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

Thursday, May 21, 2020, 6:00 p.m.
Microsoft Teams Conferencing

MISSION - MIDDLESEX-LONDON HEALTH UNIT

The mission of the Middlesex-London Health Unit is to promote and protect the health of our community.

MEMBERS OF THE BOARD OF HEALTH

Ms. Maureen Cassidy (Chair)
Ms. Aina DeViet (Vice-Chair)
Mr. John Brennan
Ms. Kelly Elliott
Ms. Tino Kasi
Ms. Arielle Kayabaga
Mr. Ian Peer
Mr. Bob Parker
Mr. Matt Reid

SECRETARY-TREASURER

Dr. Christopher Mackie

DISCLOSURE OF CONFLICTS OF INTEREST

APPROVAL OF AGENDA

MINUTES

Approve: April 16, 2020 Board of Health meeting
May 13, 2020 Special Meeting of the Board of Health
April 16, 2020 Relocation Advisory Committee

Item #	Delegation	Recommendation	Information	Report Name and Number	Link to Additional Information	Overview and Lead
Reports and Agenda Items						
1		**x**	**x**	By Law Amendment Regarding Electronic Participation Report No. 022-20	Appendix A Appendix B	To provide an update and approve changes to By-Law No.3. This by-law will allow electronic participation in Board of Health meetings when an emergency has been declared. Lead: Ms. Laura Di Cesare, Director, Healthy Organization
2			**x**	Impact of the COVID-19 Pandemic on Adherence to the Nurse-Family Partnership (NFP) Core Model Elements Report No. 023-20	Report No. 039-19 Report No. 016-20	To provide an update on the impacts to the NFP Program during the COVID-19 Pandemic. Lead: Ms. Heather Lokko, Chief Nursing Officer
3			**x**	Staffing Update Report No. 024-20		To provide an update on staffing in the context of COVID-19. Lead: Ms. Laura DiCesare, Director Healthy Organization Division
4			**x**	Verbal Update: COVID-19		To provide an update on COVID-19. Lead: Dr. Alex Summers, Associate Medical Officer of Health
5			**x**	Medical Officer of Health / CEO Activity Report for May Report No. 025-20		To provide an update to activities of the MOH/CEO since the last Board of Health meeting. Lead: Dr. Christopher Mackie, Medical Officer of Health / CEO
Correspondence						
6		**x**	**x**	May 2020 Correspondence		To receive correspondence items a) through f) and endorse item g) and h).

OTHER BUSINESS

- Next Board of Health Meeting: June 18, 2020

CONFIDENTIAL

The Board of Health will move in-camera to consider matters regarding labour relations, identifiable individuals and advice that is subject to solicitor-client privilege, including communications necessary for that purpose.

ADJOURNMENT

PUBLIC SESSION – MINUTES
MIDDLESEX-LONDON BOARD OF HEALTH

Thursday, April 16, 2020, 6:30 p.m.

Web-Based

MEMBERS PRESENT:
Ms. Maureen Cassidy (Chair)
Ms. Aina DeViet (Vice-Chair) – arrived at 7:04 p.m.
Mr. John Brennan
Ms. Kelly Elliott – left at 6:50 p.m. due to technical difficulties
Ms. Tino Kasi
Ms. Arielle Kayabaga
Mr. Bob Parker
Mr. Ian Peer
Mr. Matt Reid

OTHERS PRESENT:
(via teleconference)
Dr. Christopher Mackie, Medical Officer of Health/CEO (Secretary Treasurer)
Ms. Lynn Guy, Executive Assistant to the Medical Officer of Health/CEO and Associate Medical Officer of Health (Recorder)
Dr. Alexander Summers, Associate Medical Officer of Health
Ms. Laura Di Cesare, Director, Healthy Organization
Ms. Heather Lokko, Director, Healthy Start
Ms. Maureen Rowlands, Director, Healthy Living
Mr. Stephen Turner, Director, Environmental Health and Infectious Disease
Dr. Michael Clarke, VP Modernization
Mr. Dan Flaherty, Manager, Communications
Ms. Elizabeth Milne, Executive Assistant to the Board of Health and Communications Coordinator
Ms. Laurie Rees, Public Health Nurse

Chair Cassidy called the meeting to order at 6:33 p.m.

DISCLOSURE OF CONFLICT OF INTEREST

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

APPROVAL OF AGENDA

It was moved by Mr. Peer, seconded by Ms. Kayabaga, *that the AGENDA for the April 16, 2020 Board of Health meeting be approved.*

Carried

MINUTES

It was moved by Mr. Reid, seconded by Mr. Parker, *that the MINUTES of the February 27, 2020 Board of Health meeting be approved.*

Carried

It was moved by Ms. Kayabaga, seconded Mr. Reid, *that the MINUTES of the March 26, 2020 Board of Health meeting be approved.*

Carried

It was moved by Mr. Peer, seconded by Ms. Kasi, *that the MINUTES of the February 27, 2020 Governance Committee meeting be received.*

Carried

It was moved by Mr. Peer, seconded by Ms. Kasi, *that the MINUTES of the March 5, 2020 Finance and Facilities Committee be received.*

Carried

REPORTS AND AGENDA ITEMS

Finance & Facilities Committee Meeting Update: March 4, 2020 (Report No. 015-20)

Ms. Cassidy provided this report forward noting that it is a recap of the 4 reports that FFC
It was moved by Ms. Kasi, seconded by Mr. Parker, *that the Board* of *Health receive Report No. 015-20 for information.*

Carried

Relocation & Advisory Committee (RAC) Meeting Update: Verbal

Mr. Peer noted that as of March 30 the move was completed and advised that there are still some outstanding deficiencies and change orders that will be addressed when business gets back to normal.

Dr. Mackie was asked by Mr. Reid to comment on the items that were left behind after the move as noted by the media.
Dr. Mackie started by saying that the 2 main objectives of this move were to establish the best facilities that meet the needs of the community and to ensure the move was as financially efficient as possible.
The move costs came in at approximately $500,000 less than expected due leaving some items being left behind, with permission of the landlord. The new office space is approximately 17,000 square feet smaller than the previous office spaces, which meant that not all of the furniture and equipment would fit or be needed in the new facility at Citi Plaza. This smaller footprint will mean that taxpayers will be paying about $200,000 less per year in lease costs which is approximately $6,000,000 over the 30-year lease.
Dr. Mackie advised that staff welcome the questions and debate and are more than happy to speak to the specifics.
Mr. Reid asked for Dr. Mackie to comment on two specific types of items left behind at 50 King St. and what the thought process for leaving these behind was. The first category was medical supplies such as syringes and scales and the second was IT equipment such as wireless microphones and computer screens.
Ms. Di Cesare was asked to comment and noted that at the time of the move, the Health Unit was able to make the move on time but on an expedited timeline due to constant threat by the contractors that they may need to stop work at any time due to being deemed non-essential workers. Also, at this time, staff were being redeployed to COVID-19 work so the staff who ended up packing the remaining things for the move were not familiar with the space and necessarily what did or didn't need to be packed. Syringes that were left behind were in a cabinet

that were missed, however they were expired and most likely dating back to 2007 and could not be used. They also did not have the mandatory safety features that are required now.
Ms. Di Cesare then discussed the remaining IT equipment, noting that a truck of obsolete equipment had been disposed of at an e-waste depot. She advised that the laptops and monitors that were left behind in the vault were missed by the people taking the other equipment to the e-waste depot as the door may have been closed in error. Ms. Di Cesare advised that the remaining laptops were in the vault area for approximately 10 years, were wiped clean and had no operating system on them. She also noted that many of them did not have working batteries.
Ms. Di Cesare noted that the monitors that were left behind were old enough that they were no longer compatible with the computers that are now being used.
Dr. Mackie advised that the IT Team took a visionary approach to updating computers during the relocation preparations, such that the vast majority of staff are able to work from home. This is evident now during COVID-19, as it has enabled staff to work remotely and not spread the virus at work as has happened in at least one other health units.
Ms. Di Cesare noted that during the move, the 5 member IT Team was not only moving all of the equipment to Citi Plaza, they were also developing a COVID-19 case and contact database that is currently being used by several other health units.

Ms. Kayabaga asked if staff were contacted by the County of Middlesex or by one of the three County representatives on the Board prior to the media being contacted about the contents that were left at 50 King St. Dr. Mackie noted that staff were not notified that the media was being notified, however there were previous conversations between Ms. Di Cesare and the county CAO in regard to what would be left behind. County staff noted that they would find partners within the county who could use some of the remaining furniture etc.
Ms. Di Cesare noted that she reached out to the County CAO to do a final walkthrough of 50 King St. but she did not receive a response.
Ms. Kayabaga noted her frustration and stated that the County's communications approach was not appropriate. She asked that the Chair be in contact with the County to find other ways to deal with situations like this and not through the media. Time and resources were wasted and could have been dealt with differently and does not want to see this happen again. She noted that later in the meeting she would be happy to put forward a motion forward.

At this time, 6:50, Ms. Elliott was not able to continue to participate in the meeting due to internet difficulties. She did not return to the meeting.

Mr. Parker asked if there is any future plan or strategy to move out this equipment? Dr. Mackie advised that through negotiations with the county, the equipment is now with the County. He noted that the building is being demolished and what is remaining makes up a very small fraction of what would need to be removed. Ms. Di Cesare advised the Board that there were many donations of equipment and furniture made to non-profit organizations throughout the move timeline.

Mr. Peer asked if at any time during this process did the County offer to delay the move out date or assist in any way due to the pandemic? Dr. Mackie noted that there was nothing done related to COVID-19 but that previously a two-week extension was offered if needed.

At 7:04 p.m. Chair Cassidy asked if Ms. DeViet was logged into the meeting yet. Ms. DeViet had just joined with IT assistance. Chair Cassidy provided Ms. DeViet a brief summary of what she missed of the meeting so far.

It was decided that all 19 of the questions put forward by Ms. Elliott would be addressed. Chair Cassidy advised that she spoke to the new owner of 50 King St. Mr. Ali Soufan today, and that he would be

disposing of and dismantling the furniture, partitions, cubicles and had also confirmed that with Health Unit Staff.

Questions put forward by Ms. Elliott:

1) Why were we not able to use the 3 smart boards left behind? Do we have new smart boards purchased?
Answer: Dr. Mackie advised that Mr. Bill Rayburn, CAO Middlesex County asked that they be left behind to use in area schools. They are not useable at Citi Plaza primarily due to their size.

2) Why were we not able to use the box of wireless microphone that were left behind?
Answer: Mr. Flaherty provided this update noting that the system is now obsolete and technically illegal to use as they broadcast on emergency frequencies.

3) Why were we not able to use the boxes of portable printers that were left behind?
Answer: Ms. Di Cesare reminded the Board that the Health Unit was moving towards a more paperless environment, moving electronic client records, reducing the number of photocopiers and printers. She noted that the smaller personal printers are not economical. There is no resale value for these printers and that some of them hadn't been used in many years.

4) Why were we not able to use the livestreaming and conferencing equipment?
Answer: Mr. Flaherty advised that the cameras that were left in the boardroom are actually discontinued home security cameras that were adapted by the Communications Team to make work as streaming cameras, and provide a low-quality picture. He also noted that one is no longer functioning.

5) Why were we not able to find a use for the newer resin filing cabinets?
Answer: Ms. Di Cesare noted that due to the reduction of offices and stored materials at Citi Plaza there wasn't a need for all of the cabinets. She also advised that all of the furniture in manager offices are their furniture from their previous office and that no new furniture was bought for those offices. All cabinets and storage that are currently at Citi Plaza are from 50 King St. and 201 Queens Ave. Ms. Di Cesare noted that there were efforts to sell this furniture.

6) There was no way to utilize any of the dozens of computer monitors that were left at all in the new office that are still relatively new and in good condition?
Answer: This was discussed earlier in the meeting.

7) There were dozens of easels, white board signs, etc that were left. We didn't need these types of office supplies at all in the new office?
Answer: Most boards were not cleanable anymore and staff do not need these resources are no longer needed due to upgrades to technology.

8) Why were we not able to find a use for the dozens of filing cabinets and bookshelves in good condition? Were all new ones purchased for the new office?
Answer: This was discussed earlier in the meeting.

9) There was a significant amount of trade show/ display accessories left behind. Do we not need these?
Answer: Mr. Flaherty provided this update noting that many of the displays left behind were for programs that are no longer offered. He also noted that staff do not use the displays in the manner that once did as programs delivery has changed and they aren't needed as often. Many displays were brought to Citi Plaza and will be redeployed with new panels. Some of the older displays have old branding on them, are very large and would be expensive to update.

10) Why was an expensive dark maple boardroom table left behind? Could it not be utilized in the new office?
Answer: Ms. Di Cesare noted that there was no room that was large enough to accommodate the large table.

11) Were new projectors for boardrooms purchased for the new office? Why could the newer ones from 50 King not be utilized?
Answer: Dr. Mackie noted that the AV Procurement Report that was previously presented to the Board highlighted the modern, updated equipment that would be purchased for a great price due to the competitive bid process. He also was happy to hear that the county would be able to utilize the older projectors.

12) There was a very new refrigerator and other kitchen appliances left behind. Did we purchase new kitchen appliances for the new office?
Answer: Ms. Di Cesare noted that one refrigerator was brought to Citi Plaza and is currently in the basement. She noted that there was an attempt to give away the other fridges but only one was donated.

13) There was significant amounts of office supplies, including boxes of paper never opened, file folders, hole punches, etc left. Could these office supplies not be utilized in the new space?
Answer: Ms. Di Cesare noted that there was a significant amount of office supplies due to the amalgamation of offices. Going forward there will be a centralized stationary ordering process to ensure there isn't an overlap of supplies.

14) There was a box of medical equipment, including dozens of surgical scissors and tweezers and equipment to flush ears left behind. Could this not be used in the new space?
Answer: Syringes were discussed earlier in the meeting. Ms. Di Cesare noted that any medical equipment left behind should have been disposed of earlier as they are outdated. Some of this equipment also was missed during the packing of the office. The baby scales were deemed too old to use and too heavy for staff to carry to visits.

15) Expensive network racking was left behind – do we not need this sort of thing in the new space?
Answer: Ms. Di Cesare noted that there was lots of racking already at Citi Centre because it was a call-centre prior to the Health Unit moving in, therefore there wasn't a need to move it all.

16) There are dozens and dozens of desks in excellent condition that were left behind and are far from being 20+ years old. Absolutely none of these could be used in the new space at all?
Answer: Some of this was previously discussed. Ms. Di Cesare noted that age and size of the furniture had to be taken into consideration. Early in this project the Health Unit applied to the Community Health Capital Program for funding. The specifications that they provided for office and cubicle size were smaller that what was being used at 50 King St. Also to consider was the ergonomic aspect and the costs associated with that benefit. Ms. Di Cesare noted that a 77% discount was received when buying the new cubicle furniture and therefore more economical to buy rather than move.Dr. Mackie noted that a crucial principle was to prioritize frontline staff, and ensuring appropriate equipment for staff was deemed essential to be able to work efficiently and in an ergonomically appropriate way.

17) Was any new waiting room furniture purchased for the new office, when the newer chairs and furniture left behind could have been used?
Answer: Ms. Di Cesare noted that several clinic spaces were amalgamated into one waiting room. No new chairs were purchased, however the cloth seat pans were replaced with vinyl so that they could be wiped down.

18) When frontline workers are saying that PPE is in dire need – why was much needed supplies left behind in piles destined for the garbage?

Answer: Ms. Di Cesare speculated that the noted "booties" that were left behind were most likely very old as it could not be determined as to what team used them. The kavi wipes that were left behind were either missed during the packing or were expired.

19) What assurance can be provided that all of the electronics, printers, cell phones, and back up tapes, were wiped of all confidential information from the MLHU and that there is no risk to any PEPIDA violations that have occurred?
Answer: The Board was assured that there is no personal health information left on any of these devices.

Chair Cassidy provided some personal comments. She noted that it would have been more appropriate for her, Dr. Mackie and Ms. Di Cesare to have received this information prior to it going to the media, as a courtesy at the least. Chair Cassidy advised that if she is approached by the media, she seeks the information first, before responding to the media. As seen at this meeting, all of the answers to the questions were answered. She also indicated that staff did and incredible job in an incredible trying circumstance.

Ms. Kayabaga agreed that this could have been handled differently.

Dr. Mackie noted that the County is an important partner, and this is an opportunity to build on the relationship. He asked if perhaps the Board Chair contact the Warden to share information back and forth. Keeping the lines of communication open is important.

Ms. Kasi inquired about addressing the public. Dr. Mackie noted that when this project is finalized and the pandemic work has abated, there will be an opportunity to draft a full Board of Health report that will highlight the 5-year process of the move project.

There was much discussion on how to work Ms. Kayabaga's motion. The following was agreed to in principle and will be reworded as needed.

It was moved by Ms. Kayabaga, seconded by Ms. Kasi, *that the Board of Health;*

1) *Direct the Chair of the Board of Health to write a letter to staff at the County of Middlesex to address the concerns and questions in regard to the items that were left behind at 50 King St.; and*
2) *To include an invitation for a meeting with the Warden to discuss the importance of the relationship with Middlesex County.*

Carried

It was moved by Mr. Peer, seconded by Mr. Brennan, *that the Board* of *Health receive verbal RAC meeting update for information.*

Carried

Further Adjustments to Health Unit Services During Pandemic (Report No. 016-20)

Dr. Mackie noted that Ms. Rowlands and Ms. Lokko drafted this report. It came about because of the need to redeploy most staff to work on COVID-19 issues.

It was moved by Mr. Peer, seconded by Mr. Parker, *that the Board of Health receive Report No. 016-20 re: "Further Adjustments to Health Unit Services During Pandemic" for information.*

Carried

Ontario Poverty Reduction Strategy Consultation (Report No. 017-20)

Ms. Rowlands provided the content for this report. She noted this important work really helps the most vulnerable in our community. This is a great example of collaborative work between MLHU staff, community partners and the government. She noted that in 2009 the Government of Ontario passed a bill towards reducing poverty and that every 5 years they do consultations. The Health Unit was happy to participate by submitting a report.

It was moved by Ms. Kasi, seconded by Mr. Reid, *that the Board of Health receive Report No. 017-20 re: "Ontario Poverty Reduction Strategy Consultation" for information.*

Carried

Public Health Inspector Enforcement Actions and Inspection Activities Q4 and 2019 Summary (Report No. 018-20)

Mr. Turner was present to speak to this report. He noted that this report represents approximately 6,000 inspections throughout the city and county. He noted that in general, compliance has been good. Mr. Turner answered that year over year statistics are fairly consistent.

It was moved by Mr. Reid, seconded by Mr. Peer, *that the Board of Health receive Report No. 018-20 re: "Public Health Inspector Enforcement Actions and Inspection Activities – Q4 and 2019 Summary" for information.*

Carried

Association of Local Public Health Agencies (alPHa) Resolution: Regulatory Measures to Address the Harms, the Availability and Youth Appeal of Vapour Products (Report No. 021-20)

Ms. Rowlands spoke to this report and highlighted the importance of the resolution as noted in the report. She noted that since the writing of this report, the government of Ontario has proposed further regulations but due to COVID-19 they will be delayed.

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

1. *Receive Report No. 021-20, "Regulatory Measures to Address the Harms, the Availability and Youth Appeal of Electronic Cigarettes and Vapour Products";*
2. *Endorse the Statement of Sponsor Commitment and the Association of Local Public Health Agencies Resolution submission, "Reducing the Harms, the Availability and Youth Appeal of Electronic Cigarettes and Vaping Products through Regulation" attached as Appendix A; and,*
3. *Direct staff to submit the resolution (Appendix A) to the Association of Local Public Health Agencies (alPHa) for consideration at the Annual General Meeting in June.*

Carried

Medical Officer of Health/CEO Activity Report for March (Report No. 019-20)
Medical Officer of Health/CEO Activity Report for April (Report No. 020-20)

Dr. Mackie noted that it has been an epic couple of months with full calendars.

It was moved by Mr. Peer, seconded by Mr. Reid, *that the Board of Health receive Report No. 019-20 re: "Medical Officer of Health/CEO Activity Report for March" and Report No. 020-20 re: "Medical Officer of Health/CEO Activity Report for April" for information.*

Carried

Verbal Update – COVID-19

Dr. Summers provided this verbal update. He reiterated that the majority of Health Unit staff have been redeployed to COVID-19 work. As of today at noon there have been 258 positive cases and 90% of those are in the City of London. There are currently 14 outbreaks in Long Term Care (LTC) and retirement homes.
Testing capacity has improved since last reported and is primarily happening at the 2 Assessment Centres but also at hospitals and in-site LTC homes. The Health Unit is working with LIHC to ensure people experiencing homelessness are able to get tested and with the help of LM EMS in-site testing in group homes. Liaison team is ensuring EMDC has the testing if needed.
Due to expanded testing, the case count will go up but this is a good thing so that cases can be identified.
Dr. Summers highlighted some new initiatives noting that MLHU is the first health unit in the province to enlist medical students to help with case and contact management. Three medical students from Western have matched to the Public Health Residency Program and these three were instrumental in training and utilizing 60 medical students to work remotely.
A new case and contact management tool was developed by the MLHU IT Team and is being used by 10 other health units
Dr. Summers said that some people are suggesting that we are peaking but that cannot be confirmed at this time. Physical distancing is helping.
Daily press briefings with the Mayor continue and today Middlesex County Warden participated.
Not remotely through this yet.
Mr. Peer noted that there is a great deal of information out there and it is being delivered in a good way. He's concerned about the pushback in areas outside of Middlesex and London and how that could affect residents here. Is there a plan to deal with this? Dr. Mackie provided some input noting that keeping up the physical distancing and other measures will continue to help. There has been a lot of compliance in the county and the city.
Ms. DeViet appreciates the daily updates that Dr. Summers provides and asked if testing in Seniors homes is occurring continuously. Dr. Summers noted that steps are in place before testing occurs. All homes are closed to everyone except workers, all congregate activities are cancelled, no new admissions unless self-isolated for 14 days, all staff are masking. If a resident is tested, the roommate and any staff who work with that patient will get tested. If the test comes back positive, the testing is expanded.
Dr. Summers noted that test results are being received within 24 to 48 hours.

Chair Cassidy asked about morbidity and mortality being related to age. Does that mean that younger people less likely to catch the virus? Dr. Summers said that what is clear is that age most predictive of the severity your symptoms will be.

Chair Cassidy noted the great work that the Health Unit is doing during.

It was moved by Mr. Parker, seconded by Ms. Cassidy, *that the Board of Health receive the COVID-19 verbal update for information.*

Carried

CORRESPONDENCE

Chair Cassidy inquired if there were any questions, hearing none she asked for a mover and seconder.

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

Carried

CONFIDENTIAL

At 8:30 p.m., it was moved by Mr. Peer , seconded by Mr. Reid, *that the Board of Health move in-camera to consider matters regarding a trade secret or financial information, supplied in confidence to the local board, which if disclosed, could reasonably be expected to prejudice significantly the competitive position or interfere significantly with contractual or other negotiations of a person, group of persons or organization, and a trade secret or financial information that belongs to the municipality or local board and has monetary value.*

Carried

At 8:45 p.m., the Board of Health returned to public session.

At this time, it was acknowledged that the Relocation and Advisory Committee would be disbanded as discussed during the RAC update that Mr. Peer provided at the beginning of the meeting.

ADJOURNMENT

At 8:55 p.m., it was moved by Mr. Brennan, seconded by Ms. Kasi, *that the meeting be adjourned.*

Carried

MAUREEN CASSIDY	**CHRISTOPHER MACKIE**
Chair	**Secretary-Treasurer**

PUBLIC SESSION – MINUTES
MIDDLESEX-LONDON BOARD OF HEALTH
SPECIAL MEETING

Wednesday May 13, 2020 6:00 p.m.
300 Dufferin Ave, London, Ontario
Committee Room 5, (2nd Floor)

MEMBERS PRESENT: **Ms. Maureen Cassidy (Chair)**
Ms. Aina DeViet
Mr. Ian Peer
Mr. Matt Reid
Mr. John Brennan
Mr. Bob Parker
Ms. Kelly Elliott
Ms. Arielle Kayabaga

REGRETS: Ms. Tino Kasi

OTHERS PRESENT: Ms. Elizabeth Milne, Executive Assistant to the Board of Health and Communications Coordinator (Recorder)
Ms. Jodi Gallagher-Healy, Partner, Hicks Morley

Chair Cassidy called the meeting to order at 6:00 p.m.

DISCLOSURE OF CONFLICT OF INTEREST

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

APPROVAL OF AGENDA

It was moved by Ms. DeViet, seconded by Ms. Elliott, *that the **AGENDA** for the May 13, 2020 Special Meeting of the Board of Health meeting be approved.*

Carried

OTHER BUSINESS

The next regular meeting of the Board of Health will be on Thursday, May 21st at 7:00 p.m.

CONFIDENTIAL

At 6:01 p.m., it was moved by Ms. Kayabaga, seconded by Mr. Parker, *that the Board of Health move in camera to consider matters regarding labour relations, identifiable individuals and advice that is subject to solicitor-client privilege, including communications necessary for that purpose.*

Carried

Ms. Milne left the meeting at 6:01 p.m. and Chair Cassidy recorded the remaining information for the purposes of these minutes.

At 9:10 p.m., it was moved by Ms. Elliott, seconded by Mr. Peer, *that the Board of Health rise and return to public session.*

Carried

At 9:10 p.m., the Board of Health returned to public session.

ADJOURNMENT

At 9:11 p.m., it was moved by Mr. Reid, seconded by Ms. DeViet, *that the meeting be adjourned.*

Carried

MAUREEN CASSIDY
Chair

AINA DEVIET
Vice-Chair

PUBLIC SESSION – MINUTES
MIDDLESEX-LONDON BOARD OF HEALTH
RELOCATION ADVISORY COMMITTEE
Web Meeting
Thursday, April 16, 2020, 6:00 p.m.

Committee Members Present:	Mr. Ian Peer**, (Chair)** Ms. Maureen Cassidy Mr. Matt Reid Mr. John Brennan
Others Present:	Mr. Robert Parker, Board of Health Ms. Arielle Kayabaga, Board of Health Ms. Tino Kasi, Board of Health Ms. Kelly Elliott, Board of Health Dr. Christopher Mackie, Secretary-Treasurer Ms. Lynn Guy, Executive Assistant to the Medical Officer of Health (Recorder) Ms. Laura Di Cesare, Director, Healthy Organization Dr. Michael Clarke, VP Modernization Dr. Alexander Summers, Associate Medical Officer of Health Mr. Stephen Turner, Director, Environmental Health and Infectious Diseases Ms. Maureen Rowlands, Director, Healthy Living Ms. Heather Lokko, Director, Healthy Start Ms. Elizabeth Milne, Executive Assistant to the Board of Health and Communications Coordinator (web meeting facilitator) Ms. Laurie Rees, Public Health Nurse (web meeting facilitator) Mr. Dan Flaherty, Manager, Communications

At 6:03 p.m., the Chair Peer called the meeting to order.

DISCLOSURE OF CONFLICT(S) OF INTEREST

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

APPROVAL OF AGENDA

It was moved by Mr. Brennan, seconded by Ms. Cassidy, *that the **AGENDA** for the April 16, 2020 Relocation Advisory Committee meeting be approved.*

Carried

MINUTES

It was moved by Ms. Cassidy, seconded by Mr. Reid, *that the minutes of the December 5, 2019 Relocation Advisory Committee be approved.*

Carried

NEW BUSINESS

4.1 Relocation Project Update (Report No. 002-20RAC)

Dr. Mackie introduced this report and started by thanking Ms. Laura Di Cesare and Mr. Joe Belancic for their leadership throughout this project and to and all staff for making this move happen during these times. He noted that there would be a chance to have an open dialogue in regard to the nineteen questions that Ms. Kelly Elliott, Deputy Mayor, Thames Centre, Middlesex County and member of the Middlesex-London Board of Health sent to Dr. Mackie and Ms. Cassidy for answers.

Committee members agreed that this discussion should happen at the Board of Health so that the full Board is present.
Ms. Cassidy noted her thankfulness to staff for the incredible job of moving over 300 people during a pandemic.

Chair Peer asked the committee to consider disbanding the relocation Advisory Committee at the end of the Board of Health meeting. This was agreed to. He also noted that any remaining issues or updates related to this project will go to the Finance and Facilities Committee.

It was moved by Ms. Cassidy, seconded by Mr. Reid, that *the Relocation Advisory Committee:*

1) *Receive Report No. 002-20RAC re: "Relocation Project Update" for information; and*
2) *Approve the disbanding of the Relocation Advisory Committee.*

Carried

CONFIDENTIAL

At 6:13 p.m. it was moved by Mr. Reid, seconded by Ms. Cassidy, that the Relocation Advisory Committee move in-camera to consider matters regarding a trade secret or financial information, supplied in confidence to the local board, which if disclosed, could reasonably be expected to prejudice significantly the competitive position or interfere significantly with contractual or other negotiations of a person, group of persons or organization, and a trade secret or financial information that belongs to the municipality or local board and has monetary value.

At 6:22 p.m. the Relocation Advisory Committee returned to public session.

ADJOURNMENT

At 6:25 p.m., it was moved by Ms. Cassidy, seconded by Mr. Brennan, *that the meeting be adjourned.*

Carried

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IAN PEER **CHRISTOPHER MACKIE**
Chair **Secretary-Treasurer**

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 022-20

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2020 May 21

BY LAW AMENDMENT REGARDING ELECTRONIC PARTICIPATION

Recommendation

It is recommended that the Board of Health:

1) ***Receive Report No. 022-20 re: "By-Law Amendment Regarding Electronic Participation" for information; and***
2) ***Approve the amendments to governance By-law #3 (Appendix A) and the Resolution (Appendix B).***

Key Points

- Per Governance Policy G-000 Bylaws, Policy and Procedures Governance policy development and Review can be initiated by the Board of Health.
- G-B30 By-law No. 3 Proceedings of the Board of Health was last reviewed February 27, 2020.
- With the onset of a Global Pandemic and corresponding changes to the Emergency Management and Civil Protection Act, RSO 1990 c.E9 further amendment was required in order to facilitate electronic participation in meetings.

Background

Per *Governance Policy G-000 Bylaws, Policy and Procedures*, the Board of Health is responsible for the Health Unit's governance by-laws and policies. Review and revision of governance policies can be initiated at any time by the Board of Health based on changing legislation or organizational needs. *G-B30 By-law No. 3 Proceedings of the Board of Health*, was last brought forward and approved by the Governance Committee and the Board on February 27, 2020. That review however did not contemplate the changes to the Emergency Management and Civil Protection Act, RSO 1990 c.E9 that would allow electronic participation in Board meetings.

With the onset of a Global Pandemic and corresponding changes to the Emergency Management and Civil Protection Act, RSO 1990 c.E9 further amendment was required in order to facilitate electronic participation in meetings. This amendment has been drafted and reviewed by legal counsel.

Next Steps

The Board of Health has the opportunity to review the appended by-law. Once satisfied with its review, the by-law will be read for approval and implementation.

This report was prepared by the Healthy Organization Division.

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

MIDDLESEX-LONDON HEALTH UNIT

Board of Health: **By-law No. 3**

Pursuant to Section 56(1) (c) of the *Health Protection and Promotion Act*, R.S.O. 1990, c. H.7, the Board of Health for the Middlesex-London Health Unit enacts By-law No.3 to regulate **the proceedings of the Board of Health.**

1. In this by-law:

(a) "Act" means the *Health Protection and Promotion Act*;

(b) "Board" means the Board of Health for the Middlesex-London Health Unit;

(c) "Chair" means the person presiding at the meeting of the Board;

(d) "Chair of the Board" means the Chairperson elected under Section 57(2) of the Act;

(e) "City" means the Corporation of the City of London;

(f) "County" means the Corporation of the County of Middlesex;

(g) "Committee" means a committee of the Board, but does not include the Committee of the Whole;

(h) "Committee of the Whole" means all the members present at a meeting of the Board sitting in Committee;

(i) "Council" means the Council of the City of London and/or the Council of the County of Middlesex;

(j) "Majority" means a simple majority of members present;

(k) "Meeting" means a meeting of the Board;

(l) "Member" means a member of the Board;

(m) "Quorum" means a majority of the members of the Board;

(n) "Secretary-Treasurer" means the Secretary-Treasurer as defined in Policy G-270 as may be amended, from time to time.

(o) “In-camera” means deliberations of the Board are closed to the public and the media.

1.0 General

1.1 In all the proceedings at or taken by this Board the following rules and regulations shall be observed and shall be the rules and regulations for the order and dispatch of business at the Board, and in the Committees thereof.

1.2 Except as herein provided, Robert's Rules of Order shall be followed for governing the proceedings of the Board and the conduct of its members.

1.3 A person who is not a member of the Board shall not be allowed to address the Board except upon invitation of the Chair or the members.

2.0 Convening Meeting

2.1 The regular meetings shall be held at a date and time as determined by the Board at its first regular meeting of the year.

2.2 The Board may, by resolution, alter the time, day or place of any meeting.

3.0 Special Meetings

3.1 A special meeting may be called by the Chair of the Board of Health.

3.2 Any three Board members by written communication to the Secretary-Treasurer may initiate a special meeting.

3.3 A special meeting shall not be summoned for a time which conflicts with a regular meeting or a meeting previously called of the Council(s) of the City of London and/or the County of Middlesex.

4.0 Notifying Board Members of Meetings

4.1 The Secretary-Treasurer shall give notice of each regular and special meeting of the Board and of each Committee to the members thereof.

4.2 The notice shall be accompanied by the "Agenda" and any other matter, so far as known, to be brought before such meeting.

4.3 The notice shall be delivered by electronic mail to each member so as to be received no later than five days prior to the scheduled Board meeting.

4.4 Lack of receipt of the notice shall not affect the validity of holding the meeting or any action taken thereat.

4.5 The notice calling a special meeting of the Board shall state the business to be considered at the special meeting and no business other than that stated in the notice shall be considered at such meeting except with the unanimous consent of the members present and voting.

5.0 Notifying the Public of Board Meetings

5.1 The Board shall give reasonable notice to the public of every of its meetings by posting in a publicly accessible location and by publishing on its website or any other print or electronic medium of mass communication:

(a) the date, time and location of the meeting;

(b) a clear, comprehensive agenda of the items to be discussed at the meeting.

6.0 Meetings Open to the Public

6.1 The Board shall ensure that its meetings are open to the public except where a closed meeting is permitted by law. See Item 7.0 re Convening In-Camera (Closed) Meeting(s).

6. 2 In accordance with Section 238 (3.1) of the *Municipal Act*, R.S.O., the Board shall ensure that members can participate electronically in a meeting which is open to the public. Any such member shall not be counted in determining whether or not a quorum of members is present at any point in time. Board members shall not be permitted to participate electronically in a meeting which is closed to the public. See Item 7.0 re Convening In-Camera (Closed) Meeting(s).

6. 3 A member who is participating electronically in a meeting shall be able to vote on any matter that is before the Board, subject to restrictions contained elsewhere in this policy, and otherwise at law.

6.4 Despite Section 6.2, during any period where an emergency has been declared to exist in all or part of the municipality under section 4 or 7.0.1 of the *Emergency Management and Civil Protection Act*, RSO 1990 c.E9,

(a) a member participating electronically in a meeting may be counted in determining whether or not a quorum of members is present at any point in time;

(b) a member may participate electronically in a meeting that is closed to the public; and

(c) the Board may hold a special meeting to amend the by-law and despite Section 6.2, a member participating electronically in such a special meeting may be counted in determining whether or not a quorum of members is present at any time during the meeting.

7.0 Convening In-Camera (Closed) Meeting(s)

7.1 Pre-requirements for in-camera sessions

Before holding a meeting or part of a meeting that is closed to the public, the Board shall state by resolution,

(a) the fact of the holding of the closed meeting and the general nature of the matter to be considered at the closed meeting; or

(b) in the case of a meeting for education or training, the fact of the holding of the closed meeting, the general nature of its subject-matter and that it is to be closed under that subsection.

7.2 Criteria for in-camera meetings

In accordance with Section 239 (2) of the *Municipal Act,* R.S.O, as amended, a meeting or part of a meeting may be closed to the public if the subject matter being considered is:

(a) the security of the property held by the Middlesex-London Board of Health;

(b) personal matters about an identifiable individual, including Board employees;

(c) a proposed or pending acquisition of land by the Middlesex-London Board of Health;

(d) labour relations or employee negotiations;

(e) litigation or potential litigation, including matters before administrative tribunals, affecting the Middlesex-London Health Unit;

(f) advice that is subject to solicitor-client privilege, including communications necessary for that purpose;

(g) a matter in respect of which a council, Board, committee or other body may hold a closed meeting under another Act.

(h) Information explicitly supplied in confidence to the Middlesex-London Health Unit by Canada, a province or territory or a Crown agency of any of them;

(i) a trade secret or scientific, technical, commercial, financial or labour relations information, supplied in confidence to the Middlesex-London Health Unit, which, if disclosed, could reasonably be expected to prejudice significantly the competitive position or interfere significantly with the contractual or other negotiations of a person, group of persons, or organization;

(j) a trade secret or scientific, technical, commercial, or financial information that belongs to the Middlesex-London Health Unit and has monetary value or potential monetary value; or

(k) a position, plan, procedure, criteria or instruction to be applied to any negotiations carried on or to be carried on or by or on behalf of the Middlesex-London Health Unit.

7.3 Criteria for in-camera voting

A meeting shall not be closed to the public during the taking of a vote, except:

(a) When item 7.2 permits or requires the meeting to be closed to the public; and/or

(b) The vote is for a procedural matter or for giving directions or instructions to officers, employees or agents or persons retained under contract of/with the Board.

7.4 In-camera record keeping requirements

The Board shall record without note or comment all resolutions, decisions and other proceedings at a meeting, whether it is closed to the public or not.

8.0 Preparation of the "Agenda"

8.1 The Secretary-Treasurer shall prepare for the use of members at the regular meetings the "Agenda" as follows:

(a) Call to Order and Declarations of Interest;

(b) Minutes of Previous Meeting;

(c) List of Items to be dealt with in open session including delegations;

(d) List of Items to be dealt with in-camera;

(e) Other Business from the Floor;

(f) Date of Next Meeting;

(g) Adjournment

8.2 For special meetings, the "Agenda" shall be prepared when and as the Chair may direct or, in default of such direction, as provided in the last preceding section so far as applicable.

8.3 The business of each meeting shall be taken up in the order in which it stands on the "Agenda", unless otherwise described by the Board.

9.0 Commencement of Meetings

9.1 As soon as there is a quorum after the hour fixed for the meeting, the Chair or Vice-Chair, or person appointed to act in their place and stead, shall take the chair and call the members to order. A majority of the Board is required for quorum (i.e. more than half of the voting members).

9.2 If the person who ought to preside at any meeting does not attend by the time a quorum is present, the Secretary-Treasurer shall call the members to order and a presiding officer shall be appointed by the members present, to preside during the meeting or until the arrival of the person who ought to preside.

9.3 If there is no quorum within thirty minutes after the time appointed for the meeting, the meeting shall then adjourn until the next day of meeting unless the Board otherwise decides.

9.4 Upon any member directing the attention of the Chair, to the fact that a quorum is not present, the Secretary-Treasurer, at the request of the Chair, shall record the names of those members present and advise the Chair if a quorum is, or is not, present.

10.0 Rules of Debate and Conduct of Members of the Board

10.1 The Chair shall preside over the conduct of the meeting, including the preservation of good order and decorum, ruling on points of order and deciding all questions relating to the orderly procedure of the meetings, subject to an appeal by any member to the Board from any ruling of the Chair.

10.2 Each delegation will be allowed a maximum of 10 minutes, but a member of the Board may introduce a delegation in addition to the speaker or speakers. Normally, a delegation will not be heard on an item unless there is a report from staff on the item.

10.3 When a member finds it impossible to attend any meeting, the onus is upon the member to advise the Secretary-Treasurer prior to the holding of such meeting, and to advise of their wishes with respect to having an agenda item tabled.

10.4 If the Chair desires to leave the chair for the purpose of taking part in the debate or otherwise, the Chair shall call on the Vice-Chair or another member in their absence, or refusal to fill their place until they resume the chair.

10.5 Every member, previous to speaking to any question or motion, shall respectfully address the Chair.

10.6 When two or more members ask to speak, the Chair shall name the member who, in their opinion, first asked to speak.

10.7 A member may speak more than once on a question, but after speaking shall be placed at the foot of the list of members wishing to speak.

10.8 No member shall speak to the same question at any one time for longer than five minutes except upon motion that the Board therefore may grant an extensions of time for speaking of up to five minutes for each time extended.

10.9 Any member may request the question or motion under discussion to be read at any time during the debate, but not so as to interrupt a member while speaking.

10.10 When a member desires to address the Board upon a matter that concerns the rights or privileges of the Board collectively or of themselves as a member thereof, they shall be permitted to raise such matter of privilege, and a matter of privilege shall take precedence over other matters.

10.11 When a member desires to call attention to a violation of the rules of procedure, they shall ask leave of the Chair to raise a point of order and after leave is granted, they shall state the point of order with a concise explanation and then not speak until the Chair has decided the point of order.

10.12 Unless a member immediately appeals to the Board the decision of the Chair shall be final.

10.13 If the decision is appealed, the Board shall decide the question without debate and its decision shall be final.

10.14 When the Chair calls a member to order, they shall immediately cease speaking until the point of order is dealt with and they shall not speak again without the permission of the Chair unless to appeal the ruling of the Chair.

11.0 Motions and Order of Putting Questions

11.1 Every motion shall be deemed to be in possession of the Board for debate after it is presented by the Chair, and seconded, but may, with permission of the Board, be withdrawn at any time before amendment or decision.

11.2 When a matter is under debate, no motion shall be received other than a motion:

(a) to accept;

(b) to recommend for approval;

(c) to approve in principle;

(d) to approve;

(e) to ratify;

(f) to adopt;

(g) to amend;

(h) * to table;

(i) to refer;

(j) to receive;

(k) * to adjourn the meeting; or

(l) * that the vote be now taken.

* these items are to be voted on without debate.

11.3 A motion to refer or table shall take precedence over any other amendment.

11.4 When a motion that the vote be now taken is presented, it shall be put to a vote without debate, and, if carried by a majority vote of the members present, the motion and any amendments thereto under discussion shall be submitted to a vote forthwith without further debate.

11.5 A motion relating to a matter not within the jurisdiction of the Board shall not be in order.

12.0 Voting

12.1 Only one amendment at a time can be presented to the main motion and only one amendment can be presented to an amendment, but when the amendment to the amendment has been disposed of, another may be introduced, and when an amendment has been decided, another may be introduced.

12.2 The amendment to the amendment, if any, shall be voted on first, then if no other amendment to the amendment is presented, the amendment shall be voted on next, then if no other amendment is introduced, the main motion, or if any amendment has carried, the main motion as amended, shall be put to a vote.

12.3 Nothing in this section shall prevent other proposed amendments being read for the information of the members.

12.4 When the question under consideration contains distinct propositions, upon the request of any member, the vote upon each proposition shall be taken separately.

12.5 After the Chair commences to take a vote, no member shall speak to or present another motion until the vote has been taken on such motion, amendment or subamendment.

12.6 Every member present at a meeting of the Board when a vote is taken on a matter shall vote thereon unless prohibited by statute; and, if any member present persists in refusing to vote, they shall be deemed as voting in the negative.

12.7 If a member disagrees with the announcement by the Chair of the result of any vote, they may object immediately to the Chair's declaration and require that the vote be retaken.

12.8 After any matter has been decided, any member may move for a reconsideration at the same meeting or may give notice of a motion for reconsideration of the matter for a subsequent meeting in the same year, but no discussion of the question that has been decided shall be allowed until the motion for reconsideration has carried, and no matter shall be reconsidered more than once in the same calendar year.

13.0 Minutes

13.1 Minutes shall be taken at all regular and special meetings by the Secretary-Treasurer or Designate.

13.2 The names of all Board members and Health Unit employees who attend the meeting shall be recorded.

13.3 All Board motions shall become effective immediately upon approval, unless otherwise stated. All approved and defeated motions shall be recorded.

13.4 There shall be a motion to approve the minutes or amended minutes of each Board meeting.

13.5 All Board of Health minutes shall be ratified by signature of the Board Chair and Secretary-Treasurer.

14.0 Adjournment

14.1 A motion to adjourn the Board Meeting or adjourn the debate shall be in order, except:

(a) when a member is in possession of the floor;

(b) when it has been decided that the vote be now taken;

(c) during the taking of the vote; no second motion to the same effect shall be made until after some intermediate proceedings shall have taken place.

15.0 Communications

15.1 Every communication intended to be presented to the Board must be written dated and signed.

15.2 Every such communication shall be delivered to the Secretary-Treasurer before the commencement of the meeting of the Board.

16.0 Proceedings on By-laws

16.1 Every by-law shall be introduced by a member upon motion for leave specifying the title of the by-law, and a by-law shall not be in form blank or incomplete.

16.2 Every by-law shall receive three readings at the Board of Health before being passed. The Board may by a majority vote provide for two or more readings at one meeting.

16.3 The procedure for approving a by-law or amendments to the by-laws is as follows:

(a) The motion “this by-law be now read for a first time" shall be decided without amendment or debate;

(b) The motion “this by-law be now read for a second time” with debate and decision that the adoption of the by-law follow thereafter;

(c) The motion “the by-law be now read for a third time” with resolution that the adoption of the by-law follow thereafter.

16.4 All amendments made at the Board of Health shall be reported by the Chair thereof to the Board which shall receive the same forthwith without debate.

16.5 The Secretary-Treasurer shall endorse on all by-laws read at the Board the dates of the several readings and of the passing thereof and shall be responsible for

the correctness of such bills should they be amended.

16.6 Every by-law which has been passed by the Board shall be sealed with the seal of the Board, signed by the Chair of the Board or by the Chair of the meeting at which the by-law was passed and by the Secretary-Treasurer and deposited with the Secretary-Treasurer for custody.

16.7 All by-laws adopted by the Board shall be kept in a separate volume.

17.0 Secretary-Treasurer

17.1 It shall be the duty of the Secretary-Treasurer:

(a) to attend or cause an assistant to attend all meetings of the Board;

(b) to keep or cause to be kept full and accurate minutes of the meetings of all the Board meetings, text of By-laws and Resolutions passed by it;

(d) to forward a copy of all resolutions, enactments and orders of the Board to those concerned in order to give effect to the same; and

(e) to forward all reports of the Board requiring City/County Council approval to the appropriate official so that the same may be considered by the Council at the next regular meeting.

18.0 Elections and Appointment of Committees

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

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

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

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

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

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

19.0 Conduct of Business in Committees

19.1 The rules governing the proceedings of the Board shall be observed in the Committees insofar as applicable.

19.2 It shall be the duty of the Committee:

(a) to report to the Board on all matters referred to them and to recommend such action as they deem necessary;

(b) to forward to the Board the minutes of meetings;

(c) to forward to the incoming Committee for the following year any matter indisposed of.

20.0 Corporate Seal

20.1 The corporate seal of the Board shall be in the form impressed hereon and shall be kept by the Medical Officer of Health / Chief Executive Officer or the Secretary-Treasurer of the Board.

21.0 Execution of Documents

21.1 The Board may at any time and from time to time direct the manner in which and the person or persons who may sign on behalf of the Board and affix the corporate seal to any particular contract, arrangements, conveyance, mortgage, obligation, or other document or any class of contracts, arrangements, by-law, conveyances, mortgages, obligations or documents.

22.0 Duties of Officers

22.1 The Chair of the Board shall:

(a) preside at all meetings of the Board;

(b) represent the Board at public or official functions or designate another Board member to do so;

(c) be ex-officio a member of all Committees to which they have not been named a member;

(d) perform such other duties as may from time to time be determined by the Board.

22.2 The Vice-Chair shall have all the powers and perform all the duties of the Chair in the absence or disability of the Chair, together with such powers and duties, if any, as may be from time to time assigned by the Board.

23.0 Remuneration

23.1 Board of Health members shall receive equal, daily remuneration, as well as payment for any reasonable and actual expense incurred as a Member of the Board. However, the rate of the remuneration paid shall not exceed the highest rate of remuneration of a member of a standing committee of a municipality within the health unit. Where no remuneration is paid to members of such standing committees, the rate shall not exceed the rate fixed by the Minister and the Minister has power to fix the rate.

23.2 However, Board of Health members, other than the chair, who are a member of the council of a municipality and are paid annual remuneration or expenses, by the municipality will not receive any remuneration of expenses.

24.0 Board of Health Performance Assessment

24.1 Board of Health members shall conduct self-evaluations of the Board's governance practices and outcomes at least biannually.

24.2 The results of the self-evaluations shall be summarized by Health Unit staff and will translate into recommendations for improvements in the Board's

effectiveness and engagement. This may be supplemented by evaluation(s) from key partners and/or stakeholders.

24.3 The self-evaluation process shall include a record of Board member attendance and consideration of whether:

(a) Decision-making is based on access to appropriate information with sufficient time for deliberations;

(b) Compliance with all federal and provincial regulatory requirements is achieved;

(c) Any material notice of wrongdoing or irregularities is responded to in a timely manner;

(d) Reporting systems provide the Board with information that is timely and complete;

(e) Members remain abreast of major developments in governance and public health best practices, including emerging practices among peers; and

(f) The Board as a governing body is achieving its strategic outcomes.

25.0 Amendments

25.1 Any provision contained therein may be repealed, amended or varied, and additions may be made to this by-law by a majority vote.

First Reading – February 27, 2020
Second Reading – February 27, 2020
Third Reading – February 27, 2020

This By-law is to be in force and effect and to remain in force and effect until otherwise amended by enactment by the Board.

Executed in London, in the Province of Ontario, on this December 8, 2016.

Reviewed by:	Governance Committee	
Approved by:	Board of Health	
Date:	February 27, 2020	
Signature:	Ms. Maureen Cassidy Chair, Board of Health	Dr. Christopher Mackie Secretary-Treasurer

Amendment to Middlesex-London Health Unit Board of Health By-law No. 3

BE IT RESOLVED THAT the following amendment to By-law No. 3 be now read for the first time without amendment or debate**:**

1. In accordance with Section 238 (3.3 and 3.4) of the Ontario *Municipal Act*, RSO, S.O. 2001, c25 and Section 16 of this by-law, the following amendment shall be added as a new Section 6.4 to this by-law:

   6.4 Despite Section 6.2, during any period where an emergency has been declared to exist in all or part of the municipality under section 4 or 7.0.1 of the *Emergency Management and Civil Protection Act*, RSO 1990 c.E9,

   (a) a member participating electronically in a meeting may be counted in determining whether or not a quorum of members is present at any point in time;

   (b) a member may participate electronically in a meeting that is closed to the public; and

   (c) the Board may hold a special meeting to amend the by-law and despite Section 6.2, a member participating electronically in such a special meeting may be counted in determining whether or not a quorum of members is present at any time during the meeting.

2. In addition to incorporating the foregoing substantive amendment into By-law No. 3, any minor changes to Bylaw No. 3, including re-numbering, changes to wording for consistency, or correction of grammatical errors are hereby approved.

3. Any member of the Board is hereby authorized and directed to give effect to the foregoing.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 023-20

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2020 May 21

Impact of the COVID-19 Pandemic on Adherence to the Nurse-Family Partnership Core Model Elements

Recommendation

It is recommended that Report No. 023-20 re: "Impact of the COVID-19 Pandemic on Adherence to the Nurse-Family Partnership Core Model Elements" be received for information.

Key Points

- Nurse Family Partnership® (NFP) continues implementation in five health units, with MLHU as the Ontario license-holder.
- Adjustments to service delivery to reduce or eliminate risk to clients and staff during the COVID-19 pandemic has impacted the ability to fully meet fidelity requirements as outlined by the program license
- Anticipated impacts on program fidelity have been discussed with and accepted by the program licensor

Background

The Nurse-Family Partnership® (NFP) is an evidence-based intensive home visiting program for young, low-income, first-time mothers, with demonstrated positive effects on pregnancy, children's subsequent health and development, and parents' economic self-sufficiency. Since 2008, steps have been taken in Ontario and British Columbia (BC) to adapt and evaluate NFP in Canada, including the Middlesex-London Health Unit's (MLHU's) completion of the Canadian Nurse-Family Partnership Education (CaNE) Project (see Report No. 039-19 "Completion of the Canadian Nurse-Family Partnership Education (CaNE) Project"). Beginning in 2019, MLHU became the provincial license holder for five Ontario public health units delivering the NFP program to high-risk clients while the program awaits the results of the Randomized Control Trial in British Columbia.

Beginning in March 2020, as part of the response to the COVID-19 pandemic, the health unit prioritized the continuation of Nurse-Family Partnership® program delivery to ensure this service remained available to its priority population (see Report No. 016-20 "Further Adjustments to the Health Unit Services During Pandemic").

Adaptations to Program Delivery (across the 5 Health Units)

As with most other public health programs and services continued during the pandemic, the NFP program has made adjustments to optimize the safety of clients and staff. Adaptations made by the five NFP-implementing health units include the following:

- Most NFP visits are being completed via telepractice, rather than as home visits; telepractice is considered the default approach and home visits are only provided when there is a strong case to do so;
- Public Health Nurses (PHNs) are using of an adapted version of guidelines for telepractice that were developed by NFP National Service Office in the United States;

- PHNs have had to adapt their approach to discussing and providing education on Intimate Partner Violence (IPV) and responding to clients experiencing IPV; an adapted guideline developed by Dr. Susan Jack is being used;
- NFP team members are using phone/video for team meetings, case conferences and 1:1 Reflection Supervision sessions;
- All accompanied home visits have been temporarily suspended;
- Some health units have redeployed some of their NFP PHN's to COVID-19 work; and
- The in-person NFP PHN core education originally planned for the spring of 2020 has been postponed

Anticipated Impacts on Program Fidelity

The NFP program has specific education requirements for PHNs and supervisors, requires home visits with clients, has set guidelines and processes related to Intimate Partner Violence (IPV), requires regular reflective supervision sessions between supervisor and PHN, and sets an expectation for accompanied home visits (visits in which both the supervisor and PHN attend). The above adaptations have resulted in the inability to fully meet these requirements. The specific impacts include:

- Inability to meet the required frequency and duration of reflective supervision sessions/team meetings/case conferences in some sites
- Reduced number of completed visits (dosage decrease overall) and total time spent with clients as telepractice visits may be shorter in duration
- Minimum team size (4 FTE PHNs) not met across all sites if NFP PHNs are redeployed
- Minimum number of annual accompanied home visits per PHN (4 annually) may be reduced for this reporting period
- Reduced number of referrals overall for this reporting period that may impact early referral rate (benchmark of 60% of referred clients before 16 weeks gestation) as many clinics and practices not seeing non-urgent patients during this time
- A delay in completion of the in-person component of the NFP education curriculum for two PHNs

Collaboration and Communication

The Ontario NFP Nursing Practice Lead has been working collaboratively with the NFP International Team as part of an emerging NFP international project focused on the NFP program during the COVID-19 pandemic. The proposed project goals include keeping the clinical leads connected during the COVID-19 pandemic to facilitate sharing of innovation and best practice and to capture the current and unfolding story of COVID-19 and its impact on the NFP program. As part of this collaboration, the anticipated impacts on program fidelity (as outlined above) have been communicated to, and accepted by, the NFP International Team and the NFP Licensor.

Conclusion

During the COVID-19 pandemic response, the NFP program continues to be considered an urgent service and is utilizing adaptive approaches to offer public health nursing support to a priority population. Program adaptations will impact MLHU's ability to fully meet program fidelity requirements during this reporting period. Anticipated impacts on program fidelity have been communicated to, and accepted by, the licensing organization in Denver, Colorado.

This report was submitted by the Office of the Chief Nursing Officer.

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

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 024-20

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health/ CEO

DATE: 2020 May 21

STAFFING UPDATE

Recommendation

It is recommended that the Board of Health Receive Report No. 024-20 "Staffing Update" for information.

Key Points

- With the redeployment of employees to the COVID-19 response, some teams have been left short-staffed and required additional temporary support; therefore, three two additional temporary full-time Public Health Nurses will be hired for the Infectious Disease Control (IDC) team, and one for the Best Beginnings (BB) team.

Temporary Hiring

In order to quickly mobilize additional staff to support the rapid increase in workload and need for resources, MLHU recruited several positions (PHNs, Managers, Program Assistants and a Receiving and Operations Coordinator) for temporary three-month assignments. Almost all of these temporary hires were recent retirees or employees who had recently resigned for other roles where their work had been put on hold. Many of these assignments will end in June, but some may need to be extended depending on the continued work associated with Covid-19. Even with these hires the redeployment of employees to the Covid-19 Task Force has left both the Infectious Disease Control (IDC) team and the Healthy Babies Healthy Children team short-staffed and in need of additional temporary support.

The Infectious Disease Control (IDC) team has been providing strong leadership to the Covid-19 Task Force as the Manager of the team, PHNs and Public Health Inspectors (PHI) are in lead roles for the Case and Contact Management teams and Outbreak and Facilities teams. In total, there have been 3 PHNs, 6 PHIs, and 1 Health Promoter redeployed to Covid-19 work from the IDC team. There continues to be ongoing infectious disease control work required in the community outside of Covid-19 and in order to meet these needs we will be hiring two temporary full-time PHNs until the end of the year.

Within HBHC, there is an anticipated need for additional support due to the compression of vacation in the third and fourth quarters, and the expected increase in births within the next year. The Best Beginnings teams have also redeployed a manager, 1.5 PHNs and 7 Family Home Visitors to support the Covid-19 work. In order to provide additional temporary support to the Best Beginnings teams, a temporary full-time PHN has been hired from May to the end of the HBHC fiscal year, March 2021. Based on historical gapping, it is likely that the HBHC budget will be able to cover this cost. Barring this, funding will be sought through the COVID funding process.

Next Steps

As work begins on the next stage of Recovery of Operations, the Human Resources team will continue to work with the Operations leads on the Incident Management System (IMS) team, as well as the leads for Continuity of Operations, to meet the resource and staffing needs for any new or ongoing work.

This report was prepared by the Healthy Organization Division.

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

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 025-20

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2020 May 21

MEDICAL OFFICER OF HEALTH / CEO ACTIVITY REPORT FOR MAY

Recommendation

It is recommended that the Board of Health receive Report No. 025-20 re: "Medical Officer of Health/CEO Activity Report for May" for information.

The following report presents activities of the Medical Officer of Health (MOH)/CEO for the period April 5, 2020 – May 8, 2020.

The MOH/CEO participates in approximately 20-25 external meetings each week on COVID-19. Not all are described here. These include calls daily, every other day, or weekly with Middlesex County, the City of London, local health partners, the Association of Local Public Health Agencies (alPHa), the Ministry of Health, Ontario Health West, the Southwest LHIN, the Office of the Chief Medical Officer of Health, and Public Health Ontario, to name a few. The MOH/CEO and London Mayor Ed Holder continue to provide daily media briefings on the COVID-19 pandemic.

The following events were also attended by the MOH/CEO.

April 5	Interview with Sofia Rodrigues, CBC London in regard to case numbers of COVID-19
April 6	Interview and question period with CBC – London Morning to provide latest update on COVID-19
April 8	Interview with Chris Soares, MyFM for an update on COVID-19
April 14	Interview with Jess Brady, AM980 in regard to the completion of the Health Unit's move to Citi Plaza
April 15	Participated on the monthly (Council of Medical Officers of Health) COMOH Executive call
April 16	Attended the Relocation and Advisory Committee and Board of Health Meeting
April 25	Interview with CTV London, Jordyn Read & Brent Lale, regarding community gardens during COVID-19 and a local update
April 26	Interview with Randy Richmond, London Free Press in regard to Long Term Care and Retirement Home COVID-19 related deaths
April 27	Introductory meeting (via phone) with Ms. Barb Maly, Executive Director, Downtown London

April 30	Interview with Rebecca, CBC London Morning to provide the latest local COVID-19 updates Interview with Jess Brady, AM980 in regard to an employee at Real Canadian Superstore testing positive for COVID-19 and any impact to the consumer
May 4	CBC National was in the Citi Plaza office for the day to interview various staff on what their new role is during the pandemic. The MOH/CEO was interviewed.
May 6	Participated in a meeting of the COMOH Executive Hosted a virtual meeting with MOH's and CEO's from Chatham-Kent Public Health, Southwestern Public Health, Huron Perth Public Health, Windsor Public Health, Lambton Public Health and Grey Bruce Public Health. This was an opportunity to provide updates on each health units efforts to combat COVID-19
May 8	Participated in a meeting of the COMOH Executive Met virtually with YMCA senior staff to discuss the eventual opening of Y's across the region. Interview with Chip Martin, London Free Press in regard to items left at 50 King St.

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

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

CORRESPONDENCE – May 2020

a) Date: 2020 April 23
Topic: Extraordinary Expenses Associated with COVID-19
From: Ontario Ministry of Health
To: All Health Units

Background:

On April 23, 2020, the Ontario Ministry of Health provided assurance to all Boards of Health that a process for reimbursement of approved one-time extraordinary cost incurred in managing the COVID-19 response will be forthcoming.

Recommendation: Receive.

b) Date: 2020 March 25
Topic: Letter of Gratitude
From: Bishop Ronald Fabbro, Diocese of London, Office of the Bishop
To: Dr. Christopher Mackie

Background:

On March 25, 2020, Bishop Fabbro wrote to Dr. Mackie expressing deep gratitude to the Middlesex-London Health Unit for leadership and service of the common good in response to the COVID-19 crisis. The Diocese of London supports the efforts of the health unit.

Recommendation: Receive.

c) Date: 2020 April 30
Topic: Provincial Leadership in the Monitoring of Food Affordability and Food Insecurity
From: Peterborough Public Health
To: Honourable Christine Elliott, Deputy Premier and Minister of Health

Background:

On April 30, 2020, the Board of Health for Peterborough Public Health wrote to Minister Elliott requesting that the Ministry of Health take leadership in developing a protocol in collaboration with Ontario's local public health agencies and Ontario Dieticians in Public Health.

Recommendation: Receive.

d) Date: 2020 April 28
Topic: Permitting the Use of Allotment Gardens and Community Gardens
From: Ontario Ministry of Health
To: All Health Units

Background:

On April 28, 2020, the Ontario Ministry of Health amended the existing Emergency Order to permit the use of allotment gardens and community gardens across the province. The amendment is in response to recognition that these gardens are an essential source of fresh food for some individuals and families, including those that face food insecurity. The Ministry of Health provided a guidance document, *COVID-19 Advice to Public Health Units regarding Allotment Gardens and Community Gardens*, to support local medical officers of health.

Recommendation: Receive.

e) Date: 2020 April 30
Topic: Consultation for a new Ontario Poverty Reduction Strategy
From: Timiskaming Health Unit
To: Minister Todd Smith, Minister of Children and Social Services

Background:

On April 30, 2020, the Board of Health for Timiskaming Health Unit wrote to Minister Todd Smith and provided recommendations for Ontario's new poverty reduction strategy.

Recommendation: Receive.

f) Date: 2020 May 11
Topic: Timely Follow-up of COVID Cases in Ontario
From: Public Health Ontario, Medical Director, Health Protection
To: Medical Officer of Health

Background:

Public Health Ontario initiated a reporting tool for health units, to capture data on timely follow-up of COVID-19 cases in Ontario. The goal for Public Health Units is to contact each new case within 24 hours of public health learning of the case. This will assist with determining if health units are able to isolate the case and find the contacts of that person as quickly as possible, to avoid further spread of the virus. The metric being used is 90% of newly identified cases to be contacted by their health unit within 24 hours from when the health was notified of the case. The Middlesex London Health Unit reported 100% contact.

Recommendation: Receive.

g) Date: 2020 May 12
Topic: Board of Education Support for Location of Carepoint Consumption and Treatment Services in London, Ontario
From: London District Catholic School Board
To: Honourable Christine Elliott, Deputy Premier and Minister of Health

Background:

Regional HIV/AIDS Connection and Middlesex-London Health Unit have been pursuing the relocation of London's Consumption and Treatment Services facility from it's current location on King St. to a more appropriate facility on York St. Although the facility meets the setback requirements from schools in the Ministry of Health's siting criteria, the Ministry has nonetheless requested letters of support from the two school boards with schools in the broader neighbourhood of the site. To this end, the Medical Officer of Health and the Executive Director of Regional HIV/AIDS Connection have met and corresponded with Directors of Education of both School Boards. On May 12, the Health Unit received a letter of support

from the London District Catholic School Board Chair and Director of Education in support of the relocation of the Carepoint program to 446 York Street in London.

Recommendation: Endorse.

h) Date: 2020 May 12
Topic: Board of Education Support for Location of Carepoint Consumption and Treatment Services in London, Ontario
From: Thames Valley District School Board
To: Honourable Christine Elliott, Deputy Premier and Minister of Health

Background:

See item g) above. On May 12, the Health Unit received a letter of support from the Thames Valley District School Board Chair and Director of Education in support of the relocation of the Carepoint program to 446 York Street in London.

Recommendation: Endorse

Ontario

Ministry of Health

Office of Chief Medical Officer of Health, Public Health
393 University Avenue, 21st Floor
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Tel.: 416 212-3831
Fax: 416 325-8412

Ministère de la Santé

Bureau du médecin hygiéniste en chef, santé publique
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Tél. : 416 212-3831
Téléc. : 416 325-8412

April 23, 2020

MEMORANDUM

TO: Chairpersons, Boards of Health
Medical Officers of Health, Public Health Units
Chief Executive Officers, Public Health Units

RE: **Extraordinary Expenses Associated with COVID-19**

We acknowledge the extraordinary and continuing efforts by boards of health to monitor, detect, and contain COVID-19 in the province.

As a follow-up to our ongoing discussions, I want to reiterate that boards of health are expected to take all necessary measures to respond to COVID-19 in their catchment areas while continuing to maintain critical public health programs and services as identified in their pandemic plans.

Given the impact of COVID-19, we anticipate that many boards of health are incurring additional expenses in support of these efforts. As announced by the government on March 25, 2020, the province is investing up to $100 million in additional funding for the public health sector to support extraordinary costs incurred. We wish to assure you that a process for reimbursement of approved one-time extraordinary costs incurred in managing your response to COVID-19 will be forthcoming. Similar to previous processes, we ask that these costs be those over and above what can be managed from within the budget of the board of health, and that you track these costs separately.

If you have any questions, please contact Brent Feeney, Manager, Funding and Oversight, at 416-212-6397 or by email at Brent.Feeney@ontario.ca.

Yours truly,

David C. Williams, MD, MHSc, FRCPC
Chief Medical Officer of Health

c: Associate Medical Officers of Health, Public Health Units
Business Administrators, Public Health Units
Senior Management Team, Office of the Chief Medical Officer of Health, Public Health

DIOCESE OF
LONDON
OFFICE OF THE BISHOP

1070 WATERLOO STREET
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519-433-0658
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25 March 2020

Dr. Christopher Mackie
Medical Officer of Health
Middlesex-London Health Unit
50 King Street
London, ON N6A 5L7

Dear Dr. Mackie,

During this extraordinary time of the coronavirus pandemic, I am reaching out to you and your team on behalf of the Catholic community of southwestern Ontario to express my deep gratitude for your leadership and service of the common good. Your efforts, which are often unseen and carried out without fanfare, are keeping us all safe. They are particularly important in the crisis we are currently facing, because they are a powerful witness to all of us of the dignity and value of every human life.

We want to acknowledge the great demands that have been placed on you and your team. Many people, those on the front line and the families supporting those on the front line, are making huge sacrifices for all of us, especially those most in need.

Our Catholic community is supporting you and your efforts.

I have mobilized our parishes throughout the diocese to reach out to their communities with particular attention to the home bound, the elderly and those with special needs. For us Catholics, the Church is not simply a building, but a community of faith that brings God's love to the world in concrete ways.

Please do not hesitate to reach out, if you believe there is more we could be doing to support your efforts.

Our prayers are with you each day. May God bless you, and may we look back on this experience and celebrate the incredible efforts of our human family. We look forward with hope and confidence to that time.

Sincerely yours,

+ Ronald Fabbro, CSB

Most Rev. Ronald P. Fabbro, C.S.B.
Bishop of London

Peterborough Public Health

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

April 30, 2020

The Honourable Christine Elliott
Minister of Health
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto ON M7A 2C4
Sent via e-mail: ***Christine.elliott@pc.ola.org***

Dear Minister Elliott:

Re: Provincial Leadership in the Monitoring of Food Affordability and Food Insecurity

Household food insecurity is a serious public health problem in Ontario. Household food insecurity is the inadequate or insecure access to food due to financial constraints, and is experienced by 13.3% of Ontario households (Tarasuk & Mitchell, 2020). Monitoring local food insecurity and food affordability is critical for Peterborough Public Health and local public health agencies (LPHAs) across Ontario to assess trends over time, identify community needs, and support access to safe healthy food. The Board of Peterborough Public Health is also required to monitor Food Affordability, as specified by the Ontario Public Health Standards.

Health Canada recently updated the National Nutritious Food Basket based on the 2019 Canada's Food Guide. A Reference Guide and spreadsheet were released in February 2020. In order for this to be used for data collection, protocols must be developed at the regional/territorial level. We ask that the Ontario Ministry of Health take leadership in developing a protocol in collaboration with Ontario's LPHAs and the Ontario Dietitians in Public Health.

Peterborough Public Health would also like to express the importance of availability of local Household Food Insecurity data from the Canadian Community Health Survey. We ask that Household Food Insecurity be included as a core module in Ontario, and that Ministry release 2018 Household Food Insecurity Data to Ontario LPHAs. This is critical for our board of health to conduct population health assessment and interventions to address local needs.

Thank you for your attention to supporting local boards of health in addressing the important issues of food insecurity and food affordability.

Sincerely,

Original signed by

Mayor Andy Mitchell
Chair, Board of Health

cc: Dr. David Williams, Ontario, Ontario Chief Medical Officer of Health
Local MPPs
France Gélinas, MPP, Health Critic
John Fraser, MPP, Health Critic
Association of Local Public Health Agencies
Ontario Boards of Health

Reference: Tarasuk V, Mitchell A. (2020) Household food insecurity in Canada, 2017-18. Toronto: Research to identify policy options to reduce food insecurity (PROOF). Retrieved from https://proof.utoronto.ca/

Ministry of Health

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April 28, 2020

MEMORANDUM

TO: Board of Health Chairs
Medical Officers of Health and Associate Medical Officers of Health

RE: Permitting the Use of Allotment Gardens and Community Gardens

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The government has amended the existing emergency order (EO), which declares the closure of outdoor recreational amenities, to permit the use of allotment gardens and community gardens across the province. This change was endorsed by the Public Health Measures Table.

The amendment is in response to recognition that these gardens are an essential source of fresh food for some individuals and families, including those that face food insecurity. The amended EO is effective immediately.

Under the amended EO, local medical officers of health should provide advice, recommendations and instructions that gardens in their health unit region must meet in order to operate. This approach recognizes that the range and type of gardens varies across the province, and that local flexibility is necessary to address these different contexts.

Attached is a document, in English and French, that may support local medical officers of health as they prepare this advice, recommendations and instructions.

If you have any questions please contact Chris Harold, A/Manager, Integrated Strategy and Policy Coordination, at chris.harold@ontario.ca, or Colleen Kiel, Director, Strategy and Planning at colleen.kiel@ontario.ca.

Thank you for your continued efforts and commitment to respond to this emergency in Ontario.

Yours truly,

David C. Williams, MD, MHSc, FRCPC
Chief Medical Officer of Health

cc: Dr. David McKeown, Acting Associate Chief Medical Officer of Health
Alison Blair, Assistant Deputy Minister, Emergency Health Services and Public Health Modernization Lead
President, Association of Municipalities of Ontario

Ministry of Health

COVID-19 Advice to Public Health Units regarding Allotment Gardens and Community Gardens

Version 1 —April 27, 2020

This advice provides basic information only. It is not intended to take the place of medical advice, diagnosis, treatment or legal advice.

The purpose of this document is to support public health officials (i.e., local medical officers of health) to provide advice, recommendations, and instructions regarding the safe use of allotment gardens or community gardens to prevent the transmission of COVID-19.

General Advice

Any person that uses allotment gardens or community gardens (herein referred to as gardens) must do so in accordance with the advice, recommendations, and instructions of their local medical officer of health or other public health official.

Below are items that local medical officers of health may consider as they develop their advice, recommendations and instructions to prevent the transmission of COVID-19.

- **Entrance Restrictions or Requirements**. For example:
    - Prohibit access to anyone who is exhibiting symptoms of COVID-19 or has had close contact with a confirmed case.
    - Restrict access to registered members, staff, and volunteers. Non-members and visitors should not be permitted to enter.
    - Permit access to plant, maintain and harvest food only.
        - Prohibit events such as flower festivals, children's events and other programming, training, group builds, etc.

- **Physical Distancing Requirements.** For example:
    - Maintain a distance of at least 2 metres (6 feet) from other people except for members of the same household.
    - Limit the number of gardeners in a space to ensure physical distancing can be maintained, if required.
- **Hand Hygiene Requirements.** For example:
    - Ensure adequate hand hygiene.
        - If hands are visibly soiled, handwashing with soap and water is preferred. Where possible, provide by providing handwashing stations in the gardens.
        - If not available, hands must be wiped clean before applying alcohol-based hand sanitizer.
    - Perform hand hygiene before entering and upon leaving the garden.
- **Sharing (Equipment, Tools) and Cleaning Requirements.** For example:
    - Provide instructions regarding how to safely share garden materials, tools, etc., including instructions on cleaning and disinfecting.
    - Instruct individuals who use gardening gloves to launder them after each use.
    - Provide instructions on cleaning and disinfecting frequently touched surfaces which are most likely to be contaminated. These may include hoses, door/gate handles, tools, etc. (refer to Resources Section below).
- **Signage Requirements.** For example:
    - Place clear, visible signage at all garden entrances reminding registered members, staff and volunteers about the signs and symptoms of COVID-19 and where to seek assistance if they have symptoms (Ontario's self-assessment tool, health care provider or Telehealth Ontario [1-866-797-0000]).

  - Place clear, visible signage throughout the garden — especially locations where shared equipment, tools, etc. are located — reminding registered members, staff and volunteers of the requirements that must be followed when using the garden to prevent the transmission of COVID-19.

- **Communication and Other Requirements**. For example:
  - Recommend gardens develop and communicate (to registered members, staff and volunteers) COVID-19 policies/protocols that are specific to the community garden based on the advice, recommendations, and instructions of the local medical officer of health.
  - Update the list of current registered members, staff and volunteers, and track those who have agreed to participate under COVID-19 policies and protocols.
  - Consider using a sign-in and sign-out system to track who is in the garden each day. This may assist with communication, close-contact tracing if required, etc.

Resources

- Refer to Public Health Ontario for fact sheets on:
  - Self-assessment
  - How to self-isolate
  - Physical distancing
  - How to wash your hands
  - Cleaning and disinfection
- Refer to Ontario's 2019 novel coronavirus webpage for general information.
- Refer to the Ministry of Health (MOH) COVID-19 webpage for Guidance Documents and the Directives, Memorandums and Other Resources webpage regularly for up-to-date directives on COVID-19.

Services de santé du TIMISKAMING Health Unit
Enhancing your health in so many ways.

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www.timiskaminghu.com

April 30, 2020

Hon. Todd Smith, Minister of Children, Community and Social Services
Ministry of Children, Community and Social Services, Hepburn Block, 6th Floor
80 Grosvenor St,
Toronto, ON M7A 1E9
Sent via e-mail: Todd.smithco@pc.ola.org

Dear Minister Smith,

Re: Consultation for a new Ontario Poverty Reduction Strategy

The Timiskaming Health Unit (THU) commends the Government of Ontario's interest in poverty reduction and applauds its public consultation to inform the development of a new provincial strategy.

THU recognizes that the prolonged stress of continually struggling to satisfy basic needs negatively impacts the physical and mental health of entire families; however, poverty doesn't just affect those experiencing it. Poverty costs the Ontario economy over $27 billion annually, with the cost of maintaining poverty far outweighing the cost of addressing it.[1] Currently, there are 1.57 million Ontarians, including 382,000 children living in poverty.[1] Despite previous declines in childhood poverty, much work remains. In the district of Timiskaming, 18% of people continue to live in low-income households, including 20% of children under the age of 18 years.[3]

Poverty persists in the presence of low unemployment rates. While a strong economy and job creation are essential combatants of poverty, low educational attainment, precarious employment, low wages, disability, as well as a lack of affordable housing and child care contribute to its maintenance. A comprehensive poverty reduction strategy must address an entire gamut of issues - from a lack of individual resources and supports to political and economic structures.[4]

Poverty is a multi-dimensional phenomenon and requires a multi-dimensional approach. Based on this premise, we have included our recommendations for Ontario's new poverty reduction strategy in Schedule A. We are confident that implementation of these recommendations will have a positive impact on reducing poverty in Ontario. Thank you for providing us with the opportunity to contribute to this worthwhile endeavour.

Sincerely,

Carman Kidd
Board of Health Chair

Enclosure

c.c. Mr. John Vanthof, MPP, Timiskaming-Cochrane
Ontario Boards of Health

ISSUE	RATIONALE	RECOMMENDATIONS
INCOME	Jobs that pay a living wage are essential. Income is a significant determinant of health as it influences overall living conditions, including psychological functioning, health-related behaviours, food security, housing, and other prerequisites of health.[5] Poor health is both the cause and the result of poverty. At present, poverty costs the Ontario health care system $3.9 billion annually.[1] In the district of Timiskaming, 18% of people continue to live in low-income households, including 20% of children under the age of 18 years.[3] Chronic stress resulting from the struggles to satisfy basic needs such as food, and shelter impacts the physical and mental health of low-income families. Increasing incomes for those living in poverty results in a reduction of stress, mental illness, and chronic disease resulting in overall health care spending[6]	**THU recommends that the province of Ontario reinstate the guaranteed basic income pilot projects and an increase in the minimum wage for Ontario workers. We endorse Bill 60 and call for increases to income assistance rates for Ontario Works (OW), as well as Ontario Disability Supports Program (ODSP) recipients to sufficiently cover basic needs (i.e., shelter, food, clothing, and transportation). THU further recommends that future adjustments to minimum wages and social assistance rates align with inflation.**
EDUCATION	Education invariably leads to better health as it is associated with higher incomes, increased civic engagement, and healthier lifestyles.[5] Post-secondary education is protective against poverty. Compared to the rest of Ontario, residents in Timiskaming are less likely to complete high school or university.[3] The Ontario Student Assistant Program (OSAP) financially assists students in obtaining a post-secondary education through loans and grants. While we commend the Government of Ontario's 10 percent decrease in tuition fees, the elimination of free tuition for low-income students is troublesome. Recent changes to the OSAP program may deter low-income students from pursuing post-secondary education and thus limiting their socioeconomic mobility.	**THU recommends increasing access to post-secondary programs for low-income students through free tuition, a return to previous grant/loan amounts, and reinstatement of the six-month interest-free grace period following graduation.**

ISSUE	RATIONALE	RECOMMENDATIONS
ASSET & CAPACITY BUILDING	Generational poverty is more than the mere absence of monetary resources and often includes insufficient support systems, role models, and coping strategies. A lack of resources hinders socioeconomic mobility while increasing the likelihood of remaining in poverty.[4] Asset building programs have the potential to assist individuals to transition out of poverty through the use of mentors and peer support. These programs can save Ontarians a substantial amount of money but more research is required.[7] It is essential for the Government of Ontario to continue to build capacity within Public Health Ontario and local public health that will facilitate the data collection, assessment and evaluation of unique initiatives such as the Bridges Out of Poverty – Circles program to assist and support individuals leaving poverty.	**THU recommends that the Government of Ontario invest in the creation, expansion, and evaluation of asset building programs (e.g., Bridges Out of Poverty- Circles). It is also recommended that the Province of Ontario continue to invest in Public Health Ontario and local public health initiatives to permit the necessary data collection, and evidence gathering to understand, prevent, and mitigate poverty.**
CHILD CARE & EARLY CHILDHOOD EDUCATION	Early childhood experiences influence later physical, social, emotional, and cognitive development, which impacts future learning, educational achievement, employment, and health. In 2018/19, throughout Ontario there were 446,596 spaces in licensed child care facilities – enough for 22.4% of Ontario's children age 0-12 years.[8] Ontario has the highest median full-time child care infant fees in the country at $1,758 per month or $21,096 annually.[9] In rural northern Ontario, pre-school child care fees are approximately $825 per month or $9,900 per year.[9] In 2019, approximately 29% of children in licensed child care centres qualified for subsidies compared to 68% of children in licensed home child care.[8] Child care must be affordable, accessible, and of high-quality to permit parents to engage in paid work, ensure the attainment of developmental milestones, and address child & family poverty in Ontario.[10]	**THU recommends the creation of a universal, high-quality, accessible, and affordable child care system provided by a well-trained and well-paid workforce.**
HOUSING	Adequate housing is vital to one's dignity, safety, and ability to contribute to society. Without proper shelter, people are not able to maintain employment, recover from mental illness, be part of their community, maintain custody of their children, leave abusive relationships, or escape situations involving human trafficking.[11] Rates of public assistance and minimum wage have not kept pace with rising rents in Ontario, which excludes vulnerable individuals from the rental market. In Timiskaming, 21% of households live in unaffordable housing, spending 30% or more of their income on shelter cost.[12]	**THU recommends the province work with municipalities to develop a strategy to address affordable housing shortages and chronic homelessness, which includes the creation of new affordable housing. Further recommendations include an increase in provincial funding for the repair and maintenance of social housing units.**

ISSUE	RATIONALE	RECOMMENDATIONS
DISABILITIES	One in seven Ontarians (15%) live with a disability.[13] People with disabilities continue to face barriers to education and employment opportunities. They are more likely to have low-income status, and less likely to live in adequate, affordable housing than people without disabilities.[13] The Ontario government has proposed changing the definition of disability to align with the Federal government's much more stringent definition used to determine eligibility for Canada Pension Plan Disability Benefits.[14] The change in definition would lead to a large number of Ontarians being ineligible for ODSP benefits. This change would lead to a greater dependence on OW, which pays much less and does not provide disability supports.	**THU recommends the Ontario government maintain its current definition of disability to determine eligibility for ODSP benefits.**
PHARMACARE	Approximately 2.2 million Ontarians have no prescription drug coverage.[15] Too frequently, cost restrictions force Ontarians to fail to fill or renew their prescriptions, skip doses, or split pills to make their medications last longer.[16] In 2015, 24% of Ontarians reported that they or someone in their household failed to take their medication as prescribed due to cost.[16] Women are particularly disadvantaged as they are more likely to be prescribed medication than men, but are less likely to have medication coverage through paid work.[17] Illness and disability prevent people from working, force many to live in poverty, and increase health care expenses.	**THU recommends the Ontario government work with the Government of Canada to create and implement a universal and comprehensive Pharmacare program for all Ontarians.**
ORAL HEALTH	Poor oral health negatively impacts general health and is associated with various health risks ranging from poor nutritional intake[18] to coronary heart disease.[19] Individuals in the lowest income group are less likely to receive preventive treatment and more likely to decline dental services due to costs compared to those with higher incomes.[20] In Timiskaming, only 56.7% of residents reported having insurance coverage for dental expenses,[21] and a mere 54.9% of residents reported visiting the dentist in the past year.[22] While THU recognizes the value of the Healthy Smiles Ontario program and commends the Government of Ontario for the implementation of the Ontario Seniors Dental Care Program, the dental needs of low-income workers age 18 to 64 years remain unmet. Facial pain, infection, and illness are barriers to employment and cost our health care system.	**THU recommends the Government of Ontario create a publicly funded system for oral health care that is accessible to all individuals living in low-income households regardless of age.**

ISSUE	RATIONALE	RECOMMENDATIONS
PAID SICK LEAVE	When employees go to work sick, they not only risk their health, but they risk the health of their co-workers as well as the general public through the spread of infectious diseases (e.g., COVID-19). However, most low-income earners have a minimal choice due to a lack of paid sick days and financial obligations. Low-income earners such as those working in the food and hospitality industry are of particular importance because illnesses such as Norovirus, Samonella Typhi, Hepatitis A, etc., are transmittable to the general public during the food production and handling process.[23] Currently, in Ontario, employers are only required to provide three "unpaid" sick days per year. The average number of sick days taken in Canada by workers in the private sector is nine days per year.[24]	**THU recommends the Government of Ontario amend the Employment Standards Act to include a minimum of Seven (7) "paid" sick days per year for employees regularly scheduled to work 30 hours or more per week. Part-time and seasonal workers to receive paid sick days based on a pro-rata basis.**

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Public Health Ontario | Santé publique Ontario

Timely Follow-up of COVID Cases in Ontario

- **Goal:** contact with a new case within 24 hours of public health unit (PHU) learning of it

- **Why are we looking at this metric?** To determine if PHUs are able to isolate the case and find the contacts of that case as quickly as possible, to avoid spreading the virus

- **Metric**: 90% of newly identified cases to be contacted by their Public Health Unit (PHU) within 24 hours from when the PHU was notified of the case

Summary:

- For new cases reported to PHUs in Ontario between May 1-6, 2020, 51.0% (1097 of 2152 cases) were contacted within 24 hours.
- If we exclude 638 cases with a missing or pending *investigation start date*, 72.5% (1097 of 1514) were followed up within 24 hours.
- 26/34 PHUs (77%) met the provincial target of 90%.
- Both Toronto and Ottawa Public Health are using alternate information systems which may have impacted data entry. If we exclude the 968 cases from these two health units, then 66.5% of new cases (787 of 1184) elsewhere in the province were contacted within 24 hours.

Methods:

- We included all cases reported to PHUs in Ontario between May 1-May 6, 2020.
- We calculated the proportion of cases that were contacted by PHUs (i.e., "*investigation start date*") within 1 day of the PHU being notified about the case (i.e., "*reported date*").
- *Reported date* is the date PHU is contacted about a new case. Note: The reported date may occur after the *investigation start date* if probable cases are being entered into iPHIS/other data systems by PHUs prior to their laboratory result being available.
- *Investigation start date* is the date the PHU successfully contacts the case and commences case follow-up. The investigation start date must be on or after the reporting date.
- A four day lag from reporting date to data analysis allows for PHUs to enter their cases into iPHIS or other local data entry systems.
- Cases missing *investigation start date* are included in the denominator to calculate the metric.
- Once 7 days of reporting date data are available, we will provide a 7 day rolling average of the proportion of cases contacted within 24 hours (i.e., on May 11, data reported to PHUs between May 1-7 will be eligible for analysis, but on May 12, this will shift to May 2-8).
- Cases referred to FNIHB, lost to follow-up/untraceable were excluded from the analysis.
- PHU in this report are classified using diagnosing PHU. Future reports will classify cases using responsible PHU.

Data Limitations:

- Surveillance systems such as iPHIS and other local data entry systems (e.g., CORES, The COD) are dynamic systems.
- Factors related to data entry may impact the metric of timely follow-up of cases. Data about a case may be entered over time due to delayed data entry, even though case follow-up may have occurred within 24 hours of case identification.
- PHUs were directed to use the *investigation start date* field in iPHIS on **May 1, 2020**. It is expected that in the first week of reporting, cases with an investigation start date will be lower than anticipated as PHUs adjust their case follow-up and data entry practices.
- The number of cases in this analysis will not match the number of new cases in the daily epidemiological summary due to differences in dates used for extraction. However, if comparing number of cases by reporting date in the epidemiologic curve, the numbers should align prior to exclusions.
- The denominator for a given reporting date may change over time if the analysis for a given reporting date is run on one day and then again the next day. This can occur due to data entry practices at the local PHU.
- We allow for a 4 day buffer between cases being entered into iPHIS/local data entry systems and providing the metric for a given day. This allows for data entry and case follow-up by the PHU, as well as data extraction and analysis at PHO. The estimation of the % of cases contacted within one day of follow-up for cases entered into iPHIS/local data entry systems on May 3 were therefore eligible for analysis taking place on May 7.
    - If starting investigation date is still missing following this buffer period, this could mean that there is a delay in the case being contacted or a delay in data entry; both issues are important to address in order for the provincial response to be based on timely data.
    - If cases are entered into iPHIS/local data entry systems after this 4 day buffer but within the 7 day rolling average period, they will contribute to the calculation of this metric. If data are entered for a case with a reporting date more than 7 days prior to the analysis date, they will not contribute to the 7 day rolling average.

Number of cases entered and contacted by PHU, overall for cases reported May 1-6, 2020

Public Health Unit	Cases reported to PHUs 01-May-20 to 06-May-20				
	% of new cases contacted within 1 day (n/N)	Number contacted within 1 day (n)	New cases (N)	Number contacted >1 day	Number with missing or pending investigation start date
ALG	100	2	2	0	0
BRN	100	3	3	0	0
CHK	100	6	6	0	0
DUR	99.3	135	136	1	0
EOH	100	19	19	0	0
GBO	100	4	4	0	0
HAL	100	42	42	0	0
HAM	86.5	32	37	1	4
HDN	0	0	1	0	1
HKP	88.9	8	9	0	1
HPE			0		
HUR	100	2	2	0	0
KFL			0		
LAM	100	10	10	0	0
LGL	90.9	10	11	0	1
MSL	100	26	26	0	0
NIA	98.1	51	52	0	1
NPS	100	2	2	0	0
NWR			0		
OTT[1]	88.8	135	152	17	0
OXE	100	3	3	0	0
PEE[2]	31.2	116	372	134	122
PQP	100	2	2	0	0
PTC	100	3	3	0	0
REN	100	1	1	0	0
SMD	100	68	68	0	0
SUD			0		
THB	80.0	4	5	1	0
TOR[1]	21.4	175	816	252	389
TSK			0		
WAT	96.4	106	110	1	3
WDG	93.8	30	32	1	1
WEC	100	68	68	0	0
YRK[3]	21.5	34	158	9	115
TOTAL	**51.0**	**1097**	**2152**[4]	**417**	**638**

Note: blank cells indicate no cases were created by that PHU during the time period; the cases with missing or pending investigation start date are included in the new cases (N) denominator

[1]Toronto and Ottawa Public Health are using alternate information systems which may have impacted data entry

[2]Peel is experiencing a backlog in case investigation date entry. PHO is assisting to update iPHIS for future reports.

[3]York is investigating whether the cause is a data entry backlog or other issue.

[4]As of data available on May 9, 2020, there were 2,153 cases reported to PHUs between May 1-6. For this analysis, 1 case was excluded as it was referred to FNIHB.

LONDON DISTRICT
Catholic School
BOARD

May 5, 2020

Honourable Christine Elliott
Deputy Premier and Minister of Health
Ministry of Health
5th Floor -777 Bay Street
Toronto, ON M7A 2J3

Re: Board of Education Support for Location of Carepoint Consumption and Treatment Services in London, Ontario

Dear Minister Elliott,

The London District Catholic School Board (LDCSB) is pleased to write this letter in support of Regional HIV/AIDS Connection (RHAC) and Middlesex London Health Unit's (MLHU) application to operate the Carepoint Consumption and Treatment Service at 446 York Street in London, Ontario.

London, Ontario, like many communities across Canada continues to be impacted by the opioid crisis and the broader complex issues associated with addiction, mental health, poverty and homelessness. Since its February 2018 inception as a Temporary Overdose Prevention Site, the Carepoint program has demonstrated its effectiveness with overdose prevention, wrap around support, linkages to care and treatment and HIV/HCV prevention. Since opening the program through to March 31, 2020, RHAC and MLHU report that the program has facilitated over 37,000 visits and reversed over 250 opioid poisonings along with facilitating hundreds of referrals to other supports including addiction treatment, housing and primary care. These statistics demonstrate the need for, and the positive impact of the Carepoint program.

Carepoint has become a vital part of the addiction response continuum in London and has been recognized for being a fine example of collaboration as the winner of a local Pillar Awards in November 2018. Also in November 2018 the program was the recipient of the Community Partner Award – Ontario Public Health Association in recognition of the outstanding contributions and commitment by TOPS to reduce social and health inequities. The program was also high-lighted by Mayor Ed Holder at the 2020 Mayor's State of the City address as a program making a positive impact in the lives of marginalized individuals in London.

In consultation with RHAC and MLHU we understand that they have explored many location options and completed extensive community consultation to determine an appropriate location for this program. As the primary operator RHAC has demonstrated its ability to work well with neighbouring community stakeholders at the current temporary location and when Carepoint relocates to 446 York, we will work collaboratively with RHAC and MLHU to address any emerging items - should they occur.

In closing, the LDCSB fully supports RHAC and MLHU in their interest to relocate the Carepoint program to 446 York Street in London, Ontario. Please do not hesitate to contact us should you have any questions.

Sincerely,

L Staudt

Linda Staudt
Director of Education

John Jevnikar
Board Chair

/ld

THAMES VALLEY DISTRICT SCHOOL BOARD

Mark Fisher, Director of Education and Secretary

2020 May 05

Honourable Christine Elliott
Deputy Premier and Minister of Health
Ministry of Health
5th Floor -777 Bay St.
Toronto, ON
M7A 2J3

Re Board of Education Support for Location of Carepoint - Consumption and Treatment Services in London ON

Dear Minister Elliott:

The Thames Valley District School Board (TVDSB) and the London District Catholic School Board (LDCSB) are pleased to write this joint letter in support of Regional HIV/AIDS Connection (RHAC) and Middlesex London Health Unit's (MLHU) application to operate the Carepoint Consumption and Treatment Service at 446 York Street in London ON.

London Ontario, like many communities across Canada continues to be impacted by the opioid crisis and the broader complex issues associated with addiction, mental health, poverty and homelessness. Since its February 2018 inception as a Temporary Overdoes Prevention Site, the Carepoint program has demonstrated its effectiveness with overdose prevention, wrap around support, linkages to care and treatment and HIV/HCV prevention. Since opening the program through to March 31 2020, RHAC and MLHU report that the program has facilitated over 37,000 visits and reversed over 250 opioid poisonings along with facilitating hundreds of referrals to other supports including addiction treatment, housing and primary care. These statistics demonstrate the need for, and the positive impact of the Carepoint program.

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In consultation with RHAC and MLHU we understand that they have explored many location options and completed extensive community consultation to determine an appropriate location for this program. As the primary operator RHAC has demonstrated its ability to work well with neighbouring community stakeholders at the current temporary location and when Carepoint relocates to 446 York, we will work collaboratively with RHAC and MLHU to address any emerging items - should they occur.

In closing the TVDSB and LDCSB fully support RHAC and MLHU in their interest to relocate the Carepoint program to 446 York Street in London ON. Please do not hesitate to contact us should you have any questions.

Sincerely,

Mark Fisher
Director of Education

Arlene Morell
Chair of the Board

MF/tl

c: Riley Culhane, Associate Director, Learning Support Services
Jeff Pratt, Associate Director, Organizational Support Services