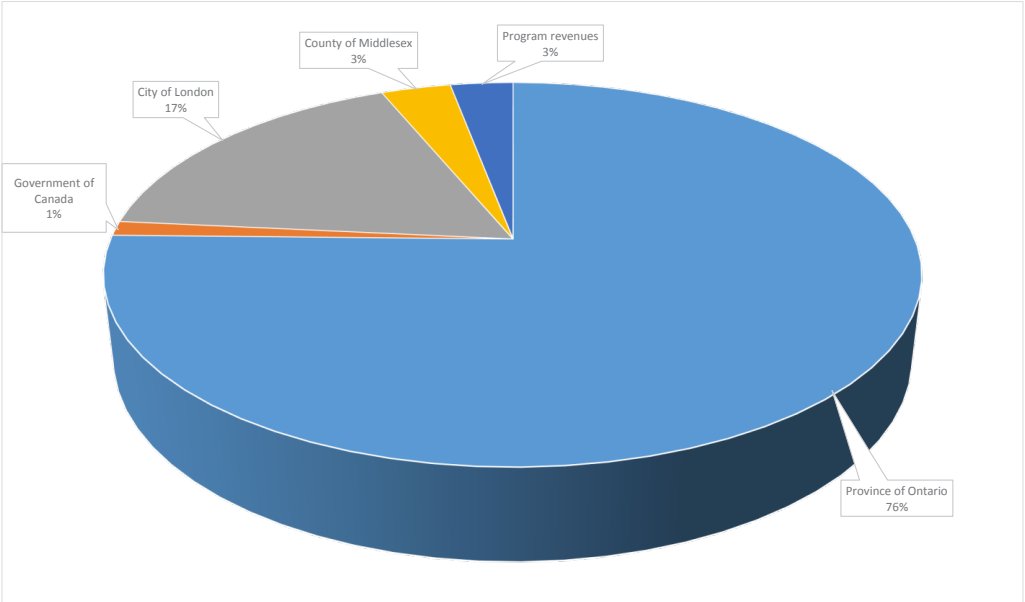
2018 Budget

EXPENDITURES 2018

Cost-Shared Programs:		
Mandatory Programs	$	24,451,514
Vector-Borne Diseases		616,000
Small Drinking Water Systems		48,340
		25,115,854
100% Funded Programs		
Infectious Diseases Prevention and Control		1,166,800
Needle Exchange		650,600
Public Health Nursing Initiatives		392,100
Healthy Babies Healthy Children		2,483,313
Smart Start for Babies		152,430
Enhanced Safe Water Initiative		35,700
Enhanced Food Safety Initiative		80,000
FoodNet		160,430
Shared Library Services		106,526
Healthy Smiles Ontario		692,700
Dental Treatment Clinic		150,000
Smoke Free Ontario		1,048,800
tykeTALK		1,893,374
Infant Hearing and Screening Program		1,081,224
Blind Low Vision		174,855
	$	**10,268,852**
Total Public Health Program Expenditures	**$**	**35,384,706**

REVENUES 2018

Sources of Funding:			
Province of Ontario		26,653,957	75.3%
Government of Canada		428,261	1.2%
City of London		6,095,059	17.2%
County of Middlesex		1,160,961	3.3%
Program revenues		1,046,468	3.0%
Total Sources of Funding	**$**	**35,384,706**	



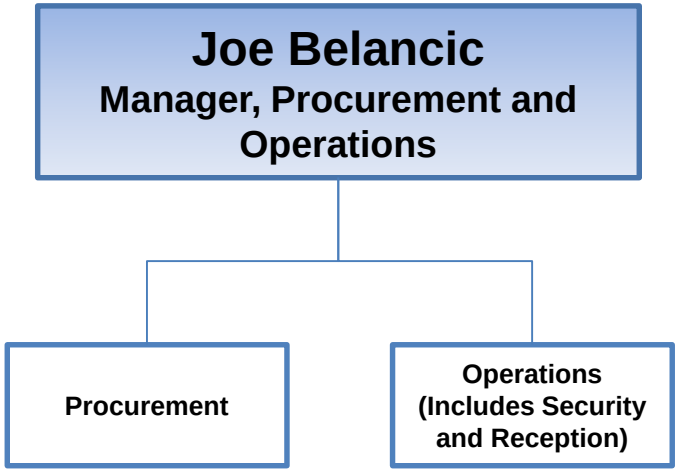
Healthy Organization
Procurement and Operations

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

Total FTEs – 3.70 FTEs

Total Budget – $283,638

2019-04-18-BOH-Program-update



Program Highlights:

- Implementation of the Great Plains Procurement Module
- Review of a Contract Management Solution
- Release of Tender to cover $5.2 million budget to retrofit Citi Plaza
- Project planning of move to Citi Plaza
- Review of Procurement Principles and Policies
- Systematizing Competitive Bid Process
- Review of current contracts

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 030-19

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health/CEO

DATE: 2019 April 18th

LOCATION PROJECT – PROJECT PLAN UPDATE AND GENERAL CONTRACTOR PRE-QUALIFICATION APRIL 2019

Recommendation

It is recommended that the Board of Health:

1) ***Receive Report No. 030-19 re: "Location Project – Project Plan Update and General Contractor Pre-Qualification April 2019" for information; and***
2) ***Approve the selection of the Pre-Qualified General Contractors for Fit-Up at Citi Plaza***

Key Points

- 90% of the design documents are complete.
- Three General Contractors are Pre-Qualified to bid on the fit-up at Citi Plaza.
- The fit-up Tender is expected to close on June 24th and will require BOH approval to begin a contractor kick-off in July.
- Additional costs of $26,000 were identified to extend the elevator to the basement.

Project Plan

The Detailed Design Development phase was completed during the month of February. This phase of the project focused on the development of floor plans in conjunction with the space needs assessment which were previously collected. The layout was presented at the February 5th Relocation Advisory Committee meeting. The detailed Project Plan is listed in Appendix A.

Subsequent meetings were held with the architect in March to review the type of finishes to be specified for flooring, ceilings and wall finishes to installed by work area. Careful consideration was taken during this meeting to ensure cost containment and maximize the useful life of the materials selected for the project. Following the conclusion of the meeting, the architectural team specified the materials to be included for the Contract Document phase. This phase produces a set of drawings that include all pertinent information required for the contractor to price and build the project. Two reviews were held at the 60% and 90% stage completion of these documents. The final review is scheduled to occur on April 30th.

In addition, a design review of the clinical space and lab was held on March 25th. This consultation with clinical managers and staff ensures the new clinic will suit the needs of the Dental Clinic, Immunization Clinic, Sexual Health Clinic, Tuberculosis Clinic and Quit Clinic. It also ensures that the new lab meets best practices for Infection Prevention and Control Standards.

Prequalification

Contractor Prequalification is an information gathering and assessment process that determines a contractor's capability, capacity, resources, management processes, and performance. Documents for the pre-Qualification of General Contractors and Sub-Trades were issued on March 14th are available in Appendix B. Prequalification submissions were posted on public bidding sites Biddingo and Bids and Tenders. Contractors were also solicited for proposals directly. An addendum was issued on March 21st to clarify questions raised by bidders which is provided in Appendix C. A total of 20 bids were received at close of the prequalification one week later. They were broken down as follows:

- 11 General Contractors
- 4 Mechanical Contractors
- 5 Electrical Contractors

A comprehensive review of all bids was completed on April 4th with our construction project management consultant and members of the OSL steering committee. The top three scoring General Contractors are recommended to be included in the tender submission. They include:

1. K&L Construction
2. Michael Clark Construction
3. Southside Group

These submissions scored well because of the experience of the staff assigned to the project, similar healthcare projects, infection control training and the references provided.

Evaluations were also completed of the Mechanical and Electrical Contractors. However, these bids did not meet the minimum 65-point threshold as required in the prequalification document due to insufficient information. As a result, there will not be any Mechanical or Electrical Contractors qualified. General Contractors will act as the Prime Contractor when the Tender is awarded and select the Mechanical or Electrical Contractors or their choice. Further information on the Tender schedule is listed in Appendix A.

Elevator Update

During the October 18th Relocation Advisory Committee meeting, Report No. 001-18RAC was approved to extend the elevator to the basement at an approximate cost of $100,000. The Middlesex-London Health Unit will cover the cost differential of $32,755. This fee did not include any contingency costs in the event that underground springs are located but it is a significant decrease in costs that were previously estimated.

Contingency costs of approximately $26,000 are estimated as a sump pump and sump pit will be required at the base of the elevator as the pit is below grade and water will need to be pumped out due to TSSA requirements.

Next Steps

MLHU staff will request Relocation Advisory Committee members to attend a tender review meeting on June 26th. Furthermore, a special Board of Health meeting is recommended on June 27th to approve the results.

The Relocation Advisory Committee will continue to be informed of expenditures related to the project and request approval for costing decisions which require Board of Health approval.

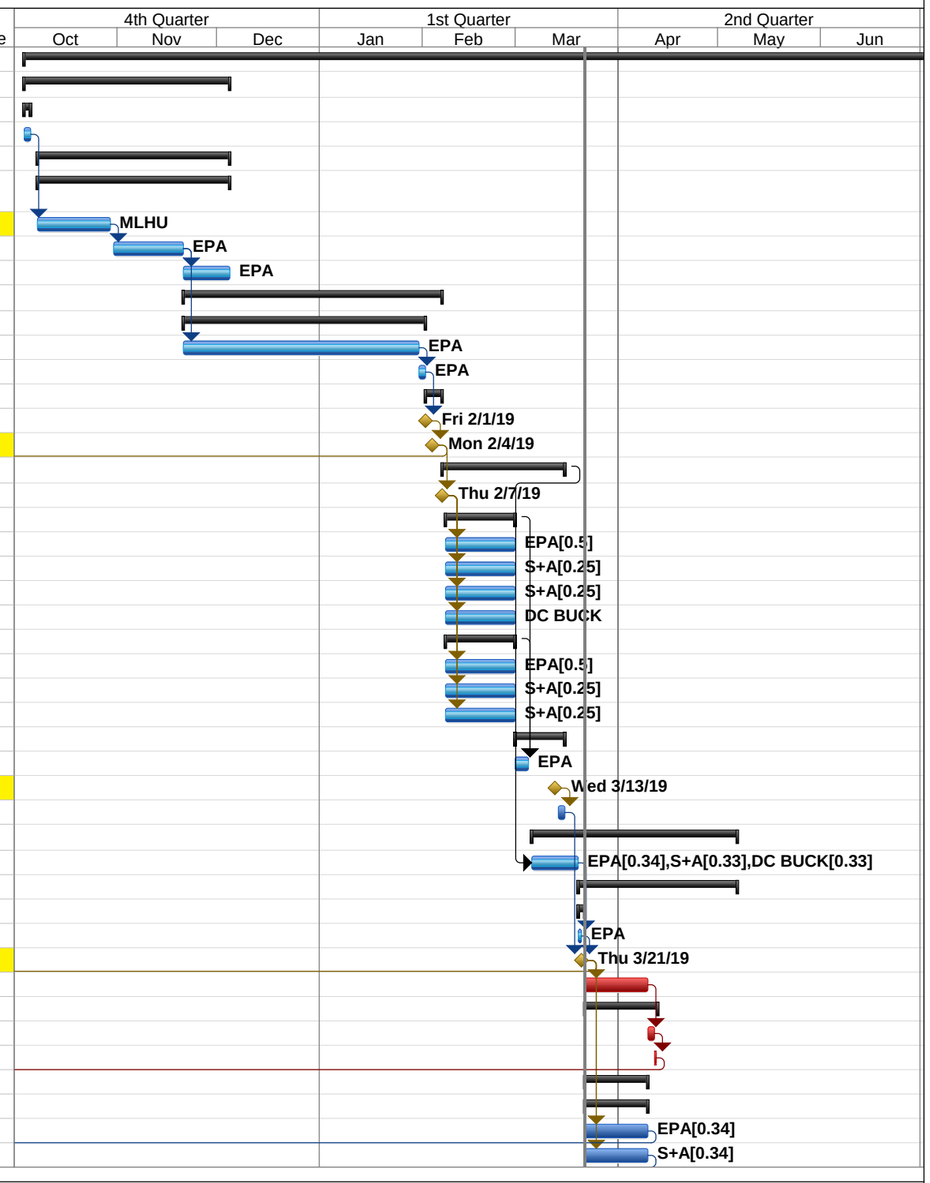
This report was prepared by Procurement and Operations, Healthy Organization Division.

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

EPA
EMMI ROLETO ARCHITECT INC.

MLHU Project Design Schedule

ID	Task Name	Duration	Start	Finish	Resource Names	Predece	% Complete
1	**MLHU - FIRST AND SECOND FLOOR**	**349 days**	**Thu 10/4/18**	**Thu 2/13/20**			**39%**
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**	**49 days**	**Wed 11/21/18**	**Wed 2/6/19**			**94%**
11	**Prepare schematic design documents**	**46 days**	**Wed 11/21/18**	**Fri 2/1/19**			**100%**
12	Schematic Plans and Review w/ client	44 days	Wed 11/21/18	Wed 1/30/19	EPA	8	100%
13	Final Floor plans	2 days	Thu 1/31/19	Fri 2/1/19	EPA	12	100%
14	**Review**	**3 days**	**Fri 2/1/19**	**Wed 2/6/19**			**0%**
15	Submit Schematics to client for review	0 days	Fri 2/1/19	Fri 2/1/19	EPA	13	100%
16	Obtain written approval for design development	3 days	Mon 2/4/19	Wed 2/6/19	MLHU	15	0%
17	**DETAILED DESIGN DEVELOPMENT**	**27 days**	**Thu 2/7/19**	**Fri 3/15/19**			**97%**
18	Review Program w/ consultants	1 day	Thu 2/7/19	Thu 2/7/19	EPA	16	100%
19	**Detailed document development**	**15 days**	**Fri 2/8/19**	**Thu 2/28/19**			**100%**
20	Architectural	15 days	Fri 2/8/19	Thu 2/28/19	EPA[0.5]	18	100%
21	Mechanical	15 days	Fri 2/8/19	Thu 2/28/19	S+A[0.25]	18	100%
22	Electrical	15 days	Fri 2/8/19	Thu 2/28/19	S+A[0.25]	18	100%
23	Structural	15 days	Fri 2/8/19	Thu 2/28/19	DC BUCK	18	100%
24	**Develop Preliminary Specifications**	**15 days**	**Fri 2/8/19**	**Thu 2/28/19**			**100%**
25	Architectural	15 days	Fri 2/8/19	Thu 2/28/19	EPA[0.5]	18	100%
26	Mechanical	15 days	Fri 2/8/19	Thu 2/28/19	S+A[0.25]	18	100%
27	Electrical	15 days	Fri 2/8/19	Thu 2/28/19	S+A[0.25]	18	100%
28	**Review**	**11 days**	**Fri 3/1/19**	**Fri 3/15/19**			**40%**
29	Submit Schematics to client for review	2 days	Fri 3/1/19	Mon 3/4/19	EPA	19,24	100%
30	Obtain written approval for design development	1 day	Wed 3/13/19	Wed 3/13/19	MLHU		0%
31	Redesign - 2nd Floor ABW'S and IT Area	2 days	Thu 3/14/19	Fri 3/15/19		30	0%
32	**CONTRACT DOCUMENT PHASE**	**44 days**	**Wed 3/6/19**	**Mon 5/6/19**			**12%**
33	Contract documents	10 days	Wed 3/6/19	Tue 3/19/19	EPA[0.34],S+A[0.33],DC BUCK[0.33]	17	100%
34	**Quality Control - Establish review dates**	**34 days**	**Wed 3/20/19**	**Mon 5/6/19**			**1%**
35	**60% review with consultants**	**2 days**	**Wed 3/20/19**	**Thu 3/21/19**			**50%**
36	meeting with consultants	1 day	Wed 3/20/19	Wed 3/20/19	EPA	33	100%
37	Presentation to SLT - Obtain Design Approval	1 day	Thu 3/21/19	Thu 3/21/19	MLHU	36,31	0%
38	Implement 60% CD Review and Continue Development	13 days	Fri 3/22/19	Tue 4/9/19	EPA[0.34],S+A[0.33],DC BUCK[0.33]	37	0%
39	**90% review with consultants**	**16 days**	**Fri 3/22/19**	**Fri 4/12/19**			**0%**
40	EPA Comments	2 days	Wed 4/10/19	Thu 4/11/19	EPA[0.5]	38	0%
41	Meeting with consultants (A,MEP AND SPECS & FINISHES)	0.5 days	Fri 4/12/19	Fri 4/12/19	EPA[0.5]	40	0%
42	**Specifications**	**13 days**	**Fri 3/22/19**	**Tue 4/9/19**			**0%**
43	**Prepare and assemble specification**	**13 days**	**Fri 3/22/19**	**Tue 4/9/19**			**0%**
44	Architectural	13 days	Fri 3/22/19	Tue 4/9/19	EPA[0.34]	37	0%
45	Mechanical	13 days	Fri 3/22/19	Tue 4/9/19	S+A[0.34]	37	0%



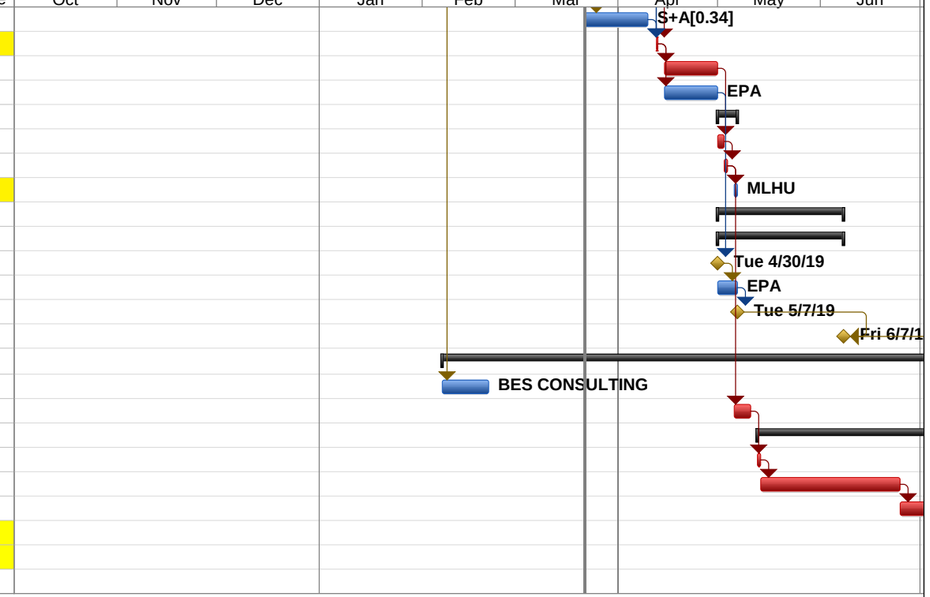
Project: 1715-2019-03-21-MLHU-Singu
Date: Fri 3/22/19

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	

EMBRY OSLER ARCHITECT INC.

MLHU Project Design Schedule

ID	Task Name	Duration	Start	Finish	Resource Names	Predece	% Complete
46	Electrical	13 days	Fri 3/22/19	Tue 4/9/19	S+A[0.34]	37	0%
47	meeting with Owner	0.5 days	Fri 4/12/19	Fri 4/12/19	MLHU	41,44,45	0%
48	Implement 90% CD Review and Continue Development	12 days	Mon 4/15/19	Tue 4/30/19	EPA[0.34],S+A[0.33],DC BUCK[0.33]	47	0%
49	Avison Young - Obtain Approval before permit	12 days	Mon 4/15/19	Tue 4/30/19	EPA	47	0%
50	**100% review with consultants**	**4 days**	**Wed 5/1/19**	**Mon 5/6/19**			**0%**
51	EPA Comments	2 days	Wed 5/1/19	Thu 5/2/19		48	0%
52	meeting with consultants	1 day	Fri 5/3/19	Fri 5/3/19	EPA[0.34],S+A[0.33],DC BUCK[0.33]	51	0%
53	meeting with Owner	1 day	Mon 5/6/19	Mon 5/6/19	MLHU	52	0%
54	**PERMITTING PHASE**	**28 days**	**Tue 4/30/19**	**Fri 6/7/19**			**0%**
55	**Obtain client written authorization**	**28 days**	**Tue 4/30/19**	**Fri 6/7/19**			**0%**
56	AY - Client Authorization for Building Permit Submission	0 days	Tue 4/30/19	Tue 4/30/19	EPA	49	0%
57	Prepare Material for Permit	4 days	Wed 5/1/19	Mon 5/6/19	EPA	56	0%
58	To submit drawings for building permit and get approval	24 days	Tue 5/7/19	Fri 6/7/19	EPA	57	0%
59	Building Permit Received	0 days	Fri 6/7/19	Fri 6/7/19	EPA	58FF	0%
60	**TENDERING PHASE**	**106 days**	**Thu 2/7/19**	**Thu 7/4/19**			**0%**
61	Pre- Qualification	10 days	Thu 2/7/19	Wed 2/20/19	BES CONSULTING	16	0%
62	Prepare Material for Permit	5 days	Mon 5/6/19	Fri 5/10/19	EPA	52	0%
63	**Distribution of Bidding and Proposal Documents**	**38 days**	**Mon 5/13/19**	**Wed 7/3/19**			**0%**
64	Distribute documents to GCs	1 day	Mon 5/13/19	Mon 5/13/19	EPA	62	0%
65	Bidding	30 days	Tue 5/14/19	Mon 6/24/19	EPA	64	0%
66	Bid and Proposal evaluation	6 days	Tue 6/25/19	Tue 7/2/19	EPA	65	0%
67	Contract sign GC	1 day	Wed 7/3/19	Wed 7/3/19	MLHU	66	0%
68	GC kick Off Meeting	1 day	Thu 7/4/19	Thu 7/4/19	MLHU[0.25],BES CONSULTING[0.25]	67	0%
69	CONTRACT ADMINISTRATION	8 mons	Fri 7/5/19	Thu 2/13/20	BES CONSULTING[0.5],EPA[0.5]	68,59	0%



Project: 1715-2019-03-21-MLHU-Singu
Date: Fri 3/22/19

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	

BIDDER QUALIFICATIONS

FOR

GENERAL CONTRACTORS
AND SELECTED SUBTRADES
(MECHANICAL AND ELECTRICAL)

FOR

MIDDLESEX-LONDON HEALTH UNIT
INTERIOR RENOVATION/TENANT FIT-UP

SUITE 110 AT CITI PLAZA, LONDON, ONTARIO

1. General

1.1 SUBMISSION REQUIREMENTS

Boards of health are required to adopt and maintain policies with respect to the procurement of goods and services according to section 270(2) of the *Municipal Act, 2001*. The *Ontario Public Health Standards: Requirements for Programs, Services and Accountability*, which are published as public health standards for the provision of health programs pursuant to section 7 of the *Health Protection and Promotion Act,* further requires that all procurement of goods and services be through an open and competitive process. The Middlesex-London Health Unit has developed Procurement Protocols to address the goals of the procurement process which include obtaining the best value by ensuring quality, efficiency and effectiveness.

.2 This project consists of constructing various patient care areas, support spaces and administration areas within the existing Level 1 and Level 2 floors of the Citi Plaza Building. In addition, this project will include a renovation to an existing Mezzanine and renovation to the existing basement, which is the primary delivery entrance. Managerial experience in expediting this type and scope of work is important and should be identified by the General Contractor.

Submissions are to include the following information:

1. A completed CCDC 11 – 2018 “Contractor’s Qualification Statement”, including:
   a. Resumes outlining credentials and experience of personnel to be assigned to this project (including superintendent and project manager).
   b. Examples of three (3) projects of similar scope and complexity successfully completed over the past five (5) years including client and consultant references.
2. Documented Infection Control training (CSA, CHES etc.)
3. CAD 7 form and the proponent’s valid WSIB.
4. Proponent’s company profile and Company Health and Safety Policy.
5. Proof of Insurance (Ability to provide General Liability Insurance ($5,000,000 minimum).
6. Disclosure of any legal action involving the firm.

Submissions will be evaluated based on the information requested to be included in the submission (refer to above). Items 1, 2, 3, 5, and 6 are considered mandatory and their omission will result in the submission being rejected without further review. Items 1a., 1b., and 4 will be utilized to evaluate the submissions further based on a weighted scoring matrix (attached as an Appendix to this Section).

.3 Inclusion of any false statement is grounds for immediate disqualification. Failure to submit a completed questionnaire with the Bid may be cause for the Bid to be considered a non-responsive. The Owner reserves the right to waive minor irregularities and to make all final determinations. The Owner will evaluate the information contained in each applicant’s questionnaire and responses received in reference checks. Contractor will be comparatively judged on the basis of, but not limited to, responses to this questionnaire, completion of work similar in scope, performance and quality of work previously completed, organizational capacity, quality of persons and financial criteria. The sole and discretionary judgment of the awarding authority will determine if the applicant is deemed qualified. The Owner may take such reasonable investigations as deemed proper and necessary to determine the ability of the Bidder to perform the work/furnish the items(s), and the bidder shall furnish to the Owner all such information and data for this purpose as may be

requested. Owner reserves the right to reject any bid if the evidence submitted by, or investigations of, such Bidder fail to satisfy Owner that such Bidder is properly qualified to carry out the obligations of the Contract and to complete the work/furnish the item(s) contemplated therein.

.4 All information provided by the Bidder will remain confidential, will be used only for purposes of qualification, and will not be disclosed except as required by law. Only Bid proposals from qualified Bidders will be considered for award of a Contract.

BIDDER QUALIFICATIONS SUPPLEMENT A – DECLARATION

Project: **Interior Renovations/Tenant Fit-up, Suite 110 Citi Plaza**
Middlesex-London Health Unit

The undersigned declares that all of the qualification information submitted with this form is true and correct, that the Bidder fully understands this qualification information is being considered for this project only, that being declared non-qualified for this project by the Owner excludes the Bidder from award of this project.

Signatures
SIGNED AND SUBMITTED for and on behalf of:

_____
(name of bidder)

_____
(signature)

_____ Witness
(name and title of person signing)

_____ _____
(signature) (signature)

_____ _____
(name and title of person signing) (name and title of person signing)

Date:_____

Bidder must answer all of the following questions and provide all requested information, where applicable. If the answer to any question is “none” or if the question is not applicable, please state in writing. Any Bidder failing to do so may be deemed non-responsive with respect to this qualification at the sole discretion of the Owner. All information submitted for qualification evaluation will be considered official information acquired in confidence, the Owner will maintain its confidentiality to the extent permitted by law. The Bidder agrees and acknowledges that being rendered not qualified applies to this project. Bidder further agrees that once the Owner considers the Bidder “not qualified”, award cannot be made to the Bidder on this project regardless of an appeal being filed. The decision of the Owner on an appeal is final and not appealable. Bidder further authorizes the Middlesex-London Health Unit or its Designee to contact any entity named in the application for purposes of verifying the information supplied by the contractor.

END OF BIDDER QUALIFICATIONS SUPPLEMENT A – DECLARATION

BIDDER QUALIFICATIONS SUPPLEMENT B – SUBMISSION CHECKLIST

Project: **Interior Renovations/Tenant Fit-up, Suite 110 Citi Plaza**
Middlesex-London Health Unit

1. A completed Bidder Qualification Declaration Form.

   YES ☐ NO ☐

2. A completed CCDC 11 – 2018 "Contractor's Qualification Statement".

   YES ☐ NO ☐

3. Resumes outlining credentials and experience of personnel to be assigned to this project (including superintendent and project manager).

   YES ☐ NO ☐

4. Examples of similar projects successfully completed over the past five years including client and consultant references.

   YES ☐ NO ☐

5. Documented Infection Control training (CSA, CHES etc. copies of certificates attained by proposed staff for this project).

   YES ☐ NO ☐

6. Copies of current CAD 7 form and a valid WSIB Certificate.

   YES ☐ NO ☐

7. Proponent's Company Profile and Company Health and Safety Policy.

   YES ☐ NO ☐

8. Proof of Insurance (Ability to provide General Liability Insurance ($5,000,000 minimum)).

   YES ☐ NO ☐

9. A letter disclosing **any** current or recent legal action involving the firm within the last five years.

   YES ☐ NO ☐

END OF BIDDER QUALIFICATIONS SUPPLEMENT B – SUBMISSION CHECKLIST

BIDDER QUALIFICATIONS SUPPLEMENT B – APPENDIX 'A'

MLHU Bidder Qualification Scoring Matrix

Mandatory Requirements (Score of 0 in any required category results rejection)

Item	YES (score 1)	NO (score 0)
CCDC 11 – 2018 fully executed (complete, signed, sealed)?		
CAD 7 included?		
WSIB Certificate of Clearance included?		
Company Profile included?		
Health & Safety Policy included?		
Ability to provide General Liability Insurance ($5,000,000 minimum)?		
Current legal action disclosure?		

Weighted Scoring (out of 100)		
Item		**Max Points Available**
1	Superintendent experience in similar healthcare projects	20
2	Project manager experience in similar healthcare projects	20
3	Documented Infection Control Training (CSA, CHES etc.)	15
4	Similar projects completed by firm in last 5 years	10
5	References from clients	15
6	References from consultants	10
7	Proven ability to maintain project schedule	10

Scoring Criteria	
1	>10 years = 25, >5 years but <10 years = 20, >3 years but <5 years = 10, <3 years = 0
2	>10 years = 20, >5 years but <10 years = 15, >3 years but <5 years = 10, <3 years = 0
3	Yes = 10, No = 0
4	5 or more projects = 10, 3 to 5 projects = 6, 2 projects = 3, 1 project = 1, 0 projects = 0
5	3 positive references from projects noted above = 15 2 positive references from projects noted above = 10 1 positive reference from projects noted above = 5
6	3 positive references from projects noted above = 10 2 positive references from projects noted above = 6 1 positive reference from projects noted above = 3
7	Yes = 10, No = 0

Note: Minimum Points Required to be Eligible = 65

END OF BIDDER QUALIFICATIONS SUPPLEMENT B – APPENDIX 'A'

PREQUALIFICATION FOR
GENERAL CONTRACTORS AND SELECTED SUB TRADES
(MECHANICAL, and ELECTRICAL)
FOR THE MIDDLESEX-LONDON HEALTH UNIT INTERIOR RENOVATION/
TENANT FIT-UP SUITE 110
AT CITI PLAZA, LONDON, ONTARIO

ADDENDUM No. 01
March 22, 2019

This addendum is issued to provide clarification to questions raised by prospective bidders. The following additions, deletions and amendments are hereby made a part of the Prequalification for General Contractors and Selected Sub Trades for the above noted project.

PREQUALIFICATION AD

1. Refer to page 1 of the Prequalification Ad, paragraph 4 regarding bonding.
   a. Add the following sentence to read:
      "A bonding letter and/or financial reference letter is not a mandatory requirement and will not be evaluated. However, financial instruments other than bonds will not be accepted at the time of tender."

2. Refer to page 1 of the Prequalification, paragraph 5, Submissions are to include:
   a. Revise sentence 1. to read:
      "1. A completed CCDC 11 – 2018 Contractor's Qualification Statement (CCDC 11-2016 will not be accepted) including":

3. Refer to page 1 of the Prequalification, paragraph 5, Submissions are to include:
   a. Revise sentence 4. to read:
      "4. Proponent's company profile and Company Health and Safety Policy Statement."

BIDDER QUALIFICATIONS

4. Refer to SUBMISSION REQUIREMENTS, paragraph .2, item 1.b.:
   a. Add second sentence to item b. to read:
      "Projects evaluated on scope, complexity, and square footage not value."

BIDDER QUALIFICATIONS SUPPLEMENT B – APPENDIX 'A'

5. Refer to Scoring Criteria, and revise schedule to read:

Scoring Criteria	
1	>10 years = 20, >5 years but <10 years = 10, >3 years but <5 years = 5, <3 years = 0
2	>10 years = 20, >5 years but <10 years = 15, >3 years but <5 years = 10, <3 years = 0
3	Yes = 15, No = 0
4	5 or more projects = 10, 3 to 5 projects = 6, 2 projects = 3, 1 project = 1, 0 projects = 0
5	3 positive references from projects noted above = 15 2 positive references from projects noted above = 10 1 positive reference from projects noted above = 5
6	3 positive references from projects noted above = 10 2 positive references from projects noted above = 6 1 positive reference from projects noted above = 3
7	Yes = 10, No = 0

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 031-19

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2019 April 18

IMPACT OF 2019 PROVINCIAL BUDGET

Recommendation

It is recommended that the Board of Health:

1) ***Receive Report No. 031-19 re: Impact of 2019 Provincial Budget for information; and***
2) ***Approve the recommended steps under the section on "Mitigation" below.***

Key Points

- On April 11th, the Ontario provincial budget introduced sweeping changes to the public health system.
- Key objectives include reducing the number of health units and Boards of Health from 35 to 10 in a new regional model, and reducing provincial public health funding by approximately $200 million, or 27%, over two to three years.
- The funding reductions are projected to cause a significant deficit for the Middlesex-London Health Unit. Estimates are that this may be as large as $3,500,000 for the current fiscal year, and $7,000,000 in 2020 based on existing funding levels. However, the timing of these reductions is unclear.

Background

Objectives outlined in the provincial budget include replacing Ontario's 35 health units with 10 regional public health entities over the next one to two years. This would include dissolving existing Boards of Health across the province.

The budget also proposes reducing total provincial funding for public health by $200 million over the next two to three years. The province currently provides $743 million to local public health and Public Health Ontario; this is a funding reduction of approximately 27% over two years.

The government intends to create efficiencies through streamlining back-office functions, adjusting the provincial-municipal cost sharing model and reducing the number of health units and Boards of Health in a new regional model. In addition, public health units will be expected to offer dental services to low-income seniors.

Discussion

Across Ontario, administrative costs general amount to approximately 15% in each health unit. Efficiencies introduced by economies of scale and more effective electronic data capture could also contribute to marginal savings. A significant adjustment to the provincial-municipal cost-sharing model may be necessary to accommodate this withdrawal of funding from the province if health units are expected to continue providing comprehensive health services to communities served.

Mitigation

MLHU faces a number of decisions in the short and medium term to balance maintaining important front-line services and mitigate any deficits. The Board can opt to initiate changes immediately, or continue to execute on the current business plan until MLHU receives greater clarity from the province and Ministry. In the face of the current uncertainty, the Senior Leadership Team recommends taking reasonable but not dramatic steps. These include:

1. Introducing a hiring freeze;
2. Focusing on select projects that enhance back office efficiencies, such as Electronic Client Records (ECR) and Enterprise Resource Planning (ERP) for Human Resources, while scaling back some other planning projects that would be best completed after the proposed restructuring; and
3. Notifying the City of London and Middlesex County of the likelihood that additional funding may be required to address a potential funding shortfall, as outlined in the Health Protection and Promotion Act.

Options that are not recommended at this time include issuing layoff notices to MLHU staff, making a formal request to the municipal funders for additional funding in 2019, and reexamining the relocation project.

Conclusion

MLHU is facing unprecedented uncertainty in light of sweeping changes proposed in the recent provincial budget, and lack of clarity over next steps to amalgamate health units in the province and cut provincial funding. Staff are currently recommending reasonable steps to ensure that MLHU's mandate to serve the community is fulfilled. Additional steps may be recommended to the Board of Health as new information is provided by the Ministry of Health and Long-Term Care.

This report was prepared by the Healthy Organization Division.

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

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 029-19

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2019 April 18

MEDICAL OFFICER OF HEALTH/CEO ACTIVITY REPORT FOR APRIL

Recommendation

It is recommended that the Board of Health receive Report No. 029-19 re: "Medical Officer of Health Activity Report for April" for information.

The following report presents activities of the Medical Officer of Health (MOH) for the period of March 11, 2019, to April 5, 2019.

March 12
Met with fellow attendees from session one of the Leading From the Inside Out: Transforming Leadership training session
Phone call with Board of Health (BOH) Chair to discuss the agenda for the upcoming Board meeting

March 13
Chaired meeting of the Council of Ontario Medical Officers of Health (COMOH) Executive Committee
Met with Cheryl Miller, former City of London councillor
Attended meeting to discuss the Citi Plaza location with MLHU staff, architects, and Project Team to review the draft design

March 14
Participated in the Partnering For Innovation event at Western University
Interviewed by Richard Joseph, VICE Canada, about consumption and treatment services
Phone call with David Billson at rTraction to discuss marketing

March 18
Participated in teleconference with co-presentors for a workshop at The Ontario Public Health Convention (TOPHC)

March 19
Met with BOH Chair
Met with Susan Toth, lawyer, Polishuk, Camman & Steele, to discuss public health and public safety

March 20
Attended session two of the Leading From the Inside Out: Transforming Leadership training session delivered by Pillar Nonprofit Network
Attended the Business Achievement Awards

March 21
Monthly one-on-one phone call with Ms. Peggy Doe, Executive Coach
Met with architects, project management, and MLHU staff to discuss the Citi Plaza location fit-up plan
Interview with Alessio Doninni, X-FM student, in regard to a documentary project
Attended BOH and Goverance Committee meetings

March 22
Attended the Premier's Council on Improving Healthcare and Ending Hallway Medicine event at Parkwood Hospital

March 25	Met with Dr. Jayne Garland, Western University
March 26	Met with Lynne Livingston, Managing Director, Neighbourhood, Children and Fire Services, City of London, to discuss targets and financial information for the City Strategy Plan Phone call with Helene Gagne, Program Director – Prevention, Ontario Neurotrauma Foundation, to discuss Falls Prevention initiatives
March 27	Attended and presented at The Ontario Public Health Convention (TOPHC) in Toronto
April 1	Monthly one-on-one phone call with Dr. Brian Schwartz, Public Health Ontario Met with Dr. Ken Lee to tour the Rapid Access Addiction Medicine (RAAM) Clinic
April 2	Participated in several media interviews on the recent increase in overdoses and the April 2 MLHU Media Release "Number of Potential Opioid Poisonings Over Last Few Days Has Health and Emergency Services on High Alert"
April 3	Attended MLHU All-Staff Town Hall Interviewed by Jane Sims, *London Free Press*, on the recent increase in opioid poisonings
April 4	Attended the Global Mental Health System Innovation event at Western University Introductory meeting with Aurélien Bonin to discuss Drug and Addiction Rehabilitation Centres Monthly one-on-one phone call with Ms. Peggy Doe, Coach
April 5	Phone call with Michael Meagher from the City of London Mayor's office to discuss the recent increase in opioid poisonings and options for assistance from City staff Participated in the London Police Services announcement in regard to increased opioid poisoning deaths in the City

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

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

CORRESPONDENCE – APRIL 2019

a) Date: 2019 March 7
Topic: Memo to Medical Officers of Health and Board Chairs re: health care transformation
From: Dr. David Williams, Chief Medical Officer of Health
To: Medical Officers of Health, Chief Executive Officers, Board Chairs

Background:

On March 6, 2019, Dr. David Williams, Chief Medical Officer of Health, issued a memorandum to advise all Medical Officers of Health, Chief Executive Officers, and Board Chairs of the recent announcement on the transformation of the health care system. Dr. Williams notes that the public health sector has a significant role to play within the larger system and that he looks forward to hearing input and collaborating as a sector to understand what the changes mean for public health.

Recommendation: Receive.

b) Date: 2019 March 8
Topic: Alcohol retail expansion consultation
From: Vic Fedeli, Minister of Finance
To: Dr. Chris Mackie

Background:

Vic Fedeli, Minister of Finance, wrote to Dr. Chris Mackie, Chair of the Council of Medical Officers of Health (COMOH), inviting up to two representatives from COMOH to participate in a roundtable discussion on alcohol retail expansion. Input will be requested on improving the rules for how alcohol products are sold and consumed, allowing new types of stores to stock these products, creating more opportunities for private sector businesses, and ensuring communities are kept safe and healthy. The Association of Local Public Health Agencies (alPHa) distributed its speaking notes for the Retail Expansion Roundtable, held by the Ontario Ministry of Finance on March 6, 2019, supporting prior correspondence to Mr. Fedeli on January 31, 2019, which provided input on the government's plan to modernize the rules governing the sale and consumption of alcohol in Ontario. In its correspondence, alPHa supports the resolution sponsored by the Middlesex-London Board of Health to conduct a formal review and impact analysis of the health and economic effects of alcohol in Ontario and thereafter develop a provincial alcohol strategy. Refer to correspondence item e) from the February 21, 2019 Board of Health agenda.

Recommendation: Receive.

c) Date: 2019 March 20
Topic: Association of Local Public Health Agencies (alPHa) Winter Symposium Proceedings
From: alPHa
To: Boards of Health

Background:

The Association of Local Public Health Agencies (alPHa) Winter Symposium was held on February 21, 2019, in Toronto. The proceedings were shared with all Boards of Health, highlighting the

following topics: 1) Plenary – Making the Connection Between Public Health and Mental Health; 2) the alPHa Strategic Plan; and 3) Panel – Managing Risk in Public Health. Dr. Chris Mackie represented the Council of Ontario Medical Officers of Health as a commentator at the plenary session.

Recommendation: Receive.

d) Date: 2019 March 20 (received March 21)
Topic: alPHa report: "Improving and Maintaining the Health of the People: The Contribution of Public Health to Reducing Hallway Medicine"
From: Simcoe Muskoka District Health Unit
To: The Honourable Christine Elliott

Background:

On March 20, 2019, the Board of Health for the Simcoe Muskoka District Health Unit wrote to Deputy Premier Christine Elliott in support of the Association of Local Public Health Agencies (alPHa) report "Improving and Maintaining the Health of the People: The Contribution of Public Health to Reducing Hallway Medicine."

Recommendation: Receive.

e) Date: 2019 March 5 (received March 21)
Topic: Support for provincial oral health program for low-income adults and seniors
From: Windsor-Essex County Health Unit
To: The Honourable Doug Ford

Background:

On March 5, 2019, the Board of Health for the Windsor-Essex County Health Unit wrote to Premier Doug Ford in support of the Halliburton, Kawartha, Pine Ridge District Health Unit's request to build a provincial dental program for low-income adults and seniors. Refer to correspondence item b) from the March 21, 2019 Board of Health agenda.

Recommendation: Receive.

f) Date: 2019 March 5 (received March 21)
Topic: Increase actions in response to the current opioid crisis
From: Windsor-Essex County Health Unit
To: The Honourable Doug Ford

Background:

On March 5, 2019, the Board of Health for the Windsor-Essex County Health Unit wrote to Premier Doug Ford in support of Peterborough Public Health's request of the federal and provincial government to increase their actions in response to the current opioid crisis. Refer to correspondence item j) from the November 15, 2018, Board of Health agenda.

Recommendation: Receive.

g) Date: 2019 March 20 (received March 22)
Topic: Support for provincial oral health program for low-income adults and seniors
From: Perth District Health Unit
To: The Honourable Doug Ford

Background:

On March 20, 2019, the Board of Health of the Perth District Health Unit wrote to Premier Doug Ford advising that a motion was passed in support of the provincial oral health program for low-income adults and seniors. Refer to correspondence item e) above.

Recommendation: Receive.

h) Date: 2019 March 20
Topic: Board of Health Fitness Challenge
From: Association of Local Public Health Agencies (alPHa)
To: Boards of Health

Background:

The Association of Local Public Health Agencies (alPHa) announced its upcoming 2019 Board of Health alPHa Fitness Challenge. The goal is to involve the entire Board of each agency in a thirty-minute walk, wheel, or other activity for half an hour sometime in April or May. The deadline for submissions is May 31, 2019.

Recommendation: Receive.

i) Date: 2019 March 27
Topic: Toronto Indigenous Overdose Strategy
From: Toronto Board of Health
To: Boards of Health and interested parties

Background:

At its meeting of February 25, 2019, the Toronto Board of Health adopted the motion to endorse the Toronto Indigenous Overdose Strategy and to urge the federal and provincial governments to fund and support the development of Indigenous-led overdose prevention and response action plans. In addition, the Toronto Board of Health is urging the federal and provincial governments to contribute funding for Indigenous-specific programs and services.

Recommendation: Receive.

j) Date: 2019 April 11
Topic: Private Members' Bill re: Inspection of Clinics
From: Peggy Sattler, MPP London West
To: The Middlesex-London Board of Health

Background:

On April 11, 2019, MPP Peggy Sattler wrote to the Board of Health to propose a Private Members' Bill to regulate community nursing clinics (CNCs) to further address the infection prevention and control lapse that occurred at ParaMed Flex Clinics in London in 2018. Currently, CNCs fall outside the regulatory framework that would provide oversight such as mandated annual inspections. Public Health Inspectors do not routinely visit these clinics but are mandated under the Ontario Public Health Standards within the *Health Protection and Promotion Act* to investigate when complaints are made about potential infection prevention and control lapses.
The proposed bill to regulate CNCs will:

- Make the Minister of Health responsible for oversight of Community Nursing Clinics
- Establish a legal definition for these clinics
- Provide Medical Officers of Health with addresses of existing and new clinics
- Mandate annual inspections of these clinics by Medical Officers of Health
- Ensure that the Home Care and Community Services Bill of Rights is posted in these clinics, and that patients are aware of their right to complain to health units

Recommendation: Endorse

k) Date: 2019 April 11
Topic: alPHa Communication – Budget 2019
From: Association of Local Public Health Agencies (alPHa)
To: Chairs, Boards of Health

Background:

The Association of Local Public Health Agencies (alPHa) sent a communication on April 11, 2019, following the release of the 2019 Ontario Budget, which included significant changes to Ontario's Public Health system. In its communication, alPHa highlights some key structural changes to public health, which include: establishing 10 regional public health entities and 10 new regional boards of health with one common governance model; adjusting provincial-municipal cost-sharing of public health funding; a $200-million-dollar reduction in provincial funding for public health over the next two years; and reorganization of back-office functions through digitizing and streamlining processes.

Recommendation: Receive.

Ministry of Health and Long-Term Care

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March 6, 2019

MEMORANDUM:

TO: Medical Officers of Health, Chief Executive Officers and Board Chairs

Dear Colleagues,

By now I am expecting you will have seen and heard the recent announcement on the transformation of our health care system.

At a high level, the announcement focused on the Ministry's plan to improve the patient experience and enable better connected care by:

- Supporting the establishment of Ontario Health Teams across the province and in every community, and
- Integrating multiple existing provincial agencies into a single health agency – Ontario Health.

While the main focus of the government's plan is currently on improving patient experience and fostering better connected care, as always, there is a significant role for the public health sector to play within the larger system. I want to assure you that the public health sector, as always, is a valuable partner and key piece of the health care system.

I look forward to hearing your input and collaborating as a sector as we work to understand what these changes mean for us. As we wait to hear more from the government, it will require us to remain nimble and adapt while we continue our work to best serve our communities. These are early days and more information will follow in the weeks/months ahead. And, my commitment is to share what I know with you when I am able to share it.

I have included the following information, for your reference, with respect to this week's announcement.

- News Release
- Backgrounder
- Minister's Remarks
- Connected Care Stakeholder Webinar
- Bill 74

Sincerely,

Original signed by

Dr. David Williams

Chief Medical Officer of Health
Office of Chief Medical Officer of Health, Public Health
Ministry of Health and Long-Term Care

Ministry of Finance
Office of the Minister

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880-2019-679

Dr. Chris Mackie
Medical Officer of Health
Council of Medical Officers of Health
Christopher.Mackie@mlhu.on.ca

Dear Dr. Mackie:

As you may be aware, the government is undertaking a comprehensive review of the alcohol sector to inform its plan to expand the sale of beverage alcohol into corner and big-box stores, and further expand into grocery stores. We are moving forward on our promise to improve customer convenience and choice, and enable more opportunities for businesses.

As part of our commitment to consult, we are reaching out to key groups, including those representing beverage alcohol producers, public health and safety organizations, retailers, and the hospitality sector.

We want to ensure that your advice helps inform and guide this review. This letter is to invite up to two representatives from the Council of Medical Officers of Health to participate in one of the roundtable discussions. During the roundtable discussion, we will be seeking your input on improving the rules for how alcohol products are sold and consumed, allowing new types of stores to stock these products, creating more opportunities for private sector businesses, and ensuring communities are kept safe and healthy.

My Parliamentary Assistant, Doug Downey, will chair three roundtables in Toronto on the following days:

- Monday March 4, 2019 (2:00-3:30 p.m.)
- Tuesday March 5, 2019 (2:00-3:30 p.m.)
- Wednesday March 6, 2019 (2:00-3:30 p.m.)

Please contact Brenda Joseph by email (Brenda.Joseph@ontario.ca) or phone (416-325-7523) to advise on the availability of your representatives and to receive more detailed information.

.../cont'd

We will continue working with stakeholders to focus our efforts on modernizing Ontario's well-established beverage alcohol sector.

Sincerely,

Vic Fedeli
Minister of Finance

c: Doug Downey, Parliamentary Assistant to the Minister of Finance

alPHa
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Retail Expansion Roundtable
Ontario Ministry of Finance

375 University Ave, 7th Floor, Toronto, ON M5G 2J5
Wednesday, March 6, 2019
Speaking Notes

Introduction

- alPHa represents all 35 boards of health and all associate/medical officers of health
- Thank you for inviting us to attend today's roundtable
- The focus of our remarks is on:
    - Rules for sale and consumption
    - Safe and healthy communities
- Alcohol is responsible for the second highest rate of preventable death and disease in Canada, following tobacco. Additionally, alcohol is responsible for the greatest proportion of costs attributed to substance use in Ontario;[i] it is well-established that increasing alcohol availability is directly related to increased consumption and alcohol-related harms. It is necessary to balance consumer demand for convenience with policy supports aimed at ensuring the health of Ontarians remains a priority.

Background

- Alcohol availability in Ontario has increased 22 percent from 2007 to 2017 and will continue to increase under the government's proposed sale expansion plan.[ii]
- Ontario has committed to making wine, beer and cider available in up to 450 grocery stores.
- In August 2018, there was a reduction in the minimum retail price of beer (below 5.6% ABV) from 1.25 to $1.00; participating manufacturers were given enhanced promotion in LCBO retail stores.
- In December 2018, alcohol retail hours of sale were extended to 9 – 11 AM, seven days a week.

Current State

- Alcohol use is associated with addiction, chronic diseases, violence, injuries, suicides, fetal alcohol spectrum disorder, deaths from drunk driving, increased HIV infections, unplanned pregnancies, violence, assaults, homicides, child neglect and other social problems.
- Alcohol causes cancers of the mouth, esophagus, throat, colon and rectum, larynx, breast and liver.
- Even low to moderate alcohol consumption can cause cancer and damage to the brain.
- Alcohol outlet density has been shown to be related to heavy episodic drinking by youth and young adults.[iii] [iv]

- Privatized liquor sales, often associated with high density and increased sales to minors, can have troubling results for youth, including significantly more hospital visits, increased theft, increased acceptance of drinking among youth, and an increase in the number of "drinking days" among youth who were already drinking.[v]
- 1 in 3 Ontarians experience harms because of someone else's drinking.
- Evidence shows a consistent and positive association between alcohol outlet density and excessive alcohol consumption and related harms. The largest effect sizes were seen between outlet density and violent crime.[vi]
- Evidence shows that restricting the physical availability of alcohol by regulating the times when alcohol can be sold and limiting outlet density will decrease alcohol harm e.g., road traffic casualties, alcohol related disease, injury and violent crime.
- Increasing the hours of sale by greater than 2 hours has been shown to be related to increases in alcohol-related harms, such as an 11% relative increase in traffic injury crashes and a 20% relative increase in weekend emergency department admissions.[vii]
- A recent study by the Canadian Institute for Health Information estimated that there were over 25,000 hospitalizations in one year in Ontario that were entirely caused by alcohol; there were more hospital admissions in Canada in 2017 for alcohol-related conditions than heart attacks.[viii]
- Increasing access to alcohol works against the government's efforts to reduce health care costs and end "Hallway Medicine".
- Alcohol-related costs currently exceed alcohol-related net income within Ontario.
- Alcohol-related costs in Ontario amount to at least $5.3 billion annually:[ix]
    - $1.5billion in healthcare
    - $1.3 billion in criminal justice
    - $2.1 billion related to lost productivity
    - $500 million in other direct costs
- In the United States, growth in life expectancy has stagnated and even decreased slightly in recent years, owing mainly to deaths attributed to alcohol and drug use or to suicide in lower socioeconomic strata; in Canada, rates of "deaths of despair" have also increased, particularly for opioid overdoses and alcoholic liver cirrhosis; as such, it is important for Canada to avoid further inequalities in income, to reduce rates of opioid prescribing and to strengthen alcohol control policies.[x]

Recommended Risk Mitigation Actions/Options:

Retail Siting and Setbacks

- Consider implementing the following setbacks, density and sensitive land use measures related to alcohol retailers:
    - Child care centres
    - Post-secondary schools
    - Elementary and secondary schools
    - Gaming facilities/casinos
    - Health care facilities, such as hospitals

- Long-term care homes
- Recreation and sports facilities
- Arcades, amusement parks, and other places where children and youth congregate
- Separation distances between retailors
- High priority neighbourhoods where there is more crime or higher socioeconomic disparity. DRHD priority neighbourhood data can be found at the following link: https://www.durham.ca/health.asp?nr=/departments/health/health_statistics/health_neighbourhoods/index.htm

Retail Density and Hours of Operation

- Take an incremental approach to alcohol sales expansion, including retail density and hours of sale, which will allow the government to monitor and evaluate the impact of any changes or increase in harms gradually.[xi]

Public Education, Prevention Strategies and Treatment Services

- Provide financial assistance to public health agencies to implement comprehensive and sustained prevention and harm reduction approaches that promote awareness of alcohol related harms and delay age of initiation amongst youth and young adults.
- Allocate a portion of additional revenue generated by increased alcohol availability directly to mental health and addictions services, which would assist in meeting current gaps in funding for direct service provision.

Pricing

- Adopt alcohol pricing policies that more effectively target hazardous patterns of drinking. These policies include:[xii]
  - setting and enforcing a minimum price per standard drink and applying it to all products
  - altering markups to decrease the price of low alcohol content beverages and increase the price of high alcohol content beverages
  - indexing minimum prices and markups to inflation to ensure that alcohol does not become cheaper relative to other commodities over time.

Note: Saskatchewan has demonstrated an effective strategy to bring revenue to the province while reducing alcohol related harms:

- increasing alcohol pricing can achieve the financial goal of increased revenues while realizing the health benefits of reduced alcohol consumption; Saskatchewan increased minimum prices and saw a decline in alcohol consumption of 135,000 litres of absolute alcohol and a revenue increase of $9.4 million last year.[xiii]

Youth

- Maintain a government monopoly for off premise sales, including strong compliance checks.
- Limit retail density in areas frequented by youth.
- Ban the use of alcohol advertising, marketing and power walls in retailers that permit youth access.

Conclusion

- Notwithstanding competing pressures and priorities, government policies should strive to work in concert to support the health of all Ontarians.
- There are a number of options available to the government as in proceeds with alcohol retail expansion to mitigate the risks, especially to youth and vulnerable populations and to ensure safe and healthy communities.
- alPHa asks the government to fully consult with health experts, including the Association of Local Public Health Agencies, Centre for Addiction and Mental Health, and Ontario Public Health Association before making changes to the availability of alcohol.
- In addition, alPHa asks the government to develop, implement and evaluate a provincial alcohol strategy in consultation with the same experts cited above.

About alPHa: The Association of Local Public Health Agencies (alPHa) is a not-for-profit organization that provides leadership to the boards of health and public health units in Ontario. Membership in alPHa is open to all public health units in Ontario and we work closely with board of health members, medical and associate medical officers of health, and senior public health managers in each of the public health disciplines – nursing, inspections, nutrition, dentistry, health promotion, epidemiology and business administration. The Association works with governments, including local government, and other health organizations, advocating for a strong, effective and efficient public health system in the province. Through policy analysis, discussion, collaboration, and advocacy, alPHa's members and staff act to promote public health policies that form a strong foundation for the improvement of health promotion and protection, disease prevention, and surveillance services in all of Ontario's communities. Further information on alPHa can be found at: www.alphaweb.org

For further information contact:
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References

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Appendix

Summary of alPHa's Submissions Related to Alcohol

- Alcohol is an important public health issue.
- Alcohol is not an ordinary commodity and should not be treated as such.
- Decisions how it is regulated, promoted and sold must be made within the broader context of its known and measurable societal harms, negative economic impacts and most importantly, public health.
- Alcohol is the most commonly used drug among Ontarians and one of the leading causes of death, disease and disability in Ontario.
- Alcohol is responsible for the second highest rate of preventable death and disease in Canada, following tobacco.
- Ontario has a significant portion of the population drinking alcohol and exceeding the low risk drinking guidelines.
- Expenditures attributed to alcohol consumption cost Ontarians an estimated $1.7 billion in direct health care costs and $3.6 billion in indirect costs in 2011, for a total of $5.3 billion.
- Direct health problems include chronic diseases such as liver diseases, diabetes, cardiovascular disease, cancer and other chronic illness along with deaths from drunk driving, homicides, suicides, assaults, fires, drowning and falls. These are but some of the more obvious examples of the adverse impacts of alcohol use and abuse.
- Indirect costs are also substantial due to alcohol-related illness, disability and death along with lost productivity in the workplace and at home.
- There is a well-established association between easy access to alcohol and overall rates of consumption and damage from alcohol.
- Increasing access works against the government's efforts to reduce health care costs. A recent study by the Canadian Institute for Health Information estimated that there were over 25,000 hospitalizations in one year in Ontario that were entirely caused by alcohol. There were more hospital admissions in Canada in 2017 for alcohol-related conditions than heart attacks. Significant health care savings could be achieved through reduced health care burden from alcohol-related diseases and death.

- It is well-established that access increases consumption, which in turn increases the numerous alcohol-related harms as well as societal costs to the Province related to law enforcement. It is estimated that law enforcement related to alcohol costs Ontarians $3.18 yearly.

- We have expressed our opposition to expanding the nature and number of retailers permitted to sell alcohol in the past, based on clear evidence that increasing access is detrimental to public health, and this remains our position. Given that such expansion continues to proceed in Ontario however, we must reinforce the importance of developing a comprehensive, provincially led alcohol strategy that can help mitigate the otherwise entirely preventable negative impacts of increased alcohol availability, which include increasing hallway medicine and waste of taxpayers' money.

- It is well-established that increasing alcohol availability is directly related to increased consumption and alcohol-related harms. A comprehensive, evidence-based approach to alcohol policy is therefore critical to limiting these harms.

EXCERPTS FROM AGO REPORT, CHAPTER 3.10 PUBLIC HEALTH: CHRONIC DISEASE PREVENTION

1.0 Summary

OVERALL MINISTRY RESPONSE

The Ministry and public health units are actively involved in promoting the Low-Risk Alcohol Drinking Guidelines to support a culture of moderation and provide consistent messaging about informed alcohol choices and responsible use. Over 65 stakeholders have been consulted to inform the development of a provincial Alcohol Strategy (p. 531).

4.1.3 Comprehensive Policy Developed and Dedicated Funding Provided for Tobacco Control but Not Physical Activity, Healthy Eating and Alcohol Consumption

Alcohol Consumption

In the case of ensuring effective controls on alcohol availability, we found that while public health is tasked with promoting Canada's Low-Risk Alcohol Drinking Guidelines to reduce the burden of alcohol-related illness and disease, in 2015 the Province expanded alcohol sales in grocery stores, farmers' markets, and LCBO e-commerce sales channels. One public health unit released a public statement noting that this move undermines the objective of public health units' work to reduce the burden of alcohol-related illness and disease.

Similarly, in their report mentioned earlier, Cancer Care Ontario and Public Health Ontario noted that the evidence shows that increased availability of alcohol is associated with high-risk drinking and alcohol-related health problems (pp. 546-547).

RECOMMENDATION 3

To better address the risk factors that contribute to chronic diseases, we recommend that the Ministry of Health and Long-Term Care develop comprehensive policies to focus on the key risk factors of chronic diseases—physical inactivity, unhealthy eating and alcohol consumption—in addition to tobacco control (p. 547).

MINISTRY RESPONSE

The Ministry and public health units are actively involved in promoting the Low-Risk Alcohol Drinking Guidelines to support a culture of moderation and provide consistent messaging about informed alcohol choices and responsible use. Over 65 stakeholders have been consulted to inform the development of a provincial Alcohol Strategy.

Building on these achievements, the Ministry is currently developing an integrated provincial strategy to further increase adoption of healthy living behaviours across the lifespan to reduce risk factors for chronic diseases including unhealthy eating, physical inactivity, harmful use of alcohol, and tobacco use, while recognizing the impact of social determinants of health.

EXCERPTS FROM AGO NEWS RELEASE DECEMBER 6, 2017: *SUCCESS OF PUBLIC HEALTH PROGRAMS IN PREVENTING CHRONIC DISEASES UNKNOWN: AUDITOR GENERAL*

The audit found that although the Ministry of Health and Long-Term Care (Ministry) has made progress in reducing smoking, a chronic disease risk factor, more work is needed to address the other risk factors such as physical inactivity, unhealthy eating and heavy drinking (3rd ¶)

A 2016 research report from the Ontario-based Institute for Clinical Evaluative Sciences, says that four modifiable risk factors that contribute to chronic diseases—physical inactivity, smoking, unhealthy eating and excessive alcohol consumption—cost Ontario almost $90 billion in health-care costs between 2004 and 2013. One of public health's functions is to prevent chronic diseases, such as cardiovascular and respiratory diseases, cancer and diabetes. In Ontario, the number of people living with these diseases has been rising (4th ¶).

The Regional Municipality of Durham

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February 20, 2019

Christopher Tyrell
Standing Committee on Public Accounts
Committee Clerk
Procedural Services Branch
Legislative Assembly of Ontario
1405-99 Wellesley Street West
Toronto, Ontario M7A 1A2

Dear Chair and Members:

Re: Public Health – Chronic Disease Prevention Audit

On behalf of my colleagues Drs. David Colby (Municipality of Chatham-Kent), Eileen de Villa (Toronto Public Health) and Janet DeMille (Thunder Bay District Health Unit), we are pleased to appear before you today to answer any questions you may have with respect to the Public Health – Chronic Disease Prevention audit of the 2017 Auditor General of Ontario's Annual Report.

Our respective biographies are listed below, and our speaking points are attached to this letter. We respectively recommend that questions related to the Ministry of Health and Long-Term Care, including the status of the audit's recommendations, and Public Health Ontario (PHO) be directed to the appropriate officials within the Ministry or PHO. In addition, if we are unable to answer your questions, we are happy to take them back to our respective public health units and report back to the Committee.

Sincerely,

R.J. Kyle, BSc, MD, MHSc, CCFP, FRCPC, FACPM
Commissioner & Medical Officer of Health

If this information is required in an accessible format, please contact 1-800-372-1102 ext. 3324.

Dr. David Colby

Originally from Chatham, Dr Colby received his MD from the University of Toronto in 1984. Dr Colby was awarded Fellowship in the Royal College in 1990 (Medical Microbiology) and was appointed Chief of Microbiology at University Hospital, London in 1993. He was President of the Canadian Association of Medical Microbiologists from 1995 to 1997. Dr Colby is a Coroner for the province of Ontario and Professor of Microbiology/ Immunology and Physiology/ Pharmacology at Western. His research interests include antimicrobial resistance and wind turbine sounds. Dr Colby is the Medical Officer of Health in Chatham-Kent.

Dr. Eileen de Villa

Dr. Eileen de Villa is the Medical Officer of Health for the City of Toronto. Dr. de Villa leads Toronto Public Health, Canada's largest local public health agency, which provides public health programs and services to 2.9 million residents. Prior to joining Toronto Public Health, Dr. de Villa served as the Medical Officer of Health for the Region of Peel serving 1.4 million residents.

Dr. de Villa received her degrees as Doctor of Medicine and Master of Health Science from the University of Toronto and holds a Master of Business Administration from the Schulich School of Business. Dr. de Villa is also an Adjunct Professor at the Dalla Lana School of Public Health at the University of Toronto.

Dr. de Villa has authored, published and presented research on issues including public health considerations for city planning and emergency preparedness, communicable and infectious disease control, and public health policy development.

Dr. Janet DeMille

Dr. Janet DeMille is the Medical Officer of Health and CEO of the Thunder Bay District Health Unit (TBDHU), one of two provincial public health units covering all of Northwestern Ontario.

Dr. DeMille has lived and worked in Northwestern Ontario (NWO) for over 20 years, initially training and then practicing in Family Medicine in rural communities in NWO as well as in the City of Thunder Bay. In 2009, she entered the post-graduate medical training at the Northern Ontario School of Medicine and successfully completed her Master of Public Health degree and her Royal College certification in Public Health and Preventive Medicine in 2012. She started working at the TBDHU after this, first in the role of Associate MOH before officially taking on the role of MOH in early 2016.

Dr. Robert Kyle

Dr. Robert Kyle has been the Commissioner & Medical Officer of Health for the Regional Municipality of Durham since 1991. He obtained his Bachelor of Science degree in chemistry from Western University and medical degree and Master of Health Science degree from the University of Toronto. He is a certificant in the Specialty of Community Medicine from the Royal College of Physicians and Surgeons of Canada and holds a certificate in Family Medicine from the College of Family Physicians of Canada.

Dr. Kyle is a Fellow of the Royal College of Physicians and Surgeons of Canada and of the American College of Preventive Medicine and is a former Medical Officer of Health for the Peterborough County-City Health Unit. He is an Adjunct Professor, Dalla Lana School of Public Health, University of Toronto and a member of the medical staffs of Lakeridge Health Corporation and Markham-Stouffville Hospital.

Dr. Kyle is an active member of many provincial and regional health groups and organizations. For example, he is currently Chair of Public Health Ontario's Board of Directors, President of the Association of Local Public Health Agencies, and Chair of the Public Health and Preventive Medicine Exam Board for the Royal College of Physicians and Surgeons of Canada.

Standing Committee on Public Accounts
Room 151, Main Legislative Building

February 20, 2019

Speaking Points

- Good morning; I am Dr. Robert Kyle, Commissioner & Medical Officer of Health, Regional Municipality of Durham
- With me are Drs. David Colby, Eileen de Villa and Janet DeMille, Medical Officers of Health for Chatham-Kent, Toronto, and Thunder Bay District, respectively
- Our bios are attached to our transmittal letter, together with these speaking points, which we would be happy to leave with the Committee Clerk
- Thank you for the invitation to appear before you today
- Thanks to the Audit Team for working with us in researching and preparing its audit report
- Before proceeding, it should be noted that section 2.1.2 of the audit (p 533) refers to the previous Ontario Public Health Standards, 2008 (revised March 2017) that were replaced by the new Ontario Public Health Standards: Requirements for Programs, Services, and Accountability, 2018 (OPHS), which are described in more detail below
- We acknowledge the public health significance of chronic diseases, in that:
    - Most chronic diseases (e.g., diabetes, cancer, etc.) are preventable, or their onset can be delayed by limiting four modifiable risk factors:
        - Physical inactivity
        - Smoking
        - Unhealthy eating
        - Excessive alcohol consumption (p 527)

    - The MOHLTC estimated that major chronic diseases and injuries accounted for 31% of direct, attributable health care costs in Ontario (p 534)
    - Preventing chronic diseases helps reduce the burden on the health-care system and promotes a better quality of life (p 534)

- Accordingly, the focus of our remarks is on the public health system and its role in chronic disease prevention

- Questions about the Ministry of Health and Long-Term Care (Ministry), the status of the Audit's recommendations, and Public Health Ontario (PHO) are best directed to Ministry and PHO officials, respectively

- Public health focuses on the health and well-being of the whole population through the promotion and protection of health and prevention of illness (p 531)

- The *Health Protection and Promotion Act* (Act) is the primary legislation that governs the delivery of public health programs and services; its purpose is to provide for the organization and delivery of public health programs and services, the prevention of the spread of disease, and the promotion and protection of the health of the people of Ontario (p 532)

- The public health system is an extensive network of government, non-government and community organizations operating at the local, provincial and federal levels (p 532)

- The key provincial players are the Ministry and PHO (p 532)

- The Ministry co-funds with obligated municipalities 35 public health units (PHUs) to directly provide public health programs and services (p 532)

- The Population and Public Health Division (Division) is responsible for developing public health initiatives and strategies, and funding and monitoring public health programs and services delivered by PHUs (P 532)

- The Division is currently led by the Chief Medical Officer of Health (CMOH) who reports directly to the Deputy Minister; his other duties include those listed on p 532
- PHO provides scientific and technical advice and support to the CMOH, Division and PHUs; it also operates Ontario's 11 public health laboratories (p 532)
- PHUs deliver a variety of program and services in their health units; examples are listed on p 533
- Health unit populations range in size from 34,000 (Timiskaming) to 3 million (Toronto) (p 533)
- Each PHU is governed by a board of health (BOH), which is accountable for meeting provincial standards under the Act (p 533)
- Each BOH appoints a medical officer of health (MOH) whose powers and duties are specified in the Act and include reporting directly to the BOH on public health and other matters (P 533)
- Governance models vary considerably across the 35 PHUs; all are municipally controlled to varying degrees (p 533)
- Each BOH has a Public Health Funding and Accountability Agreement with the Ministry, which sets out the terms and conditions governing its funding (p 533)
- The Ministry develops standards for delivering public health programs and services as required by the Act; each BOH is required to comply with these standards (p 533)
- On January 1, 2018, each BOH began implementing the new OPHS, Protocols and Guidelines
- The OPHS set out the minimum requirements that PHUs must adhere to in delivering programs and services

- The OPHS consist of the following nine Program Standards:
    - Chronic Disease Prevention and Well-being
    - Food Safety
    - Healthy Environments
    - Healthy Growth and Development
    - Immunization
    - Infectious and Communicable Diseases Prevention and Control
    - Safe Water
    - School Health
    - Substance Use and Injury Prevention

- The OPHS also consist of the following four Foundational Standards that underlie and support all Program Standards:
    - Population Health Assessment
    - Health Equity
    - Effective Public Health Practice, which is divided into 3 sections:
        - Program Planning, Evaluation, and Evidence-Informed Decision-Making
        - Research, Knowledge Exchange, and Communication
        - Quality and Transparency
    - Emergency Management

- 23 Protocols provide direction on how BOHs shall operationalize specific requirement(s) identified within the OPHS; the aim is to have consistent implementation of specific requirements across all 35 BOHs; in the past and now, BOHs must comply with these Protocols

- 20 Guidelines provide direction on how BOHs shall approach specific requirement(s) identified within the OPHS; the aim is to provide a consistent approach to/application of requirements across all BOHs while also allowing for variability in programs and services across PHUs based on

local contextual factors as defined in the guidelines; now, BOHs must comply with these Guidelines

- It should be noted that although there are fewer Program Standards, there are more Foundation Standards and taken together with the Protocols and Guidelines, more requirements with which BOHs must comply
- Under the Act, provincial funding of PHUs is not mandatory but rather is provided as per Ministry policy; the Act requires obligated (upper-tier or single-tier) municipalities to pay the expenses incurred by or on behalf of the PHUs to deliver the programs and services set out in the Act, the regulations and the OPHS (p 534)
- Currently, the Ministry funds up to 75% of mandatory programs and up to 100% of priority programs (p 534)
- The Ministry updates the schedules in the Public Health Funding and Accountability Agreement annually (p 534)
- The new OPHS takes a coordinated approach to the Standards listed above and a more robust Accountability Framework that covers the following domains:
    - Delivering of Programs and Services
    - Fiduciary Requirements
    - Good Governance and Management Practices
    - Public Health Practice
    - Common to All Domains
- Accordingly, beginning in 2018, each BOH submits a prescribed Annual Service Plan and Budget Submission to the Division for approval
- It should be noted that BOHs are now providing the PPHD with far more information; moreover, beginning in the fall of 2018, BOHs must report on their risk management activities; finally, commencing with the 2019 ASPBS,

BOHs must report on their 2018 program activities, as specified by the PPHD

- With respect to chronic disease prevention, the OPHS require each BOH to develop and implement a program of public health interventions using a comprehensive health promotion approach that addresses chronic disease risk and protective factors

- The following topics (by program) are considered based on an assessment of local needs:

    - Built environment (Chronic Disease Prevention and Well-being {CDP})
    - Comprehensive tobacco control (Substance Use and Injury Prevention {SUIP})
    - Healthy eating behaviours (CDP, School Health {SH})
    - Mental health promotion (CDP, SH, SUIP)
    - Oral health (CDP, SH, SUIP)
    - Physical activity and sedentary behaviour (CDP, SH)
    - Substance use (SH, SUIP) and harm reduction (SH)
    - UV exposure (CDP, SH)

- Several Guidelines (i.e., *Chronic Disease Prevention*, *Health Equity*, *Mental Health Promotion*, and *Substance Use Prevention and Harm Reduction*) and one Protocol (*Tobacco, Vapour and Smoke)* guide the work in this area

- For these three (CDP, SH, SUIP) programs, each BOH shall collect and analyze relevant data and report and disseminate the data and information in accordance with the *Population Health Assessment and Surveillance Protocol, 2018*

- As regards program evaluation, each BOH is required to:

    - Routinely monitor program activities and outcomes to assess and improve the implementation of programs and services

- Ensure a culture of on-going program improvement and evaluation, and conduct formal program evaluations where required
- Ensure all programs and services are informed by evidence

- Each BOH must comply with 2 research and knowledge exchange (KE) requirements:

  - Engage in KE activities with public health practitioners, etc. regarding factors that determine populations health
  - Foster relationships with researchers, academic partners and others to support research and KE activities

- In closing, Ontario has a mature, inter-connected, and well-regulated public health system
- The system is capably led by the Ministry and ably assisted by the CMOH and the Division
- PHO provides the Ministry and PHUs with superb scientific, technical and laboratory support
- PHUs are governed by BOHs each of which appoints a MOH who ensures the delivery of a wide array of public health programs and services, including chronic disease prevention, in accordance with the Act, regulations, OPHS, Protocols and Guidelines
- As with all well-functioning health systems, there is always room for continuous quality improvement
- With the foregoing in mind, we would be happy to answer your questions

alPHa
Association of Local PUBLIC HEALTH Agencies

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

alPHa Sections:

Boards of Health Section

Council of Ontario Medical Officers of Health (COMOH)

Affiliate Organizations:

Association of Ontario Public Health Business Administrators

Association of Public Health Epidemiologists in Ontario

Association of Supervisors of Public Health Inspectors of Ontario

Health Promotion Ontario

Ontario Association of Public Health Dentistry

Ontario Association of Public Health Nursing Leaders

Ontario Dietitians in Public Health

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Hon. Vic Fedeli
Minister of Finance
Room 281, Main Legislative Building,
Queen's Park
Toronto, Ontario M7A 1A1

January 31 2018

Dear Minister Fedeli,

Re: Alcohol Choice & Convenience and a Provincial Alcohol Strategy

On behalf of the Association of Local Public Health Agencies (alPHa) and its member Medical Officers of Health, Boards of Health, and Affiliate organizations, I am writing to provide our input to your Government's plans for modernizing the rules for the sale and consumption of alcohol in Ontario. We are especially interested in helping you achieve the stated goal of ensuring safe and healthy communities by reiterating our call for a Provincial Alcohol Strategy.

Over the past few years, Ontario has been steadily increasing the availability of and access to beverage alcohol by relaxing long-standing controls over its sale and distribution, such as expanding the number and type of retail outlets, extending hours of service, allowing online ordering with home delivery and reducing over-the-counter prices. Your Government's plan to expand the sale of alcohol to corner stores, additional grocery stores and big-box stores would be a significant move towards further loosening these controls.

While we understand the consumer convenience aspect of these decisions, we are very concerned that the negative societal and health impacts of increasing the availability of alcohol continue to be overlooked.

Alcohol is no ordinary commodity. It causes injury, addiction, disease, and social disruption and is one of the leading risk factors for disability and death. Its contributions to liver disease, fetal alcohol spectrum disorder, acute alcohol poisoning and various injuries owing to intoxication are well known and evidence of its links to mental health disorders and a range of cancers continues to mount. In fact, a recent study by the Canadian Institute for Health Information (CIHI) estimated that there were over 25,000 hospitalizations in one year in Ontario that were entirely caused by alcohol[1].

In addition to the personal health impacts, alcohol is a significant factor in the public costs associated with health care, social services, law enforcement and justice, and lost workplace productivity.

We have expressed our opposition to expanding the nature and number of retailers permitted to sell alcohol in the past, based on clear evidence that increasing access is detrimental to public health, and this remains our position. Given that such expansion continues to proceed in Ontario however, we must reinforce the importance of developing a comprehensive, provincially led alcohol strategy that can help mitigate the otherwise entirely preventable negative impacts of increased alcohol availability, which include increasing hallway medicine and waste of taxpayers' money.

It is well-established that increasing alcohol availability is directly related to increased consumption and alcohol-related harms. A comprehensive, evidence-based approach to alcohol policy is therefore critical to limiting these harms.

We would be pleased to meet with you to further discuss our views on the public health impacts of alcohol availability and to lend our expertise to the development of a made-in-Ontario alcohol strategy. To schedule a meeting, please have your staff contact Loretta Ryan, Executive Director, alPHa, at loretta@alphaweb.org or 647-325-9594.

Sincerely,

Dr. Robert Kyle,
alPHa President

COPY: Hon. Doug Ford, Premier of Ontario
Hon. Christine Elliott, Minister of Health and Long-Term Care
Dr. David Williams, Chief Medical Officer of Health

Encl.

1. *Canadian Institute for Health Information. Alcohol Harm in Canada: Examining Hospitalizations Entirely Caused by Alcohol and Strategies to Reduce Alcohol Harm. Ottawa, ON: CIHI; 2017.*

alPHa
Association of Local PUBLIC HEALTH Agencies

alPHa RESOLUTION A11-1

TITLE: **Conduct a Formal Review and Impact Analysis of the Health and Economic Effects of Alcohol in Ontario and Thereafter Develop a Provincial Alcohol Strategy**

SPONSOR: **Middlesex-London Board of Health**

WHEREAS There is a well-established association between easy access to alcohol and overall rates of consumption and damage from alcohol; and (Barbor et al., 2010)

WHEREAS Ontario has a significant portion of the population drinking alcohol (81.5%), exceeding the low risk drinking guidelines (23.4%), consuming 5 or more drinks on a single occasion weekly (11.2%), and reporting hazardous or harmful drinking (15.6%); and (CAMH Monitor)

WHEREAS Ontario youth (grades 9-12) have concerning levels of alcohol consumption with 69.4% having drank in the past year, 32.9% binge drinking (5 or more drinks), and 27.5% of students reporting drinking at a hazardous level; and (OSDUHS Report)

WHEREAS Each year alcohol puts this province in a $456 million deficit due to direct costs related to healthcare and enforcement; and (G. Thomas, CCSA)

WHEREAS Billions of dollars are spent each year in Canada on indirect costs associated with alcohol use (illness, disability, and death) including lost productivity in the workplace and home; and (The Costs of Sub Abuse in CAN, 2002)

WHEREAS Nearly half of all deaths attributable to alcohol are from injuries including unintentional injuries (drowning, burns, poisoning and falls) and intentional injuries (deliberate acts of violence against oneself or others); and (WHO – Alcohol and Injury in EDs, 2007)

WHEREAS Regulating the physical availability of alcohol is one of the top alcohol policy practices in reducing harm; and (Barbor et al., 2010)

WHEREAS The World Health Organization (WHO, 2011) has indicated that alcohol is the world's third largest risk factor for disease burden and that the harmful use of alcohol results in approximately 2.5 million deaths each year. Alcohol is associated with increased levels of health and social costs in Ontario and is causally related to over 65 medical conditions;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) petition the Ontario government to conduct a formal review and impact analysis of the health and economic effects of alcohol in Ontario and develop a provincial Alcohol Strategy.

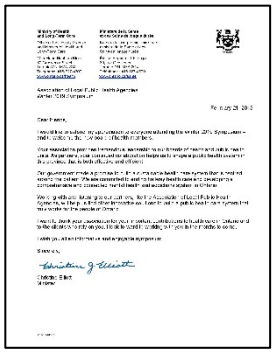
ACTION FROM CONFERENCE: **Resolution CARRIED**

Association of Local PUBLIC HEALTH Agencies

WINTER SYMPOSIUM PROCEEDINGS
Thursday, February 21, 2019
Chestnut Conference Centre
89 Chestnut St., Toronto

Welcoming Remarks *Symposium Chair: Dr. Robert Kyle, alPHa President*

Dr. Robert Kyle, President of alPHa welcomed delegates to alPHa's Winter Symposium, with an acknowledgement that it was held on the Ancestral Traditional Territories of the Ojibway, the Anishnabe and the Mississaugas of the New Credit, which is covered by the Upper Canada Treaties.



He thanked the Medical Officers of Health, Associate Medical Officers of Health, Affiliates, and Board of Health members – particularly those who are new to their role – for demonstrating their dedication to the public health system by attending this event in an unpredictable climate, both political and actual. He also read a letter of greeting that was received from the Minister of Health and Long-Term Care.

Plenary – Making the Connection Between Public Health and Mental Health

Speaker: Lori Spadorcia, Vice President, Communications and Partnerships, Centre for Addiction and Mental Health (CAMH)

Commentators: Trudy Sachowski, Chair, alPHa Boards of Health Section & Dr. Christopher Mackie, Chair, Council of Ontario Medical Officers of Health

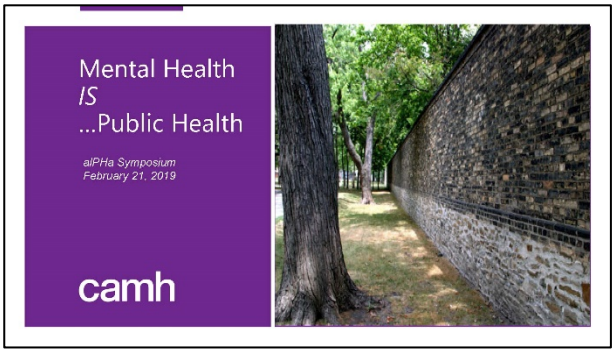
Lori Spadorcia gave a brief history of the Centre for Addiction and Mental Health's Toronto campus, to illustrate the importance of breaking down both literal and figurative walls to drive policy change and attitudes related to mental health. The campus itself has evolved from an asylum isolated from the city to an integral and welcome part of the surrounding neighbourhood, as have many of the people who have benefitted from its services.

Despite the measurable progress, there are still science, justice and advocacy gaps. Research on the physiological and psychological factors underlying mental health continues but what is unknown still outweighs what we have learned. Investments in how the justice system deals with mental health are not where they should be and public funding of effective treatments (e.g. cognitive behavioural therapies) is largely absent. The stigma that remains around mental health issues aggravates these gaps, in that it makes advocacy by or on behalf of people living with mental health issues very difficult.

She then reinforced the importance of asking why some diseases get treatment and others get judgment with the

assertion that the burden of mental illness and addictions is higher than that for all cancers combined. It has in other words become an enormous and poorly addressed health issue that could benefit from the same upstream approaches that we use to address physical wellbeing.

She used the example of housing, which has become one of CAMH's top advocacy priorities, to illustrate this idea. The evidence that stable housing is one of the strongest determinants of health is robust and CAMH has had a great deal of success, despite the predictable challenges and resistance, in transitioning close to 100 patients into the community. This however remains a matter that is not being adequately addressed through public policy, and even the most complex cases can be transitioned with the proper supports within a well-connected system of multisectoral care with central access points, strong continuing care and monitoring.



A broader advocacy focus is the message that mental health is health, because it remains marginalized and poorly understood by the health and education systems, employers and society at large. This magnifies the haphazard approaches following diagnoses of mental disease, which in turn highlights the importance of achieving parity with the clear and accepted responses following diagnosis of physical disease. She submitted that the upstream determinants of health approach will be an important foundation for employing a common language for both. In addition, discovery and innovation will remain the foundation of treating mental health the same way that we do physical health, opening options for treatment and, most importantly, providing hope.

Following Lori's presentation, Trudy Sachowski (Chair of alPHa's Boards of Health Section) and Dr. Christopher Mackie (Chair of alPHa's Council of Ontario Medical Officers of Health) were invited to provide further comments from a public health perspective and lead the ensuing discussion.

Trudy spoke of the prevalence of alcohol abuse in her community and the importance of getting to people when they are young through schools, teams, positive reinforcement, supports for assistance, seminars and educational sessions. In the north, this also requires partnering with indigenous associations to ensure that any intervention or program is culturally sensitive and is led by the indigenous community.

Lori agreed with these points and added that having different partners at the table has contributed to the success of a variety of initiatives. Implementing mental health strategy takes a village, which includes schools, social services, police, public health etc., as the audiences are often the same, so innovation and a variety of coordinated approaches can be employed. It is also important to understand that audience through involvement – there is no standard approach that can be expected to work in all cases.

Dr. Chris Mackie continued with a reference to the stigma, noting that the subject of his Master's degree was de-institutionalization of mental health and indicating that this needs to focus on providing supports to individuals who need them and not strictly on reducing the burden on the institutions themselves. He observed that mental health was only incorporated into the Ontario Public Health Standards in 2018, and that this will provide an important foundation for building on the activities that public health had already initiated (e.g. early years, anti-bullying and post-partum programs) by making it a core part of its practice and facilitating further collaboration to reduce the enormous burden of illness. Public health can have a tremendous impact through prevention approaches, especially if the potential of programs such as Healthy Babies, Healthy Children can be unlocked

through proper funding and resources. Roles in secondary and tertiary prevention where mental illnesses and physical illnesses such as TB intersect are also becoming clearer.

The ensuing discussion covered the importance of raising awareness and translating it into action and well-resourced programs and services (the Bell "Let's Talk" campaign was referenced), addressing workplace culture, building community capacity, and reinforcing the idea that determinants of health – especially when applied in the earliest stages of life – will improve mental health outcomes just as much as they do physical ones.

alPHa Strategic Plan

Speaker: Maria Sanchez-Keane, Principal Consultant, Centre for Organizational Effectiveness

Dr. Robert Kyle welcomed Maria Sanchez-Keane to facilitate a session that would give delegates the opportunity to provide feedback on the new alPHa Strategic Plan, which has been under development throughout the past year.

She provided a summary of the process so far and the agreed-upon strategic directions, indicating that this phase is intended to gather further direction from the membership on implementation of the plan. The work on this began some time ago and has been developed through input from two alPHa Boards and their respective Executive Committees as well as alPHa staff. Delegates were asked to continue the focus on what alPHa can do to advance public health through the leveraging of its diversity of membership and variety of perspectives in three key areas and considering criteria that should be employed in decision-making processes.

Small-group discussions were organized for each of the key areas (strengthen the local public health system, especially local public health, by leading the dialogue with governments and Ministries; provide leadership in building collaborations and alliances focusing on provincial and municipal levels; build opportunities for multiconstituent connections amongst alPHa members). Written / oral feedback was collected to inform the next version of the Plan. Further work on this will be done by the alPHa Board of Directors during their February 22nd and April 26th meetings. The final Strategic Plan is expected to be presented to the membership during the June 2019 Conference in Kingston.

Panel – Managing Risk in Public Health

Moderator:
Dr. Peter Donnelly, President & CEO, Public Health Ontario

Panelists:
Dr. Penny Sutcliffe, MOH, Public Health Sudbury & Districts
Dr. Robert Kyle, MOH, Durham Region Health Department

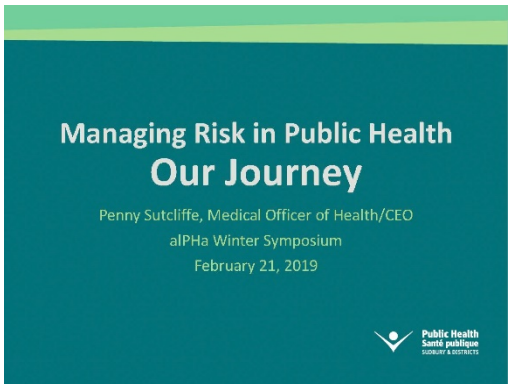
This panel was assembled to provide members with a chance to build on previous alPHa sessions on risk management (2015 and 2016) at a time when significant systemic changes are occurring.

Dr. Peter Donnelly launched the panel with introductory comments, observing that managing risk should be closely integrated into governance and there can be consequences if it isn't. He shared a story from his former career about a board of health CEO whose sole focus was on achieving targets without paying attention to process and inherent risk led to high levels of workplace stress, "hockling the books" and an ignorance of underlying governance shortcomings. The negative outcome of this approach was entirely predictable, and the resulting organizational damage took years to undo.

He continued with a similar story about a board of health in a small and insular community that concerned itself entirely too much with the day-to-day activities of operational staff without paying much attention to matters of governance. When the local dysfunction became apparent, the government had to send in agents to redress the situation, which was not looked upon kindly by the community.

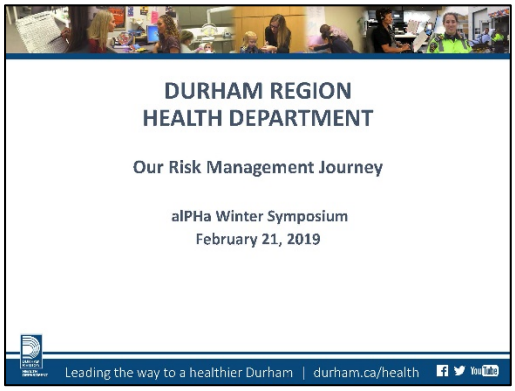
Taken together, these stories were meant to convey the idea that an effective governance structure keeps its eyes on but hands off what it is governing. By focusing on governance, it is easier to identify organizational risks to operational undertakings. In any case, it is essential to remind front-line staff of the value and importance of what they are doing.

Dr. Penny Sutcliffe continued with the storytelling direction, recalling a hot day in July 2016 when an overheated server room resulted in a critical failure of all Public Health Sudbury and Districts' communications systems. This in turn caused serious implications for service delivery and led to the realization that because there was no contingency plan, the outcome of this failure was far worse than it needed to be.



The response was a full examination of potential risks and their likely impacts in order to make decisions about allocating resources and included consideration of risk tolerance to make sure that opportunities would not be missed. The formal risk management policy and procedure is now embedded into the culture and operations of the agency, which equipped it well for the incorporation of risk management into the accountability requirements of the 2018 Ontario Public Health Standards.

She concluded with a summary of lessons learned and indicated that risk management must be a continuous process if it is to be effective. Dr. Donnelly referred to the summary of the process in Dr. Sutcliffe's presentation and suggested that while it may appear intimidating, one must measure this front-loaded work against what might be required after a failure that results from not doing it.



Robert Kyle, presenting in place of originally-scheduled Corinne Berinstein, outlined his health department's risk management journey, which, like in Dr. Sutcliffe's case, was prompted by a crisis.

The loss of an unencrypted USB key that contained the personal health information of more than 83,000 people who had visited Durham's H1N1 immunization clinics in 2010 sensitized the Region to the importance of examining and fortifying its data and information systems. It has also been a primary consideration in Durham's decision not to sign on to Panorama precisely because data hosting agreements have no language about managing risk in a shared information system.

The formalization of the general local risk management approach contained many of the same elements outlined by Dr. Sutcliffe, including keeping organizational values and risk appetite in the background, developing risk-mitigation plans, and continual monitoring, reporting and evaluation. He echoed the importance of integrating risk management into the institutional culture, with leadership from the executive team and engagement of the management team.

Dr. Donnelly then summarized risk management as both a science and an art. It must be methodical and detailed, informed by risk appetite, and developed with the knowledge that, irrespective of the quality of planning, the human response to crises is rarely governed completely by reason.

The ensuing discussion focused on different kinds of risk and the incredible value of the application of lessons learned in planning. Many suggested that alPHa could have an important role in facilitating a system-wide risk management dialogue among its members, as well as supporting collective responses to some of the persistent issues where technology and protection of personal information intersect.

Evening Reception & Special Guest Lecture co-hosted by alPHa and the Dalla Lana School of Public Health

Introductions: Dr. Robert Kyle, President, alPHa & Professor Adalsteinn (Steini) Brown, Dean, Dalla Lana School of Public Health

Special Guest Speaker: Dr. Rueben Devlin, Special Advisor and Chair of the Premier's Council on Improving Health Care and Ending Hallway Medicine

alPHa delegates were invited to conclude the day with an evening presentation from Dr. Rueben Devlin, who provided additional details and context for the vision of the Premier's Council on Improving Health Care and Ending Hallway Medicine that was described in the Council's initial report.

COLLECTED SLIDE DECKS

SPEAKER BIOS
(in order of appearance)

ROBERT KYLE has been the Commissioner & Medical Officer of Health for the Regional Municipality of Durham since 1991. He is an active member of many provincial and regional health organizations. For example, he is currently President of the Association of Local Public Health Agencies; Chair of tdohe Durham Nuclear Health Committee; past Chair of the Port Hope Community Health Centre; Chair of the Public Health Ontario Board of Directors and Chair of its Governance Committee. Dr. Kyle is a former Medical Officer of Health for the Peterborough County-City Health Unit and Associate Medical Officer of Health for the Borough of East York Health Unit. He is also an Adjunct Professor, Dalla Lana School of Public Health, University of Toronto.

LORI SPADORCIA serves as the Vice President, Communications and Partnerships at the Centre for Addiction and Mental Health (CAMH). Her portfolio includes community engagement, public affairs, public policy, strategic planning and the Provincial Systems Support Program. She supports the alignment of mission critical activities which are designed to be responsive to CAMH's many stakeholders, and engaging partners and resources to better position the hospital to make a sustainable system contribution to mental health. As a senior advisor to Cabinet Ministers at the federal and provincial level, Ms. Spadorcia played a key role in finding solutions that yield advancements in public policy. In Ontario, she served as a senior adviser to the Minister of Finance, where she advised on the creation and execution of the provincial budget. As a policy and communications expert, Ms. Spadorcia is bringing awareness and understanding of mental illness to the broader public and working with governments and communities to develop policies to promote better health systems, support vulnerable populations and drive social change.

MARIA SANCHEZ-KEANE is the Principal Consultant for the Centre for Organizational Effectiveness, an organization she founded in 2000 that is focused on assisting non-profit and public organizations in the areas of strategy, capacity building and evaluation. She has worked within health, public health, child welfare, children's mental health, education and community health sectors.

TRUDY SACHOWSKI is a provincially appointed, active member of the Northwestern Board where she currently serves as Vice Chair, Chair of the Executive Committee and Chair of the Constitution Review Work Group. Trudy's volunteering has included numerous local, regional and provincial organizations for which she has received recognition locally and provincially. Trudy has completed one term on the alPHa Board of Directors as the North West region board of health representative. In this capacity, she serves on the current alPHa Executive Committee, chairs the Boards of Health Section and has participated on the alPHa 2018 Election Task Force and other planning tables for the association.

CHRISTOPHER MACKIE is the Medical Officer of Health and CEO for the Middlesex-London Health Unit, and is an Assistant Professor, Part Time at McMaster University. Before coming to London, Dr. Mackie was Associate Medical Officer Health for the City of Hamilton for four years. He also worked as a Public Health Physician with Public Health Ontario. As a COMOH representative for the South West Region, he is the current Chair of COMOH, a section of alPHa.

PETER DONNELLY is President and CEO of Public Health Ontario (PHO), which provides evidence for policy formulation and undertakes public health capacity building, as well as provides integrated public health laboratory and surveillance systems. Prior to joining PHO, Dr. Donnelly was the Professor of Public Health Medicine at the University of St. Andrews in Scotland, where he established and led public health medicine research and teaching. From 2004 to 2008 he was the Deputy Chief Medical Officer to the Scottish Government, providing senior leadership and coordination at a national level. As the Director of Public Health in two jurisdictions, he was responsible for the delivery of local public health services and programs.

PENNY SUTCLIFFE was appointed as Medical Officer of Health for the Sudbury & District Health Unit in August 2000. Before coming to Sudbury, she was the Medical Officer of Health for Yellowknife, Northwest Territories. Her first position as Medical Officer of Health was with the Burntwood Regional Health Authority in northern Manitoba. A specialist in Community Medicine, Dr. Sutcliffe has a longstanding interest in socioeconomic inequalities in health and is a strong advocate for incorporating broader determinants of health into core public health programming. She is particularly interested in pursuing opportunities for healthy public policy development at the local and regional level

and to this end is engaged with local healthy community initiatives and with critically examining and modifying local public health practice.

DENIS DOYLE studied at Carleton University and York University. After a long career at Xerox Canada, Denis spent six years in Information Technology management at CIBC. Warden Doyle began serving on Township Council in 2006 and was elected as Mayor of Frontenac Islands in 2010. At the County, Warden Doyle serves on the Sustainability Advisory Committee and the Trails Advisory Committee. Denis was County Warden in 2014 – 2015 and has served on the Kingston, Frontenac, Lennox and Addington Board of Health since 2014. He has been Chair of the Board since January 2017.

KIERAN MOORE is the Medical Officer of Health for the Kingston, Frontenac, Lennox and Addington (KFL&A) Public Health Unit. At Queen's University, he is a Professor of Family and Emergency Medicine and the director for the Public Health & Preventive Medicine Residency Program. He is also an Attending Physician in the Department of Emergency and Family Medicine at the Kingston Health Sciences Centre. A champion for a national Lyme disease surveillance network to government, he presently serves as Network Director of the Canadian Lyme Disease Research Network.

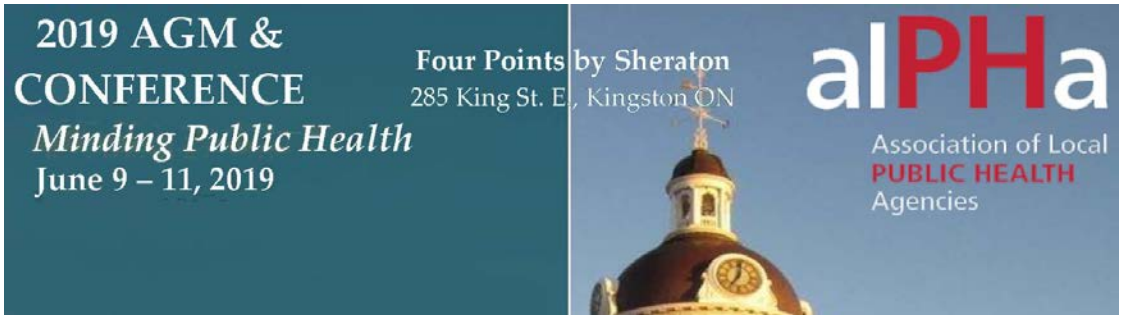
EVENING GUEST LECTURE:

ADALSTEINN (STEINI) BROWN is Dean of the Dalla Lana School of Public Health at the University of Toronto and the Dalla Lana Chair of Public Health Policy at the University of Toronto. He is currently a member of the Premier's Council on Improving Healthcare and Ending Hallway Medicine. His past roles include senior leadership roles in policy and strategy within the Ontario government, founding roles in start-up companies, and extensive work on performance assessment. He received his undergraduate degree in government from Harvard University and his doctorate from the University of Oxford, where he was a Rhodes Scholar.

REUBEN DEVLIN is an orthopaedic surgeon who completed his medical school and orthopaedic training at the University of Toronto. During his 17 years practicing in Newmarket, he held senior hospital positions, including Chief of Surgery and Chair of the Medical Advisory Committee. He had a special interest in joint replacement and sports medicine. Subsequently, Dr. Devlin served as the President and Chief Executive Officer of Humber River Hospital in Toronto from 1999 to 2016. He was appointed as Special Advisor and Chair of the Premier's Council on Improving Health Care and Ending Hallway Medicine in June 2018. As Chair, he is leading a group of visionary health system leaders who have come together to identify for the Premier of Ontario and Minister of Health and Long-term Care strategic priorities and actions that will lead to improved health and wellness outcome for Ontarians, high patient satisfaction, and more efficient use of government investment using an effective delivery structure.

PLEASE JOIN US IN KINGSTON FOR THE alPHa ANNUAL CONFERENCE!

Dr. Kieran Moore, Medical Officer of Health and Dennis Doyle, Board of Health Chair for the Kingston, Frontenac, Lennox and Addington (KFL&A) health unit were on hand to personally invite Symposium delegates to alPHa's June 2019 AGM and Conference in Kingston, Ontario.



simcoe muskoka
DISTRICT HEALTH UNIT

March 20, 2019

Honourable Christine Elliott
Deputy Premier
Ministry of Health and Long-Term Care
Hepburn Block 10th Floor, 80 Grosvenor St.
Toronto, ON M7A 2C4

Dear Minister Elliott,

On February 20th the Board of Health for the Simcoe Muskoka District Health Unit indicated its support for the alPHa report, *Improving and Maintaining the Health of the People: The Contribution of Public Health to Reducing Hallway Medicine* (attached). This is in recognition of the critical importance of local public health services to protect and promote health, and prevent disease. These services represent excellent value for money, reducing costs to the health care system and to the province, as identified with specific examples in this report. Maintaining the integrity of the public health system is essential to helping the province end hallway medicine. This is accomplished through actions that address the underlying causes of illness in our communities.

As the Province proceeds with fundamental change in the health care system, we do raise the inherent value and effectiveness of the public health system, and its ability to work with a very wide range of sectors to achieve maximum health benefit for minimum cost. The close working relationship of public health with municipalities, schools, community agencies and health care institutions enables for such creative and nimble action, allowing us to successfully address and control health challenges both long standing and emerging, and to help to avoid large scale health incidents.

The public health approach – employing a wide range of professionals, working with a wide range of players across our communities, using both innovation and evidence-informed practice to prevent disease, and keep people healthy and productive – has been a necessary part of the health care system for well over a century, and will always be essential.

The Board of Health for the Simcoe Muskoka District Health Unit has demonstrated these principles and approaches. These include the development of the Simcoe Muskoka Opioid Strategy in partnership with over forty local agencies pursuing a full range of activities within five pillars. Another example is the creation of a dental operatory in our Gravenhurst office to provide the oral health services (including

through the difficult winter months) to clients found with our surveillance data to be at greatest need in our district.

We thank you for considering the importance of maintaining a strong, complete and sufficiently resourced public health system in order to achieve your objectives for an effective and sustainable health care system.

Sincerely,

ORIGINAL Signed By:

Anita Dubeau
Chair, Board of Health

AD:CG:cm

Att. (1)

cc. Dr. David Williams, Chief Medical Officer of Health
Ontario Boards of Health
Association of Local Public Health Agencies
Ontario Public Health Association
Mayors and Councils in Simcoe Muskoka
Members of Provincial Parliament for Simcoe and Muskoka
Central Local Health Integration Network
North Simcoe Muskoka Local Health Integration Network

alPHa
Association of Local
PUBLIC HEALTH
Agencies

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E-mail: info@alphaweb.org

Improving and Maintaining the Health of the People

The Contribution of Public Health to Reducing Hallway Medicine

As the Government of Ontario considers one of its most high-profile election commitments – the elimination of "Hallway Medicine" in Ontario – this paper has been developed to explain the work of the public health sector and to highlight the important role that the sector can play in meeting that challenge.

One of the answers to keeping people out of hospital hallways is to reduce the demand for hospital and primary care services. Building healthy communities through an efficient, proactive and locally managed public health system, mandated to lead on preventative measures to protect and promote the health of Ontarians, can go a long way to reducing that demand.

Ontario's public health system delivers value for money, ensuring Ontarians remain healthy, and are able to contribute fully to a prosperous Ontario. Studies have shown tremendous return on investment. For example, every $1 spent on:

- **mental health and addictions** saves $7 in health costs and $30 dollars in lost productivity and social costs;
- **immunizing children** with the measles-mumps-rubella vaccine saves $16 in health care costs; and
- **early childhood development and health care** saves up to $9 in future spending on health, social and justice services.

A systematic review of international public health investments published in 2017 concludes that cuts to public health budgets in high income countries represent a false economy and are likely to generate billions of dollars of additional costs to health services and the wider economy.

At the same time, the public health system supports an effective health care system by reducing the demand for hospital services through:

- advising and convening diverse stakeholders (e.g. schools, police, healthcare) to improve mental health and addictions treatments in community settings;
- ensuring people are treated for sexually transmitted infections and tuberculosis and preventing infections and related hospital visits;
- safeguarding the community from harms caused by impure drinking water and environmental hazards;
- reducing the impact of outbreaks, such as influenza in Long Term Care Homes and hospitals; and
- providing a point of access to supports and information for people with greater needs, whether rural, newcomers or others isolated in urban environments.

In short, public health actions now can result in fewer emergency room and doctor's office visits today and in the future.

The geographic breadth of Ontario means that the needs of residents differ from region to region. Public health and community-based programs and services require localised input and delivery, leveraging existing partnerships with schools, municipalities, business networks, health care providers and social services organizations, resulting in the ability to quickly and efficiently respond to the needs

of the people:

- In 2016, the Middlesex-London Health Unit identified an outbreak of HIV in London. Provincially, HIV rates largely driven by men who have sex with men, had been declining for a decade. In London, rates were spiking, and driven by IV drug use. The Health Unit put boots on the ground, assembled an outreach team to find people on the street, and connected them with HIV testing and treatment. Today, the outbreak is over.
- As the opioid crisis became critical in 2017, Ottawa Public Health supported people most at risk, informed schools and parents, made naloxone available across the city, and created a new real-time surveillance system. Today, the public health unit is using the surveillance data to inform and organize a Mental Health and Substance Use Summit, with The Royal Hospital. A broad range of stakeholders is identifying actions to increase prevention and create a more integrated approach to improve mental health assessment and access to treatment.
- Recently, the North Bay Parry Sound Health Unit identified a need for enhanced dental services for low-income adults, based on data about high rates of emergency room visits for dental problems. The health unit solved the problem by starting a now well-used dental clinic for people who meet the financial and program criteria.
- Last year, Toronto Public Health completed implementation of a wireless strategy that allows personal services setting inspectors and nurses inspecting vaccine fridges in doctors' offices to complete their visits using tablets that upload results in real time rather than recording the inspection on paper and entering it on the website later. This means that results of inspections, information on the BodySafe website that people use each day to shop for a nail salon or other personal service, is the most current information.
- Local public health units are increasingly using technology to serve people, improving convenience and cost-effectiveness, such as through interactive web-based prenatal education and chats with nurses on Facebook and by using on-line video to observe people taking tuberculosis medication instead of in-person observation. Such innovations begin locally and have spread across the province.

These local solutions show that, when combined with stable, designated funding, the public health system has the capacity to relieve pressure on doctors and hospitals. Furthermore, accountability is firmly established by provincial legislation and policy ensuring that the money spent on public health is spent effectively and with purpose.

Together we serve the people of Ontario to ensure:

- that healthy people can support a strong economy, providing a direct economic impact;
- coordination of responses to community health concerns such as mental health and addictions, in partnership with community level organizations;
- reduction of pressures on doctors and hospitals by concentrating on the health of the community, starting at birth; and,
- a significant, cost-effective contribution to the elimination of hallway medicine.

In conclusion, public health works as a system that is greater than the sum of its parts - leveraging the skills and experience of nutritionists, nurses, health promoters, inspectors, epidemiologists, doctors, dentists and dental hygienists, board members and administrators, and more – to together support and protect the health of the people of Ontario. Public health delivers promotion, protection and prevention services on behalf of, and in partnership with, the Ontario Government.

WINDSOR-ESSEX COUNTY HEALTH UNIT
Bureau de santé de Windsor-comté d'Essex

519-258-2146 | www.wechu.org

Windsor 1005 Ouellette Avenue, Windsor, ON N9A 4J8
Essex 360 Fairview Avenue West, Suite 215, Essex, ON N8M 3G4
Leamington 33 Princess Street, Leamington, ON N8H 5C5

March 5th, 2019

The Honourable Doug Ford
Premier of Ontario
Legislative Building, Queen's Park
Toronto, ON M7A 1A1
premier@ontario.ca

Dear Premier Ford

Re: Support for Provincial Oral Health Program for Low-Income adults and seniors

On behalf of our board of health, I am writing you to express our support for Haliburton, Kawartha, Pine Ridge District Health Units request to the Government of Ontario to build a provincial dental program for low-income seniors. The financial, health and social impacts of poor oral health in seniors and adults has been a priority for our health unit and Board.

The 2016 Community Needs Assessment for Windsor-Essex (Windsor-Essex County Health Unit, 2016) identified the dental health of adults in Windsor-Essex as a concern, and the second most reported service need for our residents. At the November 2016 meeting, our Board passed a resolution endorsing the importance of oral health as part of overall health and recommending the Province of Ontario expand publically funded oral health programs to include low income and vulnerable adults and seniors.

In November of 2018, the Windsor-Essex Health Unit released the results, *Dental Health of Adults and Seniors in Windsor-Essex Survey Results (2018)*. This report examined the experiences of adults and seniors with the oral health system in Windsor-Essex and identified a significant barrier in accessing routine and emergency services. In particular, lack of insurance and financial security were the top barriers for improving oral health of respondents. Our community has some community supports including a low-cost/no-cost dental program for adults through the Downtown Mission of Windsor and St. Clair College, however these services have hundreds on their waiting list are scarcely enough to address the growing need in Windsor-Essex, leaving many residents with no option other than avoiding care or visiting the emergency room.

The Ontario Progressive Conservative Party has pledged to implement a publicly funded dental care program for low-income seniors. Windsor-Essex County Health Unit (WECHU) has increased our services through our healthy smiles program year over year since 2010. We see first hand the benefit these programs have for children and their families and often receive calls and requests for adults needing further support. The WECHU supports expanded publicly funded dental care programs to include low-income seniors and would like to encourage the government to consider including all low-income adults. We look forward to receiving further news related to public health's role in reducing barriers to oral health and welcome the opportunity to increase our service delivery to the most vulnerable in our community.

The Windsor-Essex County Health Unit thanks you for your consideration.

Sincerely,

Gary McNamara
Chair, Board of Health

Theresa Marentette
Chief Executive Officer

cc: Honorable Christine Elliot, Minister of Health and Long-Term Care, Deputy Premier
Dr. David Williams, Chief Medical Officer of Health
Local MPPs
Local Municipal Councils
Essex-County Dental Society
Ontario Dental Association
Association of Local Public Health Agencies (alPHa)
Ontario Boards of Health
Windsor-Essex Board of Health

References

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WINDSOR-ESSEX COUNTY HEALTH UNIT
Bureau de santé de Windsor-comté d'Essex

519-258-2146 | www.wechu.org

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Essex 360 Fairview Avenue West, Suite 215, Essex, ON N8M 3G4
Leamington 33 Princess Street, Leamington, ON N8H 5C5

March 5th, 2019

The Honorable Doug Ford
Premier of Ontario
Legislative Building, Queen's Park
Toronto, ON M7A 1A1
Doug.fordco@pc.ola.org

Dear Premier Ford,

Re: Increase actions in response to the current opioid crisis

On behalf of our board of health, I am writing you in support of Peterborough Public Health's request of the federal and provincial government to increase their actions in response to the current opioid crisis.

Throughout Canada the misuse of opioids, particularly fentanyl, is a growing public health crisis resulting in epidemic-like numbers of overdose deaths. In Windsor-Essex we have focused on multi-sector collaboration aimed at addressing the four pillars of harm reduction, prevention, treatment and enforcement. A comprehensive approach such as this requires significant investment and ongoing support and sustainability.

We support our colleagues in urging all levels of government to continue their efforts and support to address the crisis in our province and county with a coordinated pan-Canadian action plan spanning all four pillars of the national drug strategy.

The Windsor-Essex County Health Unit thanks you for your consideration.

Sincerely,

Gary McNamara
Chair, Board of Health

Theresa Marentette
Chief Executive Officer

https://www.wechu.org/boh-docs

https://www.peterboroughpublichealth.ca/wp-content/uploads/2019/01/BOH-Agenda-Jan-12-2019-original.pdf

cc: The Right Hon. Justin Trudeau, Prime Minister of Canda
The Hon. Ginette Petitpas Taylor, Minister of Health
The Hon. Christine Elliott, Minister of Health and Long-Term Care
Dr. Theresa Tam, Chief Public Health Officer of Canada
Dr. David Williams, Ontario Chief Medical Officer of Health
Association of Local Public Health Agencies (alPHa)
Ontario Boards of Health
Windsor-Essex MPP's

Windsor-Essex Board of Health

Peterborough Public Health
1889-2019 LOCAL & STRONG

Jackson Square, **185 King Street**, Peterborough, ON K9J 2R8
P: **705-743-1000** or 1-877-743-0101
F: 705-743-2897
peterboroughpublichealth.ca

January 7, 2019

The Honourable Doug Ford
Premier of Ontario
Legislative Building, Queen's Park
Toronto, ON M7A 1A1
doug.ford@pc.ola.org

Dear Premier Ford,

On behalf of the Board of Health for Peterborough Public Health, I am writing a letter of support for Southwestern Public Health's request of both the provincial and federal governments to increase their actions in response to the current opioid crisis.

Throughout Canada the misuse of opioids, particularly fentanyl, is a growing public health crisis resulting in epidemic-like numbers of overdose deaths. The overall economic cost (healthcare costs, lost productivity costs, criminal justice costs and other direct costs) of substance use in Canada in 2014 was estimated to be $38.4 billion. This estimate represents a cost of approximately $1,100 for every Canadian regardless of age. Opioids contributed $3.5 billion or 9.1% of these total costs.

Our current approaches to managing this situation- focused on changing prescribing practices and interrupting the flow of drugs- have failed to reduce the death toll. An enhanced comprehensive public health approach based on the evidence-informed four pillars of harm reduction, prevention, treatment and enforcement is necessary. This approach should include the meaningful involvement of people with lived expertise as well as stakeholders including Indigenous peoples' governance organizations to establish prevention, harm reduction and health promotion programs that meet the needs of their communities.

The time to act is now. In the Chief Public Health's Officer's Report on the State of Public Health in Canada 2018: Prevention Problematic Substance Use in Youth, Dr. Theresa Tam states that "The national life expectancy of Canadians may actually be decreasing for the first time in decades, because of the opioid overdose crisis".

We are urging all levels of government to continue their efforts to address this crisis in our country with a coordinated pan-Canadian action plan spanning all four pillars of the national drug strategy.

Sincerely,

Original signed by

Councillor Henry Clarke
Chair, Board of Health

/ag
Encl.

cc: The Right Hon. Justin Trudeau, Prime Minister of Canada
The Hon. Ginette Petitpas Taylor, Minister of Health
The Hon. Christine Elliott, Minister of Health and Long-Term Care
Dr. Theresa Tam, Chief Public Health Officer of Canada
Dr. David Williams, Ontario Chief Medical Officer of Health
Local MPs
Local MPPs
Association of Local Public Health Agencies
Ontario Boards of Health

SOUTHWESTERN Public Health
Oxford • Elgin • St.Thomas

St. Thomas Site
Administrative Office
1230 Talbot Street
St. Thomas, ON
N5P 1G9

Woodstock Site
410 Buller Street
Woodstock, ON
N4S 4N2

October 24, 2018

The Honourable Doug Ford
Premier of Ontario
Legislative Building, Queen's Park
Toronto, ON M7A 1A1

Dear Honourable Doug Ford,

On behalf of the Southwestern Public Health Board, I am writing to both our provincial and federal government leaders to reinforce the urgency of the opioid poisoning emergency in our country and urge both the provincial and federal governments to increase actions in response to this emergency based on the evidenced-informed four pillar approach of harm reduction, prevention, treatment and enforcement.

There is an expanding opioid crisis in Canada that is resulting in epidemic-like numbers of overdose deaths. These deaths are the result of an interaction between prescribed, diverted and illegal opioids (such as fentanyl) and the recent entry into the illegal drug market of newer, more powerful synthetic opioids. The current approaches to managing this situation – focused on changing prescribing practices and interrupting the flow of drugs – have failed to reduce the death toll and should be supplemented with an enhanced and comprehensive public health approach. Such an approach would include the meaningful involvement of people with lived experience. [1]

We call on both levels of government to support initiatives that address the causes and determinants of problematic substance use, to make all tools and resources available to support efforts to address the opioid crisis at a community level, to expand and strengthen the integration of surveillance information between provincial and federal partners, to expedite approvals for newer therapeutic modalities for medication assisted and opioid substitution treatment, to provide funding to municipalities and regional health services to establish safe consumption facilities, and to support harm reduction and health promotion services needed to mitigate the opioid crisis at a regional level.

Injection drug use is associated with many serious drug-related harms, such as the transmission of blood borne infections (HIV, Hepatitis C, Hepatitis B), and with fatal and non-fatal overdoses and injection site bacterial infections. In some parts of the world, these harms are widespread among people who inject drugs. Access to interventions such as needle and syringe exchange, opioid substitution therapies, naloxone distribution, sharps management strategies, overdose prevention sites, and supervised consumption sites are essential to reducing these harms and improving the health of the people who use drugs.[2]

We are urging both our federal and provincial Ministers of Health to continue their efforts to address this crisis in our country with a coordinated pan-Canadian action plan spanning all four pillars of the national drug strategy.

Sincerely,

Bernie Wiehle
Chair, Board of Health
Southwestern Public Health

copy:

Honourable Justin Trudeau, Prime Minister of Canada
Honourable Ginette Petitpas Taylor, Federal Minister of Health
Honourable Christine Elliott, Minister of Health and Long-Term Care, Deputy Premier
Honourable Jeff Yurek, Member of Provincial Parliament, Elgin – Middlesex – London
Honourable Ernie Hardeman, Member of Provincial Parliament, Oxford
Association of Local Public Health Agencies
Ontario Boards of Health

1 https://www.cpha.ca/opioid-crisis-canada
2 Harm reduction international www.hri.global/public-health-approaches-to-drug-related-harms

Perth District Health Unit
653 West Gore Street
Stratford, Ontario N5A 1L4
(519) 271-7600 • www.pdhu.on.ca

March 20, 2019

The Honourable Doug Ford
Premier of Ontario
Legislative Building, Queen's Park
Toronto ON M7A 1A1

Dear Premier Ford:

Re: SUPPORT FOR PROVINCIAL ORAL HEALTH PROGRAM FOR LOW-INCOME ADULTS AND SENIORS

The Board of Health of the Perth District Health Unit has received correspondence from several Public Health Units regarding support for a publicly-funded oral health program for low-income seniors, and encouraging the provincial government to expand access to this program to low-income adults.

The Board has reviewed correspondence received to date. At its regular meeting on February 20, 2019 the Board passed the following motion:

"That the Board send a letter of support regarding oral health program for low-income adults and seniors and copy Boards of Health and the provincial government."

The Perth District Health Unit has been exploring the challenges low-income adults and seniors face with accessing dental care, and the impact this has on their lives. Stories collected from Perth County residents in the fall of 2018 illustrate how dental problems worsen existing health conditions, affect people's ability to eat, talk, and smile, and decrease their self-esteem, social connectedness, and employability.

When people have dental issues and cannot afford care, they often go to the ER or their physician. Ontario data show that every nine minutes someone goes to a hospital Emergency Room and every three minutes someone visits a doctor's office due to dental problems. This is an unnecessary burden on our health care system that costs at least $38 million annually – with no treatment of the underlying dental problem. In 2015, there were 18,747 physician visits in the Southwest LHIN and over 500 visits to Perth County's three hospitals for dental problems.

Adults and seniors living with low income in Ontario would benefit greatly from access to dental preventive and treatment services. A provincial oral health program for seniors is a welcome addition to existing publicly-funded dental programs.

Sincerely,

Kathy Vassilakos, Chair
Board of Health

KV/ikl

c. Ontario Boards of Health

alPHa

Association of Local
PUBLIC HEALTH
Agencies

2019 ALPHA FITNESS CHALLENGE FOR BOARD OF HEALTH MEMBERS

alPHa is inviting all Boards of Health to participate in the Fitness Challenge!

The challenge to our Board of Health members is to involve the entire Board in a 30-minute walk, wheel, whatever.....just be active for half an hour!

HERE'S HOW TO PARTICIPATE

READY - Designate someone to co-ordinate and keep count of your participants.
SET – Participate in a minimum of 30 minutes of walking or wheeling during the months of April or May as part of a Board of Health activity. Can't get together? You can still participate and head out on your own! As long as everyone on the Board participates, you are a winner!
GO - Have your designated co-ordinator complete the results form and email it back to us at info@alphaweb.org.

EASY TIPS TO GET ACTIVE!

Before or After Your Board of Health Meeting - Go out for a 30-minute walk before or after your Board meeting in April or May.

At Lunch - Many of us have sedentary jobs, why not brainstorm project ideas with fellow Board members during a lunchtime walk or wheel?

After work or on the Weekend – Not enough time before or after your Board meeting and lunch time is too busy? Set up another date and time to meet in April or May and go for a walk or wheel!

Completed forms must be received by 12:00 noon on Friday May 31, 2019; send them to info@alphaweb.org

30-minute walk...wheel...whatever!

HERE ARE THE RULES

Boards of Health must complete the attached aIPHa Fitness Challenge Form. All Board of Health with 100% group participation will be considered winners

CONTEST RULES AND GUIDELINES

1 - Only members of Boards of Health are eligible.

2 - The 30-minute walk or wheel can be completed anytime during April or May and it is encouraged that this takes place before or after the May meeting. If no meeting is scheduled then the Board members are encouraged to get together and walk or wheel at another time.

3 - Board members can complete their 30-minute walk or wheel individually, however, it is encouraged that this to be a group activity.

4 - Any 30-minute walk or wheel will be considered as an eligible activity.

5 - The winning Board of Health(s) will be recognized at the Conference in June.

AND THE WINNER IS ..

The results will be broadcast on the allhealthunits listserv in June and via aIPHa's Twitter account: @PHAgencies. The winning Board of Health(s) will also receive an award at the 2019 aIPHa Annual General Membership meeting in June.

2019 BOARD OF HEALTH alPHa FITNESS CHALLENGE

Deadline to submit: Friday, May 31, 2019
Email completed form to: info@alphaweb.org

Please fill in the fields below:

BOARD OF HEALTH:_____

COORDINATOR(S):_____

COORDINATOR'S EMAIL:_____

Number of Members on the Board of Health (incl. Chair):_____

Number of BOH members participating in at least 30 minutes of physical activity: _____

BOH member participation rate: _____

If BOH members participated in a **group activity**, please include a short description of the activity:

If BOH members participated as individuals, please list the activities they participated in:

TORONTO

Ulli S. Watkiss
City Clerk

City Clerk's Office

Secretariat
Julie Lavertu, Secretary
Board of Health
Toronto City Hall, 10th Floor, West Tower
100 Queen Street West
Toronto, Ontario M5H 2N2

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March 27, 2019

SENT VIA E-MAIL

To: Interested Parties

Subject: Toronto Indigenous Overdose Strategy (Item HL3.1)

The Toronto Board of Health, during its meeting on February 25, 2019, adopted Item HL3.1, as amended, and:

1. Endorsed the Toronto Indigenous Overdose Strategy, as outlined in Attachment 1 to the report (February 6, 2019) from the Medical Officer of Health.

2. Again urged the Government of Canada and the Province of Ontario to fund and support the development of Indigenous-led overdose prevention and response action plans at the federal and provincial levels.

3. Urged the federal and provincial governments to align 2019/2020 (and beyond) funding calls with practical and immediate overdose responses, in particular, access to funding supports for Indigenous agencies to create, strengthen, and enhance culturally-safe outreach, mobile, and peer support services to Indigenous Peoples who use substances.

4. Urged the federal and provincial governments to contribute funding to Toronto Public Health's Toronto Urban Health Fund Indigenous Stream, which is under development, to support Indigenous agencies.

5. Urged the federal and provincial governments to contribute funding to Toronto Public Health's Toronto Urban Health Fund to enhance support to Indigenous-specific programs and services in mainstream organizations to expand their outreach and harm reduction capacity.

6. Urged the Ministry of Health and Long-Term Care to dedicate funding for 24/7 Indigenous-led Consumption and Treatment Services in Toronto, as part of the new Consumption and Treatment Services Program.

7. Urged the Ministry of Health and Long-Term Care to ensure the availability of culturally-safe medical care to Indigenous Peoples who use substances now and into the future. Health care providers should explore opportunities to support the use of traditional medicines and approaches to healing, including facilitating access to Ceremony, Healing Circles, Elders, and/or Healers, for their Indigenous clients.

8. Urged the Ministry of Health and Long-Term Care to require all provincially-funded health care providers that provide medical services to Indigenous Peoples in Toronto to demonstrate accountability through formal mandates and strategic plans for their investments and outcomes related to culturally-safe care for Indigenous Peoples, including ongoing Indigenous cultural-safety training and education for non-Indigenous health care providers.

9. Urged the Ministry of Health and Long-Term Care to increase and target funding to support the development and operationalization of culturally-safe, appropriate, and on-demand abstinence-based treatment spaces for Indigenous Peoples.

10. Directed that the Toronto Indigenous Overdose Strategy, as outlined in Attachment 1 to the report (February 6, 2019) from the Medical Officer of Health, be forwarded to the Ministry of Health and Long-Term Care, the Toronto Indigenous Health Advisory Circle, the City's Aboriginal Affairs Committee, the City's Indigenous Affairs Office, the City's Shelter, Support and Housing Administration Division, the Toronto Aboriginal Support Services Council, and all local public health units in Ontario.

11. Directed the Medical Officer of Health to provide a one-year progress report on the implementation of the Toronto Indigenous Overdose Strategy to the Board of Health and the Toronto Indigenous Health Advisory Circle in 2020.

12. Requested that Michelle Sault, Principal Consultant, Minokaw Consulting, make a presentation on the Toronto Indigenous Overdose Strategy at a future Board of Health meeting in 2019.

To view this item and background information online, please visit: http://app.toronto.ca/tmmis/viewAgendaItemHistory.do?item=2019.HL3.1.

Please note that the above recommendations have been sent to the Prime Minister, the Premier, the Minister of Health and Long-Term Care, and various organizations listed in Recommendation 10.

Sincerely,

Julie Lavertu

Julie Lavertu/ar
Secretary
Board of Health

Sent (via e-mail) to the following organizations and individuals:

- The Honourable Christine Elliott, Deputy Premier and Minister of Health and Long-Term Care (sent under separate cover)
- Tracy Sheridan, Manager, Health Access and Equity, Toronto Public Health (sent for the attention of the Toronto Indigenous Health Advisory Circle)
- Selina Young, Manager, Indigenous Affairs Office, City of Toronto (sent for the attention of the Aboriginal Affairs Committee and the City's Indigenous Affairs Office)
- Paul Raftis, Interim General Manager, Shelter, Support and Housing Administration, City of Toronto

- Crystal Basi, Executive Director, Toronto Aboriginal Support Services Council

Sent (via e-mail) to the following Public Health Units in Ontario:

- Algoma Public Health
- Brant County Health Unit
- Chatham-Kent Public Health Unit
- Durham Region Health Department
- Eastern Ontario Health Unit
- Grey Bruce Health Unit
- Haldimand-Norfolk Health Unit
- Haliburton, Kawartha, Pine Ridge District Health Unit
- Halton Region Health Department
- Hamilton Public Health Services
- Hastings Prince Edward Public Health
- Huron County Health Unit
- Kingston, Frontenac and Lennox & Addington Public Health
- Lambton Public Health
- Leeds, Grenville & Lanark District Health Unit
- Middlesex-London Health Unit
- Niagara Region Public Health Department
- North Bay Parry Sound District Health Unit
- Northwestern Health Unit
- Ottawa Public Health
- Peel Public Health
- Perth District Health Unit
- Peterborough Public Health
- Porcupine Health Unit
- Public Health Sudbury and Districts
- Region of Waterloo Public Health
- Renfrew County and District Health Unit
- Simcoe Muskoka District Health Unit
- Southwestern Public Health
- Thunder Bay District Health Unit
- Timiskaming Health Unit
- Wellington-Dufferin-Guelph Public Health
- Windsor-Essex County Health Unit
- York Region Public Health Services

cc (via e-mail):

- Dr. Eileen de Villa, Medical Officer of Health, Toronto Public Health
- Meenakshi Jha, Administrative Assistant to the Medical Officer of Health, Toronto Public Health

Private Members' Bill re: Inspection of Clinics

Background

In 2018, 3001 patients who received nursing care at the ParaMed Flex Clinic in London were notified that they may have been exposed to blood-borne infection because of a lapse in infection prevention and control (IPAC) over a 10 year period. These patients were advised to consider testing for hepatitis B, hepatitis C and HIV as a result of wound care instruments being re-used without sterilization or hi-level disinfection between patients. These improper sterilization practices were discovered after a complaint was made to the Middlesex-London Health Unit. Public Health Inspectors do not routinely visit these clinics but are mandated under the Ontario Public Health Standards of the *Health Protection and Promotion Act* to investigate when complaints are made about potential infection prevention and control lapses.

Flex clinics (also known as community nursing clinics) provide nursing services that would ordinarily be provided in the home, such as intravenous treatments, PICC lines, urinary catheterization and wound care, for ambulatory patients. These clinics offer an alternative to clients receiving homecare services in their residence. They are administered by private homecare operators like ParaMed, Bayshore, and Saint Elizabeth, as well as non-profits like the VON. In 2010, there were 17 FlexClinics in the South West CCAC. A 2015 Globe and Mail investigation estimated that 111 such clinics across the province have been established over the last decade, with the number projected to increase as a way of containing costs for the delivery of homecare.

A 2016 report from Health Quality Ontario identifies these clinics as falling outside the regulatory frameworks for Ontario's approximately 935 Independent Health Facilities (IHF) and 273 Out-of-Hospital Premises (OHP).[1] While the health professionals who practice in these clinics are subject to the oversight of their regulatory college, "the premises in which they practice may or may not be subject to oversight. Depending on the services provided or the models under which they are funded, non-hospital medical clinics may not fall under any system of quality oversight."

The *Oversight of Health Facilities and Devices Act, 2017*, which was included as Schedule 9 of the *Strengthening Quality and Accountability for Patients Act, 2017*, creates a new regulatory framework for "community health facilities" which covers both IHFs and OHPs. The legislation has not yet been enacted, however, it is expected that flex clinics will remain outside this regulatory framework.

I am proposing Private Members' Bill to regulate community nursing clinics (CNCs) that will:

- Make the Minister of Health responsible for oversight of community nursing clinics
- Establish a legal definition for these clinics
- Provide medical officers of health with addresses of existing and new clinics
- Mandate annual inspections of these clinics by medical officers of health
- Ensure that the Home Care and Community Services Bill of Rights is posted in these clinics, and that patients are aware of their right to complain to health units

[1] Health Quality Ontario, *Building an Integrated System for Quality Oversight in Ontario's Non-Hospital Medical Clinics, p. 14*

Legislative Overview

Ministry of Health and Long-Term Care Act (MOHLTCA)

- Add oversight and inspection of community nursing clinics to s.6 Duties of the Minister

Health Protection and Promotion Act (HPPA)

- Add definition of community nursing clinics to s. 1 (1) ("*any premise where homecare nursing services are provided other than a place that is being used as a dwelling*")
- Require new community nursing clinics to notify the medical officer of health of the health unit in which the premise will be located of intention to operate (similar to requirement for operation of food premise under s. 16 (2) Notice of Intention to Commence Operation)
- Add inspection of community nursing clinics at least once annually to s. 10 Duty to Inspect

Home Care and Community Services Act (HCCSA)

- Add Community Nursing Clinics to s. 2 (7) list of Professional Services
- Under s. 3 (1) paragraph 8 of Bill of Rights (*"A person receiving a community service has the right … to be informed in writing of the procedures of initiating complaints about the service provider"*) ensure that patients are notified about ability to complain to medical officers of health
- Add new posting requirement to s. 31 Posting (similar to posting requirements for Long-Term Care Bill of Rights):
    - Posting of information

      Every community nursing clinic shall ensure that the required information is posted on the premises, in a conspicuous and easily accessible location, in a manner that complies with the requirements, if any, established by the regulations.
- Add new provisions to Part IX Complaints & Appeals indicating that complaints about "health hazards related to occupational or environmental health" (wording from HPPA) in community nursing clinics should be directed to medical officers of health
- Add new inspection powers to s. 62 for medical officers of health (similar to those of program supervisors), requiring medical officers of health to enter community nursing clinic premises at least once annually to inspect the premises and the records relevant to the inspection
- Add new section under Part VIII Rules Governing Service Providers requiring service providers that operate community nursing clinics to give the address of the clinic to the medical officer of health of the health unit in which the community nursing clinic is located

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Agencies

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Dear alPHa Members,

Re: 2019 Ontario Budget, Protecting what Matters Most

Unlike previous recent budgets, the 2019 Ontario Budget contains a section devoted specifically to Modernizing Ontario's Public Health Units, so the traditional chapter-by-chapter summary of other items of interest to alPHa's members will be delayed as our immediate focus will be need to be on the significant changes that are being proposed for Ontario's public health system.

It appears that the Government intends to create efficiencies through streamlining back-office functions, adjusting provincial-municipal cost-sharing, and reducing he total number of health units and Boards of Health from 35 to 10 in a new regional model. As details about how they will do this are scarce, verbatim excerpts from the two areas that are directly relevant are reproduced here (*comments added in italics*):

VERBATIM EXCERPT FROM CHAPTER 1, A PLAN FOR THE PEOPLE: MODERNIZING ONTARIO'S PUBLIC HEALTH UNITS (P. 119)

"Ontario currently has 35 public health units across the province delivering programs and services, including monitoring and population health assessments, emergency management and the prevention of injuries. Funding for public health units is shared between the Province and the municipalities.

However, the current structure of Ontario's public health units does not allow for consistent service delivery, could be better coordinated with the broader system and better aligned with current government priorities. This is why Ontario's Government for the People is modernizing the way public health units are organized, allowing for a focus on Ontario's residents, broader municipal engagement, more efficient service delivery, better alignment with the health care system and more effective staff recruitment and retention to improve public health promotion and prevention.

As part of its vision for organizing Ontario public health, the government will, as first steps in 2019-20:

- Improve public health program and back-office efficiency and sustainability while providing consistent, high-quality services, be responsive to local circumstances and needs by adjusting provincial-municipal cost-sharing of public health funding (*ed. Note: what this means is not spelled out, i.e. it is not clear how such an adjustment would contribute to efficiency and if they are considering a change to the relative share, they have not revealed what it will be*).

- Streamline the Ontario Agency for Health Protection and Promotion to enable greater flexibility with respect to non-critical standards based on community priorities (*ed. Note: again, not spelled out*).

The government will also:

- Establish 10 regional public health entities and 10 new regional boards of health with one common governance model by 2020-20 (*based on the excerpt from chapter 3 below, it is likely that this means consolidation and not the establishment of another regional layer*);

- Modernize Ontario's public health laboratory system by developing a regional strategy to create greater efficiencies across the system and reduce the number of laboratories; and

- Protect what matters most by ensuring public health agencies focus their efforts on providing better, more efficient front-line care by removing back-office inefficiencies through digitizing and streamlining processes.

VERBATIM EXCERPT FROM CHAPTER 3, ONTARIO'S FISCAL PLAN AND OUTLOOK (HEALTH SECTOR INITIATIVES, P. 276-7):

Health Sector expense is projected to increase from $62.2B in 2018-19 to $63.5B in 2021-22, representing an annual average growth rate of 1.6% over the period…Major sector-wide initiatives will allow health care spending to be refocused from the back office to front-line care. These initiatives include:

- Modernizing public health units through regionalization and governance changes to achieve economies of scale, streamlined back-office functions and better-coordinated action by public health units, leading to annual savings of $200M by 2021-22.

Gordon Fleming and Pegeen Walsh (ED, OPHA) were able to ask a couple of questions of clarification of Charles Lammam (Director, Policy, Office of the Deputy Premier and Minister of Health and Long-Term Care), and he mentioned that strong local representation and a commitment to strong public health standards will be part of the initiative, and the focus of the changes is more on streamlining the governance structure. He also indicated that many of the details (including the cost-sharing model) will need to be ironed out in consultation with municipal partners and hinted that there is a rationale behind the proposed number of health units though he couldn't share that level of detail at this time.

Please click here for the portal to the full 2019 Ontario Budget, which includes the budget papers, Minister's speech and press kits.

alPHa's Executive Committee will be holding a teleconference at 9 AM on Friday April 12 to begin the formulation of a strategic approach to obtaining further details about the foregoing and responding to the proposals. As always, the full membership will be consulted and informed at every opportunity.

We hope that you find this information useful.

Loretta Ryan,
Executive Director