Middlesex-London Health Unit

2020 Annual Service Plan

February 2020

2020 PBMA Disinvestments

Division	No.	Proposal	Value	FTE	Score
EHID	1-0016	IDC Budget Streamlining	-$ 5,639	0.00	0
EHID	1-0020	CERV Recruitment Budget	-$ 5,000	0.00	-80
EHID	1-0019	VPD Program Supplies	-$ 10,000	0.00	-42
EHID	1-0031	Mileage Reduction	-$ 8,000	0.00	0
HL	1-0001	PHN – Young Adult Team	-$ 53,383	-0.50	-133
HL	1-0006	PHN – Child Health Team	-$ 53,383	-0.50	-133
HL/OMOH	1-0009	Policy Analyst	-$ 121,198	-1.00	-129
Cross MLHU	1-0024	Reduction of ASO Premiums	-$ 100,000	0.00	0
HO	1-0026	Restructure of HR Manager Role	-$ 17,627	0.00	-24
HO	1-0029	Library Subscription and Access Copyright	-$ 5,000	0.00	-65
HO	1-0030	Elimination of MLHU Van	-$ 6,080	0.00	-90
HS	1-0004	HBHC Family Home Visitor	-$ 68,998	-1.00	-40
HS	1-0008	PHAC Funding for SSFB Dietitian	-$ 19,080	0.00	0
HS	1-0010	Healthy Start Operational Reductions	-$ 20,000	0.00	0
		Total	**-$ 493,388**	**-3.00**	

Disinvestment Descriptions

#1-0016 – IDC Budget Streamlining
Introduction of Electronic Client Records (ECR) will streamline record keeping and eliminate the need for consulting fees and casual PHN support to maintain older databases that will be decommissioned. Centralized purchasing of supplies for Vaccine Preventable Disease (VPD) and Environmental Health will also contribute further savings.

#1-0020 – CERV Recruitment Budget
This proposal is to suspend recruitment for Community Emergency Response Volunteers (CERV) as Emergency Response currently has 100 volunteers and engagement activities or emergency events are limited. The department maintains sufficient budget for ad hoc recruitment in the event of an emergency.

#1-0019 – VPD Program Supplies
The number of immunization clinics held per week was reduced as clients are directed to receive vaccines from their family physician. Clinics are now shifting focus to serve priority populations. As a result, the cost of clinic supplies, notably vaccines purchased for resale has also declined.

#1-0031 – Mileage Reduction
Work assignments were reconfigured in January 2019 based on recommendations from a Public Health Inspector review. More efficient routing of work assignments has resulted in lower transportation costs. These improvements have already realized cost savings y in 2019.

#1-0001 – PHN Young Adult Team
The Young Adult Team has shared a full-time public health nurse with the Child Health Team to provide support for programming in schools and to act as lead for joint-team initiatives. The role for the shared resource is currently vacant and the work of the team has been reprioritized.

#1-0006 – PHN Child Health Team
The Child Health Team has also shared a full-time public health nurse with the Young Adult Team to provide support for programming in schools and to act as lead for joint-team initiatives. The role for the shared resource is currently vacant and the work of the team has been reprioritized.

#1-0009 – Policy Analyst
The change in provincial government, along with the proposed amalgamation of health units provides an opportunity to take a regional approach to enable healthy public policy adaptation. An opportunity also exists to explore best practices for public health advocacy within a regional lens once the new regional health unit is operating. Teams within the Health Unit will continue local and provincial knowledge exchange and policy adoption with partners and municipal governments.

#1-0024 – Reduction of ASO Premiums
In reviewing MLHU's experience in funding Administrative Services Only (ASO) personal insurance claims for employees, the monthly contribution to the Health Unit's insurer (Great West Life) has consistently exceeded the ASO pay out for insurance claims submitted. A portion of the excess contributions that have accumulated will be withdrawn in fiscal 2019 and the monthly premiums will be reduced in 2020 by approximately $8,333 or $100,000 per annum. This proposal will be presented by Aon Hewitt on behalf of the Health Unit when they renegotiate the rate of premiums that will be payable to the insurer for the 2020 fiscal period.

#1-0026 – Restructure HR Manager Role

This proposal is to permanently move the HR Manager position to a Band 6 to align with the other functional managers on the Healthy Organization management team who are also at the same band. In addition, the proposal will move the Acting Manager into this permanent role. This allows for a growth opportunity for the current incumbent to gain management experience and supports succession planning within the HR team.

#1-0029 – Library Subscription and Access Copyright
The Health Unit and Shared Library Services Partnership (SLSP) have a combined budget of approximately $40,000. This budget is used for subscriptions to databases and journals required to conduct evidence-informed public health practice. This proposal would reduce the Health Unit library budget by $5,000 which would result in the purchase of fewer journal titles and a disinvestment from Access Copyright which allows electronic sharing of journal articles throughout the Health Unit.

Currently, SLSP uses Access Copyright with its client health units by sending articles electronically when individual journal copyright allows or otherwise sending a hard copy. The Health Unit would retain access to the same journal titles, albeit some would come through inter-library loans and shared databases.

#1-0030 - Elimination of MLHU Van
This proposal recommends the disposal of the Health Unit's van. Operating costs are expected to increase significantly in the coming years which do not support its relatively low usage. Disposal is planned to occur after completing the move to Citi Plaza. This will provide enough time to complete purge activities and provide support for moving-related activities.

#1-0004 – HBHC Family Home Visitor
The Best Beginnings Team propose to decrease the number of Family Home Visitors (FHV) by 1.0 FTE. This position is currently vacant and a permanent decrease in complement would not significantly impede the capacity of the remaining team members to meet current demand for service.

#1-0008 – PHAC Funding for SSFB Dietitian
The Health Unit previously provided funding for a dietitian for Smart Start for Babies (SSFB) program. Under this proposal, funding for this position (0.2 FTE) will originate from Public Health Agency of Canada (PHAC), commencing in their next fiscal period which starts April 1, 2020.

#1-0010 – HS Operational Reductions
With increased access to resources online as well as increased use of social media for campaigns, reduced spending of $20,000 for program supplies can be realized which reflects savings of $10,000 from each of the Reproductive Health and Early Years teams respectively.

MIDDLESEX-LONDON HEALTH UNIT
2020 BOARD OF HEALTH DRAFT BUDGET SUMMARY

	2018 Budget	2019 Budget	2020 Budget	$ increase/ ($ decrease) over 2019	% increase (% decrease) over 2019	Notes
Healthy Organization						
Office of the Director	$ 318,316	$ 354,699	$ 366,239	$ 11,540	3.3%	
Finance	453,697	455,506	376,539	(78,967)	-17.3%	1.
Human Resources	669,478	701,599	718,985	17,386	2.5%	
Information Technology	947,981	1,069,292	1,208,932	139,640	13.1%	2.
Privacy Risk & Governance	154,099	153,110	159,272	6,162	4.0%	
Procurement & Operations	260,844	283,638	187,821	(95,817)	-33.8%	3.
Program Planning & Evaluation	857,409	873,039	889,028	15,989	1.8%	
Strategic Projects	248,436	263,202	276,792	13,590	5.2%	
Total Healthy Organization	**$ 3,910,260**	**$ 4,154,085**	**$ 4,183,608**	**$ 29,523**	**0.7%**	
Healthy Living Division						
Office of the Director	$ 257,311	$ 379,454	$ 264,565	$ (114,889)	-30.3%	4.
Child Health	1,641,728	1,685,760	1,666,881	(18,879)	-1.1%	
Chronic Disease and Tobacco Control	1,421,291	1,407,541	1,595,629	188,088	13.4%	5.
Healthy Communities and Injury Prevention	1,141,295	1,168,241	1,142,960	(25,281)	-2.2%	
Oral Health	1,249,924	1,116,045	3,442,248	2,326,203	208.4%	6.
Southwest Tobacco Control Area Network	436,500	436,500	441,345	4,845	1.1%	
Young Adult Health	1,151,813	1,137,457	1,108,234	(29,223)	-2.6%	
Total Healthy Living Division	**$ 7,299,862**	**$ 7,330,998**	**$ 9,661,862**	**$ 2,330,864**	**31.8%**	
Officer of the Medical Officer of Health						
Office of the Medical Officer of Health	$ 604,384	$ 576,556	$ 484,130	$ (92,426)	-16.0%	7.
Communications	517,194	531,685	585,917	54,232	10.2%	8.
Associate Medical Officer of Health	346,748	295,831	332,008	36,177	12.2%	
Population Health Assessment & Surveillance	523,273	593,835	549,380	(44,455)	-7.5%	
Community Outreach & Clinical Support Services	-	-	952,414	952,414		9.
Total Officer of the Medical Officer of Health	**$ 1,991,599**	**$ 1,997,907**	**$ 2,903,849**	**$ 905,942**	**45.3%**	
Environmental Health & Infectious Disease Division						
Office of the Director	$ 283,276	$ 302,938	$ 308,774	$ 5,836	1.9%	
Emergency Management	181,317	180,848	133,818	(47,030)	-26.0%	10.
Food Safety & Healthy Environments	1,814,777	1,727,958	1,459,602	(268,356)	-15.5%	11.
Infectious Disease Control	1,772,289	1,814,317	1,834,640	20,323	1.1%	
Safe Water, Rabies & Vector-Borne Disease	1,379,946	1,382,228	1,682,618	300,390	21.7%	11.
Sexual Health	3,231,615	3,279,751	2,853,039	(426,712)	-13.0%	12.
Vaccine Preventable Disease	1,771,588	1,638,371	1,662,785	24,414	1.5%	
Total Environmental Health & Infectious Disease Division	**$ 10,434,808**	**$ 10,326,411**	**$ 9,935,276**	**$ (391,135)**	**-3.8%**	

MIDDLESEX-LONDON HEALTH UNIT
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	2018 Budget	2019 Budget	2020 Budget	$ increase/ ($ decrease) over 2019	% increase (% decrease) over 2019	Notes
Healthy Start Division						
Office of the Director	$ 260,678	$ 208,616	$ 212,473	$ 3,857	1.8%	
Best Beginnings	3,069,406	3,105,295	3,106,227	932	0.0%	
Early Years Health	1,601,916	1,648,166	1,586,332	(61,834)	-3.8%	8.
Reproductive Health	1,542,914	1,368,189	1,395,827	27,638	2.0%	
Screening Assessment and Intervention	3,191,771	2,124,932	-	(2,124,932)	-100.0%	13.
Total Healthy Start Division	**$ 9,666,685**	**$ 8,455,198**	**$ 6,300,859**	**$ (2,154,339)**	**-25.5%**	
Office of the Chief Nursing Officer	**$ 428,022**	**$ 778,328**	**$ 789,317**	**$ 10,989**	**1.4%**	
General Expenses & Revenues	**$ 2,586,433**	**$ 2,683,323**	**$ 2,675,102**	**$ (8,221)**	**-0.3%**	14.
Expected Agency Gapping Budget	**$ (932,963)**	**$ (1,124,269)**	**$ (1,140,858)**	**$ (16,589)**	**1.5%**	15.
TOTAL MIDDLESEX-LONDON HEALTH UNIT EXPENDITURES	**$ 35,384,706**	**$ 34,601,981**	**$ 35,309,015**	**$ 707,034**	**2.0%**	
Funding Sources						
Ministry of Health & Long-Term Care (Cost-Shared)	$ 16,617,100	$ 17,101,100	$ 20,442,198	$ 3,341,098	-3.4%	16.
Ministry of Health & Long-Term Care (100%)	4,297,565	4,066,700		$ (4,066,700)		
The City of London	6,095,059	6,095,059	6,704,565	$ 609,506	10.0%	16.
The County of Middlesex	1,160,961	1,160,961	1,277,057	$ 116,096	10.0%	16.
Ministry of Health & Long-Term Care (100%- Senior Dental)			2,561,400	$ 2,561,400		17.
Ministry of Children, Community & Social Services (100%)	5,632,766	4,580,072	2,483,313	$ (2,096,759)	-45.8%	18.
City of London - CLIF Tobacco Enforcement	-	-	166,846	$ 166,846		19.
Public Health Agency of Canada	428,261	428,261	443,714	$ 15,453	3.6%	
Public Health - Ontario	106,526	106,526	106,526	$ -	0.0%	
User Fees	828,090	678,090	678,090	$ -	0.0%	
Other Offset Revenue	218,378	385,212	445,306	$ 60,094	15.6%	
TOTAL MIDDLESEX-LONDON HEALTH UNIT EXPENDITURES	**$ 35,384,706**	**$ 34,601,981**	**$ 35,309,015**	**$ 707,034**	**2.0%**	

Notes to Team Budget Summary:

1 Payroll coordinator position eliminated in 2019 in connection with outsourcing of payroll to external service provider.
2 Reflects transfer of payroll position financing to offset costs to outsource payroll and transfer of telecom budgets from General expense
3 Procurement coordinator contract position was not extended and reception program assistant positions were transferred to Community Outreach & Clinical Support Services
4 Policy advisor position was eliminated
5 Addition of two Tobacco Enforcement Officers to be funded directly by City of London (CLIF)
6 New Senior Dental program announced in 2019 to be funded 100% by Ministry of Health & Long-Term Care (MOHLTC)
7 Decrease includes a reduction of $100,000 for one-time professional fees in connection with the relocation to Citi Plaza

MIDDLESEX-LONDON HEALTH UNIT
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		2018 Budget	2019 Budget	2020 Budget	$ increase/ ($ decrease) over 2019	% increase (% decrease) over 2019	Notes
8	Change reflects transfer of 0.5 FTE for Public Health Nurse position from Early Years Team to Communications						
9	Community Outreach & Clinical Support Services team was formed by aggregating common services distributed throughout the health unit to improve triage of all requests for services more effectively.						
10	0.5 FTE transferred from Emergency Preparedness to Community Outreach & Clinical Support Services						
11	3 FTE transferred from Food Safety & Healthy Environments to Safe Water, Rabies & Vector-Borne Disease in realignment of duties						
12	Reflects transfer of 5 FTE from HIV Prevention & Control Team (outreach team) to Community Outreach & Clinical Support Services						
13	Transfer of children's screening programs to Thames Valley Children's Centre (TVCC) in Q3 2019						
14	Increase to occupancy costs and planned financing charges for 2020 partly offset by elimination of $250,000 reserve appropriation and reduction of $100,000 for one-time professional fees in connection with the relocation to Citi Plaza - *detail outlined below*						
15	Changes to Gap reflects cummulative impact of inflationary pressures on salaries and wages offset by a one-time $250,000 refund of overcontribution of ASO premiums and a planned $100,000 reduction to ASO premiums (PBMA 1-0024) offset by a planned $100,000 partial payment of incremental bank debt related						
16	MOHLTC eliminated 100% funding for all programs with exception of new funding for Senior Dental Program. Funding for all programs is set at 70% with municipalities increasing contribution to 30%. As a transitional measure, municipal increases in 2020 are capped at 10% and MOHLTC will provide one-time mitigating funds to cover the shortfall. Overall, funding is flat to 2019 and MLHU has employed PBMA principles to free up sufficient funds to offset inflationary pressures on employment costs and incremental occupancy costs related to relocation to Citi Plaza						
17	New MOHLTC 100% funding for Senior Dental Program announced in 2019						
18	Decrease in funding from MCCSS reflects transfer of children's screening programs to TVCC						
19	Represents new funding for tobacco and cannabis enforcement from City of London						

YOY Continuity of General Expense		
Opening Budget - 2019	**$**	**2,683,323**
Transfer of Staff development budget to centralized budget		(1,800)
One-time refund of overcontribution of ASO premiums		(250,000)
Remove Technology & Infrastructure Reserve		(250,000)
Remove Incremental Professional Fees (Relocation)		(100,000)
Incremental occupancy costs - 2020		377,491
Incremental insurance costs		13,800
Finance charges related to Debt Servicing Costs		264,268
Incremental Mileage charges		20,000
Transfer telephone budgets to IT		(76,200)
PBMA proposal - elimination of MLHU van		(5,780)
Proposed budget - 2020	**$**	**2,675,102**

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2020 MLHU Programs

		Budget	FTE
Emergency Management			
400	Emergency Management	$ 145,652	1.06
Effective Public Health Practice			
401	Communications	$ 585,916	5.70
403	Quality and Transparency	$ 185,426	1.56
402	Program Planning and Evaluation	$ 627,886	6.10
404	Research and Knowledge Exchange	$ 354,061	3.36
Health Equity			
410	Health Equity and Indigenous Public Health Practice	$ 419,791	3.40
Population Health Assessment			
415	Population Health Assessment and Surveillance	$ 611,662	5.10
	Total Foundational Standards	**$ 2,930,395**	**26.28**
Chronic Disease Prevention Well-Being			
420	Healthy Eating Behaviours	$ 389,938	3.57
421	Oral Health	$ 499,683	5.51
422	Physical Activity and Sedentary Behaviours (Active Living)	$ 266,553	2.37
423	Mental Health Promotion	$ 138,393	1.23
424	Ultraviolet Radiation and Sun Safety	$ 90,567	0.81
479	Seniors Dental Care	$ 2,455,451	8.38
	Total Chronic Disease Prevention Well-Being	**$ 3,840,584**	**21.87**
Food Safety			
425	Food Safety	$ 1,702,736	15.76
	Total Food Safety	**$ 1,702,736**	**15.76**
Healthy Environments			
430	Health Hazard Response	$ 374,779	3.46
431	Healthy Environments and Climate Change	$ 98,984	0.89
	Total Healthy Environments	**$ 473,763**	**4.35**

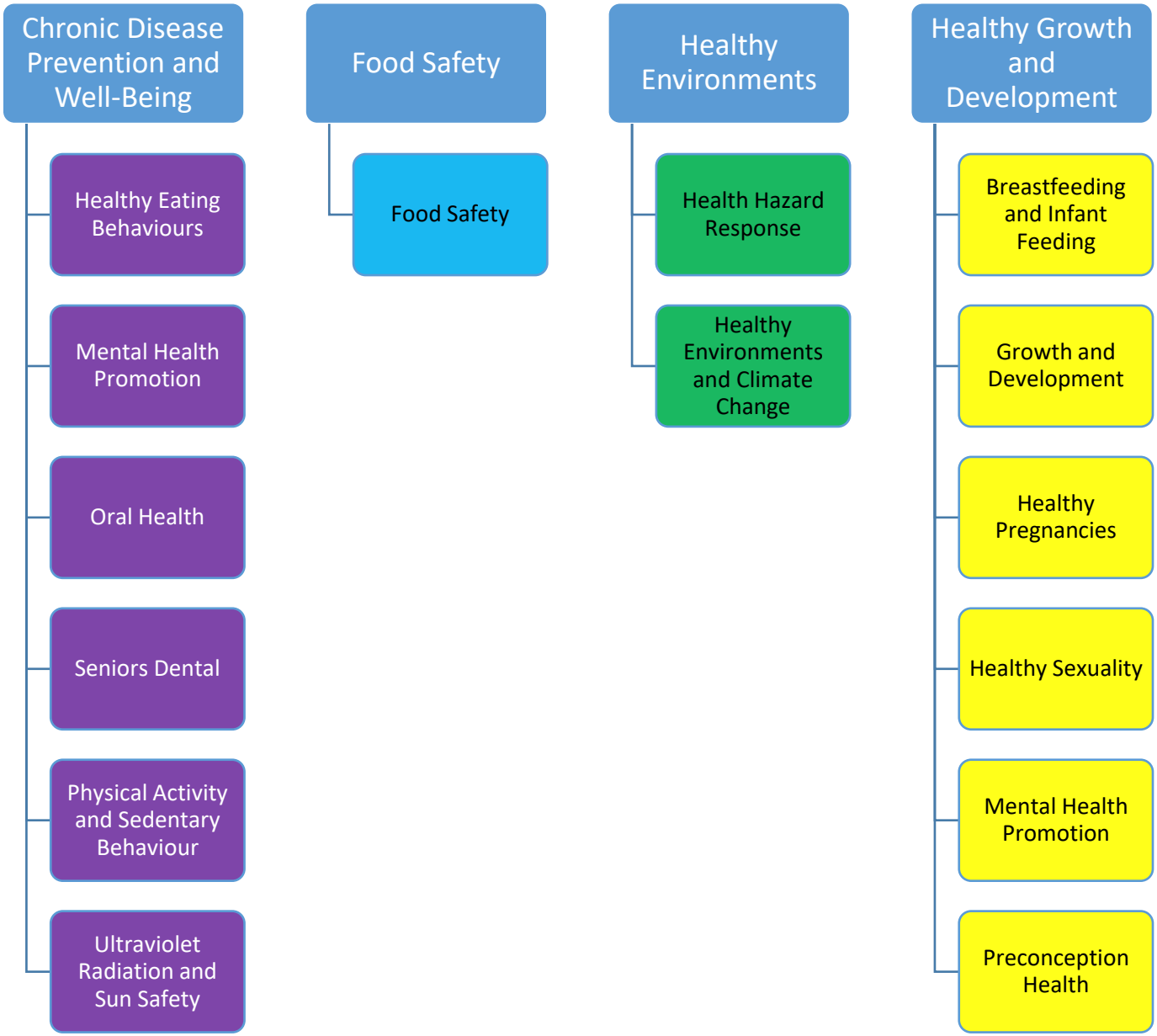
Salaries & Wages	$	22,312,607
Overtime / Shift Premium	$	83,288
Benefits	$	5,454,965
Expected vacancies	$	(1,020,858)
Travel	$	318,857
Program Supplies	$	1,469,222
Board expenses	$	45,500
Staff Development	$	192,956
Occupancy	$	1,971,599
Professional Services	$	2,401,718
Furniture & Equipment	$	1,319,049
Other Program Costs	$	760,111
Expenses by Program	**$**	**35,309,015**

MOHLTC (Cost Shared)	$	28,423,819
MOHLTC (100%)	$	2,561,400
MCCSS	$	2,483,313
CLIF Tobacco Enforcement	$	166,846
PHAC	$	443,714
Public Health Ontario	$	106,526
User Fees	$	678,090
Other Offset Revenue	$	445,306
Revenue by Program	**$**	**35,309,015**

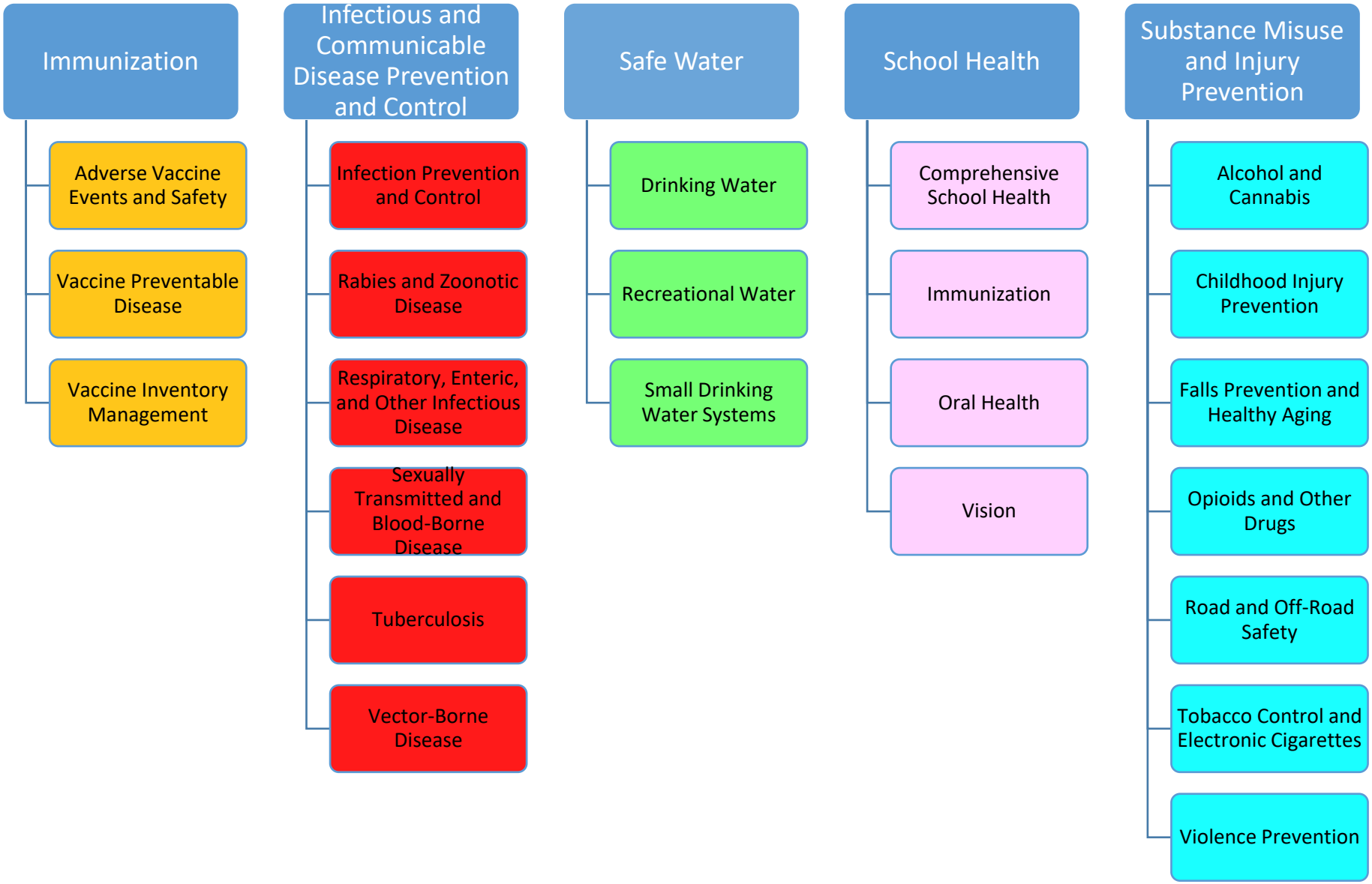
			Budget	FTE
Healthy Growth and Development				
440	Breastfeeding and Infant Feeding	$	1,422,802	12.60
441	Growth and Development	$	2,034,810	20.50
442	Healthy Pregnancies	$	1,325,452	11.67
443	Healthy Sexuality	$	214,760	1.36
444	Mental Health Promotion	$	703,124	6.15
445	Preconception Health	$	416,861	3.67
	Total Healthy Growth and Development	**$**	**6,117,808**	**55.95**
Infectious and Communicable Disease Prevention and Control				
450	Infection Prevention and Control	$	467,616	4.37
451	Rabies and Zoonotic Disease	$	359,484	3.03
452	Respiratory, Enteric, and Other Infectious Disease	$	722,813	6.45
453	Sexually Transmitted and Blood-Borne Disease	$	2,774,191	18.00
454	Tuberculosis	$	440,318	3.79
455	Vector-Borne Disease	$	493,050	5.97
	Total	**$**	**5,257,471**	**41.60**
Immunization				
460	Adverse Vaccine Events and Safety	$	27,968	0.22
461	Vaccine Inventory Management	$	225,444	2.37
462	Vaccine Preventable Disease	$	591,176	5.29
	Total Immunization	**$**	**844,589**	**7.88**
School Health				
465	Comprehensive School Health	$	2,827,873	25.25
466	Immunization - School Health	$	1,016,424	10.45
467	Oral Health - School Health	$	482,920	5.50
468	Vision	$	32,438	0.27
	Total School Health	**$**	**4,359,654**	**41.47**

			Budget	FTE
Substance Use and Injury Prevention				
470	Alcohol and Cannabis	$	452,675	4.18
471	Childhood Injury Prevention	$	147,788	1.32
472	Falls Prevention and Healthy Aging	$	148,033	1.31
474	Opioids and Other Drugs	$	429,228	2.77
475	Road and Off-Road Safety	$	179,506	1.61
476	Southwest Tobacco Control Area Network	$	457,233	2.49
477	Tobacco Control and Electronic Cigarettes	$	892,858	8.54
478	Violence Prevention	$	346,225	2.91
	Total Substance Use and Injury Prevention	**$**	**3,053,547**	**25.13**
Safe Water				
480	Drinking Water	$	194,910	1.62
481	Recreational Water	$	313,285	2.62
482	Small Drinking Water Systems	$	78,319	0.63
	Total Safe Water	**$**	**586,513**	**4.87**
Required Support				
490	Strategic Projects	$	297,378	2.60
491	Finance	$	397,125	4.10
492	Procurement	$	83,047	0.60
493	Governance	$	74,128	0.60
494	Human Resources	$	784,570	7.60
495	Information Technology	$	1,229,517	3.10
496	Operations	$	606,073	7.90
497	Privacy and Records	$	126,742	1.15
498	Risk Management	$	87,580	0.75
	Total Required Support	**$**	**3,686,159**	**28.40**
Required Support				
498	General Revenues and Expenditures	$	1,604,044	-
498	CNO / MOH / Admin / Secretarial	$	851,753	6.33
	Total Required Support	**$**	**2,455,797**	**6.33**
Total MLHU Programs 2020		**$**	**35,309,015**	**279.89**

MLHU Programs by Standard / Requirement



MLHU Programs by Standard / Requirement



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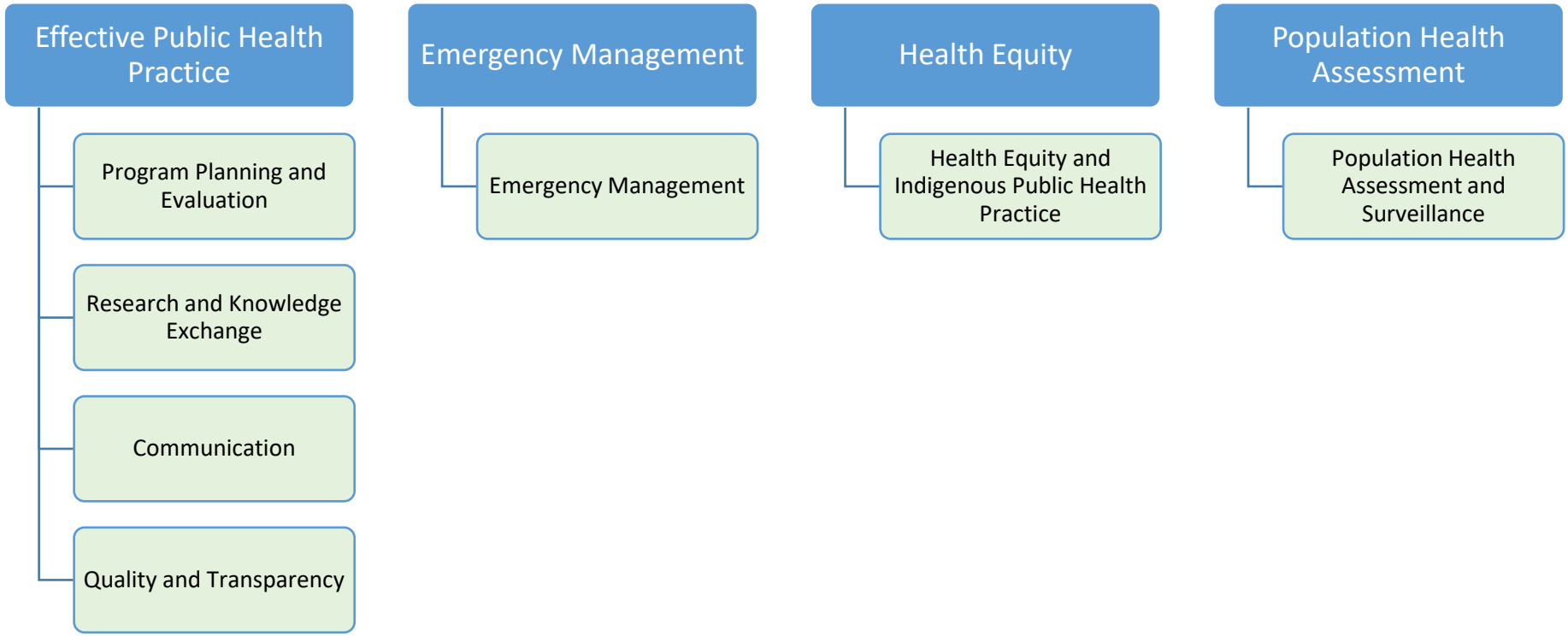

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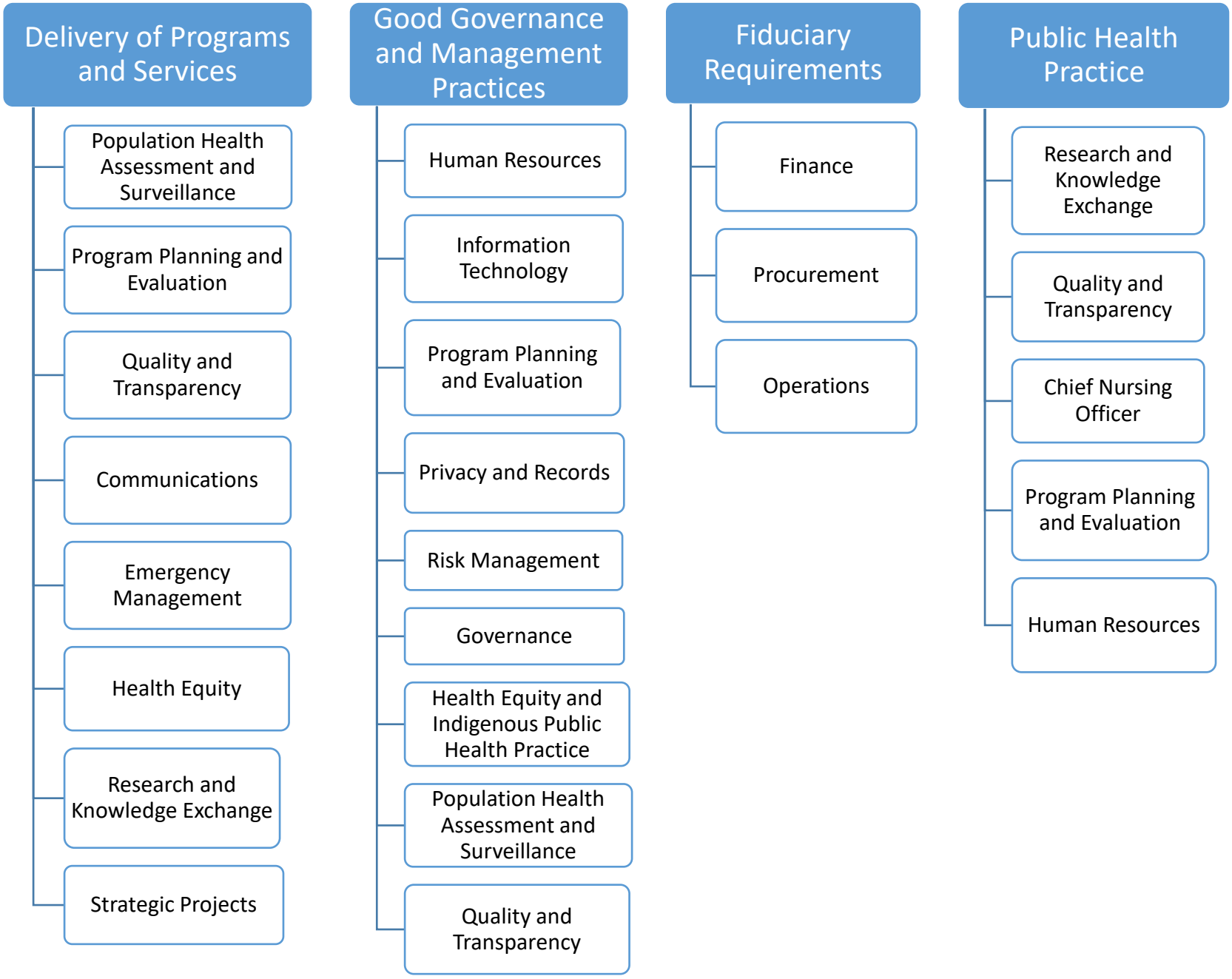

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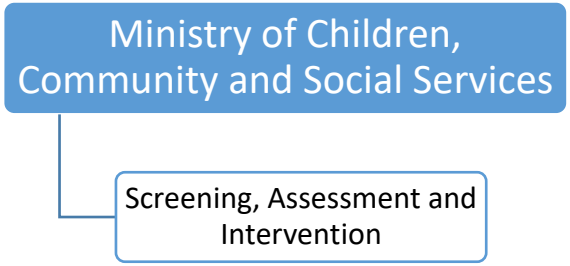
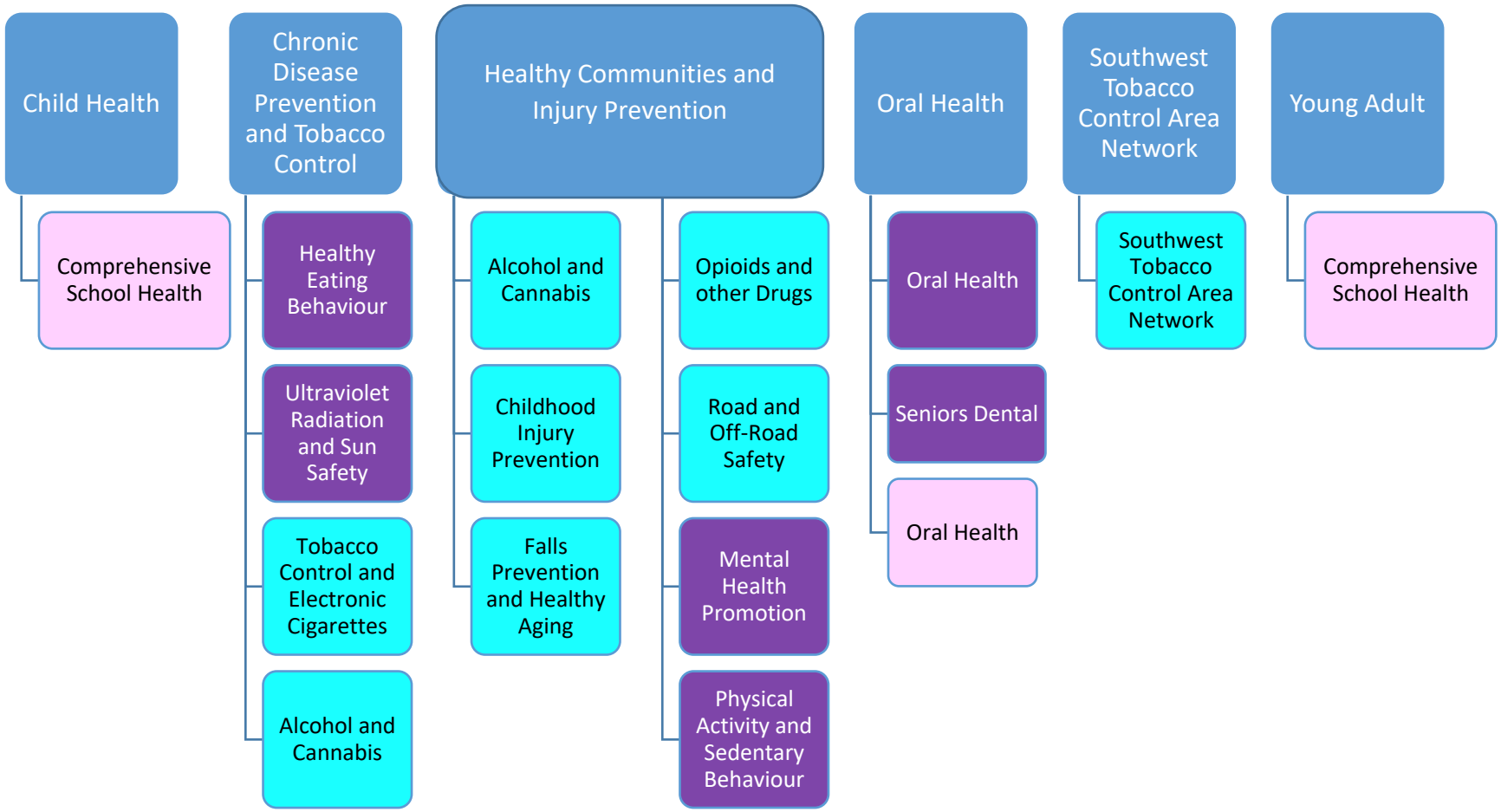


Programs Delivered by Teams



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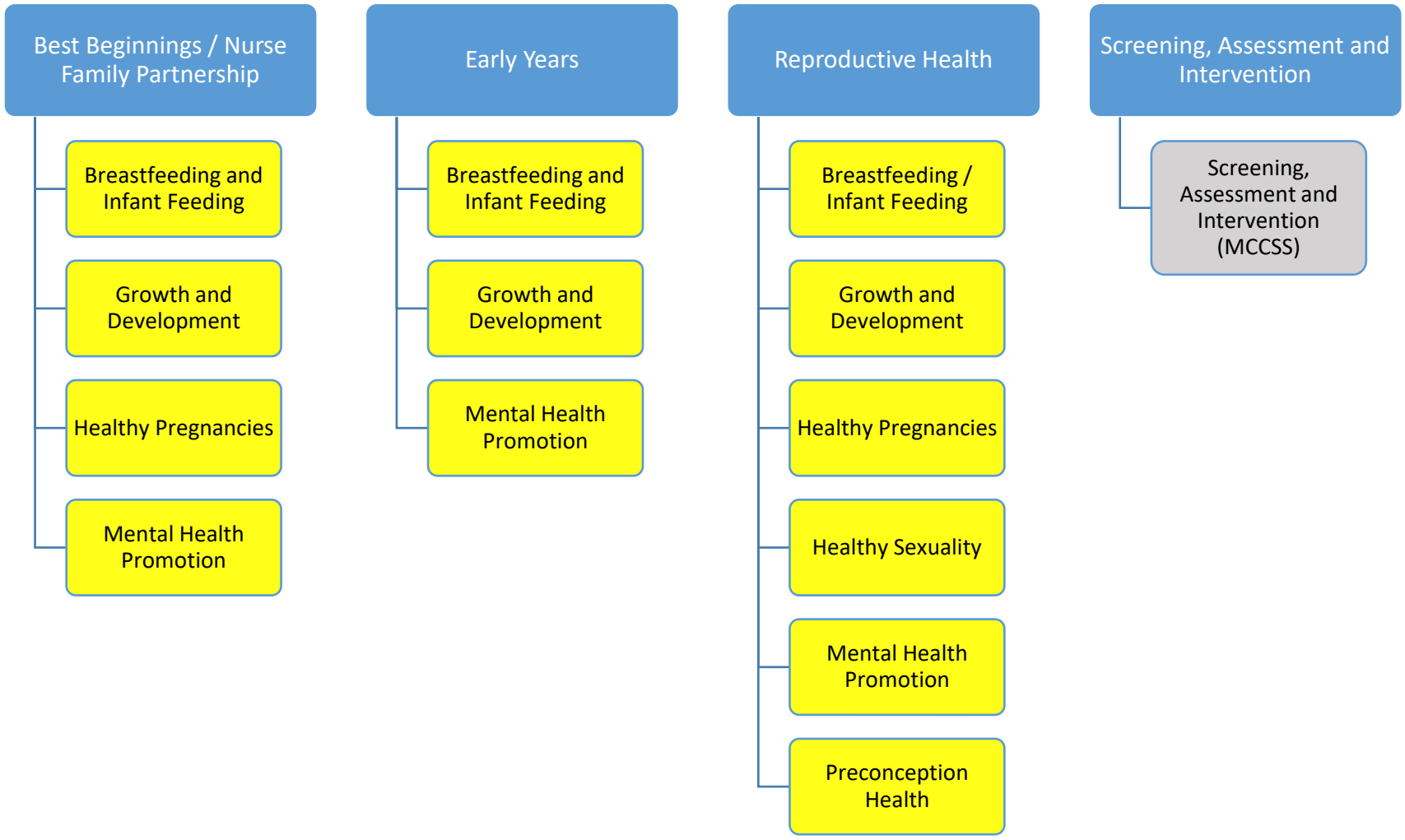

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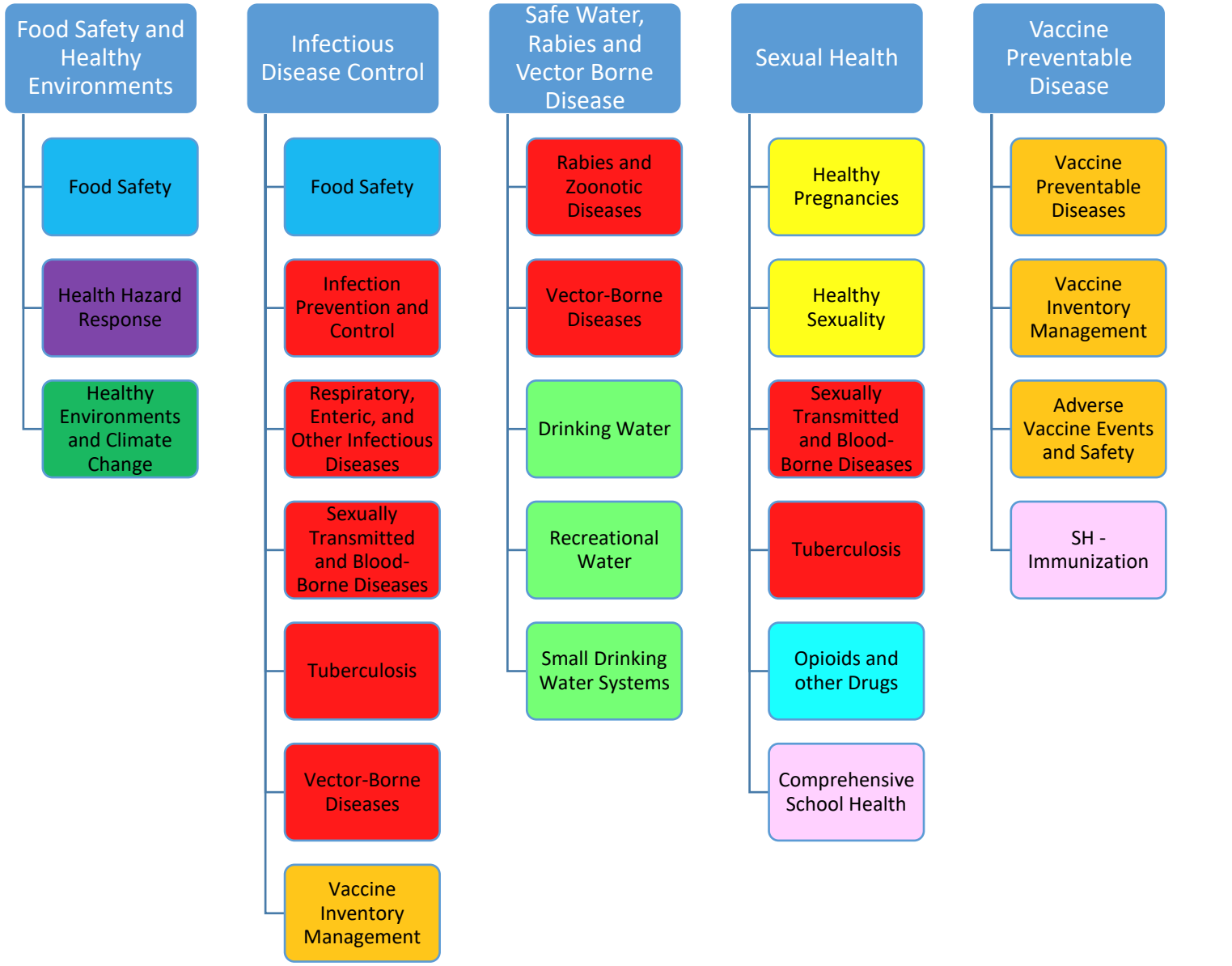

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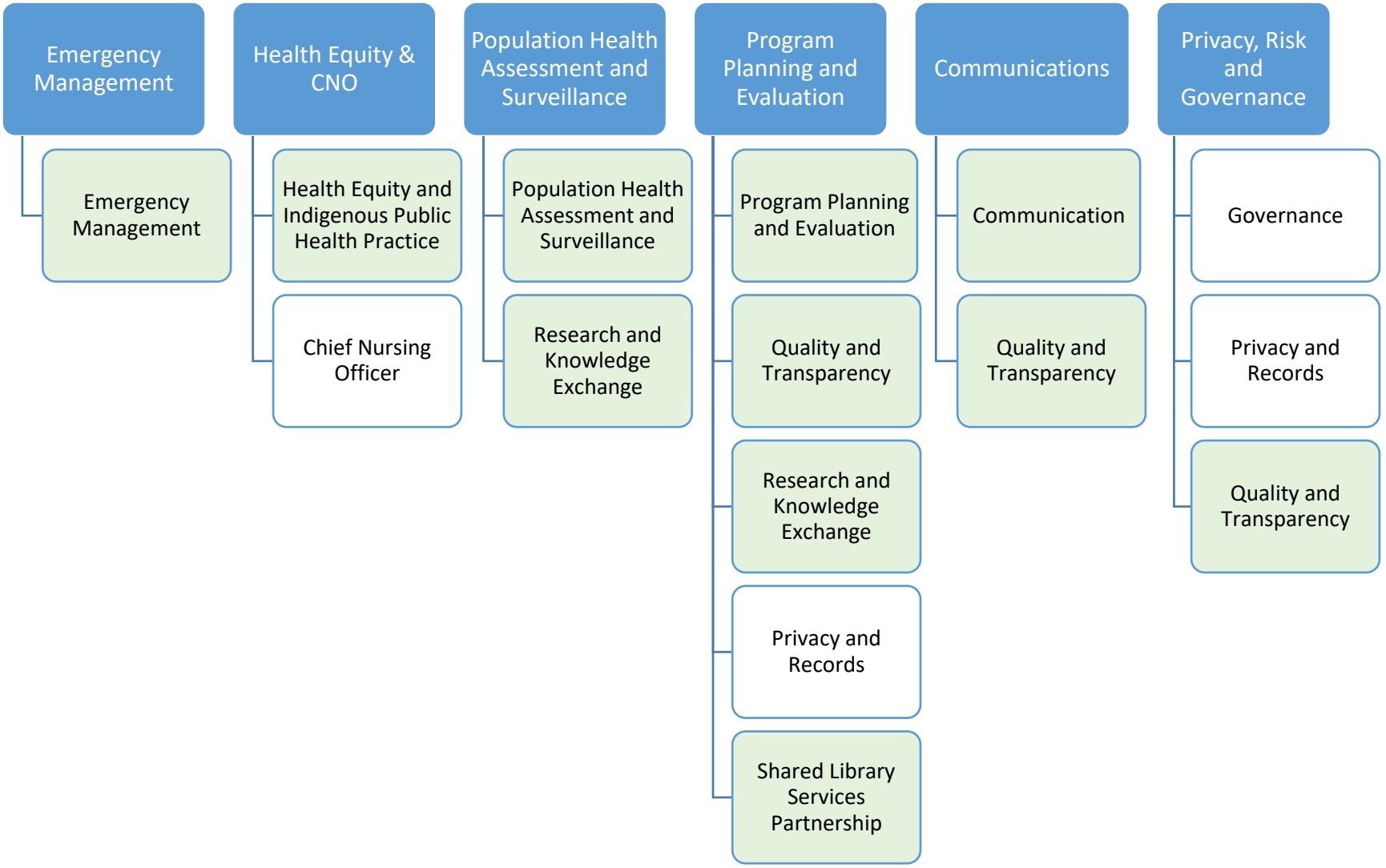
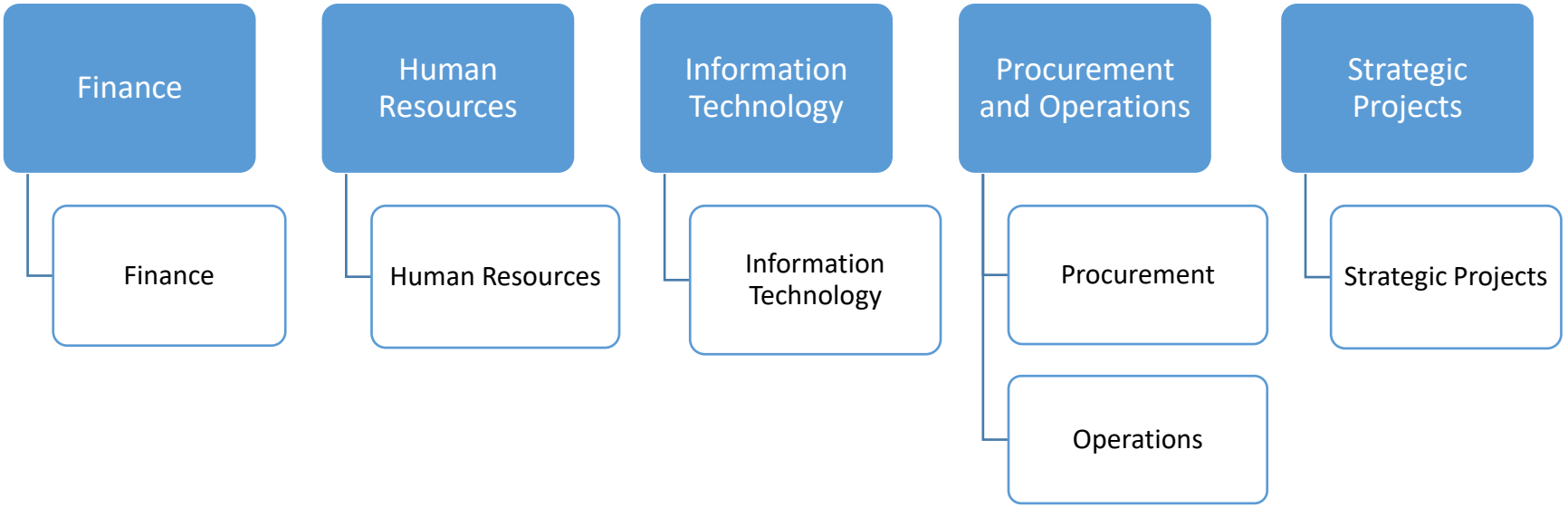


Programs Delivered by Teams



CDPWB
ICD
FS
SW
HEV
SH
HGD
SUIP
IMM
Foundational
MCCSS
Requirements

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Emergency Management					400
Standard	Emergency Management		**Director Name**	Stephen Turner	
Lead Team	Emergency Management		**Manager Name**	Judy Green	
Supporting Team(s)	MLHU Team				
Budget	$ 145,652		**FTE**	1.06	

Summary of Program

Effective emergency preparedness, response, and recovery ensures that the Health Unit is ready to address and recover from threats to public health or disruptions to public health programs and services. This is accomplished through a range of activities carried out in coordination with other partners. The Health Unit will effectively prepare for emergencies to ensure timely, integrated, safe, and effective response to, and recovery from emergencies with public health impacts, in accordance with Ministry policy and guidance documents.

Components of the Emergency Management Program include:
1. Identification of Hazards and Risks
2. MLHU Emergency Response and Business Continuity Planning
3. Emergency Management Training and Exercises
4. Respirator Fit-Testing
5. Emergency Notification System Maintenance and Testing
6. Compliance with Ministry of Health and Long-Term Care standards
7. Mass Immunization Planning
8. Manage Community Emergency Response Volunteer Team

Program Mandate and Relevant Legislation

Emergency Management & Civil Protection Act, R.S.O. 1990, c. E. 9.
- Health Protection and Promotion Act, R.S.O. 1990, c. H. 7
- Incident Management System (IMS) for Ontario Doctrine, 2008
- Occupational Health and Safety Act and Regulations, R.S.O. 1990
- Fire Protection and Prevention Act and Ontario Fire Code (2016)
- Exposure of Emergency Service Workers to Infectious Diseases Protocol (MOHLTC)

Program Management

The Emergency Management Team is responsible for the delivery of the MLHU Emergency Management Program.

All teams across MLHU are responsible for adopting the Incident Management System, plans, procedures, and policies when addressing emergencies or challenges in maintaining critical organizational activities. Designated employees are responsible for being familiar with plans and participating in exercises and orientations and the Emergency Management Team encourages and supports learning and participation.

Key Partners and Stakeholders

Emergency Management works with the other emergency management leads across the City, County, and province to deliver this program and as the spread of disease and infection is not often isolated the above parties may be impacted to varying degrees. The following stakeholders are the most likely impacted or engaged in preparing for emergencies.

Middlesex-London Emergency Medical Services, London Police Service, Fanshawe College, Thames Valley Conservation Authority, University of Western Ontario, Community Emergency Response Volunteers, City of London Fire Department, Municipal Community Emergency Management Coordinators, London Health Sciences Centre, St. Joseph's Health Care London, London International Airport, CN Rail, Via Rail, Pharmacies, Ministry of Transportation, Ministry of Environment, Funeral homes, Ministry of Community Safety & Correctional Services, Chief Coroner (Western Region), Ministry of Natural Resources, Ministry of Health and Long Term Care, Insurance Institutions, London District Catholic School Board, Thames Valley District School Board, Conseil Scolaire Catholique Providence, Conseil Scoliare Viamonde, Private Schools, Local Places of Worship, Red Cross, Salvation Army, St. John Ambulance, Regional HIV Aids Connection, Local Businesses.

Organizational Needs and Priorities

The MLHU is a lean organization and often competes with the broader health sector for resources. This results in the need to redeploy employees from other program areas across the organizations to fill vacant positions or support operational demands that are consequences of outbreaks or vaccine campaigns to prevent disease.

The Emergency Planning Team works with the health unit program managers to develop continuity plans to ensure a consistent approach to contingency planning and a level of competency in the maintenance and activation of plans so that services and supports are maintained at a level that meets the needs of the community at all times.

Target and Priority Populations

Emergency response strategies take into consideration the unique circumstances of the event and impact to vulnerable populations to ensure that services and supports remain accessible and meet the needs of the population impacted by the event. These populations would change depending on the event, and a risk assessment is completed in the onset of an emergency or in planning for an anticipated event that would identify risks to priority and vulnerable populations and strategies would be developed to address inequities or accessibility barriers.

Intended Program Outcomes

Long-Term	• The Board of Health is ready to respond to an recover from new and emerging events and/or emergencies with public health impacts. • Adaptation to climate change
Intermediate	• Adaptation to climate change • Aging population increases vulnerability
Short-Term	• Implement ERMS as the Emergency Notification Tool to support Public Health Modernization • Fully implement a business continuity framework across MLHU

Program Interventions		
1	Assess Hazards and Risks	Maintain an assessment of hazards and risks to public health, and threats to the continuity of public health, time critical programs and services, contribute to city, county, and local municipal hazard identification and risk assessments, create public awareness and education materials to provide information on risks to public health and threats to public health time critical programs and services.
2	Emergency Response and Business Continuity Plans	Ensure that both documents are accurate, appropriate and up to date, that all health Unit employees with responsibilities outlined in both documents are trained and able to perform those duties, that external partner agencies are aware of the health Unit Emergency Response Plan and Business Continuity Plans, that both plans align with the City of London, County of Middlesex and local municipal Emergency plans, Incident Management System - Standard Operating Guidelines are developed and training and testing related to Fire Safety plans occurs.
3	Emergency Notification	Administer the Emergency Notification Systems (Everbridge, EMCT, amateur radio, etc.) to ensure appropriate stakeholders can be contacted and given appropriate instructions during any emergency or continuity of operations event.
4	Public Awareness and Education	Provide public health emergency preparedness, response and recovery practices education and support the City of London and County of Middlesex public awareness and training activities, including the nine Local Municipalities.
5	Community Emergency Response Volunteers	Manage, engage and deploy a team of citizen Community Emergency Response Volunteers (CERV) to support the work efforts of Health Unit programs and services.
6	Respirator Fit Testing	Ensure MLHU staff are fit-tested for respirators according to MLHU policy.

Performance / Service Level Indicators			
Indicator	2018	2019	2020 (target)
Employees and volunteers respond to ERMS emergency notifications	N/A	N/A	90% of MLHU employees and volunteers respond to an emergency notification within 2 hours of alert.
MLHU employees and volunteers have completed Respirator Fit-Testing and Training	100 % of the required employees and volunteers complete the respirator Fit-testing and Training	100 % of the required employees and volunteers complete the respirator Fit-testing and Training	100 % of the required employees and volunteers complete the respirator Fit-testing and Training
Emergency plans are current	80%	80%	MLHU emergency plan is up to date

Highlights / Initiatives Planned for 2020

Fully implement an operational and tactical level business continuity framework across MLHU that encourages a consistent and coordinated approach to redeployment of resources that meets the needs of priority populations and supports MLHU service level objectives in the event of an emergency or significant surge in demand of services and supports. Continue to build relationships with health units for Public Health Modernization. Continue to explore and identify opportunities to engage CERV. Support the City of London's efforts to engage the local indigenous communities in preparing to host communities that are displaced because of fire or floods.

Program Challenges and Risks

Risk

1.Emergency Notification continues to be a manual call tree process.

2.MLHU does not occupy a space that would host a mass immunization clinic and needs to depend on outside sources.

Challenges

1.Identifying opportunities to keep CERV engaged.

2.The interconnectedness and dependencies on the public and private sector increases the complexity of disasters and the opportunity for unanticipated consequences.

Staffing Complement

	2019 Total FTEs	2020 Total FTEs	Δ
Program Manager	1.00	1.00	0.00
Program Assistant	0.50	0.00	-0.50
Associate Medical Officer of Health	0.00	0.01	0.01
Director	0.00	0.05	0.05
Total Program FTE	***1.50***	***1.06***	***-0.44***

Expenditures					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 124,106	$ 110,231	(13,875)	-11%
Benefits		$ 31,254	$ 14,447	(16,806)	-54%
Expected Vacancies		$ -		-	
Travel		$ 3,000	$ 3,043	43	1%
Program Supplies		$ 9,648	$ 9,726	78	1%
Board Expenses		$ -		-	
Staff Development		$ 1,250	$ 1,288	38	3%
Occupancy		$ -		-	
Professional Services		$ -	$ 277	277	
Furniture & Equipment		$ -	$ -	-	
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 11,590	$ 6,639	(4,951)	-43%
Total Expenditures		***$ 180,847***	***$ 145,652***	***-$ 35,196***	

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 61,217	$ 145,229	84,011	137%
MOHLTC (100%)		$ 119,630		(119,630)	-100%
MCCSS		$ -		-	
PHAC		$ -		-	
PHO		$ -		-	
User Fees		$ -		-	
Other		$ -	$ 423	423	
Total Revenues		***$ 180,847***	***$ 145,652***	***-$ 35,196***	

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Communications				401
Standard	Effective Public Health Practice	**Director Name**	Chris Mackie	
Lead Team	Communications	**Manager Name**	Dan Flaherty	
Supporting Team(s)				
Budget	$ 585,916	**FTE**	5.70	

Summary of Program

The Communications Team acts as an internal Media and Stakeholder Relations, Advertising, Marketing, Graphic Design, and Communications agency for the Middlesex-London Health Unit. Its role is to promote and enhance the MLHU's brand and profile as a leader in public health in London and Middlesex County, and across Ontario. This is done through a communications support program that includes: strategic and risk communications initiatives, media relations support and training, the development and coordination of targeted advertising, marketing, and promotional campaign materials; the development and maintenance of the Health Unit's website, online content and social media channels and a Healthcare Provider Outreach program that establishes and maintains direct contact with local professionals in the healthcare sector through annual in-person office visits and a monthly eNewsletter.

Program Mandate and Relevant Legislation

Effective Public Health Practice Standard
Delivery of Public Health Programs and Services Domain
Additional mandate exists in supporting the communications and health promotion aspects of most other Ontario Public Health Standards.

Program Management

The Communications Team is responsible for the delivery of the Communications Program in partnership with the Medical Officer of Health and all other Health Unit programs. Team members consult with and advise front-line staff and managers from other Divisions of the Health Unit to develop strategies and initiatives to reach target audiences with relevant public health messages.

Key Partners and Stakeholders

Health Unit program staff, residents of London and Middlesex County, local media outlets, Healthcare Providers in London and Middlesex County, social media audiences, funders.

Organizational Needs and Priorities

A crucial component to enhanced population health is the link between evidence-based information, programs and services, and those whose health will benefit from these interventions. The Middlesex-London Health Unit delivers a wide variety such of programs and services across the demographic spectrum, as well as timely announcements and information that may have an impact on the health of the community, including time-sensitive or emergency information. In order to meet this need, the Communications team has built and fostered relationships with local media, advertisers, and other partners, and has established media relations, advertising, social media strategies to share messages promptly and effectively.

Target and Priority Populations

The Communications Team works with all Health Unit programs to ensure that they are able to adequately communicate with their target and priority populations. In addition, the Healthcare Provider Outreach program targets primary care providers to ensure that they have the information they need about Health Unit programs and other public health issues.

Intended Program Outcomes

Long-Term	• Public health practitioners, policy -makers, community partners, health care providers, and the public are aware of the factors that determine the health of the population. • Public health communication strategies reflect local needs and utilize a variety of communication modalities to ensure effective communication. • The public and community partners are aware of ongoing public health program improvements. • The public and community partners are aware of inspection results to support making evidence-informed choices.
Intermediate	• Revision of corporate graphic standards program • Increased use of video to communicate health unit messages • Increased public awareness of programs and services
Short-Term	•Improved internal communications processes to enhance information sharing •Improved adherence to corporate graphic standards •Continued relationship development with local healthcare providers

Program Interventions		
1	Media Relations	Through its Media Relations work, Communications enhances awareness of the Health Unit's programs and services and their value to the residents of London and Middlesex County. Communications issues periodic media releases and updates, highlighting programs, services, announcements, and achievements. Communications also responds to media requests, and works with staff to prepare spokespeople for interviews. Communications also assists in developing key messages, Q&As, media lines, backgrounders, and other resources with staff members, when needed and as necessary.
2	Advertising and Promotion	This component supports MLHU initiatives & services by developing campaign material and marketing products (graphics, posters, videos, audio files, displays, marketing and/or promotional products etc.) and placing ads in print, broadcast, online, and/or display media. The Marketing Coordinator oversees the development of campaign materials, with support as needed from other Communications staff. Communications collaborates with program team members and contracted design firms to develop resources as needed. Projects are initiated using Communications Consultation Request Forms and projects are tracked using dockets. Proposals are developed in consultation with program teams, focusing on target audience, demographics, program goals, budget, and success indicators. Communications coordinates the booking of advertising and liaises with contracted graphic design firms as necessary.
3	Online Activities	Communications maintains, updates, and coordinates all MLHU online activities. These activities aim to provide credible, up-to-date public health information to local residents through the MLHU website as well as other online resources, such as the inspections disclosure website (food premises, public pools and spas; personal service settings and tattoo shop inspections disclosure website). MLHU social media channels (Instagram, Twitter, Facebook, YouTube) provide additional opportunities for interaction with clients and community members. Web-based activities also include online contests, responses to user comments and feedback (social media and MLHU website), and interactions through the "health@mlhu.on.ca" email account.

4	Graphic Standards and Services	Through the Marketing Coordinator, Communications oversees and maintains Corporate Graphic Standards for the Middlesex-London Health Unit that outline and govern how the Health Unit logo and wordmarks are to be used. Communications also maintains a series of templates and guides that includes corporate letterhead, business cards, and "shells" for brochures, pamphlets, posters, fact sheets, media releases, public service announcements. The Marketing Coordinator leads a *Graphic Services Committee* , which includes representation from all Divisions of the Health Unit. Communications also provides some in-house graphic design expertise at no charge for teams with limited budgets.
5	MLHU Annual Report	Communications drafts the Health Unit's Annual Report. The MLHU's Annual Report is made available primarily in an online format, with a limited number of hard copies also being produced. Design and layout work is done in-house in order to reduce costs. Hard copy versions of any of the MLHU's previous annual reports may also be printed directly from the online pdf versions available on the MLHU website, as needed.
6	Staff Day	Communications coordinates the planning of the MLHU's Annual Staff Day event. The Staff Day Planning Committee is chaired by the Communications Manager and includes representation from all Divisions. Staff Day celebrates the Health Unit's achievements from the current year, acknowledges staff contributions, recognizes the winner of the Charlene E. Beynon Award, and presents awards to staff for their years of service. Each year, Board of Health members are invited to attend Staff Day.
7	Healthcare Provider Outreach	The Healthcare Provider Outreach program is increasing awareness of the Health Unit's role and brand among area practitioners. The Resource Binders which had been a fixture of the program will be discontinued in 2020 in favour of online resources. However HCPs will be able to request printed material as needed. Monthly eNewsletters reach some 1,300 recipients. Contact lists are managed through the Health Unit's Upaknee account. The HCP staff ensure consistency of message, distribution of program and service area resources and information, providing a feedback mechanism for healthcare providers about MLHU services, programsm, and initiatives and advising of potential communications challenges or opportunities that may exist with this important audience group. In-person visits with healthcare providers are conducted in the fall.

Performance / Service Level Indicators			
Indicator	2018	2019	2020 (target)
Media Stories	1,155	1,200	Maintain
Facebook impressions	2.6 million	3.0 million	Maintain
Facebook posts	401	450	Maintain
Facebook: new followers	954	950	Maintain
Twitter impressions	1.1 million	1.3 million	Maintain
Tweets	2,500	2,750	Maintain
Twitter: new followers	664	700	Maintain
Office visits with HCPs	296	300	Maintain
HCP eNewsletter emails sent	15,430	16,000	Maintain
HCP Alert emails sent	7,716	7,500	Maintain

Highlights / Initiatives Planned for 2020

External communications campaign to advise about the Middlesex-London Health Unit's relocation to Citi Plaza in the first quarter of 2020. Dependant on decisions at the provincial level, a new MLHU logo and branding may be introduced to staff in 2020, dependant on decisions at the provincial level regarding Public Health Modernization. This will pickup on work already done in 2019 and include an audit of internal program and promotional collateral (brochures, posters, displays, etc.), and a determination of which will continue to be used in 2020 and beyond. This will likely require significant re-design work and production. As part of the revised branding a new Corporate Graphic Standards Manual will be created, which will be shared widely with administration staff once it is completed, potentially in 2020.

Program Challenges and Risks

The MLHU's relocation to Citi Plaza in early 2020 will require significant involvement from the Communications Team, which will stretch limited resources already taken up in the day-to-day operations of the department. Work related to Public Health Modernization could have a dramatic impact on all programs and services, requiring substantial work by communications professionals in order to adequately inform clients and the public of changes.

Staffing Complement

	2019 Total FTEs	2020 Total FTEs	Δ
Program Assistant	0.50	0.50	0.00
Public Health Nurse	1.00	1.50	0.50
Communications Coordinator	0.70	0.70	0.00
Program Manager	1.00	1.00	0.00
Marketing Coordinator	1.00	1.00	0.00
Online Communications Coordinator	1.00	1.00	0.00
Total Program FTE	***5.20***	***5.70***	***0.50***

Expenditures					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 398,164	$ 451,285	53,121	13%
Benefits		$ 98,866	$ 109,977	11,111	11%
Expected Vacancies		$ -		-	
Travel		$ 3,050	$ 3,050	-	0%
Program Supplies		$ 14,460	$ 14,460	-	0%
Board Expenses		$ -		-	
Staff Development		$ 2,265	$ 2,265	-	0%
Occupancy		$ -		-	
Professional Services		$ -		-	
Furniture & Equipment		$ 500	$ 500	-	0%
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 14,380	$ 4,380	(10,000)	-70%
Total Expenditures		***$ 531,685***	***$ 585,916***	***$ 54,231***	

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 531,685	$ 585,916	54,231	10%
MOHLTC (100%)		$ -		-	
MCCSS		$ -		-	
PHAC		$ -		-	
PHO		$ -		-	
User Fees		$ -		-	
Other		$ -		-	
Total Revenues		***$ 531,685***	***$ 585,916***	***$ 54,231***	

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Program Planning and Evaluation						402
Standard	Effective Public Health Practice		**Director Name**	Laura Di Cesare		
Lead Team	Program Planning and Evaluation		**Manager Name**	Jordan Banninga		
Supporting Team(s)						
Budget	$ 627,886		**FTE**	6.10		

Summary of Program

The Program Planning and Evaluation (PPE) program is responsible for the delivery of program planning, evaluation, and evidence-informed decision-making services. This is to enable public health programs and services to be reflective of local population health issues, utilize the best available evidence, and adapt to the local context. This program also aims to utilize evaluation findings to generate new public health knowledge.

The PPE program can support decision-making in many different ways. For example, the PPE program can support the planning of a new program or intervention, establishing routine monitoring of key indicators, and assessing the impact, effectiveness, or efficiency of existing programs.

Interventions of the PPE program include:
- Planning and Evaluation Framework
- Planning and Evaluation Consultations and Support
- Planning and Evaluation Project Delivery
- Training and Capacity Building; and
- Annual Service Plan Development.

Program Mandate & Relevant Legislation

• Effective Public Health Practice Standard
• Delivery of Public Health Programs and Services Domain
• Public Health Practice Domain

Additional mandate exists in supporting program planning and evaluation aspects of most other Ontario Public Health Standards.
Alignment with the MLHU Strategic Plan and priorities in the Program Excellence and Client and Community Confidence quadrants.

Program Management

The Program Planning and Evaluation Team is responsible for the delivery of the Program Planning and Evaluation Program. The program requires close coordination with other programs delivering the Foundational Standards and Organizational Requirements.

Key Partners and Stakeholders

• Ontario Public Health Evaluators Network
• Public Health Ontario

Project specific partners:
• Western University
• Regional HIV/AIDS Connection
• Public Health Agency of Canada (PHAC)

Organizational Needs and Priorities

In 2015, the MLHU Strategic Plan identified planning and evaluation in the Program Excellence quadrant of the Balanced Scorecard. At this time, internal consultations with key stakeholders across the organizations identified the need for a framework to address the steps of planning, implementation, and evaluation. This framework needed to be flexible, scalable, and easy to use. In 2017, the MLHU Planning and Evaluation Framework was launched. Ongoing efforts have been made by the PPE team to utilize the PEF in supporting prioritized and strategic projects. The PPE Team has also provided support to staff and managers through consultations and deliverables to make use of the PEF guides and tools. Through these efforts, the PPE team has identified several areas for improvement in planning and evaluation, including identifying outcomes, developing indicators, setting up routine monitoring, etc.
The work of Program Planning and Evaluation considers community health issues and the local context, community and political preferences and actions, research, and available public health resources.

Target and Priority Populations
N/A

Intended Program Outcomes	
Long-Term	• Public health programs and services are reflective of local population health issues, the best available evidence, new public health knowledge, and adapted to the local context. • The organizational culture supports the use of planning and evaluation results in decision-making. • Communications with internal and external stakeholders regarding planning and evaluation are clear and transparent.
Intermediate	• Public health programs and services are modified to address issues related to program effectiveness. • Public health practitioners, policy-makers, community partners, health care providers, and the public are aware of the factors that determine the health of the population. • PEF guides and tools are used in all program planning and evaluation projects. • Planning and evaluation projects are conducted for public health programs to balance cost, quality, and time. • Planning and evaluation is integrated into appropriate organizational processes. • Management and staff have confidence to undertake planning and evaluation activities. • Programs and interventions are evaluated on a regular basis.
Short-Term	• All managers are aware of the PEF, its purpose and the alignment with the organizational processes, such as the Annual Service Plan. • Managers and Directors are routinely monitoring key indicators in all interventions. • Managers and Directors are able to identify the need for program planning and evaluation support for their programs. • Training and capacity building needs are identified through a review of Annual Service Plan content, identified gaps in program documentation, and patterns in service requests. • MLHU staff have adequate planning and evaluation knowledge and skills. • Results of planning and evaluation projects are incorporated into decision-making.

Program Interventions		
1	Planning and Evaluation Framework	Ongoing review, development, and implementation of the Planning and Evaluation Framework (PEF) that is used by all MLHU programs. This includes the review and enhancement of guides and tools, researching new planning and evaluation practices, and facilitating full-scale PEF adoption at MLHU. This includes the maintenance of PEF guides and tools on the external facing website. Activities in 2020 will include building an intervention description and intervention logic model for Planning and Evaluation Framework intervention.
2	Planning and Evaluation Consultations and Support	Program Evaluators are assigned to teams to provide planning and evaluation consultations. These consultations can include the following: reviewing planning documents, developing logic models, reports, data collection tools, analyzing data, CheckMarket training, and administration, etc. A focus in 2020 will be to prioritize the establishment of routine monitoring for interventions with electronic databases (e.g. ECR, Hedgehog, ISCIS) by working with staff and managers to develop customized reporting. This will help to gather a mix of key indicators to identify program effectiveness, efficiencies, etc. Regular program manager and director touchdowns are also provided.
3	Planning and Evaluation Project Delivery	This intervention supports the delivery of planning, implementation, and evaluation of approved projects for MLHU programs. For example, this includes organization-wide strategic initiatives that link with program planning and evaluation.
4	Training and Capacity Building	Explore the use of the LDCP Evaluation Capacity Building Tool in 2020 to assess organizational needs. Based on the assessment findings, training and capacity building activities will be developed and implemented. Activities in 2020 will include building an intervention description and logic model to support this training and capacity building intervention.
5	Annual Service Plan Development	Train managers, and facilitate and maintain the organizational process of completing the ASP through use of PEF tools. Gather lessons learned from the 2020 ASP process and use those findings to improve the 2021 process. Review the ASP content from 2020 to identify gaps in program documentation in order to identify areas for future training and capacity building.

Performance / Service Level Indicators

Indicator	2018	2019	2020 (target)
% of PEF guides and tools reviewed within the last two years	100% (41/41)	n/a	100%
# of planning and evaluation requests supported	125 est. (tracking introduced mid-year)	58	Increase
# of planning and evaluation consultations completed	97 (tracking introduced mid-year)	50	Increase
# of planning and evaluation deliverables	22 (tracking introduced mid-year)	28	Increase
# of planning and evaluation projects lead or supported	15	11	Provide status reports and evaluate each project

Highlights / Initiatives Planned for 2020

• Review and update of all Planning and Evaluation Framework Guides and Tools in 2020.
• Training needs for the PEF will be determined and delivered based on current organizational needs.
• Provide more planning and evaluation capacity building activities with managers and staff with a focus on supporting the identification of key indicators and establishing routine monitoring of indicators.
• Provide support for emerging public health issues.
• Continue to contribute to strategic projects and program projects, such as the Client Experience Survey, Photo Study involving CarePoint Consumption and Treatment Services, PHAC Evaluation of Outreach Educational Sessions, Health Promoter Review, and other projects identified as priorities.
• Continued support for the Annual Service Plan.

Program Challenges and Risks

• Transition to Citi Plaza early in 2020 may limit the capacity of programs to engage in program planning and evaluation activities
• Leaves of absence (LOAs) and other staffing changes in 2019 have resulted in three new members to the PPE Team. In 2020, efforts will be made to redefine a vision for the PEF, and consider additional strategies to mitigate risks of future staffing changes (e.g. cross training among divisions, peer mentoring).
• Significant commitments to projects (e.g. Community partner projects, such as the Photo Study) in 2019 and 2020 have limited the teams' ability to focus on supporting divisional planning and evaluation needs and capacity building across the organization.
• It is unclear how Public Health Modernization in 2020 into a new public health entity will impact the planning and evaluation interventions.

Staffing Complement

	2019 Total FTEs	2020 Total FTEs	Δ
Director	0.00	0.10	0.10
Program Manager	0.70	0.70	0.00
Program Evaluator	5.10	5.10	0.00
Program Assistant	0.20	0.20	0.00
Total Program FTE	***6.00***	***6.10***	***0.10***

Expenditures

	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 451,038	$ 476,130	25,092	6%
Benefits		$ 117,254	$ 120,658	3,404	3%
Travel		$ 733	$ 1,808	1,075	147%
Program Supplies		$ 29,824	$ 26,509	(3,315)	-11%
Staff Development		$ 67	$ 2,226	2,159	
Professional Services		$ -	$ -	-	
Other Program Costs		$ 507	$ 556	49	10%
Total Expenditures	***$ -***	***$ 599,423***	***$ 627,886***	***$ 28,463***	

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 528,406	$ 556,869	28,463	5%
MOHLTC (100%)		$ -		-	
MCCSS		$ -		-	
PHAC		$ -		-	
PHO		$ 71,017	$ 71,017	-	0%
User Fees		$ -		-	
Other		$ -		-	
Total Revenues	***$ -***	***$ 599,423***	***$ 627,886***	***$ 28,463***	

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Quality and Transparency					403
Standard	Effective Public Health Practice		**Director Name**	Laura Di Cesare	
Lead Team	Program Planning and Evaluation		**Manager Name**	Jordan Banninga	
Supporting Team(s)	Chief Nursing Officer				
Budget	$ 185,426		**FTE**	1.56	

Summary of Program

The Quality and Transparency Program facilitates compliance with the Ontario Public Health Standard requirements to ensure a culture of quality and continuous organizational self-improvement that underpins programs services, and public health practice and demonstrates transparency and accountability to clients, the public, and other stakeholders.

Interventions of the Quality and Transparency Program include:
- Continuous Quality Improvement (CQI) Methods and Supports
- Client Experience Measurement
- Program Procedures, Practice Policies, and Medical Directives Administration
- External Peer Review / Accreditation
- Professional Practice Onboarding Support
- Competency-Based Performance Evaluation for Nurses
- Fidelity to the Nurse-Family Partnership core model elements
- Support and promote professional certification

Program Mandate & Relevant Legislation

Effective Public Health Practice Standard
Delivery of Public Health Programs and Services Domain
Public Health Practice Domain
Alignment with the MLHU Strategic Plan and priorities in the Program Excellence and Client and Community Confidence quadrants

Program Management

The Program Planning and Evaluation, Privacy, Risk and Governance, Office of the Medical Officer of Health, and the Office of the Chief Nursing Officer are responsible for the delivery of the Quality and Transparency Program with each team responsible for different program components.

Key Partners and Stakeholders

Public Health Ontario

Organizational Needs and Priorities

The Ontario Public Health Standards requires that organizations ensure a culture of quality and continuous organizational self-improvement. This includes:

•The identification and use of tools, structures, processes and priorities to measure and improve the quality of programs and services, such as a quality committee, and or the development and monitoring of a quality improvement plan.
•Measurement of client, community, community partner and stakeholder experience to inform transparency and accountability.
•Routine review of outcome data that includes variance from performance expectations and implementation of remediation plan.

Target and Priority Populations

N/A

Intended Program Outcomes	
Long-Term	• Public health practice is transparent, responsive to current and emerging evidence, and emphasizes continuous quality improvement • Ongoing program improvements enhance client and community partner experience and address issues identified through various means • The public has confidence in the quality and transparency of MLHU programming
Intermediate	• Public health program and services are modified to address issues related to program effectiveness
Short-Term	• Program activities and processes are routinely monitored and reviewed using quality improvement tools, structures and processes to improve their overall quality • Program data is routinely reviewed to understand performance, variance, implementation fidelity and potential areas for improvement • Client, community and community partner experience is routinely measured to inform transparency and accountability • Mandatory performance results are posted publicly

Program Interventions		
1	Continuous Quality Improvement (CQI)	CQI focuses on the ongoing improvement of activities, processes and tasks associated with the delivery of programs and interventions. The focus of the CQI intervention in 2020 will be to identify specific methods and tools staff can use for CQI processes. These methods and tools will be used to identify problems, remove waste, reduce variation, and improve performance. To ensure interventions are prepared for future CQI efforts, the Program Planning and Evaluation Program will work with staff to establish key indicators and routine monitoring. The CNO and Community Health Nursing Specialist focus in particular on supporting CQI in nursing practice, and look for opportunities to support practice quality within other public health disciplines.
2	Client Experience Measurement	A validated client experience survey was implemented in 2019 for use with service-seeking clients. This survey will help programs measure how people experience their interactions with MLHU staff. Results will be reported on in early 2020. This tool will be used by MLHU to monitor trends and inform quality in service. Due to the Public Health Modernization announcement in 2019, planning for an assessment of how those clients MLHU is legislated to work with experience their interactions with MLHU staff was put on hold. In addition, planning for an assessment of how non-English and non-French speaking clients experience their interactions with MLHU staff was also put on hold. Discussions regarding these areas of client experience measurement will occur in 2020.
3	Program Procedures, Practice Policies, and Medical Directives Administration	Program procedures, practice policies, and medical directives systematize and documents processes to improve performance, promote excellence in practice, ensure compliance with relevant standards, and reduce wastes and duplication. The Quality and Transparency program provide the framework and systems for the development of program procedures and consultation on the development of program procedures and practice policies.
4	External Peer Review / Accreditation	External peer review is an ongoing, voluntary process used to assess and improve the quality of programs and services by providing a process for quality assurance in order to identify areas for improvements in efficiency and performance related to leadership, management and delivery of services. The Middlesex-London Health Unit opted to not pursue external peer review in 2019 but will continue to monitor and assess whether or not it is a direction that that should be considered in 2020 with considerations given to Public Health Modernization.

5	Professional Practice Onboarding Support	The Community Health Nursing Specialist provides additional onboarding support to all new nurses to promote excellence and quality in nursing practice.
6	Competency-Based Performance Evaluation for Nurses	MLHU uses a comprehensive competency-based performance evaluation tool for nurses. Competency domains align with the PHN Discipline-Specific Core Competencies, with expected proficiency levels identified and competency indicators highlighted to strengthen the performance evaluation process (both self-evaluation and evaluation by manager). Competency domains which are areas for growth are identified, with learning goals and activities collaboratively planned and monitored by managers. The Officer of the Chief Nursing Officer provides consultative support to managers and staff regarding this competency-based performance evaluation tool.
7	Fidelity to the Nurse-Family Partnership core model elements	A primary responsibility of the Community Health Nursing Specialist: Ontario NFP Nursing Practice Lead will be to develop and implement a province-wide quality assurance program and processes for the five health units currently implementing NFP (London, York, Toronto, Niagara, Hamilton). Fidelity to NFP's core model elements is critical to realizing intended outcomes with this program. The overall focus of this advanced practice is to ensure excellence in nursing practice within the NFP program.
8	Support and promote professional certification	Certification has been found to have positive outcomes for nurses, clients, and organizations, with increased job satisfaction, sense of empowerment, level of competence, and better collaboration with other healthcare professionals. Additionally, certification can reduce turnover rates that negatively impact client safety and quality of care. The Office of the Chief Nursing Officer provides support for those interested in pursuing certifications relevant to public health practice (i.e., infection control, community health nursing, lactation consultant). Support includes study group facilitation, linking to learning resources, consultation, promotion of learning opportunities internally and externally, and when possible, reimbursement of some of the costs of certification.

Performance / Service Level Indicators

Indicator	2018	2019	2020 (target)
Determine CQI methods and tools (2020)	N/A	N/A	Type of CQI methods and tools identified
Incorporate CQI methods and tools into Planning and Evaluation Framework (2020)	N/A	N/A	CQI documentation incorporated into the PEF
Number of service-seeking interventions where CES implemented (2019)	N/A	10	N/A
Organizational relational practices score (2019/20)	N/A	(target 85%)	N/A
# of Nursing / Professional Practice consultations provided	64	176	190
Organizational participatory practices score (2019/20)	N/A	(target 85%)	N/A

Highlights / Initiatives Planned for 2020

- Reporting on the results of the client experience survey with service-seeking clients in 2019
- Development of continuous quality improvement framework to complement existing processes
- Enhancement of required policies to guide program work

Program Challenges and Risks

- Extensive technological and process changes throughout 2020
- Determine the prerequisites to implement CQI, such as the further refinement of program indicators and establishment of routine monitoring of key indicators
- Onboarding of new Community Health Nursing Specialist

Staffing Complement

	2019 Total FTEs	2020 Total FTEs	Δ
Community Health Nursing Specialist	0.90	0.90	0.00
Program Assistant	0.10	0.10	0.00
Program Evaluator	0.40	0.40	0.00
Program Manager	0.10	0.10	0.00
Chief Nursing Officer	0.00	0.06	0.06
Total Program FTE	***1.50***	***1.56***	***0.06***

Expenditures

	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 122,830	$ 132,687	9,857	8%
Benefits		$ 30,552	$ 32,263	1,712	6%
Expected Vacancies		$ -		-	
Travel		$ 1,093	$ 1,155	62	6%
Program Supplies		$ 2,847	$ 2,591	(256)	-9%
Board Expenses		$ -		-	
Staff Development		$ 958	$ 1,010	52	5%
Occupancy		$ -		-	
Professional Services		$ 12,365	$ 13,107	742	6%
Furniture & Equipment		$ -		-	
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 2,468	$ 2,614	146	6%
Total Expenditures	***$ -***	***$ 173,113***	***$ 185,426***	***$ 12,313***	

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 104,544	$ 163,911	59,367	57%
MOHLTC (100%)		$ 47,937		(47,937)	-100%
MCCSS		$ -		-	
PHAC		$ -		-	
PHO		$ 5,918	$ 5,918	-	0%
User Fees		$ -		-	
Other		$ 14,714	$ 15,597	883	6%
Total Revenues	***$ -***	***$ 173,113***	***$ 185,426***	***$ 12,313***	

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Research and Knowledge Exchange						404
Standard	Effective Public Health Practice		**Director Name**	Laura Di Cesare		
Lead Team	Program Planning and Evaluation		**Manager Name**	Jordan Banninga		
Supporting Team(s)	Chief Nursing Officer		Population Health Assessment and Surveillance			
Budget	$ 354,061		**FTE**	3.36		

Summary of Program

Exploring an issue or investigating a question is accomplished through research - the organized and purposeful collection, analysis, and interpretation of data. Research may involve the primary collection of new data or the analysis or synthesis of existing data and findings.

Knowledge exchange is collaborative problem-solving among public health practitioners, researchers, and decision-makers. It results in mutual learning through the process of planning, producing, disseminating, and applying existing or new research in decision-making.

Interventions include:
- Reference and Information Services
- Research Integrity and Copyright
- Education, Training and Capacity Building
- Collection Development and Maintenance
- Resource Lending System
- Research Advisory Consultations

MLHU operates its own library services and also hosts one of the Shared Library Services Partnership (SLSP) HUB libraries. The core objectives of the SLSP HUB are to provide Ontario public health units without an in-house library with access to up-to-date information and scientific resources, and to preserve the existing library infrastructure across the province. Having an existing library is a pre-requisite for being an SLSP HUB. NOTE: The 405 SLSP Program Description for 2019 was merged into the 404 RKE for 2020.

Program Mandate & Relevant Legislation

Effective Public Health Practice Standard
Public Health Practice Domain
Copyright Act (R.S.C., 1985, c. C-42)

Program Management

The RKE program is managed by the Program Planning and Evaluation Team, the Office of the Chief Nursing Officer, and Population Health Assessment and Surveillance Team.

Key Partners and Stakeholders

The RKE program, through the Program Planning and Evaluation Team, the Office of the Chief Nursing Officer, and Population Health Assessment and Surveillance Team, works with all teams within MLHU to support work and expand capacity in research and knowledge exchange.

SLSP Hub Libraries (KFL&A, Simcoe Muskoka District Health Unit, Thunder Bay District Health Unit), Ontario Public Health Libraries Association, Western University, Public Health Ontario, Ontario Public Health Evaluators Network, Chief Nursing Officers Network, professional practice leads in public health units across the province, Nurse-Family Partnership® in Canada and USA, health units implementing NFP. SLSP client health units include: Chatham-Kent Public Health, Haldimand-Norfolk Public Health, Lambton Public Health, Niagara Region Public Health Department, and Windsor-Essex County Health Unit.

Organizational Needs and Priorities

The Research and Knowledge Exchange and Shared Library Services Partnership facilitate access to and enable the use of existing information and findings by the public health programs and services for 5 regional public health units.

The Access to Library Resources and Services for Public Health Units in Ontario: Environmental Scan Report (2011) by Public Health Ontario found that health units without access to library services may have a more difficult time providing staff with the resources and support to perform proper research as compared to health units with libraries.

The Evaluation of the Shared Library Services Partnership (SLSP) (2016) found that, among client respondents, access to library services:
- improved the quality of their work (83.9%)
- promoted the use of up-to-date information and scientific resources at their health unit (83.6%)
- increased their health unit's capacity for evidence-informed decision making (83.5%)
- facilitated information sharing among staff in their health unit (68.2%)

A local assessment was completed which determined that the majority of people significantly rely on their healthcare provider for information related to health and wellness. As a result, a robust healthcare provider outreach program has been developed to ensure an agency-wide integrated and coordinated approach to this work.

The RKE program supports the research activities of the MLHU. In 2019, 11 projects were reviewed, and 10 consultations were provided through the Research Advisory Consultation process.

Target and Priority Populations

N/A

Intended Program Outcomes	
Long-Term	• Research evidence-information programming will result in population health changes
Intermediate	• Research information and knowledge will become integrated into health unit program design and delivery • Enhance the resources and capacity of existing public health unit libraries • Promote knowledge exchange within health units in Ontario
Short-Term	• Delivery of library services to MLHU and client health units will result in uptake of research information and knowledge. • Delivered literature searches, articles, and books to MLHU and client health units will result in immediate transfer of research information and knowledge • Provision of training on library resources to MLHU and client health units will result in public health staff being able to locate and access research information and knowledge for themselves • Strengthen the relationships between the HUB Libraries and client health units • MLHU will undertake and participate in high-quality and missioned-centered research that is compliant with methodological, ethical and privacy standards.

Program Interventions		
1	Reference and Information Services	Provide MLHU and client health units with literature searching, article retrieval, book loans, quick reference questions, and critical appraisal to facilitate evidence-informed decision-making.
2	Research Integrity and Copyright	MLHU Librarian acts as the Copyright Officer for MLHU. MLHU Librarian and SLSP Librarian conduct copyright consultations for public health staff to ensure that materials are publicly used in compliance with copyright law. In addition, both librarians provide citing/referencing consultation and review.
3	Education, Training and Capacity Building	Design, delivery and evaluation of training and capacity building activities to provide MLHU and client health units' staff with opportunities to obtain, improve and retain skills, knowledge and experience required to perform the duties associated with Research and Knowledge Exchange. The Community Health Nursing Specialist works with the Nursing Practice Council to provide learning opportunities 1-2x/year to support knowledge exchange internally. Resources to support enhancement of nursing practice are disseminated regularly to nursing staff across the organization (e.g., best practice guidelines). Some educational opportunities are extended to public health staff at health units in the southwest region and to community partners. The Community Health Nursing Specialist: Ontario NFP Nursing Practice Lead is responsible for coordinating, revising and offering all Nurse-Family Partnership education to prepare nurses and nurse managers to implement the NFP program, and to support ongoing learning.
4	Collection Development and Maintenance	Manage the MLHU/SLSP Library collection through book selection and acquisition, cataloguing books, book deselection, journal selection and subscription, and cataloguing journals.
5	Resource Lending System	The Resource Lending System (RLS) is a lending library of educational and promotional resources. The inventory is managed electronically with scheduling, sign-out and check-in capability for use by staff. Resources include, but are not limited to, videos/DVDs, posters, displays, teaching kits, etc.
6	Research Advisory Consultations	Research and evaluation is undertaken by the MLHU and directed towards the determinants of health, public health planning, program evaluation, policy analysis and service delivery. It is intended to be practical, often involve community, and be defined by actual and emerging public health issues. Research Advisory Consultations (RACs) are provided to staff to ensure the research aligns with MLHU’s mission, that sound evidence is used in public health practice, that methodological, ethical and privacy standards are met as well as other organizational goals.

Performance / Service Level Indicators			
Indicator	2018	2019	2020 (target)
% of MLHU library resources delivered within 5 business days, 12 days for books	98% (905/927)	94% (991/1050)	Maintain
% of MLHU research questions answered in 2-4 weeks, or by specified date	86% (31/36)	92% (33/36)	Maintain
# of MLHU literature searches conducted in answering research questions	541	332	Maintain
% of SLSP library resources delivered within 5 business days, 12 days for books	95% (1927 / 2037)	97% (1392/1437)	Maintain
% of SLSP research questions answered in 2-4 weeks, or by specified date	59% (16/27)	86% (31/36)	Maintain
# of SLSP literature searches conducted in answering research questions	590	380	Maintain
# of Research Advisory Consultations provided	N/A	10 (new 2019)	Maintain
# of research and evaluation projects reviewed through the Research Advisory Consultations process	N/A	11 (new 2019)	Maintain

Highlights / Initiatives Planned for 2020

- Staff capacity building associated with Research and Knowledge Exchange.
- Continued consultation support for research and evaluation projects.
- Establishing library at Citi Plaza location in January 2020.
- Establishing the Resource Lending Library at Citi Plaza location in March 2020.

Program Challenges and Risks

- Move planning
- Annual increases in the costs of journals and database subscriptions

Staffing complement

	2019 Total FTEs	2020 Total FTEs	Δ
Community Health Nursing Specialist	0.90	0.90	0.00
Epidemiologist	0.20	0.20	0.00
Librarian	0.80	1.80	1.00
Program Assistant	0.30	0.30	0.00
Program Manager	0.10	0.10	0.00
Associate Medical Officer of Health	0.00	0.05	0.05
Chief Nursing Officer	0.00	0.01	0.01
Total Program FTE	***2.30***	***3.36***	***1.06***

Expenditures

	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 177,555	$ 265,136	87,581	49%
Benefits		$ 42,867	$ 61,485	18,617	43%
Expected Vacancies		$ -		-	
Travel		$ 1,252	$ 1,419	167	13%
Program Supplies		$ 5,910	$ 9,749	3,840	65%
Board Expenses		$ -		-	
Staff Development		$ 1,107	$ 1,149	41	4%
Occupancy		$ -		-	
Professional Services		$ 12,365	$ 12,489	124	1%
Furniture & Equipment		$ -		-	
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 2,524	$ 2,635	111	4%
Total Expenditures	***$ -***	***$ 243,581***	***$ 354,061***	***$ 110,480***	

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 162,889	$ 312,710	149,821	92%
MOHLTC (100%)		$ 52,650		(52,650)	-100%
MCCSS		$ -		-	
PHAC		$ -		-	
PHO		$ 13,020	$ 24,856	11,836	91%
User Fees		$ -		-	
Other		$ 15,022	$ 16,495	1,473	10%
Total Revenues	***$ -***	***$ 243,581***	***$ 354,061***	***$ 110,480***	

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Health Equity and Indigenous Public Health Practice						410
Standard	Health Equity		**Director Name**	Heather Lokko		
Lead Team	Chief Nursing Officer		**Manager Name**	Joe Antone		
Supporting Team(s)	Population Health Assessment and Surveillance		Program Planning and Evaluation		Human Resources	
Budget	$ 419,791		**FTE**	3.40		

Summary of Program

In 2018, a new Health Equity Standard was provided by the Ministry of Health and Long-Term Care. Additionally, health equity featured much more prominently throughout the revised Ontario Public Health Standards (2018). Notably, the Health Equity Standard includes direction regarding the need to build relationships with Indigenous peoples, communities, and organizations. Relationships between boards of health and Indigenous communities and organizations need to come from a place of trust, mutual respect, understanding, and reciprocity; one important first step for boards of health is to ensure relationship-building is done in a culturally safe way.

Many populations experience health inequities, such as Indigenous peoples, those living in poverty, newcomers, and racialized populations. Addressing health inequities in London and Middlesex County is critical to improving the health of our population. Health equity features prominently on MLHU's strategic plan, with a number of internally-focused initiatives. The goal of these initiatives is to enhance individual and organizational capacity to understand and address health inequities in London and Middlesex County.

Interventions of the Health Equity Program include:
- Implementation of reconciliation plan
- Health equity staff capacity building
- Assessment, development and monitoring of health equity indicators for MLHU and programs
- Integrating a health equity lens into the MLHU planning and evaluation framework
- Newcomer service coordination
- Participating in prenatal education with members of a priority population
- Engagement in policy development to address health inequities

Program Mandate & Relevant Legislation

Ontario Public Health Standards:
- Health Equity Standard
- Health Equity Guideline
- Public Health Practice Domain
- Delivery of Programs and Services Domain

Relationship with Indigenous Communities Guideline
MLHU Strategic Plan
Health Equity Indicators for Ontario Local Public Health Agencies
Health Promotion and Protection Act 1990 – section 50 agreements

Program Management

As Health Equity Standard is a Foundational Standard, all program teams across the health unit are responsible for understanding and responding to public health's responsibility to reduce health inequities. Activities which are focused on reducing health inequities with priority populations are reported within each program.

The Health Equity and Reconciliation Team (HEART) focuses on enhancing individual and organizational capacities to understand and address health inequities. The team is responsible for moving the agency's health equity-related strategic initiatives forward, and reports to the Chief Nursing Officer. HEART provides leadership to the Health Equity Advisory Taskforce (HEAT), which has representation from across the health unit. Members of HEAT support agency-wide strategic initiatives, act as health equity champions in their divisions, and support communication. HEAT has 3 working groups that support the delivery of specific health equity interventions, including the Health Equity Indicator workgroup, Staff Capacity Building workgroup, and the Indigenous Reconciliation workgroup. Additionally, the Newcomer services coordinator chairs the Newcomer Services Coordination Advisory Committee.

HEART members are available to programs across the health unit for consultation and support regarding health equity. HEART works collaboratively with other teams focused on Foundational Standard implementation.

Key Partners and Stakeholders

Core: members of priority populations (Newcomers, Oneida Nation of the Thames, Chippewas of the Thames First Nation, Munsee Delaware Nation, MLHU clients)
Involved: community partners/service providers - Southwest Ontario Aboriginal Health Access Centre, N'Amerind Friendship Centre, At'lohsa Healing Centre, Settlement Agencies (LCCLC, LUSO, SLNRC) Across Languages
Interested: London-Middlesex Local Immigration Partnership: Health and Well-being Sub-council, Networking for an Inclusive Community, other members of Newcomer Health Settlement Committee (Madame Vanier Children's Services, London Health Sciences Centre, London Intercommunity Health Centre, the Local Health Integration Network, Canadian Mental Health Association, Muslim Resource Centre, Thames Valley Children's Centre), Centre for Research on Health Equity and Social Inclusion (Western University & a number of community partners).

Community Needs and Priorities

The proportion of Middlesex-London (M-L) residents living with low income was 10.9% higher in 2016 at 18.8% compared to 2015 at 17.2%. The low income rate was higher among those under 18 years of age. While the number of households in M-L has increased by 11.5% between 2006 and 2016, the median total income of households has changed -1.2% over the same period. The overall unemployment rate is 7.4%, lower than previous years. The rate is 17.5% for those aged 15-24 years.
In 2015, 2,670 unique individuals accessed emergency shelters increased by 21% to 41 nights. London has a Homeless Prevention System and a number of community assets to provide emergency and longer-term housing for those in need. In a 2017 survey of homeless individuals in London: 58% experienced homelessness for 6 months or more in the past year; 50% reported homelessness was caused by an experience of abuse or trauma; and 33% reported housing loss due to substance misuse. Among individuals with unstable housing and those who inject drugs, diseases such as HIV, hepatitis C, invasive group A streptococcal infections, and infective endocarditis, as well as opioid misuse and overdoses are primary areas of concern.
Teen pregnancy rates in M-L are higher compared to Ontario. With regards to risk factors for healthy child development, M-L has a significantly higher percentage of infants whose mother is a single parent, whose family is in need of newcomer support, and whose family has concerns about money.
Education- 10% of Londoners age 25-64 do not have a high school diploma or better.
Indigenous adults aged 25-64 years in London had a lower rate of high school completion (54%) compared to the general Ontario population (90%).
Indigenous health – Indigenous people in London experience far higher rates of poverty than the average Londoner, with 90% of Indigenous adults and 92% of Indigenous children living below the Low-Income Cut-Off. Indigenous adults experience higher incidences of chronic diseases compared to the average Londoner, such as diabetes (15% compared to 6%), asthma (20% compared to 9%), and Chronic Obstructive Pulmonary Disease (COPD) (7% compared to 3%).
London welcomes a significant number (up to 400 recently) of refugees each year. In the last few years, London has been a major settlement site for Karen, Bhutanese, Syrian, Yazidi, and Rohinga refugees.

Target and Priority Populations

Target Populations

All MLHU Staff

The agency-wide health equity initiatives primarily target MLHU employees. Employees have various levels of understanding and expertise in addressing health inequities and include public health nurses, public health inspectors, dietitians, health promoters, program evaluators, epidemiologists, program assistants, clinical team assistants, dental hygienists, dental assistants, administration, tobacco enforcement officers, and family home visitors. A KAP (knowledge, attitudes, practices) survey was completed to understand learning needs and to guide health equity program development.

Sub-target populations:

New employees and students

Each have been identified as sub-targeted populations due to potential need for increased capacity building regarding introduction to basic concepts and public health practices related to building health equity into programs and services than long term employees.

MLHU as an organization

This is also a focus for the health equity program, since process and system changes are also needed to effectively address health inequities.

Community Partners/Service Providers

Provide services to Newcomers and Indigenous people.

Priority Populations

Newcomers

Within the health equity program, there is a focus on newcomers as they represent 22% of London's population. Of these newcomers, most are immigrants but many arrived as refugees who are at particular risk for experiencing a myriad of challenges, some of which may be: limited communication due to lack of English language skills or illiteracy; low income; difficulty finding employment; minimal education; inability to work within their field of education, due to certification requirements in Canada; lack of social support; lack of affordable housing; psychological challenges due to experiencing trauma; culture shock; and difficulty accessing health services.

Indigenous people

Indigenous people are a focus for the health equity program as they also experience significant and long-standing health disparities that are driven by the social determinants of health, including determinants that are specific to Indigenous peoples, including a lack of self-determination, a lack of cultural continuity, and colonialism. These are in addition to the impact of more traditional determinants such as income, educational participation, and food security. Data from the Our Health Counts research study of urban Indigenous people confirms what we have known for a long time, that urban Indigenous people in London have among the worst health outcomes of any specific population of people in virtually any measure of health, be it morbidity, mortality, rates of chronic disease, and others.

All other MLHU staff and clients experiencing socially produced barriers to achieving full health potential are considered to be priority populations.

Intended Program Outcomes	
Long-Term / Population Health	Public health practice results in decreased health inequities such that everyone has equal opportunities for optimal health and can attain their full health potential without disadvantage due to social position or other socially determined circumstances. • Improved health outcomes among priority populations • MLHU work environment is safe for everyone
Intermediate	• MLHU programs and services have been enhanced based on identification and engagement of priority populations • Increased participation of priority populations in MLHU programs • MLHU's programs have been enhanced by implementing and measuring processes which address health equity • All MLHU policies and procedures will support equity-oriented decision making •Community partners, including Indigenous service providers, participate more effectively in multi-sectoral collaboration •Enhanced relationships with indigenous communities and partners
Short-Term	• Language barriers are reduced when accessing MLHU programs and services, • Increased confidence of staff in application of knowledge related to Indigenous health • Increased confidence of staff in application of knowledge related to Public Health Sciences • Increased familiarization of program staff with the Planning and Evaluation Framework through consultation with HEART members • Increased capacity to meet health equity goals through hiring of a HEART Manager

Program Interventions		
1	Implementation of Reconciliation Plan	The “Taking Action for Reconciliation: An Organizational Plan for MLHU” was created to demonstrate commitment to the Truth and Reconciliation Commission of Canada’s Calls to Action; to provide a supportive environment for reflection, knowledge and skill building; to serve to disrupt ongoing colonial practices that exist; to enhance organizational capacity to address racially-based health inequities; and to enhance ability to build relationships and meaningful engagement with Indigenous communities and organizations. The Calls to Action, wise practices, best practices identified by Indigenous scholars within peer-reviewed and grey literature, and contributions/direction local First Nations, urban Indigenous-led organizations and Indigenous individuals informed the plan. Recommendations are grouped by the following themes: awareness and education, supportive environments, relationships, research, workforce development, governance, and equitable access & service delivery. Prioritization and implementation of the Plan's recommendations will be the focus in 2020.
2	Health Equity Staff Capacity Building	In 2020, efforts will focus on the following domains: Indigenous Public Health Practice, Public Health Sciences, and Diversity and Inclusion. Learning opportunities will be offered throughout the year, with some learning activities as mandatory and others as optional based on program need, prioritization and/or individual interest. Capacity opportunities will be delivered through online modules, workshops, team discussions, resource development and sharing, internal policy development and consultations. Collaboration with program managers, the Program Planning and Evaluation Team, the Public Health Assessment and Surveillance Team, and Communications occurs as needed and appropriate. The team will participate in local, regional and national networks when relevant to the work plan, when capacity exists, and/or when responding to emerging opportunities (e.g. SW SDOH PHN network, NCCDH, Health Equity Collaborative Network). Interventions will be provided by HEART, HEAT, and staff with advanced knowledge of topics.

3	Assessment, Development and Monitoring of Health Equity Indicators for MLHU programs	MLHU's compliance with the Health Equity Indicators for Ontario Local Public Health Agencies (2016) is being assessed, improved and tracked. So far, 8 indicators have been assessed with recommendations developed. This project has been delayed due to reprioritization in 2019 with Ministry announcements. Activities include: ensure indicators are SMART; assess baseline status; set targets and benchmarks; develop recommendations for effective processes to increase compliance; engage key stakeholders; provide orientation to teams of approved processes and related monitoring systems and ongoing consultation as needed; track/collate data to measure progress towards compliance with indicators; report progress annually. Interventions are provided by HEAT, key stakeholders and management teams provide consultation, SLT and BOH provide direction/approval; program teams implement processes and provide data for tracking progress.Progress towards compliance with indicators will be assessed and tracked annually and support will be provided to teams/programs as requested, i.e. at team consultations or to individuals.
4	Diversity and Inclusion Assessment	In 2019, a diversity and inclusion committee was formed, an RFP was posted, a consultant was selected and contracted, and an initial workplan was drafted. The workplan included several components: assessment of diversity within the workplace, assessment of employee experience of inclusion in the workplace, assessment of organizational policies and procedures, and development of recommendations for enhancing inclusion. This initiative was deferred following Ministry announcements in 2019, however, is expected to be reinitiated in Q4 of 2020.
5	Newcomer Services Coordination	Newcomer Services coordination focuses on individuals and populations within Middlesex-London who have arrived in Canada as immigrants, refugees or refugee claimants as well as on services provided by community partners (e.g. 3 local settlement agencies) working with newcomers. The work of the coordinator has both an internal and external focus. Associated activities will include: enhancing effectiveness of communication between internal programs which serve these populations, i.e. share information, planning, activities between division reps at committee meetings then share highlights with entire HU; enhancing co-ordination of MLHU programs, services, policies, and initiatives, i.e. attend program meetings to introduce/participate in creation of resources to support coordination; enhancing awareness of MLHU programs within external community service providers, i.e. provide information upon request and seek out opportunities to share; enhance awareness within MLHU of programs and services provided by external service providers, i.e. create a resource listing programs and services provided. Interventions will be provided by Newcomer Services Coordinator and the Newcomer Services Coordination Advisory Committee. Information about MLHU programs and services will be offered in presentation format upon request and in a resource list which will be available on the HU website.

6	Integrating a Health Equity Lens into MLHU Planning and Evaluation Framework	A health equity lens has previously been embedded into the MLHU Planning and Evaluation Framework and associated tools by HEART and PPET. Associated activities will include: supporting program teams as they use framework and tools to identify effective local strategies to reduce health inequities; supporting inclusion of a health equity perspective in organization level planning, e.g. graphic standards, electronic client record, physical environment of clinic spaces; informing BOH of organizational impacts of Health Equity Standard; continually updating framework and tools based on feedback and evidence to assure health equity perspective is reflected; supporting the development of internal partnerships to ensure inequities in MLHU service delivery are minimized. Interventions will be provided by the Health Equity and Reconciliation Team and the Program Planning and Evaluation Team. Consultation will be provided as requested throughout planning, implementation and evaluation of programs and services and during committee meetings. BOH will be updated annually through board reports.
7	Participating in Prenatal Education with Members of Priority Population	One of the SDOH PHN's on HEART works supports the work of the Reproductive Health Team in their Smart Start for Babies program, an intervention that focuses on priority populations. The HEART PHN facilitates sessions and supports the integration of health equity considerations into program planning.
8	Engagement in policy development to address health inequities	Associated Activities will include: developing policies; seeking internal and external sources of evidence and expertise to support development; introducing staff to policies and associated procedures. Interventions will be provided by HEART, HEAT – Health Equity Staff Capacity Building Workgroup and Indigenous Reconciliation Workgroup. Policies and procedures will be introduced to staff through LMS modules and Workshops.

Performance / Service Level Indicators

Indicator	2018	2019	2020 (target)
% of teams consulting with HEART regarding consideration of health equity in program planning, implementation and evaluation.	0	17/29= 59%	65%
Self-reported employee capacity to address public health needs of Indigenous clients and communities in a culturally safe manner.	N/A	N/A	Complete assessment of baseline
Perceived collaboration between health unit and Indigenous organizations related to reconciliation.	N/A	N/A	Complete assessment of baseline Increase
Self-reported employee knowledge, attitudes, and practices related to health equity.	N/A	N/A	Increase (since last KAP survey)
Level of self-reported employee diversity.	N/A	N/A	Complete assessment of baseline
Self-reported employee experience of inclusion in the workplace.	N/A	N/A	Complete assessment of baseline

Highlights / Initiatives Planned for 2020

HEART is working collaboratively with PHAST to determine what sociodemographic data can be collected through the ECR Health unit wide, and this will be a significant improvement in data collection and reporting. An interpretation and translation policy and procedure will be finalized and implemented early in 2020. After a pause on staff capacity building in 2019 due to Ministry announcements, capacity building efforts will increase again. Prioritization and implementation of the organization's reconciliation plan will be a significant focus. The organizational diversity and inclusion assessment will be reinitiated at the end of 2020.

Program Challenges and Risks

Implementation of most of the health equity initiatives takes a significant period of time. Changing organizational and employee perspectives and processes requires careful consideration of change management approaches. The team does not have the capacity at this time to engage in external system-wide health equity work. The team has experienced significant staffing shortage due to illness and delay in recruitment; these shortages are expected to impact the team into 2020. Collaborating with other teams in the health unit can result in delays in workplan completion.

Staffing Complement			
	2019 Total FTEs	2020 Total FTEs	Δ
Chief Nursing Officer	0.20	0.10	-0.10
Program Assistant	0.30	0.30	0.00
Health Promoter	0.50	0.50	0.00
Program Manager	1.00	1.00	0.00
Public Health Nurse	2.00	1.50	-0.50
Total Program FTE	***4.00***	***3.40***	***-0.60***

Expenditures					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 342,996	$ 292,821	(50,175)	-15%
Benefits		$ 81,621	$ 68,704	(12,916)	-16%
Expected Vacancies		$ -		-	
Travel		$ 4,127	$ 3,508	(619)	-15%
Program Supplies		$ 1,448	$ 1,230	(217)	-15%
Board Expenses		$ -		-	
Staff Development		$ 3,810	$ 3,238	(571)	-15%
Occupancy		$ -		-	
Professional Services		$ 49,460	$ 42,041	(7,419)	-15%
Furniture & Equipment		$ -		-	
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 9,703	$ 8,248	(1,456)	-15%
Total Expenditures	***$ -***	***$ 493,165***	***$ 419,791***	***-$ 73,373***	

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 242,562	$ 369,762	127,201	52%
MOHLTC (100%)		$ 191,746		(191,746)	-100%
MCCSS		$ -		-	
PHAC		$ -		-	
PHO		$ -		-	
User Fees		$ -		-	
Other		$ 58,857	$ 50,029	(8,828)	-15%
Total Revenues	***$ -***	***$ 493,165***	***$ 419,791***	***-$ 73,373***	

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Population Health Assessment and Surveillance					415
Standard	Population Health Assessment		**Director Name**	Alex Summers	
Lead Team	Population Health Assessment and Surveillance		**Manager Name**	Alex Summers	
Supporting Team(s)					
Budget	$ 611,662		**FTE**	5.10	

Summary of Program

The Population Health Assessment and Surveillance Program aims to monitor, assess, and report on the status of the health of residents of Middlesex-London. This includes demographic information, the prevalence of health behaviours, the occurrence of diseases and other health events, and factors that contribute to health and wellness. This information is used to better understand local health priorities and to inform program planning that addresses the identified needs.

Specific components include:

- Provide population health assessment and surveillance data and analysis to programs according to the Population Health Assessment and Surveillance Protocol to support planning and evaluation
- Update and sustain the Community Health Status Resource, a publicly-accessible and web-based source of information on the population and sub-population health status of residents in London and Middlesex County
- Provide team-specific surveillance data and analysis on an ongoing and/or as-needed basis, including data required for Accountability Agreement indicator reporting to the Ministry of Health
- Provide support for outbreaks and other emerging investigations
- Consult and develop tools to build infrastructure to collect and maintain local data
- Provide expertise in data stewardship though, for example, ensuring the adherence and maintenance of relevant data sharing agreements across the organization

Program Mandate & Relevant Legislation

Population Health Assessment Standard
Population Health Assessment and Surveillance Protocol
Immunization of School Pupils Act, R.S.O. 1990, c. I.1
Health Protection and Promotion Act, R.S.O. 1990, c. H.7
Infectious and Communicable Disease Prevention and Control Standard

Program Management

The Population Health Assessment and Surveillance (PHAS) Team is solely dedicated to fulfilling the requirements of this foundational standard. The Team works closely with all other programmatic areas to embed population health assessment and surveillance in the day-to-day work of the Health Unit.

The team reports through the Associate Medical Officer of Health to the Medical Officer of Health.

Key Partners and Stakeholders

Ontario Health (formerly Southwest Local Health Integration Network), community service providers who share data with MLHU (e.g., London Health Sciences Centre, St. Joseph's Health Care London, London District Catholic School Board, Thames Valley District School Board, Conseil Scolaire Catholique Providence, Conseil Scoliare Viamonde); other groups with expertise in analytical approaches relevant for public health (e.g., Association of Public Health Epidemiologist of Ontario, Western University); and agencies providing provincial leadership in surveillance and assessment (e.g., Public Health Ontario, Ministry of Health).

Organizational Needs and Priorities

The PHAS Team aims to achieve the following objectives in order to provide programmatic areas with key information and data:

1. Conduct, interpret and use surveillance to communicate information on risks to relevant audiences.
2. Assess current health status, health behaviours, demographics, preventive practices, risk and protective factors, and health care utilization relevant to public health.
3. Provide population health information, including social determinants of health and health inequities, to the Board of Health, programs, and external partners to help identify the needs of the local population and identify priority populations.
4. Provide population health, social determinants of health, health inequity information and other relevant sources of information to public, partners and health care providers.

Target and Priority Populations
The PHAS Team assists other programmatic areas to identify priority populations by fulfilling the objectives previously stated.

Intended Program Outcomes	
Long-Term	The PHAS Team monitors and assists in the development of long-term population health outcomes for the other programmatic areas in the Health Unit.
Intermediate	• The PHAS Team monitors and assists in the development of intermediate health outcomes for the other programmatic areas in the Health Unit. • The Team also strives to ensure that community partners and public are aware of local health needs.
Short-Term	The PHAS Team monitors and assists in the development of short-term health outcomes for the other programmatic areas in the Health Unit. The team also strives to achieve the following outcomes: 1. Monitor and detect important health issues and emerging priorities in the local population. 2. Ensure that data from external sources are analyzed and interpreted to provide critical health status information to internal and external partners. 3. Identify health inequities and priority populations.

Program Interventions		
1	Surveillance	The PHAS Program will provide ongoing surveillance information to programs and teams at MLHU. The PHAS Program will monitor relevant external and internal data sources to provide reliable and consistent data.
2	Population Health Assessment	The PHAS Program will regularly assess and describe the health of the Middlesex-London population, and present the relevant interpretations to internal and external partners. The program will update and maintain the Community Health Status Resource in addition to looking for additional venues to report on the health status of the community. Particular consideration will be given to the assessment of health equity in the region.
3	Technical Service Delivery and Consultation	The PHAS Program will support ongoing and ad hoc needs of the programs and teams at MLHU, including statistical and technical consultation. The PHAS Program will also routinely lead and support projects within the organization.
4	Training and Capacity Building	The PHAS Program will contribute to developing and supporting data and statistical literacy within MLHU to ensure that population health data is being incorporated in to organizational planning.
5	Data Management	The PHAS program will provide expertise in data stewardship though, for example, ensuring the adherence and maintenance of relevant data sharing agreements across the organization.

Performance / Service Level Indicators

Indicator	2018	2019	2020 (target)
Percentage of Accountability Agreement indicators where support from the PHAS program was requested and was delivered	100%	TBD	100%
Percentage of indicators in publicly-facing population health assessment tool that are up-to-date	NA	NA	100%
Percentage of consults requested of PHAS program staff which are completed	NA	NA	90%
Percentage of data sharing agreements in compliance	NA	NA	100%

Highlights / Initiatives Planned for 2020

The PHAS Program will be developing enhanced procedures, templates, and tools for the program.

The PHAS program will continue to update the Community Health Status Resource (CHSR).

The PHAS Program will continue to respond to evolving community needs, such as the use of electronic cigarettes in youth.

Program Challenges and Risks

The PHAS Program must respond at times to unexpected community health needs. For example, increases in HIV and invasive Group A streptococcus have in the past demanded extensive PHAS Program involvement.

Staffing Complement			
	2019 Total FTEs	2020 Total FTEs	Δ
Associate Medical Officer of Health	1.00	0.30	-0.70
Data Analyst	2.00	2.00	0.00
Epidemiologist	3.30	2.80	-0.50
Executive Assistant	0.50	0.00	-0.50
Total Program FTE	***6.80***	***5.10***	***-1.70***

Expenditures					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 693,475	$ 486,412	(207,063)	-30%
Benefits		$ 161,753	$ 116,210	(45,543)	-28%
Expected Vacancies		$ -		-	
Travel		$ 2,914	$ 2,880	(34)	-1%
Program Supplies		$ 2,720	$ 2,688	(32)	-1%
Board Expenses		$ -		-	
Staff Development		$ 4,857	$ 3,280	(1,577)	-32%
Occupancy		$ -		-	
Professional Services		$ -		-	
Furniture & Equipment		$ -		-	
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 194	$ 192	(2)	-1%
Total Expenditures	***$ -***	***$ 865,914***	***$ 611,662***	***-$ 254,252***	

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 707,744	$ 601,862	(105,883)	-15%
MOHLTC (100%)		$ 148,477		(148,477)	-100%
MCCSS		$ -		-	
PHAC		$ -		-	
PHO		$ -		-	
User Fees		$ -		-	
Other		$ 9,692	$ 9,800	108	1%
Total Revenues	***$ -***	***$ 865,914***	***$ 611,662***	***-$ 254,252***	

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Healthy Eating Behaviours					420
Standard	Chronic Disease Prevention and Well-Being		**Director Name**	Maureen Rowlands	
Lead Team	Chronic Disease Prevention and Tobacco Control		**Manager Name**	Linda Stobo	
Supporting Team(s)					
Budget	$ 389,938		**FTE**	3.57	

Summary of Program

The Healthy Eating Behaviour (HEB) program decreases the morbidity and mortality from preventable chronic diseases through the adoption of healthy eating behaviours and increased access to nutritious, culturally appropriate foods. The HEB program also supports efforts toward a safe, healthy, and accessible local Middlesex-London food system that is socially, economically and environmentally sustainable. Intervention areas include food insecurity, food literacy, changes to the food environment, and promoting healthy eating.

Following an ecological framework, the HEB program considers the social, economic and environmental conditions that influence eating behaviours, examining the broader context in which food choices occur. A healthy community food system integrates food production, processing, distribution and consumption to enhance environmental, economic, social and nutritional health. Program interventions include collaboration/capacity building, healthcare provider outreach, public education and skill building, the creation of healthy food environments through coalition building, and the development and promotion of healthy public policy.

Program Mandate & Relevant Legislation

Ontario Public Health Standard: Chronic Disease Prevention and Well-Being Standard
OPHS Protocols and Guidelines: Menu Labelling Protocol, 2018; Population Health Assessment and Surveillance Protocol, 2018; Nutritious Food Basket Protocol (past protocol); Chronic Disease Prevention Guideline, 2018; Health Equity Guideline, 2018
Legislation: *Healthy Menu Choices Act, 2015* and Regulation 50/16 including
Other: Middlesex-London Community Food Assessment, A Call to Action for Healthy Eating: Using a Food Literacy Framework

Program Management

The Nutrition Practice Group, comprised of the Health Unit's Registered Dietitians and their Managers, meets quarterly and on an ad-hoc basis to facilitate agency-wide coordination of food and nutrition-related programs (e.g. interventions and activities under the Healthy Growth and Development and School Health standards). The FTEs attached to the HEB program act as food literacy, food system, food insecurity and healthy eating program content consultants within the Health Unit. The FTEs in the HEB program are responsible for the promotion of healthy eating and teaching related to understanding menu labels by consumers, while the Food Safety and Healthy Environments Team is responsible for the enforcement of the *Healthy Food Choices Act, 2015*. The HEB staff also works closely with the Healthy Communities and Injury Prevention Team and the Food Safety and Healthy Environments Team to coordinate efforts related to the natural and built environment and the food system, including food production and waste.

Key Partners and Stakeholders

Local/Regional: City of London; County of Middlesex and the eight lower tier Municipalities; London's Child and Youth Network (CYN) Ending Poverty Priority and Healthy Eating and Healthy Physical Activity (HEHPA) Priority groups; United Way London and Middlesex; Youth Opportunities Unlimited; London and Area Food Bank; Craigwood Youth Services; Anago-Parkhill Therapeutic Care Residence, London and Middlesex Children's Aid Society; South Central Ontario Region Economic Development Corporation; London Training Centre; Growing Chefs; Western Fair District; Middlesex-London Food Policy Council membership agencies (administrative and coordination lead); Harvests Bucks Steering Committee partners (administrative and financial lead).
Provincial/National: The Ontario Dietitians in Public Health; Sustain Ontario; Ontario Food Collaborative; Public Health Ontario; Dietitians of Canada; UnlockFood.ca; Marketing 2 Kids Coalition; Locally Driven Collaborative Project on Food Literacy (co-lead agency).

Community Needs and Priorities

• Food insecurity, a key social determinant of health, impacts one in seven households in Middlesex-London; this translates to approximately 52,807 people (13.7%), aged 12 and older in Middlesex-London in 2013/14. Generally, Middlesex-London households with children under the age of 18 were more food insecure (13.9%) than those households without children under 18 (11.2%). Food insecurity disproportionately affects certain populations, including Indigenous peoples, lone-parent families, and low-income households. A family of four with a median income spends only about 11% of their after-tax income on food, whereas households with low incomes spend up to 37% of their incomes on food, demonstrating the need for income-based solutions to food insecurity.
• Food literacy is recognized as an important influence on eating patterns. There has been a decline in domestic food preparation skills (known as 'deskilling' in the literature) due to a lack of introduction to and opportunity for the acquisition of cooking skills from parents, grandparents, and/or school environments. Independent of preparation skills, there are also several factors that drive an individual's food selection including physiology, food availability, taste, price, marketing, convenience, social norms and cues.
• The growing prevalence of large-scale and fast food retail outlets along with the modernization of the global food system means that consumers have greater access to low-cost, energy dense, and nutrient poor foods and beverages. According to the Middlesex-London Community Food Assessment, 82% of adults agreed with the statement that it is important that children, youth and young adults learn about food and the food system.
• About one-third of the population of Middlesex-London (31.0%) consumed vegetables and fruits five or more times per day. Just over one-quarter of youth aged 12–17 (27.4%) reported consuming vegetables and fruits five or more times per day.

Target and Priority Populations

• Food insecurity: disproportionately affects certain populations, including Indigenous peoples, lone-parent families, and low-income households. Initiatives that target income inadequacy are most effective in reducing household food insecurity. Efforts are directed at influencing policy at the municipal, provincial and federal levels of government.
• Promoting healthy eating and food literacy: at-risk youth, children, youth, young adults and their parents are a priority population for food literacy programming.
• Creating a healthy food environment: municipal and community partner stakeholders from across the food system (from production to consumption to waste management) are partners and target populations for food system-related policies and interventions that can influence the food environment. These stakeholders can positively influence the health of the food environment and can influence the development of healthy public policy.

Intended Program Outcomes	
Long-Term / Population Health	Food Systems: To support efforts toward a safe, healthy, and accessible local Middlesex-London food system that is socially, economically and environmentally sustainable. Food Insecurity / Food Literacy / Food Skills: To decrease the morbidity and mortality from preventable chronic diseases through the adoption of healthy eating behaviours and through increased access to nutritious, culturally appropriate foods
Intermediate	• Decreased % of households in Middlesex-London that are food insecure • Increased use of healthy, local food by public sector organizations • Reduced access to high calorie, low-nutrient food, beverages and snacks • Increased access to and consumption of local healthy foods • Increased % of Middlesex-London residents 12 years and older reporting eating fruits and vegetables, 5 or more times per day • Improved food literacy: preparation skills, self-efficacy, food/nutrition knowledge and dietary behaviour
Short-Term	• Increased number of workplace, organizational, municipal, provincial and federal policies that support the creation of healthy food environments • The creation of a local forum for discussing local food issues and to support collective community action • Increased number of policies and bylaws enacted to promote urban agriculture and small scale farming • Increased access to local foods through education, environmental supports and local food procurement policies • Increased number of community-based programs with an evidence-informed food literacy component in Middlesex-London • The creation of a validated tool that would be used by public health practitioners to evaluate food literacy programs and their effectiveness at improving healthy eating outcomes.

Program Interventions		
1	Food Literacy Sessions	Following the Locally Driven Collaborative Project (LDCP) Food Literacy Framework as its guide, HEB staff deliver **food literacy sessions** in partnership with community agencies that provide direct service to priority populations. These interactive, hands-on cooking opportunities for youth and young adults aim to improve overall food literacy, including: increased food and nutrition knowledge; improved food skills; increased self-efficacy and confidence in food preparation; improved dietary behaviour that contributes to health and well-being; and, enhanced knowledge about food systems and the role that socio-cultural influences have on eating practices. In addition to the provision of sessions, HEB staff provide **consultation services to community partners providing food literacy programming** to help inform program curriculum and evaluation methodology, increasing the utilization of the LDCP Food Literacy framework.
2	Food Systems – Public Awareness and Health Education	**Ontario Food Collaborative Strategic Messaging Committee** - to develop and implement provincial/consistent messaging related to food waste prevention and sustainable diet messaging; Continued efforts in partnership with members of the **Middlesex-London Food Policy Council** to promote the importance of urban agriculture strategies and agri-business innovation to strengthen the local food system, and to create healthy food environments; the promotion of policies that make the healthy choice the easy choice; the development and promotion of the **Get Fresh Eat Local** map, in partnership with the County of Middlesex; increased awareness and knowledge of the local food environment and its influence on health; the importance of restrictions on **food and beverage marketing to children and youth**.
3	Food Systems – Advocacy, Policy and Supportive Environments	**Middlesex-London Food Policy Council** - in partnership with members of the Local Food Policy Council, HEB staff support the promotion and development of local food procurement, and support municipal bylaw/zoning changes required to support urban and small scale agriculture, including city 'farm gate sales'; **Workplace Nutrition Policies** - HEB staff support workplaces to make improvements to the food environment, including policy development; **Municipalities Policy Development Support** - HEB staff support the implementation of changes to the food environment in municipally-run facilities (vending machines, concession stands); **Creation of Collective/Community kitchens -** the creation of teaching kitchen spaces available at low or no cost to other community groups offering food literacy programming, which is currently a paucity in the City of London; **Municipal, provincial and national policy windows** - HEB staff take advantage of opportunities that arise to advocate for healthy public policies that positively influence food systems and the food environment.

4	Food Systems - Collaboration, Partnerships and Capacity Building	**Middlesex-London Food Policy Council**: the Health Unit provides administrative and implementation/coordination support to the Council and its Working Groups. The Council is a forum for discussing local food issues, empowers citizens to be involved in food system decisions, fosters coordination between sectors in the food system, evaluates and works to influence policy, and supports programs and services that address local food system needs. **Ontario Food Collaborative Strategic Messaging Committee**: the Health Unit is an active member of the Ontario Food Collaborative exploring the development of food waste prevention and sustainable diet messaging. **Marketing 2 Kids Coalition**: the Board of Health is a signed member agency of the Coalition and staff contribute to advocacy efforts calling for federal legislation that would prohibit the marketing of unhealthy food and beverage to children under the age of 13 yrs.
5	Food Insecurity/Food Literacy - Surveillance and Evaluation	**Nutritious Food Basket -** Collection and analysis annually to establish a measure of the cost of basic healthy eating and food affordability by comparing the local cost of the food basket and rental costs to various individual and family income scenarios; **Harvest Bucks Evaluation** - annual evaluation of the Harvest Bucks program to improve reach and reimbursement rates; **Community Food Assessment and Middlesex-London Food Policy Council Strategic Plan -** to inform the Health Unit's and Council's progress on program developments/enhancements to improve the food system; **Locally Driven Collaborative Project on Food Literacy -** as co-lead of the project, HEB staff are creating and validating an evaluation tool to measure the impact of food literacy programs on eating behaviours and health outcomes; **Food and Healthy Eating Sub-group of APHEO** - HEB staff supporting the review and revision of indicators for household food insecurity, fruit and vegetable consumption, BMI and food costing to improve measurement and surveillance efforts.
6	Food Insecurity / Food Literacy – Public Awareness and Health Education	**Food Insecurity -** Participate, promote and disseminate public education materials and social media messages that promote income-based solutions to food insecurity, including a basic income guarantee, the living wage, social assistance rates tied to inflation, and opportunities at the local level to get involved in supporting those experiencing food insecurity. **Healthy Eating Outreach and Promotion** - HEB staff engage in public education and outreach to promote the new Canada's Food Guide, and promote UnlockFood.ca and Telehealth to consumers and to healthcare providers to increase the utilization of these services by the Middlesex-London community; **Edible Cannabis Implications on Healthy Eating** - collaborate and consult with Alcohol and Cannabis program staff to ensure that dietary considerations are factored into messaging regarding lowering harms from consuming edible cannabis. **Healthy Menu Choices Act, 2015 -** pending any amendments to the *Act,* HEB program staff work with Food Safety staff to respond to the changes and promote healthy eating messages to consumers.

7	Food Insecurity / Food Literacy –Advocacy and Policy	HEB staff work collectively and in collaboration with community influencers to: influence and promote the integration of food literacy into community garden programs; increase the number of collective/community kitchens to support community-based food literacy programming; create/promote incentives for local businesses to offer commercial kitchens for food literacy programming; promote and support implementation of programs that promote healthy food donations (in collaboration with the London and Area Food Bank); support the development and implementation of policies, programs and services that support community gardens, urban agriculture and small-scale farming initiatives to enhance/address food literacy, food insecurity and innovation in agri-business; take advantage of opportunities that arise to advocate for healthy public policies that positively influence food systems and the food environment.
8	Food Insecurity / Food Literacy – Collaboration, Partnerships, Capacity Building	**Harvest Bucks Program** - the administrative/coordination lead of this partnership that integrates the provision of fresh fruit and vegetable vouchers for redemption at Farmer's Markets into food literacy/community health programming; L**DCP Food Literacy** - the Health Unit is the co-lead of this collaborative project that aims to create a validated tool to measure the effectiveness of food literacy programs; **Community Volunteer Income Tax Program** - in partnership with the Child and Youth Network - Ending Poverty Sub-Committee, HEB staff aim to increase community capacity and reduce barriers for low income residents to access free income tax preparation clinics; **ODPH Food Literacy, Advocacy and Food Insecurity Working Groups -** facilitate coordination and collaboration across public health units; **Middlesex-London Food Policy Council Food Literacy Working Group** - establishing a coordinated system of food literacy programming in M-L; **Kitchen Tools Lending Pilot Project** - leading the development, implementation and evaluation of a Lending Program.
9	Food Insecurity - Promotion of the availability of Emergency Food	The HEB program staff collate and distribute the monthly meal calendar, in partnership with emergency food providers. This service includes regular communication with emergency food providers and the individuals/agencies who receive and promote the location of emergency food. HEB staff update the monthly calendar and post on the Health Unit website.

Performance / Service Level Indicators			
Indicator	2018	2019	2020 (target)
Proportion of ML population (age 12+) who report food insecurity, including marginal food insecurity (CCHS)	13.7% (2013/2014 data)	13.7% (2013/2014 data)	Decrease
Proportion of ML population (age 12+) that report consuming fruit and vegetables at least 5 times/day (CCHS)	31% (2015/2016 data)	31% (2015/2016 data)	Increase
Proportion of students (g 7-12) who reported drinking pop, sports drink, fruit cocktails, etc. (sugar sweetened beverages), daily or more in the past 7 days (OSDUHS)	11% (2017 ON data)	11% (2017 ON data)	Decrease
Proportion of students (grade 7-12) who report that they often or always go to bed or school hungry (OSDUHS).	7% (2017 ON data)	7% (2017 ON data)	Decrease

Highlights / Initiatives Planned for 2020

• LDCP Food Literacy Project: Final development and dissemination of the evaluation tool planned for 2020.
• Edible Cannabis Legalization: An edible cannabis working group of public health dietitians will continue to work with cannabis program staff to monitor impact and develop consistent public health messaging to address unintended consequences related to healthy eating.
• Middlesex-London Food Policy Council: The implementation of the Strategic Plan under the leadership of a Council with new membership and a new partnership with the Western Fair District's "The Grove" will be a primary area of focus.
• Community Volunteer Income Tax Program: Exploring mechanisms to increase community capacity, and to promote free tax preparation clinics (including drop-off services) in M-L to vulnerable members of the public through social media and community engagement.
• Cooking Towards Indepence: in collaboration with Children's Aid Society London & Middlesex, staff offer a food literacy program in a safe environment for youth transitioning to independent living; exploring means to expand reach and measure social inclusion.

Program Challenges and Risks

• Social determinants of health, such as income, food insecurity, housing and employment are interrelated factors that help explain the wide health inequalities in Ontario, and they are strongly influenced by government public policy decisions. Initiatives that target income inadequacy are most effective in reducing household food insecurity and the ability to access nutritious, culturally appropriate food.
• Canada's new Food Guide requires continued promotion to translate the 'plate' into healthy eating recommendations for Canadians and publicly-funded organizations. Resources that provide recommendations about the amounts and types of food to consume for a healthy diet may be released in 2020 that will require HEB staff to mobilize. Program priorities, nutrition staff, and staff that work in healthcare provider outreach will need to be flexible to incorporate the roll-out of these materials agency-wide.
• The enactment of the proposed amendments to the *Healthy Menu Choices Act, 2015* may require HEB program staff to work with Food Safety staff to respond to any changes made to the food environment, and to promote healthy eating messages to consumers.

Staffing Complement

	2019 Total FTEs	2020 Total FTEs	Δ
Dietitian	3.00	3.00	0.00
Program Assistant	0.30	0.35	0.05
Program Manager	0.20	0.20	0.00
Youth Leaders	0.08	0.00	-0.08
Director	0.00	0.02	0.02
Total Program FTE	***3.58***	***3.57***	***-0.01***

Expenditures					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 261,373	$ 270,062	8,689	3%
Benefits		$ 67,223	$ 68,421	1,197	2%
Expected Vacancies		$ -		-	
Travel		$ 6,240	$ 5,671	(570)	-9%
Program Supplies		$ 36,453	$ 32,947	(3,507)	-10%
Board Expenses		$ -		-	
Staff Development		$ 521	$ 501	(20)	-4%
Occupancy		$ -		-	
Professional Services		$ 3,050	$ 2,802	(248)	-8%
Furniture & Equipment		$ -	$ 13	13	
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 10,535	$ 9,521	(1,014)	-10%
Total Expenditures	***$ -***	***$ 385,396***	***$ 389,938***	***$ 4,542***	

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 223,503	$ 389,938	166,435	74%
MOHLTC (100%)		$ 161,893		(161,893)	-100%
MCCSS		$ -		-	
CLIF Tobacco Enforcement		$ -	$ -	-	
PHAC		$ -		-	
PHO		$ -		-	
User Fees		$ -		-	
Other		$ -		-	
Total Revenues	***$ -***	***$ 385,396***	***$ 389,938***	***$ 4,542***	

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Oral Health					421
Standard	Chronic Disease Prevention and Well-Being		**Director Name**	Maureen Rowlands	
Lead Team	Oral Health		**Manager Name**	Misty Golding/Donna Kosmack	
Supporting Team(s)	Safe Water, Rabies and Vector-Borne Disease				
Budget	$ 499,683		**FTE**	5.51	

Summary of Program

The overall goal of the Oral Health Program is to enable an increased proportion of children to have optimal oral health. The program achieves this through identifying those at risk of poor oral health outcomes and ensuring they have appropriate information, education and access to oral health care.

Program interventions include:
- Healthy Smiles Ontario
- Fluoride Varnish
- Smile Clean
- Water Fluoridation

Program Mandate & Relevant Legislation

Safe Water Standard (2018)
Chronic Disease Prevention and Well-Being Standard (2018)

Oral Health Protocol (2018)
Safe Drinking Water and Fluoride Monitoring Protocol (2018)

Program Management

The Oral Health Program is managed by the Oral Health Team with collaboration from the Safe Water, Rabies and Vector-Borne Disease Team on issues pertaining to fluoride.

Key Partners and Stakeholders

London Cross Cultural Learning Centre, London Child and Youth Network, Healthcare providers including dentists, physicians, nurses and others, School Boards, Childcare Centres, London Intercommunity Health Centre, Family Centres, Early-ON Centres, London District Dental Society, Western University's Children's Dental Clinic, Fanshawe College - Dental Hygiene Program, Southwest Ontario Aboriginal Health Access Centre

Community Needs and Priorities

In 2013/14, only 64% of families living in Middlesex-London had dental insurance. 71% of families reported visiting a dentist within the last year. 46% of families reported having oral or facial pain within the last month.
During the initial implementation of HSO (2016 and 2017), 20,950 Middlesex-London residents qualified financially for the HSO program, 74% of those eligible were enrolled in HSO, 64% of those enrolled have utilized the HSO program.
Children in Grade 8 have on average 4 teeth that are impacted by dental decay.
More than 50% of children in Grade 2 have teeth that have been impacted by dental decay.
During school screening, MLHU reports on average more than 4000 children who would qualify for preventive services.
25% of children entering junior kindergarten have teeth impacted by decay. Of the children who have been impacted by decay have at least 4 teeth effected.

Target and Priority Populations

Healthy Smiles Ontario
• All children 17 years and under who are clinically eligible for the HSO program and/or have difficulty accessing dental services due to financial hardship.
Fluoride Varnish
• Children in JK, SK, Grade 1 and Grade 2 who are at risk for dental decay
Smile Clean
• Adults who are on Ontario Works
• Adults who have children enrolled in HSO

Intended Program Outcomes	
Long-Term / Population Health	The oral health status of children, youth and adults is improved.
Intermediate	Children, youth and adults have increased access to oral health services.
Short-Term	Children, youth and adults have increased awareness of oral health services at MLHU.

Program Interventions		
1	Dental Screening - HSO-EESS	Children are screened at the 50 King Street Dental Clinic by a Registered Dental Hygienist to determine their eligibility for the HSO program including dental treatment and preventive services. If children are deemed eligible based on difficulty accessing dental services due to financial hardship and clinical findings, families are enrolled into the appropriate HSO program using Ministry required forms as per the HSO Protocol (2016). Certified Dental Assistants provide client navigation to families who require assistance in finding a local dental provider. Dental screenings are offered on a daily basis and the number of children screened is reported to the MOHLTC as per the Oral Health Protocol (2018).
2	Preventive Services - HSO-PSO	A Registered Dental Hygienist, with the support of a Certified Dental Assistant, provide preventive services such as dental cleaning, dental sealants, fluoride application and oral health education to eligible children based on clinical findings and difficulty accessing dental services due to financial hardship. Preventive services are provided at the 50 King Street Dental Clinic on a daily basis. The number of services provided is reported to the MOHLTC as per the Oral Health Protocol (2018).
3	Case Management	Registered Dental Hygienists are required to follow up on all urgent dental conditions identified during school screening and screening at the 50 King Street Dental Clinic to ensure the child has received the required care as per the Oral Health Protocol (2018).
4	HSO Program Promotion	MLHU promotes the HSO program to internal and external stakeholders including clients, community partners and health care providers.

5	Monitoring and Reporting	Oral health trends and the associated risk factors within the community are monitored and reported in the Annual Oral Health Report. As required, programs and services are adjusted in response to observed trends. Evidence-informed interventions are provided when programs and services are adjusted.
6	Fluoride Varnish Application in Elementary Schools	A Certified Dental Assistant with parental permission apply fluoride varnish to eligible children in select elementary schools. Fluoride varnish clinics are offered three times per school year.
7	Fluoride Monitoring	The Oral Health Manager monitors fluoride levels in community water systems as per the Safe Drinking Water and Fluoride Monitoring Protocol (2018). The Oral Health Manager will collaborate with the City of London and Safe Water, Rabies and Vector Borne Disease Manager to investigate abnormal fluoride levels in community water. The Oral Health Manager will collaborate with the Communications Team to inform the pubic about abnormal levels of fluoride in community water.
8	Smile Clean	The Smile Clean program provides dental cleaning for adults who are on Ontario Works or adults who have a child who is on the HSO Program. These adults have difficulty accessing dental services due to financial hardship. A Registered Dental Hygienist, with support from a Certified Dental Assistant, provide preventive services to qualifying adults. Smile Clean appointments are book on a maximum basis of 5 clients per week.

Performance / Service Level Indicators

Indicator	2018	2019	2020 (target)
% of the population 12+ that reported having had oral or facial pain the past month	46.3% 2015/16 CCHS	46.3% 2015/16 CCHS	Decrease
% of the population 12+ that reported having visited the dentist in the past year	73.5% Compared to Ontario 72.7% 2015/16 CCHS	73.5% Compared to Ontario 72.7% 2015/16 CCHS	Increase
# of fluoride varnish applications provided	2279	Awaiting Provincial Data	Increase or Maintain
# of children who received a fluoride varnish application	1251	Awaiting Provincial Data	Increase or Maintain
# of eligible children who received preventive services	1,203	Awaiting Provincial Data	Increase or Maintain
# of dental screenings provided for HSO-EESS	594	Awaiting Provincial Data	Increase or Maintain

Highlights / Initiatives Planned for 2020

The Oral Health Team is looking to expand their fluoride varnish program to other high risk elementary schools and childcare centres.

Program Challenges and Risks

Some school boards require that fluoride varnish be applied to children's teeth during the lunch hour at elementary schools. Staff have difficulty completing this service while trying to maintain client satisfaction and accuracy.

Staffing Complement			
	2019 Total FTEs	2020 Total FTEs	Δ
Dental Assistant	4.20	2.97	-1.23
Dental Hygienist	3.22	2.31	-0.91
Dentist	0.00	0.00	0.00
Program Manager	0.70	0.20	-0.50
Director	0.00	0.03	0.03
Total Program FTE	***8.12***	***5.51***	***-2.61***

Expenditures					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 526,340	$ 335,500	(190,841)	-36%
Benefits		$ 140,753	$ 90,065	(50,688)	-36%
Expected Vacancies		$ -		-	
Travel		$ 10,872	$ 8,607	(2,265)	-21%
Program Supplies		$ 32,667	$ 23,122	(9,545)	-29%
Board Expenses		$ -		-	
Staff Development		$ 3,153	$ 2,414	(739)	-23%
Occupancy		$ -		-	
Professional Services		$ 353	$ 920	567	160%
Furniture & Equipment		$ 8,698	$ 12,904	4,206	48%
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 36,861	$ 26,152	(10,709)	-29%
Total Expenditures	***$ -***	***$ 759,697***	***$ 499,683***	***-$ 260,015***	

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 66,997	$ 499,683	432,685	646%
MOHLTC (100%)		$ 692,700		(692,700)	-100%
MCCSS		$ -		-	
PHAC		$ -		-	
PHO		$ -		-	
User Fees		$ -		-	
Other		$ -		-	
Total Revenues	***$ -***	***$ 759,697***	***$ 499,683***	***-$ 260,015***	

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Physical Activity and Sedentary Behaviours						422
Standard	Chronic Disease Prevention and Well-Being		**Director Name**	Maureen Rowlands		
Lead Team	Healthy Communities and Injury Prevention		**Manager Name**	Rhonda Brittan		
Supporting Team(s)	Child Health		Early Years		Food Safety and Healthy Environments	
Budget	$ 266,553		**FTE**	2.37		

Summary of Program

The Active Living program addresses physical activity, sedentary behaviour and sleep, and follows a social ecological approach including interventions at the individual, community, and public policy levels. It incorporates the sharing of evidence-based information for specific populations, creating supportive environments, collaborating with community stakeholders and encouraging healthy public policy that supports opportunities for active living through healthy community design. The 24-Hour Movement Guidelines demonstrate that physical activity, sedentary behaviour and sleep are closely interrelated. Only 16.4% of Canadian Adults achieve the level of physical activity recommended by the Canadian Physical Activity Guidelines (CPAG) for Adults -18-64 years and only 35% of children ages 5 to 17 are meeting the physical activity recommendations within the Canadian 24-hour Movement Guidelines for Children and Youth (2014-15 CHMS, Stats Can). A large proportion of the population across the life course is not meeting the CPAG. Active transportation (walking, biking, rollerblading or skateboarding) can increase physical activity. Only 21% of Canadian children aged 5 to 19 report typically using active modes of transportation (2014-16 CANPLAY, Canadian Fitness and Lifestyle Research Institute). Targeting children's mode of travel to and from school is the focus of the Active and Safe Routes to School (ASRTS) program and is a key opportunity to increase activity levels. Sedentary behaviour: On average, Canadian adults spend 9.8 hours of their daily waking hours being sedentary. Research shows that sedentary behaviour is associated with chronic disease and other poor health outcomes (PHAC). Sleep is an important health behaviour, as it is a restorative activity. It is a key component of an individual's physical, mental and overall well-being and has been associated with health outcomes. Long term intended population health outcomes of this program include increasing levels of physical activity, reducing time spent sedentary, and increasing the proportion of the population getting adequate sleep. The ultimate long term outcome of this program is reducing the burden of chronic diseases of public health importance and improve well-being (OPHS, 2018).

Program Mandate & Relevant Legislation

Chronic Disease Prevention and Well Being Standard (OPHS, 2018)
MLHU Board of Health Endorsement of the Toronto Charter for Physical Activity (February 2012)
A Common Vision for increasing physical activity and reducing sedentary living in Canada: Let's Get Moving, 2018
ParticipACTION Report Card, 2018
The Chief Public Health Officer's Report on the State of Public Health in Canada 2017, Designing Healthy Living;
Canadian Society of Exercise Physiology (CSEP) Guidelines, 2017
Ontario Planning Act R.S.O. 1990, c. P.13
City of London Cycling Master Plan, 2016

Program Management

This Program is managed by the Healthy Communities and Injury Prevention Team (HCIP). HCIP serves as content lead with program interventions and activities focused at the 0-6, elementary-aged school children and adult populations. Collaboration occurs with the Child Health, Early Years, Reproductive Health, and Environmental Health Teams. HCIP content leads liaise with other MLHU team key contacts ad hoc, e.g. provide new physical activity related information/ evidence; collaborates to bring content expertise to interventions and activities of other MLHU program teams (e.g. development of Sedentary Behaviour Toolkit for schools); Co- Chairs the Elgin Middlesex London Active and Safe Routes to School (ASRTS); partners with stakeholders to develop resources and implement targeted School Travel Planning program as well as universal campaigns; and encourages adoption of municipal policy that enables and promotes physical activity and active transportation through focus on built environment/healthy community design and active transportation initiatives.

Key Partners and Stakeholders

City of London, YMCA, Investing in Children, Canadian Cancer Society, Reforest London, Southwestern Ontario Student Transportation Services, London Police, Planning Department, Environmental & Engineering Services/Road & Transportation Dept., Cycling workgroup, Neighbourhood Resource Centres, TVDSB, LDCSB,- Parent Involvement and School Committees; Western University- HEAL Lab, Child Development and Physical Activity Lab; Community Living London, Canadian Centre for Activity and Aging, City of St. Thomas, Counties of Oxford, Elgin & Middlesex, Ontario Provincial Police, Green Communities Canada, London Children's Connection Family Centres, Southwest Health Units, Ministry of Culture, Tourism and Sport, Ministry of Seniors Accessibility Affairs (MTCS) Ophea. Partnership tables include: City of London Child and Youth Network (CYN) Physical Activity partnership table; Southwest Physical Activity Promoters Network; London Celebrates Cycling; City of London Cycling Advisory Committee; Active and Safe Routes to School; Age-Friendly London Network (Transportation and Outdoor spaces & Buildings workgroup); Southwest Built Environment Working Group.

Community Needs and Priorities

London and Middlesex obesity rates have risen 33% since 2007, for those 18 years and older from 17.9% in 2007 to 23.9% in 2016 (London Community Foundation Vital Signs Report, 2018).

Less than two thirds (62.4%) of the Middlesex-London population aged 18 and over were active according the Canadian Physical Activity Guidelines in 2015/16. About one in 10 people was moderately active (10.1%) and somewhat active (10.5%), nearly 20%, or one in five, were sedentary. (MLHU Community Health Status Resource (CHSR))

46.3% of Middlesex-London aged 18 and above reported using active transportation (AT) during the past week in 2015/16. Broken down by age: 18–44 years old, 57%; 45-64, 37.7%, 65+, 36.5%. (MLHU CSHR).

About half the population of Middlesex-London (52.8%) aged 12 and older met the guidelines for sleep, specific to their age, in 2015/16. Nearly one in five adults aged 18 and older (18.3%) reported that, most or all of the time, they had trouble going to sleep or staying asleep. This compared to just over half (55.0%) who rarely or never had difficulty (MLHU CSHR)

For children, national data from the 2018 ParticipACTION Physical Activity Report Card for Children and Youth shows that only 35 per cent of 5 to17year-olds and 62 per cent of 3 to 4 year-olds meet recommended physical activity for their age group; only 20-26% of children and youth are using active transportation to get to and from places such as school, park, etc.; 76% of 3- to 4-year-olds are engaging in more screen time than the 1 hour/day recommended; less than half the children are meeting the recommended levels of physical literacy

County of Middlesex specific data (2010-2013): 41% of kids have 3 or more TV/video screens in their room; 24% have active travel mode to school (bike, walk) (County of Middlesex HKCC Community Needs Assessment Report,2016)

City of London specific data: 42% of children engage in 60 minutes of physical activity everyday; 56% of kids have 3 or more TV/video screens in their room (HKCC City of London Community Needs Assessment, 2016)

Increasing physical activity and physical literacy, and increasing active transportation and supporting infrastructure are identified priorities in many partnership tables on which MLHU sits and aligns with municipal priorities.

Target and Priority Populations

Early Years (0-4 years) Getting children active during this early year's period is critical for healthy development. Research shows lifestyle patterns set before the age of five predict obesity and health outcomes in later childhood and through adulthood. Children and Youth (5-17 years) - are not getting adequate physical activity. Elementary School Children (4-13 Years) - this is the target group for initiatives related to promoting active school travel.

Adults (18-64 years) Being physically active and meeting the guidelines can reduce the risk of chronic disease, premature death, osteoporosis and supports mental health and wellbeing.

Older Adults (65 Years & Older) Physical Activity can help prevent falls and fractures and maintain health and quality of life

Further work is needed to identify priority groups and interventions *within* these target populations including consideration of local level data, literature, and evidence of effective interventions.

Target audience for program interventions varies by intervention, but includes adults, parents, caregivers, child care centres and early childhood educators, schools, school age children, municipal decision makers.

Intended Program Outcomes	
Long-Term / Population Health	• To increase the proportion of the population across the lifespan meeting the 24-Hour Movement and Activity Guidelines for physical activity, sedentary behaviour and sleep •To reduce the burden of chronic diseases of public health importance and improve well-being (OPHS, 2018).
Intermediate	• With community partners, to increase opportunities for physical activity in the community with consideration of SDOH e.g. across SES levels • To increase child care centre adoption of practices and policies that increase opportunities for active living among children • To increase the use of active transportation options for people travelling to and from where they live, work, learn and play • To increase the number of elementary school aged children using active transportation to and from school • To continue to increase commitment for policy that supports healthy community design (HCD) & active transportation (AT) initiatives / projects / features by municipal planners / decision makers, developers as well as public • Increased HCD & AT features within the built environment • Provincial and municipal decision makers adopt policies that promote active living through HCD and safe AT
Short-Term	• To increase community and target population knowledge of evidence and information related to active living including 24-hour Movement Guidelines • To improve Early Childhood Educators (ECE) knowledge and practice of implementing physical literacy principles with children • To increase the number of schools with School Travel Plans and the effectiveness and efficiency of School Travel Plans • To increase decision maker and general public knowledge about HCD & AT • To increase knowledge and skills in using active transportation related to pedestrians, cycling, road safety • To decrease barriers to AT while considering health inequities and accessibility needs of population

Program Interventions		
1	Education and Awareness	Provide evidence-based information and resources re physical activity; reducing sedentary behavior and improving sleep e.g. Canadian Physical Activity and 24-Hour Movement Guidelines to the community across the life course e.g. MLHU website, partnership websites, social media, presentations, healthcare provider and workplace newsletters, via relevant MLHU teams, community partners, public events. Conduct education campaigns to increase community awareness of and how to use infrastructure that supports physical activity and active transportation, i.e. cycle tracks, bike share. Provide education and training to early childhood educators re physical literacy to increase the use and promotion of physical literacy with children in child care centres. Collaboration with SW partners to promote active living opportunities and evidence informed consistent information. As part of ASRTS develop educational and promotional materials and resources for elementary school communities, including students, parents, school staff and the broader community. Develop and distribute campaign resources include posters, social media posts, newsletters, announcements, etc. (e.g. Walk to School Day, Spring into Spring, Winter Walk Day).
2	Supportive Environments & Collaboration	Increase the use and promotion of physical literacy with children in child care centres. As a partner in London Child and Youth Network – Healthy Eating Healthy Physical Activity (CYN HEHPA) Committee, work with partners to promote active living opportunities in the City of London. Promote active living, including information and tools in area workplaces through MLHU Health at Work 4 All related to physical activity sedentary behaviour and sleep. Promote active transportation with continuation of Give Active Transportation a Go! Campaign (to general public with focus on workplaces, via social media and other communication means). Chair and provide leadership and coordination support to Elgin, Oxford, Middlesex-London, Active and Safe Routes to School (ASRTS) Committee, to promote active and safe school travel. conduct program planning & evaluation, provide opportunities for strategizing, coordinating and sharing knowledge (i.e. committee meetings, working groups, knowledge exchange events) throughout the tri-county; collect local data and leverage ASRTS partners and resources. Continue to foster new partnerships that promote active school travel e.g. Canadian Cancer Society to pilot and evaluation Walking School Bus program.
3	Healthy Public Policy	Promote and support the adoption of policy that enables and promotes active living: i.e. in schools, childcare settings, workplaces, including provincial and municipal policy (e.g. decreased speed limits in school zones). Review & provide recommendations to various land development applications / initiatives regarding healthy community design hat supports physical activity and active transportation for the City of London and County of Middlesex as appropriate – Official Plans, Area Plans, Secondary Plans, Master Plans, Environmental Assessments. Collect local data and provide input with data and evidence into policy and/or environmental changes at variety of government levels to support active school travel.

Performance / Service Level Indicators

Indicator	2018	2019	2020 (target)
# of M-L Elementary Schools active in School Travel Plan (STP) initiative	5 new = 28 total	5 new = 29 total	35
# unique distribution points for physical activity guideline education (workplace or healthcare provider newsletters, presentations/events)	25	29	25
# land development / municipal initiatives where MLHU input to support active living and healthy community design were provided	6	7	6 to 10

Highlights / Initiatives Planned for 2020

•Active and Safe Routes to School (ASRTS): will be developing a Toolkit for schools to create 'Drop Zones' to encourage parking away from the school and walking the rest of the way; will be evaluating the Wayfinding Sign Project; will host a Sharing Day event to provide an overview of ASRTS, sharing of successes and challenges, and update on new resources.
•City of London will be finalizing the new Cycling Master Plan which will guide infrastructure plans to support cycling. Bike Share program initiative planned to be implemented – this will entail increased promotion for active transportation.
•A health promotion campaign on unstructured play is planned, targeted at parents and caregivers of the early years. Unstructured play happens when children follow their own instincts, ideas, and interests without an imposed purpose or outcome. When children are engaged in their own play they move more, sit less, further develop movement skills and play longer. They learn to balance challenges with their own safety, develop confidence, self -esteem, independence, cooperation and self-regulation.

Program Challenges and Risks

Lack of available local level data to inform program need, including identification of priority populations.
ASRTS relies heavily on its partners. Ontario Active School Travel funding that has provided two STP facilitators is ending in May 2020. These changes are likely to impact the speed and level of impact of the program.

Staffing Complement			
	2019 Total FTEs	2020 Total FTEs	Δ
Program Assistant	0.10	0.10	0.00
Program Manager	0.20	0.15	-0.05
Public Health Nurse	2.10	2.10	0.00
Director	0.00	0.02	0.02
Total Program FTE	***2.40***	***2.37***	***-0.03***

Expenditures					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 203,151	$ 204,476	1,325	1%
Benefits		$ 50,511	$ 49,860	(651)	-1%
Expected Vacancies		$ -		-	
Travel		$ 2,671	$ 2,715	43	2%
Program Supplies		$ 5,944	$ 5,815	(130)	-2%
Board Expenses		$ -		-	
Staff Development		$ 1,256	$ 1,252	(4)	0%
Occupancy		$ -		-	
Professional Services		$ 1,234	$ 1,317	84	7%
Furniture & Equipment		$ 135	$ 151	17	12%
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 926	$ 967	40	4%
Total Expenditures	***$ -***	***$ 265,828***	***$ 266,553***	***$ 725***	

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 265,828	$ 266,553	725	0%
MOHLTC (100%)		$ -		-	
MCCSS		$ -		-	
PHAC		$ -		-	
PHO		$ -		-	
User Fees		$ -		-	
Other		$ -		-	
Total Revenues	***$ -***	***$ 265,828***	***$ 266,553***	***$ 725***	***0%***

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Mental Health Promotion						423
Standard	Chronic Disease Prevention and Well-Being		**Director Name**	Maureen Rowlands		
Lead Team	Healthy Communities and Injury Prevention		**Manager Name**	Rhonda Brittan		
Supporting Team(s)	Reproductive Health		Young Adult		Child Health	
Budget	$ 138,393		**FTE**	1.23		

Summary of Program

During 2019, a situational assessment was undertaken to identify program need, existing strengths/resources/gaps and identify priorities and interventions going forward for a more comprehensive program of public health interventions for Mental Health promotion at MLHU. In 2020, recommendations will be finalized for program decision making.

Mental health is defined as a positive state of health where we can feel, think and act in ways that allow us to enjoy life, deal with the stresses of life and work productively, contributing to the communities where we live. If we are mentally healthy, we have positive emotional and spiritual wellbeing and we are respective of culture, equity, social justice, interconnections, and personal dignity. Mental health is an important component of overall wellbeing and population mental health promotion involves actions and processes taken to enhance supportive behaviours to create supportive environments that will strengthen the mental health of populations, communities and individuals (WHO, PHAC).

Population specific interventions related to mental health promotion occur across MLHU under several Standards and programs including: Chronic Disease Prevention and Well-Being, School Health, Healthy Growth and Development. While some public health work is directly focused on affecting mental health and wellbeing, other strategies are embedded, e.g. reducing stigma and strength-based approaches.

As it relates to Chronic Disease Prevention and Wellbeing, current mental health promotion work focuses on workplaces and workers as part of the Health at Work 4 All! Initiative. A psychologically healthy and safe workplace promotes and supports employees' psychological well-being and actively works to prevent harm to their psychological health. Interventions include increasing education and awareness, creating supportive environments and influencing workplace policy. Long term intended program outcomes are to increase the number of workplaces that embrace and have mentally healthy environments and to reduce the burden of mental ill health and improve well-being.

Program Mandate & Relevant Legislation

Chronic Disease Prevention and Wellbeing Standard (OPHS, 2018)
Substance Use and Injury Prevention Standard (OPHS, 2018)
Healthy Growth and Development Standard (OPHS, 2018)
School Health Standard (OPHS, 2018)
Health Equity Guideline, 2018
Mental Health Promotion Guideline, 2018
Substance Use Prevention and Harm Reduction Guideline, 2018
CSA Standard for Psychological health and safety in the workplace, 2013

Program Management

The Healthy Communities and Injury Prevention Team (HCIP) has been leading a situational assessment to be completed in 2020 to identify public health mental health promotion priorities and interventions; HCIP will play a coordination role in advancing MLHU Mental Health Promotion Program work going forward. Interventions and activities related to Mental Health Promotion occur across the organization including Child Health, Young Adult, Reproductive Health, Best Beginnings/Nurse Family Partnership and Sexual Health Teams. Some examples of interventions that support mental health and wellbeing across the lifespan include Smart Start for Babies, Healthy Babies/ Healthy Children, Well Baby Clinics, anti bullying, LBGTQ, and anti-stigma focus in schools, promotion of active living, work that happens as part of substance use, tobacco cessation, needle syringe program an outreach. These program areas and interventions are reported under the relevant Programs within the ASP document.

Key Partners and Stakeholders

Canadian Mental Health Association, Mental Health Commission of Canada, Great West Life Centre for Mental Health in the Workplace, The Mindful Employer, The Elgin, Middlesex Oxford Workforce Planning and Development Board, The Ontario Workplace Health Coalition workplaces across Middlesex-London.

Community Needs and Priorities

Overall, most Middlesex-London residents (70.2%) reported having very good or excellent mental health in 2015/16. However, 7.5% of residents rated their mental health as fair or poor. Risk of poorer mental health is higher among sub-groups including lower household income groups, unemployed and urban dwellers (MLHU CHSR).

Differences in mental health indicators exist between Middlesex-London (M-L) or Western Ontario and Ontario including: Significantly more youth in Western ON rate their mental health as fair or poor compared to across ON. Mental health ED visit rates in M-L for the highest SES group are lower than ON, however, rates for the lowest SES group are higher than the same SES group across ON. The rate of ED visits for self-harm in M-L was higher than across ON, with the rate of increase higher in M-L than in ON (MLHU CHSR).

Sense of community belonging has been associated with positive physical and mental health outcomes. Over 70% of M-L residents aged 12 and over reported a strong or somewhat strong sense of community belonging. However, 21.9% reported their sense of community belonging was weak, and 6.6% reported it to be very weak in 2015/16 (MLHU CHSR).

Related to workplace, Canadians spend an average of 37.7 hours at work per week (StatsCan, 2018). 62% of the population over age15 in M-L are employed (MLHU CHSR), this gives potential to reach 2/3 of the M-L adult population through workplaces.

Evidence shows that one in five Canadians will experience a mental health problem or illness in any given year. Mental health problems and illnesses are a leading cause of worker absenteeism and disability in Canada; estimated to account for nearly 30% of all Long-Term Disability claims (Mental Health Commission of Canada (2013) “Making the Case for Investing in Mental Health in Canada”.

Target and Priority Populations

Target populations for focused mental health program interventions under the Chronic Disease Prevention and Wellbeing Standard are workplaces and workers. Mental health promotion is additionally embedded within the Active Living program.

There is evidence to inform the association between workers and mental health/welling. Mental health disorders are more than 60 per cent higher among working Canadians than the general population. Relating to vulnerable workplace: Women, younger workers, services sector employees are more likely to experience mental health issues due to lower pay, fewer benefits, reduced likelihood of full-time work, and a tendency to communicate with dissatisfied clients the prevalence of a mental illness in a worker’s lifetime is highest in the public administration; information, culture and recreation and educational services industries (occupations connected social science, education, and government services; and art, culture, and recreation); lowest prevalence of mental illness is in agriculture, forestry, and mining. Research indicates that rates of depression are highest in industries that have the most interaction with the public or with clients (The Conference Board of Canada, “The Footprint of Mental Health Conditions: Healthy Brains at Work”, 2015.

Intended Program Outcomes	
Long-Term / Population Health	• To reduce the burden of mental ill health and improve well-being • To increase the number of workplaces that embrace and have mentally healthy environments.
Intermediate	• To increase the number of private and public sector workplaces that implement the Psychological Health and Safety Standard, (the Standard) • To raise awareness of, and encourage action on, the 13 risk factors outlined in “the standard” where employers can impact the mental health and wellbeing of the employees • To increase capacity for organizations and business to implement comprehensive approaches to mentally healthy workplaces.
Short-Term	•To increase knowledge of workplaces and workers regarding ways to promote mentally health workplace environments •To increase workplace and worker awareness of resources for those affected by mental health challenges •To increase public health staff mental health literacy

Program Interventions		
1	Education and Awareness	Promote adoption of the CSA Standard or use the components to work towards supporting employee mental health in workplaces through: Presentations to employer/ leader/wellness groups to promote the implementation of the standard and the resources created to address it; Presentations on stress, work-life balance, building resilience; Links to resources in biweekly newsletters to 217 workplace contacts in London and Middlesex; Links to local resources in the workplace/employer section of the MLHU website; Create and adapt resources that help employers address mental wellbeing in the workplace e.g. @ work kit, fact sheets and booklet of local resources; promotion of the MLHU program resources and information covering the lifespan with a concentration on mental health promotion initiatives that support workers and their families.
2	Supportive Environments	Plan and deliver a workshop for employers and workplaces focusing on mental health and addiction. Build health unit staff knowledge and capacity related to mental health promotion including mental health literacy.
3	Policy development	Offer consultation support to workplaces in developing policies that support workplace mental health.

Performance / Service Level Indicators

Indicator	2018	2019	2020 (target)
# of workplace wellness e-newsletters and related metrics regarding content	23 newsletters 63 articles r/t workplace mental health	18 newsletters 115 articles r/t workplace mental health	maintain
# workplace presentations related to CSA Standard, mental wellbeing, building resilience	16	6	maintain
# consultations for resources	>20	12	maintain

Highlights / Initiatives Planned for 2020

A focus of 2020 will be on internal education and capacity building related to mental health literacy.

The situational assessment will be completed in 2020. Recommendations coming out of this situational assessment will serve to further refine organizational direction and priorities for mental health promotion.

Program Challenges and Risks

Dedicated staff time will be needed to complete the situational assessment and further determine, coordinate and implement priorities and interventions related to mental health promotion.

Staffing Complement

	2019 Total FTEs	2020 Total FTEs	Δ
Program Assistant	0.10	0.10	0.00
Program Manager	0.10	0.10	0.00
Public Health Nurse	1.00	1.00	0.00
Director	0.00	0.03	0.03
Total Program FTE	***1.20***	***1.23***	***0.03***

Expenditures					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 100,260	$ 106,124	5,864	6%
Benefits		$ 25,019	$ 25,829	810	3%
Expected Vacancies		$ -		-	
Travel		$ 1,336	$ 1,426	90	7%
Program Supplies		$ 2,972	$ 3,023	51	2%
Board Expenses		$ -		-	
Staff Development		$ 628	$ 670	42	7%
Occupancy		$ -		-	
Professional Services		$ 617	$ 722	105	17%
Furniture & Equipment		$ 67	$ 90	23	34%
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 463	$ 508	45	10%
Total Expenditures	***$ -***	***$ 131,363***	***$ 138,393***	***$ 7,030***	

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 131,345	$ 138,393	7,048	5%
MOHLTC (100%)		$ -		-	
MCCSS		$ -		-	
PHAC		$ -		-	
PHO		$ -		-	
User Fees		$ 18		(18)	-100%
Other		$ -		-	
Total Revenues	***$ -***	***$ 131,363***	***$ 138,393***	***$ 7,030***	

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Ultraviolet Radiation and Sun Safety						424
Standard	Chronic Disease Prevention and Well-Being		**Director Name**	Maureen Rowlands		
Lead Team	Chronic Disease Prevention and Tobacco Control		**Manager Name**	Linda Stobo		
Supporting Team(s)	Healthy Communities and Injury Prevention		Food Safety and Healthy Environments		Child Health	
Budget	$ 90,567		**FTE**	0.81		

Summary of Program

Exposure to the sun and other sources of ultraviolet radiation (UVR), such as tanning equipment, without sufficient protection are established causes of skin cancer and can increase the risk of eye diseases (IARC, 2012). Melanoma is the most deadly form of skin cancer in Canada and nearly all melanomas are related to ultraviolet radiation (UVR) exposure from the sun or indoor tanning. The Ultraviolet Radiation (UVR) and Sun Safety program works in collaboration with staff members from many different teams across the Health Unit to increase public protection from both artificial and natural sources of ultraviolet radiation and to decrease the burden of disease resulting from overexposure to ultraviolet radiation.

Components of the UVR and Sun Safety Program include:
- Policy Development and Healthy Environments
- Public Awareness and Health Education
- Partnerships, Capacity Building and Collaboration
- Enforcement of the *Skin Cancer Prevention Act, 2013* and Regulation 99/14

Past national surveys have suggested that an increasing number of Canadians spent more time in the sun without ensuring that they are protected against harmful UVR exposure (Canadian Partnership Against Cancer, 2010). In 2016, about 6,800 Canadians were diagnosed with melanoma and 1,200 will die from it. Fortunately, early detection can improve treatment and survival.

Program Mandate & Relevant Legislation

Ontario Public Health Standard: Chronic Disease Prevention and Well-Being Standard
OPHS Protocols and Guidance Documents: Tanning Beds Protocol, 2018; Chronic Disease Prevention Guideline, 2018; Healthy Environments and Climate Change Guideline, 2018
Legislation: *Skin Cancer Prevention Act, 2013 (SCPA, 2013)* and Ontario Regulation 99/14
Other: Ontario Sun Safety Working Group Sun Safety Toolkit for Public Health Units

Program Management

The UVSS Program Staff act as ultraviolet radiation and sun safety program content consultants within the Health Unit. The UVSS Program Staff are responsible for the promotion of sun safety messages and protective measures that would reduce over exposure to ultraviolet radiation. The UVSS Public Health Nurse works with the Enforcement Officers, designated to enforce the *Skin Cancer Prevention Act* , *2013,* and the Program Assistant responsible for tracking inquiries/complaints, fielding inquiries from tanning bed operators and members of the public asking about tanning bed/skin cancer risk and tanning bed laws. The UVSS Public Health Nurse works in collaboration with the Healthy Communities and Injury Prevention (HCIP) Team (Built Environment, Workplace Program, Child Safety), the Healthy Environments Team (Climate Change program lead), the Child Health and Young Adult Teams (comprehensive school health), and the Early Years and Reproductive Health Teams (newcomers, new/young moms, prenatal) to increase public protection from artificial and natural sources of UVR.

Key Partners and Stakeholders

City of London – connections through Environmental Health to the Tree and Forests Advisory Committee (see Environmental Health component for more details); Canadian Cancer Society – Sun Sense; Southwest Regional Cancer Program; Ontario Sun Safety Working Group; ReForest London; TD Friends of the Environment; Toyota Everygreen; Tree Canada; Thames Valley District School Board; and, London Catholic District School Board.

Community Needs and Priorities

Ultraviolet Radiation Exposure: 31.6% of adults in Middlesex-London aged 18 yrs. plus reported getting a sunburn in the last 12 months in 2017. Incidence rates of malignant melanoma were generally significantly higher in Middlesex-London compared to Ontario from 2010 to 2014. The incidence rate of malignant melanoma in Middlesex-London in 2014 increased with age and was highest among the oldest age group (age 80+). Incidence rates of malignant melanoma were higher among males compared to females in Middlesex-London in 2014, but the differences were not statistically significant.

According to the Canadian Cancer Society, in 2019, it is estimated that:

- 7,800 Canadians will be diagnosed with melanoma skin cancer;
- 1,300 Canadians will die from melanoma skin cancer;
- 4,300 men will be diagnosed with melanoma skin cancer and 840 will die from it; and,
- 3,500 women will be diagnosed with melanoma skin cancer and 280 will die from it.

Risk of skin cancer, particularly melanoma, increases by 59% when tanning beds are used prior to the age of 35 because artificial tanning devices emit 15X the amount of UV rays as from sun exposure. Despite the enactment of tanning bed legislation, research conducted by the Ontario Sun Safety Working Group shows that there was no reduction in adolescence tanning bed use prevalence; therefore, ongoing work is required at the local level to support the provincial policy.

Outdoor workers are up to 2.5 to 3.5 times more likely to be diagnosed with skin cancers (Ontario Sun Safety Working Group). In Middlesex-London, younger people, males and those in lower socio-economic groups were less likely to report sun protection behaviours.

Target and Priority Populations

- Youth and young adults: to promote the dangers of artificial tanning to reduce tanning bed use prevalence
- Community partners/child-serving agencies (daycare and early years centres, day camps, schools, etc.): to promote the utilization of sun protective behaviours, and to influence the development of policies to reduce child, youth, and outdoor worker exposure to UVR
- Outdoor workers and employers with outdoor workers: outdoor workers are up to 2.5 to 3.5 times more likely to be diagnosed with skin cancers.
- Low income families: the cost of sunscreen can be prohibitive; therefore, strategies and interventions that reduce barriers to sunscreen access will be explored including the provision of free (or low cost) sunscreen to families that the Health Unit is working with through other Health Unit programs (e.g. Best Beginnings/Early Years Teams, Prenatal Immigrant Program, Nurse Family Partnership).

Tanning Bed Operators: to increase compliance with the *SCPA, 2013* and to reduce youth access to tanning services.

Intended Program Outcomes	
Long-Term / Population Health	• Decreased UVR exposure • Decreased incidence of skin cancer (melanoma & NMSC) in males and females in Middlesex-London
Intermediate	• Increased adoption of sun protective behaviours • Increased capacity with the healthcare provider community to facilitate early detection of skin cancer cells • Increased compliance with youth access provisions under the *SCPA, 2013*
Short-Term	• Increased knowledge of the importance of sun protective behaviours and support for policies to reduce UVR exposure • Increased number of policies within municipalities, workplaces, schools and childcare facilities that promote access to shade and promote sun protective behaviours • Increased awareness and understanding of the risks associated with artificial tanning • Reduced youth access to artificial tanning services • Decreased number of tanning bed operators in Middlesex-London • Priority populations will have greater access to sunscreen

Program Interventions		
1	Policy Development and Healthy Environments	The UVSS program staff promote sun protective behaviours and supports the development of policy that: creates shade, ensures the provision of sunscreen to priority populations, and protects people from the dangers of over exposure to UVR. Utilizing existing relationships and partnerships within the Health Unit and within the community (school programing, child care centres, workplace health promotion program, built environment and healthy community design), the UVSS program staff works with daycares, schools, workplaces, and municipalities to influence the development of policies. The UVSS program staff are working collaboratively with the Healthy Environments program to explore the creation of a 'business case' for a municipal shade policy for use with Middlesex-London municipalities.

2	Public Awareness and Health Education	The UVSS program staff stays abreast of the latest evidence and works across the agency with those teams that work with specific priority populations/target groups to ensure the delivery/promotion of consistent, evidence-informed UVR/sun safety messages. The UVSS program staff does outreach to organizations and agencies that provide direct service to children, youth and young adults to promote sun/UVR protective behaviours. Activities include the continued dissemination of the OSSWG Sun Safety Factsheets and Toolkit and the translation of OSSWG Sun Safety factsheets into Arabic, Standard Chinese, and other languages to reach newcomer populations. The promotion of the risks associated with artificial tanning to youth, young adults and parents using social media and targeted outreach strategies are planned for 2020.
3	Partnerships, Capacity Building and Collaboration	**CCS' Sun Sense Program**: promote the program within the Child Health Team and explore opportunities to increase program uptake by local school boards; **Ontario Sun Safety Working Group**: continued participation to help inform and support local program development and implementation, tapping into the expertise of sun safety/UVR research experts. **Healthcare Provider Outreach:** continued partnership with the Healthcare Provider Outreach Team to disseminate materials to healthcare providers in Middlesex-London to promote the early detection of skin cancer cells. **Sun Safety Kit for Priority Population Collaborative:** the development of medical directive to support the dispensing of sunscreen to priority populations, along with other sun protective resources.
4	Enforcement and Compliance	Inspectors conduct one annual inspection and education visit of every tanning bed operator in Middlesex-London to review operator obligations. Inspectors respond to all inquiries and complaints received regarding non-compliance with the *SCPA, 2013* and support the City of London in their Licensing Bylaw by inspecting any new tanning bed operator that has applied for a license. UVSS program staff are exploring the development and implementation of an "Under 25" youth access education program to evaluate tanning bed operator compliance with the "under 25" provisions under the *SCPA, 2013,* and to use the results to inform a public education strategy for 2020/2021.

Performance / Service Level Indicators

Indicator	2018	2019	2020 (target)
# of tanning bed operators in the Middlesex-London area	35	36	Decrease
% of tanning bed operators in Middlesex-London inspected at least once annually.	63%	100%	100%
% of ML adults 18+ who reported having a sunburn in the past 12 months (RRFSS)	39% (2013 data)	32% (2017)	Decrease
% of ML adults 18+ who reported using a tanning bed or a booth with tanning lamps in the previous year (CCHS)	3.6% (2015/2016 data)	3.6% (2015/2016 data)	Decrease

Highlights / Initiatives Planned for 2020

• Research conducted by members of the Ontario Sun Safety Working Group found that despite the enactment of the *SCPA, 2013*, many adolescents under the age of 18 yrs. report being sold tanning services. The Health Unit intends to explore the implementation of a pilot program that involves youth access test shopping and the provision of education for the “under 25” ID requirements.
• The exploration of strengthened collaborative relationships with Healthy Environments/Climate Change staff to pursue the advancement of shade policy.
• The development and implementation of a medical directive that would enable Health Unit staff to dispense free/low cost sunscreen as part of a Sun Safety Kit that would be integrated into existing programs and services delivered to priority populations by other Health Unit programs (e.g. Prenatal Newcomer Program, Nurse Family Partnership, Smart Start for Babies, etc.).

Program Challenges and Risks

• The Inspectors that are designed to enforce the *Skin Cancer Prevention Act, 2013* are also designated to enforce the *Smoke-free Ontario Act, 2017.* With the increased demands and pressures on the Tobacco and E-Cigarettes Program (mandated retailer inspections, complaints, inquiries and youth vaping issues), it is difficult to remain proactive and timely with tanning bed operator enforcement/education.
• The City of London licensing bylaw, which requires tanning bed operators to pay an annual licensing fee of $189, involves annual inspections of tanning bed operators by Health Unit *SCPA, 2013* Inspectors. There exists an opportunity to better streamline communication and coordination of inspections between City bylaw inspectors and Health Unit inspectors. This will be explored further in 2020.

Staffing Complement			
	2019 Total FTEs	2020 Total FTEs	Δ
Program Assistant	0.10	0.10	0.00
Program Manager	0.10	0.10	0.00
Public Health Nurse	0.50	0.50	0.00
Tobacco Enforcement Officer	0.10	0.10	0.00
Youth Leaders	0.06	0.00	-0.06
Director	0.00	0.01	0.01
Total Program FTE	***0.86***	***0.81***	***-0.05***

Expenditures					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 61,338	$ 64,735	3,397	6%
Benefits		$ 13,247	$ 14,181	934	7%
Expected Vacancies		$ -		-	
Travel		$ 1,499	$ 1,289	(210)	-14%
Program Supplies		$ 8,757	$ 7,440	(1,317)	-15%
Board Expenses		$ -		-	
Staff Development		$ 125	$ 122	(4)	-3%
Occupancy		$ -		-	
Professional Services		$ 733	$ 645	(87)	-12%
Furniture & Equipment		$ -	$ 7	7	
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 2,531	$ 2,150	(381)	-15%
Total Expenditures	***$ -***	***$ 88,230***	***$ 90,567***	***$ 2,337***	

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 49,339	$ 90,567	41,228	84%
MOHLTC (100%)		$ 38,891		(38,891)	-100%
MCCSS		$ -		-	
CLIF Tobacco Enforcement			$ -	-	
PHAC		$ -		-	
PHO		$ -		-	
User Fees		$ -		-	
Other		$ -		-	
Total Revenues	***$ -***	***$ 88,230***	***$ 90,567***		

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Descriptions

Food Safety					425
Standard	Food Safety		**Director Name**	Stephen Turner	
Lead Team	Food Safety and Healthy Environments		**Manager Name**	David Pavletic	
Supporting Team(s)	Infectious Disease Control				
Budget	1,702,736		**FTE**	15.76	

Summary of Program

The Food Safety program aims to prevent and reduce the burden of foodborne illness through inspections, monitoring, education, and enforcement activities.

The program target populations are food premises operators and volunteer groups who prepare high risk foods for vulnerable populations within Middlesex-London, including community serving kitchens.

Interventions of the Food Safety Program include:

- Surveillance
- Awareness, Education and Training
- Risk Assessment and Inspection of food premises
- Complaint and outbreak investigation
- Food Recall
- Food Premises Disclosure (including DineSafe)
- Enforcement

Program Mandate & Relevant Legislation

• Ontario Public Health Standards, Food Safety Standard, 2018
• Food Safety Protocol, 2019
• Operational Approaches for Food Safety Guideline, 2019
• Health Protection and Promotion Act, R.S.O. 1990, c. H.7 (sections 10 - 18)
• O. Reg. 493/17 Food Premises
• O. Reg. 503/17 Recreational Camps
• City of London Business Licensing By-Law L.131-16, Food Premises Inspection and Mandatory Food Handler Training Bylaws (City of London and Middlesex County)

Program Management

The Food Safety Program is managed by the Food Safety and Healthy Environments Team (FSHET). The Infectious Disease Control Team (IDCT) also conducts food safety inspections at Institutional food premises (hospitals, day nurseries, long-term care homes etc.). Food premises inspections are disclosed through the food premises inspection disclosure program (website and on-site posting). The majority of the food premises inspected by IDCT are risk categorized as High, due primarily to the population served. These food premises inspections are combined with the food premises inspections by FSHET to comprise all food premises inspections for reporting purposes. PHIs on IDCT also coordinate with PHIs on FSHET to investigate reports of suspected and lab-confirmed foodborne illness. FoodNet is a federal program funded by the Public Health Agency of Canada (PHAC), and MLHU is a sentinel site, administered by the IDCT, which contributes data for surveillance purposes.

Key Partners and Stakeholders

London Training Centre; City of London - Licensing department; Ontario Ministry of Agriculture Food and Rural Affairs (OMAFRA); Canadian Food Inspection Agency (CFIA); Health Canada (HC); Public Health Agency of Canada (PHAC), Ministry of Children, Community and Social Services (MCCSS)

Community Needs and Priorities

a) There are approximately 2,500 food premises including 160 institutions, long term care homes, retirement homes and child care facilities that are inspected three times per year due to the vulnerability of the population. The number of food premises in Middlesex-London typically increases every year in concert with the growing population base.

In addition to food premises that are risk assessed annually and inspected throughout the year, PHIs complete pre-operational licensing inspections in the city of London and inspections at special events and farmers markets (assessments). Operators of temporary special events and markets often experience greater challenges in ensuring food safety due to hot summer temperatures and temporary food safety provisions.

MLHU receives reports of suspected and lab-confirmed foodborne illness as well as reports of unsafe food handling at food premises in Middlesex-London, and Public Health Inspectors conduct on-site investigations to determine the level of risk to the general public. A closure of a food premises may be warranted in situations where there is a known and substantial risk. Local and province-wide outbreaks are investigated as well as requirements under the direction of the Ministry of Health to conduct product checks at food premises when food recalls have been initiated, and the general public is at risk of consuming a contaminated food item.

b) Local priorities focus on providing food safety awareness and education for individuals who serve vulnerable populations and where food safety lapses have been discovered through inspections and investigations in high risk environments. Food premises where there is higher risk for foodborne illness, considering previous foodborne illness outbreaks and complaint volume, are a priority for ongoing focus including assisted compliance measures and potential enforcement measures.

Target and Priority Populations

People who may experience challenges with literacy, English language comprehension, and financial means are priority populations for our food safety interventions (including food safety education and food handler training).

Target populations include volunteer groups who prepare and serve food at community meal programs as well as food premises operators who may experience challenges with regulatory compliance.

Intended Program Outcomes	
Long-Term / Population Health	• To prevent or reduce the burden of food-borne illnesses
Intermediate	• Timely and effective detection, identification, and response to food-borne illnesses, their associated risk factors, emerging trends, and unsafe food offered for public consumption • Food-borne illness risks are mitigated • Food handlers are educated in food safety to handle and manage food for public consumption in a safe and sanitary manner • The public and community partners are aware of safe food-handling practices and food safety issues • The public and community partners have the knowledge and skills needed to handle food in a safe manner • There is reduced incidence of food-borne illnesses
Short-Term	• Infractions identified during food premises inspections are rectified • Clients who receive food handler course instruction pass the course and become certified food handlers

Program Interventions		
1	Surveillance	MLHU maintains an inventory of food premises within Middlesex-London for surveillance purposes, as well as some food premises that are not under direct health unit jurisdiction, where food safety issues have arisen. Food premises exempt from O. Reg. 493/17 (farmer's markets, residential homes, churches / service clubs / fraternal organizations for special events) are monitored and assessed regularly. All information is maintained within the Hedgehog database and updated regularly throughout each calendar year. Ongoing collaboration with partner agencies is maintained to identify known food safety risks within the Middlesex-London area as well as internally, through the MLHU FoodNet sentinel site surveillance program.
2	Awareness, Education and Training	MLHU staff collaborate with the London Training Centre (LTC), through a Memorandum of Understanding (MOU). The MOU requires the LTC to deliver food handler training to residents in Middlesex County and London, in accordance with the MLHU Operational Approaches for Food Safety Guideline, 2019. MLHU provides food handler training course instruction to priority populations within the community and administers food handler training exams to the general public. Additionally, MLHU staff provide food safety in-services and presentations to promote safe food handling practices throughout the year. Food safety information is made available to the general public and facility operators on-line www.healthunit.com. Public Health Inspectors also provide food safety education to operators during inspection activities which aims to assist in regulatory compliance.

3	Risk Assessment and Inspection of food premises	MLHU staff conduct annual risk assessments of all food premises in Middlesex-London. All food premises including year-round, seasonal and pre-operational are inspected and re-inspected when necessary to achieve regulatory compliance. Food premises within the city of London are inspected prior to operation, to assist the city of London with the licensing of food premises. Temporary food premises (special events) are risk assessed and receive inspections or food safety education prior to, and during operation, depending upon an assessment of the risks.
4	Compliance and outbreak investigation	MLHU staff investigate, risk assess and respond to all food safety complaints and service requests in a timely manner (within 24 hours). Service requests include reported food safety complaints at food premises, reports of suspected and lab-confirmed foodborne illness or any other food safety request for service. PHIs in Food Safety collaborate internally with the Infectious Disease Control Team (IDCT) during local outbreak investigations when case interviewing implicates local food premises as potential suspect sources. PHIs also collaborate with other Public Health Units (PHU) and partner agencies (Canadian Food Inspection Agency; Ontario Ministry of Agriculture, Food and Rural Affairs, Health Canada) during Ontario Outbreak Investigation Coordination Committee (OOICC) meetings or national Outbreak Investigation Coordination Committee (OICC) meetings for the management of foodborne illness outbreaks.
5	Food Recall	PHIs monitor food recalls through email notification from the CFIA. MLHU staff provide support for food recalls when a request is made by the Ministry of Health to conduct on-site food product verification checks. Product checks can either by conducted in large scale by contacting all food premises operators where recalled food product is likely to be found, or on a smaller scale during times when food premises inspections are conducted. This is determined based on the level of risk communicated by the Ministry of Health.
6	Food Premises Disclosure (including DineSafe)	MLHU provides public disclosure of food safety inspection summaries as well as on-site posting or through a request for information. The public disclosure website is monitored periodically to identify website glitches, accuracy of data and public request through an email link. Food premises within Middlesex-London are required to post a sign at the entrance to the food premises, in accordance with the Food Premises Inspection and Mandatory Food Handler Training Bylaws (City of London and Middlesex County) and Reg. 493/17 Food Premises. The signs indicate Pass (Green), Conditional Pass (Yellow), Closure (Red) and DineSafe is Coming (Rainbow), as well as general certificates of inspection for premises not included in DineSafe. Signs are delivered by PHIs upon completion of a food safety inspection, re-inspection or complaint-based inspection.

7	Enforcement	Legal action(s) are taken, as when necessary in accordance with the Food Safety Protocol, 2019. Closure Orders, under the authority of the Health Protection and Promotion Act, R.S.O. 1990, c. H.7 are served to food premises owners when health hazards are identified by Public Health Inspectors. Additionally, PHIs enforce the Food Premises Inspection and Mandatory Food Handler Training Bylaws (City of London and Middlesex County) for compliance. Enforcement actions under the Health Protection and Promotion Act also include the acts of seizure and destruction of food, when PHIs are of the opinion that the condition of the food may constitute a health hazard.

Performance / Service Level Indicators

Indicator	2018 (to Nov 19)	2019	2020 (target)
% of high risk premises inspected once every 4 months	100%	99.8	100%
% of moderate risk premises inspected once every 6 months	100%	99.6	100%
Compliance with Food Premises Inspection and Mandatory Food Handler Certification Bylaws (FHT Certification Requirement) / Food handler or supervisor present during operation has completed food handler training	100%	Discontinued, will develop a new indicator in 2020 to reflect provincial requirement.	To be developed, target of 100%
Compliance with Food Premises Inspection and Mandatory Food Handler Certification Bylaws (Posting Requirement) / Inspection results posted in accordance with the PHIs request	91%	Discontinued	Discontinued
# Responses to Reports of Foodborne Illnesses	146	133	To reduce number from previous year
# of tickets issued to Food Premises	6	6	6
# of summons issued to Food Premises	N/A	0	0
# of closure orders issued to Food Premises	9	6	To reduce number from previous year

Highlights / Initiatives Planned for 2020

• Continue to implement evidence-informed and culturally relevant food safety interventions that address the SDOH / Health Equity need during education and inspection activities.
• Deliver education geared towards the proposed regulatory amendments to Reg 493/17 Food Premises, and apply risk-based common approaches to inspection and enforcement activities.
• Deliver and review 'food safety management plan' with operators who currently are not following an established food safety management plan.
• Review and revisit current food safety indicators and look to establish some program process indicators and short-term / medium term program outcome indicators, and indicators with a health equity focus.
• Create and adopt a Risk Assessment tool that is more objective in determining when to inspect for special events.

Program Challenges and Risks

• The number of special events within Middlesex-London are growing in number, and the events are continuing to grow in size which places added demands on the inspection program. Currently the team only conducts inspections at events where there are many vendors, high risk foods are sold etc. These environments can present higher risk due to the temporary set up and outdoor environments.
• Pest control challenges continue to be a significant issue identified during inspections, particularly as it relates to cockroach activity, so there are additional challenges in working with operators to control infestations and respond to complaints.
• The city of London is looking to adopt 'Urban Farm Gate' sales, under the Urban Agriculture Strategy which may result in more assessment and follow up. Also, pending approval of regulatory changes, MLHU could see increased volume of complaints regarding dogs in food premises and unsafe food handling at community meal programs.

Staffing Complement

	2019 Total FTEs	2020 Total FTEs	Δ
Program Assistant	0.85	0.85	0.00
Program Manager	0.95	0.95	0.00
Public Health Inspector	13.90	13.75	-0.15
Director	0.00	0.20	0.20
Associate Medical Officer of Health	0.00	0.01	0.01
Total Program FTE	***15.70***	***15.76***	***0.06***

Expenditures					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 1,247,764	$ 1,296,334	48,570	4%
Benefits		$ 302,140	$ 306,962	4,823	2%
Expected Vacancies		$ -		-	
Travel		$ 22,310	$ 24,926	2,616	12%
Program Supplies		$ 13,545	$ 18,927	5,381	40%
Board Expenses		$ -		-	
Staff Development		$ 7,298	$ 8,765	1,467	20%
Occupancy		$ -		-	
Professional Services		$ 2,007	$ 26,156	24,148	
Furniture & Equipment		$ -	$ 110	110	
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 16,879	$ 20,557	3,678	22%
Total Expenditures	***$ -***	***$ 1,611,942***	***$ 1,702,736***	***$ 90,794***	

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 1,368,706	$ 1,658,229	289,523	21%
MOHLTC (100%)		$ 200,232		(200,232)	-100%
MCCSS		$ -		-	
PHAC		$ 28,004	$ 28,796	792	3%
PHO		$ -		-	
User Fees		$ 15,000	$ 15,000	-	0%
Other		$ -	$ 711	711	
Total Revenues	***$ -***	***$ 1,611,942***	***$ 1,702,736***	***$ 90,794***	

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Health Hazard Response					430
Standard	Healthy Environments		**Director Name**	Stephen Turner	
Lead Team	Food Safety and Healthy Environments		**Manager Name**	David Pavletic	
Supporting Team(s)					
Budget	$ 374,779		**FTE**	3.46	

Summary of Program

The Health Hazard Response program aims to reduce the burden of illness from potential, suspected and / or identified health hazards through hazard identification, risk assessment and risk management strategies both in the natural and built environment. Target populations include vulnerable occupancies and newcomer communities who reside in housing environments where there has been identified need for public health intervention.

Interventions pertaining to the Health Hazard Response program include:
- Surveillance
- Inspection
- Management and Response
- Awareness, education and training

This program aims to reduce exposure to health hazards in the environment and in facilities within Middlesex-London. Public Health Inspectors monitor, educate, inspect and respond to reported health hazards in the Middlesex-London communities. These interventions are delivered by MLHU, oftentimes in collaboration with partner agencies and stakeholders.

Program Mandate & Relevant Legislation

Ontario Public Health Standards, Healthy Environments Standard 2018
O. Reg. 503/17 Recreational Camps
Health Protection and Promotion Act, R.S.O. 1990, c. H.7
Health Hazard Response Protocol, 2019
Population Health Assessment and Surveillance Protocol, 2018
Informal Residential Care Facility Licensing By-Law, CP-21

Program Management

The Health Hazard Response Program is managed by the Food Safety and Healthy Environments Team (FSHET).

Key Partners and Stakeholders

City of London and Middlesex County Building Inspectors, Municipal Bylaw Enforcement Officers and Fire Inspectors; Vulnerable Occupancy Protocol Working Group; Ministry of Environment, Conservation and Parks; Public Health Ontario, Ministry of Health

Community Needs and Priorities

a) Information is provided to MLHU staff through community calls, agency referrals or through involvement on community working groups which suggests that individuals may be at an increased public health risk. MLHU maintains an inventory of calls of complaints and service requests and facility locations in Middlesex-London, which serves to provide historical context and previous actions taken by MLHU staff.

b) MLHU has identified a local need to prioritize inspection and public health interventions geared towards individuals living in vulnerable occupancies and in newcomer communities. There are group homes within London and Middlesex County that are maintained and operated without much regulatory oversight where health hazards have been identified. Additionally, there are newcomer populations who may experience language, cultural and financial barriers that challenge the ability to achieve healthy housing environments.

From a health equity approach, the FSHET focuses public health interventions in communities that are more vulnerable and susceptible to the impacts of health hazards.

Target and Priority Populations

The priority populations for the Health Hazard Response program, include people who are at increased risk to poor health outcomes, due to the housing environment. Individuals who are at increased risk to the impacts of environmental hazards both within the built and natural environment may include people who experience financial challenges, language barriers, as well as physical and mental health related illnesses. MLHU has identified a local need to provide public health interventions for the following target populations:

• Newcomer Populations: people (communities) who have recently immigrated to Canada and are experiencing challenges in adjusting to new way of life.
• Vulnerable Occupancies: locations known to the MLHU, where people reside in homes that have significant health hazards and lack of care provisions / supports.

Intended Program Outcomes

Long-Term / Population Health	• To prevent or reduce the burden of illness from potential, suspected and / or identified health hazards associated with the built and natural environment in Middlesex-London.
Intermediate	• Individuals living in vulnerable occupancies will live in healthier and safer environments. • The public and community partners are aware of the risks of health hazards at facilities and in environments where the evidence suggests increased risk. • Operators of facilities and community members within Middlesex-London will be better informed on how to maintain healthier environments and protect themselves from known health hazards.
Short-Term	• Improvements are made in living conditions at vulnerable occupancies. • Community members are informed of known risks whenever MLHU receives reports.

Program Interventions		
1	Surveillance	MLHU collects information pertaining to facilities where there have been health hazard investigations completed or where there has been a need to create an inventory given the risk of health hazards existing. Some facilities include buildings that operate cooling towers and residential homes where there have been Cannabis Growing Operations. This information currently resides within the Hedgehog database as well as in paper files. PHIs review evidence related to potential health hazards in Middlesex-London, and liaise with partner agencies including Public Health Ontario, the city of London, Middlesex County and MECP to risk assess, risk manage and communicate the public health risks in the community, as well as for regular information sharing on issues of a local significance.
2	Inspections	PHIs inspect boarding and lodging homes, group homes, vulnerable occupancies, seasonal farm homes and recreational camps. Provincially licensed group homes, including the Community Homes for Opportunity, are inspected on request from operating agencies, and inspections apply to all living quarters, common areas and the kitchen area. The Food Premises Regulation applies in homes where there are greater than 9 individuals residing within the home. Lodging homes are inspected upon operation and Informal Care Group Homes are inspected upon licensing and then on a complaint basis.
3	Management and Response	PHIs respond, in collaboration with other community stakeholders, to notifications through the Vulnerable Occupancy Protocol (VOP) in the city of London, related to unhealthy and unsafe living conditions in homes considered to be vulnerable occupancies. MLHU has a 24/7 response system in place for responding to reports of health hazards in the Middlesex-London community, and the reported hazards are risk assessed at intake, and responded to in a timely fashion in accordance with the level of risk. PHIs also respond to emergencies and collaborate with the Manager of Emergency Management when necessary.

4	Awareness Education and Training	PHIs provide additional supports and consultation to clients and housing operators, related to unhealthy living conditions, to improve upon housing conditions. In-services are delivered in a variety of community settings including schools, apartments / social housing, partner agencies and internal colleagues (MLHU). In-services focus on pest control, indoor air quality / hazards as well hazards that impact neighbourhoods. Internal collaborations are also established to proactively achieve better health outcomes, where there is demonstrated need identified during inspection or health hazard investigation work. PHIs work with external stakeholders including the VOP group and the Hoarding Support Services Working Group to help provide awareness and to assist in making referrals when necessary.

Performance / Service Level Indicators

Indicator	2018 (to Nov 19)	2019	2020 (target)
Responses to health hazard complaints and service requests	1415	1293	To reduce number from previous year

Highlights / Initiatives Planned for 2020

• Continue to deliver public health interventions geared towards our target populations (newcomers population and vulnerable occupancies).
• Update team procedures under the health hazard response program to reflect OPHS requirements under the Health Hazard Response Protocol, 2019.
• Finalize Cooling Tower registration / risk assessment process, and provide education and awareness to priority populations (LTC homes, retirement homes etc.), in attempt to increase uptake.
• Review and develop new program indicators for health hazard response programming.
• Update Health Impact Assessment (HIA) tool for land use planning work, as well as a Human Health Risk Assessment tool for risk assessing, managing and communicating potential environmental hazards.

Program Challenges and Risks

• Achieving sustained improvements in vulnerable occupancies can be difficult, given many of the life challenges facing our vulnerable residents. These are often transient environments which can prove challenging for meaningful public health intervention.
• Providing education and awareness on housing related matters to newcomer populations is challenging given the language and cultural barriers.
• There is a demonstrated need for enhanced collaboration in providing public health intervention to these target populations.

Staffing Complement

	2019 Total FTEs	2020 Total FTEs	Δ
Program Assistant	0.20	0.20	0.00
Program Manager	0.20	0.20	0.00
Public Health Inspector	3.00	3.00	0.00
Associate Medical Officer of Health	0.00	0.01	0.01
Director	0.00	0.05	0.05
Total Program FTE	***3.40***	***3.46***	***0.06***

Expenditures

	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 270,188	$ 286,510	16,323	6%
Benefits		$ 65,361	$ 67,828	2,468	4%
Expected Vacancies		$ -		-	
Travel		$ 5,192	$ 5,925	733	14%
Program Supplies		$ 2,832	$ 4,373	1,540	54%
Board Expenses		$ -		-	
Staff Development		$ 1,569	$ 1,987	418	27%
Occupancy		$ -		-	
Professional Services		$ -	$ 6,492	6,492	
Furniture & Equipment		$ -	$ 29	29	
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 450	$ 1,634	1,184	263%
Total Expenditures	***$ -***	***$ 345,592***	***$ 374,779***	***$ 29,187***	

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 325,592	$ 370,356	44,764	14%
MOHLTC (100%)		$ 16,000		(16,000)	-100%
MCCSS		$ -		-	
PHAC		$ -		-	
PHO		$ -		-	
User Fees		$ 4,000	$ 4,000	-	0%
Other		$ -	$ 423	423	
Total Revenues	***$ -***	***$ 345,592***	***$ 374,779***	***$ 29,187***	

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Healthy Environments and Climate Change				431
Standard	Healthy Environments	**Director Name**	Stephen Turner	
Lead Team	Food Safety and Healthy Environments	**Manager Name**	David Pavletic	
Supporting Team(s)				
Budget	$ 98,984	**FTE**	0.89	

Summary of Program

MLHU works to develop approaches for promoting healthy built and natural environments to enhance population health and mitigate environmental health risks, in alignment with the Healthy Environments and Climate Change Guideline, 2018. PHIs work to identify and mitigate hazards to protect residents in Middlesex-London from environmental exposures that are of significance, including hazards that have been well established as leading carcinogens and / or burdens of illness in Ontario, as well as hazards that are of local significance. PHIs review research and collaborate with community stakeholders and partner agencies, to protect and promote the health of people in our communities. Interventions include:

Public Awareness and Education
Extreme Temperature Notifications
Municipality Engagement
Participation on Working Groups and Committees

Target populations include people in Middlesex-London who are at increased risk to the impacts of climate change (extreme temperature and weather events), those being people who are homeless, the elderly and school aged children as well as people who are at increased risk to unhealthy housing environments including the newcomer population.

Program Mandate & Relevant Legislation

- Healthy Environments Standard
- Healthy Environments and Climate Change Guideline, 2018
- Harmonized Heat Warning and Information System for Ontario, 2016
- Assessment of the Vulnerability to the Health Impacts of Climate Change in Middlesex-London, 2014
- Ontario Climate Change and Health Toolkit, 2016
- Ontario Planning Act

Program Management

The Healthy Environments and Climate Change Program is managed by the Food Safety and Healthy Environments Team (FSHET). There is also collaboration with the Healthy Communities and Injury Prevention Team (HCIPT). Program leads from these teams collaborate in an effort to develop internal policies and position statements and to review significant land use notices that may require public health input. The interdivisional collaboration between the teams aligns with the following objective identified in the Healthy Environments and Climate Change Guideline, 2018;

Align existing public health initiatives across boards of health to ensure optimum delivery from both the Healthy Environments and Chronic Disease Prevention Standards

Key Partners and Stakeholders

City of London; Middlesex County; Public Health Ontario; Ministry of Environment, Conservation and Parks

Community Needs and Priorities

a) The 2014 Assessment of Vulnerability to the Health Impacts of Climate Change in Middlesex-London, provides some key recommendations to better inform vulnerability planning in Middlesex-London in the areas of extreme weather events, air quality, vector-borne diseases and waterborne / foodborne illnesses and food security.

As well, the MLHU Community Health Status Resource (updated November 2019) contains Healthy Environments information pertaining to a variety of environmental health related topic areas including local air quality data. The FSHET at MLHU works in collaboration with the MECP and other community stakeholders to obtain local environmental surveillance data.

b) MLHU focuses healthy environments program work on vulnerable residents, those being individuals most at risk to the impacts of environmental hazards and events related to climate change.

Target and Priority Populations

Priority populations are individuals who are more vulnerable to the impacts of environmental hazards including hazards associated with the impacts of climate change, and very much influenced by the SDOH. Individuals more at risk to environmental health hazards may include people who have language barriers, financial barriers or cultural barriers. Housing that is structurally substandard, located in close proximity to sources of pollution, and lacks adequate air conditioning will present additional risks to public health. Vulnerable populations may experience challenges related to securing safe and affordable housing, and are therefore considered priority populations.

Target populations related to the Healthy Environments program include the newcomer population, people who experience precarious housing situations, the elderly and very young.

Intended Program Outcomes

Long-Term / Population Health	• To reduce exposure to health hazards and promote the development of healthy built and natural environments that support health and mitigate existing and emerging risks, including the impacts of a changing climate
Intermediate	• The board of health is aware of and uses data to influence and inform the development of local healthy public policy and its programs and services related to reducing exposure to health hazards and promoting healthy built and natural environments. • Board of health programs and services are designed to address identified needs of the community, including priority populations, associated with health hazards and healthy built and natural environments. • There is a decrease in health inequities related to exposure to health hazards. • Timely and effective detection, identification and response to health hazards and associated public health risks, trends and illnesses. • Public and community partners are aware of the risks of health hazard incidents and health protection and prevention activities related to health hazards and conditions that create healthy built and natural environments.
Short-Term	• Internal plan for increased program activities to address climate change is completed in collaboration with Healthy Communities and Injury Prevention Team.

Program Interventions		
1	Public Awareness and Education	PHIs provide healthy environments awareness and education to the general public by providing information on the health unit website, delivering community presentations, responding to public complaints and service requests and attending environmental workshops. PHIs also provide public health direction to various community groups and stakeholders on potential health hazards that are of significance and / or have local context. PHIs investigate and communicate the risks of potential, suspected and / or identified environmental hazards to municipal partners, community groups and concerned residents. The work is conducted in collaboration with partner agencies through 'in-person' meetings, committee meetings and in-services, phone calls and email.
2	Extreme Temperature Notifications	MLHU issues Extreme Temperature Notifications within Middlesex-London to vulnerable populations (schools, Long-Term Care Homes, Shelters etc.) as well as the general public through email / fax but will soon be upgrading to new a communication platform. Heat Warnings / Extended Heat Warnings / Heat Alerts: MLHU issues heat warnings and extended heat warnings in accordance with the *Harmonized Heat Warning and Information System, 2016*. In addition, a Heat Alert is issued when temperatures are heating up and / or the extreme heat is only forecasted to be 1 day in duration. Cold Weather Alerts: MLHU issues Cold Weather Alerts and Special Weather Statements when temperatures are expected to reach -15C at any time during day or night (this is not currently a provincial standard).
3	Municipality Engagement	PHIs work with municipalities in many different capacities as it relates to promoting and protecting the health of our communities, within the built and natural environments. Intersectoral approaches are important in helping to achieve healthier outcomes in our communities, and PHIs draw on the expertise of municipal partners in the areas of property standards, fire prevention, planning, waste management and licensing. Activities include conducting joint inspections, attending opportunities for information sharing, consulting on bylaw related matters and contributing to the development of local policy in matters related to land use planning, built environment and climate change.

4	Participation on Working Groups and Committees	PHIs participate on a variety of committees and working groups including Public Liaison Committee Meetings, the Advisory Committee for the Environment (ACE), the Trees and Forest Advisory Committee (TFAC) and several internal working groups related to the Built Environment and Climate Change . Through the participation on these committees and working groups, PHIs work to create internal policy, serve as public health advocates, build strong community and stakeholder connections and liaise with partner agencies in an effort to enhance healthy environments and communicate potential environmental risks to concerned residents within Middlesex-London. These activities are typically delivered face-to-face and with various forms of accompanying communication (phone, email).

Performance / Service Level Indicators

Indicator	2018	2019	2020 (target)
# of cold weather alerts issued by the MLHU	5	5	To maintain issuing whenever criteria met
# of heat alerts issued by the MLHU	6	3	To maintain issuing whenever criteria met
# of extreme weather events requiring public health emergency interventions per year	new indicator	0	To maintain response when necessary
# of climate change adaptation measures implemented	new indicator	4 (presentations, project work, interviews, committee participation) *Note: this indicator will be further developed for next year.	To increase number from previous year

Highlights / Initiatives Planned for 2020

• Strengthen efforts related to vulnerability planning, building on the recommendations from the Middlesex London Vulnerability Assessment, 2014.
• Modernize and transition to improved Extreme Temp Notification platform.
• Develop a MLHU Climate Change Position Statement.
• Promote RentSafe Housing Initiative, to advocate for healthier housing outcomes.
• Establish scheduled meetings with municipal partners and partner agencies to facilitate information sharing.
• Update policies and procedures to reflect the new requirements in the OPHS / Healthy Environments and Climate Change Guideline, 2018.

Program Challenges and Risks

• Internal collaboration is important to ensure that consolidated and comprehensive public health messaging is being delivered. Risks related to contradictory messaging can occur given the breadth of public health programming delivered within our communities. The FSHET and the HCIPT work collectively in areas of land use planning, built environment and climate change and it is possible that health protection messaging may conflict with some health promotion messaging.

Staffing Complement

	2019 Total FTEs	2020 Total FTEs	Δ
Program Assistant	0.05	0.05	0.00
Program Manager	0.05	0.05	0.00
Public Health Inspector	0.75	0.75	0.00
Associate Medical Officer of Health	0.00	0.01	0.01
Director	0.00	0.03	0.03
Total Program FTE	***0.85***	***0.89***	***0.04***

Expenditures					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 67,547	$ 75,866	8,319	12%
Benefits		$ 16,340	$ 17,825	1,485	9%
Expected Vacancies		$ -		-	
Travel		$ 1,298	$ 1,508	210	16%
Program Supplies		$ 708	$ 1,132	424	60%
Board Expenses		$ -		-	
Staff Development		$ 392	$ 526	134	34%
Occupancy		$ -		-	
Professional Services		$ -	$ 1,690	1,690	
Furniture & Equipment		$ -	$ 14	14	
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 113	$ 423	311	276%
Total Expenditures	***$ -***	***$ 86,398***	***$ 98,984***	***$ 12,586***	

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 81,398	$ 97,619	16,221	20%
MOHLTC (100%)		$ 4,000		(4,000)	-100%
MCCSS		$ -		-	
PHAC		$ -		-	
PHO		$ -		-	
User Fees		$ 1,000	$ 1,000	-	0%
Other		$ -	$ 365	365	
Total Revenues	***$ -***	***$ 86,398***	***$ 98,984***	***$ 12,586***	

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Breastfeeding and Infant Feeding					440
Standard	Healthy Growth and Development		**Director Name**	Heather Lokko	
Lead Team	Early Years		**Manager Name**	Ronda Manning	
Supporting Team(s)	Reproductive Health		Best Beginnings		
Budget	$ 1,422,802		**FTE**	12.60	

Summary of Program

The primary goals of the Breastfeeding/Infant Feeding Program are to increase the duration and exclusivity of breastfeeding and to decrease health inequities related to infant feeding within Middlesex-London. Strategies include supporting families during the prenatal period to make an informed decision regarding infant feeding; providing direct breastfeeding support; increasing families' and healthcare providers' knowledge, awareness, and skills related to infant feeding; enhancing consistency in evidence-based infant feeding messaging; collaborating with community partners; and implementing Baby-Friendly Initiative policy actions. Interventions incorporate a client-centered approach which is nonjudgmental, flexible, sensitive to the unique needs of every individual, and which validates and enhances a parent's sense of empowerment and self efficacy regardless of their feeding choice.

Interventions of the Breastfeeding / Infant Feeding Program include:

- Early Years Breastfeeding Home Visits
- Nurse Family Partnership (NFP) and Healthy Babies Healthy Children (HBHC) Home Visiting
- Healthy Growth and Development Phone Support
- Second Planned Calls
- Middlesex-London Infant Feeding Surveillance System (MLIFSS)
- Baby Friendly Initiative (BFI) Designation Maintenance
- Local and Provincial BFI/Breastfeeding Initiatives
- Healthy Start Infant Drop in's
- Website and Social Media

Program Mandate & Relevant Legislation

Health Protection and Promotion Act, R.S.O. 1990, c.H.7
Healthy Growth & Development Standard (2018) and Healthy Growth & Development Guideline (2018)
Health Equity Standard (2018) and Health Equity Guideline (2018) and Relationship with Indigenous Communities Guideline (2018)
Effective Public Health Practice Guideline (2018) and Mental Health Promotion Guideline (2018)
Healthy Babies Healthy Children Protocol (2018) and Healthy Babies Healthy Children Guidance Document (2012)
Child, Youth & Family Services Act, 2018 and Duty to Report Legislation
Municipal Freedom of Information and Protection of Privacy Act, R.S.O. 1990 (MFIPPA)
Personal Health Information Protection Act, R,S,O, 2004 (PHIPA)
Nurse-Family Partnership® Core Model Elements

Program Management

Working groups with PHN and manager representation from all teams coordinate provision of services and processes across the division. The Planning and Evaluation Team has supported planning and development of indicators relevant to the outcomes identified.
Early Years: provides support to breastfeeding clients that score without risk and/or with lower risk factors on the HBHC screen through home visits, second planned call, Healthy Growth and Development Phone Support, and drop-ins
Best Beginnings (HBHC): provides information regarding breastfeeding in the prenatal period and breastfeeding/infant feeding support to clients that score with higher risk factors on the HBHC Screen through home visits and Healthy Growth and Development Phone Support
Nurse-Family Partnership (NFP): provides information regarding breastfeeding prenatally and breastfeeding support postpartum through home visits.
Reproductive Health: provides breastfeeding information through on-line prenatal education, Smart Start for Babies and Prenatal Immigrant Program, and Healthy Growth and Development Phone Support
Health Care Provider Outreach: provides information and resources to assist HCPs in supporting families to breastfeed, information in newsletters, and referral information.

Key Partners and Stakeholders

Involved
Middlesex-London Elgin Breastfeeding Coalition for common resource development

Interested
Physicians and Pediatricians, Nurse Practitioners, Midwives, EarlyON's, Family Centres, LHSC Mother-Baby Care Unit, LHSC NICU In-Patient/Outpatient Support, Middlesex Hospital Alliance – Strathroy Middlesex General Hospital Site Mom & Baby Clinic, Postnatal Wellness Clinic, La Leche League, Doula's

Community Needs and Priorities

Middlesex-London Interim BFI Report 2019:

Intention to breastfeed remained stable from 2013 (92.2%) to 2018 (92.5%) and slightly lower than Ontario, but not statistically significant, and higher compared to its Peer Group A. Exclusively breastfeeding at entry to public health service (discharge from hospital or birth centre, or home births 3-days post partum) increased between 2013 and 2017, but decreased slightly in 2018. The proportion in 2018 (61.6%) is statistically higher compared to in 2013 (57.2%), and comparable to the proportions in Peer Group A and Ontario. At 2 weeks postpartum, approximately 9 of 10 women are still reporting any breastfeeding, however, this drops to approximately 7 of 10 women by 4-months postpartum, and to 2–3 of 10 women by 12-months postpartum. At 18-months, 1 of 10 mothers are still reporting providing breast milk to their child. Duration of any and exclusive breastfeeding up to 6-months postpartum for infants in the 2015 to 2018 MLIFSS birth cohorts was:

- for any breastfeeding, the percentage drops gradually over the 6-month period postpartum.
- for exclusive breastfeeding, the largest drop occurs between 4 and 6 months postpartum.
- for 2018, 62.3% of infants were exclusively fed breast milk at 2-weeks compared to 2017 at 47.3%.
- by 6-months, 19.7% had breastmilk exclusively.

In a 2017 review, research suggests that planned scheduled interventions either by phone or face-to-face are more effective than unplanned, unscheduled ones such as drop-ins. Therefore, in 2018 a home visiting program to focus on breastfeeding was implemented.

Target and Priority Populations

At this time, data for priority populations with M-L is not available through the infant feeding surveillance system, however, Best Start provides Ontario breastfeeding trends which help identify priority populations. Intermediary target groups include healthcare providers in M-L who provide service to postpartum women, internal partners and community partners who provide service to postpartum women.

Target Population(s): prenatal and postpartum women and their families living in the City of London and Middlesex County.

Priority Population(s): M-L clients of low socio-economic status, participating in behavioural risks, who are new to Canada in the last 2-3 years, and/or who are socially isolated, and women under the age of 25 and over 34.

In addition, the BB and NFP Teams also support clients from the following priority populations: women subject to intimate-partner violence, women with previous poor reproductive health outcomes, pregnant teens (and their partners), women who engage in high-risk sexual behaviours, and clients with cognitive impairment.

Intended Program Outcomes	
Long-Term / Population Health	•Decreased health inequities related to breastfeeding, infant feeding. •Increased proportion of newborns in Middlesex London are exclusively breastfed for 6 months. •Increased proportion of newborns in Middlesex London are partially breastfed for 6 months.
Intermediate	•Influence and inform the development of local healthy public policy and its programs and services related to breastfeeding and infant feeding. •Increased ability to make informed decisions related to breastfeeding and infant feeding . •Increased in lactation consulting skill and capacity across the region. •Increased collaborative relationships with community partners to build capacity for supporting the breastfeeding dyad. •Increased use of consistent up-to-date messaging by healthcare professionals and those offering breastfeeding support with expectant and breastfeeding mothers across the region. •Increased duration and exclusivity of breastfeeding.
Short-Term	• Increased awareness of the importance of the exclusivity of breastfeeding of parents/caregivers as the optimal method of infant feeding as reflected in the current Health Canada recommendations. • Increased intention to breastfeed beyond 6 months with the addition of complementary foods and continued breastfeeding for 2 years and beyond***. • Increased awareness of breastfeeding supports at MLHU (HCP, parents/caregivers, community partners). • The public is aware of the importance of creating safe and supportive environments that promote breastfeeding. • Breastfeeding women have improved knowledge and skills related to breastfeeding.

Program Interventions		
1	Early Years Team Breastfeeding Home Visits	Through the HBHC Screening Tool completed face-to-face by the screening liaison nurse at LHSC/Strathroy Hospital, client requests made at drop-in's or through Health Connection, or by healthcare provider referrals, clients 'not identified with risk' or who do not complete the screen and who are breastfeeding are contacted by phone by the EY Team. Home visiting support with clients experiencing breastfeeding challenges is delivered during the early postpartum period, based on assessment of client need. Home visits are scheduled at a mutually-agreed upon time during regular business hours, Monday to Friday, and frequency is based on PHN assessment and client. Follow-up calls post-home visits are initiated by the PHN or client for continued breastfeeding support.
2	Nurse-Family Partnership	This home visiting intervention is delivered by PHN's who begin to visit women early in pregnancy (prior to 29 weeks gestation) and continue until the child's second birthday. Visits typically occur every 2 weeks with some exceptions. Infant feeding discussions begin prenatally, continue postnatally, and throughout infancy. Clients are encouraged to make informed infant feeding decisions and provided with education and support that aligns with their infant feeding goals. Home visits are offered weekly during the first 6 weeks after the baby is born to support postpartum adjustment and infant care including infant feeding. Breastfeeding initiation and duration rates are supported through a therapeutic nurse-client relationship, a client-centred approach to practice and use of Motivational Interviewing. Evidence: NFP Research/ strongly encouraged program provincially/nationally.
3	Healthy Babies Healthy Children (HBHC)	Women 'identified with risk' on the HBHC screen receive their breastfeeding support through the Best Beginnings Team (HBHC). Home visits are provided Monday to Friday by Public Health Nurses (PHN) for early postpartum home visits to support breastfeeding. Home visit scheduling is negotiated between the client and PHN, with more intense visits to establish breastfeeding. When working with clients during the prenatal period, clients are supported to make informed infant feeding decisions. Evidence: Provincially Mandated Program

4	Healthy Growth and Development Phone Support	Universal telephone-based breastfeeding counselling and support is provided by Public Health Nurses to clients and community partners through the provision of client/family-centred assessments and provision of information and support regarding breastfeeding and infant feeding. Through this telephone-based service, referrals to MLHU programs including breastfeeding home visits and community services are made, as appropriate. Located at the MLHU main office and offered during regular business hours (8:30-4:30), Monday to Friday.
5	Second Planned Call	Early postpartum clients contacted by the Early Years and the Best Beginning Teams are contacted on two occasions, at a minimum (with consent). The second planned call is offered to all clients who had no breastfeeding concerns on the first telephone call, clients who had breastfeeding concerns and declined the home visit, and clients who had breastfeeding concerns in hospital. The assigned PHN completes this second contact within seven days to further assess need for breastfeeding support. PHN's call clients assigned to them Monday to Friday during regular business hours (8:30-4:30).
6	Middlesex-London Infant Feeding Surveillance System (MLIFSS)	This retrospective survey of infant feeding practices is conducted with all postpartum mothers who consent (when in hospital) to be contacted by email or telephone by a Program Assistant at two, six, and 12 months. Annual results are shared with the Healthy Start Leadership Team and the Breastfeeding Committee for Canada annually. Indicators monitored through this surveillance inform planning processes and measure outcomes of the Breastfeeding and Infant Feeding Program.
7	Baby Friendly Initiative (BFI) Designation Maintenance	Mandatory orientation is provided by a PHN on the Reproductive Health Team to all new staff, students, volunteers and Board of Health. Additional educational materials are disseminated to existing staff to maintain competencies. The BFI PHN lead ensures all program materials are in compliance with BFI best practices (e.g. resources, teaching material, media releases, health unit website etc.). The organizational BFI policy, and other related policies, are reviewed annually.

8	Local and Provincial BFI/Breastfeeding Initiatives	The BFI PHN coordinates with internal PHNs and the local birthing hospital representative to provide the 20-hour BFI course to health care providers (completion of the RNAO online breastfeeding course and a one day workshop). MLHU and the local birthing hospital collaborate to develop common messaging and materials for use with a shared population. The BFI PHN participates in Infant Provincial Surveillance Workgroup to collaborate on BFI/ breastfeeding initiatives and consistent data collection tools/methods for surveillance. MLHU participates on the OPHA Breastfeeding Promotion Network to create provincial breastfeeding messaging and to more efficiently engage in breastfeeding promotion strategies. MLHU's BFI lead is the Communication Lead on the BFI Ontario Executive, and also sits on the BFI Expo (bi-annual conference) planning committee, with the next conference to be held October 2020 in Waterloo.
9	Healthy Start Infant Drop-in's	Drop-Ins are an in-person, targeted universalism intervention, delivered by Public Health Nurses on the Early Years team. The Heathy Start Infant Drop-in's are provided for all families within the City of London and Middlesex County with infants/children 0-6 months of age. Drop-ins are strategically located and offered Monday through Friday in partnership with Libraries, EarlyOn's, and Family Centres through the city/county on a four-week rotation which increase accessibility for more vulnerable families. Vulnerability was determined by socio-economics, EDI scores, and accessibility to community programming. Public Health Nurses provide breastfeeding and infant feeding information and support at Healthy Start Infant Drop-ins.
10	Website and Social Media	Evidence-informed, up-to-date, and comprehensive breastfeeding and infant feeding information is available on the MLHU website, in text and video format. Social media (e.g., Twitter, Facebook) is used to raise awareness and engagement. Health promotion campaigns are conducted annually, such as Skin-to-Skin Campaign (May) and World Breastfeeding Week Campaign (October).

Performance / Service Level Indicators

Indicator	2018	2019	2020
Any breastfeeding rates: entry to community / 2 months / 6 months / 12 months	92.2%/ 81.5% / 67.2% / NA	data not yet available	Increase 2, 6, and 12 month rates by 2-4%
Exclusive breastfeeding rates: entry to community / 2 months / 6 months	61.6% / 50.7% / 19.7%	data not yet available	Increase 2, 6, and 12 month rates by 2-4%
# Health Connection calls regarding breastfeeding/infant feeding	540 (primary reason only)	estimate 480	May decrease as increase in home visits.
# 20-hour breastfeeding workshops for Health Care Providers offered / # of HCP's attending	3 workshops / 61 HCPs	5 workshops / 88 HCPs	Increase workshops to 7
# clients receiving EYT breastfeeding home visits / # breastfeeding visits	282 / 435 (June to December only)	785 / 1543	Maintain
# drop-in visits related to breastfeeding / infant feeding	1091	665	Indicator to be reassessed in 2020
Any breastfeeding rates in NFP program: initiation / 6 months / 12 months	N/A	N/A	New Indicator for 2020
Exclusive breastfeeding rates in NFP program: initiation / 6 months	N/A	N/A	New Indicator for 2020

Highlights / Initiatives Planned for 2020

- Processes and expectations related to breastfeeding home visits will continue to be refined
- 20-hour breastfeeding course and breastfeeding education to HCP's will be offered more frequently than in 2019.
- Revision of the infant feeding survey timelines from 6, 12, 18 months to 2, 6, 12 months.
- Potentially increase data collection related to the implementation of a new electronic documentation system (Profile).
- Review of breastfeeding indicators.

Program Challenges and Risks

• Current tracking processes may be insufficient to capture program data and may need to be adjusted accordingly.
• Unsure if capturing priority populations in surveillance data.
• Breastfeeding outcomes in community may be dependent on hospital support and practices.
• Uncertainty of consistent community key messages and communication.
• Not fully clear on the potential impacts of choosing to retain BFI activities, but not redesignating.
• Healthcare providers including midwives lack of knowledge/confidence in breastfeeding support and commitment to 2 days for the 20-hour breastfeeding course. HCPs often supplement/switch to formula without first exploring support/latch/position/etc. Other opportunities for increasing knowledge and confidence in breastfeeding support.
• Families screened with risk on the HBHC Screening Tool and have a higher risk score are not being seen as quickly as those with a lower risk score due to the waitlist on the BB Team. Therefore, there are health inequities in the population.

Staffing Complement

	2019 Total FTEs	2020 Total FTEs	Δ
Program Assistant	1.39	0.79	-0.60
Program Manager	1.19	0.81	-0.38
Public Health Nurse	10.15	10.90	0.75
Family Home Visitor	0.80	0.00	-0.80
Director	0.00	0.10	0.10
Total Program FTE	***13.53***	***12.60***	***-0.93***

Expenditures					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 1,091,723	$ 1,085,220	(6,503)	-1%
Benefits		$ 273,988	$ 264,647	(9,341)	-3%
Expected Vacancies		$ -		-	
Travel		$ 16,363	$ 16,771	408	2%
Program Supplies		$ 37,380	$ 36,891	(488)	-1%
Board Expenses		$ -		-	
Staff Development		$ 5,004	$ 5,944	940	19%
Occupancy		$ -		-	
Professional Services		$ 20,257	$ 10,176	(10,081)	-50%
Furniture & Equipment		$ 5,417	$ 2,227	(3,189)	-59%
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 1,285	$ 926	(360)	-28%
Total Expenditures	***$ -***	***$ 1,451,417***	***$ 1,422,802***	***-$ 28,615***	

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 977,986	$ 1,229,562	251,577	26%
MOHLTC (100%)		$ -		-	
MCCSS		$ 443,449	$ 174,999	(268,450)	-61%
PHAC		$ 18,292	$ 17,316	(976)	-5%
PHO		$ -		-	
User Fees		$ 977	$ 925	(52)	-5%
Other		$ 10,714		(10,714)	-100%
Total Revenues	***$ -***	***$ 1,451,417***	***$ 1,422,802***	***-$ 28,615***	

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Growth and Development					441
Standard	Healthy Growth and Development		**Director Name**	Heather Lokko	
Lead Team	Best Beginnings		**Manager Name**	Jenn Proulx, Suzanne Vandervoort, Isabel Resendes	
Supporting Team(s)	Early Years		Reproductive Health		
Budget	$ 2,034,810		**FTE**	20.50	

Summary of Program

The goals of the Growth and Development Program are to achieve optimal newborn, child, parental and family health, to optimize developmental outcomes for children, to improve children's readiness for school, and to reduce health inequities related to growth and development. The Healthy Start division provides a range of services designed to address the physical, emotional, and social growth and development of children from birth to school entry. Multi-strategy approaches are implemented to educate, raise awareness, create supportive environments, strengthen community action and partnership, link and facilitate access to MLHU and community services, and build personal skills and self-efficacy with families and caregivers.

Interventions of the Growth and Development Program include:
- Nurse Family Partnership (NFP) Home Visiting
- Healthy Babies Healthy Children (HBHC) Home Visiting
- Website and Social Media
- Healthy Start Infant Drop-ins
- Healthy Growth and Development Phone Support
- Community Partnership and Collaboration
- Health Care Provider Outreach

Program Mandate & Relevant Legislation

Health Protection and Promotion Act, R.S.O. 1990, c.H.7
Healthy Growth & Development Standard (2018) and Healthy Growth & Development Guideline (2018)
Health Equity Standard (2018) and Health Equity Guideline (2018) and Relationship with Indigenous Communities Guideline (2018)
Effective Public Health Practice Guideline (2018) and Mental Health Promotion Guideline (2018)
Healthy Babies Healthy Children Protocol (2018) and Healthy Babies Healthy Children Guidance Document (2012)
Child, Youth & Family Services Act, 2018 and Duty to Report Legislation
Municipal Freedom of Information and Protection of Privacy Act, R.S.O. 1990 (MFIPPA)
Personal Health Information Protection Act, R,S,O, 2004 (PHIPA)
Nurse-Family Partnership® Core Model Elements

Program Management

The Growth and Development Program is implemented by the three Best Beginnings Teams, Early Years Team, and Reproductive Health Team. The Best Beginnings Team implements the HBHC Program and NFP Program. The Early Years Team provides the Healthy Start Infant Drop-Ins and takes primary responsibility for website and social media. While the Early Years Team is most significantly engaged in community partnership and collaboration related to growth and development, the Best Beginnings Team is also involved in this work. In 2020, the Health Connection work will be supported by all Healthy Start Teams. The Early Years Team collaborates with the Health Care Provider Outreach Team (with Early Years contributing a 0.5 FTE to the HCP Outreach Program with a significant focus on early childhood development).

Key Partners and Stakeholders

Involved: Aboriginal Babies and Beyond Committee; Child and Youth Network - 4 priority areas: Ending Poverty, Literacy, Healthy Eating Healthy Physical Activity, and Creating a Family and Child Service System. The Community Early Years Partnership (MLHU chair) - disseminate, share information and promote optimal infant and early childhood development to healthcare providers, community partners, parents and caregivers (0 to school entry). A sub-committee of CYN is Healthcare Provider Committee - develop and implement universal and targeted approaches fostering infant/child growth and development. Middlesex Children's Services Network - any organization/agency/individual with a mandate or interest in the service/education/awareness and/or well-being of children (prenatal to 12).
Supported: Child and Family Centres (drop-in's), Early ONs (drop-in's), Child Care Providers – increased knowledge exchange, Southwest Ontario Aboriginal Health Access Centre (SOAHAC) support prenatal education, London Health Sciences Centre – HBHC screening liaison PHN, Child Reach – support Young Mom's Group.
Interested: Western University/Fanshawe College
Referrals: Children's Aid Society of London and Middlesex, Thames Valley Children's Centre, Vanier Children's Services, Child & Parent Resource Institute (CPRI), Developmental Resources for Infants (DRI), TykeTALK, Child Reach, Merrymount Children's Centre, Addiction Services Thames Valley (Heart Space), London Intercommunity Health Centre, Muslim Resource Centre, St Leonard's Community Services London and Region, Street Level Women at Risk.

Community Needs and Priorities

MLHU, Population Health Data: Early Growth & Development, May 2019

HBHC Screening Tool: In 2018, HBHC postpartum screening (93% of mothers) resulted in 57% of infants "identified with risk" and 43% of infants "not identified with risk", with the percentage of those infants with risk decreasing slightly over time from 2015 to 2018. Families in need of newcomer support was 8.3% in 2018, up from 6.2% in 2015. 7.6% had concerns about money to pay for housing/rent and the family's food, clothing, utilities and other basic necessities. The percentage of those involved with Child Protection Services has dropped (4.2% in 2018 and 6.9% in 2016).

Early Developmental Instrument: Identification of percentage of children demonstrating risk: Physical Health and Well-being cycles 2 (12.0%) and 4 (17.0%), (Ontario 16.1%). Social Competence cycles 2 (6.6%) and 4 (10.2%), slightly lower compared to Ontario. Emotional Maturity cycles 2 (8.6%) and 4 (12.6%), (Ontario 10.3%). Language and Cognitive Development cycles 1 (8.5%) and 4 (5.8%), (Ontario 9.6%). Communication Skills and General Knowledge cycles 1 (10.6%) and 4 (9.4%), (Ontario 12.1%). Overall, 28.3% were vulnerable on at least one domain in Cycle 4, (Ontario 29.4%). The percent increased over time between cycles 2 (2006/7–2008/9) and 4 (2015). In each of the cycles, the percent vulnerable was higher in the City of London versus Middlesex County. In each EDI cycle, a higher percent of males (34.4%) in Middlesex-London were vulnerable on a least one domain compared to females (22.1%).

All Kids Belong (2018) Annual Childcare educators survey of Child Indicators: Percentage of children in which concerns were identified: City of London: Communication/Language (31%), Social (28%), Behavioural (26%), Emotional (23%). Middlesex County: Communication/ Language (36%), Social (36%), Self-Help (36%), Fine Motor (29%). 45% of participants concerns are behaviour-related. Current programming relates to attachment, mental health (children and caregivers), literacy, child development, physical literacy.

Target and Priority Populations

Target Population(s): Parents/mothers and caregivers of children from birth to school entry.

Priority Population(s): Priority populations of parents/mothers/caregivers of children from birth to school entry that are: Arabic-speaking newcomers (5 years or less in Canada); Indigenous; living with low income and other SES-related concerns; young (<25 years of age); who score "with risk" on the HBHC screening tool; mothers of babies/young children with attachment concerns (related to either mom or child); newcomers; exposed (or their children are exposed to) violence. For the NFP program, eligible women are those who are 21 years old or younger, pregnant with their first child and/or first- time parenting, pregnant 28 weeks or less, experiencing financial hardship or limited resources.

Intermediary: Health Care Providers. Early Childhood Educators (ECE's) at Child and Family Centres and Early ON Centres and other staff at Family Centres. Child Care Providers ECE's. Kindergarten Teachers.

Intended Program Outcomes	
Long-Term / Population Health	•To achieve optimal newborn, child, parental and family health (OPHS Goal) •To improve/optimize developmental outcomes of children •To improve children's readiness for school
Intermediate	•Maintain and strengthen existing community partnerships •Increase parents' ability to use skills and strategies to optimize infant and childhood mental health •Increase families who can effectively foster healthy growth and development skills at different life stages, and successfully progress through the transitions between these stages (OPHS 2018) •Increase Individual and family access to local supports (OPHS 2018) •Decrease in health inequities related to healthy growth and development (OPHS 2018) •Children at risk of poor health and developmental outcomes are supported and referred to services prior to school entry
Short-Term	•Increase community partner and healthcare provider awareness regarding the importance of providing information and resources to parents/caregivers during the early years •Increase, individual and family awareness of factors associated with healthy growth and development, and the importance of creating safe and supportive environments that promote healthy growth and development (OPHS 2018) •Increase community partner knowledge of the factors associated with and effective programs for the promotion of healthy growth and development as well as managing the stages of the family life cycle (OPHS 2018) (supportive environments) •Increase individuals and family awareness about how to access to local supports (OPHS 2018) •Increased parent and caregiver knowledge about the importance of early identification of developmental and mental health concerns

Program Interventions		
1	Website and Social Media	MLHU maintains a high-quality website with credible, up-to-date, comprehensive information related to healthy growth and development in the early years, for families and community partners. Facebook and Twitter are also used for awareness-raising with parents who use social media. Target is residents of Middlesex-London (universal), health professionals, educators. Information related to healthy growth and development in the early years as a way to provide service, education, and information.
2	Healthy Start Infant Drop-Ins	Targeted Universalism drop-ins are an in-person intervention, delivered by PHN's on the Early Years team for families (0-6 months). Drop-ins are offered weekly at 4 locations as a stand-alone intervention in the City of London. Drop-ins are offered monthly or bi-weekly in 6 locations in Middlesex County at Early ON locations (during the times of Early ON programming). They are open to all postpartum families, and are strategically located through the city/county in community partner locations which increase accessibility for more vulnerable families. Community survey completed in approximately 2006 showed vulnerable neighbourhoods and drop-ins were placed in these vulnerable locations. Information and support is provided to families with infants, covering topics such as nutrition (including breastfeeding and infant feeding), safety, infant growth and development, parenting, attachment, adjustment to parenting, and community resources.
3	Nurse Family Partnership	The Nurse Family Partnership is a home visiting intervention delivered by Public Health Nurses (PHNs) who begin to visit women in their home early in pregnancy and continue until the child's second birthday. Visits typically occur every two weeks with some exceptions. PHNs support clients to provide sensitive and competent caregiving with the goal of improving child health and development. Program activities include: providing education on infant/toddler nutrition, health, growth & development and environmental safety; using dyadic assessment tools to guide interventions to promote sensitive parent- child interactions; assessing infant/toddler's development and providing guidance as needed; promoting adequate use of well-child care; and making referrals to other health and human services as needed. Achievement of program goals is facilitated through the development of a therapeutic nurse-client relationship, a client-centered approach to practice, and use of Motivational Interviewing. **Evidence:** NFP Research/ strongly encouraged program provincially/nationally.

4	Healthy Babies Healthy Children	A blended home visiting program delivered by Public Health Nurses (PHNs) and Family Home Visitors (FHVs). This is done in accordance with Healthy Babies Healthy Children Protocol, 2018. It is for women and families in the prenatal period and with children from birth until transition to school. Families screened with risk can enter the program during pregnancy, postpartum, or the early years. The program includes screening, assessment, support services, home visiting, service coordination, and referrals to community resources and supports. Home visits are provided Monday to Friday by Public Health Nurses and Family Home Visitors who support families to reach their identified goals in the areas of infant feeding, caring for self and baby, growth & development, attachment, play and positive parenting. Home visit scheduling is negotiated between the client and visitor, however, typically are provided weekly, bi-weekly or monthly for approximately 6 to 18 months. **Evidence:** Provincially Mandated Program through Ministry of Children, Community and Social Services.
5	Healthy Growth and Development Phone Support	PHNs conduct client/family-centred screenings (including the HBHC Screening Tool) and assessments, provide information on a wide range of health topics, including healthy growth and development. Referrals to MLHU programs and community services are made, as appropriate. This universal telephone-based intervention is offered Monday to Friday during regular business hours (8:30-4:30), and is available to families, individual clients, healthcare providers, and community partners.
6	Community Partnerships and Collaboration	PHN's provide leadership and/or actively engage in a variety of partnerships with community partners that work with early year's families. **London's Child and Youth Network (CYN)** has over 150 agencies/individuals from multiple sectors, and uses a collective impact approach to address 4 priority areas (poverty, literacy, healthy eating and physical activity, and creating a Family-Centred Service System). **Middlesex Children's Services Network** consists of organizations/individuals with a mandate/interest in the provision of service/well-being of children, prenatal to age twelve, and their families, in Middlesex County. Working Groups are established; a gap analysis and comprehensive database of services is being completed. **Aboriginal Babies and Beyond Committee** has 4 areas of focus: Book Bundles (literacy), Prenatal and Parenting Fairs, car seat clinics, and FASD. Monthly meetings involve resource-sharing, speakers, discussion of various programs. The **Early Years Partnership** with a variety of health, social service, and early years partners focuses on promoting health/wellbeing, with a current emphasis on infant/maternal mental health. Efforts with this partnership will be reignited in 2020.
7	Healthcare Provider Outreach	Healthy Start works closely with the Healthcare Provider Outreach Team, providing information, resources, and supports to healthcare providers in London and Middlesex in the area of healthy growth and development. Provided by a collaboration of MLHU's Communications Team and Early Years Team by doing scheduled office visits, regular communications, and website information.

Performance / Service Level Indicators			
Indicator	2018	2019	2020 (target)
total # clients enrolled in the NFP program / % enrolled prior to 16 weeks gestation	81 / 38%	81/36%	Remove indicator for 2020
# drop-in visits related to healthy growth and development	851	364	Potential removal for 2020
# Healthy Growth and Development Phone Support calls regarding healthy growth and development	380 (primary reason only)	465	>500
% postpartum HBHC screens completed out of live births	86.6%	90.0%	91.0%
# families receiving HBHC home visits / # HBHC visits provided	890 / 2912	943 / 3,046	Maintain
Reach of health promotion campaigns that promote the importance of creating safe and supportive environments	N/A	1 Campaign - 12,152	2 Campaigns - 20,000
# of families referred to a Family Home Visitor	179	182	Maintain
Average length of time in the HBHC program	N/A	5.9 months	Maintain

Highlights / Initiatives Planned for 2020

The next phase for the Healthy Start planning initiative will focus on Growth and Development and is expected that program intervention recommendations will be identified through this process. Defining PH role(s) in community related to growth and development. Unclear of role within community and by community partners. Screen Time Campaign. Build on existing programs (i.e. PAIR clinic post-sessions). Refine growth and development indicators.

Program Challenges and Risks

Current tracking processes may be insufficient to capture program data and may need to be adjusted accordingly. Some Drop-ins are run at different times in the city than other programming at Family Centres (space issues, “we have always done it that way”). The drop-ins run at the same time as other programs in the County, but the drop-ins are held in a separate room than other programs. Clients are usually seen individually, and not as a group, although some group talks occur. In South London the drop-in is held at a separate location from Early ON programming (2 campus model). Changes have been made regarding age group under 6 months possibly without informed evidence. (Clients with babies >6 months were attending for weight checks only and were not interested in other services/education). Client goals can be different than PHN goals. Potential for a liaison PHN to connect with Childcare Centres, Early ON and Family Centres to increase capacity of ECE and have greater efficiency for staff time. “ECEs may prefer PHN to do teaching rather than train the trainer” model. Lack of PHN capacity to support all Childcare Centres/ECEs in the community. Gap for clients who may not be eligible for HBHC and need greater support for attachment (PAIR Clinic), growth and development (Childreach, Merrymount, Family Centres, EarlyON). Potential exploration of literature.

•No evidence regarding effectiveness of drop-ins, and what public health’s role should be. Possibly need to look at our involvement in community partnerships and our role to increase the community impact for growth and development.
•Not sure what the intended outcomes should be for the team related to growth and development.
•Need increased use of social media (blogging? website maintenance).
•Public Health Modernization -funding?
•MLHU move

Staffing Complement

	2019 Total FTEs	2020 Total FTEs	Δ
Dietitian	0.50	0.50	0.00
Program Assistant	1.53	2.33	0.80
Program Manager	1.58	1.48	-0.10
Public Health Nurse	13.18	8.93	-4.25
Family Home Visitor	6.40	7.00	0.60
Director	0.00	0.26	0.26
Total Program FTE	***23.19***	***20.50***	***-2.69***

Expenditures

	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 1,733,049	$ 1,519,168	(213,881)	-12%
Benefits		$ 441,940	$ 385,485	(56,454)	-13%
Expected Vacancies		$ -		-	
Travel		$ 27,412	$ 24,838	(2,574)	-9%
Program Supplies		$ 32,616	$ 24,684	(7,932)	-24%
Board Expenses		$ -		-	
Staff Development		$ 6,586	$ 5,979	(607)	-9%
Occupancy		$ -		-	
Professional Services		$ 53,824	$ 53,831	8	0%
Furniture & Equipment		$ 17,120	$ 17,336	216	1%
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 3,320	$ 3,489	169	5%
Total Program Expenditures	***$ -***	***$ 2,315,868***	***$ 2,034,810***	***-$ 281,058***	

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 866,583	$ 618,139	(248,444)	-29%
MOHLTC (100%)		$ -		-	
MCCSS		$ 1,406,942	$ 1,408,322	1,380	0%
PHAC		$ 7,926	$ 7,926	-	0%
PHO		$ -		-	
User Fees		$ 423	$ 423	-	0%
Other		$ 33,994		(33,994)	-100%
Total Program Revenues	***$ -***	***$ 2,315,868***	***$ 2,034,810***	***-$ 281,058***	

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Healthy Pregnancies					442
Standard	Healthy Growth and Development		**Director Name**	Heather Lokko	
Lead Team	Reproductive Health		**Manager Name**	Debbie Shugar	
Supporting Team(s)	Best Beginnings		Early Years		
Budget	$ 1,325,452		**FTE**	11.67	

Summary of Program

Employing a population health promotion approach, the objectives of the Healthy Pregnancies Program are to increase the incidence of babies born with healthy birth weights and at term, create safe and supportive environments that promote healthy pregnancies by decreasing rate of intimate partner violence, decrease incidence of mental health concerns during pregnancy, decrease health inequities related to healthy pregnancies, increase accessibility to services and community supports for pregnant women, support preparation for parenthood, and build partnerships within communities. Additionally, the program intends to increase understanding of and ability to navigate Ontario's health care system, with priority populations.

Interventions of the Healthy Pregnancies Program include:
- Nurse Family Partnership (NFP) Home Visiting
- Healthy Babies Healthy Children (HBHC) Home Visiting
- Prenatal e-Learning and Website
- Prenatal Immigrant Program (PIP)
- Smart Start for Babies (SSFB)
- Indigenous Perinatal Program (IPP)
- Healthy Growth and Development Phone Support

Program Mandate & Relevant Legislation

Health Protection and Promotion Act, R.S.O. 1990, c.H.7
Healthy Growth & Development Standard (2018) and Healthy Growth & Development Guideline (2018)
Health Equity Standard (2018), Health Equity Guideline (2018) & Relationship with Indigenous Communities Guideline (2018)
Effective Public Health Practice Guideline (2018) and Mental Health Promotion Guideline (2018)
Healthy Babies Healthy Children Protocol (2018) and Healthy Babies Healthy Children Guidance Document (2012)
Child, Youth & Family Services Act, 2018 and Duty to Report Legislation
Municipal Freedom of Information and Protection of Privacy Act, R.S.O. 1990 (MFIPPA)
Personal Health Information Protection Act, R,S,O, 2004 (PHIPA)
Nurse-Family Partnership® Core Model Elements

Program Management

The Healthy Pregnancies Program is implemented by the Reproductive Health, Best Beginnings, and Early Years Teams. The Reproductive Health Team has primary responsibility for e-Learning and website, PIP, SSFB, and IPP. The three Best Beginnings Teams provides the home visiting through HBHC and NFP. The Early Years Team focuses on the IPP. In 2020, the Healthy Growth and Development Phone Support will be staffed by all Healthy Start Teams. The Registered Dietitian from the Young Adult Team co-facilitates nutrition education and food literacy at SSFB. The Health Care Provider Outreach program in Communications also supports the Healthy Pregnancies Program.

Key Partners and Stakeholders

EarlyON Centres; Child and Youth Network Family Centres; Health Zone Nurse Practitioner-Led Clinic; Children's Aid Society, health care providers, South London Community Resource Centre, Northwest London Community Resource Centre, Muslim Resource Centre for Social Support and Integration, London Health Sciences Centre; Southwest Ontario Aboriginal Health Access Centre; City of London; County of Middlesex; Childreach; Merrymount Children's Centre; Addiction Services Thames Valley (Heart Space); Health Care Provider Champions Committee; London Intercommunity Health Centre; St Leonard's Community Services London and Region; Street Level Women at Risk; Thames Valley District School Board; Youth Opportunities Unlimited, Vitamin Angels.

Community Needs and Priorities

There are between 4000-5000 births each year in M-L. M-L data showed statistically significantly higher risk than ON in: infant's mother is a single parent; no designated primary care provider for mother/infant; infants with families in need of newcomer support (highest in ON); infants with families who have concerns about money; parent or partner with mental illness; parent or partner with disability; and involvement of Child Protection Services (PHO Risk Factors for HCD, 2015). A significantly higher proportion of women in Middlesex-London reported having a mental health concern during pregnancy compared to women in Ontario from 2013 to 2017 (30% in M-L compared to 18.1% in ON). Women in Middlesex-London tended to gain more than the recommended amount of weight during pregnancy from 2013 to 2017; there was no significant difference in weight gain between urban and rural populations from 2015 to 2017. The proportion of women in Middlesex-London who reported smoking cigarettes, drinking alcohol, and using other drugs (including cannabis) during pregnancy was significantly higher compared to Ontario in 2017. Females under the age of 20 had the highest reported use of these substances during pregnancy and the proportion of women reporting use among this age group increased from 2013 to 2017. Pregnancy rates in Middlesex-London were lower compared to Ontario from 2006 to 2016. Pregnancy rates across age groups in Middlesex-London followed a similar trend to Ontario and the Peer Group, and were highest among females aged 30 to 34 years. Teenage pregnancy rates in Middlesex-London decreased significantly from 2006 to 2016, and although M-L rates are higher than ON the difference is not statistically significant. The percent of women in Middlesex-London who had a prenatal care visit with a physician or midwife during the first trimester of pregnancy (up to 12 weeks of gestation) was 96.5% in 2017, compared to 91.3% in Ontario. From 2013 to 2017, the percentages in Middlesex-London increased over time and remained significantly higher than Ontario, and was similar among the urban and rural population of Middlesex-London from 2013 to 2017.

Target and Priority Populations

- General population of women who are pregnant and their support persons (e-learning and website, HC)
- Pregnant women who score “high risk”(2 or more) on the HBHC screen (HBHC home-visiting)
- Women who are 21 years old or younger, pregnant with their first child and/or first time parenting, pregnant 28 weeks or less, experiencing financial hardship or limited resources (NFP). Prenatal referrals to the HBHC program are triaged to NFP according to program eligibility criteria.
- Arabic-speaking, pregnant, Syrian newcomers (SSFB/PIP)
- Pregnant women and teens, and their support persons who face barriers to accessing healthy food (SSFB)
- Indigenous women who are pregnant (IPP)

Intended Program Outcomes	
Long-term / Population Health	• A decrease in health inequities related to healthy pregnancies • Minimize risk of neural tube defects • Increase the incidence of babies born at term • Increase the incidence of babies born with healthy birth weights • Create safe and supportive environments that promote healthy pregnancies by decreasing rate of intimate partner violence • Decrease incidence of mental health concerns during pregnancy
Intermediate	• Increase self-efficacy regarding preparation for labour, birth, and newborn care • Maintain and strengthen existing community partnerships • Increase self-efficacy regarding planning, purchasing, and preparing meals that include healthy food choices • Reduction or cessation of tobacco, alcohol, or other drug use during pregnancy • Reduction of exposure to second hand smoke exposure during pregnancy • Increase in the ability to access Ontario's health care system during pregnancy • Increase access to prenatal health information and services in the community • Increase access of priority populations to community services
Short-Term	• Increase awareness regarding prenatal health topics • Increase awareness of prospective parents regarding where to find accurate prenatal information and services in the community • Increase knowledge and skills related to healthy eating, healthy weight gain, and food literacy • Increase knowledge and skills regarding economic ways to buy and prepare healthy foods within priority populations during the prenatal period • Increase awareness, knowledge and skills related to the benefits of reducing or stopping tobacco, cannabis, alcohol, and other drug use during pregnancy • Increase community partner knowledge of effective programs for the promotion of healthy pregnancies • Increase perceived knowledge of labour, birth, and newborn care of pregnant women

Program Interventions		
1	Nurse Family Partnership	The Nurse Family Partnership is a home visiting intervention delivered by Public Health Nurses (PHNs) who begin to visit women in their home early in pregnancy (prior to 29 weeks gestation) and continue until the child's second birthday. Visits typically occur every two weeks with some exceptions, including weekly home visits for the first four weeks following enrollment. Early enrolment allows time both for the client and NFP nurse to establish a relationship before the birth of the child and to address important prenatal health behaviors that affect the child's neurodevelopment and birth outcomes – including: accessing prenatal care, following a healthy diet, and avoiding use of substances. Behaviour change is facilitated through the development of a therapeutic nurse-client relationship, a client-centered approach to practice, and use of Motivational Interviewing.
2	Healthy Babies Healthy Children	The Healthy Babies Healthy Children program supports women and families in the prenatal period continuing until the transition to school. It includes screening, assessment, home visiting, service coordination, and referrals to community resources and supports. Families screened with risk can enter the program during pregnancy. Home visits are provided by Public Health Nurses, who support families to reach their identified goals in the areas of prenatal health including accessing care, following a healthy diet and avoiding the use of substances.
3	Prenatal e-Learning and Website	Prenatal education for the general population is provided through an online e-learning program offered at no cost. Additionally, credible, up-to-date, and comprehensive information related to healthy pregnancies is available on the MLHU website in text and video format. A variety of topics related to health pregnancies are addressed, such as informed decision-making, healthy lifestyle, preterm labour, healthy birth practices, skin-to-skin, postpartum adjustment, preparation for parenthood, perinatal mental health, emergent literacy, and newborn characteristics, care and safety.
4	Prenatal Immigrant Program (PIP)	For Arabic-speaking newcomers, this weekly, tailored, client-centred, culturally relevant prenatal and nutrition education and skill-building program covers topics such as parenting, labour and birth, breastfeeding, food skills & literacy, prenatal and child/family nutrition, informed decision-making, mental wellness, community and health unit resources and services, and health care access/navigation. Women are welcome to attend these weekly sessions throughout their pregnancy. Efforts are made to enhance connections, promote a sense of belonging, and build a circle of support during pregnancy and beyond. The program is facilitated by a Public Health Nurse and Registered Dietitian, with an interpreter. Arabic speaking volunteers also assist with the program. The PIP program is a specialized program of SSFB, and the curriculum has been adapted for this population..

5	Smart Start for Babies (SSFB)	SSFB is a free prenatal and nutrition education and skill-building program for pregnant women and teens and their support persons who face barriers to accessing healthy food. Clients can begin sessions at any stage of pregnancy, although they are encouraged to begin as early as possible. Grocery store cards and Harvest Bucks, food literacy tools and print resources are provided to support access to proper nutrition and to support cooking at home. Prenatal vitamins and Vitamin D for breastfed infants are offered to all participants at no charge. The program covers topics such as prenatal nutrition, low cost healthy eating, healthy lifestyles, food literacy, attachment, healthy relationships, mental wellness, breastfeeding, newborn care, preparation for parenthood, sexual health and contraception, emergent literacy, and infant safety.
6	Indigenous Perinatal Program	The Southwest Ontario Aboriginal Health Access Centre is collaborating with MLHU in the provision of a perinatal program for Indigenous women and families. MLHU supports curriculum development and group facilitation, while SOAHAC directs and/or provides the majority of the curriculum development and facilitation to ensure the program will meet client needs and realize positive outcomes. Talking points are developed collaboratively on a variety of topics related to healthy pregnancy and early postpartum. Support persons and older children are welcome to attend the 3-hr sessions, which are offered every other week at SOAHAC.
7	Healthy Growth and Development Phone Support	Through this telephone-based service, public health nurses conduct client/family-centred assessments and provide information and support regarding healthy pregnancies. Referrals to MLHU programs and community services are made, as appropriate.

Performance / Service Level Indicators

Indicator	2018	2019	2020 (target)
# of clients who have used the e-learning program/ # of clients who have registered	NA	NA	95%
total # clients attending SSFB sessions	204	200	210
total # clients participating in PIP program	41	88	90
total # clients enrolled in the NFP program	81	81	100
% NFP clients enrolled prior to 16 weeks gestation	38%	36%	40%
% prenatal HBHC screens completed out of number of live births (Ministry target 10%)	7%	5%	10%
% clients in SSFB and PIP who registered prior to 16 weeks gestation	NA	NA	35%
% clients in SSFB and PiP who registered and answered yes to the question #26 (financial constraint) on the HBHC screen	NA	NA	95%
% babies born to participants of PIP, NFP, HBHC and SSFB at term (>37 weeks)	NA	NA	90%
% babies born to participants of PIP, NFP, HBHC and SSFB with birth weight between 2500 and 4000 gms	NA	NA	90%

Highlights / Initiatives Planned for 2020

- Explore additional sites for SSFB
- Analyze indicators for SSFB/PIP using the ECR
- Continue to promote new enhanced online prenatal program through social media and HCP Outreach
- Explore additional opportunities to partner with Indigenous-led organizations
- Identify strategies to increase percentage of women who enter HBHC prenatally, and to increase enrollment of NFP clients prior to 16 weeks gestation
- Implement ECR which will support collaboration between teams and effective collection of indicator data
- Modify triage process at Healthy Growth and Development Phone Support to combine HBHC and Early years referrals
- Increase capacity for HBHC to see clients prenatally
- Continue to pursue partnerships to assist with funding for food, food literacy tools and vitamins and minerals

Program Challenges and Risks

- Capacity to meet demand in the HBHC program continues to be a challenge

Staffing Complement

	2019 Total FTEs	2020 Total FTEs	Δ
Dietitian	0.50	0.50	0.00
Program Assistant	1.95	1.50	-0.45
Program Manager	0.95	0.80	-0.15
Public Health Nurse	6.95	8.75	1.80
Director	0.00	0.12	0.12
Total Program FTE	***10.35***	***11.67***	***1.32***

Expenditures					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 807,590	$ 965,694	158,104	20%
Benefits		$ 202,785	$ 237,285	34,500	17%
Expected Vacancies		$ -		-	
Travel		$ 9,561	$ 11,347	1,787	19%
Program Supplies		$ 73,806	$ 64,542	(9,264)	-13%
Board Expenses		$ -		-	
Staff Development		$ 3,550	$ 4,355	805	23%
Occupancy		$ -		-	
Professional Services		$ 30,305	$ 35,866	5,561	18%
Furniture & Equipment		$ 2,849	$ 4,159	1,310	46%
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 811	$ 2,204	1,393	172%
Total Expenditures	***$ -***	***$ 1,131,257***	***$ 1,325,452***	***$ 194,195***	

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 801,421	$ 901,251	99,830	12%
MOHLTC (100%)		$ 3,465		(3,465)	-100%
MCCSS		$ 221,724	$ 324,997	103,273	47%
PHAC		$ 91,986	$ 87,190	(4,796)	-5%
PHO		$ -		-	
User Fees		$ 7,303	$ 4,656	(2,647)	-36%
Other		$ 5,357	$ 7,357	2,000	37%
Total Revenues	***$ -***	***$ 1,131,257***	***$ 1,325,452***	***$ 194,195***	

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Healthy Sexuality						443
Standard	Healthy Growth and Development		**Director Name**	Stephen Turner		
Lead Team	Sexual Health		**Manager Name**	Shaya Dhinsa		
Supporting Team(s)	Reproductive Health		Best Beginnings		Young Adult	
Budget	$ 214,760		**FTE**	1.36		

Summary of Program

The program raises awareness, provides education, and/or engages in advocacy on topics such as contraception, pregnancy testing and options, healthy sexuality, and sexual orientation.

The Birth Control Clinic is focused on Priority Populations and the services include: Birth Control Counselling, Low cost birth control, Low cost emergency contraception, Pregnancy testing (*based on assessment), Cervical Cancer Screening, STI/infection checks/Pelvic Pain, IUD consultation and insertions.

Sexual Health team engages in numerous health promotion strategies intended to promote healthy sexuality in the residents of Middlesex-London. Some of these strategies include providing opportunities for education and skill building, creating and fostering supportive environments, raising awareness through mass media campaigns and using social media. The team engages in numerous health promotion strategies to promote healthy sexuality in the residents of Middlesex-London.

The SH team is creating supportive environments for sexual health. Much of this work focuses on Positive Space Training and encouraging organizations and community partners to offer inclusive services and resources for the Lesbian Gay Bisexual Transgender Queer (LGBTQ) population within Middlesex-London.

Program Mandate & Relevant Legislation

Healthy Growth and Development Standard
School Health Standard
School Health Guideline, 2018 (or as current)
Healthy Sexuality Guideline
Ontario Sex Education Curriculum

Program Management

The Sexual Health Team manages the Healthy Sexuality Program and collaborates with the Young Adult Team, Child Health Team, Reproductive Health Team and the Best Beginnings Team. If there is a request for sexual health related presentation in the primary or secondary schools the Sexual Health Team is available to provide support and resources. Clients who are pregnant and meet the criteria of 21 years old or younger, pregnant with your first child and/or first time parenting, pregnant 28 weeks or less, experiencing financial hardship or limited resources, and living in the London and Middlesex area. The Sexual Health team often collaborates with MLHU Communications team in the development of sexual health campaigns and resources.

Key Partners and Stakeholders

Western University; Fanshawe College; Youth Opportunities Unlimited; Genest; King Street Group Home; Antler River Elementary School; Maitland Street Group Home;TVDSB and LCDSB schools;

Community Needs and Priorities

• Teen pregnancy rates are higher in M-L than ON

As youth grow from childhood, through the teen years and into adulthood, they experience many changes. A supportive environment for promoting positive sexual health is inclusive and non-judgmental. A supportive environment will help students to feel more comfortable and safe when learning about and exploring their own sexual health. Parents/caregivers and teachers/school staff, as well as students are all responsible for creating a supportive environment. Some of the changes may include sexual orientation and gender identity. Schools are often seen as one of the best places for students to learn about sexual health. However, there is also concern about the best ways to provide this information and the best people to provide this information. By working with community partners, schools will have greater access to resources, information and support to provide sexual health education to students. As a result, this may help to promote positive sexual health among students.

Young adults between the ages of 15-29 are two high-risk populations that require targeted sexual health interventions. Locally, the MLHU continues to see counts of chlamydia that are higher than counts in 2018 almost every month. The rate is already at 304.3 cases per 100,000, which if continues on the same path until the end of the year, will reach the highest rate of at least 450.5 cases per 100,000. The MLHU has had rates higher than that seen provincially since 2005. Using both primary and secondary prevention strategies are important to promote safer sex practices. A Sexual Health Campaign will focus on these strategies to reduce the rates of Bacterial STIs in Middlesex-London.

Target and Priority Populations

Young and young adults under the age of 30 years are a priority and target population. The more specific population that has been prioritized is youth between the ages of 15-24 years of age due to the increased risk of unintended pregnancy and STBBIs. The population for young adults under the age of 30 was chosen as a result population health data. The rates of chlamydia and gonorrhea reported in this age group are higher than any other age group.

Intended Program Outcomes	
Long-Term / Population Health	• To achieve optimal health of school-aged children and youth through partnership and collaboration with school boards and schools. • To achieve optimal preconception, pregnancy, newborn, child, youth, parental, and family health • The goal is to decrease unintended pregnancy • To reduce the burden of communicable diseases and other infectious diseases of public health importance
Intermediate	Youth have knowledge of contraception, healthy sexuality, healthy fertility, and healthy pregnancies To minimize the number of reportable diseases in the Middlesex-London Community. To mitigate and control the transmission of reportable diseases in Middlesex London community. To ensure priority populations have access to the Birth Control Clinics and their services i.e. low cost birth control.
Short-Term	• Increase sexual health awareness and promote increased STI/BBI testing. • OPHS-Outcome School Health The board of health shall offer support to school boards and schools, in accordance with the School Health Guideline, 2018 (or as current), to assist with the implementation of health-related curricula and health needs in schools, based on need and considering, but not limited to: -Healthy Sexuality • Working with community partners, schools will have greater access to resources, information and support to provide sexual health education to students to help promote positive sexual health among students. • Create supportive environments to promote healthy sexual practices, access to sexual health services, and harm reduction programs and services for priority populations; • To successful connect with contacts of clients with reportable diseases. • To provide treatment and follow up information as required. • Surveillance of reportable internal database and iPHIS.

Program Interventions		
1	Presentations/Education	Topics include: STIs, Safer Sex, LGBTQ2+, Birth Control, Puberty, Reproductive Health Team has programming in the justice system supply information about sexual health information.
2	Family Planning Clinic	Supply low cost birth control, emergency contraception , Cervical cancer screening, free condoms, pregnancy tests based on assessment, and Sexual health education.

Performance / Service Level Indicators			
Indicator	2018	2019	2020 (target)
Number of priority population clients between the ages of 15-24 years of age who access the Birth Control Clinic services.	2,681	3,119	3,000
Number of presentations i.e. STIs, Safer Sex, LGBTQ2+, Birth Control, Puberty	75	65	65

Highlights / Initiatives Planned for 2020

Get Tested Western will take place close to Valentine's Day to encourage the target population of 17-24 years to get tested as well as educate youth on safer sex practices. This event is with the support of MLHU Communications and the Young Adult Team. A campaign will be developed and launched in 2020 focusing on reducing the burden of Bacterial STI's particularly among the ages of 15-24 years of age. There will be primary and secondary strategies. The Pride parade continues to be a focus and each year and encouraging MLHU staff and volunteers to attend and provide their support.

Program Challenges and Risks

Challenge is reducing the increasing rate of STI's in Middlesex-London using primary and secondary strategies.

Staffing Complement			
	2019 Total FTEs	2020 Total FTEs	Δ
Health Promoter	0.10	0.10	0.00
Program Manager	0.15	0.25	0.10
Public Health Nurse	0.20	1.00	0.80
Director	0.00	0.01	0.01
Total Program FTE	***0.45***	***1.36***	***0.91***

Expenditures					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 36,712	$ 115,519	78,808	215%
Benefits		$ 8,970	$ 27,899	18,929	211%
Expected Vacancies		$ -		-	
Travel		$ 369	$ 1,165	795	215%
Program Supplies		$ 5,952	$ 24,961	19,009	319%
Board Expenses		$ -		-	
Staff Development		$ 171	$ 433	262	153%
Occupancy		$ -		-	
Professional Services		$ 7,785	$ 42,925	35,140	451%
Furniture & Equipment		$ 68	$ 148	80	117%
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 324	$ 1,710	1,386	428%
Total Expenditures	***$ -***	***$ 60,351***	***$ 214,760***	***$ 154,409***	

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 44,317	$ 180,758	136,441	308%
MOHLTC (100%)		$ 6,930		(6,930)	-100%
MCCSS		$ -		-	
PHAC		$ 4,104	$ 5,487	1,384	34%
PHO		$ -		-	
User Fees		$ 5,000	$ 28,515	23,514	470%
Other		$ -		-	
Total Revenues	***$ -***	***$ 60,351***	***$ 214,760***	***$ 154,409***	

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Mental Health Promotion						444
Standard	Healthy Growth and Development		**Director Name**	Heather Lokko		
Lead Team	Early Years		**Manager Name**	Ronda Manning		
Supporting Team(s)	Best Beginnings		Reproductive Health			
Budget	$ 703,124		**FTE**	6.15		

Summary of Program

Providing a range of services designed to address the emotional, and social growth and development of parents. Strong attention to incorporate principles of health equity to promote mental health and prevent mental illness will continue to be a focus of work including early identification and referral. Interventions incorporate supporting a strong attachment to a caregiver, and for parents to develop positive parenting practices, which serve as protective factors for a child's mental health.

The Healthy Start division strives to:

- To achieve optimal pregnancy, newborn, child, parental, and family mental health (OPHS Goal)

Multi-strategy approaches are implemented to:

- Programs and services are designed to address the identified needs of the community, including priority populations associated with improved mental health outcomes for families with children 0- 6 years old. (OPHS Outcome)
- Collaborate with community partners and parents to include mental health in the planning, development, implementation, and evaluation of programs, services, and policies.
- Priority populations are linked to child/family health information programs and services

Interventions to achieve these outcomes include the following:

1. Nurse Family Partnership Home Visiting Program
2. Healthy Babies Healthy Children Home Visiting Program
3. Breastfeeding Home Visiting Program
4. Website and Social Media
5. Preparation for Parenting
6. Community Partnerships and Collaboration
7. Healthy Growth and Development Phone Support

Program Mandate & Relevant Legislation

Healthy Growth & Development Standard, Healthy Growth & Development Guideline (2018), Health Equity Guideline (2018), Mental Health Promotion Guideline (2018), Healthy Babies Healthy Children Protocol (2018), Relationship with Indigenous Communities Guideline (2018), Healthy Babies Healthy Children Guidance Document (2012) revised (2015), Nurse-Family Partnership® Core Model Element, Health Protection and Promotion Act, R.S.O. 1990, c.H.7, Child & Family Services Act, 1990: Duty to Report Legislation, Municipal Freedom of Information and Protection of Privacy Act, R.S.O. 1990 (MFIPPA), Personal Health Information Protection Act, R,S,O, 2004 (PHIPA).

Program Management

Best Beginnings Team provides home visiting clients who meet the program criteria during the prenatal, postpartum and early childhood periods. PHNs provide screening of perinatal mental health and use NCAST materials supported by FHVs to provide interventions in the promotion of positive mental health and safe and supportive environments. **Nurse Family Partnership** home visiting provides information and interventions regarding the promotion of positive mental health and creating safe and supportive environments in the prenatal and postpartum period until the child is 2 years of age. **Early Years Team** partners in the Precious Moments intervention for Arabic speaking mothers, and support in the Young Moms groups. **Reproductive Health Team** offers the Preparation for Parenthood sessions during the prenatal period and has mental health topics incorporated into the Prenatal Immigrant Program (PIP) for Arabic postpartum women and Smart Start For Babies sessions for women identifying with food insecurities. Both Early Years and Reproductive Health Teams provide web-based information. All Healthy Start teams are engaged in community partnerships, perinatal mental health screening, providing Healthy Growth and Development Phone Support, and the division-wide Perinatal Mental Health working group. **Health Care Provider Outreach Team** (Collaborative between Early Years and Communications with Early Years contributing a 0.5 FTE to provide education and updated information on early childhood development, common screening tools, and improved process for referral to healthcare providers. **Child Health & Injury Prevention Team** as the main lead for mental health within MLHU.

Key Partners and Stakeholders

Involved: Child and Youth Network - 4 priority areas: Ending Poverty, Literacy, Healthy Eating Healthy Physical Activity, and Creating a Family and Child Service System (FCSS). Governance (MLHU representatives) - Subcommittee - The Community Early Years Partnership (MLHU chair) to disseminate, share information and promote with healthcare providers, community partners, parents and caregivers. Middlesex Children's Services Network - targeted to families with young children in the county.
Supported: Child and Family Centres - (drop-in's), Early ONs - (drop-in's), Child Care Providers – capacity building (committees: Strive, Child Health Action Team [CHAT], All Kids Belong [AKB]), Southwest Ontario Aboriginal Health Access Centre (SOAHAC) prenatal education, Child Reach – support in Young Mom's Group and Mother Reach mental health support group for postpartum women, Precious Moments - Arabic-speaking newcomer mothers of infants less than 4 months of age, Young Moms Groups – women with children < 21 years of age (Childreach, SLNRC).
Interested: Children's Aid Society of London and Middlesex – referral, Thames Valley Children's Centre – referrals, Vanier Children's Services - referrals, Child & Parent Resource Institute (CPRI) – referrals, Developmental Resources for Infants (DRI) – referrals, Child Reach - referrals, Merrymount Children's Centre – referrals and child care centre, London Intercommunity Health Centre -referrals, Muslim Resource Centre - referrals, Street Level Women at Risk – referrals, Ontario NFP Community of Practice, NFP Governance Committee, Addiction Services Thames Valley (Heart Space), St. Leonard's Community Services London Region, Southwest Ontario Aboriginal Health Access Centre, Youth Opportunities Unlimited.

Community Needs and Priorities

Middlesex-London Community Health Status Resource (2019) (Women): Nearly 30% in 2017 reported a mental health concern during pregnancy, Ontario (18.1%). Mental health concern during pregnancy 2013 (21.6%) to 2017 (29.8%). Less than 20 years of age reported the highest percentage of mental health concern during pregnancy 2013 (38.5%) and 2017 (61.1%) (25.3% women aged 30 to 34). Mental health concern during pregnancy significantly higher among the urban population compared to the rural population from 2013 (22.3% and 16.4%) to 2017 (30.8% and 24.4%) respectfully. Anxiety during pregnancy was 16.6% in 2017, compared to 11.6% in Ontario. Depression during pregnancy was 18.3% in 2017, compared to 8.8% in Ontario. Anxiety during pregnancy, 2013 (7.9%) to 2017 (16.6%). History of postpartum depression 2016 (8.2%), Ontario (3.9%), Peer Group (4.9%). 31% of Indigenous adults reported very good or excellent mental health, versus 70% of the general Ontarian population. Over 4 in 10 Indigenous adults think about dying by suicide, versus 1 in 10 in Ontario general population. In London, the prevalence of low income in 2015 based on LIM-AT was 11.6% representing 43,860 individuals. This was higher than Ontario (9.8%) and Canada (9.2%).
HBHC Screening Tool: In need of newcomer support (8.3% in 2018, 6.2% in 2015), significantly higher than Ontario and the Peer Group. Parent with concerns about money to pay for housing/rent, food, clothing, utilities and other necessities was 7.6% in 2018, significantly higher compared to Ontario. City of London (2019), low income in 2015 (11.6%), (43,860 individuals), Ontario (9.8%). Parent had a history of depression, anxiety, or mental illness in 2018 (26.3%), 2016 (31.0%).

Target and Priority Populations

Target Population(s): Women and children (0-6) in families: That lack proficiency in host country language, Who are refugee and/or asylum-seeking, Mother is < 25 years of age, With a low-income cut-off after tax (an income threshold below which families will likely devote a larger share of their income on the necessities of food, shelter, and clothing than the average family), Has a history or identify on the HBHC Screening Tool a mental health concern.

Priority Population(s): Women and children in families who: Are immigrant, Are Indigenous, Lack proficiency in host country language, Lack social support such as has assistance available from other people, and is part of a supportive social network.

Intended Program Outcomes

Long-Term / Population Health	• To achieve optimal pregnancy, newborn, child, parental, and family mental health (OPHS Goal)
Intermediate	• Programs and services are designed to address the identified needs of the community, including priority populations associated with improved mental health outcomes for families with children 0- 6 years old. (OPHS Outcome) • Collaborate with community partners and parents to include mental health in the planning, development, implementation, and evaluation of programs, services, and policies. • Priority populations are linked to child/family health information programs and services
Short-Term	• Ensure public is aware of the importance of creating safe and supportive environments that promote healthy child growth and development (OPHS Outcome) • Increase awareness of health promotion activities to parents that promote protective factors such as positive parenting and attachment.

Program Interventions

1	Nurse Family Partnership Home Visiting	The Nurse Family Partnership is a home visiting intervention delivered by Public Health Nurses (PHNs) who begin to visit women in their home early in pregnancy and continue until the child's second birthday. Visits typically occur every two weeks with some exceptions. Six program domains provide structure for nursing assessments, interventions and evaluations of client care. Maternal mental health is addressed under the Personal Health Domain. Program activities include: completing mental health screening and assessment; providing health education; promoting self-efficacy by strengthening emotional skillsets and building coping strategies; and making referrals to other health and human services as needed. Achievement of program goals is facilitated through the development of a therapeutic nurse-client relationship, a client-centered approach to practice, and use of Motivational Interviewing.

2	Healthy Babies Healthy Children Home Visiting	Healthy Babies Healthy Children is a home visiting program delivered by Public Health Nurses (PHNs) who visit clients in their home. This is done in accordance with Healthy Babies Healthy Children Protocol, 2018. The program is for women and families in the prenatal period and with children from birth until transition to school. Families screened with risk can enter the program during pregnancy, postpartum, or the early years. The program includes screening, assessment, home visiting, service coordination, and referrals to community resources and supports. Home visits are provided Monday to Friday by Public Health Nurses who support families to reach their identified goals re mental health. Home visiting frequency is scheduled according to client needs. PHN's provide routine perinatal mental health screening. **Evidence:** Provincially Mandated Program through Ministry of Children, Community and Social Services
3	Breastfeeding Home Visits	Home visiting support is delivered face-to-face during the early postpartum period, based on assessment of client need. Initial contact made either face-to-face by the screening liaison nurse at LHSC or Strathroy Hospital, client initiated at drop-in's or by telephone at Health Connection, or by other healthcare provider referrals. Home visits are scheduled during regular business hours, Monday to Friday at a mutually agreed upon time between the client and PHN, and frequency is based on PHN assessment and client. Follow-up calls post-home visits as initiated by client or PHN for continued breastfeeding support. PHN's provide routine perinatal mental health screening
4	Website and Social Media	Universally provided to share credible, up-to-date, and comprehensive information related to healthy pregnancies on the MLHU website in text and video format. Specific sections on pages include "Pregnancy", "Prenatal Health", and the "Prenatal eManual". Messages shared publicly through Facebook and Twitter. Annual promotion of mother's mental health delivered in May to coincide with Mother's Day and the promotion of father's mental health delivered in June to coincide with Father's Day. Website and Social Media outlets are monitored by PHNs within the Healthy Start Division program areas.
5	Preparation for Parenting	This one-time session is offered during the prenatal period, Pregnant women and their supports explore a variety of areas related to transition to parenthood, including in-law relationships, communication, intimacy, parenting styles, budgeting, co-parenting, healthy conflict resolution, postpartum mood disorders, common relationship challenges experienced during the postpartum period, changes in lifestyle and use of time. During this interactive and skill-based session, a number of tools are shared with participants to support their ongoing communication and preparation for parenthood.

6	Community Partnerships and Collaboration	**PHN's provide leadership and/or actively engage in a variety of partnerships with: London's Child and Youth Network (CYN)** composed of over 170 agencies and individuals spanning the education, health, recreation and social services sectors. Shared vision to build strong families and breaking down the barriers that put our children, youth and families at risk. Four priority areas were collectively identified: 1. Ending poverty; 2. Improving literacy; 3. Improving healthy eating and physical activity; and 4. Creating a Family-Centred Service System. Each priority area has a specific vision, goals and outcomes they aim to achieve. Uses a Collective Impact approach and an assessment has provided an understanding of the strengths and opportunities to leverage. https://www.londoncyn.ca/background-documents/ **Middlesex Children's Services Network is a**ny organization, agency or individual with a mandate and/or interest in the provision of service and/or the well-being of children, prenatal to age twelve, and their families residing in Middlesex County. Working Groups or Task Forces are established as needed such as: A Collective Impact Action Plan including the establishment of the Action Planning Team to work on a gap analysis and comprehensive database of service agencies/services including mental health. **The Mother Reach Coalition** is focused on promoting perinatal mental health and preventing perinatal mental illness; efforts are underway to revitalize it, revision its objectives, and develop collective action plans. **Towards an Integrated Mental Health System (TIMHS**) to support infants, children, youth, parents, couples, and adults, and their families and natural support networks receiving high quality mental health and addictions services in a timely and coordinated manner.
7	Healthy Growth and Development Phone Support	Population is families, individual clients, healthcare providers, and community partners where PHNs conduct client/family-centred assessments including routine screening of perinatal mental health, provide information on a wide range of health topics including mental health. Referrals to MLHU programs and community services are made, as appropriate. Universal telephone-based intervention offered Monday to Friday during regular business hours (8:30-4:30).

Performance / Service Level Indicators

Indicator	2018	2019	2020 (target)
# Preparation for Parenthood sessions / # attendees	13 / 266 (unique persons)	13/378 (unique persons)	Maintain
# postpartum group sessions / # attendees	21 / 171	35 / 230	Maintain
# Healthy Growth and Development Phone Support calls regarding mental health promotion	43 (primary reason only)	24	35
Reach of health promotion campaigns that promote mental health	N/A	1 campaign - 12,442	Maintain
# of clients that received an NCAST	87	200	225

Highlights / Initiatives Planned for 2020

Implement prenatal mental health recommendations from prenatal health planning process conducted in 2018. Consider implications of new Mental Health Promotion Guideline (2018). Create a collaborative approach across the organization. Refine indicators. Implement universal mental screening for all women entering the Healthy Start Division services and programs.

Program Challenges and Risks

Current tracking processes will need to be adjusted to capture program data more effectively.

Staffing Complement			
	2019 Total FTEs	2020 Total FTEs	Δ
Program Assistant	0.93	0.43	-0.50
Program Manager	0.88	0.89	0.01
Public Health Nurse	7.65	4.75	-2.90
Family Home Visitor	0.80	0.00	-0.80
Director	0.00	0.08	0.08
Total Program FTE	***10.26***	***6.15***	***-4.11***

Expenditures					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 816,953	$ 534,119	(282,834)	-35%
Benefits		$ 204,033	$ 128,196	(75,837)	-37%
Expected Vacancies		$ -		-	
Travel		$ 12,016	$ 7,621	(4,395)	-37%
Program Supplies		$ 28,722	$ 17,182	(11,540)	-40%
Board Expenses		$ -		-	
Staff Development		$ 3,498	$ 2,455	(1,043)	-30%
Occupancy		$ -		-	
Professional Services		$ 19,129	$ 10,264	(8,865)	-46%
Furniture & Equipment		$ 5,025	$ 2,611	(2,415)	-48%
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 1,091	$ 677	(414)	-38%
Total Expenditures	***$ -***	***$ 1,090,466***	***$ 703,124***	***-$ 387,342***	

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 649,422	$ 481,819	(167,604)	-26%
MOHLTC (100%)		$ -		-	
MCCSS		$ 411,198	$ 208,332	(202,866)	-49%
PHAC		$ 18,901	$ 12,316	(6,585)	-35%
PHO		$ -		-	
User Fees		$ 1,009	$ 658	(352)	-35%
Other		$ 9,935		(9,935)	-100%
Total Revenues	***$ -***	***$ 1,090,466***	***$ 703,124***	***-$ 387,342***	

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Preconception Health					445
Standard	Healthy Growth and Development		**Director Name**	Heather Lokko	
Lead Team	Reproductive Health		**Manager Name**	Debbie Shugar	
Supporting Team(s)	Best Beginnings				
Budget	$ 416,861		**FTE**	3.67	

Summary of Program

Preconception health initiatives at MLHU are intended to increase the proportion of individuals who have a reproductive plan, and who reach optimal preconception health prior to conception and during interception. PHAC highlights that preconception interventions consider physical, psychosocial, behavioural or environmental risks to reproductive health and future pregnancies, and include all women and men of reproductive age, including during interconception.

Interventions of the Preconception Health Program include:
- Home visiting (NFP and HBHC)
- Website and social media
- Healthcare provider outreach
- Local and provincial collaboration & advocacy
- Healthy growth and development phone support

Program Mandate & Relevant Legislation

Health Protection and Promotion Act, R.S.O. 1990, c.H.7
Healthy Growth & Development Standard (2018) and Healthy Growth & Development Guideline (2018)
Health Equity Standard (2018), Health Equity Guideline (2018) & Relationship with Indigenous Communities Guideline (2018)
Effective Public Health Practice Guideline (2018) and Mental Health Promotion Guideline (2018)
Healthy Babies Healthy Children Protocol (2018) and Healthy Babies Healthy Children Guidance Document (2012)
Municipal Freedom of Information and Protection of Privacy Act, R.S.O. 1990 (MFIPPA)
Personal Health Information Protection Act, R,S,O, 2004 (PHIPA)
Nurse-Family Partnership® Core Model Elements
Public Health Agency of Canada Family-Centred Maternity and Newborn Care: National Guidelines Chapter Two: Preconception Care

Program Management

The Preconception Health Program is managed by the Reproductive Health Team. Other teams that support this program include the Best Beginnings, Healthy Communities Injury Prevention, Sexual Health, and Young Adult Teams. The Health Care Provider Outreach program in Communications also supports the Preconception Health Program.

Key Partners and Stakeholders

London Health Sciences Centre, London District Catholic School Board, Thames Valley District School Board, Elgin-Middlesex Detention Centre, London Family Court Clinic, Western University, Fanshawe College, Health Care Providers, Ontario FASD Strategy Expert Panel, and FASD groups: FASD ONE, FASD ELMO, ML CDAS, FASD CoP's

Community Needs and Priorities

Nearly 50% of pregnancies in North America are unplanned (PHAC, 2017) and the first weeks of gestation are critical for embryonic growth & development.

The percent of women who reported taking folic acid supplements prior to pregnancy was significantly higher in Middlesex-London compared to Ontario and the Peer Group from 2013 to 2016. In 2016, 44.3% of women in Middlesex-London who gave birth reported taking folic acid supplements before getting pregnant compared to 33.5% in Ontario. Folic acid use among the rural population of Middlesex-London was significantly higher than the urban population from 2013 to 2017. In 2017, 56.2% of women in the rural population reported taking folic acid supplements prior to pregnancy compared to 41.4% in the urban population.

Target and Priority Populations

Preconception health targets all people of reproductive age. Those individuals involved in the justice system may be more likely to engage in risky behaviours and have risk factors that could negatively impact reproductive health outcomes (e.g., substance use, risky sexual behaviours, poor nutrition, etc.), and often experience health inequities. Health care providers are the “preferred and trusted source” for health information (OPHA, 2014); it is important to provide information and resources to HCPs to support consistent messaging, and encourage discussion and provision of preconception health care. MLHU's Preconception Health program targets all people of reproductive age, and currently prioritizes:

- youth involved in the criminal justice system
- incarcerated women
- secondary school students
- health care providers and students

Intended Program Outcomes

Long-Term / Population Health	To reach optimal preconception health prior to conception and during interconception.
Intermediate	• Individuals in their reproductive years use available information, skills, and supports to adopt health promoting practices. • Individuals in their reproductive years live, work, play, and learn in safe and supportive environments. • Priority populations are linked to reproductive health information, programs, and services. • Policy-makers have the information required to enable them to amend current policies or develop new policies that would have an impact on the promotion of reproductive health.
Short-Term	• Enhance awareness of the importance of preconception health and pregnancy planning. • Enhance knowledge and skills related to preconception health and pregnancy planning • Establish and/or enhance internal and external relationships to support promotion of preconception health.

Program Interventions		
1	Nurse-Family Partnership Program	The Nurse Family Partnership is a home visiting intervention delivered by Public Health Nurses (PHNs) who begin to visit women in their home early in pregnancy and continue until the child's second birthday. Six program domains provide structure for nursing assessments, interventions and evaluations of client care. Interconception health is addressed under the Personal Health and Life Course Development Domains. The promotion of thoughtful pregnancy planning along with regular use of a reliable method of contraception is a core element of the program. Program activities include: exploring client goals related to planning future pregnancies; providing health education on contraception options; promoting interconception health including avoidance of substances and use of prenatal vitamins; and making referrals to other health and human services as needed.
2	Healthy Babies Healthy Children Program	The Healthy Babies Healthy Children Program is a home visiting intervention delivered by Public Health Nurses (PHNs) who visit women in their home. Clients can enter into the program during pregnancy, postnatally and during early child development. Interconception health information, resources, and supports are provided through home visiting programs, as well as 1-1 smoking cessation counselling and NRT, and prenatal vitamins.
3	Healthy Growth and Development Phone Support	Through this telephone-based service, public health nurses conduct client/family-centred assessments and provide information and support regarding preconception and interconception health. Referrals to MLHU programs and community services are made, as appropriate.
4	Website and Social Media	Credible, up-to-date, comprehensive preconception health information is available on our website for anyone with internet access. Social media initiatives are used to reach reproductive-aged populations engaged with social media. Pre-pregnancy Planner Tool is included on the website.

5	Healthcare Provider Outreach	Healthcare providers can benefit from preconception health-related education and resources, point-of-care tools, and information about relevant MLHU/community resources. Evidence-based information on preconception on the MLHU website and the 'Baby Steps to a Healthy Pregnancy' booklet are promoted with HCP's, and preconception information will be included periodically in the HCP Outreach newsletters distributed by MLHU.
6	Local and Provincial Collaboration & Advocacy	MLHU participates in the OPHA Preconception Health Task Group, which is focused on strengthening preconception health knowledge, enhancing preconception resources, and engaging in provincial preconception health advocacy efforts (i.e., preconception health billing code for physicians). Collaborative work is also being done regarding FASD prevention, through participation on the Ontario FASD Strategy Expert Panel, and FASD groups.

Performance / Service Level Indicators

Indicator	2018	2019	2020 (target)
# secondary school students participating in 'Got a Plan' Day	313	309	TBD - see notes below
# sessions at Elgin Middlesex Detention Centre and London Family Court Clinic / # attendees	33 / 127	12 / 64	TBD - see notes below

Highlights / Initiatives Planned for 2020

In 2020, the RHT, supported by the PPE and PHAS teams, and with representation from the YAT and SHT, will be conducting a comprehensive preconception health program planning process. Group education (i.e. Got a Plan Day and presentations) will be suspended during the winter of 2020 in order to focus on this work. It is anticipated that revised and/or new interventions and indicators will be identified for implementation later in 2020.

Program Challenges and Risks

• Providing education to incarcerated women was suspended as the jail was unable to provide a safe space for MLHU staff to meet with the women.
• There is some uncertainty about the effectiveness of some of the preconception health interventions currently in place, such as the presentations to youth involved in the criminal justice system; the planning process in 2020 will address these uncertainties
• Local and provincial collaborations require patience

Staffing Complement

	2019 Total FTEs	2020 Total FTEs	Δ
Program Assistant	0.20	0.45	0.25
Program Manager	0.15	0.47	0.32
Public Health Nurse	0.50	2.70	2.20
Director	0.00	0.05	0.05
Total Program FTE	***0.85***	***3.67***	***2.82***

Expenditures					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 63,216	$ 307,891	244,675	387%
Benefits		$ 15,227	$ 75,258	60,030	394%
Expected Vacancies		$ -		-	
Travel		$ 717	$ 3,777	3,060	427%
Program Supplies		$ 7,963	$ 16,209	8,247	104%
Board Expenses		$ -		-	
Staff Development		$ 330	$ 1,190	860	261%
Occupancy		$ -		-	
Professional Services		$ 2,098	$ 10,110	8,012	382%
Furniture & Equipment		$ 14	$ 1,991	1,978	
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 19	$ 435	417	
Total Expenditures	***$ -***	***$ 89,582***	***$ 416,861***	***$ 327,278***	

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 78,664	$ 236,434	157,771	201%
MOHLTC (100%)		$ -		-	
MCCSS		$ -	$ 158,332	158,332	
PHAC		$ 10,365	$ 20,974	10,609	102%
PHO		$ -		-	
User Fees		$ 554	$ 1,120	567	102%
Other		$ -		-	
Total Revenues	***$ -***	***$ 89,582***	***$ 416,861***	***$ 327,278***	

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Infection Prevention and Control				450
Standard	Infectious and Communicable Diseases Prevention and Control	**Director Name**	Stephen Turner	
Lead Team	Infectious Disease Control	**Manager Name**	Mary Lou Albanese	
Supporting Team(s)				
Budget	$ 467,616	**FTE**	4.37	

Summary of Program

The purpose of this program is to ensure surveillance, inspection, investigation, education, enforcement and reporting requirements with respect to infection prevention and control (IPAC) in settings, to minimize the risk of contracting blood-borne and other types of infections with an emphasis on personal service settings and licensed child care settings. All licensed child care and personal service settings are inspected annually to ensure adherence to IPAC practice. A risk-based approach is used to determine the priority and need for additional inspections; to investigate complaints and/or reports related to IPAC practice in accordance with the Infection Prevention and Control Complaint Protocol, 2018. Using local data to influence and inform the development of local healthy public policy and its programs and services for prevention of infectious and communicable diseases.

MLHU staff educate owners/operators for personal service settings, licensed child care, medical clinics, dental clinics, labs and other agencies along with members of the public on appropriate IPAC practices.

A 24/7 on call response system is maintained throughout the year. Investigations are started within 24 hours of complaint. Effective case management results in limited secondary cases, reduced transmission of infections and communicable disease, reduced progression from latent tuberculosis infection to active TB disease and reduced development of acquired drug-resistance among active TB cases.

Program Mandate & Relevant Legislation

Infectious and Communicable Diseases Prevention and Control
Infectious Diseases Protocol, 2018 (or as current)
Infection Prevention and Control Complaint Protocol, 2018 (or as current)
Infection Prevention and Control Disclosure Protocol, 2018 (or as current)
Personal Service Settings Guideline, 2018 (or as current).
Healthy Environments and Climate Change Guideline, 2018 (or as current)

Program Management

The IDC Team is primarily responsible for implementation of the IPAC Program.

Key Partners and Stakeholders

MOHLTC, MOE, PHO, Health Care Providers, London Intercommunity Health Centre, Mission Services Shelter, Salvation Army Shelter, Canadian Mental Health Association, Royal College of Dentists, Canadian Physician and Surgeons Organization, SW LHIN, Municipality of London and Middlesex County, other community agencies that service vulnerable individuals e.g. meal programs

Community Needs and Priorities

Diseases of public health significance data that is collected from various sources.
Internal database is reviewed by BOH to determine/address local priorities in IDC.

Rates of blood borne infections in the community.

Homelessness, under-housed, illicit drug use, poverty, health inequity.

Target and Priority Populations

Target and priority population are the most vulnerable in our community i.e. under housed or homeless and people who inject drugs. Public Health inspectors inspect for infection prevention and control purposes every personal service settings and licensed child care settings in Middlesex London. Using a risk based approach each premise is inspected from 1 to 3 times annually. Inspectors work with the owner/operator to ensure that regulations and infection control practices are met. Often this involves ongoing education. IDC Team provides a phone line 24/7 and an online mailbox for members of the public to notify MLHU of any IPAC concern. A public health inspector and public health nurse are assigned to investigate all IPAC complaints outside of mandated settings. Surveillance monitoring demonstrated an increase number of diseases of public health significance in homeless, under housed and people who use drugs e.g. iGAS, Hepatitis A, TB. Shelter staff educated about early detection of infectious disease to prevent secondary cases. Each staff of the IDC assigned to investigate and monitor diseases of public health significance to limit secondary cases and reduce transmission. The team prioritize the education of health care providers to identify, diagnose, treat and report diseases of public health significance.

Intended Program Outcomes

Long-Term / Population Health	To reduce the burden of communicable diseases and other infectious disease of public health significance.
Intermediate	• The board of health is aware of and uses local data to influence and inform the development of local healthy public policy and its programs and services for the prevention of infectious and communicable diseases. • Board of health programs and services are designed to address the identified needs of the community, including priority populations, associated with infectious and communicable diseases. • Effective and efficient management and mitigation of public health risks associated with infection prevention and control lapses. • Increased awareness and use of infection prevention and control practices in settings that are required to be inspected.

Short-Term	The board of health shall provide public education to increase awareness related to infection prevention and control measures, including respiratory etiquette, and hand hygiene • To notify the public of a lapse according to the IPAC Disclosure protocol. • To educate public about IPAC best practices. • To raise awareness of the general public of infection control requirements. • To increase the knowledge of the general public about infection prevention and control. The board of health shall work with community partners and service providers to determine and address the need for knowledge translation resources and supports in the area of infection prevention and control • To educate stakeholders about IPAC best practices. • To increase the knowledge of Health Care Providers regarding mandatory reporting requirements and management of infectious diseases. • To provide information and resources in many formats and repeatedly over time to meet the needs and reach various target groups. The board of health shall work with appropriate partners to increase awareness among relevant community partners, including correctional facilities, health care, and other service providers, of Infection prevention and control practices and reporting requirements for diseases of public health significance. The board of health shall receive reports of complaints regarding infection prevention and control practices and respond to and/or refer to appropriate regulatory bodies (OPHS) • Effective and efficient management and mitigation of public health risks associated with infection prevention and control lapses. • To respond and investigate IPAC complaints in a timely manner. • To investigate IPAC lapses. • To respond to and/or refer IPAC complaints to appropriate regulatory bodies. The board of health shall inspect and evaluate infection prevention and control practices in personal service settings • To inspect all required facilities. • To ensure compliance with the infectious disease protocol. • To educate owner/operators and staff of the inspected facilities on the infection control practices required in each of the specific service settings. The board of health shall inspect settings associated with risk of infectious diseases of public health significance.

Program Interventions		
1	Inspections	Compliance inspections completed using risk assessment as per protocol. Re-inspection required when non-compliance/violations are found. - Program assistant and staff ensure that updated/current list of premises entered into Hedgehog.
2	Public Education	Disclosure of all inspection results posted on the MLHU website. Resources and information relating to Infection Prevention and Control Practices posed on MLHU website
3	IPAC Investigations	Phone and online system for public to notify re IPAC concerns; notification of regulatory body as needed; investigation of complaint; consultation with PHO as needed; IPAC lapse disclosure as needed; case report and sharing of findings with clients.
4	Partner and Service Provider Education	Health Care Provider monthly infectious disease article for e-newsletter; Health Care Provider IDC resources for office binder; Review and update of paper and electronic resources on website. Online fillable diseases of public health significance form.
5	Surveillance	Monthly review by the IDC epidemiologist of iPHIS and internal database to prepare the monthly infectious disease surveillance report for the AMOH and IDC Manager. Monthly meeting to discuss results of report. Epidemiologist follows up on any outliers. Monthly influenza surveillance report November to May (annually).
6	Advocacy	Discussion with PHO and MOHLTC regarding the need for shelter IPAC guidelines and regulations to control the spread of disease. City of London regarding the need for more affordable housing. SW LHIN regarding the need for health care services in shelters.

Performance / Service Level Indicators

Indicator	2018	2019	2020 (target)
% of personal service setting inspections completed	100% (620/620)	85% (591/695)	100%
# IPAC Complaints	8	13	To reduce from previous years
# IPAC Lapses investigated by sector (% of IPAC Lapses Investigated by sector)	12 (100%)	13 (100%)	100%
# Community Health Promotion and Educational (HCP newsletter, presentations, workshops, posters, fact sheets etc.)	27	30	Maintain

Highlights / Initiatives Planned for 2020

• Improving IPAC response system as per MOHLTC Protocol (2018 highlight)
• Improve the documentation process for 2019.
• Educating the public about the role of public health.

Program Challenges and Risks

• With increasing education and awareness of the importance of infection control practices, there have been increased local complaints requiring extensive investigation.
• Increasing number of PSS inspections and community complaints due to home based businesses. Language barrier with PSS operators creates challenge when inspecting and educating owner/operators and staff.

Staffing Complement			
	2019 Total FTEs	2020 Total FTEs	Δ
Health Promoter	0.10	0.10	0.00
Program Assistant	0.75	0.80	0.05
Program Manager	0.20	0.40	0.20
Public Health Inspector	2.30	2.00	-0.30
Public Health Nurse	0.50	0.73	0.23
Outreach Worker	0.00	0.20	0.20
Associate Medical Officer of Health	0.00	0.10	0.10
Director	0.00	0.04	0.04
Total Program FTE	***3.85***	***4.37***	***0.52***

Expenditures					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 286,897	$ 352,513	65,616	23%
Benefits		$ 69,895	$ 83,805	13,910	20%
Expected Vacancies		$ -		-	
Travel		$ 3,649	$ 3,603	(46)	-1%
Program Supplies		$ 4,158	$ 3,689	(469)	-11%
Board Expenses		$ -		-	
Staff Development		$ 1,858	$ 2,344	486	26%
Occupancy		$ -		-	
Professional Services		$ 5,535	$ 5,409	(126)	-2%
Furniture & Equipment		$ -		-	
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 17,328	$ 16,253	(1,075)	-6%
Total Expenditures	***$ -***	***$ 389,319***	***$ 467,616***	***$ 78,297***	

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 202,820	$ 423,843	221,023	109%
MOHLTC (100%)		$ 154,493	$ -	(154,493)	-100%
MCCSS		$ -		-	
PHAC		$ 30,852	$ 37,379	6,527	21%
PHO		$ -		-	
User Fees		$ -		-	
Other		$ 1,154	$ 6,393	5,239	454%
Total Revenues	***$ -***	***$ 389,319***	***$ 467,616***	***$ 78,297***	

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Rabies and Zoonotic Disease					451
Standard	Infectious and Communicable Diseases Prevention and Control		**Director Name**	Stephen Turner	
Lead Team	Safe Water, Rabies and Vector-Borne Disease		**Manager Name**	Andrew Powell	
Supporting Team(s)	Infectious Disease Control				
Budget	$ 359,484		**FTE**	3.03	

Summary of Program

The purpose of the program is to prevent the occurrence of rabies in Middlesex-London residents. The target population is the people living in Middlesex-London Region. The main interventions to prevent the rabies occurrence of rabies includes investigating human exposures to animals suspected of having rabies; confirming the rabies vaccination status of the animals (suspected of having rabies); ensuring individuals requiring treatment have access to rabies post exposure prophylaxis; liaising with Canada Food Inspection Agency for the testing of animals for rabies; organizing rabies awareness programs; sending reminders to stakeholders (healthcare providers, police department) to report related incidents.

Program Mandate & Relevant Legislation

Infectious and Communicable Diseases Prevention and Control Standard
Infectious Diseases Protocol, 2018 (or as current)
Population Health Assessment and Surveillance Protocol, 2018 (or as current)
Management of Potential Rabies Exposures Guideline, 2018 (or as current)
Rabies Prevention and Control Protocol, 2018 (or as current)
Management of Avian Chlamydiosis in Birds Guideline, 2018 (or as current)
Management of Avian Influenza or Novel Influenza in Birds or Animals Guideline, 2018 (or as current)
Management of Echinococcus Multilocularis Infections in Animals Guideline, 2018 (or as current)

Program Management

The Safe Water, Rabies and VBD team leads this program and works closely with the Vaccine Preventable Disease team for rabies post exposure prophylaxis storage, delivery and administration when necessary. The Infectious Disease Control team coordinates the management of Avian Chlamydiosis in birds, management of Avian Influenza or Novel Influenza in Birds or Animals and management of Echinococcus Multilocularis infections in animals. The Safe Water, Rabies and VBD team provides support as needed. The Vaccine Preventable Disease Team may also collaborate on the delivery of this program.

Key Partners and Stakeholders

City of London, Middlesex County, Ministry of Health and Long-Term Care, Public Health Ontario, Ministry of the Environment, Conservation and Parks, Ministry of Natural Resources and Forestry, Ministry of Agriculture Food and Rural Affairs, Canadian Food Inspection Agency, London Health Sciences Centre, Local and Provincial Police Departments, Ontario Association of Veterinary Technicians, City of London Library, Middlesex County Library, Township of Adelaide Metcalfe, Township of Lucan Biddulph, Municipality of Middlesex Centre, Municipality of North Middlesex, Municipality of Southwest Middlesex, Municipality of Strathroy-Caradoc, Municipality of Thames Centre, Village of Newbury, Western University

Community Needs and Priorities

The Safe Water, Rabies and VBD team investigates all cases where there has been an animal/person contact in Middlesex-London which have been increasing steadily each year. The following is the four-year summary of the number of investigations and number of people who accessed to rabies post exposure prophylaxis (PEP) treatment:
2016: Total number of investigations: 967 PEP received: 138
2017: Total number of investigations: 1060 PEP received: 105
2018: Total number of investigations: 1094 PEP received: 122
2019: Total number of investigations (as of Oct 31): 1003 PEP received: 81

Target and Priority Populations

The target population for the program is the entire population of Middlesex-London. People of all ages may come into contact with animals.

Intended Program Outcomes	
Long-Term / Population Health	• To prevent the occurrence and/or reduce the burden of rabies and other zoonotic diseases in our community
Intermediate	• To use local data local data to develop programs and services for the prevention of rabies and other zoonotic diseases • To identify and address the needs of the community, including priority populations, associated with rabies and other zoonotic diseases • To ensure community partners, and health care providers and the public report all potential rabies exposures • To ensure veterinarians report all animal cases of avian chlamydiosis, avian influenza, novel influenza and Echinococcus multilocularis infection for appropriate follow up of human contacts of infected animals
Short-Term	• To manage risk communications to appropriate stakeholders on identified risks associated with rabies and other zoonotic diseases. • To receive and respond to all reported cases of potential rabies exposures received from the public, community partners, and health care providers • To address the prevention and control of rabies threats as per a local Rabies Contingency Plan and in consultation with other relevant agencies and orders of government • To receive and respond to all reported animal cases of avian chlamydiosis (infection of birds with the causative agent of psittacosis in humans), avian influenza, novel influenza, and Echinococcus multilocularis infection • To ensure 24/7 availability to receive reports of and respond to potential rabies exposures and animal cases of avian chlamydiosis, avian influenza, novel influenza, or Echinococcus multilocularis infection

Program Interventions		
1	Investigate suspected rabies exposures	All reported animal exposures are to be investigated within 24 hours of notification.
2	Provision of rabies PEP	When a healthcare provider decides to administer the PEP, the delivery of the vaccine and RIG are completed in a timely manner.
3	Rabies awareness activities	Rabies awareness activities such as the promotion of the low-cost rabies clinics are accomplished throughout the year.
4	Veterinarian Notification	Each veterinarian in Middlesex and London was sent a letter informing them of the new regulations re. public health reporting requirements for the following zoonotic diseases, avian chlamydiosis, avian influenza and Echinococcus multilocularis infection.

Performance / Service Level Indicators			
Indicator	2018	2019 (as of Oct. 31)	2020 (target)
% of suspected rabies exposures reported with investigation initiated within one day of public health unit notification	99.5% (1088/1094)	99.8% (1001/1003)	100%
Provision of rabies post exposure prophylaxis treatment to those individuals where the need is indicated	122	81	90
# of potential rabies exposures investigated by health units annually (OPHS Health Indicator)	1094	1003	1000
# of animals investigated that are current on their rabies vaccination (OPHS Health Indicator)	407	383	400

Highlights / Initiatives Planned for 2020

- Promotion of low cost rabies vaccination clinics for pets by partnering with local veterinarians
- Dissemination of rabies awareness materials to local libraries in Middlesex-London

Program Challenges and Risks

Historically, the Rabies Program fulfilled the requirements of the investigation process using paper documentation and record keeping. New in 2020, the program is migrating toward a completely electronic process that will allow for increased analytics, consistency among investigators and ease of reporting, as well as efficient record retention processes. It is anticipated that the program will require intensive training and adjustment throughout the first quarter of the year with continued adjustments and adaptations to throughout the remainder of the year.

Staffing Complement

	2019 Total FTEs	2020 Total FTEs	Δ
Program Assistant	0.30	0.25	-0.05
Program Manager	0.30	0.25	-0.05
Public Health Inspector	2.50	2.50	0.00
Associate Medical Officer of Health	0.00	0.02	0.02
Director	0.00	0.01	0.01
Total Program FTE	***3.10***	***3.03***	***-0.07***

Expenditures

	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 244,761	$ 249,042	4,281	2%
Benefits		$ 59,052	$ 58,713	(339)	-1%
Expected Vacancies		$ -		-	
Travel		$ 9,044	$ 7,154	(1,891)	-21%
Program Supplies		$ 8,105	$ 7,018	(1,087)	-13%
Board Expenses		$ -		-	
Staff Development		$ 2,174	$ 1,902	(272)	-13%
Occupancy		$ -		-	
Professional Services		$ 33,395	$ 29,186	(4,210)	-13%
Furniture & Equipment		$ 157	$ 137	(20)	-13%
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 7,601	$ 6,333	(1,269)	-17%
Total Expenditures	***$ -***	***$ 364,290***	***$ 359,484***	***-$ 4,806***	

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 340,041	$ 356,755	16,714	5%
MOHLTC (100%)		$ 21,401		(21,401)	-100%
MCCSS		$ -		-	
PHAC		$ 2,848	$ 2,057	(791)	-28%
PHO		$ -		-	
User Fees		$ -		-	
Other		$ -	$ 673	673	
Total Revenues	***$ -***	***$ 364,290***	***$ 359,484***	***-$ 4,806***	

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Respiratory, Enteric, and Other Infectious Disease						452
Standard	Infectious and Communicable Diseases Prevention and Control		**Director Name**	Stephen Turner		
Lead Team	Infectious Disease Control		**Manager Name**	Mary Lou Albanese		
Supporting Team(s)	Food Safety and Healthy Environments		Sexual Health		Vaccine Preventable Disease	
Budget	$ 722,813		**FTE**	6.45		

Summary of Program

The Respiratory, Enteric, and Other Infectious Disease Program aims to reduce the burden of respiratory, enteric and other infectious disease of public health significance. This is done through Reportable Disease Follow-up and Case Management, Outbreak Management, and Surveillance of diseases of public health significance.

Program Mandate & Relevant Legislation

Infectious and Communicable Diseases Prevention and Control
Infectious Diseases Protocol, 2018 (or as current)
Population Health Assessment and Surveillance Protocol, 2018
Institutional/Facility Outbreak Management Protocol, 2018 (or as current)
Mandatory Blood Testing Act, 2006)
Control of Respiratory Infection Outbreaks in Long-Term Care Homes, 2018

Program Management

This program is managed by the Infectious Disease Control Team and other MLHU Teams that are responsible for delivering interventions related to this program include Food Safety and Environmental Health, Sexual Health, and Vaccine Preventable Disease.

Key Partners and Stakeholders

Public Health Ontario, Public Health Ontario Laboratory, OMAFRA, CFIA, PHAC, FoodNet Canada, local physicians, hospitals, food premises operators, long term care homes, retirement homes, schools, child care centres.

Community Needs and Priorities

To monitor respiratory, enteric and other infectious diseases staff document suspect and confirmed disease of public health significance and outbreaks in iPHIS and the internal database. Daily and monthly surveillance reports summarizes the diseases of public health significance in the Middlesex and London region. The surveillance reports inform the local program planning, prioritization and interventions. A daily outbreak report is generated and distributed to internal and external stakeholders e.g. LTC institutions and hospitals. During influenza season, from November to May, MLHU distributes a weekly a Community Influenza report to local stakeholders and is posted on the MLHU website. The local priorities include interventions to address outbreaks in vulnerable populations by partnering with shelters for early recognition and treatment, education re. infection prevention; education of Health care practitioners about diseases of public health significance and reporting requirements.

Board of Health reports are regularly submitted e.g. influenza report, Hepatitis A outbreak report. Local issues: homelessness, under housed, illicit drug use, health inequities, social determinants of health.

Target and Priority Populations

The target and priority population for this program are higher risk individuals such as people who use drugs, under-housed and are homeless. Including, those over the age of 65 in the community or long term care homes and children.

Associated social determinants of health(SDH)are Housing, Education, Employment, Health services, Income and social status, Healthy child development, Gender.

Through the investigation process, data related to SDH is collected and entered in data base. Community health status report is prepared by epidemiologist providing population statistics for program planning purposes. Focus is given to those populations that are assessed to be subject to health inequity and higher risk due to physical and social environment. Surveillance monitoring of rates of diseases of public health significance through iPHIS and internal database.

Intended Program Outcomes	
Long-Term / Population Health	To reduce the burden of respiratory, enteric and other infectious disease of public health significance.
Intermediate	The board of health is aware of and uses local data to influence and inform the development of local healthy public policy and its programs and services for the prevention of respiratory, enteric and other infectious disease. (OPHS) Board of health programs and services are designed to address the identified needs of the community, including priority populations, associated with respiratory, enteric and other infectious disease. (OPHS) Timely and effective detection, identification, and management of exposures and local cases/outbreaks respiratory, enteric and other infectious disease of public health significance, including diseases of public health significance, their associated risk factors, and emerging trends. (OPHS) Effective case management results in limited secondary cases. (OPHS)
Short-Term	The board of health shall conduct population health assessment and surveillance regarding respiratory, enteric and other infectious disease and their determinants (OPHS). • Surveillance of diseases of public health significance internal database and iPHIS. • To document internally and in iPHIS. The board of health shall communicate, in a timely and comprehensive manner, with all relevant health care providers and other partners about urgent and emerging respiratory, enteric and other infectious disease. (OPHS)

Program Interventions		
1	Reportable Disease Follow-up and Case Management	Assignment of diseases of public health significance to either public health nurse or public health inspector. Cases are reported through IDC Phone intake line, secure fax line, secure email, and week end on call system.
2	Outbreak Management	LTC, retirement homes and child care facilities assigned to IDC Team to provide infection control support during outbreak to minimize the transmission and after outbreak to review the process. Staff support facilities in preparation for annual influenza season ensuring that the facility is prepared with necessary materials and supplies, vaccine, etc. Public Health Inspectors support child care facilities during outbreaks. Provide educational material and regular updates to facilities Monitoring and distribution of a daily Outbreak Report. From November to May a weekly Community Influenza Surveillance Report is distributed to community agencies, facilities and media to notify them of the influenza situation in Middlesex London.
3	Surveillance of reportable diseases	Daily Surveillance Report is prepared and distributed to key stakeholders to notify them about the current cases being monitored in our community. Monthly Surveillance Report prepared by epidemiologist and reviewed by Manager and AMOH. A monthly internal review is held to review the monthly surveillance report.

Performance / Service Level Indicators

Indicator	2018	2019	2020 (target)
# of cases of reportable disease followed-up	1572	1533	Decrease
# of confirmed / potential outbreaks managed (% of confirmed/potential outbreaks managed)	221 (100%)	248 (100%)	100%
# of phone calls resolved through the phone duty intake line	1695	15,154	Maintain
# of confirmed / potential enteric outbreaks managed	57 (100%)	78 (100%)	Decrease
# of confirmed / potential respiratory outbreaks managed	162 (100%)	169 (100%)	Decrease
# of confirmed / potential community outbreaks managed	2 (100%)	3 (100%)	Decrease

Highlights / Initiatives Planned for 2020

To reduce the incidence and morbidity related to respiratory, enteric and other infectious disease through the following interventions: early notification, early treatment and/or prophylaxis and education/health promotion. To provide Health Care provider education in the form of e-newsletters and other communication media regarding infectious disease. To simplify the reporting process of infectious disease for health care providers.

Program Challenges and Risks

- iGAS Outbreak Management started in 2016
- Higher than normal Influenza cases and outbreaks in 2017/18 season.
- Hepatitis A Community Outbreak
- Increased number of salmonella cases
- The rate of diseases of public health significance will continue to increase and be influenced by health inequities and social determinants of health.

Staffing Complement			
	2019 Total FTEs	2020 Total FTEs	Δ
Health Promoter	0.20	0.20	0.00
Program Assistant	0.65	0.65	0.00
Program Manager	0.20	0.20	0.00
Public Health Inspector	1.15	1.50	0.35
Public Health Nurse	3.45	3.65	0.20
Associate Medical Officer of Health	0.00	0.05	0.05
Director	0.00	0.20	0.20
Total Program FTE	***5.65***	***6.45***	***0.80***

Expenditures					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 448,079	$ 544,533	96,454	22%
Benefits		$ 105,633	$ 126,046	20,414	19%
Expected Vacancies		$ -		-	
Travel		$ 5,438	$ 6,141	703	13%
Program Supplies		$ 5,600	$ 5,870	270	5%
Board Expenses		$ -		-	
Staff Development		$ 2,708	$ 3,138	430	16%
Occupancy		$ -		-	
Professional Services		$ 3,845	$ 4,960	1,115	29%
Furniture & Equipment		$ -		-	
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 29,095	$ 32,125	3,030	10%
Total Expenditures	***$ -***	***$ 600,397***	***$ 722,813***	***$ 122,416***	

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 278,182	$ 657,033	378,851	136%
MOHLTC (100%)		$ 268,580		(268,580)	-100%
MCCSS		$ -		-	
PHAC		$ 53,635	$ 63,762	10,127	19%
PHO		$ -		-	
User Fees		$ -		-	
Other		$ -	$ 2,018	2,018	
Total Revenues	***$ -***	***$ 600,397***	***$ 722,813***	***$ 122,416***	

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Sexually Transmitted and Blood-Borne Disease				453
Standard	Infectious and Communicable Diseases Prevention and Control	**Director Name**	Stephen Turner	
Lead Team	Sexual Health	**Manager Name**	Shaya Dhinsa	
Supporting Team(s)	Infectious Disease Control			
Budget	$ 2,774,191	**FTE**	18.00	

Summary of Program

To prevent the spread of sexually transmitted infections, people with laboratory-confirmed sexually transmitted infections (chlamydia, gonorrhea, syphilis, HIV/AIDS, and Hepatitis B & C) are reported to the Health Unit. A Public Health Nurse begins the follow-up process by contacting the client (if they were diagnosed at an MLHU Clinic), or by contacting the ordering health care provider (if the client was tested elsewhere). The nurse will ensure the client has been counselled and treated, and ask for contact information for the clients' sexual contacts and/or encourage the client to notify their own contacts. Case contacts are encouraged to be tested and treated either at an MLHU STI clinic or at another health care provider. Information on the client and their contacts are entered into the MOHLTC's electronic Integrated Public Health Information System (iPHIS) database.

The Sexually Transmitted and Blood-Borne Disease Program aims to prevent and control sexually transmitted and blood-borne infections (STBBIs) completing STI follow-up and case management and contact tracing to ensure the appropriate treatment and education in provided, and conducting population health assessment and surveillance regarding infectious and communicable diseases and their determinants.

Program Mandate & Relevant Legislation

Infectious and Communicable Diseases Prevention and Control Standard
Healthy Growth and Development Standard
Infectious Diseases Protocol, 2018 (or as current)
Population Health Assessment and Surveillance Protocol, 2018
Sexual Health and Sexually Transmitted/Blood-Borne Infections Prevention and Control Protocol.
Mandatory Blood Testing Act, 2006
Canadian Guidelines on Sexually Transmitted Infections

Program Management

The STI-BBI Program is managed by the Sexual Health Team. They work closely with the Infectious Disease Control Team, Healthy Communities and Injury Prevention Team, Young Adult Team and Child Health Team. The Sexual Health Promotion Team develops resources and campaigns that target ages 15-24 years of age to reduce the rate of infectious diseases. The YAT works with the population 15-17 years of age and both programs often connect with SHP about resources as well as training for medical directives i.e. testing for GC and CT. There are often clients who may be diagnosed with Group A strep which is reported to the Infectious Disease Team. IDC will then connect with SH and the Outreach Team as this client may already be a part of the caseload and have another infectious disease i.e. Hep C or HIV. The client then would be managed by the team who has a relationship with the client.

Key Partners and Stakeholders

Walk-in clinics, hospitals, EMDC healthcare, private practice, First Nations health centres, Infection Disease Care Program, Community Health Access Centres, University/College health care, London Intercommunity Health Centre, Regional HIV/AIDS Connection, Southwest Ontario Health Access Centre, Shelters, Ministry of Health, Southwest Public Health Unit, London Cares Homeless Response, HIV Leadership Team

Community Needs and Priorities

The burden of STI/BBIs in the ML region are calculated using local and provincial disease counts retrieved from the iPHIS.

• M-L has high chlamydia & gonorrhea rates in individuals <30 yrs. of age.

• Teen pregnancy rates are higher in M-L than ON.

The burden of STI/BBIs in the ML region provides the context in which The Clinic offers services. Rates are calculated using local and provincial disease counts retrieved from the iPHIS i.e.: Chlamydia was the most commonly reported STI in the ML region with a total of 2,068 cases in 2017 compared to 1,525 in 2016. 1,726 as of Oct 31, 2018.

Case counts of interest

Annual counts

-The number of syphilis (all types) cases reported to date in 2019 (n=79) exceeds 2SD of the annual average (76.9) from the previous five years (2014-2018).

-To date in 2019, 38.0% (30/79) of cases are other (not infectious) syphilis. The year to date count exceeds 2SD of the annual average (21.6).

-62.0% (49/79) of cases are infectious syphilis. The year to date count for infectious syphilis exceeds the annual average from the previous five years (28.6), but does not exceed 2SD.

-The number of gonorrhea cases reported to date in 2019 (n=195) exceeds the annual average (157.0), but does not exceed 2SD.

Monthly counts

-The number of syphilis (all types) cases reported in September (n=12) exceeds 2SD of the monthly average from the previous five years (6.75).

-In September, all cases reported were other (not infectious) syphilis. The number of other (not infectious) syphilis cases exceeds 2SD of the monthly average (2.19).

-The number of chlamydia cases reported in September (n=159) exceeds the monthly average from the previous five years (148.00), but does not exceed 2SD.

HIV, and Hepatitis C infection were significantly higher in Middlesex-London when compared to provincial rates, and these increases were felt to be related, in part, to the use of injection drugs by community members (Middlesex-London Health Unit, 2018).

Prior to 2013, HIV rates in Middlesex-London were lower than or similar to the rate in Ontario. Since 2014, HIV rates have increased in Middlesex-London whereas the provincial rate has gradually declined. The decline observed in 2017 may be associated with decreased testing and detection, as several testing agencies experienced capacity issues. In 2016 and 2017, more than 70% of people diagnosed with HIV had experience with injection drug use. As of December 31, 2018, the number of newly diagnosed cases reported in 2018 had fallen to 29, representing a 52% decrease from the outbreak peak in 2016. As well, the number of cases reporting injection drug use as a risk factor has decreased from 74% of cases in 2016 to 52% of cases in 2018. Currently there have been 21 cases of HIV reported for 2019 (September 30, 2019).

Target and Priority Populations

• Young and young adults under the age of 30 years are a target population
• The more specific population that has been prioritized is youth between the ages of 15-24 years of age due to the increased risk of unintended pregnancy and STBBIs.
• The population for young adults under the age of 30 was chosen as a result population health data. The rates of chlamydia and gonorrhea reported in this age group are higher than any other age group.

Intended Program Outcomes

Long-Term / Population Health	To reduce the burden of sexually transmitted and blood-borne disease of public health significance.
Intermediate	The board of health is aware of and uses local data to influence and inform the development of local healthy public policy and its programs and services for the prevention of sexually transmitted and blood-borne infections . (OPHS) Board of health programs and services are designed to address the identified needs of the community, including priority populations, associated with sexually transmitted and blood-borne infections. (OPHS) Timely and effective detection, identification, and management of exposures and local cases/outbreaks of sexually transmitted infections and blood-borne infections of public health significance, including their associated risk factors, and emerging trends. (OPHS) Effective case management results in limited secondary cases. (OPHS)

Short-Term	The board of health shall conduct population health assessment and surveillance regarding sexually transmitted infections and blood-borne infections and their determinants (OPHS). • Surveillance of internal database and iPHIS. • To document internally and in iPHIS. The board of health shall communicate, in a timely and comprehensive manner, with all relevant health care providers and other partners about urgent and emerging sexually transmitted infections and blood-borne infections. (OPHS) The board of health shall, based on local epidemiology, supplement provincial efforts in managing risk communications to appropriate stakeholders on identified risks associated with sexually transmitted infections and blood-borne infections of public health significance. (OPHS) The board of health shall provide public health management of cases, contacts, to minimize the public health risk. (OPHS) Reportable Disease Follow-up • To minimize the number of sexually transmitted infections and blood-borne infections in the Middlesex London community. • To mitigate and control the transmission of sexually transmitted infections and blood-borne infections in Middlesex London community. • To successfully connect with contacts of clients with sexually transmitted infections and blood-borne infections. • To provide treatment and follow up information as required. Case Management • Timely notification from our community partners regarding potential increases of sexually transmitted infections and blood-borne infections. • To monitor the number of potential and confirmed sexually transmitted infections and blood-borne infections in the community. • To mitigate the transmission and control of sexually transmitted infections and blood-borne infections to potential contacts. • To provide timely treatment and follow up information when required. • To document internally and in iPHIS.

Program Interventions		
1	Case Management	Confirmation of diagnosis and treatment from the health care provider may be required if client was tested by health care provider. Contact the case as soon as possible to decrease the risk of transmission. Enter into IPHIS with contact of case as per Sexual Health and Sexually Transmitted/Blood-Borne Infections Prevention and Control Protocol, 2018.
2	Contact Tracing	Begin contact tracing and contact notification as soon as possible after the index case is contacted. Obtain history of any symptoms of contact. Provide disease-specific education and awareness of risk of STBBIs. Provide testing and treatment options.
3	Mandatory Blood Testing Act	Phone line 24/7 for reporting re. mandatory blood testing act. Infectious Disease staff provides case management and counselling re. testing and treatment.
4	STI Clinic	The Sexually Transmitted Infections (STI) Clinic operates on a drop-in basis with no appointment or health card necessary. Free testing, treatment and counselling for STIs, free pregnancy testing, emergency contraception (the morning after pill) and free condoms.
5	STI Campaigns	The SH team develops social media and mass media campaigns to promote various sexual health messages. Campaigns will be in response to surveillance i.e. increased rates of STBBI's. They will target the population most impacted or increased risk factors. In the past, the team has used various health behaviour theories to develop online interactive games, engaging social media campaigns and poster displays to spread the importance of STI testing and to promote MLHU sexual health services.
6	Community Outreach Team	The Community Outreach Team receives referrals internally and through community partners, such as St. Joseph's Infectious Diseases Care Program. The model includes two street-level outreach workers and two outreach PHN's that work collaboratively with systems partners to engage hard-to-reach HIV-positive individuals and connect them to care and ongoing treatment. The team serves people experiencing marginalization related to substance use and homelessness and uses assertive engagement to connect with individuals who may be lost to follow-up through traditional clinical practices. Clients are retained in care through ongoing engagement and support with accessing the healthcare system, which includes accompanying clients to appointments and advocating on the client's behalf. The team provides harm reduction education, community presentations, Naloxone training, as well as practical assistance with services such as accessing ID clinics, shelter, and other supports upon release from hospital or corrections facility.

Performance / Service Level Indicators

Indicator	2018	2019	2020 (target)
# of Chlamydia, Gonorrhea, Syphilis, HIV, Hep B and C reported and follow-up	2,124/195/69/29/0/256	2,185/284/126/27/1/200	1700/150/50/0/180
Total Visits to Sexually Transmitted Infection (STI) Clinic and Family Planning Clinic	9,946/3,538 London 239 Strathroy	11,061/4,006 London 177 Strathroy	11,000/4,000 London 150 Strathroy
# Effective treatment provided for individuals diagnosed with gonorrhea and # % of Gonorrhea case follow-up initiated within 0-2 business days to ensure timely case management (accountability indicators)	64.3% / 100%	69.5% / 97.9%	100%
# of presentations, health fairs, and clinic tours	73	65	65
# of Outreach Caseload, clients retained in care, client encounters, appointments attended, referrals	143/121/1406/315/760	183/130/2372/420/514	163/126/1890/368/637

Highlights / Initiatives Planned for 2020

• Annual workshops Hep C Day, World AIDS Day, Pride 2020

• Get Tested Western February 2020. Fall of 2019 there was a mini campaign at each residence to provide education about STI's and where to get tested as well as an opportunity for testing. This was to target new students in residence. The large campaign will be located at main campus and build on the education shared at residence but also another opportunity for testing and education. STI Campaign focusing on CT, GC and Syphilis to be the largest focus for 2020. There will be primary and secondary strategies developed to reduce the number of cases of bacterial STI transmission in the Middlesex-London region.

Program Challenges and Risks

• STI rates for CT, GC and Syphilis continue to rise and need to develop effective strategies for campaign to target ages 15-24 years of age.

Staffing Complement			
	2019 Total FTEs	2020 Total FTEs	Δ
Clinical Team Assistant	3.64	3.64	0.00
Community Outreach and Harm Reduction Program Lead	0.10	0.00	-0.10
Health Promoter	0.40	0.40	0.00
Outreach Worker	0.20	1.60	1.40
Program Assistant	1.05	1.00	-0.05
Program Manager	0.50	0.90	0.40
Public Health Nurse	8.53	10.26	1.73
Director	0.00	0.10	0.10
Associate Medical Officer of Health	0.00	0.10	0.10
Total Program FTE	***14.42***	***18.00***	***3.58***

Expenditures					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 1,060,374	$ 1,393,394	333,020	31%
Benefits		$ 263,905	$ 340,631	76,726	29%
Expected Vacancies		$ -		-	
Travel		$ 11,429	$ 13,145	1,715	15%
Program Supplies		$ 259,427	$ 331,729	72,302	28%
Board Expenses		$ -		-	
Staff Development		$ 5,346	$ 6,588	1,241	23%
Occupancy		$ -		-	
Professional Services		$ 515,031	$ 658,895	143,865	28%
Furniture & Equipment		$ 4,632	$ 2,103	(2,528)	-55%
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 23,118	$ 27,707	4,589	20%
Total Expenditures	***$ -***	***$ 2,143,261***	***$ 2,774,191***	***$ 630,930***	

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 1,219,069	$ 2,277,547	1,058,478	87%
MOHLTC (100%)		$ 500,305	$ -	(500,305)	-100%
MCCSS		$ -		-	
PHAC		$ 76,301	$ 37,855	(38,446)	-50%
PHO		$ -		-	
User Fees		$ 347,587	$ 444,335	96,748	28%
Other		$ -	$ 14,454	14,454	
Total Revenues	***$ -***	***$ 2,143,261***	***$ 2,774,191***	***$ 630,930***	

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Tuberculosis				454
Standard	Infectious and Communicable Diseases Prevention and Control	**Director Name**	Stephen Turner	
Lead Team	Infectious Disease Control	**Manager Name**	Mary Lou Albanese	
Supporting Team(s)				
Budget	$ 440,318	**FTE**	3.79	

Summary of Program

The TB program is assigned to Public Health Nurses who monitor the community for LTBI and active TB. The objectives of the program are to:

- reduce the progression from latent TB infection (LTBI) to active TB disease,
- treat anyone who is identified as having LTBI,
- monitor and identify active TB in a timely manner so that case can be treated effectively,
- prevent the spread of active TB,
- reduce the development of acquired drug-resistance among active TB cases and
- educate health care providers for early detection and treatment.

The target population for the program is any person from an endemic country, resident or immigrant, and those in contact with a positive active TB case. MLHU follows all cases referred through the immigrant surveillance system.

Program Mandate & Relevant Legislation

Infectious and Communicable Diseases Prevention and Control Standard
Infectious Diseases Protocol, 2018 (or as current)
Population Health Assessment and Surveillance Protocol, 2018 (or as current)
Tuberculosis Prevention and Control Protocol, 2018 (or as current)
Tuberculosis Program Guideline 2018 (or as current)
Canadian TB Standards

Program Management

The IDC Team is primarily responsible for implementation of the TB Program.

Key Partners and Stakeholders

MOHLTC, London Health Sciences Centre, Health Care Providers, London Intercommunity Health Centre, Cross Cultural Learning Centre, Ministry of Culture and Immigration, Secondary and Post secondary institutions

Community Needs and Priorities

Data sources providing the following stats/numbers:

- LTBI
- IMS
- Active
- Suspect
- Immigration
- Government assisted refugees
- Rates of active TB and multidrug resistance TB.
- Immigration, health inequities, education, social economics
- # of new immigrants from countries endemic with TB
- # immigration medical surveillance cases
- # suspect TB cases
- # active TB cases
- # LTBI cases being treated

Target and Priority Populations

The target and priority population are Canadian citizens and new immigrants from endemic countries;
• International students at colleges and universities from endemic countries; and
• referrals to MLHU through the Immigration Surveillance System.
New immigrants are subject to health inequity and social determinants of health in particular housing, social economics, genetics, education/literacy, health services, social environment, employment.
MLHU collaborates with Cross Cultural Learning Centre (CCLC) who notifies us when new government assisted refugees (GARS) come to London. Monthly or as needed TB staff educate the GARS about LTBI and TB.
The immigration surveillance system notifies MLHU of new immigrants which are followed as per the IMS protocol in collaboration with Ministry of Culture and Immigration. Many of these individuals are international students requiring public health to collaborate with the secondary and post secondary education institutions.

Intended Program Outcomes

Long-Term / Population Health	To reduce the burden of tuberculosis in our community.
Intermediate	The board of health is aware of and uses local data to influence and inform the development of local healthy public policy and its programs and services for the prevention of tuberculosis. (OPHS) Board of health programs and services are designed to address the identified needs of the community, including priority populations, associated with tuberculosis. (OPHS) Reduced progression from latent tuberculosis infection (LTBI) to active tuberculosis (TB) disease. Reduced development of acquired drug-resistance among active TB cases.
Short-Term	The board of health shall conduct population health assessment and surveillance regarding tuberculosis. (OPHS) The board of health shall communicate, in a timely and comprehensive manner, with all relevant health care providers and other partners about tuberculosis. (OPHS) The board of health shall, based on local epidemiology, supplement provincial efforts in managing risk communications to appropriate stakeholders on identified risks associated with tuberculosis. (OPHS) The board of health shall provide public health management of cases, contacts, and outbreaks of tuberculosis to minimize the public health risk. (OPHS) The board of health shall facilitate timely identification of active cases of TB and referrals of persons through immigration medical surveillance and shall provide or ensure access to TB medication at no cost to clients or providers. (OPHS)

Program Interventions		
1	Suspect Tuberculosis Follow-up and monitoring	All suspect TB cases are referred to MLHU. A public health nurses(PHN) follows the suspect until determination of final diagnosis.
2	Active TB Follow-up and case management	All active TB cases are managed by a primary PHN to ensure the prevention of secondary infection and multidrug resistant TB. Isolation and daily observed therapy is implemented immediately upon diagnosis. Case follow up and management implemented immediately with screening. Each active TB case is followed to treatment completion.
3	Outreach	LTBI and Active TB presentations to health care providers and family medical clinics.
4	LTBI	In collaboration with Cross Cultural Learning Centre LTBI presentation and targeted screening provided to government assisted refugees on monthly bases or as needed.
5	Immigration Surveillance	Screening of new immigrants and government assisted refugees.
6	Contact Management	Counselling of active TB contacts to reduce fears and myths.
7	Daily Observed Therapy	Confirmed Active TB cases are put on daily observed therapy to ensure compliance to medication regime.
8	Surveillance	Surveillance of all suspect, confirmed, screened, treated and not-treated LTBI cases

Performance / Service Level Indicators

Indicator	2018	2019	2020 (target)
# active TB (suspect cases)	51	70	Decrease
# active TB (confirmed cases)	14	13	Decrease

Highlights / Initiatives Planned for 2020

• Hosted a workshop for health care providers in October 2018 (CME credits available to physicians)
• In 2019 plan to continue with education of health care providers especially post secondary student health clinic staff. Development of on-line teaching kits e.g. chat box.

Program Challenges and Risks

• Increasing number of suspect TB cases requiring staff to rule out active disease.
• Continued immigration from endemic countries requiring LTBI treatment and potential to activate. Increase of number of Immigration Medical Surveillance individuals coming to London for education.
• Ongoing need to educate health care providers who do not think of TB as a potential diagnosis.

Staffing Complement

	2019 Total FTEs	2020 Total FTEs	Δ
Clinical Team Assistant	0.20	0.20	0.00
Health Promoter	0.20	0.20	0.00
Program Assistant	0.10	0.10	0.00
Program Manager	0.20	0.20	0.00
Public Health Nurse	3.20	3.00	-0.20
Associate Medical Officer of Health	0.00	0.07	0.07
Director	0.00	0.02	0.02
Total Program FTE	***3.90***	***3.79***	***-0.11***

Expenditures					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 318,378	$ 322,138	3,760	1%
Benefits		$ 77,736	$ 74,913	(2,823)	-4%
Expected Vacancies		$ -		-	
Travel		$ 3,720	$ 3,557	(162)	-4%
Program Supplies		$ 7,277	$ 7,849	572	8%
Board Expenses		$ -		-	
Staff Development		$ 1,847	$ 1,834	(13)	-1%
Occupancy		$ -		-	
Professional Services		$ 9,685	$ 11,577	1,892	20%
Furniture & Equipment		$ 64	$ 30	(35)	-54%
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 19,372	$ 18,419	(953)	-5%
Total Expenditures	***$ -***	***$ 438,080***	***$ 440,318***	***$ 2,237***	

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 214,249	$ 395,726	181,477	85%
MOHLTC (100%)		$ 182,815		(182,815)	-100%
MCCSS		$ -		-	
PHAC		$ 36,179	$ 35,995	(184)	-1%
PHO		$ -		-	
User Fees		$ 4,838	$ 6,271	1,434	30%
Other		$ -	$ 2,325	2,325	
Total Revenues	***$ -***	***$ 438,080***	***$ 440,318***	***$ 2,237***	

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Vector-Borne Disease					455
Standard	Infectious and Communicable Diseases Prevention and Control		**Director Name**	Stephen Turner	
Lead Team	Safe Water, Rabies and Vector-Borne Disease		**Manager Name**	Andrew Powell	
Supporting Team(s)	Infectious Disease Control				
Budget	$ 493,050		**FTE**	5.97	

Summary of Program

The Vector-Borne Disease (VBD) program is comprised of larval mosquito surveillance and identification, larviciding, adult mosquito trapping and viral testing, human surveillance, source reduction, public education, responding to public inquiries, and passive and active tick surveillance. The long –term outcome is to reduce all Middlesex-London residents' exposure to mosquito and tick bites in order to reduce the incidence of disease transmission through the following interventions.

•Assess standing water sites in Middlesex-London on public property and develop local vector-borne disease control strategies based on this data.
• Adult mosquito surveillance and viral testing, monitoring for invasive vector species.
• Detailed surveillance of Environmentally Sensitive Areas (ESAs), as per Ministry of Natural Resources and Forestry, and Ministry of the Environment and Climate Change permit requirements.
• Assess private properties when standing water concerns are reported and oversee remedial actions.
• Active and Passive tick surveillance to identify Lyme disease risk areas.
• Respond to complaints and inquiries from residents regarding WNV, EEE and LD.
• Distribute educational /promotional materials.
• Educate and engage residents in practices and activities at local community events in order to reduce exposure to WNV, LD and EEE.
• Monitoring and investigation of positive human lab results .
• Consultation with Health Care Providers regarding PPE.

Program Mandate & Relevant Legislation

Infectious and Communicable Diseases Prevention and Control, January 2018
Ontario Regulation 199 (Control of West Nile Virus)
Infectious Diseases Protocol, 2018 (or as current) (West Nile Virus and Lyme Disease sections)
Population Health Assessment and Surveillance Protocol, 2018 (or as current)
Other documents:
West Nile Virus: Preparedness and Prevention Plan for Ontario

Program Management

This program is managed by the Safe Water, Rabies and Vector-Borne Disease Team. The Infectious Disease Control Team monitors and investigates all positive human case lab reports. The collection of epidemiological data, which includes the incidence, prevalence, source and cause of the infectious disease, assists in determining biological and environmental risk factors for acquiring the infection. The Infectious Disease Control team collects the reported exposure location, this data is used to direct the VBD team's enhanced mosquito surveillance and control in the given location. West Nile Virus (WNV) and Lyme disease (LD), are classified as diseases of public health significance under the Health Protection and Promotion Act.

Key Partners and Stakeholders

City of London, Middlesex County, Ministry of Health and Long-Term Care, Public Health Ontario, Ministry of the Environment, Conservation and Parks, Ministry of Natural Resources and Forestry, City of London Library, Middlesex County Library, Township of Adelaide Metcalfe, Township of Lucan Biddulph, Municipality of Middlesex Centre, Municipality of North Middlesex, Municipality of Southwest Middlesex, Municipality of Strathroy-Caradoc, Municipality of Thames Centre, Village of Newbury, Thames Valley District School Board, London Catholic District School Board, Middlesex EarlyON Child & Family Centre, Ontario Early Years Centres, Western University, Wild Child Outdoor Group, Hydro One, Union Gas London Hydro, Children's Museum, Chippewas of the Thames Nation, Oneida Nation of the Thames.
Health Care Providers in London and Middlesex County

Community Needs and Priorities

The key data and information which demonstrates the public health issue and communities needs for public health intervention come from a variety of sources both internal and external. Since 2002, West Nile Virus has been a focus across the province because the virus was being found in birds and mosquitoes across the province. Similarly, in 2009, Lyme Disease became a priority across the province because Blacklegged Ticks were found to be carrying the disease. The Vector Borne Disease team has tracked, recorded and shared local VBD activity, with our partners at the Ministry of Health and Long-Term Care as well as Public Health Ontario.

Based on the on the data below and the OPHS:

- Significant increase in WNV human cases acquired within Middlesex-London.
- Increase in the number of WNV positive mosquitoes
- Increase in requests to attend special events throughout the community
- Increase in educational materials requested/distributed
- Increase in traffic to the VBD webpage
- Media requests/coverage related to Vector-Borne diseases

The following data will be collected to determine priority interventions:

- # of blacklegged ticks submitted/identified vectors/positive
- # of WNV positive mosquito pools
- # of surveillance site visits
- # of catch basins treated
- # of standing water sites treated
- # and type of requests received from the public
- # of requests/private properties investigated
- # of standing water sites remediated
- # of positive lab confirmed human cases

To support the above requests from Ministry and local partners, our Vector Borne Disease team has prioritized increasing our outreach for public education events across the community. Similarly, since North Middlesex was flagged as a Lyme Disease risk area, our program has increased our efforts around ticks and Lyme Disease awareness by increasing active and passive tick surveillance across the community. Finally, since the identification of Aedes albopictus and Aedes aegypti mosquitoes found in the Windsor region in 2016, adult mosquito trapping across Middlesex-London has incorporated BG-Sentinel traps in hopes of identifying these potential Zika carrying mosquito early before they become established in our region.

Target and Priority Populations

The target population for our Vector Borne Disease program is the entire population of Middlesex-London. People of all ages may come into contact with mosquitoes and ticks across the entire region, therefore it is important for versatile messaging. Education about ticks and mosquitoes and the diseases and viruses they can transmit is key to helping to our population stay healthy. Our team's priority populations focus on people who choose to spend time outdoors for work or leisure because they are more likely to come into contact with mosquitoes and ticks.

a) People who make up our priority population include outdoor sports enthusiasts, campers, hikers, etc. Additionally, people who work outdoors such as farmers, construction workers, etc., also can come in contact with both mosquitoes and ticks during their work day.
b) Possible social determinants of health and/or health inequities associated with our Vector Borne Disease program can impact new immigrants to Canada or those with language barriers because it's possible they come from an area where mosquitoes and ticks are not a health concern.

When presenting at educational opportunities across Middlesex-London, we utilize the approach of building accurate base knowledge with whatever population we are speaking to. That way we are better able to tailor our messaging depending on the knowledge level our audience has about mosquitoes, tick and the potential disease they can transmit. Additionally, our team continuously develops a variety of products and educational resources to help support the community as a whole. These items are strategic and effective, but most importantly are based on community need.

Intended Program Outcomes	
Long-Term / Population Health	To prevent the occurrence and/or reduce the burden of vector-borne diseases in our community.
Intermediate	To use local data and develop programs and services for the prevention of vector-borne diseases. To address the identified needs of the community, including priority populations, associated with vector-borne diseases. To timely and effectively detect, identify, and manage exposures and local cases/outbreaks vector-borne diseases of public health significance, including diseases of public health significance, their associated risk factors, and emerging trends. To reduce the transmission of vector-borne diseases. • Provide tools and resources to assist and increase resident's capacity to independently identify and remediate WNV and LD risk factors. • Increase/encourage the public to reduce mosquito breeding habitat on private property. To reduce the transmission of WNV and LD to humans by encouraging the community to practice personal protection, submit samples (e.g. ticks).
Short-Term	To develop a local vector-borne management strategy based on surveillance data and emerging trends in accordance with the Infectious Diseases Protocol, 2018 (or as current). • Raise knowledge/awareness of positive WNV and LD activity to reduce associated risks. • Increase public knowledge of personal protection methods and how to identify signs and symptoms related WNV and LD. • Increase the public's ability to self identify tick samples so they can reach out their health care provider in a timely manner. • Increase awareness among the media and residents of recent WNV and LD activity in Middlesex-London and Ontario. • Increase public engagement by educating and assisting residents in managing risk factors (e.g. Removal of mosquito and tick habitat and permanent source reduction)

Program Interventions		
1	Vector Borne Disease Surveillance	WNV surveillance • Identify and monitor significant standing water sites on public property • Adult Mosquitoes collected by MLHU staff • Mosquitos are shipped for testing for WNV and Zika virus at the accredited lab Lyme Disease surveillance • Receive and identify all tick submissions • Conduct active tick surveillance; several field activities organized through the season to monitor tick activity • Identify Lyme disease risk areas through surveillance
2	Complaints, Comments, Concerns, Inquiries & public education	• Respond to all concerns/ inquires (VBD) • Receive requests and inquiries from residents, advise on WNV and LD protection/prevention information and investigate requests, taking remedial action to manage risk factors associated with WNV and LD. • Promote personal protection against WNV and LD, raise public awareness by attending special events, work with other health unit teams and distribute • educational/promotional materials. Inform residents of WNV and LD activity on the health unit's website, social media platforms and media releases when VBD activity is identified.
3	West Nile Virus Treatment	Standing water sites and roadside catch basins are treated o Larvicide treatment in standing water locations where required based on larval identification o Three larvicide treatments of all catch basins on public property o encourage permanent remediation.
4	Human Case Monitoring	Lab confirmed results of human West Nile Virus and Lyme disease reports monitored. Case follow up and investigation. Mapping of tick location. Collaboration with VBD Team.
5	Surveillance	All human cases are entered into iPHIS and IDC database.
6	Health Education	Annual update of website with resources including Lyme disease algorithm for health care practitioners. Annual e-Newsletter to Health Care Providers re WNV and Lyme Disease prevention and treatments. Webinar provided in 2019 by AMOH and VBD staff person.

Performance / Service Level Indicators			
Indicator	2018	2019	2020 (target)
# of standing water sites monitored on public property	229	230	235
# of mosquito larvae identified in MLHU laboratory	6255	5104	5000
Area (in hectares) of larvicidal treatment	15.2ha	6.89ha	12ha
# of larvicidal treatments in catch basins on public property	110821	113,132	115,000
# of Adult mosquitos collected	77170	69966	73000
# of viral tests completed	1013	968	1100
# of educational events	40	60	60
# of tick submissions	301	510	450
# of tick surveillance events	53	98	100
# of tick surveillance sites	29	63	70

Highlights / Initiatives Planned for 2020

• Review and evaluate surface water Tier system to ensure priority sites are identified, surveyed and controlled
• Surveillance of VBD activity in Middlesex-London, including Zika Virus and EEE vectors
• Increased active tick surveillance in and around PHO established risk areas
• • Climate change related surveillance, expanding active tick surveillance
• Increase public's ability to self identify ticks
• Increase physician capacity for tick submission and testing process
• Develop appropriate signage and install in Lyme disease risk areas
• Expand social media

Program Challenges and Risks

• The presence of other tick species (Lone Star) will require expanded active tick surveillance
• Data from tick surveillance is showing the potential for a larger portion of Middlesex-London becoming a Lyme disease risk area as outlined by PHO
• Possibility of invasive mosquito species (i.e. Aedes aegypti, albopictus) establishing itself in Middlesex-London, will require expanded mosquito surveillance and control
• Climate Change is showing its effects on mosquito and tick populations, species distribution, expansion and population is closely related to the local climate

Staffing Complement

	2019 Total FTEs	2020 Total FTEs	Δ
Program Assistant	0.30	0.30	0.00
Program Manager	0.30	0.30	0.00
Public Health Inspector	0.30	0.30	0.00
Public Health Inspector Student	4.00	3.02	-0.98
Vector-Borne Disease Coordinator	1.00	1.00	0.00
Vector-Borne Disease Field Technician	1.00	1.00	0.00
Associate Medical Officer of Health	0.00	0.02	0.02
Director	0.00	0.03	0.03
Total Program FTE	***6.90***	***5.97***	***-0.93***

Expenditures					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 328,283	$ 327,174	(1,108)	0%
Benefits		$ 64,119	$ 64,753	634	1%
Expected Vacancies		$ -		-	
Travel		$ 20,494	$ 13,965	(6,529)	-32%
Program Supplies		$ 18,342	$ 13,703	(4,639)	-25%
Board Expenses		$ -		-	
Staff Development		$ 4,880	$ 3,715	(1,164)	-24%
Occupancy		$ -		-	
Professional Services		$ 76,205	$ 56,624	(19,582)	-26%
Furniture & Equipment		$ 359	$ 266	(93)	-26%
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 16,418	$ 12,850	(3,569)	-22%
Total Expenditures	***$ -***	***$ 529,099***	***$ 493,050***	***-$ 36,050***	

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 484,265	$ 487,196	2,932	1%
MOHLTC (100%)		$ 40,088		(40,088)	-100%
MCCSS		$ -		-	
PHAC		$ 4,746	$ 5,142	396	8%
PHO		$ -		-	
User Fees		$ -		-	
Other		$ -	$ 711	711	
Total Revenues	***$ -***	***$ 529,099***	***$ 493,050***	***-$ 36,050***	

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Adverse Vaccine Events and Safety					460
Standard	Immunization		**Director Name**	Stephen Turner	
Lead Team	Vaccine Preventable Disease		**Manager Name**	Jody Paget	
Supporting Team(s)					
Budget	$	27,968	**FTE**		0.22

Summary of Program

The Vaccine Preventable Disease (VPD) Team promotes reporting of adverse events following immunization (AEFIs) by health care providers to the Board of Health in accordance with the Health Protection and Promotion Act.
Suspect AEFI reported to public health is investigated and reviewed by the Associate Medical Officer of health for follow-up recommendations.
AEFIs meeting provincial reporting criteria, are forwarded to Ministry using the Integrated Public Health Information System (iPHIS).
Epidemiological analysis of surveillance data for adverse events following immunization is conducted yearly in collaboration with the Population Health Assessment and Surveillance (PHAS) team.

Program Mandate & Relevant Legislation

Requirements for adverse event monitoring and Reporting are under the Immunization Program Standard within the Ontario Public Health Standards:
• Reporting of AEFIs by health care professionals is mandated under Section 38 of the Health Protection and Promotion Act (HPPA).
• The Infectious Disease Protocol, 2018 outlines the requirements to promote reporting of adverse events following immunization by health care providers to the board of health as well as provincial reporting requirements.
• The Population Health Assessment and Surveillance Protocol, 2018 outlines surveillance requirements

Program Management

Program is managed by the VPD team as follows:

• Health care providers are provided with education and guidance on an annual and individual basis regarding the requirements to report AEFIs to the Board of Health.

• All reported AEFIs are investigated and monitored by a lead and alternate public health nurse in consultation with AMOH.

• AEFis that meet provincial reporting criteria are reported to the Ministry through IPHIS.

• The VPD team works with the Health Care Provider Outreach Team to provide education and updates on a regular basis.

Key Partners and Stakeholders

• Public Health Ontario

• Ministry of Health and Long-Term Care

• Health Care Providers

Community Needs and Priorities

Vaccine safety surveillance is essential to the success of immunization programs.

The VPD team has been focusing on promoting the reporting of AEFIs by Health Care Providers due to the small number of suspect reports received in the past (.2 per 100,000 in 2015-2017).

According to Public Health Ontario's Annual report on Vaccine Safety in Ontario, In 2018 the average number of reports meeting case definition was 5.1 per 100,000 population. In Middlesex-London, the reported rate was 1.6 per 100,000.

Target and Priority Populations

• Health Care Providers

• Individuals receiving vaccines

Intended Program Outcomes	
Long-Term / Population Health	Reduce or eliminate the burden of vaccine preventable diseases through immunization
Intermediate	Increased surveillance and reporting of AEFIs by HCPs and individuals receiving immunizations
Short-Term	•Promote reporting of AEFIs by HCPs •Promote reporting of AEFIs by individuals receiving immunizations •Monitor, investigate, consult with AMOH, and report AEFIs meeting case definition to the Ministry

Program Interventions		
1	Surveillance	Conduct epidemiological analysis of surveillance data for adverse events following immunization, including monitoring of trends over time, emerging trends, priority populations, and community educational needs in collaboration with the PHAS Team.
2	Educate Health Care Providers	Educate and provide instructions to health care providers administering vaccine to report adverse vaccine events to the board of health during annual cold-chain inspections (educational materials and dialogue with HCP). Include content about reporting adverse vaccine events in the Health Care Provider Outreach eNewsletter.
3	Report	Review and report adverse vaccine events to the Ministry of Health and Long Term care as required in the Infectious Disease Protocol, 2018 utilizing the integrated public health reporting system (IPHIS). Upon receipt of an AEFI, PHN reviews report. AMOH is consulted on all suspect adverse events for follow-up recommendations. All adverse events that meet case definition are then entered into IPHIS by Lead PHN within 24 hrs.
4	Public Education	Inform individuals receiving vaccines about the importance of reporting AEFIs.

Performance / Service Level Indicators

Indicator	2018	2019	2020 (target)
# of e-newsletter articles about AEFIs	N/A	New Indicator	2
# of hits on e-newsletter articles about AEFIs	N/A	New Indicator	50
% of cold chain visits where reporting of AEFIs is discussed.	N/A	New Indicator	100%
# of AEFIs that do not meet provincial case definition	8	20	>20
# of AEFIs that meet provincial case definition	8	3	Increase
Rate of AEFI event reporting per 100,000 (all vaccines)	1.6	0.6 (preliminary)	5.1 (Ontario average)

Highlights / Initiatives Planned for 2020

Continue Incorporating information regarding AEFI reporting into the HCP e-newsletter in addition to the annual cold chain visits.
Future initiatives to consider:

- Develop/incorporate client reminders to report AEFIs for internal use and for HCPs
- Develop internal procedures for AEFI program to document current process
- Enhance education to health care providers regarding reporting AEFIs

Program Challenges and Risks

- HCPs may not be aware of the requirements to report AEFIs to the BOH
- Individuals receiving immunization may not be aware that they can report AEFIs to the BOH

Staffing Complement			
	2019 Total FTEs	2020 Total FTEs	Δ
Public Health Nurse	0.20	0.15	-0.05
Program Manager	0.00	0.05	0.05
Associate Medical Officer of Health	0.00	0.01	0.01
Director	0.00	0.01	0.01
Total Program FTE	***0.20***	***0.22***	***0.02***

Expenditures					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 16,724	$ 21,406	4,682	28%
Benefits		$ 4,169	$ 5,071	903	22%
Expected Vacancies		$ -		-	
Travel		$ 141	$ 152	11	8%
Program Supplies		$ 1,223	$ 1,141	(82)	-7%
Board Expenses		$ -		-	
Staff Development		$ 22	$ 41	19	85%
Occupancy		$ -		-	
Professional Services		$ 21	$ 77	56	268%
Furniture & Equipment		$ 40	$ 41	1	2%
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 29	$ 39	10	36%
Total Expenditures	***$ -***	***$ 22,369***	***$ 27,968***	***$ 5,599***	

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 18,969	$ 25,393	6,424	34%
MOHLTC (100%)		$ 1,207		(1,207)	-100%
MCCSS		$ -		-	
PHAC		$ -		-	
PHO		$ -		-	
User Fees		$ 1,355	$ 1,377	22	2%
Other		$ 838	$ 1,198	360	43%
Total Revenues	***$ -***	***$ 22,369***	***$ 27,968***	***$ 5,599***	

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

2019 Annual Service Plan

Vaccine Inventory Management					461
Standard	Immunization		**Director Name**	Stephen Turner	
Lead Team	Vaccine Preventable Disease		**Manager Name**	Jody Paget	
Supporting Team(s)	Infectious Disease Control				
Budget	$ 225,444		**FTE**	2.37	

Summary of Program

The Vaccine Preventable Disease (VPD) team is responsible for maintaining an inventory of publicly funded vaccine from Government Pharmacy including the following management processes: vaccine ordering, storage, distribution, maintenance and wastage monitoring according to the Vaccine Storage and Handling Protocol, 2018.

• Annual cold chain inspections are conducted by PHNs on the VPD Team and PHIs on the IDC Team wherever vaccine is being stored in the community.

• Suspect cold chain incidents reported by HCPs are investigated to ensure that the vaccine is safe and effective for use.

• In collaboration with the Infectious Disease Control (IDC) and Health Care Provider Outreach teams the VPD team provides health care providers with comprehensive information and education to promote effective inventory management for provincially funded vaccines in accordance with Ministry Vaccine Storage and Handling Guidelines, 2018

Program Mandate & Relevant Legislation

• Ontario Public Health Standards-Immunization, 2018

• Vaccine Storage and Handling Protocol, 2018

• Vaccine Storage and Handling Guidelines, 2018

Program Management

This program is managed by the VPD team. The VPD team conducts cold chain inspections in other community health care provider settings where publicly funded vaccines is stored. The IDC team provides support for this program by conducting annual cold chain inspections and investigating suspect cold chain incidents in long term care facilities and hospitals. The VPD team
Collaborates with the HCP Outreach team to provide vaccine updates and information required for effective inventory management

Key Partners and Stakeholders

- Hospitals
- Long Term Care Facilities
- Health Care Providers (working in a variety of settings. E.g. Family practice, Community Clinics
- Pharmacists
- Large workplaces with Occupational Health Services
- Western University Student Health Services
- Fanshawe College Student Health Services

Community Needs and Priorities

All HCPs require timely and convenient access to publicly funded vaccine. Over 400 HCPs and organizations order, maintain, store and administer vaccines to the public in Middlesex-London. Priority is to ensure that HCPs have access to provincially funded vaccine and the knowledge required to optimize vaccine safety, efficacy and reduce wastage.

Target and Priority Populations

Target and Priority populations for this program are settings where publicly funded vaccines are stored:

- Pharmacies
- Health Care Clinics
- Nursing agencies
- Workplaces
- Hospitals

Intended Program Outcomes	
Long-Term / Population Health	• To reduce or eliminate the burden of vaccine preventable diseases through immunization
Intermediate	• Effective inventory management of provincially funded vaccines by the Board of Health and HCPs in the community where provincially funded vaccines are stored according to the Vaccine Storage and Handling Protocol, 2018
Short-Term	• Health care providers will be provided with information and training according to Ministry Vaccine Storage and Handling Guidelines, 2018 during yearly cold chain inspections at all locations where provincially funded vaccine is stored. • Vaccine cold chain incidents will be investigated in order to ensure vaccine safety and efficacy • Reduction in the amount of vaccine wastage due to cold chain incidents and expired vaccine according to the Vaccine Storage and Handling Protocol, 2018

Program Interventions		
1	Vaccine Inventory	Vaccine inventory management process including vaccine ordering, storage, distribution, and return are the responsibility of a full time Program Assistant (PA) and alternate. Panorama is used for all vaccine inventory and management processes. PA reviews current inventory in Panorama on a regular basis and also conducts a physical count of the vaccines on hand according to Panorama Inventory Data Standards and Best Practices. Vaccine is ordered from the Ontario Government Pharmacy through Panorama HCPs submit vaccine orders to the vaccine inventory PA via fax or e-mail. Before releasing vaccine, the vaccine inventory management PA reviews temperature logs to determine whether vaccine is being stored between 2°C and 8°C and assesses ordering patterns to ensure that clinics are storing less than a two-month supply of vaccines. Expired or wasted vaccine is returned to the health unit and entered in Panorama.
2	Routine Inspections	Designated PHNs and PHIs conduct annual on-site cold chain inspections for all sites who order and maintain a supply of vaccines in order to assess the level of compliance with Ministry Vaccine Storage and Handling Guidelines, 2018. The Vaccine Cold Chain Inspection Maintenance Report Form is used and results are documented in Panorama. HCPs who do not adhere to vaccine clod chain requirements will not be able to order Publicly Funded Vaccine.

3	Cold Chain Incident follow up	Designated PHNs and PHIs Investigate all reports of cold chain incidents in HCP premises within 24 hours (or the next business day) to determine whether vaccine can be used based on recommendations of vaccine manufacturer PHNs and PHIs provide follow-up recommendations and ensure that vaccine cold chain requirements are being followed before future vaccine orders can be maintained on the premise Results of the Cold Chain incident investigations, remediation strategies and monetary value of vaccine loss are communicated to the HCP. Vaccine incidents and wastage are document in Panorama and returned to Government Pharmacy via MLHU.
4	Education	HCPs are provided with information and educational material before vaccines can be ordered from the MLHU and during annual cold chain inspections according to the Vaccine Storage and Handling Protocol, 2018. Vaccine updates are communicated as needed via HCP e-newsletter and vaccine information inserts. Topics include: Vaccine inventory, storage, and handling requirements; vaccine ordering process; temperature monitoring and refrigerator maintenance; publicly funded vaccine criteria and recommendations for use; vaccine return process; and cold chain incident reporting and management.

Performance / Service Level Indicators

Indicator	2018	2019	2020 (target)
# of cold chain incidents	35	35	Decrease
% of inspected vaccine storage locations that meet storage and handling requirements	400/400 = 100%	382/382=100%	100%
# of orders received/processed for health care providers' offices	3500	3633	>3633
% of doses wasted annually for all publicly funded vaccine # of doses wasted/total # of doses distributed	.050% 15,899/320,235	.048% 16,087/333,515	<.05%

Highlights / Initiatives Planned for 2020

• Continue to enhance education for health care providers about the Vaccine Storage and Handling specifically, in reference to the transporting vaccine
• Move towards electronic ordering by e-mail with updated fillable forms accessible on our website
• Create separate order form for high-risk vaccines

Program Challenges and Risks

• Limiting the amount of vaccine wastage particularly in small community health care facilities and primary care offices without fridge alarms
• Maintaining timely and convenient access to publicly funded vaccine for HCPs in MLHUs new location

Staffing Complement			
	2019 Total FTEs	2020 Total FTEs	Δ
Program Assistant	1.10	1.10	0.00
Public Health Inspector	0.50	0.60	0.10
Public Health Nurse	0.90	0.45	-0.45
Program Manager		0.20	0.20
Director		0.01	0.01
Associate Medical Officer of Health		0.01	0.01
Total Program FTE	***2.50***	***2.37***	***-0.35***

Expenditures					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 169,166	$ 166,223	(2,942)	-2%
Benefits		$ 44,290	$ 42,027	(2,262)	-5%
Expected Vacancies		$ -		-	
Travel		$ 1,892	$ 1,865	(27)	-1%
Program Supplies		$ 12,725	$ 9,929	(2,796)	-22%
Board Expenses		$ -		-	
Staff Development		$ 459	$ 538	79	17%
Occupancy		$ -		-	
Professional Services		$ 548	$ 665	116	21%
Furniture & Equipment		$ 405	$ 339	(65)	-16%
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 2,864	$ 3,857	993	35%
Total Expenditures	***$ -***	***$ 232,348***	***$ 225,444***	***-$ 6,904***	

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 169,831	$ 199,509	29,678	17%
MOHLTC (100%)		$ 35,840		(35,840)	-100%
MCCSS		$ -		-	
PHAC		$ 4,746	$ 7,199	2,452	52%
PHO		$ -		-	
User Fees		$ 13,549	$ 11,362	(2,187)	-16%
Other		$ 8,382	$ 7,374	(1,007)	-12%
Total Revenues	***$ -***	***$ 232,348***	***$ 225,444***	***-$ 6,904***	

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Vaccine Preventable Disease					462
Standard	Immunization		**Director Name**	Stephen Turner	
Lead Team	Vaccine Preventable Disease		**Manager Name**	Jody Paget	
Supporting Team(s)	Infectious Disease Control				
Budget	$ 591,176		**FTE**	5.29	

Summary of Program

The Vaccine Preventable Disease program aims to reduce or eliminate the burden of vaccine preventable diseases through immunizations interventions aimed at:

- Reducing the incidence of vaccine preventable diseases;
- Increasing knowledge and public confidence in immunizations;
- Increasing HCP knowledge and awareness of Publicly Funded Immunization Schedule;
- Timely and effective detection and identification of children susceptible to vaccine preventable diseases, their associated risk factors and emerging trends;
- Identifying priority populations facing barriers to immunizations, their associated risk factors and emerging trends;
- Co-ordinating access to immunization services in the community; and
- Providing immunization services to eligible priority populations who do not have access to provincially funded immunization programs and services.

Program Mandate & Relevant Legislation

Ontario Public Health Standard, 2018 - Immunization
- Immunization for Children in Schools and Licensed Child Care Setting Protocol, 2018
- Infectious Disease Protocol, 2018
- Population Health Assessment and Surveillance Protocol, 2018
- Child Care and Early Years Act, 2014

Program Management

The program is managed by the Vaccine Preventable Disease team in collaboration with the Sexual Health, Infectious Disease, and health care Provider Outreach teams in order to provide information, increase knowledge, and in some cases, administer vaccines to individuals meeting publicly funded criteria particularly individuals at high risk and/ or contacts of vaccine preventable diseases.

Key Partners and Stakeholders

Health care providers who administer vaccines
Middlesex London Paramedicine Program
Child Care Centres
School Boards
Schools
Shelters

Community Needs and Priorities

Vaccines services for Individuals/students who:
- Do not have a valid health card
- Are suspended from school
- Do not have a primary health care provider

Target and Priority Populations

- Individuals living in the Middlesex-London area who do not have a health care provider
- Individuals living in the Middlesex-London area who do not have a valid Ontario health card
- Individuals living in the Middlesex-London area aged infant to 18 years

Intended Program Outcomes	
Long-Term / Population Health	To reduce or eliminate the burden of vaccine preventable diseases through immunizations
Intermediate	• Children have up to date immunizations according to the current Publicly Funded Immunization Schedules for Ontario, and in accordance with the Immunization of School Pupils Act and the Child Care and Early Years Act, 2014 • Reduced incidence of vaccine preventable diseases • Increase public confidence in immunizations • Timely and effective detection and identification of children susceptible to vaccine preventable diseases, their associated risk factors and emerging trends • Timely and effective detection and identification of priority populations facing barriers to immunizations, their associated risk factors and emerging trends
Short-Term	• Timely and effective detection and identification of children susceptible to vaccine preventable diseases, their associated risk factors and emerging trends • Timely and effective detection and identification of priority populations facing barriers to immunizations, their associated risk factors and emerging trends • Eligible persons, including underserved and priority populations, have access to provincially funded immunization programs and services

Program Interventions		
1	Immunization Clinics	• Operate immunization clinics two days a week at 50 King and once a month in Strathroy for individuals aged infant to 18 years of age, and individuals living in the Middlesex-London area who do not have a health care provider and/or health card • Offer post-exposure vaccines • Offer Tuberculin Skin Testing for medical purposes • Offer paid vaccine in immunization clinic for high risk and individuals without a primary health care provider

2	High Risk Immunization Clinics	• Offer influenza immunization clinic for Newcomers to Middlesex-London in collaboration with Dr. Kazi, Dr. Bhayana, Dr. Lovesey, Schulich school of medicine, London Cross Cultural Learners Center and the London Paramedicine Program. • Offer influenza vaccine to high risk populations in collaboration with the London Paramedicine Program (Homeless Shelters, Supervised Consumption sites, Supportive housing units) • Offer Immunization Clinics in the event of a community outbreak to individuals at risk, on an as needed basis
3	Investigation and follow-up of Vaccine Preventable Reportable Disease	• Infectious Disease Control Team investigates all suspect and confirmed vaccine preventable diseases. • Provide phone line 24/7 for reporting and staff available for case management. • Provide education, recommendations for chemoprophylaxis, immunizations, isolation and/or advice to seek medical attention to the person with the infection and suspect contacts • Case contact follow up and chemoprophylaxis. • Report investigation of disease of public health significance in iPHIS • Notification of schools and licensed day cares of exposures/contacts
4	HCP Education and Consultation	• Communicate immunization updates to HCPs through the HCP outreach team eNewsletter, website, faxes, vaccine inserts and annual vaccine fridge inspections • Provide and support and consultation to health care provider regarding immunizations via phone or email within 1 business day • Organize information sessions as needed about the immunization schedule and building confidence around administering vaccines.

Performance / Service Level Indicators

Indicator	2018	2019	2020 (target)
# of VPD confirmed cases/investigations completed by IDC (measles, mumps, pertussis, chickenpox, invasive meningococcal, Polio, Diphtheria, Tetanus, HIB)	23/174	32/203	Decrease
# of community clinics organized/delivered in collaboration with community partners specifically for priority populations beyond regular immunization clinics	1	9	10
# of calls to Triage / # of consultations through incoming email	16,283 / 1670	15,154 / 1107	Decrease # of consultations through e-mail
# of client visits/ vaccines given at MLHU Immunization Clinics	5,196 / 10,535	5,310 / 10,808	Maintain
# of education sessions organized for HCPs	New Indicator	2	>2
# of HCP e-newsletter inserts and Alerts	33	30	Increase
# MLHU Immunization Clinics	110	112	Maintain

Highlights / Initiatives Planned for 2020

•Expand community influenza clinic for Newcomers families who are not connected with the London Cross Cultural Centre and are experiencing barriers to accessing vaccine due to language, insurance coverage, transportation)
•Continue working with the London Paramedicine program to other individuals experiencing barriers to accessing influenza vaccine (shelters, community living, homebound individuals)
•Clinic criteria and process review
•Consider electronic methods of providing vaccine information updates for physicians (webinars, web based learning)

Program Challenges and Risks

• Meeting all of the screening and suspension requirements legislated under the Immunization of School Pupils Act (ISPA).
• Meeting the requirements under the Child Care and Early Act due to the prioritization of ISPA activities

Staffing Complement			
	2019 Total FTEs	2020 Total FTEs	Δ
Program Assistant	3.29	0.80	-2.49
Program Manager	1.00	0.40	-0.60
Public Health Nurse	2.60	3.97	1.37
Associate Medical Officer of Health	0.00	0.10	0.10
Director	0.00	0.02	0.02
Total Program FTE	***6.89***	***5.29***	***-1.60***

Expenditures					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 471,649	$ 447,530	(24,118)	-5%
Benefits		$ 119,011	$ 107,575	(11,437)	-10%
Expected Vacancies		$ -		-	
Travel		$ 4,859	$ 3,723	(1,136)	-23%
Program Supplies		$ 42,132	$ 29,128	(13,004)	-31%
Board Expenses		$ -		-	
Staff Development		$ 757	$ 720	(36)	-5%
Occupancy		$ -		-	
Professional Services		$ 717	$ 658	(59)	-8%
Furniture & Equipment		$ 1,394	$ 1,063	(331)	-24%
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 996	$ 779	(217)	-22%
Total Expenditures	***$ -***	***$ 641,514***	***$ 591,176***	***-$ 50,337***	

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 524,374	$ 530,248	5,873	1%
MOHLTC (100%)		$ 41,588		(41,588)	-100%
MCCSS		$ -		-	
PHAC		$ -		-	
PHO		$ -		-	
User Fees		$ 46,677	$ 35,601	(11,076)	-24%
Other		$ 28,874	$ 25,328	(3,547)	-12%
Total Revenues	***$ -***	***$ 641,514***	***$ 591,176***	***-$ 50,337***	

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Comprehensive School Health				465
Standard	School Health	**Director Name**	Maureen Rowlands	
Lead Team	Child Health & Young Adult	**Manager Name**	Darrell Jutzi/Anita Cramp	
Supporting Team(s)				
Budget	$ 2,827,873	**FTE**	25.25	

Summary of Program

It is undisputed that healthy students are better prepared to learn. Studies demonstrate that promoting student health and well-being can help schools meet their educational goals, such as reduced absenteeism, fewer behavioural problems, and higher school-wide test scores and grades (Centers for Disease Control and Prevention, 2014). A healthy school not only provides educational opportunities but creates a supportive environment for health and well-being. The Child and Youth Program Teams work with students, parents, teachers, principals, board staff and community partners to plan and implement evidence-based activities, influence the development and implementation of healthy policies, and create or enhance supportive environments. We meet the requirements of the Public Health School Standard (OPHS, 2018) and align all our work with the Ministry of Education's The Foundations for a Healthy School resource.

The comprehensive school health model encourages schools to pick one or two priority health topics and develop and implement an action plan for the school year which seeks to improve student awareness, knowledge, skills and behaviour and create a supportive environment.

This is accomplished by:

• providing students with opportunities to contribute to and give input on classroom and school level decisions

• engaging students in the planning and implementation of healthy school initiatives

• creating positive social and physical environments that support health and well-being, including healthy school policies and structuring the physical environment to support health

• engaging parents and community partners to enhance learning opportunities relating to the priority health topic

Program Mandate & Relevant Legislation

Standards: Chronic Disease Prevention and Well-Being, Food Safety, Healthy Growth and Development, Immunization, Infectious and Communicable Diseases Prevention and Control, Safe Water, School Health, Substance Use and Injury Prevention,
Protocols and Guidelines: School Health Guideline (2018) or as current; Child Visual Health and Vision Screening Protocol, 2018 (or as current), Chronic Disease Prevention Guideline, 2018 (or as current), Food Safety Protocol, 2018 (or as current)Health Equity Guideline, 2018 (or as current); Healthy Growth and Development Guideline, 2018 (or as current); Immunization for Children in Schools and Licensed Child Care Settings Protocol, 2018 (or as current); Infectious Diseases Protocol, 2018 (or as current); Injury Prevention Guideline, 2018 (or as current)
Mental Health Promotion Guideline, 2018 (or as current); Oral Health Protocol, 2018 (or as current); Safe Drinking Water and Fluoride Monitoring Protocol, 2018 (or as current); Sexual Health and Sexually Transmitted/Blood-Borne Infections Prevention and Control Protocol, 2018 (or as current); Relationship with Indigenous Communities Guideline, 2018 (or as current); Substance Use Prevention and Harm Reduction Guideline, 2018 (or as current);
Other: Ministry of Education's Foundations for a Healthy School Framework Ministry of Education); Achieving Excellence: A Renewed Vision for Education in Ontario (Ministry of Education)

Program Management

The Comprehensive School Program is jointly managed by the Child Health and Young Adult Teams. They collaborate with Healthy Communities and Injury Prevention, Chronic Disease and Tobacco Control, Infectious Disease Control, Vaccine Preventable Disease, and Oral Health through an internal School Health Planning workgroup.

Key Partners and Stakeholders

Thames Valley District School Board, London District Catholic School Board, Conseil Scolaire Viamonde, Conseil Scholaire Catholique: Superintendents, Learning Coordinators, Principals, Vice-principals, teachers, social workers, and educational assistants
Some private schools & First nations schools
City of London: Child and Youth Network Pillar Chairs, Transportation Department, City Councilors;
County of Middlesex: Child and Youth Services Coordinator
Western University, 4th R Coordinators, Faculty of Education, HEAL Lab, Southwestern Public Health, Parent Volunteers, Family Centres, Ontario Student Nutrition Program, Settlement Service Agencies: Settlement workers in schools (SWIS)

Community Needs and Priorities

MLHU uses provincial and local level children and youth data such as:
- Ontario Student Drug Use and Health Survey (OSDUHS)
- Canadian Community Health Survey (CCHS)
- COMPASS
- Local school board climate survey data
- School Engagement and Assessment Tool

Needs have been identified for Healthy Eating, Physical Activity and Sedentary Behaviour, Healthy Sexuality, Mental Health / School Connectedness, and Substance Use.

Target and Priority Populations

Target population for the Comprehensive School Health Program includes all elementary and secondary school communities.
The priority population varies with the topic and interventions and includes:
- school age children and youth at prioritized schools
- school administrators and staff at prioritized schools
- parents and caregivers of students at prioritized schools
- First Nations school communities
- Newcomer students and parents

Health Unit staff who work in school settings complete school assessments (School Engagement and Assessment Tool – SEAT) with each principal to determine how to most effectively work together to support the development of a healthy school community. As a result, all schools receive Health Unit services and supports, but the level of investment in each school is related to the assessed need and capacity.
The results of the SEATs determine which schools receive universal vs. targeted interventions in order to reduce inequities among school communities. PHNs conduct the SEAT every 1-2 years with school administrators and staff.

Intended Program Outcomes

Long-Term / Population Health	To achieve optimal health of school-aged children and youth through partnership and collaboration with school boards and schools.
Intermediate	There is an increased adoption of healthy living behaviours among school-aged children and youth.
Short-Term	School boards and schools are meaningfully engaged in the planning, development, implementation, and evaluation of public health programs and services relevant to school-aged children and youth.

Program Interventions / Components		
1	Awareness	Awareness involves any interaction where information is provided for the purpose of increasing awareness. For example, the teams create health messaging to be posted in schools and use social media to engage students, school staff, and parents to improve the comprehensiveness of health interventions and messages in school communities. Social media posts are designed to enhance and supplement message delivered in school, improve awareness and education of target health topics and improve comprehensiveness of health communication. Currently the teams support two active social media accounts: Middlesex-London Schools Twitter Account - @MLSchoolHealth Middlesex-London Teens Instagram Account - @MLteens. Daily content and monitoring of both social media accounts are done by members of the CYPT.
2	Education	Education includes presentations/workshops and curriculum resources for students, teachers, school committees, school-board level committees, and/or parent groups to provide credible health information on the topics listed in the OPHS. These presentations and curriculum resources are typically done in collaboration with school or school board staff. Members of the CYPT develop educational fact sheets, reach and teach kits, and presentations pertaining to the topics in the School Health Standard to assist schools with the implementation of health-related curriculum. The educational resources are available to all schools, but the schools determined to have the greatest need receive additional support from public health staff to promote implement the resources.
3	Skill Building and Behaviour Change	Skill building involves partnering with school staff (e.g., teacher, social worker, educational assistants, etc.) to facilitate evidence-based small group training and skill building sessions to a group of students, staff, and/or parents. Small group sessions involve more intense level of knowledge and skill development in order to improve health behaviours and outcomes relating to healthy eating and food safety, physical activity and sedentary behaviour, mental health, substance use, and healthy sexuality.

4	Supportive Environments	Involves principals, teachers, parents, students, neighborhood and/or community partner engagement in the planning, creation, development, and implementation of social and physical environments that support health. Examples include creating supportive nutrition environments, where classroom celebrations and rewards do no include the provision of low nutrition value foods (e.g., candy, chips), school cafeterias provide healthy options, and schools provide student engagement activities to encourage students to stay at school during lunch versus accessing fast food restaurants. Other examples, include creating supportive school environments that support student well-being where schools have "chill rooms", extra supports during exam and high stress times, and the offering school activities that promote social inclusion.
5	Situational Supports	The purpose of situational supports is to provide youth, school staff (e.g., teachers, principals, social workers) and parents with consulting health services. Example topics addressed through this service include providing up to date information of community services, referral processes, hygiene, sexual health information and services, healthy eating, and reviewing health-related school policies. Most situational supports are conducted in schools and some occur over the telephone. The goal of this intervention is to assess the health concern, link the individual with necessary community supports, and follow up to further support next steps.
6	Advocacy and Policy	Public health staff support schools and school boards with the development, modification, implementation, evaluation of specific policies and advocacy initiatives. Public health staff meet with school board representatives on a quarterly basis to discuss and plan policy related initiatives.

Performance / Service Level Indicators

Indicator	2018	2019	2020 (target)
% of schools that CYPT staff service as priority schools.	40%	84% (Secondary Schools) 45% (Elementary Schools) 51% (Total Elementary and Secondary)	85% (Secondary Schools) 45% (Elementary Schools)
% of schools that implement a comprehensive school action plan targeting one of the priority topics	50%	64% (Secondary Schools) 86% (Elementary Schools) 88% (Total Elementary and Secondary)	75% (Secondary Schools) 90% (Elementary Schools)
# of unique curriculum resource downloads	NA	134 resources, 5880 downloads	90 resources, 6000+ downloads
# of situational supports conducted by CYPT staff relating to priority topic areas	2400	1600	1800
# of @MLSchoolHealth followers	516	920	1200
# of @MLSchoolHealth profile visits	2099	6371	5000
# of @MLTeens Instagram followers	147	522	650

Highlights / Initiatives Planned for 2020

- Signed partnership declarations and data sharing agreements with the public and catholic school boards.
- New school assessment tool and process based on social determinants of health data.
- Research project on understanding teachers' beliefs and behaviours related to using low nutritional value foods in the classroom.
- OSDUHS oversample of students in the Middlesex-London area.
- Implementation of the 4th R Plus curriculum.
- New Curriculum Toolkit for Elementary Schools on Substance Use Prevention
- Professional development for school Board administrators and educators on vaping and other health related topics as needed
- Regional and provincial coordination for planning curriculum supports, resources, and initiatives for French school boards

Program Challenges and Risks

- Labour disruption within school boards
- Priorities and external factors salient to school partners

Staffing Complement

	2019 Total FTEs	2020 Total FTEs	Δ
Dietitian	2.00	2.00	0.00
Health Promoter	1.10	1.00	-0.10
Program Assistant	0.95	0.95	0.00
Program Manager	2.00	1.90	-0.10
Public Health Nurse	20.40	19.00	-1.40
Director	0.00	0.40	0.40
Total Program FTE	***26.45***	***25.25***	***-1.20***

Expenditures

	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 2,197,559	$ 2,177,370	(20,188)	-1%
Benefits		$ 546,536	$ 528,045	(18,491)	-3%
Expected Vacancies		$ -		-	
Travel		$ 30,011	$ 30,328	317	1%
Program Supplies		$ 71,219	$ 61,459	(9,760)	-14%
Board Expenses		$ -		-	
Staff Development		$ 8,820	$ 9,220	400	5%
Occupancy		$ -		-	
Professional Services		$ 26,446	$ 5,940	(20,506)	-78%
Furniture & Equipment		$ 193	$ 260	67	35%
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 15,905	$ 15,250	(655)	-4%
Total Expenditures	***$ -***	***$ 2,896,689***	***$ 2,827,873***	***-$ 68,817***	

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 2,845,660	$ 2,815,313	(30,347)	-1%
MOHLTC (100%)		$ 20,790		(20,790)	-100%
MCCSS		$ -		-	
PHAC		$ 3,166		(3,166)	-100%
PHO		$ -		-	
User Fees		$ 14,513		(14,513)	-100%
Other		$ 12,560	$ 12,560	-	0%
Total Revenues	***$ -***	***$ 2,896,689***	***$ 2,827,873***	***-$ 68,817***	

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Immunization					466
Standard	School Health		**Director Name**	Stephen Turner	
Lead Team	Vaccine Preventable Disease		**Manager Name**	Jody Paget	
Supporting Team(s)	Child Health		Young Adult		
Budget	$ 1,016,424		**FTE**	10.45	

Summary of Program

The School Health Immunization Program aims at reducing or eliminating the burden of vaccine preventable diseases in schools and licensed child care settings by:

• Providing children students and parents with information about the importance of vaccines, publicly funded schedules and legislative requirements;

• Conducting yearly immunization screening and suspensions initiatives according to the Immunization of School Pupils Act and Child Care and Early Years Act, 2014; and

• Organizing Grade 7 school-based immunization clinics for Hepatitis B, Human Papilovirus Human papillomavirus, and Meningococcal disease in the fall and Spring.

Program Mandate & Relevant Legislation

Ontario Public Health Standards, 2018 - School Health- Immunization
Immunization for Children in Schools and Licensed Child Care Settings Protocol, 2018
Immunization of School Pupils Act
Child Care and Early Years Act

Program Management

The School Health Immunization Program is managed by the Vaccine Preventable Disease Team in collaboration with the Child Health and Young Adult Teams to deliver immunization clinics and education in Middlesex-London Schools and licensed child care settings.

Key Partners and Stakeholders

Child Health Team
Young Adult Team
School boards
Elementary and high school administrative staff and educators
Licensed childcare operators

Community Needs and Priorities

There are over 19,000 school age children enrolled form JK to Grade 12 in the Middlesex-London and 110 licensed child care settings with over 13,000 attendees.

Target and Priority Populations

- School aged children JK-grade 12 who are not up to date with required vaccines under the Immunization and School Pupils Act.
- Students in Grade 7 who have never received vaccines that offer protection against HPV, Hep B, and Meningococcal disease.
- Children attending licensed childcare settings who are not up to date with required vaccines under Child Care and Early Years Act.

Intended Program Outcomes	
Long-Term / Population health	Optimal health of school aged children and youth through partnership and collaboration with school boards, schools, and child care settings
Intermediate	• Students have up-to-date immunizations according to the current Publicly Funded Immunization Schedules for Ontario and in accordance with the Immunization of School Pupils Act • Children have up-to-date immunizations according to the current Publicly Funded Immunization Schedules for Ontario and in accordance with the Child Care and Early Years Act • All Middlesex-London schools with grade 7 students are offered an opportunity to have on-site vaccine clinics for Hepatitis B, HPV, and Meningococcal vaccine. • All grade seven students will be provided an opportunity to receive school aged vaccines. • Identify opportunities to improve knowledge and confidence in immunizations for school aged children
Short-Term	• Screen and suspend grades 1-6 and grade 11 in 2019-2020 school year according to the Immunization of School Pupils Act. • Screen children attending licensed child care settings according to the Child Care and Early Years Act • Offer grade 7 school aged vaccine clinics in participating schools • Provide school aged vaccines to HCPs upon request for students who did not receive vaccines in school clinics • Provide school aged vaccines in MLHU upon request for students who did not receive vaccines in school clinics and are unable to access vaccine through their HCP

Program Interventions		
1	Screening and Enforcement of Immunization Records	• Screen immunization records of students in Grade 2-6 and 11 in Elementary and secondary schools • Screen and enforce immunization records for students in Grades 2-6 and 11 who do not have up-to date immunization records according to the Immunization of School Pupils Act • Notify parents/guardians via letters on incomplete immunization records through six rounds of screening and suspensions. • Deliver a group or 1-1 mandatory vaccine exemption education session for parents/guardians who choose to seek an exemption for their school aged child • Distribute by mail "No information" letters to JK and grade 1 students in the summer • Screen immunization records for children attending licensed child care settings who are not up to date for publicly funded vaccines and according to the Child Care and Early Years Act • Notify childcare operators of required immunization records for children in their care
2	School-Based Immunization Clinics	• Schools send home consent forms to grade 7 students though elementary schools two weeks before the clinic. • Organize and deliver immunization clinics for Meningococcal, Hepatitis B and Human Papillomavirus vaccines in schools for Grade 7 students in the fall and Spring • Letters are mailed to students with no record of meningococcal vaccine in the summer
3	Education	• Provide opportunities for schools to have a PHN come into the classroom to talk about school aged vaccines • Identify opportunities to improve knowledge and confidence in immunization for school-aged children through school newsletters, websites, parent and student e-mail or social media communication

Performance / Service Level Indicators			
Indicator	2018	2019	2020 (target)
% of 7 year olds who have up to date immunization for tetanus, diphtheria, pertussis, polio, measles, mumps and rubella	90%	As of Aug 30, 2019 Coverage: MMR 89.9%, TDPP 89.7%	Increase
% of 17 year olds who have up to date immunization for tetanus, diphtheria, pertussis, polio, measles, mumps and rubella in this school year	Not available	As of Aug 30, 2019 Coverage: MMR 93.9%, TDPP 84.4%	Increase
% of Grade 7 students who are up to date for HPV vaccine in this school year	52%	Pending PHO data	Increase
% of grade 7 students who are up to date for Hepatitis B vaccine in this school year	63%	Pending PHO data	Increase
% of Grade 7 students who are up to date for meningococcal vaccine in this school year	78%	Pending PHO data	Increase
HPV# of doses administered/Total #clients at school clinics	5409/3153	6750/3854	Maintain
Menactra of doses administered at school clinics	3282	4517	Maintain
HepB# of doses administered/Total #clients at school clinics	5301/3162	6377/3695	Maintain
% licensed child care settings that submitted immunization records	New Indicator	~72.6% includes those who sent records or gave letters to parents (for ICON)	Increase
Number of students suspended under ISPA	977	965	Decrease
Number of students whose parent or guardian received at least one notice or request for immunization information under ISPA	12088	12152	Maintain

Highlights / Initiatives Planned for 2020

• Continue collaborate with Child Health and Young Adult teams to increase uptake of immunizations provided to students in grade 7, immunization reporting to the health unit, and knowledge of publicly funded vaccines and legislative requirements
• Increase the number of students screened JK to grade 12 in accordance with ISPA (screen and suspend grades 2-7 and 11 2020-2021 school year
• Continue to promote the use of ICON for immunizations reporting
• Screen and suspend students attending Alternative Education Programs
• Investigate electronic solutions for licensed childcare settings to submit immunization records for children in their care

Program Challenges and Risks

• Increased uptake of school vaccines offered in school based clinic will lead to an increase in resource required to run the school program
• Increasing the number of students screened under ISPA too rapidly could increase the amount of data entry beyond current capacity which could lead to students being suspended despite providing required documentation
• Not enough PA staff capacity to keep up with data entry from child care settings
• Child care operators will not have the capacity for electronic immunization reporting

Staffing Complement

	2019 Total FTEs	2020 Total FTEs	Δ
Program Assistant	2.92	5.18	2.26
Program Manager	0.10	0.50	0.40
Public Health Nurse	5.34	4.47	-0.87
Director	0.00	0.20	0.20
Associate Medical Officer of Health	0.00	0.10	0.10
Total Program FTE	***8.36***	***10.45***	***2.09***

Expenditures					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 597,850	$ 754,720	156,870	26%
Benefits		$ 152,580	$ 189,810	37,230	24%
Expected Vacancies		$ -		-	
Travel		$ 5,954	$ 7,514	1,560	26%
Program Supplies		$ 50,609	$ 57,018	6,409	13%
Board Expenses		$ -		-	
Staff Development		$ 954	$ 1,404	451	47%
Occupancy		$ -		-	
Professional Services		$ 911	$ 2,225	1,314	144%
Furniture & Equipment		$ 1,661	$ 2,056	395	24%
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 1,196	$ 1,676	480	40%
Total Expenditures	***$ -***	***$ 811,716***	***$ 1,016,424***	***$ 204,708***	

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 672,135	$ 901,315	229,181	34%
MOHLTC (100%)		$ 49,556		(49,556)	-100%
MCCSS		$ -		-	
PHAC		$ -		-	
PHO		$ -		-	
User Fees		$ 55,619	$ 68,860	13,241	24%
Other		$ 34,406	$ 46,248	11,842	34%
Total Revenues	***$ -***	***$ 811,716***	***$ 1,016,424***	***$ 204,708***	

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Oral Health				467
Standard	School Health	**Director Name**	Maureen Rowlands	
Lead Team	Oral Health	**Manager Name**	Misty Golding/Donna Kosmack	
Supporting Team(s)				
Budget	$ 482,920	**FTE**	5.50	

Summary of Program

Publicly-funded elementary schools, some faith based private schools and schools located in neighbouring Indigenous Nations participate in the school-based dental screening program. Students in JK, SK and Grade 2 are screened for urgent dental needs in accordance with the Oral Health Protocol (2018). Based on the screening results of the Grade 2 students at each school, the school is categorized into the following levels of screening intensity: low, medium and high as per the protocol.

The Oral Health team screens all grade 7's, regardless of screening intensity of the school, because that is the last opportunity to provide dental screening in schools. The parents of the students in these grades who decline to have their children screened advise the school administrators who then pass this information on to MLHU staff. Children whose parents have consented to screening but who are absent on the day of the screening may be screened on a subsequent screening day. Student level data is collected by Registered Dental Hygienists, with the support of a Clinical Dental Assistant, and stored in the ministry application OHISS. The need for urgent dental care or preventive dental services is recorded and parents are advised by sending forms home with eligible children.

Program Mandate & Relevant Legislation

School Health Standard
Oral Health Protocol (2018)

Program Management

The program is managed by the Oral Health Team who collaborates with the Child Health Team to conduct work in elementary schools.

Key Partners and Stakeholders

Thames Valley District School Board
London District Catholic School Board
Private Schools
Conseil scolaire catholique Providence
Conseil scolaire Viamonde

Community Needs and Priorities

During the 2018-2019 school year, 1,332 (8.2%) students were found to have urgent dental needs and 6,279 (38.5%) students would benefit from preventive services (dental cleaning, dental sealants, fluoride application). 17 (13%) of elementary schools were classified as medium intensity and 13 (10%) of elementary schools were classified as high intensity.

Target and Priority Populations

JK, SK and Grade 2 students are the priority populations to be screened in schools as set out by the Oral Health Protocol (2018).
JK/SK Students: • Children 3-5 years of age in Junior and Senior Kindergarten
• Children entering school have often not visited a dental provider and should be screened for urgent dental conditions.
Grade 2 Students: • Children 7-8 years of age in Grade 2
• Children entering Grade 2 are starting to get their 6-year molars. This is the perfect time to place dental sealants to prevent tooth decay in permanent teeth.
Grade 7 Students: • Children 12-13 years of age in Grade 7
• Children entering Grade 7 are starting to get their 12-year molars. This is the perfect time to place dental sealants to prevent tooth decay in permanent teeth. Screening children in Grade 7 allow for a final screening and allows the Registered Dental Hygienist to ensure treatment has been initiated prior to high school.

Intended Program Outcomes	
Long-Term / Population Health	To achieve optimal health of school-aged children and youth through partnership and collaboration with school boards and schools.
Intermediate	1. Children and youth from low-income families have improved access to oral health care. 2. The oral health of children and youth is improved.
Short-Term	The board of health achieves timely and effective detection and identification of children and youth at risk of poor oral health outcomes, their associated risk factors, and emerging trends.

Program Interventions		
1	Dental Screening	Dental screening is provided each school year in all publicly-funded elementary schools, some faith based private schools and schools located in neighbouring Indigenous Nations. Registered Dental Hygienists, with support from Certified Dental Assistants, conduct dental screening in all schools. Children are identified as requiring urgent dental care or preventive services and parents are notified by sending dental report cards home from school. Ministry forms are sent home with children who require urgent dental care and Registered Dental Hygienists follow-up on all urgent cases identified. Certified Dental Assistants follow-up on children who require preventive services and offer an appointment at the 50 King Street Dental Clinic.

Performance / Service Level Indicators

Indicator	2018	2019	2020 (target)
% of eligible students screened	77%	78%	Increase or Maintain
% of publicly-funded schools screened	100%	100%	100%
% of children screened that are identified as requiring urgent dental care	11%	8%	Decrease
% of children screened that are identified as requiring preventive services (cleaning, dental sealants, fluoride)	39%	39%	Maintain
% of schools classified as High Risk based on dental screening results of Gr 2's	15%	10%	Decrease
Decay/Missing/Filled rate	0.04	0.04	Maintain
% of children absent during the school-based dental screening program	5%	6%	Maintain
% of children excluded from the school-based dental screening program	17.00%	17.00%	Decrease

Highlights / Initiatives Planned for 2020

MLHU and Southwestern Public Health are working together to streamline the dental screening processes and forms. MLHU and SWPH want to have similar processes and forms to be consistent across all schools in shared school boards. This will increase efficiencies and build upon relationships with school boards.

Oral Health, Vaccine Preventable Disease and Child Health Teams are working together to streamline work that is done in schools. We have created a centralized booking system for scheduling schools which allows teams to know who is at which school. We have created a school database which allows teams to know who is responsible for each school with contact information.

Program Challenges and Risks

One of the school boards require positive consent. This is challenging because it results in less children participating in the dental screening program.

Staffing Complement

	2019 Total FTEs	2020 Total FTEs	Δ
Dental Assistant	1.80	2.97	1.17
Dental Hygienist	1.38	2.31	0.93
Program Manager	0.30	0.20	-0.10
Director	0.00	0.02	0.02
Total Program FTE	***3.48***	***5.50***	***2.02***

Expenditures

	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 225,574	$ 334,114	108,540	48%
Benefits		$ 60,323	$ 89,787	29,464	49%
Expected Vacancies		$ -		-	
Travel		$ 4,659	$ 7,347	2,687	58%
Program Supplies		$ 14,000	$ 23,122	9,121	65%
Board Expenses		$ -		-	
Staff Development		$ 1,351	$ 2,398	1,047	77%
Occupancy		$ -		-	
Professional Services		$ 151	$ -	(151)	-100%
Furniture & Equipment		$ 3,728	$ -	(3,728)	-100%
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 15,798	$ 26,152	10,354	66%
Total Expenditures	***$ -***	***$ 325,585***	***$ 482,920***	***$ 157,335***	

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 325,585	$ 482,920	157,335	48%
MOHLTC (100%)		$ -		-	
MCCSS		$ -		-	
PHAC		$ -		-	
PHO		$ -		-	
User Fees		$ -		-	
Other		$ -		-	
Total Revenues	***$ -***	***$ 325,585***	***$ 482,920***	***$ 157,335***	

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Vision					468
Standard	School Health		**Director Name**	Maureen Rowlands	
Lead Team	Oral Health		**Manager Name**	Misty Golding/Donna Kosmack	
Supporting Team(s)	Child Health				
Budget	$ 32,438		**FTE**	0.27	

Summary of Program

Child visual health initiatives at MLHU are intended to increase the proportion of individuals who understand the importance of visual health, including the importance of early detection of vision disorders. Additionally, promotion of OHIP-covered comprehensive eye examinations and service navigation assistance are intended outcomes of MLHU visual health initiatives. Staff work with school boards, teachers and parents to support awareness of, access to, and utilization of visual health services by notifying parents of the importance of visual assessments and assisting parents in finding a local optometrist.

Program Mandate & Relevant Legislation

School Health: Vision Standard (2018)

Program Management

The Vision Program is provided by the Oral Health Team, in collaboration with the Child Health Team.

Key Partners and Stakeholders

Thames Valley District School Board
London District Catholic School Board
Private Schools
Conseil scolaire catholique Providence
Conseil scolaire Viamonde
Family Centres in Middlesex London

Community Needs and Priorities

In 2016 there were 19,845 children in the Middlesex-London area between the ages of 3 and 6 years of age. It is projected that in 2020 that number will increase to 20,864.

Source: Population Estimates, Date Extracted: Dec 23, 2019, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH Ontario.

According to the Ontario College of Optometrists there are 84 Optometrists registered to practice in the City of London. However, it is not known if all of these individuals see children. In Middlesex County there are 13 Optometrists (Dorchester (4), Strathroy (4), Parkhill (1) and Glencoe (4).

Target and Priority Populations

The Child Visual Health and Vision Screening Protocol (2018) identifies that Senior Kindergarten (SK) students are the priority population. However, Children in Junior Kindergarten (JK) are eligible for The Eye See…Eye Learn® program which would provide them with a free pair of glasses if required, therefore, MLHU staff will promote visual health to parents/guardians of JK and SK aged children to promote the importance of visual health.

Intended Program Outcomes	
Long-Term / Population Health	• To achieve optimal health of school-aged children and youth through partnership and collaboration with school boards and schools. • The visual health of children is improved.
Intermediate	• Children from low-income families have improved access to visual health care. • An increased proportion of JK and SK children receive preventative eye examinations
Short-Term	• The board of health and parents/guardians are aware of the visual health needs of school-aged children • An increased number of parents/caregivers are aware that the Canadian Association of Optometrists (CAO) recommends that preschool children at low risk should have at least one eye exam between ages two and five years old

Program Interventions		
1	Education and Awareness	The Oral Health Team in conjunction with the Child Health Team works with school boards and Family Centres in Middlesex London to disseminate information related to the visual health needs of school-aged children, the importance of having at least one eye exam between the ages of two and five years old, and the wide availability of annual free eye examinations for children. MLHU will continue to keep visual health information available on the website. Additionally, information will be provided to parents/guardians of children aged 3-6yrs of age (JK/SK). This will be done though outreach and educational activities both in schools and in other community settings with the understanding that not all children aged 3-6 are enrolled in school. MLHU staff will also provide assistance to parents/guardians to find an optometrist and/or programs that may provide cost free eyewear.
2	Supportive Environments & Collaboration	In conjunction with partner organizations such as school boards, Family Centres and the Child Health Team at MLHU, the Oral Health team will ensure that parents/caregivers are able to navigate the health care system to find an optometrist and programs that may provide cost free eyewear.

Performance / Service Level Indicators

Indicator	2018	2019	2020 (target)
% of Middlesex-London elementary schools where visual health information was disseminated to parents	0	0	100%
% of Family Centres/Early ON Center distributing information regarding visual health information	0	0	100%

Highlights / Initiatives Planned for 2020

MLHU staff will continue to refine the implementation process for the Vison Standard (2018) promotion in 2020.

Program Challenges and Risks

School boards have expressed several concerns regarding implementation of SK vision screening. Particularly, school boards were concerned with obtaining parental consent and with the estimated time required to complete the screening process during the school day. Additionally, MLHU has had to make hard budgetary decisions and because no additional base funding was provided for the implementation of this protocol, it was determined that the screening portion of the vision screening protocol will not be possible for 2020.

Staffing Complement

	2019 Total FTEs	2020 Total FTEs	Δ
Director	0.00	0.01	0.01
Program Manager	0.00	0.10	0.10
Dental Assistant	0.00	0.09	0.09
Dental Hygienist	0.00	0.07	0.07
Total Program FTE	***0.00***	***0.27***	***0.11***

Expenditures					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 18,745	$ 22,173	3,428	18%
Benefits		$ 8,026	$ 5,489	(2,537)	-32%
Expected Vacancies		$ -		-	
Travel		$ 469	$ 367	(102)	-22%
Program Supplies		$ 1,408	$ 2,268	860	61%
Board Expenses		$ -		-	
Staff Development		$ 136	$ 77	(58)	-43%
Occupancy		$ -		-	
Professional Services		$ 15	$ -	(15)	-100%
Furniture & Equipment		$ 375	$ -	(375)	-100%
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 1,589	$ 2,064	475	30%
Total Expenditures	***$ -***	***$ 30,763***	***$ 32,438***	***1,676***	***5%***

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 30,763	$ 32,438	1,676	5%
MOHLTC (100%)		$ -		-	
MCCSS		$ -		-	
PHAC		$ -		-	
PHO		$ -		-	
User Fees		$ -		-	
Other		$ -		-	
Total Revenues	***$ -***	***$ 30,763***	***$ 32,438***	***$ 1,676***	***5%***

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Alcohol and Cannabis					470
Standard	Substance Use and Injury Prevention		**Director Name**	Maureen Rowlands	
Lead Team	Healthy Communities and Injury Prevention		**Manager Name**	Rhonda Brittan	
Supporting Team(s)	Chronic Disease Prevention and Tobacco Control				
Budget	$ 452,675		**FTE**	4.18	

Summary of Program

The Alcohol and Cannabis program, through interventions that focus on education and dissemination of evidence-based information, creating supportive environments, partnership and capacity building, policy development, and cannabis use enforcement aim: to decrease alcohol-related harms including injury, chronic disease and death; to decrease cannabis-related harms including injury, chronic disease and death; to create a culture of alcohol moderation and reduced normalization; and, to normalize a smoke-free and vapour-free culture.

The Health Unit alcohol program and corresponding interventions focus on preventing early onset of use, and preventing and minimizing harms. Cannabis for non-medical purposes became legal in Canada in 2018 and in October 2019, cannabis edibles, extracts and topicals were also legalized for purchase. Current research indicates health-related harms of non-medical cannabis use include: respiratory effects; cannabis use disorder; mental health concerns ; cannabis and driving; brain development impacts from youth and young adult use; issues related to cannabis use in pregnancy; and, poisoning from accidental consumption by children.

Interventions focus on education and dissemination of evidence-based information, creating supportive environments, partnership and capacity building, policy development, and related to cannabis, policy enforcement (S*moke-free Ontario Act, 2017).* The alcohol and cannabis program staff work collaboratively with targeted populations/stakeholders including youth, parents, young adults, schools, healthcare providers, workplaces, municipal leaders and places of entertainment.

Program Mandate & Relevant Legislation

Ontario Public Health Standards: Substance Use and Injury Prevention Standard, Chronic Disease Prevention and Wellbeing Standard, and School Health Standard
OPHS Protocols and Guidance Documents: Substance Use Prevention and Harm Reduction Guideline 2018, Chronic Disease Prevention Guideline, 2018, Tobacco, Vapour and Smoke Protocol, 2018; and Tobacco, Vapour and Smoke Guideline, 2018;
Legislation: *Smoke-Free Ontario Act, 2017* (*SFOA, 2017*) and Ontario Regulation 268/18; *The Municipal Act, 2001* ; *The Residential Tenancies Act, 2006; Cannabis Control Act, 2017* ; *Cannabis License Act, 2018* ; *Cannabis Act, 2018* (Federal)
Other: Canada's Low- Risk Alcohol Drinking Guidelines; Canadian Centre on Substance use and Addiction; Canada's Lower-Risk Cannabis Use Guidelines (LRCUG); Canadian Research Initiative in Substance Misuse/ Centre for Addiction and Mental Health; Middlesex-London Community Drug and Alcohol Strategy Report

Program Management

The Healthy Communities and Injury Prevention (HCIP) Team and the Chronic Disease Prevention and Tobacco Control (CDPTC) Team work collaboratively to coordinate efforts and ensure alignment between the Tobacco Control and E-cigarettes program and the Alcohol and Cannabis Program. The alcohol and cannabis program staff act as content consultants within the Health Unit, ensuring consistent messaging and the dissemination of best/promising practices or new evidence across the Health Unit for integration into Teams that work with specific target populations (e.g. Young Adult, Child Health, Reproductive Health, Early Years, Sexual Health and Clinic as well as Healthy Environments and Healthy Eating Behaviours programming). The HCIP and CDPTC Teams work collaboratively with members of the Southwest Tobacco Control Area Network Team (SWTCAN) to ensure the development of consistent "smoke" and "vaping" messages within the southwest region, and across the seven Tobacco Control Area Networks (TCANs).

Key Partners and Stakeholders

Ontario Public Health Units; Thames Valley District School Board; London District Catholic School Board; Western University; Fanshawe College; City of London – Bylaw and Licensing Department, Planning, Parks and Recreation, Building Division, Fire Prevention, Facilities, Finance, Human Resources, Government Relations, Strategic Initiatives, Communications; County of Middlesex; Addiction Services of Thames Valley; Thames Valley Council of Home and School; London Health Sciences Centre; The Centre for Addiction and Mental Health; Canadian Centre on Substance Use and Addiction; London Police Services; Middlesex County OPP; Strathroy-Caradoc Police Services; Ministry of Finance; Ministry of Transportation; Ontario Campaign for Action Against Tobacco; Alcohol and Gaming Commission of Ontario; Southwest Tobacco Control Area Network; Middlesex-London Community Drug and Alcohol Strategy partners; Ontario Public Health Association Alcohol Working Group; Ontario Public Health Collaboration on Cannabis; the OPP Cannabis Unit; and, Health Canada.

Community Needs and Priorities

Alcohol: In Middlesex-London (ML) 24% of those 19 years and older reported heavy drinking (five or more drinks at least once a month in the past year). 48% of those 19 years and older reported exceeding the low-risk alcohol drinking guidelines (increasing the risk of long and/or short-term harms) (CCHS, 2015/2016). Alcohol is the most prevalent substance used by teens: 43% of ON students reported drinking alcohol in the past year (grades 7-12); 68.3% in Grade 12; 17% report binge drinking in the past month (grades 7-12); 14% report drinking hazardously in the past year (grades 9-12) (ODSUS 2017).

Cannabis: In Ontario and Middlesex-London, there has been an increase over time in emergency department (ED) visits associated with cannabis, related to both poisonings and mental or behavioural disorders (MLHU Community Health Status Resource (CHSR)). 19% of Ontario grade 7-12 students and 37% of grade 12 students used cannabis in past year (OSDUHS 2017). Research has found that youth tend to have more misconceptions around the harms associated with cannabis which can rationalize use thereby putting them at a greater risk of harm (CCA, 2017). Nearly half (46%) of the M-L population (19+) has used cannabis in their lifetime, 14% reported use in the previous 12 months and 6% used daily or a few times per week in 2015/16 (CCHS). 53% of Ontario cannabis users report moderate or high risk of problems (ASSIST-CIS 4+) (CAMH Monitor 2017). In ML, the 15–24 age group had, by far, the highest rate of cannabis-related ED visits (269.9 per 100,000) followed by the 25–34 age group (127.1 per 100,000) (MLHU CHSR) In ML, nearly four percent (3.8%) of women who gave birth reported cannabis use during their pregnancy in 2017. This is significantly higher than 2.3% reported in 2013. ML had a significantly higher rate of use than its peer group comparator and Ontario. (Pregnancy, BORN Information System).

Target and Priority Populations

Alcohol: Special-risk populations for this program include youth [1 in 6 students grades 7-12 report binge drinking at least once in the last month and 1 in 7 high school students report drinking hazardously or harmfully, (OSDUHS, 2017)], people exceeding the low-risk alcohol drinking guidelines (LRADG) [48% of the ML population 19 years and older report exceeding LRADG (CCHS, 2015/16)], young women (increasing rates of alcohol attributed emergency department visits in Ontario between 2014-2017, with a significant increase among women and young adults).

Cannabis: Special-risk populations for this program are those who have been identified as having higher risks for cannabis-related harms, including: users with a history or family history of mental health problems, youth under the age of 25 yrs., and pregnant and breastfeeding women; and, parents/caregivers of young children related to prevention of accidental ingestion and poisoning. In ML the 15–24 age group had the highest rate of cannabis-related ED visits relative to other age groups. Protection from second-hand smoke and vapour, and concerns related to severe lung illness from vaping cannabis are emerging topics of public health interest.

Intended Program Outcomes	
Long-Term	• To decrease alcohol related harms including injury, chronic disease and death • To decrease cannabis related harms including injury, chronic disease and death • To create a culture of alcohol moderation and reduced normalization • To reduce exposure to cannabis use to normalize a smoke-free and vapour-free culture
Intermediate	Alcohol: • To increase the proportion of the population that adheres to the Low-Risk Alcohol Drinking Guidelines • To increase the implementation of healthy public policy and the creation of environments that reduce alcohol related harms. Cannabis: • To reduce the number of youth using cannabis • To increase the proportion of the population that adheres to the Lower-Risk Cannabis Use Guidelines • To reduce incidence of accidental cannabis exposure and poisoning • Reduce exposure to second-hand cannabis smoke and vapour through the enactment of policies, bylaws and provincial legislation • Increase compliance with the *SFOA, 2017* through public education and collaboration with enforcement agencies and municipal bylaw enforcement
Short-Term	Alcohol: • To increase public awareness of both short and long-term alcohol related harms • To increase awareness and shift attitudes of young adults related to alcohol harms and use • To increase public awareness of Low-Risk Alcohol Drinking Guidelines • To ensure that municipalities have the necessary tools and evidence to implement comprehensive Municipal Alcohol Policies (MAPs) to reduce alcohol related risks and harms • To increase knowledge-transfer of evidence informed alcohol-related resources with local stakeholders Cannabis: • To increase public awareness of the health impacts, risks and associated harms of cannabis use • To increase public awareness of Lower Risk Cannabis Use Guidelines • To increase the number of policies and partnerships with school boards, post-secondary campuses, municipalities, and workplaces to promote smoke-free and vapour-free cultures • To reduce exposure to second-hand smoke and exposure to cannabis use (e.g. smoke-free housing, and 100% smoke-free property policies) • Increase in knowledge-transfer of cannabis-related resources with local stakeholders

Program Interventions		
1	Alcohol - Public Education and Awareness	Provide of up to date information and current evidence related to alcohol and reducing alcohol related harms to the general public using website, social media, traditional media, and through communication vehicles within the Workplace Health Promotion Program and Healthcare Provider Program areas; Promote and share Rethink Your Drinking campaign messaging related to Low-Risk Alcohol Drinking Guidelines; Promote and disseminate Rethink Your Drinking Parents Matter campaign focused on strategies for parents/adults to prevent and delay alcohol and other drug use with children and youth; Provide training to residence advisors at Western University and Fanshawe College related to substance use and substance misuse prevention and response; Provide information and resources at targeted events to keep alcohol harms and risk reduction messages omnipresent; Work with Southwestern Public Health on a youth alcohol awareness campaign utilizing the Use Your Instincts campaign model.
2	Alcohol – Creating Supportive Environments	Provide information to organizations applying for Special Occasion Permits regarding minimizing alcohol harms and lowering alcohol liability; Support Alcohol Screening and Brief Intervention processes in MLHU Birth control clinic; Promote and act on opportunities for knowledge exchange on Alcohol Screening and Brief Intervention with local healthcare providers.
3	Alcohol – Policy Development	Municipal Alcohol Policies: Provide consultation support and input into Municipal Alcohol Policies within London and Middlesex County municipalities; OPHA's Alcohol Working Group: continue to support efforts for healthy public policy to reduce alcohol related harms; Middlesex-London Community Drug and Alcohol Strategy partnership: as a partner of the collaborative, identify and act on opportunities to influence healthy public policy related to alcohol as appropriate.

4	Cannabis – Public Education and Awareness	Share and disseminate MLHU's YouNeedToKnow campaign messages (along with relevant provincial and federal messages) and resources related to cannabis legalization, harms, and harm reduction strategies; Disseminate Smoke is Smoke public education materials, posters, postcards, social media messages, and the workplace kit; Work with MLHU Child Health team on the development of substance use toolkits; Promotion and dissemination of the Lower Risk Cannabis Use Guidelines; Knowledge exchange regarding current and emerging evidence related to cannabis with health unit teams internally, to healthcare providers, and community partners; Promotion of the new *SFOA, 2017* and the restrictions on the smoking and vaping of cannabis; Collaboration with HCIP Child Safety Prevention lead on cannabis poison prevention education; and, Collaboration with CDPTC Healthy Eating Behaviours program on messages pertaining to healthy eating and the consumption of edible cannabis.
5	Cannabis – Creating Supportive Environments	Ongoing outreach to the City of London and Middlesex County municipalities: increase knowledge about cannabis legalization, municipal implications, and the identification of what kinds of supports or information municipal partners need within a legalized cannabis market. Workplace and smoke-free housing policy development: in partnership with the SWTCAN, the promotion and dissemination of the updated *SFOA 2017* Workplace Kit and the Smoke-Free Housing Toolkit, promoting compliance and the need for smoke-free and vapour-free policies. Outreach to Special Event Organizers: prior to the implementation of outdoor special events, Cannabis Enforcement staff meet to review proprietor/employer obligations under the law, and to consult on actions that can be taken to promote compliance with the law. Referrals: Cannabis Program Staff nurture relationships with and facilitate referrals to other regulatory agencies, including AGCO, local police services, and Health Canada Cannabis Compliance Division.
6	Cannabis – Policy Development	School Board Policy: ongoing collaboration with the Thames Valley District School Board and the London Catholic District School Board to update School Board policy and Codes of Conduct to address all substances; Ontario Public Health Collaboration on Cannabis: Cannabis Program Staff have continued membership to facilitate knowledge exchange and collaboration across Ontario public health units to reduce duplication and to build consensus, to inform/influence municipal, provincial and federal regulations; Municipal Bylaw Development Support and Consultations: work with the City of London and the municipalities within Middlesex County to amend/enact municipal bylaws that further restrict cannabis use beyond protections provided under the *SFOA, 2017*. Workplace Policy: provide information, evidence and advice for workplaces exploring the development and implementation of Substance Use at Work policies.

7	Alcohol and Cannabis – Population Health Assessment and Measurement Surveillance	In collaboration with the Population Health Assessment and Surveillance Team, conduct routine surveillance activities to monitor population-level cannabis program indicators and outcomes, for dissemination to municipal and community partners.
8	*SFOA, 2017* Policy Enforcement	Inspections: Inspectors, designated by the Minister of Health, conduct complaint-based and pro-active inspections (as time and resources permit) of workplaces and public places, including: schools; hospital property; bars, restaurants and special events; and outdoor public spaces, including playgrounds, sports fields, and community recreation facility property. Compliance Support: Cannabis Program Staff facilitate the ordering and delivery of signage, and the provision of education regarding employer and proprietor obligations. Inspectors have been collaborating with the School Health Teams, school administrators, and school board administration to address growing concerns related to youth vaping, including the vaping of THC inside schools and on school property. Smoke-Free Information Line (phone and email): Cannabis Program staff triage inquiries and complaints received, answering questions, making referrals, and responding to Requests for Service (e.g. presentations, signage requests, etc.).
9	SFOA 2017 Enforcement Partnerships and Collaboration	SW TCAN Enforcement Sub-Committee: To facilitate consistent application of the *SFOA, 2017,* inspectors and managers meet bi-monthly and communicate by email to share enforcement scenarios and to ensure consistent interpretation of the law. Networking and Referrals: Every municipality has been assigned an Inspector lead/point of contact to create, maintain and enhance relationships with other enforcement agencies (municipal and provincial), and Enforcement Manager maintains relationships and issues referrals to Health Canada Cannabis Compliance Division staff to support compliance with federal legislation. Ministry of Health Enforcement Managers' Teleconference: Enforcement Manager participates in monthly teleconference with Ministry tobacco, vapour and smoke staff.

Performance / Service Level Indicators			
Indicator	2018	2019	2020 (target)
# of municipalities received evidence informed input and feedback to minimize alcohol related harms (e.g. municipal alcohol policies)	None in 2018	None in 2019	5
# post-secondary institution Residence Advisors(RAs) trained about substance use and risk	38 RAs (oversee ~2000 students)	46 RAs (oversee ~2000 students)	40-50 RAs
Social media metrics for You Need To Know online cannabis campaign: # impressions #engagements	N/A	240191 impressions 14207 engagements	Maintain
# page views on MLHU You Need to Know Cannabis website	1620	6712 (Jan – Nov 2019)	Maintain
Proportion of the ML population (age 19+) who reported using cannabis in the past 12 months (CCHS)	14% (2015/2016)	14% (2015/2016)	Decrease
Proportion of ON youth (grades 7 to 12) who reported using cannabis within the past 12 months (OSDUHS)	19% (2017)	19% (2017)	Decrease
Proportion of ON youth (grades 7 to 12) who reported using alcohol within the past 12 months (OSDUHS)	42.5% (2017)	42.5% (2017)	Decrease
Rate of cannabis-related visits to the emergency department in ML	74 visits per 100,000 (2017)	74 visits per 100,000 (2017)	Decrease

Highlights / Initiatives Planned for 2020

• Program need related to legalization of non-medical cannabis decreased alcohol programming resources in 2018/19. Related to alcohol, planned 2020 focus is on interventions directed toward women and alcohol, youth and alcohol, and alcohol screening and brief intervention

• Continued monitoring of non-medical cannabis use prevalence and associated harms

• Expanded dissemination of cannabis-related education and health messaging to general and program priority populations focused on decreasing harms, including You Need to Know campaign.

• The promotion and roll-out of the new *SFOA, 2017,* including sign delivery and installation and increased proprietor will continue; community need has exceeded enforcement capacity to respond.

• The engagement of municipal partners to support the retail sale of cannabis and to explore the amendment or enactment of municipal bylaws that exceed the protections provided under the new *SFOA, 2017* will be a priority for 2020.

Program Challenges and Risks

• The changing landscape of alcohol policy will continue to challenge ability to achieve intermediate and long term alcohol program outcomes

•The SFOA, 2017 includes the prohibition of use of cannabis (medical and non-medical) and the use of e-cigarettes in all places where tobacco use is already banned. The number of mandated inspections for tobacco and e-cigarette retailers is resource intensive, expending current enforcement team capacity. Ability to meet expanded mandate and public demand for enforcement of cannabis use and vaping will be challenged by current funding and staff capacity.

Staffing Complement

	2019 Total FTEs	2020 Total FTEs	Δ
Health Promoter	0.50	0.50	0.00
Program Assistant	0.20	0.20	0.00
Program Manager	0.50	0.45	-0.05
Public Health Nurse	1.15	1.15	0.00
Tobacco Enforcement Officer	0.45	1.85	1.40
Youth Leaders	0.10	0.00	-0.10
Director	0.00	0.03	0.03
Total Program FTE	***2.90***	***4.18***	***1.28***

Expenditures					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 229,908	$ 325,774	95,866	42%
Benefits		$ 58,394	$ 83,215	24,821	43%
Expected Vacancies		$ -		-	
Travel		$ 3,831	$ 5,784	1,953	51%
Program Supplies		$ 15,578	$ 26,539	10,961	70%
Board Expenses		$ -		-	
Staff Development		$ 1,126	$ 1,300	173	15%
Occupancy		$ -		-	
Professional Services		$ 2,024	$ 3,048	1,024	51%
Furniture & Equipment		$ 103	$ 124	22	21%
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 3,640	$ 6,892	3,252	89%
Total Expenditures	***$ -***	***$ 314,603***	***$ 452,675***	***$ 138,072***	***44%***

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 268,097	$ 284,545	16,448	6%
MOHLTC (100%)		$ 45,222		(45,222)	-100%
MCCSS		$ -		-	
CLIF Tobacco Enforcement			$ 166,846	166,846	
PHAC		$ 1,219	$ 1,219	-	0%
PHO		$ -		-	
User Fees		$ 65	$ 65	-	0%
Other		$ -		-	
Total Revenues	***$ -***	***$ 314,603***	***$ 452,675***	***$ 138,072***	***44%***

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Childhood Injury Prevention						471
Standard	Substance Use and Injury Prevention		**Director Name**	Maureen Rowlands		
Lead Team	Healthy Communities and Injury Prevention		**Manager Name**	Rhonda Brittan		
Supporting Team(s)	Early Years		Child Health		Reproductive Health	
Budget	$ 147,788		**FTE**	1.32		

Summary of Program

Unintentional Injury is the number one cause of preventable death in children in Canada. MLHU work related to Childhood Injury Prevention focuses on promoting safety and preventing and minimizing harms. Public health interventions include dissemination of evidence-based education and information, creating supportive environments, and where possible influencing policy. Child injury prevention messaging and programming is disseminated and delivered with and through both internal and external partners across program areas. e.g. Child Safety Middlesex London Coalition. The Childhood Injury Prevention program focuses on topics of public health importance including: falls, concussions, safe sleep, child passenger safety, poisoning, water safety/drowning prevention, helmet safety, product safety, choking prevention, burns and scalds, winter safety.

Target populations/stakeholders include parents/caregivers, children & youth, schools, hospitals, emergency services, child care and family centres.

The short term intended outcomes of this program include: increasing community partner/service provider knowledge and consistent application of evidence-based information and practices related to preventing childhood injuries; increasing parent/caregiver awareness and knowledge of child injury risk factors and how to prevent injuries in children; increasing community partner capacity to support measures that reduce childhood injury. To increase educator knowledge of policy related to child safety (i.e. child care centres, schools). Intermediate term intended outcomes include increasing parent/caregiver confidence and ability to institute measures to prevent injury and that subsequently parents and caregivers implement strategies to prevent injuries in children, and to increase the use of protective equipment in children and youth. The long-term population level goal is to reduce incidence and severity of childhood injuries.

Program Mandate & Relevant Legislation

Substance Use and Injury Prevention Standard (OPHS 2018); School Health Standard (OPHS, 2018)
Injury Prevention Guideline, (OPHS, 2018)
RNAO Best Practice Guideline - Working with Families to Promote Safe Sleep for Infants 0-12 months old, 2014
Ministry of Tourism, Culture and Sport *CONCUSSION GUIDELINES, 2018.
Canadian Guideline on Concussion in Sport, Parachute, 2017
Ontario's Highway Traffic Act R.S.O. 1990, c. H.8 related to use of infant car seats, and booster seats
Bill 193, Rowan's Law (concussion safety) 2018.
PPM 158 Ministry of Education, School Board Policies on Concussion (effective January 31st, 2020).
Ontario Concussion Prevention Network – Current research and information disseminated through this network

Program Management

This program is managed by the Healthy Communities and Injury Prevention Team (HCIP). Collaboration occurs with: Early Years Team (work together on child safety initiatives focused on early years including Early Years Partnership for consistent and evidence informed messaging),Child Health Team (schools/school age population), Reproductive Health Team (families preconception and during pregnancy and through curriculum of Smart Start for Babies and on-line prenatal). Best Beginnings/Nurse Family Partnership Teams (with new families) and Young Adult Team (in high schools and youth population - concussion).
HCIP team serves as the content specialist for MLHU programming related to childhood injury prevention. The HCIP content lead liaises with team key contacts routinely and ad hoc: provide and coordinate information and new evidence (e.g. safe infant sleep, product recalls); collaborates to bring content expertise to interventions and initiatives of other teams e.g. development of resources, health promotion campaigns.

Key Partners and Stakeholders

Child Safety Middlesex London: Oneida Health Centre; London Police Service (LPS); Childreach Resource Centre; Strathroy EarlyON; Middlesex-London Paramedic Service; Ontario Early Years Perth Middlesex; London Children's Connection, Early ON; London Health Sciences Centre ;Thames Valley District School Board (TVDSB); London District Catholic School Board (LDSCB); Health Canada; la Ribambelle; London Fire Department; Children's Services, County of Middlesex; London French Day Care; YMCA of Western Ontario Middlesex Children's Services. **Helmets on Kids Coalition**: Ontario Trial Lawyers; M-L Paramedic Service; LPS; TVDSB; LDCSB; LHSC; MTO; Brain Injury Association of London. **Risk Watch**: Middlesex-London Paramedic Service; LPS; OPP; London Fire; Middlesex Centre Fire; TVDSB; LDCSB; St Thomas Fire; Strathroy Caradoc Police. **YMCA Children's Safety Village**: LDCSB; TVDSB; Middlesex-London Paramedic Service; London Fire; London Police. **Drowning Prevention:** London Pool and Hot Tub Council. **Ontario Child Injury Prevention Committee (OCIPC).**

Community Needs and Priorities

Child Passenger /Motor Vehicle Safety: While at least 75 per cent of young children are restrained in car seats, nearly 75 per cent of children age 4-9 years were not protected by booster seats according to Transport Canada. (Parachute Canada). Every dollar spent on a booster seat saves society $71 and every dollar spent on a car seat saves society $64 (Parachute Canada, Cost of Injury Report, 2015)

Falls: In the 0-19 age group in 2016 in Middlesex-London, falls were the leading cause of ED visits for injury: 4,812 visits per 100,000 populations. (PHO snapshots). Those under 5 had the second highest rate of fall-related ED visits, with males significantly more likely to visit the ED for a fall compared to females. (MLHU Community Health Status Resource, 2019)

Concussion: Rates of concussion more than tripled between 2005 and 2017 and most affect those under age 19. The rate has been significantly higher in M-L than both Peer Group and the province for the entire period. The age specific rates of concussion-related ED visits were highest in the 10-14 and 15-19 age groups, more than double all other age groups. Ages 5-9 experienced the next highest rate of ED visits for concussions. (MLHU Community Health Status Resource 2019). Across Canada - falls and transport related incidents accounted for 81% of concussions resulting in hospitalizations (Canadian Injury Compass 2013). Using bicycle helmets reduces head injuries by more than 40 per cent, serious head injuries by 60 per cent, and traumatic brain injury by 53 per cent (Parachute Canada).

Poisoning prevention: In States where cannabis use is legal, there is increased risk of unintentional cannabis overdose injuries among children.

Drowning: Drowning prevention is a priority focus for local Pool and Hot Tub Council and MLHU partners annually in this education campaign. Canadian data shows that children under the age of 5 are particularly vulnerable to drowning in a backyard pools. Swimming lessons, life jackets/PFD's and keeping children within arms reach are the protective factors associated with drowning prevention.

Safe Sleep: Following safe sleep practices is one known strategy to decrease SIDS. Of cases reviewed by the Coroners Office Death Under 5 Committee in 2017, 44% of infants were found in unsafe sleeping environments. Following safe sleep practices is one known strategy to decrease SIDS.

Target and Priority Populations

Primary target population is infant to elementary school age. Early Years (0-4): Injuries occur in children as they develop and explore their surroundings. They are learning new skills and don't have the risk management skills to judge whether or not activities are safe. Injuries can often be prevented by creating an environment, inside and outside the home, that is safe to explore. Parental and caregiver supervision is the key to injury prevention in this age group. School Age/Children & Youth (5-17): are becoming more confident and therefore engaging in more risk- taking. This age category tends to overestimate their own skill and abilities making them more prone to injury. Education is still directed at parents and caregivers, but incorporating children and youth is necessary as well.

Target for program interventions varies with the topic and includes parents/ caregivers, community partners as well as children/youth. While child safety messaging is delivered in a universal way e.g. website, social media, traditional media; targeted strategies are used for priority populations. For example, the 'Kids Need a Boost' initiative promotes booster seat use through broad awareness building efforts to parents in general. Booster seats are also made available at no cost to families in need through partnership with the Child Safety committee and newcomer settlement workers and related resources are translated into other languages.

Intended Program Outcomes	
Long-Term Population Health	•To reduce incidence and severity of childhood injuries.
Intermediate	•To increase parent/caregiver confidence and ability to institute measures to prevent injury. •Parents and caregivers implement strategies to prevent injuries in children. •To increase the use of protective equipment in children and youth.
Short-Term	• To increase community partner/service provider knowledge and consistent application of evidence based information and practices related to preventing childhood injuries. • To increase parents'/caregivers awareness and knowledge of child injury risk factors and how to prevent injuries in children . • To increase community partner capacity to support measures that reduce childhood injury. • To increase educator knowledge of policy related to child safety (i.e. child care centres, schools).

Program Interventions		
1	Education and Awareness	Deliver drowning prevention campaign (annual campaign in partnership with Pool & Hot Tub Council) • Provide awareness-raising and education related to identified child injury prevention issues to parents and caregivers via consultations, presentations and community events • Develop and deliver poisoning prevention education and awareness specific to Cannabis edibles, targeting parents and grandparents • Develop and distribute Safety Never Hurts e- newsletter to organizations and professionals working with children & other newsletters e.g. healthcare provider • Continue to promote "Give your Child a Safe Start" video and resource promoting safety related to falls, burns and scalds, poisoning, choking, car safety, product safety, water safety and safe sleep. • Lead and participate in the planning and delivery of annual Safe Kids Week campaign • Review and maintain currency of MLHU child injury prevention website content • Provide presentations to community groups, schools etc. to increase health knowledge re injury prevention and mitigation, e.g. concussion

2	Supportive Environments	Continue “Kids Need a Boost” program, including limited and targeted distribution of booster seats to families in need. • Provide consultations, professional development/in-service for child care providers, school staff, and other community partners on child safety topics • Train volunteers to properly fit helmets • Support and participate in 2 car-seat clinics in London and Middlesex to support caregivers to safely install child safety seats • Chair the Infant Safe Sleep Committee (internal) to support accurate and consistent knowledge and practices by staff within the agency and with community partners as well as develop and maintain the Safe Sleep module for this purpose. • Chair and provide leadership to the Child Safety Middlesex London committee networking, shared resource development, consistent messaging • In partnership with LHSC – distribute Home Safety Kits.
3	Healthy Public Policy	Identify and act on policy windows and priorities related to child safety as appropriate.

Performance / Service Level Indicators

Indicator	2018	2019	2020 (target)
# of booster seats distributed to families with need	53	38	Maintain
# of bicycle helmets distributed with Helmets on Kids Coalition to children with need	900	over 900	Maintain
Social media metrics for Safe Kids Week online campaign: # of impressions, # of engagements	25,428 impressions 599 engagements	27,439 impressions 623 engagements	Increase
Social media metrics for Drowning Prevention online component of campaign: # of impressions, # of engagements	146301 impressions	163,601 impressions 11,528 engagements	Increase

Highlights / Initiatives Planned for 2020

Work with the Child Health team, school boards and Health Care providers on consistent messaging and management of student concussion symptoms.
Focus on safe sleep (infant). Working with internal staff and acute care and hospital partners to coordinate messaging regarding safe sleep practices (i.e. not swaddling).
With legalization of cannabis edibles, focus will be placed on prevention of child accidental exposure and poisoning.
ATV use by children and ATV related injury has been a voiced as a concern by acute care and other partners. 2020 plan to further explore program need and possible interventions in collaboration with partners including Road and Off-Road Safety program area.

Program Challenges and Risks

Continuation of booster seat distribution initiative will be dependent on available budget and receipt of additional funding.

Staffing Complement

	2019 Total FTEs	2020 Total FTEs	Δ
Program Assistant	0.10	0.10	0.00
Program Manager	0.10	0.10	0.00
Public Health Nurse	1.10	1.10	0.00
Director	0.00	0.02	0.02
Total Program FTE	***1.30***	***1.32***	***0.02***

Expenditures					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 107,950	$ 113,296	5,345	5%
Benefits		$ 26,987	$ 27,643	657	2%
Expected Vacancies		$ -		-	
Travel		$ 1,447	$ 1,520	73	5%
Program Supplies		$ 3,220	$ 3,241	21	1%
Board Expenses		$ -		-	
Staff Development		$ 680	$ 707	26	4%
Occupancy		$ -		-	
Professional Services		$ 668	$ 751	83	12%
Furniture & Equipment		$ 73	$ 89	17	23%
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 502	$ 541	40	8%
Total Expenditures	***$ -***	***$ 141,527***	***$ 147,788***	***$ 6,261***	***4%***

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 141,527	$ 147,788	6,261	4%
MOHLTC (100%)		$ -		-	
MCCSS		$ -		-	
PHAC		$ -		-	
PHO		$ -		-	
User Fees		$ -		-	
Other		$ -		-	
Total Revenues	***$ -***	***$ 141,527***	***$ 147,788***	***$ 6,261***	***4%***

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Falls Prevention and Healthy Aging					472
Standard	Substance Use and Injury Prevention		**Director Name**	Maureen Rowlands	
Lead Team	Healthy Communities and Injury Prevention		**Manager Name**	Rhonda Brittan	
Supporting Team(s)					
Budget	$ 148,033		**FTE**	1.31	

Summary of Program

MLHU work in the Falls Prevention Program focuses on falls prevention for older adults and includes: education and information sharing to older adults and service providers: leading and participating in both local and Southwest region collaborative tables; delivery of 'Step Ahead to Fall Prevention in Older Adults' education to PSW students; participation in London's Age Friendly London supporting implementation the Three Year Action Plan (2017-2020) related to Community support and health services, Outdoor spaces and buildings, Transportation.

Short term intended program outcomes include: increasing older adult knowledge related to risk and protective factors for healthy aging and preventing falls; increasing older adult skill related to healthy aging and reducing fall risk; increasing capacity of community partners to promote healthy aging and falls prevention using evidence and best practice; increasing knowledge among healthcare providers /non-health sector community partners on impact of falls, fall risks and evidence-based fall prevention strategies in older adults; Increasing knowledge of Personal Support Worker (PSW) students on the impact of falls, fall injuries and fall risks in older adults, and strategies that prevent falls. Intermediate intended outcome is to enhance supportive physical environments that promote healthy aging and reduce risk of falls; while the long term population level goal is to promote healthy aging and reduce the frequency, severity, and impact of injuries related to falls in older adults.

Program Mandate & Relevant Legislation

Substance Use and Injury Prevention Standard (OPHS, 2018)
Injury Prevention Guideline, 2018
Health Equity Guideline, 2018
Seniors' Falls in Canada second report, 2014, Public Health Agency of Canada
World Report on Ageing and Health, 2015, WHO

Program Management

The Fall Prevention and Healthy Aging program is managed by the Healthy Communities and Injury Prevention (HCIP)Team. Linkages exist with the following program areas: Childhood Injury Prevention; program focuses on fall prevention in the 0-6 population. Collaboration between the programs is related to intergenerational messaging. Active Living: Collaboration/cross-over between programs is related to promotion of active living in older adults. Both programs are on the HCIP team reporting to the same manager.

Key Partners and Stakeholders

London Health Sciences Centre, St. Joseph's Health Care London (Third Age Outreach), Horton Street Seniors Centre, St. Joseph's Health Care London (ConnectCare), Westervelt College, South West LHIN, Home & Community Care, Southwestern Public Health, City of London - Age Friendly London, Alzheimer Society London & Middlesex, VON, Canadian Hearing Society, Middlesex London EMS, Fanshawe College, London InterCommunity Health Centre, Osteoporosis Canada, YMCA, Arthritis Society, Chelsey Park Retirement Community, Fox Hollow Retirement Residence, London Audiology Consultants, South London Neighbourhood Resource Centre, Waverley Retirement Residence, Hutton House, Canadian Centre for Activity and Aging; Southwest Health Units

Key partnership/collaborative tables include: Middlesex-London Fall Prevention Collaborative; Southwest Ontario Fall Prevention Network; Stepping Out Safely Planning Committee; Age Friendly London.

Community Needs and Priorities

Falls are the leading cause of injury-related deaths and emergency department visits in Middlesex-London. The rates of injuries due to falls have been increasing in Middlesex-London since 2016 after showing a decreasing trend in the years before. Death rates due to falls increase as age increased, increasing dramatically after age 75 (214.8 per 100,000) (Middlesex-London Community Health Resource, 2019). The age-standardized rate of emergency department visits due to falls in Middlesex-London has increased significantly between 2015 (3,228.8 per 100,000) and 2017 (3,536.9). The rate of ED visits due to falls in Middlesex-London was significantly higher than both the Peer Group and the provincial rate in recent years (Middlesex-London Community Health Resource, 2019).

Between 20% and 30% of older Canadians fall at least once a year (Public Health Agency of Canada, 2014). It is anecdotally known that falls by older adults in the community are under-reported related to fear of loss of independence and stigma. Population aging is happening in Middlesex-London as it is across Canada. The 65 and older age group in Middlesex-London is expected to increase the most of any age group between 2016 and 2041 (90.6%). The number of seniors will almost double in the 25-year time period, from an estimated 78,259 to a projected 149,137. (Middlesex-London Community Health Resource, 2019). Fall-related injuries are expected to increase due to the aging Canadian population as baby boomers grow older (Parachute & Injury Prevention Centre, 2015).

Healthy Aging is a local priority. With the lead by the City of London in 2010, London was the first Canadian city to join the World Health Organization's (WHO) Global Network of Age Friendly Cities. MLHU is part of the London Age Friendly Partnership. "Older adults rate London as an excellent or good place to live and report that they enjoy an overall positive quality of life. Although reporting that their quality of life is positive, aging is not without its challenges. Survey respondents identified concerns about personal health and having to slow down as their main challenges as they age. These concerns became more common with increasing age." (City of London, Age Friendly London report to the Community, October 2016).

Target and Priority Populations

Community dwelling older adults 65 years & older: The 65+ age group in M-L is expected to increase the most of any age group between 2016 and 2041 (90.6%) (MLHU Community Health Resource). Falls are the leading cause of death and ED visits.
Ethnic older adults: About 20% (75,125) Londoners reported being a visible minority (2016 Fact sheet Immigration and Ethno-cultural Diversity). Ethnic seniors often experience barriers to health information and services due to language and cultural barriers
Personal Support Worker (PSW) students: PSWs often work closely with older adults providing supportive care in various settings.
Adults 55 to 64 : The age of 55 years has been increasing used by community organizations to define the age for programs for older adults, e.g. City of London and YMCA. A proactive approach to inform this population on concepts such as physical literacy will enhance their knowledge on ways to promote healthy aging and to prevent falls before they turn 65 years of age.
Interconnected health determinants influence the risk of falls and fall injuries. Lower SES is associated with increases in fatal and serious (all cause) injuries in Canada. Seniors and indigenous people were identified as populations with higher injury risk (Atlantic Collaborative on Injury Prevention, 2011). Further information and data is needed to identify and reduce fall risk and prevalence in priority populations.

Intended Program Outcomes	
Long-Term / Population Health	• To promote healthy aging and reduce the frequency, severity, and impact of injuries related to falls in older adults
Intermediate	• To increase adoption of strategies and behaviours by older adults that reduce risk of falls • To enhance supportive physical environments that promote healthy aging and reduce risk of falls • To promote change in practice among Personal Support Workers regarding injury prevention in seniors.
Short-Term	• To increase older adult knowledge related to risk and protective factors for healthy aging and preventing falls. • To increase older adult skill related to healthy aging and reducing fall risk. • To increase capacity of community partners to promote healthy aging and falls prevention using evidence and best practice • To increase knowledge among healthcare providers /non-health sector community partners on impact of falls, fall risks and evidence-based fall prevention strategies in older adults • To increase and maintain collaboration with community partners to promote healthy aging and fall prevention • To increase knowledge of Personal support worker (PSW) students on the impact of falls, fall injuries and fall risks in older adults, and strategies that promote healthy aging and preventing falls in older adults

Program Interventions		
1	Awareness and Education	• Provide evidence-based messaging and resources related to falls prevention and healthy aging on MLHU website. • With community partners, plan community activities targeted at awareness and education in Middlesex-London such as Fall Prevention Month in November • With partners, develop/adapt and disseminate information and tools to older adults and health care providers related to: general fall prevention strategies, activities/exercises for older adults to maintain strength and physical activity, screening for fall risk • Share printed and electronic resources with community partners to promote consistent evidence informed messaging in fall prevention • Continue to provide the 'Step Ahead to Fall Prevention in Older Adults' PSW education program in 2020. Explore shift to an on-line learning module as an alternative to face-to-face delivery of this program.

2	Supportive Environments & Collaboration	• Chair and provide leadership to the Middlesex-London Fall Prevention Collaborative supporting networking, shared resource development and consistent messaging. • Participate in the Southwest Ontario Fall Prevention Network for networking, shared resource development and consistent messaging, • As part of Age Friendly London (AFL) Community Support & Health Services workgroup: participate in actions that improve older adult awareness of existing programs and services that support healthy aging. • As part of AFL Outdoor Spaces and Buildings working group: participate in actions that influence neighbourhood design to support aging in place, Increase the age friendliness of parks, pathways, and trails. • As part of AFL Transportation working group: participate in actions that focus on improved the accessibility of city roads and sidewalks, active transportation initiatives, accessibility of public transit, transportation options for older adults.
3	Policy development	• Provide public health input and support as appropriate toward the implementation of the Age Friendly London 3-year Action plan • Identify and act on other policy windows and priorities related to fall prevention and healthy aging.

Performance / Service Level Indicators

Indicator	2018	2019	2020 (target)
# of PSW students receiving Step Ahead training	31 students trained	63 students trained	Increase
# of participants and # of community partner organizations supporting Stepping Out Safety event	90 participants 14 organizations	75 participants 12 organizations	On hold for 2020
Fall Prevention Month kick-off event	N/A	100+ participants 20 organizations	Increase

Highlights / Initiatives Planned for 2020

• Explore shift to an on-line learning module as an alternative to face-to-face delivery of the “Step Ahead to Fall Prevention in Older Adults” training. An evaluation of the this intervention was done in 2019. The training has shown to have enhanced the knowledge of the PSW students towards fall prevention in older adults. A recommendation from the evaluation is to “explore options to shift to an interactive, online module in order to scale up the intervention to other post-secondary institutions". An online module could increase the reach to more PSW students and employed PSWs and other healthcare providers that provide support to community dwelling seniors within the Middlesex-London area.
• Explore Fall Prevention Month engagement strategies and activities in Middlesex County with community partners (these have been historically held only in London).
• Work with HCIP physical activity program lead to develop a work plan to promote physical literacy and physical activity in older adults.

Program Challenges and Risks

It is known through the literature that effective fall prevention strategies are complex and multi-factorial, necessitating investment and commitment from a broad range of stakeholders and sectors.

There is evidence that lower SES and other complex factors that build over a life course are associated with increase risk of injury including from falls. Further information is needed, including data to better identify priority population older adults as it relates to falls, as well as evidence of effective strategies. It is anticipated with growing economic disparity and a growing senior population, that increased efforts over time will be needed to positively affect fall rates, and injury outcomes.

Staffing Complement

	2019 Total FTEs	2020 Total FTEs	Δ
Program Assistant	0.10	0.10	0.00
Program Manager	0.10	0.10	0.00
Public Health Nurse	1.10	1.10	0.00
Director	0.00	0.01	0.01
Total Program FTE	***1.30***	***1.31***	***0.01***

Expenditures					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 109,620	$ 113,620	4,000	4%
Benefits		$ 27,279	$ 27,666	388	1%
Expected Vacancies		$ -		-	
Travel		$ 1,447	$ 1,500	53	4%
Program Supplies		$ 3,220	$ 3,214	(6)	0%
Board Expenses		$ -		-	
Staff Development		$ 680	$ 691	11	2%
Occupancy		$ -		-	
Professional Services		$ 668	$ 726	58	9%
Furniture & Equipment		$ 73	$ 83	10	14%
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 502	$ 534	32	6%
Total Expenditures	***$ -***	***$ 143,489***	***$ 148,033***	***$ 4,545***	***3%***

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 143,489	$ 148,033	4,545	3%
MOHLTC (100%)		$ -		-	
MCCSS		$ -		-	
PHAC		$ -		-	
PHO		$ -		-	
User Fees		$ -		-	
Other		$ -		-	
Total Revenues	***$ -***	***$ 143,489***	***$ 148,033***	***$ 4,545***	***3%***

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Opioids and Other Drugs					474
Standard	Substance Use and Injury Prevention		**Director Name**	Stephen Turner	
Lead Team	Sexual Health		**Manager Name**	Shaya Dhinsa	
Supporting Team(s)	Healthy Communities and Injury Prevention				
Budget	$ 429,228		**FTE**	2.77	

Summary of Program

The primary goal of the Opioid and Other Drugs Program is to reduce the burden of illness relating to substance use. Middlesex-London Health Unit (MLHU) is largely funded by the MOHLTC. MLHU funds the following: RHAC to support Counterpoint and other satellite locations, MLHU sharp disposal (under regular budget), and Park and Recreation sharp disposal costs

The Harm Reduction Program Enhancement (HRPE) will build on and leverage programs and services already offered by PHUs and community partners. The HRPE will also establish PHUs, or their designated organizations, as naloxone distribution leads for community organizations, which will increase dissemination of kits to priority populations by agencies where these individuals are already receiving services. PHUs may choose to delegate this role to a community organization in their region.

PHUs or designated naloxone distribution leads ("PHU/Distribution leads") are responsible for identifying eligible community organizations to distribute naloxone to their clients. Eligible naloxone distribution sites include:

• Community Health Centers, including Aboriginal Health Access Centres, AIDS Service Organizations, Shelters, Withdrawal Management Programs, Outreach Programs

Program interventions include:

- Needles Syringe Program
- Naloxone Program
- Consumption and Treatment Services
- Health Promotion Campaign
- Community Drug and Alcohol Strategy

Program Mandate & Relevant Legislation

Substance Use and Injury Prevention Standard
Infectious and Communicable Disease Prevention and Control Standard
Infectious Diseases Protocol, 2018 (or as current)
Sexual Health and Sexually Transmitted/Blood-Borne Infections Prevention and Control Protocol.
Substance Use Prevention and Harm Reduction Guideline, 2018 (or as current)
Middlesex-London Community Drug and Alcohol Strategy – A Foundation for Action (2018)

Program Management

The Opioids and Other Drugs Program is managed by the Sexual Health Team (SH) in collaboration with the Healthy Communities and Injury Prevention Team (HCIP).
~The Middlesex-London Community Drug and Alcohol Strategy (CDAS) is based on the Four Pillar" approach of Prevention, Treatment, Harm Reduction, and Enforcement and focuses on all substances, with the exception of tobacco. The CDAS is a partnership model with a Steering Committee comprised of community partners; the manager of HCIP serves as Chair. The Sexual Health Team is a part of the Harm Reduction Pillar which includes the Needle Syringe Program, Naloxone program and Consumption and Treatment Services. Because there is overlap between pillars, implementation of the strategy must focus across pillars and across recommendations and SH and HCIP are interconnected for this purpose.

Key Partners and Stakeholders

Regional HIV/AIDS Connection (RHAC), My Sisters' Place, Coffee House-CMHA, Mission Services Community Mental Health Program, local pharmacies, some first nations, London Intercommunity Health Centre, Addiction Services Thames Valley, London Cares, Southwest Ontario Health Access Centre, and Canadian Mental Health Association, City of London, London Police Service, London Cares, Southwest LHIN, London Health Sciences Centre, EMS, Elgin Middlesex-Detention Centre, Community Mental Health Services, Downtown London, Old East Village Business Improvement Area, Goodwill Industries, Salvation Army Centre of Hope, St. Joseph's Health Care Centre, OPP, Unity Project, Anova.

Community Needs and Priorities

Death rates have been fluctuating in Middlesex-London since 2005. The highest rate of deaths related to opioid toxicity was seen in the first quarter of 2018. Emergency Department visits have generally been higher in Middlesex-London than the province since 2003. Middlesex-London rates have been increasing since 2014 and in 2016 we saw the highest number of 188. Hospitalizations for opioid toxicity have been increasing generally over time in both Middlesex-London and Ontario. In recent years, the rate in Middlesex-London has been increasing at a higher pace than the province. Monthly ED visits, hospitalization and death data provide a picture of the variability seen across the past few years. An increase in number of ED visits was seen starting in April, 2017 and there has since been variation in the number of monthly visits. Preliminary data from August to October 2017 show that the monthly rate of death per 100,000 was similar to previous months and years. The number of naloxone kits distributed in Middlesex-London steadily increased from 2014 to 2018. In the first 3 quarters of 2019 there have been 4,284 kits distributed. Prior to 2013, HIV rates in Middlesex-London were lower than or similar to the rate in Ontario. Since 2014, HIV rates have increased in Middlesex-London whereas the provincial rate has gradually declined. In 2016, approximately 70% of people diagnosed with HIV had experience with injection drug use. As of December 31, 2018, the number of newly diagnosed cases reported in 2018 had fallen to 29, representing a 52% decrease from the outbreak peak in 2016. Between 2007 and 2016, Hepatitis C rates were significantly higher in Middlesex-London when compared to provincial rates. In 2016 alone, more than half of the people diagnosed with Hepatitis C had experience with injection drug use. Endocarditis which is also called infective endocarditis, is an infection and inflammation of the heart valves and the inner lining of the heart chambers. It can occur when infectious organisms, such as bacteria or fungi, enter the bloodstream and settle in the heart People who inject drugs are at high risk of acute endocarditis, because numerous needle punctures give bacteria many opportunities to enter the blood through broken skin. Re-using drug paraphernalia increases the risk. Endocarditis is treated through intravenous antibiotics and surgery may be required in some cases. If untreated, this form of endocarditis can be fatal in less than six weeks.

Each year in London, more than 3 million clean needles are distributed to people who inject drugs; of these, about 60% are recovered. People tend to use drugs in public areas, because they don't otherwise have a safe location to do so. This public drug use can lead to unsafe consumption practices, which increase the risk of overdose and the spread of diseases, such as hepatitis C and HIV. In addition, discarded equipment, such as used needles, pose a potential risk of injury for those who use public spaces where people inject drugs.

Target and Priority Populations

People who use Drugs: London has a large population of people who inject drugs (PWID) and is believed to be one of the largest in the country relative to its population. While the exact size of the population of PWID remains largely unknown, it has been estimated that there are approximately 6,000 PWID in London (about 2% of London's total population of 404,699). There are inequities influences by the social determinants of health, that put certain groups that are more at-risk for problematic substance use and disproportionate harm. These groups include: People who are unstably housed or homeless, Those with mental health problems, People with a history of trauma, Lesbian, gay, bisexual, transgender, queer or questioning (LGBTQ2+) youth, Indigenous persons, populations in correctional facilities.

Intended Program Outcomes	
Long-Term / Population Health	• To reduce the burden of preventable injuries and substance use • To reduce the burden of communicable diseases and other infectious diseases of public health significance
Intermediate	• Connect clients to community supports such as mental health, addictions, housing, primary care etc.
Short-Term	• Reduce the number of overdose deaths by providing naloxone to those at risk for overdose and their friends and family • Prevent overdoses • Provide safer injection education and community resources and referrals • Reduce the spread of STBBIs • Increase access to harm reduction services • Reduce the amount of discarded needles and syringes found in public spaces and the risks associated with potential injury • Reduce unsafe injection practices • Improve access to other health and social services • Increase knowledge and awareness of community members and service providers regarding substance use risk and protective factors, harm reduction, addictions and stigma around drug use

Program Interventions		
1	Needle Syringe Program	Currently MLHU and RHAC Counterpoint Syringe Program provides anonymous access to clean needles/syringes and other injection equipment such as safer inhalation kits and naloxone kits. Another role of the NSP program is to connect or refer clients to programs and services in the community. The program accepts used needles/syringes and other equipment. MLHU provides funding to the Regional HIV/AIDS Connection who supports the Counterpoint Needle Syringe Program. One of the key initiatives is to expand satellite locations for NSP to ensure clients have access to harm reduction supplies i.e. pharmacies, shelters, community health access centres. There is a mobile unit who delivers NSP and naloxone door-to-door. Currently all clients who access the Needle Exchange Program and satellite sites in Middlesex-London visits are tracked in the NEO database. A module was added to the NEO database to capture the Temporary Overdose now the Consumption and Treatment Services Data. This data is provided to the MOHLTC for reporting purposes.

2	Naloxone Program	The Harm Reduction Program Enhancement (HRPE) builds on and leverages programs and services already offered by PHUs and community partners. MLHU is the designated naloxone distribution lead ("PHU/Distribution leads") in Middlesex-London and are responsible for identifying eligible community organizations to distribute naloxone to their clients. This designated role allows for increased dissemination of kits to priority population by agencies individuals already receiving services. Eligible naloxone distribution sites include shelters, outreach teams, withdrawal management programs, community access centres, police and fire. Eligible organizations were provided training on the administering and dispensing naloxone which includes signs and symptoms of an overdose. Each organization developed policies and procedures for naloxone distribution. There are signed agreements between eligible community organizations and the Middlesex-London Health Unit, and each organization provides quarterly reporting to MLHU which is collated and sent to MOHLTC.
3	Consumption and Treatment Services	Provide a supervised and hygienic space for people who use drugs (PWUD) to use their drugs CTS provides a safe space for clients to consume drugs and to connect with community services (e.g. housing supports, mental health, primary care, addiction services and other social supports) and peer support services as requested. The role of staff at CTS is to stablish trusting relationships with clients, provide naloxone during overdose, and the provision of harm reduction supplies, including, but not limited to needles, syringes and other safe drug use equipment.
4	Health Promotion Campaign	Local research, concluding that bacterial and viral counts could be reduced by simply heating the drug substance to a boil, prompted a public health response. In September 2018, we collaborated with St. Joseph's Infectious Diseases Clinic to launch a project study with two key objectives: identify unknown barriers/deficits that prevent access to this practice; determine the most effective method(s) to disseminate education and resources to front-line staff and PWID. Project results informed a harm reduction campaign to provide these educational resources: two targeted slide decks; print resources with key messages that align with Harm Reduction Best Practice Recommendations and provision of a heat source. This will be the first campaign in Ontario to promote cooking drugs to reduce infectious harms associated with drug injection practice.
5	Community Drug and Alcohol Strategy	• Support training opportunities for health and other professionals about addiction, harm reduction, and injection drug use. • Provide opportunities for community members and organizations to learn about substance use, harm reduction, addictions and stigma around drug use. • Advocate for and support cultural safety and trauma-informed care training to agencies and organizations • Increase public awareness of existing treatment information and pathways to treatment services in Middlesex-London

Performance / Service Level Indicators

Indicator	2018	2019	2020 (target)
# of CDAS priority actions underway	21 / 59	34 / 59	47 / 59
# of Naloxone kits provided/successful resuscitations	2,381 / 355	5,289 / 690	5,500 / 650
# visits to NEP, # needles and syringes distributed, # returned to the Needle Exchange Program at MLHU	1,840 / 209,583 / 64,379	1,187 / 151,653 / 71,015	1,200 /150,000 / 75,000
# of locations of Needle Syringe Programs/Satellite locations in Middlesex and London	16	18	20
# of visits/OD reversals/soft referrals at CTS site	11,533 / 72 / 799	18,911 / 137 / 2,787	18,000 / 150 / 3,000

Highlights / Initiatives Planned for 2019

• Health promotion strategy to increase awareness about the benefits of safe injection preparation practices. May also apply results from this project to advocate for potential modification of harm reduction kit inventory provided by the Ontario Harm Reduction Distribution Program
• Continued work on establishing permanent locations for Supervised Consumption Facilities
• Need to increase the availability of harm reduction supplies across London and Middlesex County
• Crystal methamphetamine will be a 2020 area of focus for the Community Drug and Alcohol Strategy.

Program Challenges and Risks

• Continued focus and attainment of Community Drug and Alcohol Strategy recommendations and actions will require continued and increased resourcing, ongoing commitment of partners, and collaboration among sectors.
• The applications for zoning of the permanent sites will proceed to City Council for consideration once the appeal to the Official Plan amendments is resolved

Staffing Complement			
	2019 Total FTEs	2020 Total FTEs	Δ
Community Drug and Alcohol Coordinator	0.50	0.00	-0.50
Community Outreach and Harm Reduction Program Lead	0.90	0.00	-0.90
Health Promoter	0.50	0.60	0.10
Outreach Worker	1.80	0.20	-1.60
Program Manager	0.60	0.70	0.10
Public Health Nurse	3.00	1.20	-1.80
Director	0.00	0.07	0.07
Total Program FTE	***7.30***	***2.77***	***-4.53***

Expenditures					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 564,553	$ 248,813	(315,740)	-56%
Benefits		$ 144,328	$ 59,964	(84,365)	-58%
Expected Vacancies		$ -		-	
Travel		$ 6,071	$ 2,144	(3,926)	-65%
Program Supplies		$ 117,749	$ 38,611	(79,138)	-67%
Board Expenses		$ -		-	
Staff Development		$ 2,841	$ 1,251	(1,591)	-56%
Occupancy		$ -		-	
Professional Services		$ 229,828	$ 74,727	(155,101)	-67%
Furniture & Equipment		$ 2,113	$ 307	(1,807)	-85%
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 10,529	$ 3,412	(7,116)	-68%
Total Expenditures	***$ -***	***$ 1,078,012***	***$ 429,228***	***-$ 648,784***	***-60%***

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 667,690	$ 369,623	(298,067)	-45%
MOHLTC (100%)		$ 221,763	$ -	(221,763)	-100%
MCCSS		$ -		-	
PHAC		$ 33,771	$ 7,310	(26,461)	-78%
PHO		$ -		-	
User Fees		$ 154,788	$ 50,172	(104,616)	-68%
Other		$ -	$ 2,123	2,123	
Total Revenues	***$ -***	***$ 1,078,012***	***$ 429,228***	***-$ 648,784***	***-291%***

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Road and Off-Road Safety					475
Standard	Substance Use and Injury Prevention		**Director Name**	Maureen Rowlands	
Lead Team	Healthy Communities and Injury Prevention		**Manager Name**	Rhonda Brittan	
Supporting Team(s)	Child Health				
Budget	$ 179,506		**FTE**	1.61	

Summary of Program

MLHU work in Road and Off-Road Safety is accomplished in collaboration with community partners as part of a 3 E's approach: education, engineering and enforcement. Health unit interventions focus on building education and awareness, building and maintaining strong collaborative partnerships, and influencing policy including the built environment.

MLHU has been a contributing member of the London Middlesex Road Safety Committee (LMRSC) for 14 years and has co-chaired and provided leadership and coordination support for the past 12 years. The LMRSC is the primary body for implementing the London Road Safety Strategy (LRSS) to which MLHU is one of several signatories. Many partners, including Middlesex County, are part of this work.

The 2014-2019 LRSS from was created from a comprehensive review of the 4-year traffic collision history (2008-2011) and combined with the findings of several forms of public input. The chosen topic areas for LRSS were: Intersections; • Distracted and Aggressive Driving; • Young Drivers; • Pedestrians; • Cyclists; and • Red Light Running. In 2017 The City of London adopted Vision Zero. The principles of Vision zero are currently being integrated throughout the LRSS and 2020 will bring development of an updated LRSS to guide actions going forward.

Active & Safe Routes to School (ASRTS) partnership, which is co-chaired by a member of the HCIP team at MLHU, delivers the actions of the LRSS, related to road safety in the promotion of active and safe transportation to the Elementary school aged students.

Rates of motor vehicle collision injuries seen in ED are on the rise with an increase seen between 2014 and 2017, after years of decline. Land transport collisions were the third leading cause of death in males (9.5 per 100,000) and females (2.6 per 100,000).

The long term goal of the Road and Off-Road Safety program is to reduce the incidence and burden of preventable road and off-road related injuries.

Program Mandate & Relevant Legislation

Substance Use and Injury Prevention Standard (OPHS, 2018)
School Health Standard (OPHS, 2018)
Injury Prevention Guideline (OPHS, 2018)
London Road Safety Strategy (LRSS) 2014-2019
Canada's Road Safety Strategy 2025: Towards Zero - The Safest Roads in the World (2016)
London Complete Streets Design Manual, 2018
City of London Cycling Master Plan, 2016

Program Management

The Road and Off-Road Safety Program is managed by the Healthy Communities and Injury Prevention Team (HCIP). HCIP acts as a coordinator and liaison connecting staff from other teams to information, opportunities for universal and targeted interventions, for request of communication and resources, and opportunities for MLHU to support pubic policy. The Child-Health team supports the implementation of Active and Safe Routes to School and school travel planning. Young Adult Team supports education to secondary school students on road safety target areas, e.g. distracted driving.

Key Partners and Stakeholders

City of London (Environmental & Engineering Services / Roads & Transportation), London Health Sciences Centre (LHSC), London Police Service LPS, Middlesex County, MTO, OPP, Strathroy-Caradoc Police Service, Western HEAL lab, Southwestern Public Health, Thames Valley District School Board, London District Catholic School Board, Student Transportation Services, London Middlesex EMS, CAA, 3M Canada, Young Drivers of Canada, Southwest region Health Units, Parachute, Windsor Regional Hospital, London Urban League, London Cycle Link, Can-Bike, City of St. Thomas, Counties of Oxford, Elgin, Green Communities Canada, TVPIC (Thames Valley Parent Involvement Committee), LDCSB PIC (London District Catholic School Board Parent Involvement Committee), Thames Valley Council of Home and School Associations

Key partnerships/collaborative tables include: London Middlesex Road Safety Committee, Elgin, Oxford, Middlesex-London Active and Safe Routes to School, Southwest Injury Prevention Network, City of London Cycling Advisory Committee and Transportation Advisory Committee

Community Needs and Priorities

In 2017, the rate of land transport related injuries seen the emergency department (ED) was 901.1 per 100,000 - this rate is significantly higher than both Ontario and Peer Group health units. The rural population had a higher rate than the urban population. Land transport collisions, such as car crashes, were the third leading cause of death in males (9.5 per 100,000) and females (2.6 per 100,000). Males and those in the 20-44 age group had significantly higher rates of ED visits related to land transport related injuries than other groups.
Collisions involving bicycles are the most common type of transport collision in Middlesex London, after MVCs. The rate of emergency department visits for injuries for bicycle collisions was, on average 186.6 per 100,000 people per year in the years 2015 to 2017. Males had more than double the rate of injuries from cycling then females. Pedestrians injury ED visits were 58.4 per 100,000 (2015-2017 average).
There was a significant and substantial decrease in the rate of MVCs causing injury or death that involved alcohol between 2008 (25.8 per 100,000) and 2015 (13.4) The 2015 rate is seven times lower than it was in 1988. However, Middlesex-London rates of alcohol involvement in MVCs causing injury or death were consistently higher than those of the province. In 2013/14 in Middlesex-London the proportion of people who reported that they had been driving after consuming two or more drinks in the hour before driving was 3.2%. In 2013/14, 9% of drivers in grades 10-12 in Erie St Clair + SW LHINs (combined) drove within one hour of using cannabis at least once during the past year. About 20% of the population in Middlesex-London reported ever using a cell phone while driving in 2013/14
All-terrain vehicles, excluding snowmobiles, had a rate of 31.7 per 100,000 ED visits and snowmobiles had a rate of 6.0 per 100,000. In both of these types of vehicles, males were significantly more likely to go to the emergency department with an injury than females (2015-2017 average).
Work in this program area is accomplished in collaboration with community partners. Local priorities for road and off-road safety are guided by decisions and workplans of partnership tables.

Target and Priority Populations

According to Vision Zero the highest priority populations are vulnerable road users, specifically pedestrians and cyclists: outcomes of injury from the collisions are usually more severe and can lead to fatalities. However, LRSS/Vision Zero is committed to an equitable approach to road safety for all users; pedestrians, cyclists, drivers, and public transit users, of all age groups and abilities.
Data of crash and injury incidence also demonstrates the following populations of priority: Youth/young adults: 16-24-year-old age group - involved in the largest proportion of collisions (CIMA, City of London 2012); 20-24-year-old age group - highest rate of ER visits due to motor vehicle collision injury (IntelliHEALTH Ontario 2013).
Distracted driving, e.g. cell phone use while driving, continues to be an area of priority. With legalization of non-medical cannabis, cannabis impaired driving is an area of concern for both education and monitoring.
London Middlesex Road Safety Committee priorities for 2014 to 2019 were set by the Vison Zero principles are being incorporated into London Road Safety Strategy (LRSS). Planning for the next period has begun and 2020 will involve the building of a renewed strategy and new priorities.

Intended Program Outcomes	
Long-Term / Population Health	To reduce the incidence and burden of preventable road and off-road related injuries.
Intermediate	• Increased policy and infrastructure put in place that creates safer road and off-road environments for drivers and vulnerable road users. • School and neighbourhood environments are designed, built, and/or retrofitted to support active and safe modes of travel for students. • Increased focus on equity and accessibility in road safety interventions including infrastructure . • Increased adoption of safety strategies by drivers, cyclists, pedestrians and other road users that decrease risk of injury and collision e.g., use of infrastructure, helmets, non-slip footwear in winter etc. • Fewer drivers practice/partake in collision risk factors (cannabis, alcohol use and driving, distracted driving).
Short-Term	• Continued and increased engagement and collaboration among community partners and members of the public related policy and built environment supports for road and off-road safety. • Decision makers are engaged in policy development and support policies and built environments that support active and safe school travel. • Increased driver awareness of collision risk factors (specifically cannabis, alcohol use and driving, distracted driving). • Increased driver awareness of laws and use of driving infrastructure that increases road safety (e.g. posted speed limits, how to drive at a PXO, laws regarding substance use and driving). • Increased cyclist and pedestrian awareness of laws and infrastructure that increases road and off-road safety. • Increase children’s knowledge in pedestrian, cycling and road safety.

Program Interventions		
1	Education & Awareness	• Continue to promote existing distracted driving media messages and campaigns at the local level (MTO and CAA messages, local Buckle-Up Phone Down campaign). • Work in collaboration with partners to develop and disseminate messaging and resources that promote road and off-road safety related to MTO book 15/18. • With partners, continue to promote messaging and campaigns related impaired driving – cannabis, alcohol and other drugs. • Collaborate with partners to provide education to drivers, pedestrians and cyclists re use of road infrastructures through social media, traditional media, signs/visual promotion materials, existing tools such as “Tony the Streetwise Cat” videos to schools and general public, and safety presentations to elementary school children. • Disseminate safer driving messaging such as distracted driving, winter driving safety to workplaces through MLHU workplace newsletter and other targeted audience’s communication vehicles (e.g. Age Friendly London). • Utilize multi-modes for messaging including website, social media, events.
2	Collaboration	• Co-chair and provide leadership and coordination support to the London and Middlesex Road Safety Committee including planning and monitoring, shared resource development and knowledge exchange. •Expand diversity of representation on LMRSC to enhance equity lens e.g. accessibility. • Maintain membership and provide public health-focused input related to road safety on City of London Transportation and Cycling Advisory Committees. • Participate on regional committees including SWIPN, Regional Trauma Network, Vision Zero. • Co-Chair and provide leadership and coordination support to ASRTS committee to promote active and safe school travel including planning, monitoring & evaluation, coordinating and sharing knowledge e.g. working groups, knowledge exchange events and leveraging partners and resources.
3	Policy & Built Environment	• Promote and support the adoption of policies and regulatory amendments that support municipal and provincial on- road and off-road safety (Automated speed enforcement, Red light cameras, speed limits). • Provide input and advocate for built road environments and infrastructure that prioritizes safety for vulnerable road users including cyclists and pedestrians – including a focus on health equity. •Provide recommendations on master plans, landscape designs through advisory committees, LRSS, other guidance documents. • Collect and use local data to provide input and evidence to support policy and/or built environment changes that support road safety including safer active school travel.

Performance / Service Level Indicators

Indicator	2018	2019	2020 (target)
Social media campaign metrics (# of impressions, # of engagements)	Pedestrian Cross Over Campaign: 286,817 impressions 174,655 engagements	MLHU Winter Driving Giveaway: 14,034 impressions 1007 engagements	Increase
# of engaged partners in London Middlesex Road Safety Committee (LMRSC)	18	21	Increase
# of distinct LMRSC road safety public education campaign focuses/topics	5	8	Maintain
Proportion of students (grade 10-12 licenced drivers) who report driving with 2 hours of consuming cannabis.	9% (2017 ODSUS Erie St Clair + SW LHINs combined)	no new data to report	Decrease
Proportion of drivers (16+) that ever used a cell phone while driving	21.8% (CCHS 2013/14 data)	no new data to report	Decrease
Proportion of drivers that drove a motor vehicle after having two or more drinks in the hour before they drove in the past 12 months	3.2% (CCHS 2013/2014 data)	no new data to report	Decrease

Highlights / Initiatives Planned for 2020

2020 will bring a renewed London Road Safety Strategy and Cycling Master Plan which will be used to dictate our countermeasures and hence activities.

ASRTS will partner with the Canadian Cancer Society who will pilot the Walking School Bus at three schools and apply for funding to expand the project further.

Program Challenges and Risks

•As indicated in 2019, funding for LMRSC road safety campaigns is historically afforded through different Ministry of Transportation grants, e.g. Road Safety Community Partnership Program RSCPP. These grants continue to be on hold. If these opportunities decrease or no longer exist, this will affect program delivery.

Staffing Complement			
	2019 Total FTEs	2020 Total FTEs	Δ
Program Assistant	0.10	0.10	0.00
Program Manager	0.10	0.10	0.00
Public Health Nurse	1.40	1.40	0.00
Director	0.00	0.01	0.01
Total Program FTE	***1.60***	***1.61***	***0.01***

Expenditures					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 134,694	$ 137,583	2,889	2%
Benefits		$ 31,263	$ 33,643	2,380	8%
Expected Vacancies		$ -		-	
Travel		$ 1,781	$ 1,841	60	3%
Program Supplies		$ 3,963	$ 3,949	(14)	0%
Board Expenses		$ -		-	
Staff Development		$ 837	$ 847	10	1%
Occupancy		$ -		-	
Professional Services		$ 822	$ 888	65	8%
Furniture & Equipment		$ 90	$ 101	11	12%
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 618	$ 655	38	6%
Total Expenditures	***$ -***	***$ 174,068***	***$ 179,506***	***$ 5,439***	***3%***

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 174,068	$ 179,506	5,439	3%
MOHLTC (100%)		$ -		-	
MCCSS		$ -		-	
PHAC		$ -		-	
PHO		$ -		-	
User Fees		$ -		-	
Other		$ -		-	
Total Revenues	***$ -***	***$ 174,068***	***$ 179,506***	***$ 5,439***	***3%***

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Southwest Tobacco Control Area Network				476
Standard	Substance Use and Injury Prevention	**Director Name**	Maureen Rowlands	
Lead Team	Southwest Tobacco Control Area Network	**Manager Name**	Donna Kosmack	
Supporting Team(s)				
Budget	$ 457,233	**FTE**	2.49	

Summary of Program

The SW Tobacco Control Area Network (TCAN) is a regional collaborative that focuses on nicotine addiction to improve population health. The TCAN's vision is to create a SW ON free from nicotine addiction and tobacco related death and disease. Cigarette smoke contains more than 7,000 chemicals and impacts almost every organ of the body, contributing to chronic diseases such as cancers, heart and lung diseases. Even people who do not smoke are affected by the harms of tobacco through exposure to second-hand and/or third-hand smoke.

The SW TCAN coordinates the implementation of the Smoke-Free Ontario Strategy in the SW region of Ontario. Through coordination and collaboration, the TCAN ensures consistent enforcement of the Smoke-Free Ontario Act, 2017 across the region and provincially. The TCAN also provides support with collaboration and capacity building offering orientation to new staff in partner PHUs and creating opportunities for knowledge exchange. Lastly, the TCAN leads the development, implementation and evaluation of comprehensive health promotion strategies. Health promotion strategies focus on:

- Increase the number of people who make a quit attempt and quit smoking
- Protect people from exposure to second-hand smoke and vapour
- Reduce exposure to the use of vapour and tobacco products to normalize a smoke-free and vapour-free culture
- Prevent the initiation of tobacco product use or vapour product use

* *Traditional tobacco use is a sacred and cultural practice for many Indigenous peoples in Canada. For the purposes of this program description, when tobacco is named, it references commercial tobacco products and related harms, unless sacred or traditional tobacco use is clearly specified.

Program Mandate & Relevant Legislation

Ontario Public Health Standards: Substance Use and Injury Prevention Standard, Chronic Disease Prevention and Well-Being, School Health
OPHS Protocols and Guidance Documents: Tobacco, Vapour and Smoke Protocol, 2018; Tobacco, Vapour and Smoke Compendium (Confidential Enforcement Guideline); Tobacco, Vapour and Smoke Guideline, 2018; Substance Use Prevention and Harm Reduction Guideline, 2018; Chronic Disease Prevention Guideline, 2018
Legislation: Smoke-Free Ontario Act, 2017 (SFOA, 2017) and Ontario Regulation 268/18; The Residential Tenancies Act, 2006; Tobacco and Vaping Products Act (Federal)
Other: Training documents and guidelines provided by Ministry of Health to provide Enforcement oversight and guidance

Program Management

The SW TCAN works collaboratively with tobacco staff from all 8 SW TCAN member PHUs to implement regional tobacco control and e-cigarette program priorities across the TCAN region. Additionally, the TCAN staff work collaboratively with the six other Tobacco Control Area Networks (TCANs) and other Smoke-Free ON Strategy partners to plan, implement and evaluate comprehensive health promotion strategies.

Internally at the Middlesex-London Health Unit the SW TCAN works collaboratively with the Chronic Disease Prevention and Tobacco Control Team as well as the and Healthy Communities and Injury Prevention Team, Child Health Team, Young Adult Team and Oral Health team. The TCAN coordinates activities regionally, but also acts as a resource internally to MLHU staff to help ensure coordination with other PHUs and partners provincially and eliminate duplication of efforts.

Key Partners and Stakeholders

Cancer Care Ontario- Indigenous Tobacco Program, Ontario Coalition for Smoke-free Movies, Smoke-Free Ontario Housing Coalition, Ontario Campaign for Action Against Tobacco, Provincial Young Adult Prevention Advisory Group, You Can Make It Happen Provincial Committee, Smokers' Helpline- Canadian Cancer Society, Telehealth Ontario, Ontario Lung Association, Heart and Stroke Foundation of Ontario, Ontario Tobacco Research Unit, Public Health Ontario, Federal Tobacco Program at Health Canada, and other TCANs.

Community Needs and Priorities

Prevention: The lifetime abstinence rate for males in the southwest 12-18 years is 87.1% (females 91.3%). This number drops drastically among males 19-24 to 54.7% (females 67.4%). (OTRU, 2016). According to the 2015 Smoke-Free Ontario Monitoring Report, among those aged 18 to 29 years, current smokers were more likely to: been born in Canada; Identified as white; be male; have unhealthy eating habits; drink in excess of the low-risk drinking guidelines; have been clinically diagnosed with a mood disorder; be inactive; work in sales, service, trades, transport, primary industry, and equipment operators' occupations; have no family doctor and have less than a high school education. There is substantial evidence that the use of vapour products by youth increases their risk of initiating cigarette smoking over time. The role that vapour products play in initiating cannabis use among youth is unclear, however, 28% of those who had used cannabis in 2017 reported using a vaporizer to consume cannabis, including 33% of youth aged 15 to 24 yrs. **Cessation:** The SW TCAN continues to grow in population and has a population of 1,544,269 in 2011 according to Census Canada. Overall, southwest region has a higher rate of current smoking compared to the overall Ontario average, with five public health unit regions currently experiencing higher than Ontario rates of current smoking (CCHS, 2009). Current Smoking Prevalence for those ages 12+ in the SW TCAN is 20.1% (CCHS, 2009). 65% of current smokers in Ontario intend to quit within the next six months (CTUMS, 2012). Of the percentage of people who smoke and recent quitters the age group with the highest percentage of quit attempts was 15-19, followed by 20-24. Quit attempts generally decreased with age (CTUMS 2010), Propel 2012). Ontarians 18+ were advised by their physician (57%), dentist (45%) to quit smoking. (CTUMS, 2012) According to CTUMS, in 2012 only 57% of physicians advised individuals to reduce or quit smoking; and only 45.4% indicated that their dentist had advised them to reduce or quit smoking. **Protection:** 26% of working Ontarians are exposed to second-hand smoke at work. This number is highest among blue collar workers, where 36.9% report workplace exposure. (OTRU, 2012) Smoke-free Ontario Scientific Advisory Group (2010) & MLHU Building the Case for Smoke-Free Public Outdoor Spaces: Technical Report. (November, 2011) At this time, the specific chemical exposure(s) associated with vaping remains unknown. There is an assortment of e-cigarette-related short- and long-term health effects in the lungs.

Target and Priority Populations

Those living in multi unit housing, individuals who work in blue collar workplaces, alternative youth and young adults, particularly young adult males, and those that are inequitably burdened with higher rates of tobacco addiction including those living with low income, those living with mental illness, and members of the LGBTQ community.

Intended Program Outcomes	
Long-Term / Population health	• To decrease tobacco-related disease and death in Southwestern, Ontario • Decrease disease and death from the use of tobacco and emerging products (vapour products, water pipe, cannabis, heat-not-burn, etc.) by preventing and delaying the initiation of use • Decrease disease and death from chronic diseases in SW ON through reduced exposure to second-hand smoke from tobacco • Reduce exposure to vapour and e-cigarette use to normalize a smoke-free and vapour-free culture. • Reduce tobacco and vapour product promotion and product accessibility
Intermediate	• Increase number of quit attempts by residents in the SW TCAN region • Increase intentions to quit smoking/vaping • Increase compliance with the Smoke-Free Ontario Act, 2017 in the SW TCAN region • Increase nicotine abstinence rates for YA Males in the SW TCAN
Short-Term	Cessation: By the end of 2020 the SW TCAN will increase the number of individuals who have registered for a provincial contest and made a quit attempt as compared to data from 2019. • By the end of 2020 there will be an increase in knowledge and confidence implementing BCI among 200 healthcare and / or social service providers across the SW TCAN. Promotion: By the end of 2020 the evaluation for the young adult Dog and Tom health promotion campaign will be launched to measure impacts in 2019/2020. • To increase brand exposure of Uprise among alternative youth aged 13-18 years surveyed in SW/CW ON's • By the end of 2020 we will see an increased number of endorsements to the ON Coalition for Smoke Free Movies by organizations in the SW TCAN region. Protection: Increase in the number of inquiries / complaints in 2020 over 2019 • Increase # of complaints and inquiries to SW TCAN complaint website for SOFA, 2017 infractions in the workplace.

Program Interventions		
1	Tobacco Protection- Policy enforcement	SW TCAN workplace kit will be provided to 100% of complaints in the SW TCAN to ensure consistent enforcement of the *SFOA, 2017.* 200 proactive inspections will be completed in the SW TCAN region in 2020 by the 8 health units within the TCAN region. Implement a campaign in October (during Canada's Healthy Workplace Month) to provide education to workplaces regarding the *SFOA, 2017* . Goal will be to increase awareness and compliance with the Act.
2	Tobacco Protection- Coalition building	SW TCAN Manager chairs the Smoke-Free Housing Ontario Coalition and the SW TCAN admin assists with maintaining the provincial website.
3	Tobacco Protection- Health promotion programming	SW TCAN Multi Unit Housing kit will be provided to 100% of complaints in the SW TCAN to ensure consistent enforcement of the SFOA, 2017. 200 proactive inspections will be completed in the SW TCAN region in 2020 by the 7 health units within the TCAN region. Implement a campaign in October (during Canada's Healthy Workplace Month) to provide education to workplaces regarding the SFOA, 2017. Goal will be to increase awareness and compliance with the Act.
4	Tobacco Cessation- Health Care Provider Outreach	Healthcare Provider – You Can Make It Happen (YCMIH) YCMIH is a provincial campaign that aims to build capacity among health care providers and social service providers to implement brief contact interventions with their clients/patients. SW TCAN Manager is a member of the provincial You Can Make It Happen committee. Committee uses common materials and a website to support health care providers (HCPs) to promote cessation using best practice evidence. The TCAN will reach out to at least 200 health care/social service providers with training and supports to enhance their capacity to provide BCI to their clients/patients. SW TCAN will work collaboratively with YCIM committee and TCAN partners to develop provincial resources to avoid duplication across the province.

5	Tobacco Cessation- Provincial Public Educational Opportunities - Social marketing	In collaboration with the other TCANs and provincial cessation partners, the SW TCAN will work with member PHUs to promote and disseminate new and existing cessation supports to promote quit attempts, including: Personal Quit Stories, WouldURather and CCS - First Week Challenge (if funded in 2020), TeleHealth cessation services, National Non-Smoking Week, and World No Tobacco Day. Regional collaboration is intended to avoid duplication and increase the number of quit attempts, using earned media, social media platforms and mass media channels.
6	TCAN Leadership	SW TCAN Manager chairs the SW TCAN Steering Committee for monthly for knowledge exchange and decision making. SW TCAN YDS chairs the Youth Prevention Subcommittee. TCAN Facilitates Cessation, Enforcement and Tobacco-Free Spaces and Policy Subcommittees to meet by-monthly to implement regional initiatives and engage in knowledge exchange. TCAN Manager and YDS meet by weekly with the other TCAN staff from the 6 other TCANs in ON to ensure provincial collaboration. Both the SW TCAN Manager and YDS are members of multiple provincial committees that guide the implementation of provincial work being done by the partners working in tobacco control in Ontario. The SW TCAN staff work in collaboration with other TCAN staff to ensure communication and collaboration with other SFO partners to assist with provincial collaboration between organizations.
7	Tobacco prevention- Young Adults	Collaborate with the Provincial Young Adult Prevention Advisory Group for KE&T regarding effective comprehensive approaches to reduce tobacco use among Ontario young adults. The SW TCAN will continue to implement a health promotion strategy in the SW TCAN called Dog and Tom. The stagey aims to educate YA men about the benefits to remaining tobacco free and to provide cessation tips in a culturally and age appropriate way. The strategy encompasses an online presence mixed with in person experiential events across the SW TCAN region. Other TCANs will be invited to patriciate in 2020.
8	Prevention – Smoke-Free Movies	The TCAN Manager co-chairs the Ontario Coalition for Smoke-Free Movies and the YDS is also a member. Through collaboration with provincial partners the TCAN will use common materials and activities that promotes www.smokefreemovies.ca to increase awareness about the issue of smoking in the movies. The TCAN will also endeavor to work with youth serving organizations to create policy to prevent movies with smoking in them to be shown to young people. Additionally, the TCAN will look to increase the number of organization in the region that have endorsed the coalition.

9	Tobacco Prevention- Uprise	In previous years the South West (SW) and Central West (CW) Ontario Tobacco Control Area Networks have worked to plan, implement and evaluation a provincial wide social identities imitative called Uprise. In 2019 the Uprise evaluation found the Uprise project provided a protective factor to the target audience. The project targeted Alternative Youth who are 2.3X more likely to use tobacco products as compared to the average teen. In 2020 the SW and CW TCAN will continue to update the Uprise website and social media account in while exploring the future of the project.
10	Prevention- Vaping	The SW TCAN will work with the provincial vaping prevention committee to ensure provincial collaboration and develop a joint health promotion strategy. A resource hub will be developed, and policy subgroups will potentially develop policy at youth serving organizations as an example and the group will look at developing provincial resources.

Performance / Service Level Indicators

Indicator	2018	2019	2020 (target)
# of multi unit housing (MUH) properties that adopt a smoke-free policy	98	4 *as of July 31, 2019	Increase by 20 new properties
Proportion of males 19-24 yrs. old who live in the SW TCAN region who have reported a lifetime abstinence from tobacco products.	58.2% *note ON was 57.9% CCHS, 2015/6	48.7% *note ON was 62.6% CCHS, 2017	Increase
Proportion of alternative youth aged 13-18 years surveyed in SW/CW ON exposed to the Uprise campaign who are more likely to show negative attitudes toward the tobacco industry	N/A Evaluation done every other year	79% of alternative youth aware of Uprise VS 68% unaware *Uprise 2019 evaluation	Project Ending
% of people who are aware that the more youth see smoking in movies the more likely they are to start	73% (using Carrot)	*Carrot defunded	N/A
# total of Health Care Providers who are members of the cessation community of practice in each of the 9 TCAN health units	389	415 *as of July 31, 2019	Increase by 20 new members
% of students in ON (grades 7 - 12) who reported using an e-cigarette for the first time in the last twelve months (OSDUHS)	10.7% *OSDHUS 2017 ON	10.7% OSDHUS 2017 ON	Decrease

Highlights / Initiatives Planned for 2020

• Young Adult Male campaign (18 to 24 yrs.) will be continued across SW TCAN and hopefully expanded to other TCANS to prevent tobacco use initiation and “prevescalation”
• Plans to work with other TCANs and provincial partners to collaborate on a provincial hub for smoking cessation services in ON
• Plans to work with other TCANs and provincial partners to collaborate on a comprehensive vaping strategy

Program Challenges and Risks

• The *SFOA, 2017* includes the prohibition of use of cannabis (medical and non-medical) and the use of e-cigarettes in all places where tobacco use is already banned. The TCANs role has been expanded in the last couple years to include work on electronic cigarettes, but it is unclear if TCAN staff should expand their scope to include cannabis. As Cannabis is included in the *SFOA 2017,* discussions regarding enforcement issues are taking place at the TCAN Enforcement Subcommittee.

Staffing Complement

	2019 Total FTEs	2020 Total FTEs	Δ
Manager	1.00	1.00	0.00
Program Assistant	0.40	0.40	0.00
Regional Youth Specialist	1.00	1.00	0.00
Director	0.00	0.09	0.09
Total Program FTE	***2.40***	***2.49***	***0.09***

Expenditures					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 187,796	$ 204,743	16,947	9%
Benefits		$ 45,181	$ 48,049	2,868	6%
Expected Vacancies		$ -		-	
Travel		$ 5,000	$ 5,180	180	4%
Program Supplies		$ 158,243	$ 158,488	245	0%
Board Expenses		$ -		-	
Staff Development		$ 1,500	$ 1,641	141	9%
Occupancy		$ -		-	
Professional Services		$ 38,780	$ 39,005	225	1%
Furniture & Equipment		$ -	$ 59	59	
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ -	$ 68	68	
Total Expenditures	***$ -***	***$ 436,500***	***$ 457,233***	***$ 20,732***	***5%***

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ -	$ 351,310	351,310	
MOHLTC (100%)		$ 436,500		(436,500)	-100%
MCCSS		$ -		-	
PHAC		$ -		-	
PHO		$ -		-	
User Fees		$ -		-	
Other		$ -	$ 105,923	105,923	
Total Revenues	***$ -***	***$ 436,500***	***$ 457,233***	***$ 20,732***	***5%***

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Tobacco Control and Electronic Cigarettes				477
Standard	Substance Use and Injury Prevention	**Director Name**	Maureen Rowlands	
Lead Team	Chronic Disease Prevention and Tobacco Control	**Manager Name**	Linda Stobo	
Supporting Team(s)				
Budget	$ 892,858	**FTE**	8.54	

Summary of Program

The Tobacco Control and Electronic Cigarettes Program aims to address the burden of tobacco, nicotine and vapour product addiction within Middlesex-London. Tobacco remains the leading cause of preventable disease and death in Canada. Electronic cigarettes (vapour products) have become widely available, are extensively promoted/marketed by the industry, and are growing in popularity, especially among youth and young adults. Vapour products expose users to harmful toxins, including cancer-causing chemicals, diacetyl, volatile organic compounds, heavy metals, and ultrafine particles that can be inhaled deeply into the lungs. These substances have been linked to increased cardiovascular and non-cancer lung disease. Program interventions focus on education and dissemination of evidence-based information, creating supportive environments, partnership and capacity building, policy development, the provision of cessation services to priority populations, and policy enforcement (S*moke-free Ontario Act, 2017* and municipal smoke-free/vapour-free bylaws).

The program aims to:

• Prevent the initiation of tobacco use and to prevent the initiation of use of vapour products
• Increase the number of people who quit smoking
• Protect people from exposure to second-hand smoke and vapour
• Reduce exposure to the use of vapour and tobacco products to normalize a smoke-free and vapour-free culture
• Counter tobacco and vapour product industry marketing with evidence-informed strategies to increase knowledge of the dangers of tobacco use and the potential risks associated with vapour product use.

** Traditional tobacco use is a sacred and cultural practice for many Indigenous peoples in Canada. For the purposes of this program description, when tobacco is named, it references commercial tobacco products and related harms, unless sacred or traditional tobacco use is clearly specified.*

Program Mandate & Relevant Legislation

Ontario Public Health Standards: Substance Use and Injury Prevention Standard, Chronic Disease Prevention and Well-Being, School Health

OPHS Protocols and Guidance Documents: Tobacco, Vapour and Smoke Protocol, 2018; Tobacco, Vapour and Smoke Compendium (Confidential Enforcement Guideline); Tobacco, Vapour and Smoke Guideline, 2018; Substance Use Prevention and Harm Reduction Guideline, 2018; Chronic Disease Prevention Guideline, 2018

Legislation: *Smoke-Free Ontario Act, 2017* (*SFOA, 2017*) and Ontario Regulation 268/18; The City of London, the Municipality of Strathroy-Caradoc and the Township of Lucan-Biddulph tobacco, vapour and smoke-related bylaws; The Municipal Act, 2001; The Residential Tenancies Act, 2006; Tobacco and Vaping Products Act (Federal)

Other: Training documents and guidelines provided by Ministry of Health to provide Enforcement oversight and guidance

Program Management

The Chronic Disease Prevention and Tobacco Control Team works collaboratively with members of the Southwest Tobacco Control Area Network Team to implement regional tobacco control and e-cigarette program priorities within the Middlesex-London community and across the seven Tobacco Control Area Networks (TCANs). The Tobacco Control and E-Cigarettes Program Staff also work collaboratively to coordinate efforts and ensure alignment with the Alcohol and Cannabis Program. The Tobacco and E-Cigarette Program staff as tobacco and vapour product content consultants within the Health Unit, ensuring consistent messaging and the dissemination of best/promising practices or new evidence across the Health Unit for integration into Teams that work with specific target populations (e.g. Best Beginnings, Reproductive Health and the Early Years).They also work collaboratively with the Child Health and the Young Adult Teams to coordinate efforts within the school environment and with the Food Safety Program Staff to share information and to coordinate efforts pertaining to licensing inspections.

Key Partners and Stakeholders

City of London, County of Middlesex and the eight lower tier Municipalities, St. Joseph's Healthcare, London Health Sciences Centre, Middlesex Hospital Alliance, Southwest Community Care Access Centre, CCS- Smokers' Helpline, TeleHealth (smoking cessation), Canadian Mental Health Association, London Intercommunity Health Centre, Southwest Regional Cancer Program, the Centre for Addiction and Mental Health (partnership agreement in place), Ontario Coalition for Smoke-free Movies, Smoke-Free Housing Ontario Coalition, Western University, Fanshawe College, London Police Services, Middlesex County OPP, Strathroy-Caradoc Police Services, Ministry of Finance, Fire Prevention Officers, Ontario Campaign for Action Against Tobacco, Thames Valley District School Board, London Catholic District School Board, the seven Tobacco Control Area Networks and their health units, Health Canada Tobacco and Vaping Product Enforcement, Health Canada Cannabis Compliance Division, OPP Cannabis Unit, and Western University's HEAL Youth Advisory Council

Community Needs and Priorities

19.7% of adults (19+) in Middlesex-London (M-L) are current smokers (daily and occasional) (CCHS 2015/16). Youth (12 - 19 yrs.) smoking abstinence rate in Middlesex-London (never smokers) is over 98% (CCHS 2015/2016). The proportion of those aged 20–44 who were daily smokers was 17.9% in Middlesex-London; this was the age group with the highest rate of daily smoking. In 2013/14, 43.6% of the ML population of current smokers, both daily and occasional, indicated that they planned on quitting in the six months following the survey, and 13.7% said they planned on quitting in the next 30 days (CCHS). The proportion that said they were planning to quit was significantly lower than the province. 36.7% of the population of Middlesex-London reported that they had tried to quit smoking for at least 24 hours in the year prior to being asked in a survey in 2013/14. In 2014, young adult smoking prevalence in ON was 10% for those 18-19, 17% for those 20-24 and 23% for those 25-29 (OTRU, Feb 2016). Youth influenced by “alternative” and “hip hop” peer crowds are 2.3x more likely to use tobacco products than youth not influenced by these peer crowds (49.2% vs 18.6%) (TCAN FACI™ research). Youth prevention and young adult “prevescalation” remain priorities because most young adults initiate prior to age 19 and 95% of ever-daily smokers under age of 30 became daily smokers by age 21 (OTRU, Feb 2016). In CA, 49% of under-aged youth got them from a retail source (CTADS 2015).

Exposure to second-hand smoke in a public place such as bars, restaurants, shopping malls, and arenas was reported by 12.9% of the population in Middlesex-London in 2013/14. Lung cancer is the third leading cause of death in Middlesex-London from 2013 to 2015.

There are emerging concerns related to vaping-related short- and long-term health effects in the lungs; further scientific study is required. There is substantial evidence that the use of vapour products by youth increases their risk of initiating tobacco smoking over time. The role that vapour products play in initiating youth cannabis use is unclear, however, 28% of those who had used cannabis in 2017 reported using a vaporizer to consume cannabis, including 33% of youth aged 15 to 24 yrs. Youth and young adults are a priority for this program.

Target and Priority Populations

Current smoking rates were higher in lower socioeconomic groups in Middlesex-London. This relationship is not unique to Middlesex-London. As education level increases the proportion of people who were current smokers decreased. Those with less than a secondary school diploma had a significantly higher proportion of people who smoked daily (32.6%) compared to the proportion of people who smoked daily with a post secondary education (11.6%). There is also a trend of decreased daily smoking rates as income level increased. Those in the lowest income quintile showed a rate of 27.9% for daily smoking compared to 5.0% for those in the highest income quintile. Urban populations (20.9%) had more than twice the rate of current smoking compared to rural populations (8.7%) in Middlesex-London in 2015/16. Local vapour product use statistics are not currently available.

Target/Priority Populations include: those living in social housing; individuals who work in blue collar workplaces; children, youth and young adults; and, those that are inequitably burdened with higher rates of tobacco and nicotine addiction including those living with low income, those living with mental illness, members of the LGBTQ community, and Indigenous peoples.

Intended Program Outcomes	
Long-Term / Population Health	• Decrease tobacco-related disease and death in Middlesex-London through the provision of cessation services targeted to priority populations. • Decrease disease and death from the use of tobacco and emerging products (vapour products, water pipe, cannabis, heat-not-burn, etc.) by preventing and delaying the initiation of use. • Decrease disease and death from chronic diseases in Middlesex-London through reduced exposure to second-hand smoke from tobacco. • Decrease youth access to tobacco and vapour products in Middlesex-London . • Reduce exposure to vapour and e-cigarette use to normalize a smoke-free and vapour-free culture. • Reduce tobacco and vapour product promotion and product accessibility.
Intermediate	• Increase number of quit attempts by Middlesex-London residents. • Decrease availability of tobacco and e-cigarette products through retail licensing and retail density controls. • Increase intentions to quit smoking. • Reduce exposure to second-hand smoke and vapour through the enactment of policies, bylaws and provincial legislation. • Increase compliance with the *Smoke-Free Ontario Act, 2017* through vendor education and collaboration with enforcement agencies and city licensing/bylaw enforcement.
Short-Term	• Increase the number of quit attempts by tobacco users by increasing access to nicotine replacement therapy and pharmacotherapies, and increasing awareness of cessation services. • The provision of cessation counselling services and increased access to nicotine replacement therapy/aids to priority populations (e.g. low income, living with mental illness, LGBTQ, etc.). • Increase the number of policies and partnerships with school boards, post-secondary campuses and municipalities to promote tobacco-free, smoke-free and vapour-free cultures. • Increase municipal prohibitions on tobacco, vapour product and smoking product use to reduce exposure to second-hand smoke and vapour, and to reduce exposure to tobacco, vapour and smoking product use (e.g. smoke-free private market and social housing, 100% smoke-free property policies, bylaws that exceed provincial *SFOA, 2017*). • Increase the number of tobacco licensing and zoning measures to reduce tobacco and e-cigarette retail density in Middlesex-London.

Program Interventions		
1	Public Education and Promotion of Available Tobacco Cessation Supports	In collaboration with the SWTCAN Cessation Sub-Committee and provincial cessation partners, local Tobacco Control and E-cigarettes program staff locally promote and disseminate new and existing cessation supports to promote quit attempts, including: Personal Quit Stories, WouldURather and CCS - First Week Challenge (if funded in 2020), TeleHealth cessation services, National Non-Smoking Week, and World No Tobacco Day. Local efforts are intended to leverage regional/provincial collaborative efforts to increase the number of quit attempts, using earned media, social media platforms and mass media channels that reach the local community.
2	Provision of Quit Services to Priority Populations	Deliver behavioural interventions, combined with the provision of free nicotine replacement therapy to priority populations, including: LGBTQ; low income; individuals living with mental health challenges; outpatients and discharged patients from St. Joseph's Healthcare and London Health Sciences Centre (including London Regional Cancer Centre) through established referral mechanisms; residents in long-term care; and, clients referred from community health care partners. The Health Unit operates a Quit Clinic three days per week. In partnership with CAMH, the Health Unit delivers 8 to 10 STOP on the Road workshops annually. Clients are provided the option of becoming a rostered client with the Health Unit Quit clinic for ongoing support. To reach different priority populations and/or to complement smoke-free policy implementation (e.g. smoke-free hospital grounds, smoke-free university campus, workplace smoke-free grounds, etc.), the Health Unit offers STOP on the Road workshops off-site where policies are being implemented.
3	Partnership Building and Capacity Building	The provision of evidence-informed best practices for cessation, including the promotion of the 3 and/or 4As into healthcare practice so that clients are screened for tobacco/vapour product use at every point of entry into the healthcare system. The Tobacco Control and E-cigarettes program staff coordinate the Middlesex-London Cessation Community of Practice to facilitate knowledge exchange and capacity building within tobacco cessation healthcare champions. Participation in regional and provincial coalitions including the SWTCAN, the Ontario Coalition for Smoke-Free Movies, Smoke-free Housing Ontario Coalition and the provincial youth vaping collaborative to facilitate collaboration and to reduce duplication. Program staff are an integral part of the Health Unit's Positive Space Committee, participating in the Pride Festival, and intend to develop a LGBTQ+ tobacco and vaping strategy. Program staff are working with the Health Unit's Health Equity and Reconciliation Team to support local Indigenous Communities with a tobacco strategy.

4	Tobacco and Vapour Product Use Prevention/Prevescalation Health Promotion Strategies	Program staff work in collaboration with Western University's HEAL Youth Advisory Council to support the development of a by-youth for youth vaping prevention strategy within the ML community. In partnership with Southwest Public Health and shared local school boards, staff are working collaboratively to develop and implement a comprehensive youth vaping strategy to address the uptick in youth vaping and to address ongoing compliance issues inside schools and on school grounds, which includes policy development, youth and parental interventions, and social media/in-school prevention/curriculum supports (e.g. Use Your Instincts and NotanExperiment.ca). In partnership with the SWTCAN, program staff implement the Dog and Tom Young Adult Male tobacco health promotion strategy locally. Staff continue to take advantage of opportunities that arise to influence the development of healthy public policies that prevent product use, including marketing, retail availability, product packaging and product promotion through digital and on screen use.
5	Policy Development and Supportive Environments	Workplace Support: The distribution of the workplace kit and signage will occur through both proactive and complaint-based inspections. Hospital Policy Development Support: staff provide assistance and support to SJHC, LHSC and MHA as they implement 100% smoke-free/vapour-free hospital ground policies, troubleshooting challenges. Bylaw/Policy Development and Implementation Support: Program Staff support/promote the new obligations under the amended SFOA, 2017 to municipalities, workplaces, and agencies that operate community recreation facilities, and promote/influence the development of policies that exceed provincial protections (e.g. Upper Thames Conservation Authority). Housing: Collaborate with the Smoke Free Housing Ontario Coalition and fire prevention partners to use common materials and messages to support housing providers and tenants. School Board Supports: supporting the school boards in the implementation of their Tobacco-Free, Vape-Free and Cannabis-Free policy and code of conduct.
6	*SFOA, 2017* – Compliance and Enforcement	Tobacco and E-Cigarette Retailers: 2 rounds of youth access inspections annually and one round of DPH inspections, new operator education visits and workshops, and Licensing inspections (London). Workplaces/Public Places/Schools: complaint-based and proactive inspections of workplaces, public places, outdoor public spaces and schools. CSAs: two CSAs are inspected twice annually. Water pipe Sampling: annual sampling inspection of establishments. Joint Inspections: with London Police Services, AGCO, Ministry of Finance, City of London Bylaw Inspectors. Public Disclosure: Activities related to charge/court outcomes and the establishment/maintenance of systems for public disclosure. Registration of Tobacconists and Specialty Vape Shops: Activities related to the annual registration of tobacconists and specialty vape shops. Smoke-Free Information Line (phone and email) – staff triage calls, answer questions, and respond to complaints, referrals and requests for service.

Performance / Service Level Indicators			
Indicator	2018	2019	2020 (target)
% ML youth (aged 12 to 17 years) smoking abstinence rate (never smokers)	98.4% (2015/2016 data)	98.4% (2015/2016 data)	Increase
% of ML adults aged 19 years and older that are current smokers (daily or occasional)	19.7% (2015/2016 data)	19.7% (2015/2016 data)	Decrease
% of students in ON (grades 7 - 12) who reported using an e-cigarette for the first time in the last twelve months (OSDUHS)	10.7% (2017 ON)	10.7% (2017 ON)	Decrease
# of tobacco and e-cigarette retailers in Middlesex-London	E-Cigarette: 175 Tobacco: 296	E-Cigarette: 247 Tobacco: 285	Decrease
% of tobacco vendors in compliance with youth access legislation at last inspection	99.30%	100.00%	$\geq$ 90%
# of inspections of public places and workplaces	1355	1200 (target)	1200

Highlights / Initiatives Planned for 2020

• Ongoing promotion and enforcement of the *SFOA, 2017* will remain a priority, including collaborative work with school partners
• Discussions with municipal partners on the need to amend or enact municipal bylaws that exceed the protections provided under the new *SFOA, 2017* will continue
• Enact enhancements to the process employed for the completion of annual licensing inspections with tobacco and e-cigarette retailers – in support of the City of London Licensing Bylaw - to increase efficiencies
• The continued enhancement/evaluation of tobacco cessation services delivered by the Health Unit to reach priority populations will remain an priority, along with the transition to an electronic client record system
• The implementation of a by-youth for-youth vaping prevention strategy, in partnership with Western University's HEAL Youth Advisory Council is planned for Q1 and Q2 of 2020

Program Challenges and Risks

• The *SFOA, 2017* includes the prohibition of use of cannabis (medical and non-medical) and the use of e-cigarettes in all places where tobacco use is banned. The number of mandated inspections for tobacco and e-cigarette retailers, and the growing number of complaint-based inspections from vapour product use is expending current enforcement capacity. In 2018, 254 complaints and 290 inquiries were actioned; between Jan 1 and Nov 1, 2019, 460 complaints and 483 inquiries have been actioned.

• The legalization of cannabis is a shared responsibility between the Chronic Disease Prevention and Tobacco Control Team and the Healthy Communities and Injury Prevention Team. Program priorities and staff will need to remain flexible to respond to imposed legislative, social norm changes and the anticipated increase in call volume from complaints regarding exposure to drifting cannabis smoke.

• Between October 17th, 2018 and November 20th, 2019, 25 charges and 288 warnings were issued against youth for vaping inside schools and/or on school property; collaborative work with local school boards and the child and youth health teams remains critical.

Staffing Complement

	2019 Total FTEs	2020 Total FTEs	Δ
Health Promoter	1.00	1.00	0.00
Program Assistant	1.50	1.45	-0.05
Program Manager	0.40	0.40	0.00
Public Health Nurse	1.95	1.95	0.00
Test Shoppers	0.20	0.20	0.00
Tobacco Enforcement Officer	2.85	3.45	0.60
Youth Leaders	0.40	0.00	-0.40
Director	0.00	0.09	0.09
Total Program FTE	***8.30***	***8.54***	***0.24***

Expenditures					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 552,073	$ 613,664	61,592	11%
Benefits		$ 142,368	$ 156,284	13,916	10%
Expected Vacancies		$ -		-	
Travel		$ 14,468	$ 13,582	(885)	-6%
Program Supplies		$ 84,515	$ 78,538	(5,977)	-7%
Board Expenses		$ -		-	
Staff Development		$ 1,208	$ 1,260	52	4%
Occupancy		$ -		-	
Professional Services		$ 7,071	$ 6,775	(296)	-4%
Furniture & Equipment		$ -	$ 59	59	
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 24,426	$ 22,695	(1,731)	-7%
Total Expenditures	***$ -***	***$ 826,128***	***$ 892,858***	***$ 66,729***	***8%***

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 459,834	$ 892,858	433,024	94%
MOHLTC (100%)		$ 366,295		(366,295)	-100%
MCCSS		$ -		-	
CLIF Tobacco Enforcement			$ -	-	
PHAC		$ -		-	
PHO		$ -		-	
User Fees		$ -		-	
Other		$ -		-	
Total Revenues	***$ -***	***$ 826,128***	***$ 892,858***	***$ 66,729***	***8%***

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Violence Prevention						478
Standard	Substance Use and Injury Prevention		**Director Name**	Maureen Rowlands		
Lead Team	Healthy Communities and Injury Prevention		**Manager Name**	Rhonda Brittan		
Supporting Team(s)	Best Beginnings - Central / Nurse Family Partnership		Young Adult		Health Equity	
Budget	$ 346,225		**FTE**	2.91		

Summary of Program

During 2019 a situational assessment has been underway to identify program strengths/resources and gaps and identify priorities and interventions related to Violence Prevention. An intentional injury (or violence) is preventable and takes many forms including self, interpersonal (family /community violence) and collective. There is no one risk factor for violence, it occurs as a result of interactions between multiple factors across the social-ecological model. Forms of violence share similar risk factors and often overlap at the same time or across different stages of development. Prevention of violence should include not only primary prevention (reducing risk factors/enhancing protective factors) but secondary prevention (screening/immediate response) and tertiary prevention (long term response/trauma informed care). Population health interventions to reduce violence involve education and awareness, developing personal skills, addressing risk and protective factors, screening and referral, creating supportive environments and encouraging healthy public policy. Violence prevention programming is delivered across many teams to address the following: healthy prenatal /early childhood development, substance use, mental health, child / youth life skills, community connectedness and support, gender and cultural norms and victim supports / services. Target populations for universal information include: parents/caregivers, children & youth, schools, neighbourhoods / communities. Priority populations for violence are those at risk of being victims: females at all ages, males (non-family violence), LGTBQ2+, persons with a disability, new immigrants / refugees and indigenous. Individuals with multiple risk factors for more than one form of violence at even greater risk. Short-term outcomes include: increased awareness of the impact of risk and protective factors and health inequities associated with intentional injuries from multiple forms violence; increase staff awareness of the risk factors, indicators, and best practices related to IPV and available community resources available for individuals experiencing violence. Intermediate outcomes include: increased capacity among staff and community partners to act on factors associated with the prevention of violence-related injuries (i.e. healthy living behaviours, public policy, & creating supportive environments); increased capacity among staff to practice from a trauma –and violence-informed perspective. Long-term population health outcomes are to reduce the burden and decrease population health inequities related to intentional injuries resulting from violence.

Program Mandate & Relevant Legislation

• Substance Use and Injury Prevention Standard (OPHS, 2018)
• School Health Standard (OPHS, 2018)
• Injury Prevention Guideline, School Health Guideline Mental Health Guideline, Health Equity Guideline (OPHS 2018)
• MLHU Policy Intimate Partner Violence & Client Care (IPV-CC): Policy # 2-050
• MLHU Policy Child Abuse and / or Neglect and Duty to Report: Policy # 2-060
• MLHU Organizational Plan for Taking Action for Reconciliation
• World Health Organization World Report on Violence and Health (2002)
• Adverse Community Experiences and Resilience: Understanding, Addressing, and Preventing Community Trauma - Prevention Institute (2016)

Program Management

The Healthy Communities and Injury Prevention (HCIP) is leading a situational assessment to be completed in 2020 to identify violence prevention priorities and public health interventions going forward in 2020 and beyond. In addition to screening for Intimate partner violence (IPV), the following teams engage in violence prevention: Best Beginnings, Nurse-Family Partnership, Early Years and Reproductive Health Teams (focus on early healthy growth and development, parenting, healthy relationships, substance use and mental health); Child Health & Young Adult Teams (focus on life skills, bullying, mental health, substance use and work to create supportive environments); Sexual Health / Clinic Team (focus on promoting gender norms, healthy relationships, and substance use); Outreach Team (focus on connecting to services /supports, mental health, substance use); Health Equity and SDOH (focus on increasing staff capacity and changing cultural norms); and HCIP (also focuses on alcohol and other drugs). A Healthy Start manager acts as a liaison with CAS and updates the “Child Abuse and/or Neglect, and Duty to Report policy”. MLHU Intimate Partner Violence (IPV) & Client Care (CC) committee maintains IPV-CC policy.

Key Partners and Stakeholders

London Coordinating Committee to End Women Abuse (LCCEWA), Middlesex Rural Alliance Coordinating Committee to End Woman Abuse (MRACCEWA), Street Level Women at Risk, MLHU Indigenous Reconciliation Committee, Children’s Aid Society, London and Middlesex Local Immigration Partnership, London Police Person’s at Risk Coordinator, Muslim Resource Centre, Regional HIV & AIDS Connection, Regional Sexual Assault & Domestic Violence Treatment Centre, London Intercommunity Health Center, Southwest Ontario Aboriginal Health Access Centre, Nurse-Family Partnership Community Advisory Board, MLHU Intimate Partner Violence and Client Care (IPV-CC) Committee, Health Unit Violence Against Women Working Group

Community Needs and Priorities

In London in 2018, there were 3008 violent crimes reported to police, resulting in: 6 homicides, 4 attempted murders, 420 sexual assaults, 2288 assaults, 63 abductions, and 235 uses of an offensive weapon. (London Police 2018 Annual Report). Since 2014, the total # violent crimes have increased over time, except for a decrease in 2017. For Middlesex County in 2016, there were 194 violent crimes resulting in: 1 attempted murder, 24 sexual assaults, 131 assaults, 2 abductions, and 36 "other" crimes against another person. Since 2014, the total # of violent crimes increased in 2015, with a slight decrease in 2016 (OPP Middlesex Detachment 2016 progress report).

With regards to police reported family violence in London, the rate of child and youth victims was 156 per 100,000, while the rate of older adult victims was 36 per 100,000; slightly lower than the Ontario average. The rate of victims of intimate partner violence is 254 per 100,000, which is slightly higher than the Ontario average (Statistics Canada, 2017). Family violence is known to be underreported.

For assault-related injury visits to the emergency department, the rate has been increasing since 2015 and was 325.6 per 100,000 in 2017, higher than Ontario (MLHU Community Health Status Resource (CHSR)).

Of Middlesex-London grade 9-12 students, 17% were bullied, while 9% had bullied other students in the previous month. Specifically, 13% were verbally attacked, 5% were cyber-bullied, and 3% were physically attacked (COMPASS, 2016-2017). A lower % of students on average across Ontario reported physical attacks (1%), while all other bullying measures reported were numerically lower in M-L than Ontario averages (OSDUHS, 2019). There have been recent media reports re school violence and possible underreporting (CBC London, 2019).

Overall, one in five London residents either strongly or somewhat agree that the crime rate in their neighbourhood makes it unsafe to walk at night (Statistics Canada, 2015).

71.5% of Middlesex-London residents reported a very or somewhat strong sense of community belonging in 2015/16 (MLHU CHSR) which reflects social engagement and participation within communities, and often translates to lower rates of violence. It is also associated with more positive physical and mental health. Similarly, 78% of high school students in M-L reported feeling that they are a part of their school, 76% close to people at school, 86% feeling safe at school (COMPASS, 2016-2017).

Target and Priority Populations

Target populations for universal information include: parents/caregivers, children & youth, schools, neighbourhoods / communities.

Priority populations for violence are those at risk of being victims: females at all ages, males (non-family violence), LGTBQ2+, persons with a disability, new immigrants / refugees and Indigenous. Those at risk of being perpetrators are males (PHAC, Stats Canada; MLHU Community Health Status Resource). Additionally, if these individuals have multiple risk factors for more than one form of violence, they are at even greater risk of being victims or perpetrators of violence. These risks can factors include: witnessing violence; history of violent victimization; poor mental health; substance use; low neighbourhood support and cohesion; history of homelessness / residential instability; poor family relationships and lack of parental involvement; association with delinquent peers; social isolation; lack of non-violent problem solving / poor impulse control; family conflict; community violence; cultural norms that support violence and gender norms (WHO, 2002; PHAC, 2016; CDC, Connecting the Dots; MLHU Community Health Status Report).

Intended Program Outcomes	
Long-Term / Population Health	• To reduce the burden of preventable injuries resulting from violence. • To decrease population health inequities related to intentional injuries resulting from violence
Intermediate	• Increased capacity among staff and community partners to act on factors associated with the prevention of violence-related injuries (i.e. healthy living behaviours, public policy, & creating supportive environments) • Increased capacity among health unit staff to practice from a trauma –and violence-informed perspective • Increased capacity among health unit staff that provide direct client care to identify and respond to intimate partner violence • Increased capacity among individuals experiencing intimate partner violence to increase their own safety, and when applicable, the safety of their children
Short-Term	• Increased awareness among health unit staff and community partners of the impact of risk and protective factors associated with intentional injuries resulting from multiple forms of violence • Increased awareness among health unit staff and community partners of the health inequities related to intentional injuries resulting from multiple forms of violence • Increase awareness among health unit staff about the risk factors, indicators, and best practices related to IPV • Increased awareness among health unit staff of available community resources available for individuals experiencing or who have experienced violence • Increased awareness among individuals and families of the characteristics of abusive vs healthy relationships and the health effects of exposure to violence

Program Interventions		
1	Education and Awareness	MLHU website contains information related to: abuse (domestic violence, sexual assault, child and elder), healthy prenatal / early growth and development, parenting, bullying, substance use, healthy relationships, homophobia, mental health etc. Information is also available for healthcare providers. Reproductive Health provides information for preconception and healthy prenatal growth & development through the Prenatal Immigrant Program, Prep for Parenthood (P4P), Smart Start for Babies and other initiatives. Early Years is working towards a common parenting philosophy with the Early Years' partnership & collaborative. Provides information related to healthy growth and development in the early years, for families and community partners via social media. Child Health and Young Adult teams develop curriculum supports related to mental health, bullying, substance use and healthy sexuality including consent. Information also disseminated through social media and through events and health walls at schools.
2	Screening and Referral	All staff that provide direct client care engage in selective screening and/or case-finding assessments for IPV and provide appropriate referrals as needed.
3	Address Risk and Protective Factors	As part of program work, staff also screen for risk factors and enhance protective factors. Reproductive Health screen for alcohol use, mental health, housing, immigrant status, and supports. Provide support through Prenatal Immigrant Program and Smart Start for Babies. Can refer to HBHC and NFP. Best Beginnings & Nurse Family Partnership (NFP) Teams screen for substance use, mental health, housing stability, social supports, newcomer status, and capacity to care for child. Home visiting, support, and referrals provided. Early Years Team screen for mental health. Support provided through healthy start drop-ins, Precious Moments and Indigenous Prenatal programs. May refer to HBHC. Outreach Team assesses for housing, income, and supports and connects to appropriate services. Young adult team provides individual supports for healthy sexuality, life skills, mental health, and bullying. Can refer to Smart Start for Babies and NFP.

4	Supportive Environments	Health Equity and SDOH team lead the MLHU Indigenous Reconciliation Plan with the Reconciliation working group and lead Indigenous Cultural training; increasing health equity knowledge and capacity among staff. Newcomer service coordination across agency. Sexual Health provides “Positive Space” training for staff, encourages organizations / community partners to offer inclusive services, and provides information related to healthy relationships/sexuality through presentations upon request. Child Health and Young adult team PHN’s provide supports to school administration through situational supports and school action plans. Healthy Communities & Injury Prevention (HCIP) Team provides support and resources for MLHU staff related to alcohol and other drugs, encourages healthy community design that supports community connectedness and safety (perceived and objective), and participate in neighbourhood safety audits. Organizationally, working to increase staff capacity in Trauma and Violence Informed practice.
5	Develop Personal Skills	The Best Beginnings and Nurse-Family Partnership Teams provide home visits to pregnant women and families with young children. Topics addressed during home visits include healthy growth and development, positive parenting, healthy relationships, substance use and mental health. Nursing interventions for clients experiencing intimate partner violence focus on building maternal agency related to enhancing safety for self and children – i.e. reviewing options; developing safety plans; engaging in system navigation; building circles of support. Outreach Team also engages in safety planning for clients that may not be related to IPV.
6	Healthy Public Policy	Identify and act on policy windows and priorities related to violence prevention as appropriate

Performance / Service Level Indicators

Indicator	2018	2019	2020 (target)
# of trainings to support implementation of Intimate Partner Violence and Client Care policy	N/A	New Indicator 1	5
# of Neighbourhood Community Safety Audits that MLHU staff participated in	N/A	New Indicator 1	Involvement based on neighbourhood identified need
Additional indicators to be determined on completion of situational assessment	N/A	N/A	N/A

Highlights / Initiatives Planned for 2020

Organizational focus on trauma-and violence-informed care.

The situational assessment will be completed in 2020 with recommendations to further determine priorities related to violence prevention interventions.

Program Challenges and Risks

Dedicated staff time will be needed to complete situational assessment and further determine and coordinate priorities and interventions related to violence prevention

Data at the local level is limited, especially for some priority populations. Indicators for violence prevention can be difficult to determine and report on as interventions related to violence prevention are often not specifically related to violence.

Staffing Complement

	2019 Total FTEs	2020 Total FTEs	Δ
Public Health Nurse	0.20	2.30	2.10
Director	0.00	0.11	0.11
Program Manager	0.00	0.50	0.50
Total Program FTE	***0.20***	***2.91***	***2.71***

Expenditures					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 17,050	$ 264,791	247,741	
Benefits		$ 3,660	$ 62,947	59,288	
Expected Vacancies		$ -		-	
Travel		$ 223	$ 3,482	3,260	
Program Supplies		$ 495	$ 2,820	2,324	
Board Expenses		$ -		-	
Staff Development		$ 105	$ 917	812	
Occupancy		$ -		-	
Professional Services		$ 103	$ 7,954	7,851	
Furniture & Equipment		$ 11	$ 2,632	2,621	
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 77	$ 681	604	
Total Expenditures	***$ -***	***$ 21,724***	***$ 346,225***	***$ 324,501***	

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 21,724	$ 137,893	116,169	535%
MOHLTC (100%)		$ -		-	
MCCSS		$ -	$ 208,332	208,332	
PHAC		$ -		-	
PHO		$ -		-	
User Fees		$ -		-	
Other		$ -		-	
Total Revenues	***$ -***	***$ 21,724***	***$ 346,225***	***$ 324,501***	***1494%***

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Seniors Dental				479
Standard		**Director Name**	Maureen Rowlands	
Lead Team	Oral Health	**Manager Name**	Donna Kosmack/Misty Golding	
Supporting Team(s)				
Budget	$ 2,455,451	**FTE**	8.38	

Summary of Program

The overall goal of the Ontario Seniors Dental Care Program (OSDCP) is to enable an increased proportion of low-income seniors to have optimal oral health. The program achieves this by requiring Public Health Units to support awareness of, access to, and utilization of the OSDCP.

Program Interventions include:
- OSDCP Promotion
- Clinical Services
- Client Navigation

Program Mandate & Relevant Legislation

Chronic Disease Prevention and Well-Being Standard (2018)

Oral Health Protocol (2019)

Program Management

The OSDCP is managed by the Oral Health Team.

Key Partners and Stakeholders

London Cross Cultural Learning Centre, Healthcare providers including physicians, nurses, gerontologists and others, Dental Providers including dentists, denturists, oral surgeons, periodontists and others London Intercommunity Health Centre, London District Dental Society, Western University's Adult Dental Clinic, Fanshawe College - Dental Hygiene Program, Southwest Ontario Aboriginal Health Access Centre, Seniors Centres, Recreational Centres, City of London, London Community Dental Alliance, Seniors Home Care, Seniors Community Centres, Seniors Fitness Centres, Recreation Centres, Long Term Care Homes

Community Needs and Priorities

In 2013/14, only 64% of families living in Middlesex-London had dental insurance. 71% of families reported visiting a dentist within the last year. 46% of families reported having oral or facial pain within the last month.
Using the 2016 Census, based on LIM after tax, 8,375 low-income seniors 65 years and older may be eligible for the OSDCP based on the income threshold identified by the government ($19,300/individual senior or $32,300/couple).
ICES estimated that 5,665 seniors from the city of London and 897 seniors from Middlesex County received the Ontario Drug Benefit program in 2018 (Total = 6,562).
The Ministry of Health has estimated Middlesex London to have 3,300 eligible seniors per year for the OSDCP.

Target and Priority Populations

Low-income seniors 65 years and older who have an individual income below $19,300 or household income below $32,300.

Intended Program Outcomes

Long-Term / Population Health	To improve the oral health status of low-income seniors.
Intermediate	To increase access to oral health services for low-income seniors.
Short-Term	To increase awareness of oral health services to low-income seniors.

Program Interventions		
1	OSDCP Promotion	MLHU promotes the OSDCP to internal and external stakeholders including clients, community partners and health care providers.
2	Clinical Services	A Dentist, with the support of a Certified Dental Assistant, provide dental treatment services such as fillings, root canals, extractions and other services to eligible seniors. A Registered Dental Hygienist, with the support of a Certified Dental Assistant, provide preventive services such as dental cleaning, fluoride application and oral health education to eligible seniors. Dental treatment and preventive services are provided at the health unit Dental Clinic on a daily basis. The number of services provided is reported to the Ministry of Health as per the Oral Health Protocol (2019).
3	Client Navigation	The Oral Health Team will support low-income seniors by: • Improving their oral health knowledge and awareness of oral health services • Assisting seniors to enroll in the OSDCP • Assisting seniors with finding a dental provider, accessing and initiating treatment as needed, and assisting with the establishment of a dental home • Increasing awareness of available oral health services among community partners and providers • Utilizing referral networks in order to assist seniors in finding a preferred dental provider and accessing oral health services

Performance / Service Level Indicators			
Indicator	2018	2019	2020 (target)
# of seniors who received treatment services	N/A	N/A	First year of program- no targets set yet
# of seniors who received preventive services	N/A	N/A	First year of program- no targets set yet
# of seniors who received dentures	N/A	N/A	First year of program- no targets set yet
# of seniors who required treatment by an oral surgeon	N/A	N/A	First year of program- no targets set yet
# of seniors required endodontic treatment	N/A	N/A	First year of program- no targets set yet
# of seniors who OH team assisted with registration	N/A	N/A	First year of program- no targets set yet

Highlights / Initiatives Planned for 2020

Implementation of new program and interventions.

Program Challenges and Risks

MLHU Dental clinic will be relocating in March/April 2020 in conjunction with the health unit relocation. Until such time a DDS will not be in place to offer treatment services to seniors.

Staffing Complement			
	2019 Total FTEs	2020 Total FTEs	Δ
Director	0.00	0.10	0.10
Dental Hygienist	0.00	2.31	2.31
Dental Assistant	0.00	2.97	2.97
Dentist	0.00	1.50	1.50
Bus Driver	0.00	1.00	1.00
Program Manager	0.00	0.50	0.50
Total Program FTE	***0.00***	***8.38***	***8.38***

Expenditures					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages			$ 755,862		
Benefits			$ 185,644		
Expected Vacancies					
Travel			$ 10,000		
Program Supplies			$ 120,000		
Board Expenses					
Staff Development			$ -		
Occupancy			$ 100,000		
Professional Services			$ 400,000		
Furniture & Equipment			$ 783,945		
Contributions to Reserves					
Other Agency Costs					
Other Program Costs			$ 100,000		
Total Expenditures	***$ -***	***$ -***	***$ 2,455,451***		

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)			$ -		
MOHLTC (100%)			$ 2,455,451		
MCCSS					
PHAC					
PHO					
User Fees					
Other					
Total Revenues	***$ -***	***$ -***	***$ 2,455,451***		

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Drinking Water					480
Standard	Safe Water		**Director Name**	Stephen Turner	
Lead Team	Safe Water, Rabies and Vector-Borne Disease		**Manager Name**	Andrew Powell	
Supporting Team(s)	Oral Health				
Budget	$ 194,910		**FTE**	1.62	

Summary of Program

Drinking Water Program aims to prevent/reduce the burden of water-borne illness related to drinking water in Middlesex-London. The target population is the people living in Middlesex-London. Key interventions of the Drinking Water Program include responding to Adverse Water Quality Incidents (AWQIs) in regulated systems; issuing Drinking/Boil Water Advisories when needed; conducting water haulage vehicle inspections; providing resources (test kits and information) and guidance to private well owners; and shipping private well water samples to the Regional Public Health Laboratory for testing.

Program Mandate & Relevant Legislation

Safe Water Standard
Safe Drinking Water Act
O. Reg. 170 (Drinking Water Systems)
O. Reg. 243 (Schools, Private Schools and Child Care Centres)
Infectious Diseases Protocol, 2018
Population Health Assessment and Surveillance Protocol, 2018
Safe Drinking Water and Fluoride Monitoring Protocol, 2018

Program Management

The Drinking Water Program is managed by the Safe Water, Rabies and Vector-Borne Disease Team. The Oral Health Team receives reports from the municipal water system operators and monitors fluoride levels. In case of an AWQI, the Safe Water, Rabies and Vector-Borne Disease team collaborates with the Oral Health team to issue an advisory.

Key Partners and Stakeholders

Ministry of Health and Long-Term Care, Public Health Ontario, Ministry of the Environment, Conservation and Parks, City of London, Middlesex County, City of London Library, Middlesex County Library, Township of Adelaide Metcalfe, Township of Lucan Biddulph, Municipality of Middlesex Centre, Municipality of North Middlesex, Municipality of Southwest Middlesex, Municipality of Strathroy-Caradoc, Municipality of Thames Centre, Village of Newbury

Community Needs and Priorities

Historical data shows that there have been over 100 AWQIs every year and public health interventions support/guide the operators in taking necessary steps to remediate those incidents.

Local Priorities

- In the councilor survey for the Middlesex County Report, 100% of respondents indicated that it is important for MLHU to focus on safe water.
- Key informants noted that the well water drop-off sites are a valuable service to Middlesex residents.
- Municipal lead testing continues to be a priority for municipal staff and residents within the City of London. Supportive documentation and educational materials will be distributed to affected property owners, public inquiries, and partner agencies.

Target and Priority Populations

The Drinking Water program serves three different population groups: General public, private well water owners and users, and children in child care centres and schools.

Rural community residents often face a variety of access barriers to services. The MLHU has been working closely with the stakeholders in rural areas to reduce the barriers for rural residents. The MLHU's enhanced private well water program stemmed from the need to enhance services in Middlesex County.

Children in child care centres and schools are among the susceptible populations and unsafe drinking water would affect their health significantly.

Intended Program Outcomes	
Long-Term / Population Health	To prevent or reduce the burden of water-borne illnesses related to drinking water
Intermediate	• To use local data to develop services related to safe drinking water. • To address the identified needs of the community, including priority populations, associated with safe water. • To respond to drinking water contaminants and illnesses, their associated risk factors, and emerging trends, including levels of fluoride outside the recommended range. • To mitigate water borne illness risks related to unsafe drinking water • To raise awareness among members of the public who use private drinking water system to safely manage private drinking water systems • To ensure the public is aware of drinking water safety, including the potential risk of illnesses related to unsafe drinking water
Short-term	• To conduct surveillance of adverse water quality • To conduct surveillance of fluoride levels. • To respond to adverse water quality incidents within 24 hours • To contact private citizens who operate their own private drinking water supplies when their test results are not satisfactory and offer guidance on the phone and on site when needed. • To increase testing of private well water in Middlesex-London region

Program Interventions		
1	Monitor adverse water quality incidents	• Monitor private well water testing information received from the PHO labs every business day • Partner with the FoodNet program for enhanced surveillance on private wells in Middlesex-London • Receive the adverse water quality incident notification from the operator or laboratory
2	Monitor fluoride levels in water	• The Oral Health Manager monitors fluoride levels in water and contacts Safe Water, Rabies and VBD team when there is an AWQI
3	Inspect water haulage vehicles	• Public Health Inspectors inspect water haulage vehicles regularly

4	Respond to adverse water quality incidents	• Issue Drinking/Boil Water Advisories as needed • Notify and discuss adverse water results with private well owners
5	Public Education & Awareness	• Provide test kits for private well-owners across Middlesex-London region • Provide water depots for test kit drop off and pick up • Arrange for transportation of test kit sample to the PHO lab • Disseminate new educational materials for private well owners • Conduct communication campaign to encourage residents to test their private well water • Use of social media and local newspapers to raise awareness for testing

Performance / Service Level Indicators

Indicator	2018	2019 (as of November 4)	2020 (target)
The number of adverse water quality events	131	114	120
The number of private well water consultations	352	230	300
The number of drinking water advisories/boil water advisories issued	3	3	3

Highlights / Initiatives Planned for 2020

• Partnership with the FoodNet program for enhanced surveillance of water quality within Middlesex-London
• Dissemination of the new educational materials for private well owners developed by the MLHU
• Adding more private well water sample pick-up/drop-off location across Middlesex-London.

Program Challenges and Risks

• Reaching out to rural residents for conveying the messages to raise awareness in safe drinking water has been an ongoing challenge.

Staffing Complement			
	2019 Total FTEs	2020 Total FTEs	Δ
Program Assistant	0.20	0.20	0.00
Program Manager	0.20	0.20	0.00
Public Health Inspector	1.20	1.20	0.00
Director	0.00	0.01	0.01
Associate Medical Officer of Health	0.00	0.01	0.01
	0.00	0.00	0.00
Total Program FTE	***1.60***	***1.62***	***0.02***

Expenditures					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 126,132	$ 133,319	7,187	6%
Benefits		$ 32,047	$ 32,920	872	3%
Expected Vacancies		$ -		-	
Travel		$ 5,003	$ 3,982	(1,022)	-20%
Program Supplies		$ 4,461	$ 3,915	(547)	-12%
Board Expenses		$ -		-	
Staff Development		$ 1,160	$ 1,032	(128)	-11%
Occupancy		$ -		-	
Professional Services		$ 18,966	$ 16,630	(2,336)	-12%
Furniture & Equipment		$ 90	$ 78	(11)	-13%
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 3,461	$ 3,034	(427)	-12%
Total Expenditures	***$ -***	***$ 191,321***	***$ 194,910***	***$ 3,589***	***2%***

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 187,241	$ 194,564	7,323	4%
MOHLTC (100%)		$ 4,080		(4,080)	-100%
MCCSS		$ -		-	
PHAC		$ -		-	
PHO		$ -		-	
User Fees		$ -		-	
Other		$ -	$ 346	346	
Total Revenues	***$ -***	***$ 191,321***	***$ 194,910***	***$ 3,589***	***2%***

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Recreational Water				481
Standard	Safe Water	**Director Name**	Stephen Turner	
Lead Team	Safe Water, Rabies and Vector-Borne Disease	**Manager Name**	Andrew Powell	
Supporting Team(s)				
Budget	$ 313,285	**FTE**	2.62	

Summary of Program

The Recreational Water Program aims to prevent/reduce the burden of water-borne illness and injury related to recreational water use in Middlesex-London.

The target population is the people living in Middlesex-London. The main program interventions include inspection of public pools, inspection of public spas, inspection of wading pools, splash pads and receiving basins, education sessions for public pool and spa operators, and complaint investigations related to recreational water facilities.

Program Mandate & Relevant Legislation

Safe Water Standard
Ontario Regulation 565: Public Pools
Infectious Diseases Protocol, 2018
Population Health Assessment and Surveillance Protocol, 2018
Operational Approaches for Recreational Water Guideline, 2018
Recreational Water Protocol, 2019

Program Management

The Recreational Water Program is managed by the Safe Water, Rabies and Vector-Borne Disease Team.

Key Partners and Stakeholders

Ministry of Health and Long-Term Care, Public Health Ontario, City of London, Middlesex County, Recreational Water Facility owners/operators

Community Needs and Priorities

Although recreational water facilities are being used by the general public, susceptible populations such as children and elderly regularly use these facilities.

A recreational water facility that is not properly operated or maintained results in unnecessary risks for bathers, including the potential exposure to water-borne illnesses and life-threatening injuries.

Target and Priority Populations

The target population for the Recreational Water Program is the people living in Middlesex-London.

Intended Program Outcomes	
Long-Term / Population Health	• To prevent or reduce the burden of water-borne illnesses and injuries related to recreational water use.
Intermediate	• To use data to influence and inform the development of its services • To address the identified needs of the community, including priority populations • To mitigate water-borne illness and injuries related to recreational water use • To ensure the operation recreational water facilities in a safe and sanitary manner • To raise awareness of potential risk of illnesses and injuries related to recreational water facilities and public beach use • To reduce public exposure to recreational water-related illnesses and injuries
Short-Term	• To conduct inspections of public pools and public spas, wading pools/splash pads and other public recreational water facilities • To ensure availability of education and training for owners/operators of recreational water facilities • To conduct environmental assessment and monitoring of public beaches in Middlesex London

Program Interventions		
1	Recreational water facility pool & spa Inspections	• Inspection of public pools and public spas other public recreational water facilities • Investigation of complaints related to recreational water facilities
2	Provide training opportunities for pool and spa operators	• Training sessions for public pool and spa operators to increase compliance with the Regulation. • Promote the Middlesex-London Health Unit Enhanced Pool /Spa Operator Training Manual to operators of regulated facilities.
3	Beach Management Inspections	• Conducting annual environmental assessment of all public beaches in Middlesex–London • Testing beaches in recreational camps in Middlesex-London • Posting signage at the beaches if the test results exceed acceptable parameters of water quality standards

Performance / Service Level Indicators			
Indicator	2018	2019	2020 (target)
% of Class A pools inspected while in operation	100%	100%	100%
% of spas inspected while in operation	100%	100%	100%
% of Class B, wading pool/splash pad/receiving basin inspections while in operation	100%	100%	100%
# of participants to training sessions for pool and spa operators	22	130	100
The number of beaches monitored and sampled between May and September	1	2	2
% of days per season beaches are posted (OPHS Indicator Framework)	None	0.13%	None

Highlights / Initiatives Planned for 2020

• Development and delivery of educational training sessions to recreational water facility operators utilizing the previous created Middlesex-London Health Unit Enhanced Pool /Spa Operator Training Manual
• Develop new training manual that reflects the new regulatory and policy changes in the Recreational Water program.
• Training manual is shared with pool/spa operators as well as with other health units in Ontario.

Program Challenges and Risks

Operator compliance with Recreational Water Regulations, specific to their individual systems, continues to highlight knowledge gaps through the inspection of these facilities. The continuation of the MLHU facilitated Recreational Water Operators Training program will be an essential component aimed at achieving compliance.

Staffing Complement			
	2019 Total FTEs	2020 Total FTEs	Δ
Program Assistant	0.20	0.20	0.00
Program Manager	0.20	0.20	0.00
Public Health Inspector	2.20	2.20	0.00
Director	0.00	0.01	0.01
Associate Medical Officer of Health	0.00	0.01	0.01
	0.00	0.00	0.00
Total Program FTE	***2.60***	***2.62***	***0.02***

Expenditures					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 204,555	$ 213,847	9,291	5%
Benefits		$ 49,719	$ 52,915	3,196	6%
Expected Vacancies		$ -		-	
Travel		$ 8,130	$ 6,465	(1,666)	-20%
Program Supplies		$ 7,250	$ 6,351	(899)	-12%
Board Expenses		$ -		-	
Staff Development		$ 1,885	$ 1,666	(219)	-12%
Occupancy		$ -		-	
Professional Services		$ 30,820	$ 26,989	(3,831)	-12%
Furniture & Equipment		$ 146	$ 127	(18)	-13%
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 5,624	$ 4,925	(699)	-12%
Total Expenditures	***$ -***	***$ 308,129***	***$ 313,285***	***$ 5,155***	

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 301,499	$ 312,939	11,439	4%
MOHLTC (100%)		$ 6,630		(6,630)	-100%
MCCSS		$ -		-	
PHAC		$ -		-	
PHO		$ -		-	
User Fees		$ -		-	
Other		$ -	$ 346	346	
Total Revenues	***$ -***	***$ 308,129***	***$ 313,285***	***$ 5,155***	

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Small Drinking Water Systems				482
Standard	Safe Water	**Director Name**	Stephen Turner	
Lead Team	Safe Water, Rabies and Vector-Borne Disease	**Manager Name**	Andrew Powell	
Supporting Team(s)				
Budget	$ 78,319	**FTE**	0.63	

Summary of Program

The Small Drinking Water Systems Program aims to prevent/reduce the burden of water-borne illness in the provision of safe drinking water from Small Drinking Water Systems (SDWSs) in Middlesex-London. The target population is the people living in Middlesex-London. The main program interventions include risk assessment of SDWSs, the regular test results monitoring of SDWSs and responding to Adverse Water Quality Incidents in SDWSs.

Program Mandate & Relevant Legislation

Safe Water Standard
Safe Drinking Water Act
Ontario Regulation 319 (Small Drinking Water Systems)
Infectious Diseases Protocol, 2018
Population Health Assessment and Surveillance Protocol, 2018
Safe Drinking Water and Fluoride Monitoring Protocol, 2019
Small Drinking Water Systems Risk Assessment Guideline, 2018

Program Management

The Small Drinking Water Systems Program is managed by the Safe Water, Rabies and Vector-Borne Disease Team.

Key Partners and Stakeholders

Ministry of Health and Long-Term Care, Public Health Ontario, Ministry of the Environment, Conservation and Parks, City of London, Middlesex County, Small Drinking Water System owners/operators

Community Needs and Priorities

Adverse Water Quality Incidents continue to occur in SDWSs. Public health intervention is needed to guide the owners and operators of SDWSs and ensure the provision of safe drinking water.

Local Priorities

• In the councilor survey for the Middlesex County Report, 100% of respondents indicated that it is important for MLHU to focus on safe water.

Target and Priority Populations

Target population is the general public. Although SDWSs are located in rural parts of Middlesex-London, with the consideration of the transient populations using drinking water from these systems, there is a significant portion of the public that has access to drinking water provided by SDWSs.

Intended Program Outcomes	
Long-Term / Population Health	To prevent or reduce the burden of water-borne illnesses related to drinking water
Intermediate	• To use the local data for developing the SDWS program. • To identify the needs of the SDWS owners/operators and users to safely operate these systems • To timely and effective detect, identify, and respond to drinking water contaminants and illnesses, their associated risk factors, and emerging trends related to SDWSs • To ensure Owners/operators of small drinking water systems operate in a safe and sanitary manner • To raise public awareness of drinking water safety, including the potential risk of illnesses related to unsafe drinking water from SDWSs
Short-Term	• To conduct risk assessments of Small Drinking Water Systems (SDWS) • To monitor test results of SDWS regularly • To respond to adverse water quality incidents in SDWS • To ensure availability of education and training for owners/operators of small drinking water systems

Program Interventions		
1	Conduct risk assessment of SDWS	Risk assessments of SDWSs are conducted as per the Regulation
2	Monitor adverse water quality incidents	SDWS test results are monitored through the LRMA system
3	Respond to adverse water quality incidents in SDWS	Adverse Water Quality Incidents are followed-up in a timely manner
4	Provide training opportunities for SDWS owners/operators	• Training manual has been developed and training sessions are being organized for SDWS owners and operators • Disseminate the small drinking water manuals to owners and operators of facilities within Middlesex-London

Performance / Service Level Indicators

Indicator	2018 (to Oct 31)	2019	2020 (target)
# of adverse water quality incidents in SDWS	18	21	0
% of adverse water quality incidents in SDWS responded to within 24 hours	100%	100%	100%
# of low and medium SDWS assessed/reassessed	48	47	40
# of Educational Training sessions provide to owners and operators of Small Drinking Water Systems	N/A	2	2

Highlights / Initiatives Planned for 2019

- Continued offering of the educational training sessions for small drinking water owners and operators
- Increased enforcement communication related to directives issued and delineated timelines

Program Challenges and Risks

Continued communication with operators reminding them of their test frequencies delineated by their individual directives. In 2020, the safe water team will create a notification system that reminds owners of their water sampling obligations prior to the outline deadlines, as well as notify when timeliness have been missed.

Staffing Complement

	2019 Total FTEs	2020 Total FTEs	Δ
Program Assistant	0.20	0.20	0.00
Program Manager	0.20	0.20	0.00
Public Health Inspector	0.20	0.20	0.00
Director	0.00	0.02	0.02
Associate Medical Officer of Health	0.00	0.01	0.01
	0.00	0.00	0.00
Total Program FTE	***0.60***	***0.63***	***0.03***

Expenditures					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 47,709	$ 54,177	6,468	14%
Benefits		$ 11,540	$ 13,229	1,689	15%
Expected Vacancies		$ -		-	
Travel		$ 1,876	$ 1,507	(369)	-20%
Program Supplies		$ 1,673	$ 1,493	(180)	-11%
Board Expenses		$ -		-	
Staff Development		$ 435	$ 403	(32)	-7%
Occupancy		$ -		-	
Professional Services		$ 7,112	$ 6,326	(786)	-11%
Furniture & Equipment		$ 34	$ 29	(4)	-13%
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 1,298	$ 1,154	(144)	-11%
Total Expenditures	***$ -***	***$ 71,676***	***$ 78,319***	***$ 6,642***	

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 70,146	$ 77,954	7,807	11%
MOHLTC (100%)		$ 1,530		(1,530)	-100%
MCCSS		$ -		-	
PHAC		$ -		-	
PHO		$ -		-	
User Fees		$ -		-	
Other		$ -	$ 365	365	
Total Revenues	***$ -***	***$ 71,676***	***$ 78,319***	***$ 6,642***	

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Strategic Projects				490
Standard	Delivery of Public Health Programs and Services	**Director Name**	Laura Di Cesare	
Lead Team	Strategic Projects	**Manager Name**	Kendra Ramer	
Supporting Team(s)				
Budget	$ 297,378	**FTE**	2.60	

Summary of Program

Strategic Projects (SP) provides support across all MLHU programs and services. The program consists of several areas of responsibility including:

- Strategic Planning and Monitoring
- Project Management and Other Duties
- Accountability and oversight over the Project Management Office (PMO), which is a set of standards, tools and practices developed by the Strategic Projects team to enhance efficiency, quality and delivery of projects at MLHU

Program Mandate & Relevant Legislation

Delivery of Public Health Programs and Services Domain

Personal Health Information Protection Act
Municipal Freedom of Information and Protection of Privacy Act

Alignment with the MLHU Strategic Plan and the following strategic priorities of the Balanced Score Card quadrants of Program Excellence, Employee Engagement and Learning, and Organizational Excellence.

Program Management

The Strategic Projects Team manages the Strategic Projects Program. Coordination occurs with all MLHU divisions who conduct a wide range of projects.

Key Partners and Stakeholders

Strategic Projects operates across a broad range of projects that impact all of MLHU. In the delivery of these projects key partners and stakeholders vary relative to each project being managed.

Organizational Needs and Priorities

Strategic Projects provides support to all programs and services and is responsible for the strategic planning and monitoring of organizational priorities. This team has direct accountability and oversight for the Project Management Office (PMO), which is a set of standards, tools and practices developed and implemented to enhance efficiency, effectiveness, quality and delivery of projects.

The strategic projects team is responsible for several large-scale, high-impact organizational projects that will achieve technological advancement, digitize administrative functions and influence organizational culture by supporting change.

Target and Priority Populations

N/A

Intended Program Outcomes	
Long-Term	Standardized approach to project management is embedded across the organization. Strategic initiatives are successfully executed and achieved according to the organization's strategic plan. Competent, well-trained project managers leading high stakes projects that can manage dependencies across multiple projects and geographical locations.
Intermediate	Project Management methodology compliments the program planning and evaluation framework (PEF). Facilitate the process for strategy development, priority setting and monitoring progress on organizational initiatives.
Short-Term	Processes are established for consistent monitoring and reporting of strategic projects and initiatives. Ongoing consultation with staff and leadership to coordinate projects that reflect current best practices and improve efficiencies through standardization of processes.

Program Interventions		
1	Strategic Planning and Monitoring	This component aims to advance the expressed strategic priorities of the Health Unit Board and Staff. This includes the planning, development, launch and implementation of a Middlesex-London Health Unit strategic plan and balanced scorecard. Additional roles include participating and supporting workgroups associated with the strategic priorities and reporting on the progress/performance to the Senior Leadership Team and the Board of Health.
2	Project Management and Other Duties	This component provides organization support for project management across MLHU. This includes the development of project management methodologies, standardization of tools and providing project coordination and leadership to all divisions and teams. This can include, but is not limited to the development of a project repository, management of specific projects and coaching and consultation for projects being lead by other divisions and teams.

Performance / Service Level Indicators

Indicator	2018	2019	2020 (target)
MLHU Strategic Initiatives Progress (Complete / On-track) Reported to the Board of Health	Yes	Yes	Yes
% of Strategic Initiatives Complete / On-Track	85%	85%	95%

Highlights / Initiatives Planned for 2020

Consultation and development of a new strategic plan to begin in 2021 will be influenced by decisions about public health modernization.
Preparation for an extended 2020 - 2021 Strategic Plan and Balanced Scorecard.
Oversight for 2020 - 2021 strategic projects including:

- Relocation Project - support of process and practice changes among staff.
- Electronic Client Record (ECR) Project - onboarding of all client and community-based programs.
- Enterprise Resource Planning (ERP) Project - support implementation of talent management modules.
- Performance Management Framework - support the execution and roll-out to all staff.
- Public Health Modernization - to focus on creating efficiencies and effectiveness of projects that span the region.

Program Challenges and Risks

The current MLHU strategic plan comes to an end in 2020 and Public Health Modernization discussion impacts the ability to develop a comprehensive strategic plan for 2021 and subsequent years to follow.

Staffing Complement			
	2019 Total FTEs	2020 Total FTEs	Δ
Manager	1.00	1.00	0.00
Project Coordinator	1.00	1.00	0.00
Program Assistant	0.50	0.50	0.00
Director	0.00	0.10	0.10
Total Program FTE	***2.50***	***2.60***	***0.10***

Expenditures					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 203,025	$ 229,167	26,141	13%
Benefits		$ 50,118	$ 54,784	4,666	9%
Expected Vacancies		$ -		-	
Travel		$ -	$ 1,075	1,075	
Program Supplies		$ 1,279	$ 1,297	18	1%
Board Expenses		$ -		-	
Staff Development		$ -	$ 2,226	2,226	
Occupancy		$ -		-	
Professional Services		$ 7,500	$ 7,500	-	0%
Furniture & Equipment		$ -		-	
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 1,280	$ 1,329	49	4%
Total Expenditures	***$ -***	***$ 263,202***	***$ 297,378***	***$ 34,175***	

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 263,202	$ 297,378	34,175	13%
MOHLTC (100%)		$ -		-	
MCCSS		$ -		-	
PHAC		$ -		-	
PHO		$ -		-	
User Fees		$ -		-	
Other		$ -		-	
Total Revenues	***$ -***	***$ 263,202***	***$ 297,378***	***$ 34,175***	

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Finance				491
Standard	Fiduciary Requirements	**Director Name**	Laura Di Cesare	
Lead Team	Finance	**Manager Name**	Brian Glasspoole	
Supporting Team(s)				
Budget	$ 397,125	**FTE**	4.10	

Summary of Program

The Finance Program provides financial management oversight required by the Board of Health to ensure compliance with applicable legislation and regulations. This is executed by leading financial planning, financial reporting, treasury services, payroll/benefits administration, and capital asset management. The team provides value through protecting the Health Unit's financial assets, containing costs through reporting and enforcement of policy, introducing system and process improvements, developing and implementing policies and procedures, and providing relevant financial reporting and support to the Board. The team also provides customer support, and acts as a resource for managers and employees throughout the organization, providing reports, answering queries, and educating as necessary.

Program Mandate & Relevant Legislation

Fiduciary Requirements Domain
Income Tax Act, Ontario Pensions Act, PSAB standards, and other relevant employment legislation.

Program Management

The Finance Team manages the Finance Program.

Key Partners and Stakeholders
Ministry of Health Long Term Care, City of London, Middlesex County, Ministry of Children Community & Social Services, Public Health Agency of Canada, Public Health Ontario Other Health Units throughout Ontario via AOPHBA (sharing best practices)

Organizational Needs and Priorities
Provides financial management oversight required by the Board of Health to ensure compliance with Ontario Public Health Standards (OPHS). This is executed by leading financial planning and reporting, treasury services, payroll/benefits administration and capital asset management. The team protects the Health Unit's financial assets, through reporting and enforcement of policy, introducing system and process improvements, developing and implementing policies and procedures, and providing relevant financial reporting and support to the Board. The team also provides customer support and acts as a resource for managers and employees throughout the organization, providing reports, answering queries, and educating as necessary.

Target and Priority Populations
N/A

Intended Program Outcomes	
Long-Term	Ensure that accounting policies and procedures continue to meet the needs of all stakeholders, including Board of Health, public funders, Senior Leadership Team, reflecting current best practices and legislative requirements.
Intermediate	Develop comprehensive reporting procedures to fully integrate budgeting, planning and periodic reporting at a program level. Provide competent financial management support to Senior Leadership Team in response to mandated change to corporate structure through Public Health Modernization.
Short-Term	Provide orientation to the Finance & Facilities Committee of the Board of Health. Provide cost effective processes to ensure that expenses are authorized and accounted for appropriately. Work jointly with the HR team to provide payroll and benefits administration support and to ensure that outsourced payroll administration is performed completely and accurately.

Program Interventions		
1	Financial Planning	Develop long term funding strategies for senior management and Board of Health and provide ongoing monitoring. Also includes the development, monitoring and reporting of annual operating budgets, preparation of quarterly financial statements, and the preparation monthly and quarterly reports.
2	Treasury Services	Accounts payable processing requiring accurate data entry and verifying payments, reviewing invoices, issuing cheques / electronic funds transfers (ETFs) ensuring proper authorizations. This also includes verifying and processing corporate credit card purchases, employee mileage statements and expense reports. Accounts receivable processing includes creating, reviewing and posting invoices, monitoring and collections activities. Treasury services also includes cash management (processing cash payments and point of sale transactions, and preparing bank deposits) and minor investment transactions to best utilize cash balances. General accounting includes bank reconciliations, quarterly HST remittances, general journal entries, and monthly allocations.
3	Payroll and Benefits Administration	Process mandatory and voluntary employee deductions when applicable, administer all group benefit plans, audit and correct time and attendance system, investigate payroll discrepancies, conduct statutory payroll reporting , prepare and remit payments due to third parties, and prepare analysis and cost estimates during negotiations.
4	Capital Asset Management	Manage the ongoing processes for accounting for capital assets and ensuring compliance with PSAB 3150 and ensures the proper inventory and tracking of corporate assets for insurance and valuation purposes.

Performance / Service Level Indicators

Indicator	2018	2019	2020 (target)
All payment of government remittances are on time, including payroll deductions, employer health tax and HST remittances	New	100%	Maintain
All payments to OMERS, including funds deducted from employees and employer contributions are remitted on time	New	100%	Maintain
All statutory filing documents and reports are filed on time with respective government agency	New	100%	Maintain

Highlights / Initiatives Planned for 2020

Finance will provide ongoing support for production of Annual Service Plan and all related financial planning and reporting. A program-based chart of accounts is envisioned to better allocate costs to specific programs and interventions. Enhancements to expense processing, including the elimination of paper and scanning of accounting records will be implemented to streamline operations. Finance will actively participate in Public Health Modernization and discussions to merge/rationalize accounts and develop common reporting strategies.

Program Challenges and Risks

Public Health Modernization mandated by provincial government could significantly impact financial processes in the near term. Capping fund increases in 2020 and changes to the mix of funding from provincial and municipal sources will also increase pressure on the Health Unit's ability to deliver all programs.

Staffing Complement			
	2019 Total FTEs	2020 Total FTEs	Δ
Accounting and Administrative Assistant	2.00	2.00	0.00
Accounting and Budget Analyst	1.00	1.00	0.00
HR Generalist / Payroll Administrator	1.00	0.00	-1.00
Program Manager	1.00	1.00	0.00
Director		0.10	
Total Program FTE	***5.00***	***4.10***	***-1.00***

Expenditures					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 358,270	$ 311,535	(46,735)	-13%
Benefits		$ 94,116	$ 79,102	(15,014)	-16%
Expected Vacancies		$ -		-	
Travel		$ -	$ 1,075	1,075	
Program Supplies		$ 2,820	$ 2,838	18	1%
Board Expenses		$ -		-	
Staff Development		$ -	$ 2,226	2,226	
Occupancy		$ -		-	
Professional Services		$ -	$ -	-	
Furniture & Equipment		$ -		-	
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 300	$ 349	49	16%
Total Expenditures	***$ -***	***$ 455,506***	***$ 397,125***	***-$ 58,381***	

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 455,506	$ 397,125	(58,381)	-13%
MOHLTC (100%)		$ -		-	
MCCSS		$ -		-	
PHAC		$ -		-	
PHO		$ -		-	
User Fees		$ -		-	
Other		$ -		-	
Total Revenues	***$ -***	***$ 455,506***	***$ 397,125***	***-$ 58,381***	

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Procurement				492
Standard	Fiduciary Requirements	**Director Name**	Laura Di Cesare	
Lead Team	Procurement and Operations	**Manager Name**	Joe Belancic	
Supporting Team(s)				
Budget	$ 83,047	**FTE**	0.60	

Summary of Program

Provides the procurement of goods and services required of the organization ensuring the Health Unit obtains the best value in compliance with the Procurement Policy. Components of this program include:

• Provide accurate and timely procurement advice to internal programs and services (customers).
• Procurement of goods and services in a fair, transparent, and open manner through Request for Tenders, Quotes, and Proposals to ensure value for expenditures.
• Provides contract management to ensure Health Unit is not at risk (Insurance & WSIB certificates, WHMIS documents, licenses, etc.).
• Prepares necessary purchase orders, contracts and agreements.
• Reviews contract language to ensure compliance with MLHU policies and procedures for both contract value and liability.
• Manage contract life cycle to ensure service levels are maintained and the prevention of contract expirations.
• Mitigate disputes between programs and external contractors.
• Participates in the Elgin Middlesex Oxford Purchasing Cooperative (EMOP) to enhance or leverage procurement opportunities.
• Participates in other provincial purchasing cooperative agreements when applicable to lower costs to the programs and services.
• Participate in Ontario Public Buyers Association/Supply Chain Management Association of Ontario to keep up to date on procurement activities and processes.
• Perform general purchasing and for program areas.

Program Mandate & Relevant Legislation

Fiduciary Requirements Domain
Good Governance and Management Practices Domain
Broader Public Sector Accountability Act, 2010, S.O. 2010, c. 25
Alignment with the Strategic Plan priorities of Program and Organizational Excellence

Program Management

The Procurement and Operations Team manages the Procurement and Operations Program.
Close collaboration is also required with Information Technology, Finance and Strategic Projects.

Key Stakeholders

Regional HIV AIDS Connection
• Negotiate lease terms for Supervised Consumption Facility
• Contract and manage services for outside contractors such as Architect and Planning Consultant
• Support community consultations and zoning application process

Co-Operative Purchasing Agreements are initiated with the following parties:
1) EMOP – Elgin Middlesex Oxford Purchasing Co-Operative
2) VOR – Vendor of Record Program provided by the Province of Ontario
3) OECM – Ontario Educational Co-Operative Marketplace

Organizational Needs and Priorities

The goal of the procurement team is to award timely and cost-effective contracts to qualified contractors, suppliers, and service providers for the provision of goods, works and services to support operations, programs, and teams in accordance with the procurement guidelines. The goal of contract administration is to ensure proper mechanisms are in place to monitor and evaluate contractors, suppliers and service providers' performance in the fulfillment of their contractual obligations, and to ensure appropriate actions are taken to promptly remedy any deficiencies observed in contract execution or the contract scope, and terms and conditions.
The procurement team supports the organization through the transparent process of vendor selection, the identification of cost-effective services, and contract management of external suppliers following the award of business. Success of the procurement team can be measured through cost reductions, reduced contract administration by the program teams, and high-quality contract execution.

Target and Priority Populations
N/A

Intended Program Outcomes	
Long-term	• Integrated Contract Management System to cover all contracts at MLHU to prevent contract expiration and proactive renewals
Intermediate	• Implementation of the procurement module in Great Plains would assist with the monitoring of requisitions and adherence to Procurement Protocols
Short-Term	• Implementation of a new automated e-procurement provided for public tenders

Program Interventions		
1	Competitive Bidding	Facilitate competitive bidding processes through the collection of information, creation of documents and evaluation of bids.
2	Contract Management	Manage MLHU contractual obligations through the collection of relevant information, creation / review of contracts, negotiation of terms, and execution of contracts.
3	Project Management	Manage significant procurement projects including, but not limited to, Supervised Consumption Facilities and the Citi Plaza relocation.
4	Co-Operative Purchasing	Provide access to co-operative purchasing agreements.

Performance / Service Level Indicators

Indicator	2018	2019	2020 (target)
Number of competitive bid processes (tender, quotation, or proposal	6	15	Decrease
Number of competitive bid processes where (3) bids were received	6	15	Decrease
Number of competitive bid processes where less than (3) bids were received	0	2	Decrease
Number of competitive bids where option year was accepted	11	3	Maintain
Number of non-competitive bid process (sole source)	3	1	Maintain
Cost savings due to new contract/supplier arrangements or purchasing initiatives	$68,833	$104,536	$177,348
Citi Plaza Construction Budget	N/A	$5,800,000	plus/minus 10%
Citi Plaza Construction and Relocation Completion Schedule	N/A	March 31st, 2020	March 30th, 2020

Highlights / Initiatives Planned for 2020

- Completion of $5.8 million retrofit at Citi Plaza
- Release of Tender to cover renovation of Supervised Consumption Facility
- Completion of move to Citi Plaza
- Review of Procurement Bid Documents & Principles
- Implementation of the Great Plains Purchasing Module
- Release of Tender to create new Senior's Dental Care Centre in Strathroy
- Implement Policy Manager Contract Management Solution

Program Challenges and Risks

- Resources may be limited due to the number of major projects due for completion and in 2020
- Increased workload is also anticipated with the rollout and execution of a requisitioning system with Great Plains

Staffing Complement

	2019 Total FTEs	2020 Total FTEs	Δ
Manager	0.50	0.50	0.00
Procurement Coordinator	0.25	0.00	-0.25
Director	0.00	0.10	0.10
Total Program FTE	***0.75***	***0.60***	***-0.15***

Expenditures

	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 62,290	$ 64,573	2,284	4%
Benefits		$ 12,926	$ 15,031	2,105	16%
Expected Vacancies		$ -		-	
Travel		$ -	$ 1,075	1,075	
Program Supplies		$ 61	$ 93	33	53%
Board Expenses		$ -		-	
Staff Development		$ -	$ 2,226	2,226	
Occupancy		$ -		-	
Professional Services		$ -	$ -	-	
Furniture & Equipment		$ -		-	
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ -	$ 49	49	
Total Expenditures	***$ -***	***$ 75,276***	***$ 83,047***	***$ 7,770***	

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 75,276	$ 83,047	7,770	10%
MOHLTC (100%)		$ -		-	
MCCSS		$ -		-	
PHAC		$ -		-	
PHO		$ -		-	
User Fees		$ -		-	
Other		$ -		-	
Total Revenues	***$ -***	***$ 75,276***	***$ 83,047***	***$ 7,770***	

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Governance					493
Standard	Good Governance and Management Practices		**Director Name**	Laura Di Cesare	
Lead Team	Privacy, Risk and Governance		**Manager Name**	Nicole Gauthier	
Supporting Team(s)	Communications				
Budget	$ 74,128		**FTE**	0.60	

Summary of Program

This program provides support for the Board of Health to fulfill their governance role for the Middlesex-London Health Unit. This support includes the development of a governance model and framework that is articulated through the Board of Health by-laws, policies and procedures.

This consists of coordination of:
- Board of Health Meeting facilitation
- Annual Governance Committee reporting calendar;
- Development and maintenance of Board of Health policies and by-laws;
- Board of Health orientation and development;
- Board of Health self-evaluation process;
- Medical Officer of Health Performance Appraisal; and
- Annual attestations.

Program Mandate & Relevant Legislation

Ontario Public Health Standards: Good Governance and Management Practices Domain
Health Protection and Promotion Act: Governance Requirements

Program Management
The Governance Program is managed by the Privacy, Risk and Governance Team in collaboration with the Communications Team where the Executive Assistant to the Board of Health reports.

Key Partners and Stakeholders
City of London, Middlesex County, Ministry of Health and Long-Term Care, Association of Local Public Health Agencies (alPHa)
Organizational Needs and Priorities
In accordance with the Health Protection and Promotion Act and Ontario Public Health Standards, boards of health are accountable for executing good governance practices to ensure effective functioning of boards of health and management of the public health units.

Target and Priority Populations
N/A

Intended Program Outcomes	
Long-Term	• Ongoing development and maintenance of a positive board culture, to support generative, effective governance. • Maintenance of governance by-laws and policies to provide clear direction for governance activity and to ensure compliance with governing standards and legislative requirements.
Intermediate	• Maintenance of the Governance Policy Manual to provide clear direction for governance activity and to ensure compliance with governing standards and legislative requirements. • Completion of Board of Health self-evaluation process to identify and address opportunities for improvement in board effectiveness and engagement. • Board development activity to support skill set and enhance Board effectiveness.
Short-Term	• Orientation of new Board of Health members to ensure all members have a strong understanding of their role and the expectations of the Board. • Annual Governance Committee Reporting Calendar to ensure Board of Health remains informed about the activities of the organization, including with respect to organizational effectiveness and strategic planning, legislative and regulatory compliance, workforce issues, risk management.

Program Interventions		
1	Board of Health Meeting Preparation and Facilitation	Each Board of Health meeting requires extensive coordination of reports, correspondence, delegations, minute-taking, knowledge of the rules of order and by-laws and live streaming to ensure that these meetings are held in a transparent and accountable manner.
2	Board of Health Policy and By-law Development and Maintenance	These bylaws and policies set the direction, limitations and accountability frameworks for MLHU. Governance Policies relate to bylaws, organizational structure, finances and legislative/regulatory compliance. The Ontario Public Health Standards address bylaws and policies that must be in place for board operation as well as suggestions for additional policies. These by-laws and policies must be reviewed as necessary, and at least every two years. All board members are required to complete annual attestations as required by governance policies and bylaws.
3	Governance Committee Reporting Calendar & Terms of Reference Review	An annual reporting calendar is prepared for the Governance Committee of the Board of Health to provide direction to MLHU staff and board members regarding expectations for the year. The Terms of Reference sets out the delegated authority of the committee and how it is accountable to the Board of Health.
4	Board of Health Orientation	All new members receive an orientation to the role and ongoing development and education. A comprehensive orientation supports a positive board culture and enriches the members' understanding of their role and the expectations of the Board of Health.
5	Board of Health Development	Board development opportunities provide a forum for improvements to generative governance, identification of recommended future directions, and the development of board goals and future education topics. Areas of focus are identified through the Board of Health Self-Assessment and proposed to the Board of Health by the Governance Committee.
6	Board of Health Self-Assessment	The Board of Health completes a self-evaluation process annually and makes recommendations for improvements in board effectiveness and engagement. Self-assessment results are also used to assist with identifying development opportunities to meet continuing education requirements outlined in the Ontario Public Health Standards.
7	Medical Officer of Health Performance Appraisal	The Medical Officer of Health & Chief Executive Officer Performance Review is conducted annually during the second quarter of the calendar year with a report coming to the Governance Committee documenting the results in the third quarter.
8	Annual Attestation	Board Members are required to confirm their awareness of their confidentiality obligations under the applicable privacy legislation and the governance policies of the Board by signing the Annual Confidentiality Attestation. Board Members are also required to complete an annual declaration form with respect to conflicts of interest.

Performance / Service Level Indicators

Indicator	2018	2019	2020 (target)
% of governance policies that are up-to-date	100%	100%	Maintain
Board of Health self-assessment completed	Yes	Yes	Yes
Board of Health development session completed	No	Yes	Yes
Board of Health orientation session completed	N/A	Yes	N/A

Highlights / Initiatives Planned for 2020

Board self-assessment process and continuing education program to support a positive board culture and increase board effectiveness.

Maintenance of Governance Policy Manual to ensure compliance with governing standards and legislative requirements.

Annual Governance Committee Reporting Calendar to ensure the Board of Health remains informed about the activities of the organization, including with respect to organizational effectiveness and strategic planning, legislative and regulatory compliance, workforce issues, risk management.

Program Challenges and Risks

Currently compliant with the Ontario Public Health Standards: Good Governance and Management Practices Domain. Public Health Modernization could impact Board structure and governance practices, with the need for a comprehensive orientation and revision of governance by-laws and policies. Allocation of resources to this portfolio is less than 0.5 FTE - assistance would be required in order to implement new governance model and practices with Public Health Modernization.

Staffing Complement			
	2019 Total FTEs	2020 Total FTEs	Δ
Manager	0.20	0.20	0.00
Executive Assistant	0.30	0.30	0.00
Director	0.00	0.10	0.10
Total Program FTE	***0.50***	***0.60***	***0.10***

Expenditures					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 39,148	$ 55,566	16,417	42%
Benefits		$ 9,198	$ 12,630	3,432	37%
Expected Vacancies		$ -		-	
Travel		$ 783	$ 1,857	1,075	137%
Program Supplies		$ 673	$ 691	18	3%
Board Expenses		$ -		-	
Staff Development		$ 652	$ 2,878	2,226	341%
Occupancy		$ -		-	
Professional Services		$ 13,265	$ 222	(13,043)	-98%
Furniture & Equipment		$ -		-	
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 235	$ 284	49	21%
Total Expenditures	***$ -***	***$ 63,954***	***$ 74,128***	***$ 10,174***	

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 56,908	$ 67,932	11,024	19%
MOHLTC (100%)		$ 7,046		(7,046)	-100%
MCCSS		$ -		-	
PHAC		$ -		-	
PHO		$ -		-	
User Fees		$ -		-	
Other		$ -	$ 6,196	6,196	
Total Revenues	***$ -***	***$ 63,954***	***$ 74,128***	***$ 10,174***	

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Human Resources				494
Standard	Good Governance and Management Practices	**Director Name**	Laura Di Cesare	
Lead Team	Human Resources	**Manager Name**	Cynthia Bos	
Supporting Team(s)				
Budget	$ 784,570	**FTE**	7.60	

Summary of Program

The Human Resources program is responsible for organization-wide HR functions, including: recruiting and onboarding, student coordination, performance management support, learning & development, employee/labour relations, occupational health & safety as well as policy and process development.

Our goal is to develop strong relationships, deliver outstanding results, and mitigate risk by identifying and responding to organizational needs, providing sound counsel, and creating effective and valuable programs and solutions internally with our divisional and union partners.

The Human Resources team strives to balance the role of functional compliance with legislated requirements and strategic partner to support an engaged and respectful workplace.

Externally, we engage with our colleagues to share best practices (e.g. AOPHBA, SOHRG) and represent MLHU with vendors / service providers, on committees and within our geographical and HR professional communities.

Program Mandate & Relevant Legislation

Good Governance and Management Practices Domain

Ontario Employment Standards Act, 2000; Labour Relations Act Ontario, 1995; Accessibility for Ontarians with Disabilities Act (AODA), 2005; Pay Equity Act, 1990; OHSA, 1990; Workplace Safety and Insurance Act, 1990, OMERS Act, 2006; Pension Benefits Act, 1990; Bill 32, 2013

Learning and Development supports the delivery of mandatory legislated and/or professional learning and development.

Program Management

The Human Resources Team manages the Human Resources Program and Occupational Health and Safety Program. Close collaboration is also required with the Finance, Operations, and Privacy, Risk and Governance teams.

Coordination occurs with all MLHU Divisions to provide organization-wide HR functions.

Key Partners and Stakeholders

Key external Stakeholders/ partners include:

- CUPE Executive Representatives;
- ONA Labour Relations Officer;
- Legal Representation (Hicks Morley);
- Employee Wellness Solutions Network - wellness consulting;
- McDowell Associates - compensation benchmarking, job evaluation and pay equity analysis;
- AON – benefits brokers;
- Workplace Safety and Prevention Services - Ergonomics Assessments and health and safety consulting;
- Post Secondary Faculty Advisors and Student Placement Coordinators (mainly Western and Fanshawe)

Organizational Needs and Priorities

Human Resources is responsible for creating, maintaining, and delivering services in recruitment, onboarding, labour relations, employee relations, learning and development, policy development, job evaluation, compensation & benefits, performance management, health and safety, employee engagement, wellness, and legal compliance.

The goal is to develop strong relationships, provide sound counsel, and mitigate risk by identifying and responding to organizational needs and ensuring fair and equitable treatment of employees.

Target and Priority Populations
MLHU employees, independent contractors, students and volunteers

Intended Program Outcomes	
Long-Term	• Talent management and development and strategic workforce planning • Employee engagement – continuous improvement and employee engagement interventions
Intermediate	• Performance enhancement and striving for excellence – enhance performance management and performance review process, support continuing education, learning and development • Employee well-being - Be Well initiatives based on 4 pillars of wellness (culture, personal health resources, physical work environment and community involvement), creating a Psychologically Safe Workplace, promotion of EFAP programs and resources, ensure health & safety of employees through training, prevention, reporting and intervention programs
Short-Term	Organizational excellence – updated HR policies and processes, new systems that allow for efficiency in administrative processes for Human Resources, and self-service features for managers and employees.

Program Interventions		
1	Recruitment and Orientation	Recruitment is the process of filling job vacancies by hiring new employees into the organization or transferring employees within the organization. The recruitment process includes: recruitment requests, job posting, applicant screening and short-listing, interview and/or assessment development, pre-screening, interviews, reference checking, offers and declines. Facilitation of the orientation process which includes communication with new employees, coordination with internal support, preparation of orientation packages, presentation of orientation information and assignment of learning requirements. New employees are provided with a better understanding of MLHU's vision and mission, organizational structure, policies and procedures, Occupational Health and Safety practices to set them up for future success.

2	Occupational Health and Safety	The Occupational Health and Safety (OHS) Program is an internally-facing program and focuses on the prevention and elimination of all workplace hazards, incidents, injuries and illnesses through hazard identification and maintaining a safety culture through the internal responsibility system. The OHS program facilitates worksite inspections, training and development, quarterly meetings of the Joint Occupational Health and Safety Committee (JOHSC), semi-annual awareness campaigns, agency policy review and incident and injury investigation. The HR Coordinator, Health and Safety also provides support in facilitating ergonomic assessments, safety planning for domestic violence, and consultation for workplace violence prevention.
3	Learning and Development	Learning and development is led by the Corporate Trainer through delivering in-class learning, development of e-learning modules, and coordination of external training. MLHU offers "Learning @ MLHU" and "Managing @ MLHU" programs with assigned mandatory role-dependent training that is tracked in a learning management system for compliance as well as for development opportunities. Succession planning is a strategy for identifying and developing future leaders within the organization, at all levels. The process used at MLHU has been to provide temporary "acting" roles to provide employees with leadership potential an opportunity to gain experience in the role. There are also development plans as part of the performance appraisal process to identify training needs for potential growth.
4	Student Program	This program supports MLHU's commitment to student education by providing an introduction to the scope of public health practice through paid and non-paid student placements. Students complete a placement at MLHU and gain knowledge of public health and how the Social Determinants of Health influence access to health equity. Student placements help bridge the gap between entry to practice which strengthens the public health workforce. Staff preceptors are trained and given the opportunity for professional development. Relationships developed between Universities and MLHU provide reciprocal learning opportunities for students and staff.

5	Job Evaluation / Design	The purpose of the Job Evaluation process is to carry out and implement a joint gender-neutral job evaluation in accordance with the general objectives and principles set out in the respective collective agreement and/or MLHU policy. The goal is to achieve Equal Pay for Work of Equal Value for all jobs within MLHU (union and non-union). The output for job evaluation is an updated position description that has been assessed unbiasedly and fairly; confirmation of appropriate pay banding, internal pay equity, and legislated pay equity compliance.
6	Compensation and Benefits	Compensation and benefits is a function of the Finance and Human Resources departments at MLHU. Benefits may include group insurance (health, dental, vision, life etc.), long-term disability program, retirement benefits/pension, sick leave, and vacation (paid and unpaid) and are dependent on employment status and collective agreement. Human Resources assesses compensation at time of hire or during a change in employment status/position. Compensation is determined in accordance with either the ONA, CUPE, or Non-Union salary schedule and are based on experience and knowledge at time of hire. The unions and the management bargaining committees are responsible for negotiating salary increases and benefit adjustments during collective bargaining.
7	Labour Relations	The labour relations process refers to the relations between MLHU and our employees and unions. The labour relations process is generally centered around collective bargaining, the grievance procedures, collective agreement interpretation and Union Management Meetings. MLHU practices interest-focused interactions with union representatives and includes the union in joint management training opportunities to ensure alignment on approaches. Regular pro-active meetings are held with union reps to address concerns prior to escalation into formal processes.
8	Employee Engagement and Well-Being	MLHU administers an external employee engagement survey to understand staff engagement and satisfaction, to inform strategic planning, HR planning and team planning, and to compare satisfaction rates year over year. MLHU also provides a wellness program, called “Be Well”. The Be Well committee coordinates programming to promote a healthy lifestyle, raise awareness on wellness, increase collaboration within the health unit, and increase engagement. MLHU offers an Employee and Family Assistance Program (EFAP) through Homewood Health to assist in supporting employees and their immediate family in assessing and resolving work, mental health and life issues.

9	Diversity and Inclusion	The diversity and inclusion program includes the prioritization of the matters of equity, access, human rights, and inclusion and ensuring that it aligns well with MLHU's Mission, Values and Strategic Plan. There is a proposed advisory group that will function as an advisory body to Human Resources, the Health Equity Core Team, and the third party engaged in conducting an organizational assessment of diversity and inclusiveness and developing recommendations. This program aims to ensure that all practices and procedures at the Health Unit are equitable and that our workplace supports best practice in workplace diversity and anti-discrimination to create a diverse and inclusive environment that is fostered and promotes respect, trust, equity, inclusion, and tolerance. This program was put on hold in 2019 due to discussions about amalgamation. Will review project in 2020.
10	Performance Management	Performance management is a communication process by which managers and employees work together to plan, monitor and review an employee's work objectives. MLHU has a formal performance appraisal system in which employees obtain specific feedback about their work performance. Human resources supports managers in delivering clear expectations and regular performance communications with employees. There is also a progressive discipline process for employees who are not meeting performance standards.

Performance / Service Level Indicators

Indicator	2018	2019	2020 (target)
MLHU turnover (% annualized FT/PT rate)	10.9%	9.3%	Maintain
Mandatory training initiatives (#)	12	14	Maintain
% of staff completing mandatory training initiatives	94%	79%	Increase
# of employee reported injuries or incidents	30	34	Maintain
# of hazards identified during worksite inspections	69	90	Decrease
% of identified hazards resolved	97%	95%	Increase

Highlights / Initiatives Planned for 2020

• Implementation and training on new Dayforce (HRIS) modules, which includes Recruitment, Onboarding, Performance Management, Document Management, Learning, and Dashboards.
• Redevelopment of processes, policies and programs based on best practices for onboarding, performance management and workforce management.
• Development of improved reporting and dashboards for HR metrics to support workforce planning.
• Support and preparation for Public Health Modernization and impacts on the organization and employees.
• Enhance and revise safety procedures and programs, including ergonomics, workplace violence and risk assessment, in response to the MLHU relocation.
• Support change management and well-being for the organization in the MLHU relocation and other organizational changes.

Program Challenges and Risks

• Changes to the majority of HR processes due to new technology will require additional consultation, collaboration, and may initially take additional time to learn.
• Supporting management and employees with various organizational changes e.g. relocation, new technology, change in administrative processes.
• Reduced capacity to support requests for the development of divisional and organization-wide online training modules as the Corporate Trainer will be leading the ERP system implementation project.
• Continuing to build partnerships with unions and monitoring employee and labour relations activity which is anticipated to increase during the significant organizational changes.

Staffing Complement

	2019 Total FTEs	2020 Total FTEs	Δ
Corporate Trainer	1.00	1.00	0.00
Human Resources Coordinator	3.00	3.00	0.00
Human Resources Partner	2.00	2.00	0.00
Program Manager	1.00	1.00	0.00
Student Coordinator	0.50	0.50	0.00
Director	0.00	0.10	0.10
Total Program FTE	***7.50***	***7.60***	***0.10***

Expenditures					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 546,020	$ 576,730	30,710	6%
Benefits		$ 143,403	$ 147,297	3,894	3%
Expected Vacancies		$ -		-	
Travel		$ -	$ 2,250	2,250	
Program Supplies		$ 1,175	$ 18	(1,157)	-98%
Board Expenses		$ -		-	
Staff Development		$ -	$ 2,226	2,226	
Occupancy		$ -		-	
Professional Services		$ 10,250	$ 55,250	45,000	439%
Furniture & Equipment		$ -		-	
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 750	$ 799	49	7%
Total Expenditures	***$ -***	***$ 701,598***	***$ 784,570***	***$ 82,972***	

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 701,598	$ 784,570	82,972	12%
MOHLTC (100%)		$ -		-	
MCCSS		$ -		-	
PHAC		$ -		-	
PHO		$ -		-	
User Fees		$ -		-	
Other		$ -		-	
Total Revenues	***$ -***	***$ 701,598***	***$ 784,570***	***$ 82,972***	

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Information Technology				495
Standard	Good Governance and Management Practices	**Director Name**	Laura Di Cesare	
Lead Team	Information Technology	**Manager Name**	Jeff Cameron	
Supporting Team(s)				
Budget	$ 1,229,517	**FTE**	3.10	

Summary of Program

Information Technology (IT) Services is a centralized service providing for the information technology needs of the programs and staff of MLHU. Information technology touches virtually every department and program as a means of recording, delivering materials and reporting on the effectiveness and outcomes across MLHU.

Program Mandate & Relevant Legislation

Good Governance and Management Practices Domain
Municipal Freedom of Information and Protection of Privacy Act (MFIPPA)
Personal Health Information Protection Act (PHIPA)

Program Management

The management of the IT Department has been contracted to Stronghold Services Corporation, a Managed IT Services Provider to deliver leadership, system administration(servers and infrastructure), strategy and internal IT (CUPE) staff management for staff support. The IT Department uses various tools and software solutions to manage IT support and provide reporting on metrics and contract fulfillment.

Key Partners and Stakeholders

• Stronghold Services Corporation – delivers management, strategy and system administration of servers and infrastructure of all Information Technology at MLHU;
• Telecom Metric – vendor support for telecommunications system within MLHU; Xerox – Vendor of Record and currently holds the lease on 10 print devices throughout MLHU;
• SmartHead – Finance vendor and support agreement for Great Plains, our financial software; Rogers Communications – Vendor of Record for MLHU smart phone usage;
• Start.ca – Our Wide Area Network Provider, this vendor manages our internet connectivity and our server infrastructure from their York Street datacentre.

Organizational Needs and Priorities

Information Technology exists as a major element of the Healthy Organization division to deliver information services to healthcare providers and all employees. Key goals of this program are to increase productivity, create accurate and effective records, protect and deliver data, and to enable innovative solutions to maximize investment in IT services.
Some specific needs of the organization include:
• Electronic Client Record (ECR) implementation to a single source requiring extensive infrastructure for delivery, reporting, management and administration. This requires all levels of technology and reporting capabilities. This process requires a centralized, scalable approach to delivery.
• A scalable, robust infrastructure for communication (MS Teams, Laptops, Smart Phones, 3CX Phones).
• A solid backup and disaster recovery/business continuity strategy that covers effects of data loss and ransomware/cyber threats.

Target and Priority Populations

N/A

Intended Program Outcomes	
Long-Term	Our long term goals are to develop and maintain an effective technology skill set and capability for the staff across MLHU. Technology has a direct effect on people's ability to deliver services across all programs and departments. Having a reliable solution(encompassing devices and software) for our staff to count on will improve outcomes across the organization.
Intermediate	The different systems and processes we use to deliver organizational services include a financial enterprise resource product (Great Plains 2018), a human resource information system (Dayforce) and an electronic client record system (IntraHealth) are tools in use across MLHU. The devices in use by each employee, notably smart phones and laptops or desktops are the backbone of the interface between systems and departments.
Short-Term	Upgrading our current infrastructure software specifically focusing on servers, databases and applications to build a data driven environment for delivery of services. Integrating our communications platform will improve productivity across all teams and programs. Completing our end-user device refresh will have all systems running supported security software for smart phones and vendor support for Windows 10 Enterprise.

Program Interventions		
1	Business Disaster Recovery / Business Continuity	Major server and infrastructure shift to datacentre and new strategy built, building a disaster recovery environment at Citi Plaza, software and strategy addresses ransomware and cyber threat response.
2	IT Infrastructure	Installing and configuring the new wide area network, large scale server decommission and rebuild to Server 2019, implementing new storage strategy, continuous improvement and consolidation of applications. Begin focus on direction of new Server strategy. Cloud based and private/public cloud hybrid solutions to be reviewed.
3	IT Applications	Managing transition and implementation of Electronic Client Records, building upon implementation of Enterprise Resource Planning for Finance and Human Resource Information Systems for Human Resources, implementing Microsoft 365 applications and communications across organization.
4	Telecommunications	Completion of implementation of entirely new telecom strategy, including network, handsets, provider and communication tools for staff.
5	IT Organization	Support across 10 major projects as a staff resource will continue delivery of services throughout 2020 across the organization. Process, ticketing, reporting and improvement will take place across team. Documentation and process improvement for team members as we transition to new location and new logistics.

Performance / Service Level Indicators

Indicator	2018	2019	2020 (target)
% of total requests addressed by MSP	26% (842/3241)	23% (1202/5228)	Increase
% of total Helpdesk requests addressed by internal staff	74% (2399/3241)	77% (4026/5228)	Decrease
Number of tickets completed in the FY	3241	5228	Increase
% of Tier 1 Helpdesk Requests	74% (2399/3241)	77% (4026/5228)	Decrease
% of SysAdmin/Management	26% (842/3241)	23% (1202/5228)	Increase

Highlights / Initiatives Planned for 2020

- Completion of or Electronic Client Record product Intrahealth
- Capital replacement of IT equipment to be rolled out (laptops and smart phones)
- Mobile Device Management(security and device registration) for all smart phones and laptops
- Enhanced protection for servers and network due to increased cyber threats,
- New WAN installation and expansion
- New location configuration for audio visual and technology and updating for organization
- Support for ERP initiatives (HR for Ceridian, finance for procurement, risk and contract management software)
- Reporting, dashboards and data development to support organizational objectives

Program Challenges and Risks

- Lack of development support will hinder the ability to fully utilize the complete strategy being implemented
- IT capital investment for server infrastructure requires extended resources

Staffing Complement			
	2019 Total FTEs	2020 Total FTEs	Δ
Desktop and Application Analyst	1.00	1.00	0.00
End User Support Analyst	2.00	2.00	0.00
Director	0.00	0.10	0.10
Total Program FTE	***3.00***	***3.10***	0.10

Expenditures					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 188,581	$ 203,940	15,359	8%
Benefits		$ 45,728	$ 48,486	2,758	6%
Expected Vacancies		$ -		-	
Travel		$ -	$ 1,075	1,075	
Program Supplies		$ 10,300	$ 6,018	(4,282)	-42%
Board Expenses		$ -		-	
Staff Development		$ -	$ 2,226	2,226	
Occupancy		$ -		-	
Professional Services		$ 417,899	$ 462,945	45,046	11%
Furniture & Equipment		$ 366,200	$ 388,000	21,800	6%
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 40,584	$ 116,827	76,243	188%
Total Expenditures	***$ -***	***$ 1,069,292***	***$ 1,229,517***	***$ 160,225***	

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 1,069,292	$ 1,229,517	160,225	15%
MOHLTC (100%)		$ -		-	
MCCSS		$ -		-	
PHAC		$ -		-	
PHO		$ -		-	
User Fees		$ -		-	
Other		$ -		-	
Total Revenues	***$ -***	***$ 1,069,292***	***$ 1,229,517***	***$ 160,225***	

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Operations				496
Standard	Good Governance and Management Practices	**Director Name**	Laura Di Cesare	
Lead Team	Procurement and Operations	**Manager Name**	Joe Belancic	
Supporting Team(s)				
Budget	$ 606,073	**FTE**	7.90	

Summary of Program

Provides oversight for the health unit “Operations” which include facility management services such as furniture and equipment, leasehold improvements, insurance and risk management, security, janitorial, parking, on-site and off-site storage and inventory management.

Other components include:
• Space planning – liaises with program areas to ensure facilities meet program requirements. This may involve leasehold improvements, furniture and equipment purchases, and relocation of employees.
• Coordinates management response to monthly Joint Occupational Health & Safety Committee (JOHSC) inspection reports.
• Resolve ergonomic concerns as identified in Ergonomic Assessments or Accommodation requests.

Program Mandate & Relevant Legislation

Good Governance and Management Practices Domain
Occupational Health & Safety Act; Accessibility for Ontarians with Disabilities Act, 2005, S.O. 2005, c. 11; Smoke-Free Ontario Act; Employment Standards Act

Program Management

The Procurement and Operations Team manages the Operations Program in collaboration with Human Resources – Health and Safety Coordinator, Information Technology, Vaccine Preventable Disease, Emergency Preparedness, other Program Assistants.

Key Partners and Stakeholders

Maintain contractors list to ensure immediate resolution to emergency situations should them be required.
Work with landlords at multiple sites to maintain building conditions.

Organizational Needs and Priorities

The goal of the Operations is to provide a safe and productive work environments to clients, visitors and program teams in accordance with principles and procedures established in legislative, and procedural guidelines.

The Operations team supports the organization through preventive maintenance of the facilities, capital replacement strategies and response to staff requests. Success of the operations team can be measured based on response times to staff requests, JOHSC reporting and through injury prevention.

Target and Priority Populations

N/A

Intended Program Outcomes	
Long-Term	Downtime reduction which impact staff member productivity • SLA's to govern turn around time for Operations requests • Creation of a Computerized Asset Management System • Ensure a safe and healthy work environment
Intermediate	• Creation of Operational metrics which could include the following: • Service Volumes; • Facilities maintenance schedule; • Implementation of the asset tracking/inventory module in Great Plains; • Expansion of Activity Based Workstations prior to the relocation of staff into a new facility; • Implementation of a centralized receiving area for all MLHU staff; and • Creation of a centralized supplies store to reduce redundant purchases of office supplies.
Short-Term	• Clean up and purge activities continue across the Health Unit are required to ensure non-essential materials are not relocated to the new location. Additional activities related to the move includes but is not limited to signage, security assessment, new receiving processes and storage. • Ensure expanded operation of facilities located at 50 King, 355 Wellington Street and Strathroy offices. • Ensure on-time turnover of 50 King and 201 Queens to landlord following relocation of staff.

Program Interventions		
1	Facilities Management	Facilities management includes general facility maintenance including minor repairs, disposal of bio-hazardous materials, meeting room set-up and take-downs, van repairs and maintenance, responds to Operations Help Desk for maintenance, supplies, deliveries, etc., liaise with general contractors for various projects (electrical, plumbing, drywall, painting, etc.)., and management of property leases including any new negotiations, renegotiations and dispute resolution (50 King Street, 201 Queens Ave in London, and 51 Front Street in Strathroy).
2	Receiving and Asset Management	This component includes receiving goods maintaining both on-site and off-site storage facilities, data entry of assets into data base, removal and disposal of obsolete/broken equipment through various disposal methods, routine maintenance and service requests for folding machines, cutters, laminators.
3	Security	Manage and maintain the controlled access and panic alarm systems.

4	Custodial	Manages and maintain the contract for janitorial services for two locations. This includes day-time and evening cleaning for the 50 King Street office, 355 Wellington Street office and evening cleaning at 51 Front Street.
5	Project Management	Management of Activity Based Workstations, Office Closure, SCF Application, Office Relocation and deliverables from Architect, Project Manager and Landlord for office move.

Performance / Service Level Indicators

Indicator	2018	2019	2020 (target)
Number of Operations Requests Received electronically	444	620	Maintain
Number of Operations requests completed within 48 hours	408	570	Increase
Number of Operations requests outstanding for >48 hours	36	50 (Approx.)	Decrease

Highlights / Initiatives Planned for 2020

- Clean up activities across the Health Unit will continue
- Additional Activities related to the Move
- Creation of a Centralized Stores
- Expansion of Activity Based Workstations
- Modifications to Citi Plaza following relocation

Program Challenges and Risks

A large volume of change requests are expected from staff following the relocation to a new site
Role clarity will be required for Receiving and Operations Coordinator following the move

Staffing Complement			
	2019 Total FTEs	2020 Total FTEs	Δ
Manager	0.50	0.50	0.00
Program Assistant	1.20	3.50	2.30
Receiving and Operations Coordinator	1.00	1.00	0.00
Procurement Coordinator	0.25	0.00	-0.25
Clinical Team Assistant		2.50	2.50
Program Manager		0.30	0.30
Director		0.10	0.10
Total Program FTE	***2.95***	***7.90***	***4.95***

Expenditures					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 165,045	$ 466,089	301,044	182%
Benefits		$ 43,077	$ 128,472	85,395	198%
Expected Vacancies		$ -	$ -	-	
Travel		$ -	$ 2,687	2,687	
Program Supplies		$ 239	$ 243	4	2%
Board Expenses		$ -	$ -	-	
Staff Development		$ -	$ 6,785	6,785	
Occupancy		$ -	$ -	-	
Professional Services		$ -	$ -	-	
Furniture & Equipment		$ -	$ -	-	
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ -	$ 1,796	1,796	
Total Expenditures	***$ -***	***$ 208,361***	***$ 606,073***	***$ 397,712***	

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 208,361	$ 415,226	206,865	99%
MOHLTC (100%)		$ -	$ 105,949	105,949	
MCCSS		$ -		-	
PHAC		$ -	$ 65,789	65,789	
PHO		$ -		-	
User Fees		$ -		-	
Other		$ -	$ 19,109	19,109	
Total Revenues	***$ -***	***$ 208,361***	***$ 606,073***	***$ 397,712***	

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Privacy and Records				497
Standard	Good Governance and Management Practices	**Director Name**	Laura Di Cesare	
Lead Team	Privacy, Risk and Governance	**Manager Name**	Nicole Gauthier	
Supporting Team(s)	Program Planning and Evaluation			
Budget	$ 126,742	**FTE**	1.15	

Summary of Program

MLHU has obligations with respect to privacy and records management as set out in the Personal Health Information Protection Act (PHIPA) and Municipal Freedom of Information and Protection of Privacy Act (MFIPPA).

In order to meet its accountabilities as a health information custodian (HIC) under PHIPA and an institution under MFIPPA, MLHU's Privacy and Records Program includes the following elements:

- Appointment of a privacy officer responsible for organizational legislative compliance
- Training and education for employees
- Policy and procedure development and maintenance
- Privacy impact assessment and consultation
- Response to access and correction requests under PHIPA and MFIPPA
- Breach response and complaint management
- Records management

Privacy and records management are shared responsibilities. The Privacy and Records Program provides the tools, advice and guidance to support teams and programs to manage personal information (PI), personal health information (PHI) and other information in the custody and control of the organization efficiently and in compliance with all policies and regulations.

Program Mandate & Relevant Legislation

Ontario Public Health Standards: Good Governance and Management Domain
Personal Health Information Protection Act (PHIPA)
Municipal Freedom of Information and Protection of Privacy Act (MFIPPA)
Health Protection and Promotion Act (HPPA)

Program Management

The Privacy, Risk and Governance Team manages the Privacy and Records Program in collaboration with the Program Planning and Evaluation Team.

Teams and programs across MLHU have an obligation to ensure records management practices align with and support privacy and freedom of information requirements; coordination/accountabilities still to be explored/defined.

Information technology team to provide relevant systems to support.

Key Partners and Stakeholders

Information and Privacy Commissioner of Ontario (IPC)

Organizational Needs and Priorities

MLHU has obligations under provincial privacy legislation (PHIPA and MFIPPA) to ensure the rights of individuals with respect to privacy, access and correction of records of their personal information and personal health information, as well as the right to access general records that pertain to MLHU operations and governance.
MLHU's Privacy Program supports compliance with these obligations through education and training, policy and procedure development, assessment and management of privacy risks, facilitation of access and correction requests, and management of potential and actual breaches that may occur.
The development and implementation of enhanced privacy and information security policies and procedures is critical to support health care digitization, including implementation of MLHU's electronic client record (ECR) system.

Target and Priority Populations

N/A

Intended Program Outcomes	
Long-Term	A culture of privacy is embedded through all levels of the organization. Staff know and understand their obligations and how this applies to their role/practices. Potential risks/concerns are proactively identified and brought forward for consultation as appropriate. MLHU services are delivered in a transparent and accountable fashion. Organizational practices comply with all legislative requirements, including with respect to collection, access, use, disclosure, retention and disposal.
Intermediate	Administrative policies are maintained to reflect current best practices and legislative requirements. Staff are aware of the privacy and records requirements of their programs and concepts of privacy and records management.
Short-Term	Staff are educated about updated administrative policies and obligations with respect to collection, access, use, disclosure, retention and disposal. Privacy and records consultations are provided as requested by programs.

Program Interventions		
1	Privacy Consultation and Support	Provide privacy consultation as requested by programs and on strategic, prioritized or program projects .
2	Access and Correction Requests	Oversee processing of access requests and correction requests (PHIPA and MFIPPA).
3	Breach Investigation	Oversee breach containment, investigation, notification and corrective action.
4	Records Classification System / Retention Schedule (CS/RS)	Maintain Classification System / Retention Schedule (CS/RS). This helps to manage risk and compliance, improve access and collaboration, as well as reducing unnecessary duplication of records. The CS/RS also outlines the records retention schedule for physical and electronic records to ensure that all records are retained according to regulatory and legal requirements.
5	Records Management Consultation and Support	Provide records management consultations as requested by programs and on strategic and program projects.
6	Retention, Access and Destruction of Inactive Physical Records	Oversee the process of retaining, accessing and destroying inactive records at MLHU. This is done through facilitating the secure storage and inventory of files, retention on premises in controlled access records room and secure off-site records storage at Command.
7	Electronic Content Management Consultation and Support	Provide consultation on the electronic capture, management, storage, preservation, and delivery of content and documents related to organizational processes. This expands beyond “records” to include other organizational information.
8	Training and Capacity Building	Design, delivery and evaluation of training and capacity building activities to provide MLHU staff with opportunities to obtain, improve and retain skills, knowledge and experience required to perform the duties associated with Privacy and Records.

Performance / Service Level Indicators

Indicator	2018	2019	2020 (target)
# of confirmed privacy breaches	2	1	Decrease
# of PHIPA access requests received	7	13	N/A
% of PHIPA access requests completed within 30 days or within 60 days with Notice of Extension	100%	100%	Maintain
# of MFIPPA access requests received	12	20	N/A
% of MFIPPA access requests completed within 30 days or in excess of 30 days with Notice of Extension or Notice to Affected Person	100%	100%	Maintain
# of PHI correction requests received	0	0	N/A

Highlights / Initiatives Planned for 2020

Implementation of enhanced privacy program, including new/revised policies, procedures and staff education.

Supporting privacy components of new IT solutions being implemented across the organization, including Clinical Connect, ONE ID and MLHU electronic client records system, to ensure compliance with legislative, regulatory and contractual requirements.

Ongoing staff education and consultation regarding records management requirements, including support for the relocation of records with the move to Citi Plaza. Additional guidelines for electronic content management will be developed and communicated to staff in 2020.

Review of off-site storage based on new retention schedule and policies.

Program Challenges and Risks

Allocation of resources to Privacy portfolio is less than 0.5 FTE; however, increased need for consultation to support strategic projects and initiatives as well as increase in numbers of access requests received/processed.

Maintaining cross-links between print records and electronic records of the same client and/or record series as the transition is made to ECR.

Staffing Complement

	2019 Total FTEs	2020 Total FTEs	Δ
Librarian	0.20	0.20	0.00
Manager	0.40	0.40	0.00
Program Assistant	0.35	0.35	0.00
Program Manager	0.10	0.10	0.00
Director		0.10	0.10
Total Program FTE	***1.05***	***1.15***	***0.10***

Expenditures

	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 80,097	$ 97,599	17,502	22%
Benefits		$ 19,369	$ 22,861	3,492	18%
Expected Vacancies		$ -	$ -	-	
Travel		$ -	$ 1,124	1,124	
Program Supplies		$ 3,106	$ 2,850	(256)	-8%
Board Expenses		$ -	$ -	-	
Staff Development		$ -	$ 2,226	2,226	
Occupancy		$ -	$ -	-	
Professional Services		$ -	$ -	-	
Furniture & Equipment		$ -	$ -	-	
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ 34	$ 83	49	145%
Total Expenditures	***$ -***	***$ 102,606***	***$ 126,742***	***$ 24,136***	

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 97,872	$ 122,007	24,135	25%
MOHLTC (100%)		$ -		-	
MCCSS		$ -		-	
PHAC		$ -		-	
PHO		$ 4,734	$ 4,734	-	0%
User Fees		$ -		-	
Other		$ -		-	
Total Revenues	***$ -***	***$ 102,606***	***$ 126,742***	***$ 24,135***	

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Program Description

Risk Management				498
Standard	Good Governance and Management Practices	**Director Name**	Laura Di Cesare	
Lead Team	Privacy, Risk and Governance	**Manager Name**	Nicole Gauthier	
Supporting Team(s)				
Budget	$ 87,580	**FTE**	0.75	

Summary of Program

This program is responsible for the implementation and maintenance of the organizational risk management plan. The risk management plan identifies, assesses and prioritizes risk of the organization and seeks to minimize, monitor or control the probability and impact of these events.

Program Mandate & Relevant Legislation

Good Governance and Management Domain

Program Management

The Privacy, Risk and Governance Team manages the Risk Management Program.

Key Partners and Stakeholders

N/A

Organizational Needs and Priorities
In accordance with the Ontario Public Health Standards (OPHS), boards of health are required to provide governance direction to the administration, and ensure it remains informed about the activities of the organization, with respect to risk management. The Board is further required to ensure a formal risk management framework is in place that identifies, assesses, and addresses organizational risks.

Target and Priority Populations
N/A

Intended Program Outcomes	
Long-Term	A strong risk management culture is embedded through all levels of the organization. Staff intentionally apply risk management principles and processes to planning and decision-making. Identified risks are brought forward for consultation as appropriate to ensure appropriate mitigations and/or acceptance of risk, in support of MLHU objectives. Policies and procedures are maintained to reflect current best practices and legislative requirements.
Intermediate	Risk assessment, mitigation, monitoring and reporting included in program planning and evaluation framework. Complete administrative policy review to ensure policy direction is current and aligned with best practices and legislative requirements. Program-level documents (standards, procedures) to be integrated into new online policy management solution to ensure documents are current and accessible to staff.
Short-Term	Implement policy requirements related to contract negotiation and renewal to ensure appropriate risk identification and mitigation.

Program Interventions		
1	Administrative Policy Development and Maintenance	Provide oversight for the MLHU Administrative Policy Manual and Governance Policy Manual. Provide consultation and collaborate with content experts to ensure administrative and governance policies reflect current best practices and legislative requirements.
2	Risk Monitoring and Reporting	Establish and maintain processes for the consistent monitoring and reporting of corporate, program and project level risks and mitigations to management and the Board of Health as appropriate.
3	Risk Consultation and Education	Provide risk consultation on strategic projects and as requested by programs. Provide coaching and education to support capacity-building across all levels of the organization. Assist with development/review of contracts.

Performance / Service Level Indicators			
Indicator	2018	2019	2020 (target)
% of administrative policies that are up-to-date	10%	62%	Increase
Corporate level risks are monitored and reported to the Board of Health as appropriate and on an annual basis	Yes	Yes	Yes

Highlights / Initiatives Planned for 2020

Risk management monitoring and reporting to the Board of Health and Ministry.
Completion of administrative policy review to ensure clear direction for staff that is aligned with current best practices and legislative requirements.
Expansion of the online policy (document) management system to include program standards/procedures and contracts.

Program Challenges and Risks

Capacity pressures due to large number of change initiatives results in inconsistent identification of risks with program-level initiatives.

Public Health Modernization would require significant resources to develop and implement an expanded risk management model - resource allocation of less than 0.5 FTE would be inadequate to coordinate risk identification/assessment, mitigation and reporting across more complex regional entity.

Staffing Complement

	2019 Total FTEs	2020 Total FTEs	Δ
Manager	0.40	0.40	0.00
Program Assistant	0.25	0.25	0.00
Director		0.10	0.10
Total Program FTE	***0.65***	***0.75***	***0.10***

Expenditures

	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
Salary & Wages		$ 51,046	$ 67,436	16,389	32%
Benefits		$ 12,350	$ 15,711	3,361	27%
Expected Vacancies		$ -	$ -	-	
Travel		$ -	$ 1,075	1,075	
Program Supplies		$ 1,065	$ 1,083	18	2%
Board Expenses		$ -	$ -	-	
Staff Development		$ -	$ 2,226	2,226	
Occupancy		$ -	$ -	-	
Professional Services		$ -	$ -	-	
Furniture & Equipment		$ -	$ -	-	
Contributions to Reserves		$ -		-	
Other Agency Costs		$ -		-	
Other Program Costs		$ -	$ 49	49	
Total Expenditures	***$ -***	***$ 64,462***	***$ 87,580***	***$ 23,118***	

Funding Sources					
	2018 Budget	2019 Budget	2020 Budget	$ increase ($ decrease)	% increase (% decrease)
MOHLTC (Cost Shared)		$ 64,462	$ 87,580	23,118	36%
MOHLTC (100%)		$ -	$ -	-	
MCCSS		$ -	$ -	-	
PHAC		$ -	$ -	-	
PHO		$ -	$ -	-	
User Fees		$ -	$ -	-	
Other		$ -	$ -	-	
Total Revenues	***$ -***	***$ 64,462***	***$ 87,580***	***$ 23,118***	