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

AGENDA
MIDDLESEX-LONDON BOARD OF HEALTH

Thursday, September 17, 2020, 6:30 p.m.
Citi Plaza Boardroom and Microsoft Teams

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: July 16, 2020 Board of Health
July 29, 2020 Special Meeting of the Board of Health
September 10, 2020 Special Meeting of the Board of Health

Receive: September 10, 2020 Finance & Facilities Committee

Item #	Delegation	Recommendation	Information	Report Name and Number	Link to Additional Information	Overview and Lead
Reports and Agenda Items						
1.	**X**	**X**	**X**	Finance & Facilities Committee September 10, 2020 Meeting Summary (Report No. 040-20)	September 10, 2020 Agenda Minutes	To provide an update of the September 10, 2020 Finance & Facilities Committee meeting. Lead: Ms. Kelly Elliott, Chair, Finance & Facilities Committee
2.			**X**	Monitoring Impacts of the COVID-19 Pandemic and Related Public Health Measures (Report No. 041-20)	Appendix A Appendix B	To provide an update on the monitoring of population-level indicators to enable the Health Unit to assess the impact of the pandemic and its related public health measures on the health and well-being of the Middlesex-London community, and help inform policy and decision-making. Lead: Dr. Alexander Summers, Associate Medical Officer of Health
3.			**X**	COVID-19 Surveillance Testing on Farms (Report No. 042-20)		To provide an update on the recent surveillance testing of migrant farm workers (MFWs) for COVID-19 over the summer months. Lead: Dr. Alexander Summers, Associate Medical Officer of Health
4.			**X**	Update on Provincial COVID-19 Case and Contact Management (CCM) System (Report No. 043-20)		To provide an update on the June 2020 Ontario Ministry of Health implementation of a new case and contact management (CCM) solution for public health units (PHUs) to manage and report on COVID-19 cases and contacts, replacing the use of the existing provincial infectious disease information system (iPHIS). Lead: Dr. Alexander Summers, Associate Medical Officer of Health
5.			**X**	COVID-19 Update (verbal)		To provide an update on COVID-19 related items.

						Lead: Dr. Alexander Summers, Associate Medical Officer of Health and Dr. Christopher Mackie, Medical Officer of Health
6.			**X**	MOH Activity Report – September (Report No. 044-20)		To provide an update on external meetings attended by the Medical Officer of Health since the last Board of Health meeting. Lead: Dr. Christopher Mackie, Medical Officer of Health
Correspondence						
7.			**X**	September 2020 Correspondence		To receive correspondence items a) through j) for information.

OTHER BUSINESS

- Next Board of Health Meeting: October 15, 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, and 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.

ADJOURNMENT

PUBLIC SESSION – MINUTES
MIDDLESEX-LONDON BOARD OF HEALTH

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

Webinar – Microsoft Teams and MLHU Boardroom

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

REGRETS: Ms. Tino Kasi

OTHERS PRESENT: Dr. Christopher Mackie, Medical Officer of Health (Secretary Treasurer)
Ms. Svetlana Mutlak, Executive Assistant, Healthy Organization (Recorder)
Dr. Alexander Summers, Associate Medical Officer of Health
Dr. Michael Clarke, CEO (Interim)
Ms. Maureen Rowlands, Director, Healthy Living
Mr. Stephen Turner, Director, Environmental Health and Infectious Disease
Ms. Heather Lokko, Director, Healthy Start and Chief Nursing Officer
Ms. Nicole Gauthier, Acting Director, Healthy Organization, Manager, Privacy and Risk Management
Mr. Dan Flaherty, Manager, Communications
Ms. Elizabeth Milne, Executive Assistant to the Board of Health and Communications Coordinator
Mr. Alex Tyml, Online Communications Coordinator
Mr. Joe Belancic, Manager, Procurement and Operations
Mr. Jeff Cameron, Manager, IT
Mr. Brian Glasspoole, Manager, Finance
Mr. Jordan Banninga, Manager, Program Planning and Evaluation
Ms. Mary Lou Albanese, Manager, Infectious Disease Control

Chair Cassidy called the meeting to order at 6:31 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. Elliot, seconded by Ms. DeViet, *that the **AGENDA** for the July 16, 2020 Board of Health meeting be approved.*

Carried

MINUTES

It was moved by Mr. Peer, seconded by Mr. Parker, *that the MINUTES of the June 18, 2020 Board of Health meeting be approved.*

Carried

It was moved by Ms. Elliott, seconded by Mr. Brennan, that the MINUTES of the June 25, 2020 Special meeting of the Board of Health be approved.

Carried

It was moved by Mr. Parker, seconded by Ms. Elliott, *that the MINUTES of the June 18, 2020 Governance Committee meeting be received.*

Carried

It was moved by Ms. DeViet, seconded by Mr. Peer, *that the MINUTES of the July 2, 2020 Finance and Facilities meeting be received.*

Carried

REPORTS AND AGENDA ITEMS

Finance and Facilities Committee Update – July 2, 2020 (Report No. 031-20)

Ms. Elliott introduced the reports from the July 2, 2020 Finance and Facilities Committee meeting.

2019 Draft Financial Statements (Report No. 015-20FFC)

It was moved by Ms. Elliott, seconded by Mr. Peer, *that the Board of Health review and approve the audited Financial Statements for the Middlesex-London Health Unit, December 31, 2019, as appended to Report No. 013-20FFC*

Carried

Single Source Contract Awards (Report No. 016-20FFC)

It was moved by Ms. Elliott, seconded by Ms. DeViet, *that the Board of Health receive Report No. 016-20FFC, re: "Single Source Contract Awards" for information.*

Carried

Ministry of Health Temporary Pandemic Pay Initiative (Report No. 017-20FFC)

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

1. *Receive Report No. 017-20FFC re: "Ministry of Health Temporary Pandemic Pay Initiative"; and*
2. *Direct staff to receive this funding.*

Carried

Discussion ensued about the following items:

- Money for the government relating to pandemic pay for eligible employees, at a rate of $4 per hour.

Cash Flow Analysis (Report No. 018-20FFC)

The Board of Health received a verbal update on this report from Ms. Elliott and Mr. Parker. Ms. Elliott mentioned that this will be assessed over time along with salaries.

Mr. Peer commented that this was in the media and asked if the Warden after the meeting contacted staff or Board members to seek clarification on this report. Mr. Peer noted that information was shared at the meeting and asked why this report has this been viewed as mismanagement in the media and by the Warden. Mr. Peer noted that he would like to know if there is a way to provide additional information to the County to clarify some of the question they have around this report.

Mr. Peer noted that the organization has been working hard and has redeployed many staff to meet the demands, noting that given the work of staff at the Health Unit, it is not good for employees to hear from the Warden in the media that the organization is being mis-managed. All Board members look at reports and collectively make decisions, including the county representatives. It would be helpful if the Warden received the information that Board members do, including the county representatives.

Ms. Cassidy noted that County Council does receive a brief summary of the motions coming out of each month's Board meeting.

Dr. Mackie noted that he appreciates the concerns raised with staff responding to the pandemic. Dr. Mackie respects the Warden's questions presented in front of her constituents.

Discussion ensued about the following items:

- That the Health Unit's net debt has gone down. This line of credit reduces the amount of interest repaying the debt overall. The line of credit is a flexible tool and a responsible approach to debt.
- That MLHU has been managing its cash position and by using reserves and available cash, has been able to keep debt down by $400,000.

Ms. Elliott noted that the media contacted her regarding the report. Ms. Elliot mentioned she was not able to complete the media request due to her schedule. She can relay the discussion to the Warden.

Ms. Cassidy noted that at the FFC meeting, that overtime costs have risen, and this could not be foreseen due to the pandemic; the organization responded in a prudent way.

Governance Committee Update (Verbal)

Ms. DeViet provided an update from the Governance meeting.

It was moved by Ms. DeViet seconded by Mr. Parker that the Board of Health:
1) Receive Report No. 011-20 re: "By-Law Amendment Regarding Special Meetings"; and
2) Approve the amendment to governance By-law #3 (Appendix A).

Carried

It was moved by Ms. DeViet seconded by Mr. Parker, *that the Board of Health receive Governance Committee verbal update for information.*

Carried

COVID -19 Verbal Update

Dr. Mackie provided an update on recent COVID-19 related activities at MLHU, which included the following updates:

- Dr. Summers has returned from Windsor-Essex County Health Unit, where he went to assist for two weeks.
- As a community, the rates of COVID-19 have decreased.
- No outbreaks institutional outbreaks currently. One small little outbreak relating to a number of parties. The outreach team did a great job offering resources in partnership with the COVID-19 IMS staff, and together they contained the outbreak.
- Staff have initiated testing on farms, which has been positive. First dozen tests came back negative; there has been one case since then on a farm, but not in a Temporary Foreign Worker. The farms have been cooperative and MLHU is making sure that the workers have the necessary supports in place such as WSIB and appropriate healthcare.
- Middlesex-London has been without a facility outbreak since end of June and early July, huge credit to the MLHU and the entire community.
- There have been lots of questions and suggestion around mandatory masking in Middlesex-London, there are many other regions who have taken on the mandatory masking that have higher rates of COVID. There has been lots of discussion with local partners. Middlesex-London hasn't implemented mandatory masking due to lower cases in Middlesex-London.
- There have been no deaths for a long time. Dr. Summers added the province is moving into Stage 3 starting July 17th, 2020. Middlesex-London will want to watch the rates and monitor the cases closely as the number of contacts with associated cases can go up with Stage 3 re-openings. Middlesex-London will be monitoring this over the next coming weeks.
- Dr. Summers thanked the Board for their support of the redeployment to Windsor-Essex along with two public health inspectors. Ms. Cassidy thanked Dr. Summers for his work.

Discussion ensued about the following items:

- Mandatory masking and why Dr. Mackie has not issued a Section 22 Order to require this in all public places.
- The low level of COVID-19 community spread in Middlesex-London.
- The independent power of a Medical Officer of Health under the *Health Protection and Promotion Act* (HPPA) and that a Section 22 Order would not be appropriate at this time since there is such a low risk of spread in the community.
- That Dr. Mackie and MLHU is watching rates closely in the community, reviewing literature and monitoring hospital data. There is currently no case under the HPPA to implement mandatory masking.
- Ms. Elliott and Ms. Kayabaga indicated that mandatory masking should be made through public health by data and evidence, rather than at the political level. Additionally, MLHU represents more than just the City of London. Middlesex County cannot enact the by law without the support of each of its other municipalities. Dr. Mackie noted that he will not let the County be left behind in this and that he has a meeting booked to discuss this with the Warden to explain every step of the process.
- Ms. Elliott stressed the need for consistency in a masking approach across the community.
- How Section 22 Order are enforced, the fines associated with not adhering to the Order, and if MLHU has the capacity to support enforcement efforts.
- That masking can reduce rates, but keeping 2 metres apart is much more effective than masking.
- The MLHU has been working very closely with Western and Fanshawe and that discussions with post-secondary institutions will continue to help institutions develop guidelines as students return to school in the fall.
- The equity of mandatory masking and ensuring all individuals are able to obtain or to purchase a mask in made mandatory.

It was moved by Mr. Reid, seconded by Mr. Parker, *that the Board of Health direct the Chair to write to the Premier of Ontario, Minister of Health and the Chief Medical Officer of Health to advocate for a province-wide approach for mandatory masks, to ensure consistency across the province*.

Carried

Ms. Kayabaga moved and Ms. Elliott seconded that:

1) *the Board of Health request the Medical Officer of Health to look to all partners to support the MLHU in providing masks to community members who cannot afford them; and*
2) *That the MOH works with the city of London and the County to find a way forward in making this work across the London-Middlesex area in order to continue to be leaders in COVID-19.*

Significant discussion around this motion ensued.

Mr. Parker commented on the motion and asked that each motion be broken down into multiple motions.

Dr. Mackie apologized if past comments made it seem like he was looking for direction, and clarified the importance of the independent medical judgment of the Medical Officer of Health in making Section 22 orders under the HPPA. He indicated that he will do whatever is possible and work with councils.

Following discussion, Ms. Kayabaga noted that she would like to withdraw the entire motion and asked Dr. Mackie for comment. Dr. Mackie mentioned that he does appreciate the comments around masking and that the Health Unit has strong vendors for non-medical and medical masks with the City offering support.

Mr. Brennan commented that the County has no jurisdiction and has no authority to do anything. Ms. Elliott commented that residents are protected regardless and looks forward to working with Dr. Mackie and attending the City Council meeting. Ms. Cassidy commented that there is not a consensus on this yet. She added that courts are hesitant to overturn orders enacted by elected officials. She also mentioned that the province has always taken a regional approach.

Sustained COVID-19 Response and Enhancements (Report No. 032-20)

Dr. Mackie introduced this report and noted the significant staff resources have been redeployed to the COVID-19 response and that there are other crucial Health Unit programs that need to continue as well. He added that Ms. Rowlands, Ms. Lokko and Ms. Di Cesare laid the foundation for this, with the work also including Ms. Locker, Ms. Gauthier, Dr. Clarke, Ms. Albanese, Mr. Banninga and Dr. Summers.

Dr. Clarke also provided context to this report, noting his support for the program, which will enable the Health Unit to get back to delivering health services and a sustained COVID-19 response. Dr. Clarke added that the volume of work required to address COVID-19 requires an expansion of the Health Unit's resources. He mentioned that this is the largest request that staff have requested from the Board, and that staff are optimistic that the province will provide funding for COVID-19. In the absence of the funding, MLHU would need to request it from the City and County partners.

Dr. Summers began by speaking to the key components of this report. He noted that this report represents what the Health Unit will need to respond to the pandemic for the next 18-24-month time frame. This proposal reflects lessons learned from the first wave of the pandemic. The program responds to a tiered strategy with a base program and after that a gradual increase. This will allow the Health Unit to be prepared to respond. Dr. Summers adds that he attended a Windsor-Essex Board meeting and they have approved a similar proposal.

Discussion ensued about the following items:

- That this is not the first time that we're hopeful that the province will come through for the Health Unit with regards to funding. This leaves the door open that we may have to go to the County or the City if funding is not received by the province.
- Ms. Elliott added as it relates to the funding from the City and Council, the County is in the same position with funding and the advocacy goes to the province. Municipalities need that funding as well.
- That this program will allow us to respond to another pathogen or outbreak in the future.
- Where funding for this program will come from, despite being needed to support this program.
- What is the plan if MLHU cannot get additional funding for this program?
- Certain HPPA guidelines around funding

Ms. Cassidy thanked all Health Unit staff for all of the good the work they have been done to respond to COVID-19 in the community.

It was moved by Mr. Parker, seconded by Mr. Reid, that the Board of Health**:** *Receive Report No. 032-20 re: "Sustained COVID-19 Response and enhancements".*

Carried

Summary Information Report (Report No. 033-20)

Dr. Mackie introduced and provided context to this report.

Discussion ensued about the Ontario Health Teams (OHT) and what that will look like. Dr. Mackie mentioned that the OHT is a great initiative and MLHU has been asked to be at the table to be involved.

Ms. Lokko spoke briefly to clinical changes. She added that the report is self-explanatory. Ms. Elliott asked how MLHU will catch up on vaccines? Dr. Mackie added that the Senior Leadership Team is working together on that approach.

It was moved by Mr. Peer, seconded by Ms. DeViet, *that the Board of Health receive "Summary Information Report for June" for information.*

Carried

CEO (Interim) Verbal Update

Dr. Clarke highlighted the Public Health Modernization Report which included consultation from MLHU. The report was submitted in February 2020. He adds that his Vice President role shifted when the pandemic began. Instead, Dr. Clarke has been supporting the COVID response and how the organization was responding to the pandemic in real time over the months of March, April and May with the support of Ms. Ramer, Ms. Sangster Bouck and Ms. Di Cesare. The final draft of the report will be presented to the Senior Leadership Team on July 28, 2020 and shortly after to the Board. Dr. Clarke highlights that Dr. Mackie and himself are collaborating to understand how the new interim CEO role will roll out.

It was moved by Mr. Peer, seconded by Ms. Elliott, *that the Board of Health receive the CEO (Interim) Verbal update for information.*

Carried

Medical Officer of Health Activity Report for July (Report No. 034-20)

Dr. Mackie introduced and provided context to this report.

It was moved by Mr. Brennan, seconded by Ms. DeViet, *that the Board of Health receive Report No. 034-20 re: "Medical Officer of Health/CEO Activity Report for July" for information.*

Carried

CORRESPONDENCE

Dr. Mackie highlighted that item a – related to CERB – as it relates to Basic Income.

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

It was moved by Ms. Elliott, seconded by Mr. Peer *that the Board of Health receive items a) through h) for information and endorse item a)*

Carried

Other Business

It was moved by Ms. DeViet, seconded by Mr. Peer *that the Board of Health cancel its scheduled FFC and Board of Health meetings in August.*

Carried

Chair Cassidy noted that the next Board of Health meeting will be September 17, 2020.

CONFIDENTIAL

At 9:27 p.m., it was moved by Ms. Elliott, seconded by Mr. Peer, *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, and 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 11:25 p.m. it was moved by Ms. DeViet, seconded by Mr. Parker, *that the Board of Health return to public session.*

Carried

ADJOURNMENT

At 11:25 p.m., it was moved by Mr. Peer, seconded by Mr. Parker, *that the meeting be adjourned.*

Carried

MAUREEN CASSIDY
Chair

CHRISTOPHER MACKIE
Secretary-Treasurer

PUBLIC SESSION – MINUTES
MIDDLESEX-LONDON BOARD OF HEALTH

Thursday, July 29, 2020, 5:30 p.m.

Citi Plaza Boardroom

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

OTHERS PRESENT: 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. Nicole Gauthier, Director (Interim), Healthy Organization
Mr. Stephen Turner, Director, Environmental Health and Infectious Disease
Dr. Michael Clarke, CEO (Interim)
Mr. Dan Flaherty, Manager, Communications

Chair Cassidy called the meeting to order at 5:35 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

There were no public agenda items to approve.

Other Business

Next meeting – September 17, 2020

CONFIDENTIAL

At 5:35 p.m., it was moved by Ms. DeViet, seconded by Ms. Kayabaga, *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, and to consider a position, plan, procedure, criteria or instruction to be applied to any negotiations carried on or to be carried on by or on behalf of the municipality or local board.*

Carried

At 6:48 it was moved by Mr. Peer, seconded by Mr. Brennan, *that the Board of Health return to public session.*

Carried

The Board asked Dr. Mackie to provide a public update on the Case and Contact Management Tool (CCM).

Dr. Mackie noted that the Health Unit has developed a CCM Tool that has been adapted by 10 other Health Units. He also advised that Toronto Public Health and Ottawa Public Health have developed one of their own. The reason for this update is to advise the Board that the Province is developing a system that would cost in the range of $20,000,000 to develop and implement. The Health Unit's tool cost approximately $95,000. All systems have the capability to upload data directly to the provincial database.

The firm that the Province has hired is a US company called Salesforce.
In comparing what MLHU has developed, and what the Province is proposing does not have all of the functionality, including reporting for data analysis. It is also not clear that the program will take all of the data that MLHU has already collected.

Dr. Mackie noted that he believes three Health Units have signed up to use the Salesforce database. It is not known if this database is already being used in the United States to collect health data.

In response to a question, Dr. Mackie noted that the Ministry is aware of the systems that London, Toronto and Ottawa have developed and are using.

Discussion ensured in regard to the following;
There is a risk that the data will not flow to the provincial database from the Salesforce tool.
The $20,000,000 price tag.
The data sharing agreement has many issues, including downloading risk from the Province to health units and through them to municipalities.
The product will need further development as it is uploaded throughout the province.
The new system will impact staff user time for training and redeployment. Some felt that this is not the time to introduce another new system when there are residents that need service.
Many Board members expressed concern over going with a US company when a Canadian solution has been developed in London Ontario.

Board members requested that speaking notes be sent in advance of Association of Municipalities of Ontario (AMO) to Board members to use when speaking with elected officials. It was noted that Ms. DeViet represents Middlesex County at AMO and will seek delegation with MPPs at the August 16th meeting. It was noted that copying all Health Units on correspondence would be beneficial.

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

1) *Receive the verbal update for information; and*
2) *Direct the Chair of the Board of Health to write a letter to the Premier of Ontario, Minister of Health, local MPPs and copy all Ontario Health Units*

Carried

ADJOURNMENT

At 7:19 p.m., it was moved by Mr. Peer, seconded by Ms. Parker, *that the meeting be adjourned.*

Carried

MAUREEN CASSIDY
Chair

CHRISTOPHER MACKIE
Secretary-Treasurer

PUBLIC SESSION – MINUTES
MIDDLESEX-LONDON BOARD OF HEALTH
Special Meeting

Thursday, September 10, 2020, 9:00 a.m.

MLHU Boardroom and Microsoft Teams

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

REGRETS: Ms. Arielle Kayabaga

OTHERS PRESENT: 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. Maureen Rowlands, Director, Healthy Living
Mr. Stephen Turner, Director, Environmental Health and Infectious Disease
Ms. Elizabeth Milne, Executive Assistant to the Board of Health and Communications Coordinator

Chair Cassidy called the meeting to order at 9:02 a.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 Mr. Peer, *that the **AGENDA** for the September 10, 2020 Board of Health meeting be approved.*

Carried

Other Business

Next meeting – October 15, 2020

CONFIDENTIAL

At 9:02 a.m., it was moved by Ms. Elliott, seconded by Mr. Peer, *that the Board of Health move in-camera to consider matters regarding identifiable individuals.*

Carried

At 9:20 it was moved by Mr. Peer, seconded by Mr. Parker, *that the Board of Health return to public session.*

Carried

ADJOURNMENT

At 9:21 p.m., it was moved by Mr. Reid, seconded by Mr. Peer, *that the meeting be adjourned.*

Carried

MAUREEN CASSIDY
Chair

CHRISTOPHER MACKIE
Secretary-Treasurer

PUBLIC MINUTES
FINANCE & FACILITIES COMMITTEE
Middlesex-London Health Unit
355 Wellington Street, Suite 110, London, Ontario
Microsoft Teams Conferencing
Thursday, September 10, 2020 9:30 a.m.

MEMBERS PRESENT: Ms. Maureen Cassidy
Ms. Aina DeViet
Ms. Kelly Elliott (Chair)
Ms. Tino Kasi
Mr. Ian Peer

OTHERS PRESENT: Ms. Arielle Kayabaga, Board Member
Dr. Christopher Mackie, Secretary-Treasurer
Dr. Alexander Summer, Associate Medical Officer of Health
Ms. Lynn Guy, Executive Assistant to the Medical Officer of Health (Recorder)
Dr. Michael Clarke, CEO (Interim)
Mr. Brian Glasspoole, Manager Finance
Mr. Joe Belancic, Manager Procurement and Operations
Mr. Mirek Pawelec, incoming Manager, Finance
Ms. Maureen MacCormick, Director, Healthy Living
Ms. Elizabeth Milne, Executive Assistant to the Board of Health and Communications Coordinator

At 9:30 a.m., Chair Elliott called the meeting to order.

DISCLOSURES OF CONFLICT(S) OF INTEREST

Chair Elliott 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. Cassidy, *that the **AGENDA** for the September 10, 2020 Finance and Facilities Committee meeting be approved.*

Carried

APPROVAL OF MINUTES

It was moved by Mr. Peer , seconded by Ms. Cassidy, *that the **MINUTES** of the July 2, 2020 Finance and Facilities Committee meeting be approved.*

Carried

NEW BUSINESS

3.1 March 31st Financial Statements (Report No. 020-20FFC)

Mr. Glasspoole provided the context for this report.

It was moved by Mr. Peer, seconded by Ms. Cassidy *that the Finance and Facilities Committee recommend that the Board of Health approve the audited Consolidated Financial Statements for the Middlesex-London*

Health Unit, March 31, 2020 as appended to Report No. 020-20FFC re: "March 31st Financial Statements."

Carried

3.2 Q2 Financial and Factual Certificate Update (Report No. 021-20FFC)

Dr. Mackie provided the introduction to this report. He noted that the report was revised to include funding for the development of a racism strategy.

Mr. Glasspoole noted that all costs related to COVID were separated for Ministry reporting.

There was a lengthy discussion in regard to the racism strategy. Dr. Mackie noted that the Health Unit is looking to find someone who is involved and connected in the black community. The funding will be used to support a temporary hire or contract consultant to be the bridge to the black community. It was noted that it will take time to build a strong relationship with communities. Dr. Mackie noted that the work that was undertaken with the indigenous community was very successful and the Health Unit hopes to build on that success.

Further discussion included:
Qualifications and criteria for hiring someone to start the development of a racism strategy
The risk for tokenism – do more at the operational level to address the diversity in the organization
Would be beneficial that the candidate has public health expertise
Informing the Board early in the process
This is not the strategy but one step among many
MLHU is beginning the internal work
MLHU is at the City of London diversity table
The Health Unit has an important role in collecting data to understand the health inequities in our community
Need to have input of the diverse community and the credibility to listen.

There will be more detailed reports coming to the Board of Health

Dr. Mackie shared his appreciation of the comments made by Board Members.

It was moved by Ms. Kasi, seconded by Ms. Cassidy *that the Finance and Facilities Committee:*

1) *Receive Report No. 021-20FFC re: "Q2 Financial Update and Factual Certificate" for information;*
2) *Approve the allocation of up to $40,000 of variance funds to support the development of a strategy to address anti-black racism; and*
3) *Approve the allocation of variance funds, above those required to offset the agency gapping budget, to relocation-related expenses to a maximum of $250,000 in 2020.*

Carried

3.3 Proposed 2021 PBMA Process, Criteria and Weighting (Report No. 022-20FFC)

Dr. Mackie introduced this report and noted no changes to the criteria this year.

There was a discussion in regard to the previously proposed 70/30 funding ratio.

It was moved by Mr. Peer, seconded by Ms. DeViet *that the Finance and Facilities Committee receive and make recommendation to the Board of Health to approve the 2021 PBMA criteria and weighting that is proposed in Appendix A to Report No. 022-20FFC.*

Carried

3.4 Emergency Contract Award (Report No. 023-20FFC)

Mr. Belancic noted that this contract was needed for COVID related purchases on an emergency basis to meet ongoing care of the community.

It was moved by Mr. Peer, seconded by Ms. Kasi *that the Finance and Facilities Committee recommends the Board of Health receive Report No. 023-20FFC, re: "Emergency Contract Award" for information.*

Carried

OTHER BUSINESS

Next meeting: October 1, 2020

CONFIDENTIAL

At 10:13 am, it was moved by Mr. Peer, seconded by Mr. Cassidy, that the *Finance and Facilities Committee will 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 10:34 a.m., it was moved by Ms. Cassidy, seconded by Mr. Peer, *that the Finance and Facilities Committee return to public session.*

Carried

At 10:34 a.m. the Finance and Facilities Committee returned to public session.

The Committee thanked Mr. Glasspoole for his services and wished him well in retirement.

ADJOURNMENT

At 10:35 a.m., it was moved by Ms. Cassidy, seconded by Ms. Kasi, *that the meeting be adjourned.*

Carried

At 10:35 a.m., Chair Elliott *adjourned the meeting.*

KELLY ELLIOTT
Chair

CHRISTOPHER MACKIE
Secretary-Treasurer

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 040-20

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2020 September 17

FINANCE & FACILITIES COMMITTEE MEETING – September 10, 2020

The Finance & Facilities Committee (FFC) met at 9:30 a.m. on Thursday, September 10, 2020. A summary of the Committee's discussions can be found in the draft minutes.

Reports	Recommendations for Information and Board of Health Consideration
March 31st Financial Statements **(Report No. 020-20FFC)**	It was moved by Mr. Peer, seconded by Ms. Cassidy, *that the Finance & Facilities Committee recommend that the Board of Health approve the audited Consolidated Financial Statements for the Middlesex-London Health Unit, March 31, 2020 as appended to Report No. 020-20FFC.* Carried
Q2 Financial and Factual Certificate Update **(Report No. 021-20FFC)**	It was moved by Ms. Kasi, seconded by Ms. Cassidy, *that the Finance & Facilities Committee recommend that the Board of Health:* *1) Receive Report No. 021-20FFC re: "Q2 Financial Update and Factual Certificate" for information;* *2) Approve the allocation of up to $40,000 of variance funds to support the development of a strategy to address anti-black racism; and* *3) Approve the allocation of variance funds, above those required to offset the agency gapping budget, to relocation-related expenses to a maximum of $250,000 in 2020.* Carried
Proposed 2021 PBMA Process, Criteria and Weighting **(Report No. 022-20FFC)**	It was moved by Mr. Peer, seconded by Ms. Deviet, *that the Finance & Facilities Committee receive and make recommendation to the Board of Health to approve the 2021 PBMA criteria and weighting that is proposed in Appendix A to Report No. 022-20FFC.* Carried
Emergency Contract Award **(Report No. 023-20FFC)**	It was moved by Mr. Peer, seconded by Ms. Cassidy, *that the Finance & Facilities Committee recommends the Board of Health receive Report No. 023-20FFC, re: "Emergency Contract Award" for information.* Carried

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

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

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 041-20

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health
Michael Clark, CEO (Interim)

DATE: 2020 September 17

MONITORING IMPACTS OF THE COVID-19 PANDEMIC AND RELATED PUBLIC HEALTH MEASURES

Recommendation

It is recommended that Report No. 041-20 re: "Monitoring Impacts of the COVID-19 Pandemic and Related Public Health Measures" be received for information.

Key Points

- Unprecedented public health measures have been implemented to help contain and reduce morbidity and mortality related to COVID-19. While the measures have been important in protecting the population from COVID-19, they may have had positive and negative impacts on other health issues and social determinants of health.
- Data will be actively monitored throughout the pandemic and beyond to assess the impact of the pandemic and its related public health measures on the health and well-being of the Middlesex-London population.
- The information can be used to weigh the benefits and harms of the public health measures and help inform decisions about the delivery of public health programs and services during the pandemic.

Background

According to the World Health Organization, over 25 million cases of COVID-19 have been reported globally as of August 31, 2020, including over 840,000 deaths. Since the outbreak of the novel coronavirus was declared a global pandemic on March 10, 2020 unprecedented public health measures have been implemented at all levels of government (regional/municipal, provincial, federal) to help contain spread and reduce morbidity and mortality related to the virus (refer to **Appendix A** for a summary of key measures). While theses measures—including encouraging staying home, travel restrictions, and closures of schools and non-essential workplaces—have been important in protecting the population from COVID-19, they may have also impacted health (e.g. social isolation, delays in seeking medical care, but also reduced vehicle collisions) and social determinants of health (e.g. unemployment, food insecurity, family violence).

As the pandemic continues, the Health Unit will monitor available data to assess the impact of the pandemic and its related public health measures on the health and well-being of individuals in the Middlesex-London community. This information will help the Health Unit and other public health authorities weigh the benefits and harms of public health measures and help inform decisions about the delivery of public health programs and services as the pandemic continues and evolves.

Current Project Status

An initial list of indicators to monitor has been developed **(Appendix B)** that includes a broad range of topics such as: social determinants of health, injuries, substance use, oral health, infectious disease, immunization coverage, health pregnancy, and birth and early development. The indicators will be monitored over time in order to capture potential long-term impacts and to account for the lag in the

availability of some data. The list of indicators may change as the pandemic evolves or as new data become available.

Data collection and analysis are currently underway by the Population Health Assessment and Surveillance team. Some dashboards have already been developed to facilitate visualization of the data. Internal processes are being developed to ensure continued monitoring of these indicators.

Preliminary findings

Some preliminary findings for the Middlesex-London population:

- *Measures to reduce the spread of COVID-19 may have also reduced the spread of influenza*. In the 2019–20 influenza season, there was a 63.2% decrease in the number of influenza cases reported in February 2020 compared to March 2020. This is higher in comparison to the 2018–19 influenza season where there was a 17.4% decrease from February 2019 to March 2019.
- *Fewer emergency department (ED) visits at the peak of the pandemic*. There was a 43% decrease in the number of ED visits in April 2020 compared to March 2020. Since May 2020, the monthly number of ED visits has increased to approximately 82% of the 2019 monthly average.
- *No significant change for indicators related to healthy pregnancy*. For women who gave birth from March to July 2020, preliminary data have not shown a change in the percentage who had depression or anxiety during the pregnancy when compared to women who gave birth before the start of the pandemic. Furthermore, the preliminary data also have not shown a change in the percentage of women who reported any alcohol or drug use during their pregnancy.
- *Initial increase in opioid-related ED visits at the beginning of the pandemic, but no increase in deaths*. In March 2020, there was a 37% increase in opioid-related ED visits compared to the previous month. However, starting in April 2020, monthly counts returned to levels observed prior to the pandemic. Preliminary mortality data have not shown an increase in opioid-related deaths in March and April 2020.

Early unemployment data for the London census metropolitan area (CMA):

- *Significant increase in the unemployment rate*. From February to June 2020, the seasonally adjusted unemployment rate for the London CMA increased from 4.9% to 12.6%. In July 2020, the unemployment rate dropped to 10.5%.

A more comprehensive assessment of the impacts of the COVID-19 pandemic on health and social determinants of health will be possible once more data become available over time.

Next Steps

As more data are collected and analyzed, findings will be disseminated to help inform public health decisions and policies. Where possible, data analysis and reporting will include consideration of particularly impacted sub-populations (e.g., particular age groups, vulnerable populations, race-based data).

Conclusion

The COVID-19 pandemic has had a major impact on our daily lives. Monitoring population-level indicators over time will enable the Health Unit to assess the impact of the pandemic and its related public health measures on the health and well-being of the Middlesex-London community, and help inform policy and decision-making.

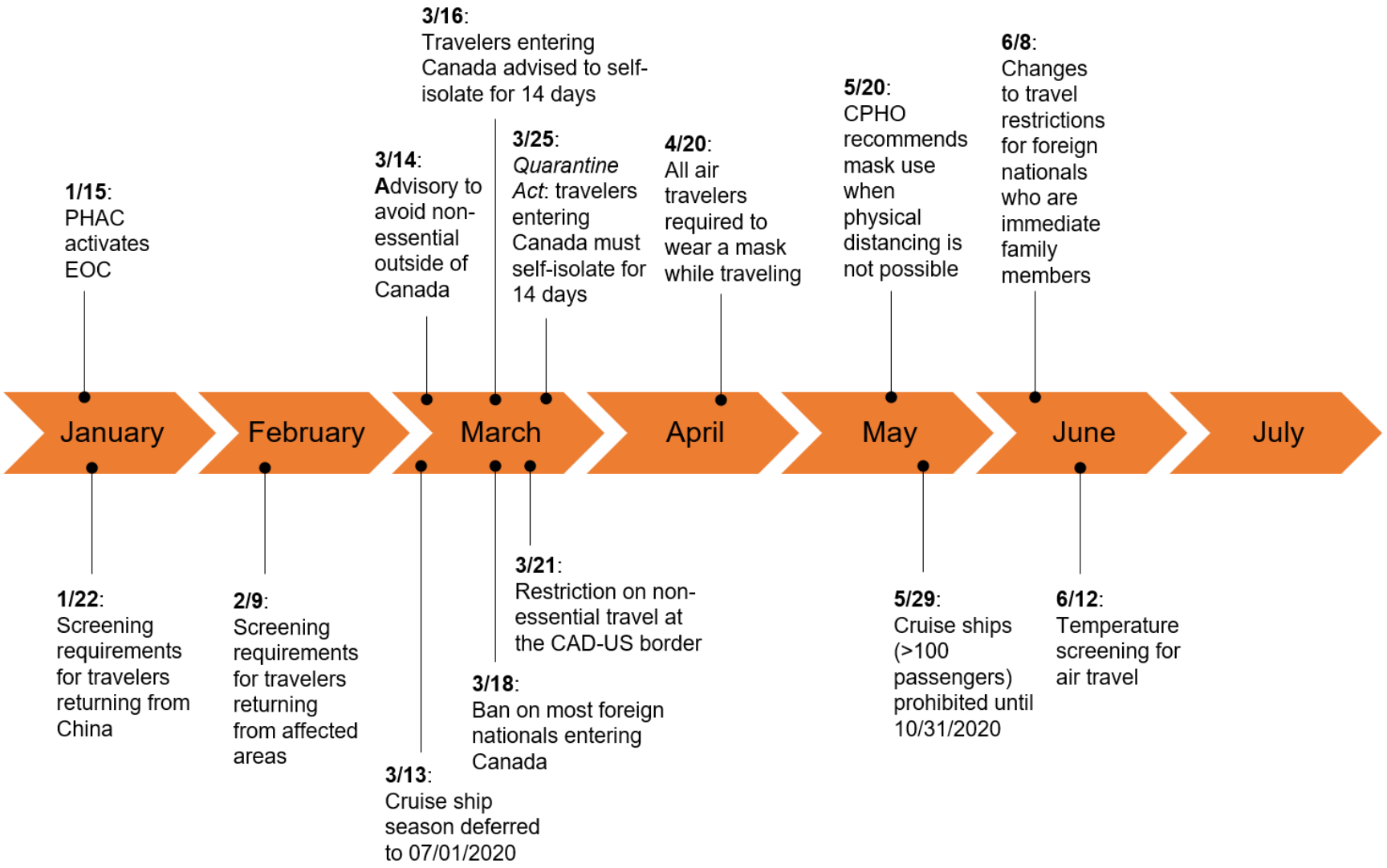
This report was prepared by the Incident Management System (IMS) Planning section and the Associate Medical Officer of Health.

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

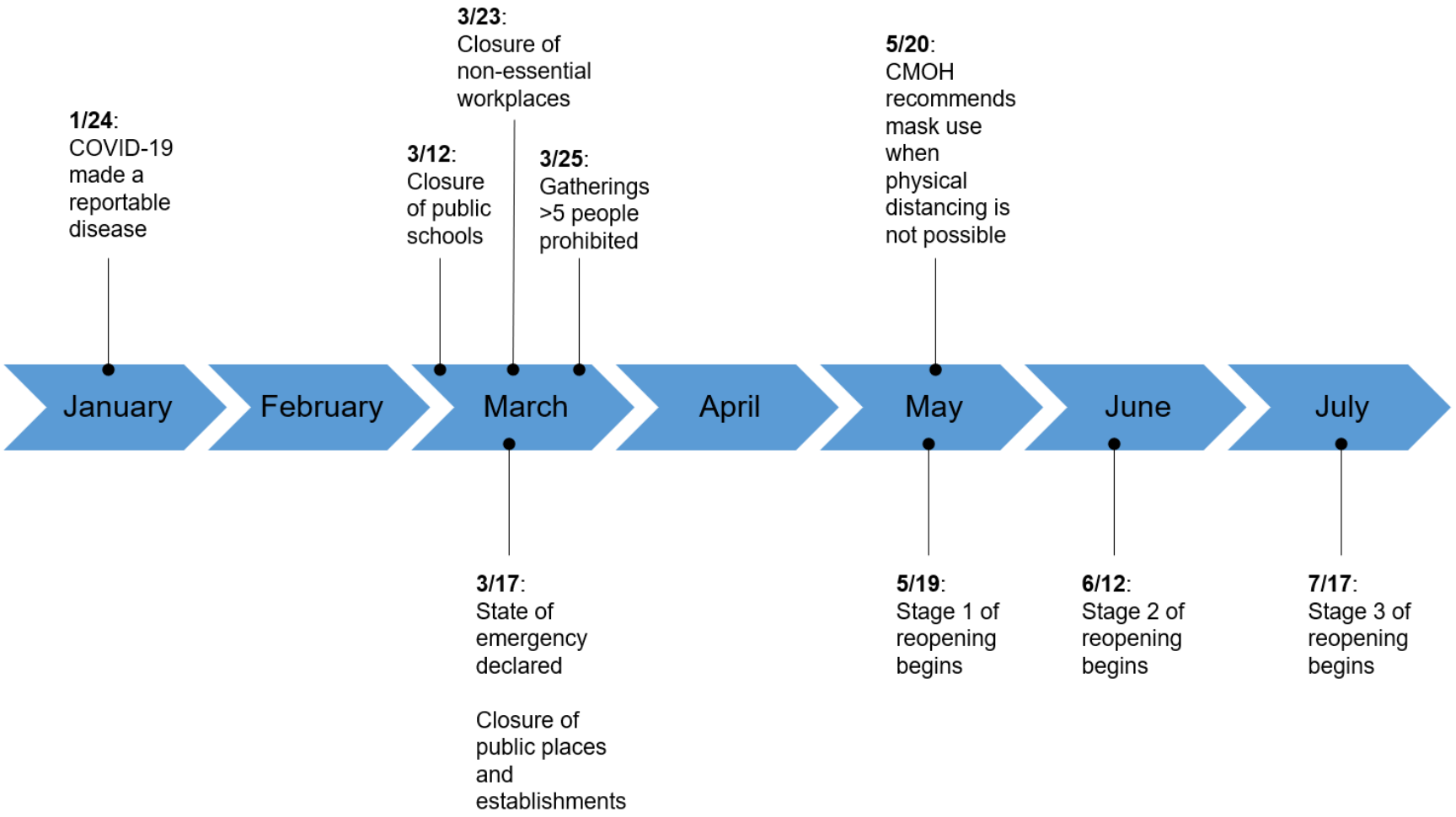
Michael Clarke, PhD
CEO (Interim)

Appendix A: Summary of key public health measures for the COVID-19 pandemic

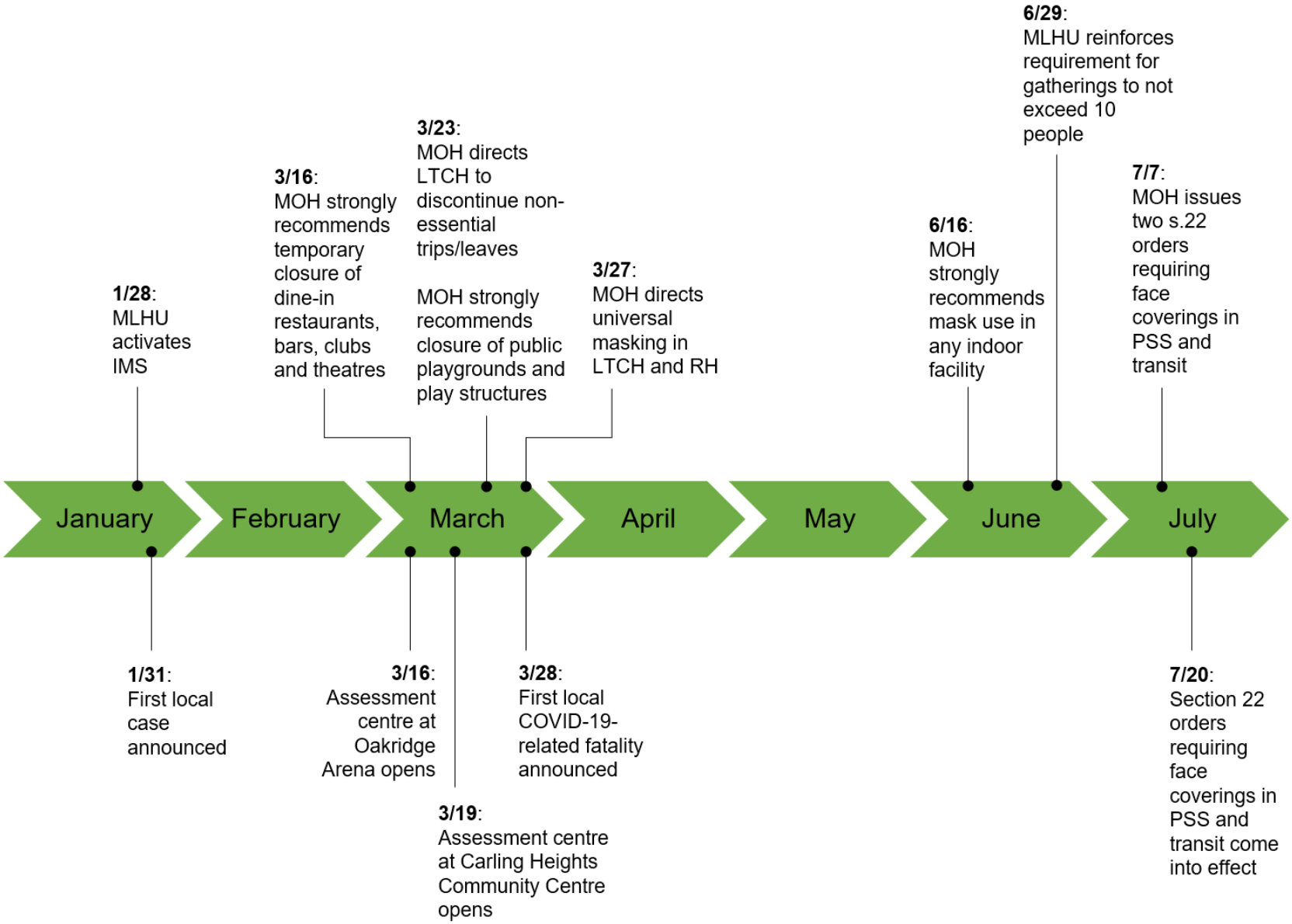
1. Federal measures



2. Provincial measures



3. Local measures



Appendix B: Indicators for monitoring impacts of the COVID-19 pandemic and related public health measures (2020-08-31)

1. Substance Use

	Indicator	Source	Data time interval	Time period	Update period
1	Opioid-related emergency department visits by type (accident, intentional, therapeutic, other)	Ministry of Health	Weekly	April 1, 2017 to present (minus a 2–3-week lag)	Weekly
2	Opioid-related emergency department visits	Ministry of Health	Monthly	April 1, 2017 to present (minus a 2–3-week lag)	Monthly
3	Opioid-related deaths for confirmed cases for which the Coroner's Opioid Investigative Aid (OIA) has been completed	PHO > Coroner's Opioid Investigative Aid	Monthly	January 2019 to present (minus a ~3 month lag)	Quarterly
		PHO > Quarterly Public Health Unit Opioid-related Death Reports	Quarterly (total, by age group, manner of death, by gender, by opioid present at death, by opioid directly contributing to death, by whether or not naloxone use by reported)	2017-Q2 to present (minus a ~4 month lag)	Quarterly
4	Probable and confirmed opioid-related deaths	PHO > Coroner's Opioid Investigative Aid	Monthly	Most recent four months in which data are available (usually a ~3 month lag)	Quarterly
5	Opioid-related deaths for confirmed cases for which the Coroner's Opioid Investigative Aid (OIA) has been completed	PHO > Quarterly Public Health Unit Opioid-related Death Reports	Total summary (total, by manner by death, by gender, by age group, male deaths by age group, female deaths by age group, by type of opioid present at death, by type of opioid directly contributing to death)	May 2017 to most recent complete quarter (minus a ~4 month lag)	Quarterly
6	Accidental opioid-related deaths for confirmed cases for which the Coroner's Opioid Investigative Aid (OIA) has been completed	PHO > Quarterly Public Health Unit Opioid-related Death Reports	Total summary (by ethnicity, by living arrangements, by release from a correctional facility in past 4 weeks, by whether or not individual was at home at time of death, by whether or not another	May 2017 to most recent complete quarter (minus a ~4 month lag)	Quarterly

			individual was present at time of incident who could intervene, by location of death, by location of incident, by whether or not there was evidence of injection drug use, by whether or not there was a resuscitation attempt, by who attempted resuscitation attempt, by whether or not naloxone use was reported, by who attempted to use naloxone)		
7	Emergency department visits for substance use (syndromes: EOH, OPI, TOX)	ACES	Grouped by week	December 28, 2018 to most complete week (Sunday to Saturday)	Weekly
8	Emergency department visits for substance use	NACRS – Intellihealth	Monthly	January 2015 to Q1 2020	Monthly
9	Emergency department visits related to crystal methamphetamines	NACRS – Intellihealth	Monthly	January 2015 to Q1 2020	Monthly

2. Injuries

	Indicator	Source	Data time interval	Time period	Update period
1	Emergency department visits for all syndromes	ACES	Grouped by week	December 28, 2018 to most complete week (Sunday to Saturday)	Weekly
2	ED visits by syndrome	ACES	Grouped by week	December 28, 2018 to most complete week (Sunday to Saturday)	Weekly

Categories	Syndromes	Notes
Healthy pregnancy and births	• OBS = related to obstetrics • GYN = gynecological, bleed, hysterectomy, PID • NEWB = newborn	
Substance use	• EOH = alcohol related: intoxication, addiction, withdrawal, end organ damage • OPI = opioid intoxication, addiction, overdose, and withdrawal	Based on ACES' *Toxicity* bucket

		• TOX = toxicology: withdrawal, substance abuse, chemical exposure (not alcohol or opioids)	
	Trauma or injury	• ORTHF = non-hip fracture • ORTHH = fracture of the femur or hip • TRMVC = trauma from MVC/ATV • TRO = trauma from another means (e.g., fall) • TRW = gunshot or stab, violence, assault	Based on ACES' *Major Accident or Injury* bucket
	Other injuries	• BURN = burns: chemical and thermal, electrical shock • CONC = concussion, head injury • FALL = undifferentiated falls • INJ = sprain, strain, laceration, dislocation, bruise, swelling • LAC = lacerations • TRS = sexual assault	
	Mental health	• MH = mental health • MHS = suicidal ideation (attempt or overdose) • SOC = social admission	Based on ACES' *Mental Health* bucket
	Cardiovascular disease	• CAD = coronary artery disease, chest pain • CHF = congestive heart failure • CV = cardiovascular (excludes MI and strokes; includes peripheral vascular disease)	Based on ACES' *Cardiovascular* bucket
	Other chronic diseases	• CARD = pericarditis, effusion, myocarditis, endocarditis • COPD = chronic obstructive pulmonary disease • DM = diabetes, related complications • NEURO = dementia, Alzheimer's, stroke, seizure, vertigo, syncope, fainting • REN = renal failure, dialysis, renal disease and complications	
	Bites and ticks	• BITE = human, animal, bug (not tick-related) • TICKS = ticks	
	Environmental health effects	• AST = asthma, wheeze, difficulty breathing, SOB • CO = carbon monoxide exposure or other gases (e.g., sulphur) • COPD = chronic obstructive pulmonary disease • DEHY = dehydration • ENVIRO = heat stroke, heat syncope, heat exhaustion, cold-frost bite, hypothermia • SI = smoke inhalation (or chemical, gases)	Based on ACES' *Environmental Health Effects* bucket, with the addition of the CO syndrome
	Respiratory infections	• BRONCH = bronchiolitis, RSV • CROUP = Croup (parainfluenza viruses) • ILI = fever, myalgia, undifferentiated flu • PN = pneumonia • RESP = respiratory infection non-croup, non-bronchiolitis	Based on ACES' *Respiratory Infections* bucket
	Gastrointestinal infections	• GASTRO = gastroenteritis • VOM = vomiting-alone-NORO like illness, not secondary to chemo or with other symptoms	
	Other infection and disease	• B = Guillain Barre syndrome, flaccid paralysis	

		• INF = non-specific infections: potential interest to public health, epiglottitis, tonsil abscess • MEN = meningitis and encephalitis • REPORT = reportable diseases • SEP = bacteremia, sepsis			
	Dermatological infections	• CELL = cellulitis, non-wound infection, non-abscess • DERM = rash, undifferentiated, lesion, wart • NEC = necrotizing fasciitis, severe cellulitis, gangrene			Based on ACES' *Dermatological Infections* bucket
	Health system continuous quality improvement (CQI)	• CDIFF = C. difficile • PO = post-operative infection or complication			Based on ACES' *Health System CQI* bucket
3	ED visits for motor vehicle collisions (MVC) to hospitals in Middlesex-London	NACRS – Intellihealth	Monthly	January 2015 to Q1 2020	Monthly

3. Social Determinants of Health

	Indicator	Source	Data time interval	Time period	Update period
1	Seasonally adjusted unemployment rate for the London CMA	Statistics Canada	Monthly	January 2016 to most complete month	Monthly (lag of ~10 days)
2	Unadjusted unemployment rate for the London CMA	Statistics Canada	Monthly	January 2016 to most complete month	Monthly (lag of ~10 days)
3	Seasonally adjusted participation rate for the London CMA	Statistics Canada	Monthly	January 2016 to most complete month	Monthly (lag of ~10 days)
4	Unadjusted participation rate for the London CMA	Statistics Canada	Monthly	January 2016 to most complete month	Monthly (lag of ~10 days)

4. Healthy Pregnancy

	Indicator	Source	Data time interval	Time period	Update period
1	Women who gave birth who had depression in this pregnancy	BORN	Monthly	2013 to most complete month	Monthly
2	Women who gave birth who had anxiety in this pregnancy	BORN	Monthly	2013 to most complete month	Monthly
3	Self-reported smoking at time of labour/admission	BORN	Monthly	2013 to most complete month	Monthly
4	Self-reported alcohol use during pregnancy	BORN	Monthly	2013 to most complete month	Monthly
5	Self-reported drug use (other than alcohol) during pregnancy	BORN	Monthly	2013 to most complete month	Monthly

5. Birth and Early Development

	Indicator	Source	Data time interval	Time period	Update period

1	Births by location type	BORN	Monthly	2013 to most complete month	Monthly
2	Emergency department visits for OBS syndrome (related to obstetrics)	ACES	Grouped by week	December 28, 2018 to most complete week (Sunday to Saturday)	Weekly
3	Emergency department visits for GYN syndrome (includes gynecological, bleed, hysterectomy, PID)	ACES	Grouped by week	December 28, 2018 to most complete week (Sunday to Saturday)	Weekly
4	Emergency department visits for NEWB syndrome (newborn)*	ACES	Grouped by week	December 28, 2018 to most complete week (Sunday to Saturday)	Weekly
5	Emergency department visits for children age 0 to 4 (all syndromes)	ACES	Grouped by week	December 28, 2018 to most complete week (Sunday to Saturday)	Weekly
6	Breastfeeding (any and exclusive) at time of discharge from hospital or midwifery care	BORN	Monthly	2013 to most complete month	Monthly

6. Immunization

	Indicator	Source	Data time interval	Time period	Update period
1	Immunization – coverage for all ISPA antigens for • All students 7–17 years old • 7-year old students • 17-year old students	Panorama – PEAR	School year (SY) to date	2017–18 SY, to 2020–21 SY to date	Bi-monthly
2	Immunization – coverage for school-based program vaccines for students 12 years old: • Hepatitis B • HPV • Meningococcal (quadrivalent)	Panorama – PEAR	School year (SY) to date	2017–18 SY, to 2020–21 SY to date	Bi-monthly

7. Infectious Disease

	Indicator	Source	Data time interval	Time period	Update period
1	STIs – Number of confirmed cases of: • Chlamydia • Gonorrhea • HIV • Syphilis – Infectious	PHO Infectious Disease Query	Monthly	2017 to most complete month	Monthly

	• Syphilis – All types				
2	STIs – Rate of confirmed cases of: • Chlamydia • Gonorrhea • HIV • Syphilis – Infectious • Syphilis – All types	PHO Infectious Disease Query	Monthly	2017 to most complete month	Monthly
3	STIs – Percent positivity of testing for: • Chlamydia • Gonorrhea • HIV	PHO STI Lab Decision Support Tool (chlamydia, gonorrhea) PHO ad hoc request (HIV)	Monthly	TBD	Monthly

8. Mental Health

	Indicator	Source	Data time interval	Time period	Update period
1	Distress line calls received by staff at Middlesex-London CMHA Branch	CMHA	Monthly	January 2019 to most complete month	Monthly
2	Emergency department visits for mental health to hospitals in Middlesex-London	NACRS – Intellihealth	Monthly	January 2015 to Q1 2020	Monthly
3	Ontario 211 clients identifying needs related to mental-health /addictions in Middlesex-London	Ontario 211	Monthly	January 2015 to most complete month	Monthly
4	Emergency department visits for mental health (syndromes: MH, MHS, SOC)	ACES	Grouped by week	December 28, 2018 to most complete week (Sunday to Saturday)	Weekly

9. Oral Health

	Indicator	Source	Data time interval	Time period	Update period
1	Emergency department visits for emergency dental care	NACRS – Intellihealth	Monthly	TBD	TBD
2	% of eligible seniors who required urgent dental care through OSDCP	OHISS / ABELDent	Monthly	December 2019 to most complete month	Monthly
3	% of eligible children who required urgent dental care through HSO	OHISS / ABELDent	Monthly	TBD	Monthly
4	% of eligible students screened in the school-based dental screening program identified as requiring urgent dental care	OHISS / ABELDent	Monthly	TBD	Monthly

10. Preventable Mortality

*Note: these data will not be available in the short term

	Indicator	Source	Data time interval	Time period	Update period
1	Preventable mortality rate (all causes)	Ontario Mortality Data – Intellihealth	Annually	2013 to most recent year	Annually or semi-annually
2	Preventable causes of mortality rates: • Cancer • Injury • Cardiovascular • Respiratory • Alcohol & drugs • Infection • Nutrition • Digestive	Ontario Mortality Data – Intellihealth	Annually	2013 to most recent year	Annually or semi-annually

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 042-20

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2020 September 17

COVID-19 SURVEILLANCE TESTING ON FARMS

Recommendation

It is recommended that Report No. 042-20 re: "COVID-19 Surveillance Testing on Farms" be received for information.

Key Points

- Surveillance testing of migrant farm workers (MFWs) for COVID-19 was undertaken in July 2020 for select farms in the Middlesex-London region. This initiative was prompted by the occurrence of outbreaks amongst this population in other jurisdictions in Southern Ontario.
- The MFW community has been identified at high risk for COVID-19 outbreaks due to congregate living environments and barriers to health care and testing.
- The campaign concluded on August 21, 2020. Approximately 64% of MFWs in the Middlesex-London region were tested and no positive cases were identified among migrant farm workers during the surveillance campaign.
- MLHU will continue to support employers and workers on farms to ensure that preventive steps are in place to limit the transmission of COVID-19.

Background

Migrant farm workers (MFWs) are employed by many farms in southwestern Ontario. With an estimated 150-200 workers in the Middlesex-London region, the scale of the migrant farmers in this jurisdiction is smaller than other neighbouring communities. Some workers live in congregate housing on the farm whereas others live in the community. Of the approximately 50 farms who employ migrant farmers in London and Middlesex, most have less than 10. A majority of the workers are employed by 3-4 farms. All of these farms also employ local workers who live in the community. The Health Unit has been working with farms since the early spring, including liaison with public health inspectors to introduce preventive actions.

Outbreaks of COVID-19 amongst MFWs in neighbouring jurisdictions has highlighted three key characteristics about this population: (1) these workers are not positioned to easily disclose symptoms of COVID-19, (2) the congregate living settings where workers live are areas of rapid transmission, and (3) barriers to health care and testing exist.

Given these characteristics, proactive testing of asymptomatic individuals had the potential to play a uniquely important role in supporting the wellbeing of this community and minimizing transmission of COVID-19. In partnership with Ontario Health, the Ontario Ministry of Agriculture, Food, and Rural Affairs (OMAFRA), and the Middlesex-London Paramedic Services (MLPS), Middlesex-London Health Unit (MLHU) organized a surveillance testing initiative of MFWs in the London-Middlesex region. Farms were identified for surveillance testing was based on the number of migrant workers employed by a particular farm and the level of risk as assessed by the Public Health Inspector. Farms were ranked by Public Health Inspectors familiar with the farms as moderate to high risk based on number of MFWs employed by that farm and whether they were living congregate settings.

Process

To increase acceptability from the farmers for the testing, public health inspectors who had developed working relationships in the past were the first point of contact. Once notification had occurred, additional members of the MLHU team supported the mobilization of on-site testing.

There was hesitancy from both farm owners and MFWs regarding the need for surveillance testing. One of the most prevalent concerns from operators included the possibility of exposing their workers to the mobile team. Fortunately, the previously established relationships between MLHU and farm owners ensured fulsome discussions could occur, providing reassurance that testing could happen safely. In the end, all identified farms agreed to have on-site testing.

The expectation for the farm owners was that they ensured all MFWs had an opportunity for testing. If interpreters were required, MLHU provided this service at the time of testing. Community paramedics from MLPS were instrumental in performing all the testing at the sites. Testing started in early July, and the initiative concluded on August 21st, 2020. Of the 137 eligible MFWs, 87 or 64% were tested.

Next Steps

MLHU will continue to support employers and workers on farms to ensure that preventive steps are in place to limit the transmission of COVID-19. The initiative highlighted the importance of established and respectful working relationships with community partners and emphasized the need for ongoing work to support the health of MFWs.

This report was prepared by the Incidence Management System (IMS) Operations section and the Associate Medical Officer of Health.

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

Michael Clarke, PhD
CEO (Interim)

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 043-20

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health
Michael Clarke, CEO (Interim)

DATE: 2020 September 17

UPDATE ON PROVINCIAL COVID-19 CASE AND CONTACT MANAGEMENT (CCM) SYSTEM

Recommendation

It is recommended that the Board of Health receive Report No. 043-20 re: "Update on Provincial COVID-19 Case and Contact Management (CCM) System" for information.

Key Points

- The Ontario Ministry of Health has directed all public health units (PHUs) to implement a new COVID-19 case and contact management (CCM) system. The tool is being built by a company called Salesforce. As of August 20, 2020, 31 out of 34 PHUs have implemented the system.
- MLHU staff have been monitoring the development of the tool closely, through participation in several provincial working groups and liaison with other PHUs who have implemented the tool.
- Although the Ministry of Health and Salesforce continue to enhance the system, there exist unresolved issues related to solution instability, data migration, record creation, and reporting. In contrast to MLHU's existing CCM solution, the current functionality of the provincial system is insufficient for the MLHU to meet its legislated mandate and its use may expose the MLHU to organizational risks.
- MLHU has delayed implementation of the provincial CCM solution until these issues are addressed. The MLHU team will continue to work with the Ministry of Health to further develop the system such that risks can be mitigated or eliminated, and a go-live date can be established.

Background

In June 2020, the Ontario Ministry of Health announced that it was implementing a new case and contact management (CCM) solution for public health units (PHUs) to manage and report on COVID-19 cases and contacts, replacing the use of the existing provincial infectious disease information system (iPHIS). Under the direction of the Ministry of Health, the companies Salesforce and Accenture have been developing the new CCM system with input from Ontario's PHUs.

Using a rapid, iterative approach, the initial release of the system was implemented by four PHUs on July 17, 2020. As of August 20, 2020, the fourth iteration of the solution was implemented by 31 of 34 Ontario PHUs. The provincial CCM system is yet to be implemented at three PHUs, all of which have locally developed COVID-19 case and contact management systems, including the Middlesex-London Health Unit (MLHU).

Leveraging the experiences of developing a successful case management tool, the MLHU has actively participated in the development of the new provincial CCM solution. While the Ministry of Health and Salesforce have been responsive to system development feedback from PHU users, several issues continue to exist regarding the functionality of the solution and the inherent organizational risks that would be assumed by MLHU once it is implemented locally.

CCM System Limitations

Based on feedback provided by other PHUs at province-wide collaboration meetings, the provincial CCM system is characterized by several limitations and deficiencies, including (but not limited to):

Solution and data instability

Between July 17 and August 20, 2020, four iterations of the provincial CCM were released. An additional three iterations are projected by mid-autumn. With each release, substantial new and updated functionality is introduced, requiring refresher training for users. Additional data fields are also migrated into the system with each release, necessitating review of existing data to verify the accuracy and completeness of records. While appreciative of expanding functionality and data availability, PHUs already using the CCM system report that it can be challenging to plan for new releases and to ensure all users are up to date on the system's functionality.

Insufficient and inaccurate data migration from existing systems into CCM solution

Only a subset of the case and contact management data that resides in existing systems is migrated into the provincial CCM solution at the time of go-live. While the number of data elements migrated has expanded with each release, the current data migration templates do not include all data elements required for fulsome case and contact management and reporting by the MLHU. Further, PHUs already using the solution report that inaccuracies have been introduced during the data migration process, due to data mapping errors.

Inaccuracies introduced by integration with the Ontario Laboratory Information System (OLIS)

Currently, positive laboratory results are faxed to the case's PHU of residence to initiate case management. The provincial CCM system integrates with the provincial laboratory system (OLIS) to automate case investigation record creation. PHUs already using the CCM solution report that some system-generated records are not created as a positive case, even though faxed results for the same individual are positive. In other instances, the OLIS feed reflects that the result was indeed positive, but the system-generated case investigation record has been flagged with a different classification. The potential for missing a report of a COVID-19 positive case requires process redundancies to be developed until these and other record-creation issues are resolved.

Decreased reporting functionality

Currently, CCM solution reports are unable to link data from different sections of the system, such as linking client demographics to the associated case investigation details. Further, the system lacks key fields that are integral to infectious diseases reporting, such as age at time of illness and earliest symptom onset date. This issue is further amplified because the report builder is restricted to one calculated field within each report. A user could build a report that calculates one of these fields, but not all. Overall, the reporting functionality currently available in the CCM solution is greatly decreased compared to what PHUs had previously. Many PHUs use parallel systems to sustain public reporting, resulting in duplicative work.

Given the currently unresolved issues related to solution instability, data migration, record creation, and reporting, the functionality of current release of the provincial CCM solution is insufficient for the MLHU to meet its legislated mandates for case and contact management, and infectious diseases surveillance and reporting.

Next Steps

Given the inadequacies noted above and the associated organizational risks, MLHU has delayed implementation of the provincial CCM solution until the system is proven to be adequate for comprehensive COVID-19 case and contact management and reporting. The MLHU CCM implementation team will continue to work with the Ministry of Health to advance data migration processes and system functionality, such that organizational risks are mitigated or eliminated, after which a go-live date can be established.

In a memo released on September 4th, 2020, the Ministry has signaled that it intends to proceed with full provincial implementation of the tool. The memo, attached in Appendix A, indicates changes to regulation that would require all reporting of COVID-19 cases to occur through the new provincial tool.

This report was prepared by the Associate Medical Officer of Health and the COVID-19 Incident Management Team.

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September 4, 2020

MEMORANDUM

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

RE: Amendments to the Infectious Diseases Protocol

Dear Colleagues:

I am writing to inform you of changes to the Infectious Diseases Protocol to accompany the implementation of the Provincial Case and Contact Management Solution (CCM). CCM will phase out the multiple tools being used across the province and replace the provincial communicable disease database (iPHIS) for COVID-19 case and contact reporting.

This release is part of the ministry's ongoing process to ensure that the Ontario Public Health Standards: Requirements for Programs, Services and Accountability (OPHS) and related Protocols, Guidelines and Appendices remain up to date and reflect current policies and programs.

The attached Infectious Diseases Protocol is effective September 4, 2020. The revised document will soon be made available in English and French on the OPHS website:
http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/infdispro.aspx .

Changes to the Infectious Diseases Protocol include:

- Revisions to incorporate the updated reporting requirements related to implementation CCM with respect to diseases caused by a novel coronavirus, and deaths from such disease. The requirements specific to CCM have been added under the Reporting of Infectious Disease, Management of Infectious Diseases – Sporadic Cases, Investigation and Management of Infectious Diseases Outbreaks, Prevention and Management of Zoonotic Diseases sections of the protocol. Please note both COVID-19 cases and contacts are to be entered into CCM.

Please do not hesitate to contact Nina Arron, Director, Health Protection and Surveillance Policy and Programs Branch, at nina.arron@ontario.ca if you have any questions or concerns.

Sincerely,

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

c: Dr. Colleen Geiger (A), President and Chief Executive Officer, Public Health Ontario
Dr. Brian Schwartz, Vice President, Public Health Ontario

Infectious Diseases Protocol, 2020

Ministry of Health
Effective: September 4, 2020

Ontario

Preamble

The Ontario Public Health Standards: Requirements for Programs, Services, and Accountability (Standards) are published by the Minister of Health and Long-Term Care under the authority of section 7 of the *Health Protection and Promotion Act* (HPPA) to specify the mandatory health programs and services provided by boards of health.[1,2] The Standards identify the minimum expectations for public health programs and services. Boards of health are accountable for implementing the Standards including the protocols and guidelines that are referenced in the Standards. Protocols are program and topic-specific documents incorporated into the Standards which provide direction on how boards of health shall operationalize specific requirement(s) identified within the Standards.

Purpose

The purpose of this protocol is to provide direction to boards of health with respect to the prevention, detection and management of infectious diseases of public health importance. This protocol should be considered as an overarching protocol to support the other infectious disease and infection prevention related protocols and disease-specific appendices, and should be utilized in conjunction with the *Population Health Assessment and Surveillance Protocol, 2018* (or as current), where applicable.[3]

This protocol is intended to provide direction regarding minimum responsibilities for analyzing, interpreting, responding to, and communicating about infectious disease events to reduce the burden of infectious diseases of public health importance. This protocol is also intended to ensure emergency service workers (ESWs) are notified by the medical officer of health, or designate, in the event that s/he may have been exposed to an infectious disease of public health importance so that appropriate action can be taken.

The protocol provides direction regarding:

- The establishment of rates of infectious diseases of public health importance and factors that influence their occurrence;
- The identification of emerging trends and changes in infectious disease rates;
- The identification of trends and changes in factors that influence the rate of infectious diseases;
- The provision of timely communications with respect to infectious disease incidence rates that are above expected rates;
- The assessment of population health status with respect to infectious diseases;
- The planning of evidence-based public health policies, programs, interventions and services to prevent, detect and control infectious diseases in the community and in high-risk settings;
- The evaluation of public health policies, programs, interventions and services related to the prevention and control of infectious diseases; and,

- The responsibilities of boards of health with regard to notifying ESWs of possible exposures to infectious diseases of public health importance where:
    - Diseases are not limited to those named under the *Mandatory Blood Testing Act*, 2006 (MBTA) (currently restricted to hepatitis B, hepatitis C and HIV/AIDS.);[4] or
    - An ESW has not made an application under the MBTA, but the board of health and/or medical officer of health or designate suspects that an ESW may have been exposed to an infectious disease of public health importance.

Appendix A, *Disease Specific Chapters*, provides information on the pathogenicity, epidemiology and public health management of all infectious disease of public health significance in Ontario. Appendix B, *Provincial Case Definitions*, provides the provincial surveillance case definitions for infectious disease of public health significance, in addition to disease-specific information, including current laboratory technologies and clinical signs and symptoms.

Further direction, with respect to sexually transmitted infections, rabies and tuberculosis prevention and control can also be found in the *Sexual Health and Sexually Transmitted/Blood-Borne Infections Prevention and Control Protocol, 2018 (or as current); the Rabies Prevention and Control Protocol, 2018* (or as current); and the *Tuberculosis Prevention and Control Protocol, 2018* (or as current).[5-7]

This protocol does not address requirements of boards of health under the MBTA which is administered by the Ministry of Community Safety and Correctional Services.[4]

Reference to the Standards

This section identifies the standards and requirements to which this protocol relates.

Population Health Assessment

Requirement 2. The board of health shall interpret and use surveillance data to communicate information on risks to relevant audiences in accordance with the *Healthy Environments and Climate Change Guideline, 2018* (or as current); the *Infectious Diseases Protocol, 2018* (or as current); and the *Population Health Assessment and Surveillance Protocol, 2018* (or as current).

Food Safety

Requirement 5. The board of health shall ensure 24/7 availability to receive reports of and respond to:

a) Suspected and confirmed food-borne illnesses or outbreaks;
b) Unsafe food-handling practices, food recalls, adulteration, and consumer complaints; and

c) Food-related issues arising from floods, fires, power outages, or other situations that may affect food safety in accordance with the *Health Protection and Promotion Act*; the *Food Safety Protocol, 2018* (or as current); the *Infectious Diseases Protocol, 2018* (or as current); and the *Operational Approaches for Food Safety Guideline, 2018* (or as current).

Healthy Environments

Requirement 1. The board of health shall:
a) Conduct surveillance of environmental factors in the community;
b) Conduct epidemiological analysis of surveillance data including monitoring of trends over time; emerging trends; and priority populations; and
c) Use information obtained to inform healthy environments programs and services

in accordance with the *Health Hazard Response Protocol, 2018* (or as current); the *Healthy Environments and Climate Change Guideline, 2018* (or as current); the *Infectious Diseases Protocol, 2018* (or as current); and the *Population Health Assessment and Surveillance Protocol, 2018* (or as current).

Immunization

Requirement 1. The board of health shall, in accordance with the *Immunization for Children in Schools and Licensed Child Care Settings Protocol, 2018* (or as current), assess, maintain records and report on:
a) The immunization status of children enrolled in licensed child care settings, as defined in the *Child Care and Early Years Act, 2014*;[8]
b) The immunization status of children attending schools in accordance with the *Immunization of School Pupils Act*; and
c) Immunizations administered at board of health-based clinics as required in accordance with the *Immunization for Children in Schools and Licensed Child Care Settings Protocol, 2018* (or as current) and the *Infectious Diseases Protocol, 2018* (or as current).

Requirement 2. The board of health shall conduct epidemiological analysis of surveillance data for vaccine preventable diseases, vaccine coverage, and adverse events following immunization, including monitoring of trends over time, emerging trends and priority populations in accordance with the *Infectious Diseases Protocol, 2018* (or as current) and the *Population Health Assessment and Surveillance Protocol, 2018* (or as current).

Requirement 10. The board of health shall:
a) Promote reporting of adverse events following immunization by health care providers to the local board of health in accordance with the *Health Protection and Promotion Act*; and
b) Monitor, investigate, and document all suspected cases of adverse events following immunization that meet the provincial reporting criteria and promptly report all cases.

Infectious and Communicable Diseases Prevention and Control

Requirement 1. The board of health shall conduct population health assessment and surveillance regarding infectious and communicable diseases and their determinants. These efforts shall include:

a) Reporting data elements in accordance with the *Health Protection and Promotion Act; the Infectious Diseases Protocol, 2018* (or as current); the *Rabies Prevention and Control Protocol, 2018* (or as current); the *Sexual Health and Sexually Transmitted/Blood-Borne Infections Prevention and Control Protocol, 2018* (or as current); and the *Tuberculosis Prevention and Control Protocol, 2018* (or as current);
b) Conducting surveillance and epidemiological analysis, including the monitoring of trends over time, emerging trends, and priority populations in accordance with the *Infectious Diseases Protocol, 2018* (or as current); the *Population Health Assessment and Surveillance Protocol, 2018* (or as current); the *Rabies Prevention and Control Protocol, 2018* (or as current); the *Sexual Health and Sexually Transmitted/Blood-Borne Infections Prevention and Control Protocol, 2018* (or as current); and the *Tuberculosis Prevention and Control Protocol, 2018* (or as current);
c) Responding to international, Federal/Provincial/Territorial and local changes in diseases epidemiology by adapting programs and services; and
d) Using the information obtained through assessment and surveillance to inform program development regarding communicable diseases and other infectious diseases of public health importance.

Requirement 11. The board of health shall provide public health management of cases, contacts, and outbreaks to minimize the public health risk in accordance with the *Infectious Diseases Protocol, 2018* (or as current); the *Institutional/Facility Outbreak Management Protocol, 2018* (or as current); the *Management of Potential Rabies Exposures Guideline, 2018* (or as current); the *Rabies Prevention and Control Protocol, 2018* (or as current); the *Sexual Health and Sexually Transmitted/ Blood-Borne Infections Prevention and Control Protocol, 2018* (or as current); and the *Tuberculosis Prevention and Control Protocol, 2018* (or as current).

Requirement 16. The board of health shall develop a local vector-borne management strategy based on surveillance data and emerging trends in accordance with the *Infectious Diseases Protocol, 2018* (or as current).

Requirement 21. The board of health shall ensure 24/7 availability to receive reports of and respond to:

a) Infectious diseases of public health importance in accordance with the *Health Protection and Promotion Act*; the *Mandatory Blood Testing Act, 2006*; the *Infectious Diseases Protocol, 2018* (or as current); and the *Institutional/ Facility Outbreak Management Protocol, 2018* (or as current);
b) Potential rabies exposures in accordance with the *Health Protection and Promotion Act*; the *Management of Potential Rabies Exposures Guideline, 2018* (or as current); and the *Rabies Prevention and Control Protocol, 2018* (or as current); and

c) Animal cases of avian chlamydiosis, avian influenza, novel influenza, or Echinococcus multilocularis infection, in accordance with the *Health Protection and Promotion Act*, the *Management of Avian Chlamydiosis in Birds Guideline, 2018* (or as current); the *Management of Avian Influenza or Novel Influenza in Birds or Animals Guideline, 2018* (or as current); and the *Management of Echinococcus Multilocularis Infections in Animals Guideline, 2018* (or as current).

Safe Water

Requirement 1. The board of health shall:

a) Conduct surveillance of:
   - Drinking water systems and associated illnesses, risk factors, and emerging trends;
   - Public beaches and water-borne illnesses associated with recreational water, risk factors, and emerging trends, and
   - Recreational water facilities;

b) Conduct epidemiological analysis of surveillance data, including monitoring of trends over time, emerging trends, and priority populations; and

c) Use the information obtained to inform safe water programs and services

in accordance with the *Infectious Diseases Protocol, 2018* (or as current); the *Population Health Assessment and Surveillance Protocol, 2018* (or as current); the *Recreational Water Protocol, 2018* (or as current); the *Safe Drinking Water and Fluoride Monitoring Protocol, 2018* (or as current); and the *Small Drinking Water Systems Risk Assessment Guideline, 2018* (or as current).

Requirement 8. The board of health shall ensure 24/7 availability to receive reports of and respond to:

a) Adverse events related to safe water, such as reports of adverse drinking water of drinking water systems, governed under the *Health Protection and Promotion Act* or the *Safe Drinking Water Act, 2002*;

b) Reports of water-borne illnesses or outbreaks;

c) Safe water issues arising from floods, fires, power outages, or other situations that may affect water safety; and

d) Safe water issues relating to recreational water use including public beaches in accordance with the *Infectious Diseases Protocol, 2018* (or as current); *Operational Approaches for Recreational Water Guideline, 2018* (or as current); the *Recreational Water Protocol, 2018* (or as current); the *Safe Drinking Water and Fluoride Monitoring Protocol, 2018* (or as current); and the *Small Drinking Water Systems Risk Assessment Guideline, 2018* (or as current).

Operational Roles and Responsibilities

Interpretation, Use and Communication of Infectious Disease Surveillance Data

1) In compliance with relevant privacy legislation (e.g., HPPA, *Personal Health Information Protection Act, 2004* [PHIPA], *Municipal Freedom of Information and Protection of Privacy Act* [MFIPPA]), the board of health shall communicate public health surveillance information, and findings on infectious diseases of public health significance and factors related to the acquisition and transmission of such diseases, to relevant audiences and stakeholders including, but not limited to: local, provincial and federal partners, health care practitioners, the general public, media, and community partners.
2) The board of health shall develop a strategy for reporting and communicating infectious diseases surveillance information and findings that outlines:
   a) The target audience for each communication;
   b) The communication format;
   c) The frequency of communication; and
   d) The characteristics and limitations of source data and information.
3) On an annual basis, the board of health shall review its public health infectious diseases communication strategy to ensure that key messages are relevant, current, and appropriate for its target audience(s), and that the communication channels used, including the frequency, are appropriate.
4) The board of health shall develop and disseminate information products on infectious diseases, their risk factors, and appropriate preventive measures in a format that is suitable given the target audiences. This may include collaboration with other boards of health, government agencies, regulatory bodies, non-governmental organizations, and community partners.
5) As appropriate, the board of health shall employ media communications such as news conferences and other public releases when information is critical, time sensitive and must be communicated as broadly as possible.

Reporting of Infectious Diseases

1) The board of health shall provide instructions as often as is necessary to persons required under the HPPA to report information to the medical officer of health with respect to infectious diseases of public health significance, reportable events (i.e., adverse events following immunization) and deaths from such diseases and events. These instructions shall specify:[2]
   a) The diseases and events that must be reported;
   b) The method or process for reporting;

c) Required information as specified in Reg. 569 under the HPPA:[9] and
d) The time or times when, or the period or periods of time within which to report.

2) The board of health shall forward reports to the Ministry of Health (the "ministry"), or as specified by the ministry, to the Ontario Agency for Health Protection and Promotion (Public Health Ontario [PHO]) using a) the Provincial Case and Contact Management Solution (CCM) with respect to both cases and contacts for diseases caused by a novel coronavirus, and deaths from such disease, and b) the integrated Public Health Information System (iPHIS), or any other method specified by the ministry, with respect to:
   a) Infectious diseases of public health significance (excluding diseases caused by a novel coronavirus), and deaths from such diseases;
   b) Any other infectious diseases that the ministry may specify from time to time; and
   c) Reportable events that may be related to the administration of an immunizing agent as defined in the HPPA.[2]

3) Reports as specified in 2) above shall comply with the minimum data elements identified in:
   a) Reg. 569 under the HPPA;[9]
   b) Disease-specific User Guides published by PHO; and
   c) Bulletins and directives issued by PHO.

4) The ministry or, as specified by the ministry, PHO, may request specific information to investigate and respond to infectious diseases or events of public health importance.

5) The board of health shall forward reports to the ministry or, as specified by the ministry, to PHO with respect to immunization coverage in accordance with the *Immunization for Children in Schools and Licensed Child Care Settings Protocol, 2018* (or as current).[10]

6) The board of health shall comply with ministry requests or, as specified by the ministry, PHO requests for immunization data and board of health-based immunization clinic data.

7) The board of health shall comply with ministry or PHO requests for vector surveillance and non-human host surveillance data using a method and format specified by the ministry.

8) A report made to the ministry or, as specified by the ministry, to PHO, using iPHIS, CCM or any other method specified by the ministry shall comply with:
   a) Enhanced Surveillance Directives (ESD) that are active at the time the report is being made;
   b) Case classifications set out in the Ontario surveillance case definitions (Appendix B) published by the ministry;
   c) Disease/event-specific User Guides published by PHO; and
   d) Timely entry of case requirements as set out in the *iPHIS Bulletin "Timely entry of cases and outbreaks" or* as current.[11]

Interpretation and Application of Surveillance Data

1) The board of health shall use infectious diseases surveillance data, immunization and reportable events data, and animal and vector surveillance data to:
   a) Establish and compare rates (incidence and prevalence) for infectious diseases and monitor trends for emerging diseases of public health importance including factors that influence their occurrence;
   b) Identify trends and changes in immunization coverage rates and monitor vaccine safety;
   c) Identify trends and changes in disease vector, animal reservoir, and host surveillance data;
   d) Identify populations at risk of exposure to infectious diseases;
   e) Develop evidence-based public health policies, programs and services to prevent and control infectious diseases in the community, in high-risk settings, and in insect vector populations; and
   f) Evaluate and/or review public health policies, programs, surveillance activities and services related to the prevention and control of infectious diseases.

2) The board of health shall analyze and interpret infectious disease data, and data related to factors influencing their occurrence, in an annual report to its target audience that describes, at a minimum, the following:
   a) The incidence (morbidity and mortality) of diseases of public health significance;
   b) The distribution of demographic and disease-specific factors influencing infectious disease incidence, including vector data;
   c) Populations at risk of exposure to infectious diseases in the community and in specific settings such as long-term care homes, hospitals, and child care centres (as defined in the *Child Care and Early Years Act, 2014*);[8] and
   d) Trends over time in the incidence of diseases of public health importance, which may include antimicrobial resistant indicators.

3) The board of health shall undertake timely monitoring, analysis, interpretation and communication of information pertaining to infectious diseases, and factors influencing their occurrence, including incidence and prevalence in animal reservoirs and insect vector species for zoonotic and vector-borne diseases. This should be done in consultation with the ministry, the Canadian Food Inspection Agency (CFIA), the Ministry of Natural Resources and Forestry, and the Ontario Ministry of Agriculture, Food, and Rural Affairs. The timing and frequency of these activities shall be determined by one or more of the following factors:
   a) Temporal/seasonal patterns of exposure or infectious disease occurrence;
   b) Likelihood of detecting meaningful change in the rate of infectious disease between monitoring intervals;
   c) The availability of data;
   d) The urgency of implementing necessary prevention and control measures;

e) The potential influence on decision-making; and
f) The characteristics of the target audience.

4) The board of health shall use provincial standard definitions of variables and health indicators where available, to conduct data analyses and interpret infectious diseases data.

5) The board of health shall use information from inspection reports of premises associated with risk of infectious diseases to plan further inspections of these premises, to assess disease transmission risks, infection prevention and control (IPAC) lapses and required interventions, and to tailor IPAC support and education to these premises (*Infection Prevention and Control Complaint Protocol, 2018* [or as current]).[12]

Public Health On-Call System

1) The board of health shall have a 24 hours per day, seven days per week (24/7) public health on-call system for receiving and responding to reports with respect to:
   a) Confirmed and suspected outbreaks of infectious diseases of public health importance occurring in institutions, premises, facilities, or in the community;
   b) Confirmed or suspected cases of, and exposures to, infectious diseases of public health significance reported by persons required under the HPPA to report information to the medical officer of health;[2]
   c) Suspected exposures to, and reports of, infectious diseases among ESWs (see the section on Exposure of Emergency Service Workers to Infectious Diseases) that occur during the course of their work and in accordance with the MBTA;[4]
   d) Confirmed or suspected cases of, and exposures to, infectious diseases reported by a member of the public;
   e) Health hazards, including IPAC lapses, that have, or that are likely to have, an adverse effect on the health of any person;
   f) Food or other product recalls issued by the ministry, the CFIA, other provincial or national regulatory agencies, or manufacturers; and
   g) Public complaints with respect to the risk of transmission of infectious diseases (*Infection Prevention and Control Complaint Protocol, 2018* [or as current])[12]
   h) Animal cases of avian chlamydiosis, avian influenza, novel influenza, or *Echinococcus multilocularis* infection.

2) The board of health shall ensure that the public and persons required under the HPPA to report information to the medical officer of health with respect to diseases of public health significance, are informed of the public health on-call system and how to access it.[2]

3) The board of health shall assess reports with respect to infectious diseases and factors influencing their occurrence that originate through the public health on-call system within 24 hours of receipt.

4) The board of health's initial response to reports with respect to infectious diseases and factors influencing their occurrence that originate through the public health on-call system, shall include the following:
   a) Review and assessment of the information provided as well as appropriate action, based on the initial assessment, to prevent, control or manage exposure to, or transmission of the infectious disease;
   b) Contacting the reporting person, facility/institution or organization to obtain additional information for the purpose of undertaking further assessment of the risk of exposure to, or transmission of, the infectious disease;
   c) Contacting the case(s) and/or contact(s) named in the report to obtain additional information for the purpose of making an assessment pertaining to the risk of exposure to, or transmission of, the infectious disease; and
   d) Conducting a site visit or an inspection where appropriate.
5) The public health on-call system shall reference standard policies and procedures for responding to health hazards including those associated with the risk of exposure to, and transmission, of infectious diseases.
6) The board of health shall transfer reports received through its on-call system to another appropriate board of health, if required, in a timely manner based on the urgency and public health risk of the incident.
7) The public health on-call system shall be documented and reviewed at least annually, or as needed, and shall include:
   a) An up-to-date schedule that specifies board of health staff, including contact information, responsible for receiving and responding to reports received through the public health on-call system;
   b) Contact information of community partners, regulatory bodies, and government agencies involved in the control and prevention of exposures to, and transmission of, infectious diseases;
   c) Contact information of the lead government body, regulatory body, or other agencies involved in the response to specific types of reports received through the public health on-call system;
   d) Contact information of all medical officers of health for the purpose of transferring reports received through the public health on-call system as well as a process for transferring reports to other boards of health;
   e) Contact information for the Population and Public Health Division of the ministry's on-call system (24/7 Health Care Provider Hotline, 1-866-212-2272);
   f) A distribution mechanism for mass notification, (as well as a back-up communications capability) of board of health staff, the ministry, community partners, other government ministries, regulatory bodies and other government agencies involved in the control and prevention of exposures to, and transmission of, infectious diseases;
   g) Information on the timeframe within which the board of health shall provide an initial response or forward an out of jurisdiction report; and

h) A process for reporting back to persons or organizations that make reports through the public health on-call system, where required.

Management of Infectious Diseases – Sporadic Cases

1) The board of health shall provide public health management of cases and contacts of infectious diseases of public health importance in accordance with this protocol.
2) The public health management of cases and contacts of infectious diseases (see Appendix A – Disease-Specific Chapters) of public health importance shall be comprised of, but not be limited to:
   a) Case management including, and where applicable: the determination of the source of disease, risk factors, exposures, and the provision of disease prevention counseling, facilitation of chemoprophylaxis, immunization or immuno-globulin and/or advice to seek medical care and submission of clinical specimens;
   b) Contact identification, tracing and notification (where appropriate);
   c) Contact management including, and where applicable: the provision of disease prevention counseling, facilitation of chemoprophylaxis, immunization or immuno-globulin and/or advice to seek medical care and submission of clinical specimens;
   d) Investigation of suspected sources of infection including environmental exposures;
   e) If the board of health's investigation indicates that an IPAC lapse has been identified, post an Initial and a Final Report online in accordance with the *Infection Prevention and Control Disclosure Protocol, 2018* (or as current);[13]
   f) Where warranted, inspection of institutions, premises or facilities where cases and/or disease transmission is suspected; and
   g) Reporting of cases of infectious diseases to the ministry using iPHIS, CCM or any other method specified by the ministry, and in accordance with the reporting criteria for infectious diseases of public health significance set out in this protocol.

Investigation and Management of Infectious Diseases Outbreaks

1) The board of health shall provide public health management of confirmed or suspected local outbreaks of infectious diseases of public health importance, as well as cross-jurisdictional collaboration when more than one jurisdiction is involved, in accordance with this protocol. Support is provided to boards of health by the ministry and PHO, as follows:
   a) The ministry and/or PHO support the investigation and management of the outbreak/incident as needed.
   b) Any request for assistance from Public Health Agency of Canada's Canadian Field Epidemiology Program, should be directed to the ministry who will then submit on behalf of the board of health or PHO.

c) For single jurisdiction outbreaks/incidents in Ontario, PHO provides epidemiological, scientific, and technical support to the board of health as requested by the local medical officer of health or the ministry.
d) For multi-jurisdictional outbreaks/incidents, PHO coordinates the investigation and management when confined to Ontario and participates with other provinces/territories in national outbreaks led by the Public Health Agency of Canada.
e) The ministry provides ongoing support, public health oversight, and policy and legislative direction as needed.
f) Specific to zoonotic disease outbreaks involving animals or potential animal exposures, the ministry coordinates the response and provides support in the management of all animal health related issues and collaborates with PHO regarding human clinical cases arising from exposure to infected animals.

2) The public health management of confirmed or suspected outbreaks of infectious diseases of public health importance shall be comprised of, but not be limited to:
a) Verification of the outbreak;
b) Consideration of declaration of an outbreak by the medical officer of health or designate;
c) Creation of an Outbreak Management Team (OMT), where required;
d) Development of an outbreak case definition;
e) Case management including the determination of exposure history and the provision of disease prevention counselling, facilitation of chemoprophylaxis, immunization or immuno-globulin (where indicated) and/or advice to seek medical care and submission of clinical specimens where applicable;
f) Contact identification, tracing and notification;
g) Contact management including the provision of disease prevention counselling, facilitation of chemoprophylaxis, immunization or immuno-globulin (where indicated) and/or advice to seek medical care and submission of clinical specimens where applicable;
h) Epidemiological analysis including, but not limited to, analyses to determine population(s) at risk, the time period at risk and most likely source(s) of infection;
i) Outbreak notification and communication of outbreak information to the ministry, regulatory bodies and other government agencies involved in the prevention and control of exposures to and transmission of the outbreak disease;
j) Outbreak notification and communication of information to the population at risk, including persons in settings associated with the outbreak, in addition to, community partners that have an identified role in the outbreak including the diagnosis, treatment and management of infectious diseases outbreaks.
k) Maintenance of ongoing surveillance for new cases and/or implementation of enhanced or active surveillance to identify new cases;
l) Implementation of infection prevention and control measures, taking into consideration the etiologic agent and the epidemiology of the outbreak;

m) Issuance of public health alerts or bulletins where infection prevention and control efforts require public compliance with implemented and/or recommended control measures;
n) Issuance of public health alerts or bulletins where necessary to advise unidentified contacts of potential exposures and the appropriate follow-up action that is required;
o) Investigation of potential exposures of infection including but not limited to collection of exposure histories, inspection of institutions, premises or facilities that have been epidemiologically linked to the outbreak (where appropriate), environmental samples and clinical specimen product trace-back;
p) If the board of health's investigation indicates that an IPAC lapse has been identified, post an Initial and a Final Report online in accordance with the *Infection Prevention and Control Disclosure Protocol, 2018* (or as current);[13] and
q) Coordination of and/or collection of clinical specimens and environmental samples in a timely manner for testing to verify etiology as well as the exposure source. Boards of health should refer to the most recent PHO labstract and test information sheets for information on pathogen specific specimen collection requirements, and testing procedures.

3) The board of health shall develop a written outbreak protocol that specifies the composition of the OMT, the use of Incident Management System, if appropriate, and their roles and responsibilities.
4) The board of health shall comply with all active ESDs and other directives with respect to ongoing provincial or multi-jurisdiction outbreaks that are issued by PHO.
5) In consultation with PHO, the board of health shall notify the ministry as soon as possible of any evidence of increased virulence based on unusual clinical presentation/outcomes, the possibility of multi-jurisdictional involvement, suspicion of a novel or emerging strain, or other novel outbreak findings in the outbreak.
6) Where, in the opinion of the medical officer of health or designate, a delay would not pose a risk of harm to individuals, the board of health shall notify the ministry and PHO in advance of any notification of the media.
7) The board of health shall report outbreaks of infectious diseases and/or cases that are linked to an outbreak to the ministry after receiving notification of an outbreak or determining that an outbreak is occurring/has occurred that has not been reported.
8) The board of health shall complete data entry and close reported outbreaks once the outbreak is declared over (as listed in disease-specific user guides).
9) A report made using iPHIS, CCM, or any other method specified by the ministry, shall comply with the data reporting criteria for infectious diseases of public health significance set out in this protocol.
10) The ministry and PHO may request additional information with respect to reports of outbreaks of infectious diseases, hospitalizations, and related deaths.

11) The medical officer of health or designate in collaboration with the OMT, where one has been established, shall determine when to declare an outbreak over, taking into consideration the etiologic agent and the epidemiology of the outbreak.

Prevention and Management of Zoonotic Diseases

1) The board of health shall provide public health management of (animal) cases and contacts of zoonotic infectious diseases of public health importance in accordance with this protocol, including but not limited to rabies, avian chlamydiosis (infection of birds with the causative agent of psittacosis), avian influenza, novel influenza and *Echinococcus multilocularis* infections, in accordance with the HPPA; the *Management of Avian Chlamydiosis in Birds Guideline, 2018* (or as current); the *Management of Avian Influenza or Novel Influenza in Birds or Animals Guideline, 2018* (or as current); and the *Management of Echinococcus Multilocularis Infections in Animals Guideline, 2018* (or as current).
2) The board of health shall ensure that all veterinarians within its jurisdiction are aware of public health reporting requirements for animal cases of avian chlamydiosis, avian influenza, novel influenza and *Echinococcus multilocularis* infection, as well as potential rabies exposures, and disseminate detailed information, at least annually, about how these cases are to be reported to the board of health.
3) Upon the receipt of a report of an animal case of avian chlamydiosis, avian influenza, novel influenza or *Echinococcus multilocularis* infection, the board of health shall notify the ministry.
4) The board of health shall ensure that human and public health risks related to exposure to the infected animal(s) are effectively minimized by the appropriate management of the infected animal(s).
5) The board of health shall consult with the ministry and any attending or primary care veterinarians to determine the most effective and appropriate management of the animal(s). In accordance with the *Health Protection and Promotion Act*, management of the animal(s) may include, but not be limited to:
   a) Ordering the isolation of the animal(s);
   b) Ordering the treatment of the animal(s);
   c) Ordering physical or laboratory diagnostic examinations of the animal(s); and
   d) Ordering the cleaning and disinfection of premises currently or previously housing the animal(s).
6) The public health management of contacts of infected animals shall be comprised of, but not limited to:
   a) Contact management including, and where applicable: assessment of risk factors, exposures to infected animals, and the provision of disease prevention

counseling, facilitation of chemoprophylaxis, immunization or immuno-globulin and/or advice to seek medical care and submission of clinical specimens;
b) Identification of other human contacts of the infected animal, tracing and notification (where appropriate);
c) Contact management including, and where applicable: the provision of disease prevention counseling, facilitation of chemoprophylaxis, immunization or immuno-globulin and/or advice to seek medical care and submission of clinical specimens;
d) Where warranted, inspection of premises or facilities where infected animals and/or disease transmission are suspected; and
e) Reporting of human cases of infectious diseases to the ministry using iPHIS, CCM or any other method specified by the ministry, and in accordance with the reporting criteria for infectious diseases of public health significance set out in this protocol.

Prevention and Management of Vector-Borne Diseases

1) The board of health shall develop, implement, and review at least annually, an integrated vector-borne diseases management strategy based on local risk assessment and other scientific evidence with respect to effective and efficient prevention and control measures.
2) The board of health shall conduct local West Nile virus risk assessments, on an annual basis, in accordance with the ministry's West Nile Virus Preparedness and Prevention Plan, or as current.[14]
3) The board of health shall develop an integrated vector-borne management plan comprised of:
   a) Vector surveillance, including surveillance of both mosquito and tick populations;
   b) Non-human host surveillance (when applicable);
   c) Human surveillance;
   d) Public education on personal preventive measures; and
   e) Vector control programs (e.g., larviciding and/or adulticiding) where required.
4) The board of health shall promptly notify Trillium Gift-of-Life of any positive results of vector-borne diseases from humans with a history of organ donation or receipt.

Exposure of Emergency Service Workers to Infectious Diseases

1) The board of health shall have a medical officer of health or designate available on a 24/7 basis to receive and respond to reports of infectious diseases of public health significance in accordance with this protocol to ensure that:
   a) Reports of a possible exposure of an ESW are received, assessed, and responded to as soon as possible, but not later than 48 hours (depending on

situation and disease, response may be required sooner) after receiving notification; and

b) Reports of all infectious diseases of public health significance are received and assessed, with particular consideration given to potential exposures of ESWs.

2) The board of health shall contact emergency services in their health unit and request that they identify designated officers for their respective emergency service (i.e., police, firefighters, ambulance) in order to facilitate the exposure notification process.

3) The board of health* shall advise designated officers in their health unit regarding the possible exposure of an ESW to an infectious disease of public health significance when made aware by:
   a) Having the medical officer of health or designate actively seek out contacts of cases with infectious diseases of public health importance, even if a designated officer has not contacted the medical officer of health or designate regarding the possible exposure and no application has been made by an individual under the MBTA;[4]
   b) Informing the respective designated officer that an ESW might have been exposed to an infectious disease of public health significance during his/her work. This is not dependent on laboratory confirmation (e.g., the case can exhibit clinical signs and symptoms of a particular infectious disease); and
   c) Informing the designated officer regarding any specific actions to be taken based on the designated officer's report, including advising ESWs to seek medical attention and the initiation of post-exposure prophylaxis if applicable.

4) When a designated officer makes an incident report of a possible exposure to an infectious disease of public health significance to the board of health, the board of health shall:
   a) Review and assess the information provided;
   b) Contact health care facilities and other persons (e.g., infection control practitioners and/or attending physicians) to obtain additional information on the specific case, as necessary, based on the assessment of the incident by the medical officer of health, or designate; and
   c) Inform the designated officer as soon as possible and no later than 48 hours after receiving notification (depending on the disease) of advised actions to be taken, including accessing medical care by the ESW.
      i) Advice shall include, but is not limited to assessing the possible risk of occupational exposure and setting standards of practice, appropriate use of personal protective equipment, and training for employees to prevent possible exposures; and
      ii) Follow up with the designated officer to ascertain what action has been taken.

* A decision by the board of health to contact the designated officer can be made on a case-by case basis, based on clinical assessment which could include, but is not limited to degree of risk, type of exposure, etc.

5) In the event that there is a disagreement between the designated officer and the medical officer of health or designate regarding a possible exposure, the designated officer may refer the matter to the Chief Medical Officer of Health or designate.

Glossary

Designated officer: A person identified in an emergency service (i.e., police officer, firefighters, etc.) who is responsible for receiving and assessing reports regarding the possible exposure of an emergency service worker to an infectious disease of public health importance and then contacting the medical officer of health or designate.

Emergency service worker: A person working in an emergency service (e.g., police, firefighters, etc.).

Enhanced Surveillance Directive: PHO may issue enhanced surveillance directives for infectious diseases of public health significance in response to a variety of circumstances including, but not limited to:

- Increased case reports of diseases of public health significance;
- Reports of emerging disease(s);
- Diseases with seasonal variation; and
- Food contamination alerts.

Each enhanced surveillance directives are mandatory when issued and will include the following:

- Situation background and current status;
- Start and end dates (if known);
- Detailed data requirements;
- Step-by-step guide for data entry into iPHIS or CCM;
- Data field definitions;
- Screenshots of data field locations; and
- Information on whom to contact for assistance.

Facility: In this protocol, facility includes facilities that are under the authority of the HPPA and/or its regulations and other facilities that are not regulated under the HPPA.

Health Hazard: (a) a condition of a premises, (b) a substance, thing, plant or animal other than man, or (c) a solid, liquid, gas or combination of any of these, that has or that is likely to have an adverse effect on the health of any person.[2]

Infection Prevention and Control (IPAC) Lapse: A lapse is defined as a failure to follow IPAC practice standards resulting in a risk of transmission of infectious diseases to clients, attendees or staff through exposure to blood, body fluids, secretions, excretions, mucous membranes, non-intact skin, or contaminated equipment and soiled items. IPAC practice standards include the most current guidance available from the Provincial Infectious Diseases Advisory Committee, Public Health Ontario, the ministry, and any relevant Ontario regulatory college IPAC protocols and guidelines.

Infectious diseases of public health importance: Infectious diseases of public health importance include, but are not limited to; those specified as diseases of public health significance as set out by regulation under the HPPA and include zoonotic and vector-borne diseases.[15] Emerging infectious diseases may be considered of public health importance based on a variety of criteria, including their designation as an emerging disease by international, Federal, and/or Provincial/Territorial health authorities, their potential for preventability or public health action, and the seriousness of their impact on the health of the population and potential spread.

Institution: In this protocol, institution has the same meaning as Section 21(1) of the HPPA.[2]

Labstract: Labstracts provide important information to health care practitioners about clinical or operational changes in laboratory testing. These can include updates in specimen collection, handling, testing or interpretation.

Reportable event: In this protocol, reportable event has the same meaning as Section 38(1) of the HPPA.[2]

Sporadic Cases: A sporadic case is an instance of disease which appears to be unrelated to a community or institutional outbreak. It can be one or more cases that do not share an epidemiological link.

Surveillance: The continuous, systematic collection, analysis and interpretation of health-related data needed for the planning, implementation, and evaluation of public health practice. Such surveillance can:

- serve as an early warning system for impending public health emergencies;
- document the impact of an intervention, or track progress towards specified goals; and
- monitor and clarify the epidemiology of health problems, to allow priorities to be set and to inform public health policy and strategies.[16]

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ISBN 978-1-4868-0758-1 PDF Queen's Printer of Ontario

Ontario

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 044-20

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2020 September 17

MEDICAL OFFICER OF HEALTH ACTIVITY REPORT FOR SEPTEMBER

Recommendation

It is recommended that the Board of Health receive Report No. 044-20 re: "Medical Officer of Health Activity Report for September" for information.

The following report presents activities of the Medical Officer of Health (MOH) for the period July 6, 2020 to August 19, 2020.

Throughout the summer, the MOH continued to participate in many external pandemic related meetings each week. 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 and London Mayor Ed Holder continue to provide COVID-19 virtual media briefings.

The MOH and the Associate Medical Officer of Health (AMOH) continued to host a weekly MLHU Staff Town Hall during the summer weeks to present on many topics, including COVID-19.

The following events were also attended by the MOH.

July 6	Live interview with Craig Needles, AM980 CFPL in regard to interim changes to management at the Middlesex-London Health Unit Meeting with the Auditor General of Ontario's office in regard to a COVID-19 audit
July 14	Interview with Jane Sims of the London Free Press in regard to COVID-19
July 15	Met with City of London staff in regard to mandatory mask legislation Live interview with Craig Needles, AM980 CFPL in regard to mandatory masking
July 16	Follow-up meeting with City of London staff in regard to mask legislation Met with Steven Hillier, Ward 14 City Councillor in regard to mask legislation Attended the Governance and Board of Health meetings
July 17	Met with Middlesex County Warden Burqhardt in regard to mask legislation Met with City staff to discuss Mask legislation
July 20	Met with Councillor Kayabaga to discuss Racism as a public health crisis
July 21	Participated on the COMOH Executive Teleconference call
July 22	Participated in the Middlesex Centre Council meeting in regard to the masking bylaw Met virtually with Ms. Alexandra Kane in regard to Black Lives Matter

July 30	Met with Ms. Maureen Cassidy, Mr. Robert Parker and Dr. Michael Clarke to discuss a potential development session for the Board of Health.
July 31	Met virtually with Mr. Robert Parker to discuss personal coaching
August 4	Check-in meeting with Ms. Maureen Cassidy
August 5	Met with Ministry staff to discuss the Temporary Pandemic Pay Mid-Term Report-Back Template
August 6	Participated in a call with Windsor Essex Health Unit in regard to resources Met with Mr. Paul Digby in regard to Black Lives Matter
August 12	Met with Thames Valley District School Board staff regarding COVID-19 preparedness Participated in the Thames Valley District School Board (TVDSB) Public Health Q & A session
August 17	Hosted a Virtual Town Hall for residents of London and Middlesex to ask questions about COVID-19
August 18	Call with Ms. Karen McKibbon in regard to the Provincial Case and Contact Management tool
August 19	Call with the Office of the Auditor General of Ontario in regard to a request for information

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

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

CORRESPONDENCE – September 2020

a) Date: 2020 July 16
Topic: Masks Indoors at Public Places
From: Community Member
To: Board of Health, Middlesex-London Health Unit

Background:

On July 16, 2020, a community member wrote to the Middlesex-London Health Unit Board of Health urging leadership to influence mandating the use of masks in indoor public spaces in our community to help fight COVID-19.

Recommendation: Receive.

b) Date: 2020 July 16
Topic: Endorsement of the Association of Local Public Health Agencies' Response to the Public Health Modernization Discussion Paper
From: Renfrew County and District Health Unit
To: Christine Elliott, Minister of Health

Background:

On July 16, 2020, the Board of Health for Renfrew County District Health Unit wrote to Minister Elliott in support of Haliburton, Kawartha, Pine Ridge District Health Unit's endorsement of the Association of Local Public Health Agencies' response to the Public Health Modernization Discussion Paper.

Recommendation: Receive.

c) Date: 2020 July 16
Topic: Endorsement of correspondence regarding the 2020 Municipal Cost Share of Public Health Funding from Eastern Ontario Health Unit and correspondence regarding COVID-19 and Reconsiderations Related to Public Health Modernization from the Association of Local Public Health Agencies
From: Renfrew County and District Health Unit
To: Christine Elliott, Minister of Health

Background:

On July 16, 2020, the Board of Health for Renfrew County District Health Unit wrote to Minister Elliott in support of Haliburton, Kawartha, Pine Ridge District Health Unit's endorsement of correspondence regarding the 2020 Municipal Cost Share of Public Health Funding from Eastern Ontario Health Unit. Renfrew County District Healthy Unit also endorses correspondence regarding COVID-19 and reconsiderations related to Public Health Modernization from the Association of Local Public Health Agencies. Refer to correspondence item h) in the July 16, 2020 Board of Health agenda.

Recommendation: Receive.

d) Date: 2020 July 16
Topic: London needs mandatory indoor mask mandate

From: Community Member
To: Board of Health, Middlesex-London Health Unit

Background:

On July 16, 2020, a community member wrote to the Middlesex-London Health Unit Board of Health in support for a mandatory indoor mask mandate in the city of London.

Recommendation: Receive.

e) Date: 2020 July 16
Topic: Mandatory masks – a request for thoughtful consideration and prompt action
From: Community Member
To: Board of Health, Middlesex-London Health Unit

Background:

On July 16, 2020, a community member wrote to the Middlesex-London Health Unit Board of Health requesting that leadership influence mandating the use of masks in indoor public spaces in the community to help fight COVID-19.

Recommendation: Receive.

f) Date: 2020 July 16
Topic: Mandatory masking from a home mask maker
From: Community Member
To: Board of Health, Middlesex-London Health Unit

Background:

On July 16, 2020, a community member wrote to the Middlesex-London Health Unit Board of Health regarding mandating the use of masks in indoor public spaces.

Recommendation: Receive.

g) Date: 2020 July 17
Topic: Make Masks Mandatory
From: Community Member
To: Board of Health, Middlesex-London Health Unit

Background:

On July 17, 2020, a community member wrote to the Middlesex-London Health Unit Board of Health regarding the concern over not making a mandatory mask policy in all indoor public places in London-Middlesex.

Recommendation: Receive.

h) Date: 2020 July 27
Topic: Basic Income for Income Security during COVID-19 Pandemic and Beyond

From: Municipality of Chatham-Kent
To: Prime Minister Justin Trudeau, Deputy Prime Minister Chrystia Freeland, and Minister Bill Mourneau

Background:

On July 27, 2020, the Board of Health for Chatham-Kent wrote to Prime Minister Trudeau, Minister Freeland and Minister Mourneau endorsing that the federal government transition the Canada Emergency Response Benefit (CERB) into basic income for all Canadians during the COVID-19 response and beyond. The Board recommends that immediate action be taken to evolve CERB into legislation as an effective long-term response to the issues of income security, poverty, food insecurity, and overall community health and well-being.

Recommendation: Receive.

i) Date: 2020 July 30
Topic: The Decriminalization of Personal Possession of Illicit Drugs
From: Municipality of Chatham-Kent
To: Honourable Patty Hajdu, Honourable David Lametti

Background:

On July 27, 2020, the Board of Health for Chatham-Kent wrote to Minister Hadju and Minister Lametti endorsing the decriminalization of personal possession of illicit drugs in pursuit of a public health approach to drug policy. The Board of Health for Chatham-Kent calls on the federal government to create a national task force to research drug policy reform.

Recommendation: Receive.

j) Date: 2020 August 19
Topic: COVID-19 Extraordinary Expenses
From: Simcoe Muskoka District Health Unit
To: Minister, Christine Elliott

Background:

On August 19, 2020, the Board of Health for Simcoe Muskoka District Health Unit wrote to Minister Elliott requesting additional funding to enable the success of the local public health response to the pandemic. The Board of Health for Simcoe Muskoka District Health Unit urges the immediate provision of the funding allocations to local boards of health regarding the COVID-19 Extraordinary Expenses and for the School-Focused Nurses in order to enable a response by local public health units that is unobstructed by local financial shortfalls.

Recommendation: Receive.

Renfrew County and District Health Unit

"Optimal Health for All in Renfrew County and District"

July 16, 2020

The Honourable Christine Elliott
Minister of Health
777 Bay Street, 5th Floor
Toronto, ON M7A 2J3
email: christine.elliottco@ola.org

Dear Minister Elliott,

Re: Endorsement of the Association of Local Public Health Agencies' Response to the Public Health Modernization Discussion Paper

At the Regular Board meeting held on June 30, 2020, the Board of Health for the Renfrew County and District Health Unit unanimously agreed to support the following motion by the Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit:

"THAT the Association of Local Public Health Agencies' response to the Public Health Modernization Discussion Paper be endorsed and THAT a letter of support be sent to The Honourable Christine Elliott".

Sincerely,

Janice Visneskie Moore

Chair, Board of Health
Renfrew County and District Health Unit

cc: Alison Blair, Executive Lead for Public Health Modernization
Jim Pine, Special Advisor, Public Health Modernization
Ontario Boards of Health
Association of Local Public Health Agencies

HALIBURTON, KAWARTHA, PINE RIDGE DISTRICT HEALTH UNIT

www.hkpr.on.ca • info@hkpr.on.ca
1-866-888-4577

June 19, 2020

The Honourable Christine Elliott
Minister of Health
5th Floor, 777 Bay St.
Toronto, ON M7A 2J3
(Sent via email to: christine.elliottco@ola.org)

Dear Minister Elliott

RE: Endorsement of the Association of Local Public Health Agencies' Response to the Public Health Modernization Discussion Paper

At its meeting held on June 18, 2020, the Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit passed the following motion:

"THAT the Association of Local Public Health Agencies' response to the Public Health Modernization Discussion Paper be endorsed and THAT a letter of support be sent to The Honourable Christine Elliott".

Sincerely

BOARD OF HEALTH FOR THE HALIBURTON,
KAWARTHA, PINE RIDGE DISTRICT HEALTH UNIT

Doug Elmslie
Chair, Board of Health

DE/aln/ed

Cc (via email): Alison Blair, Executive Lead for Public Health Modernization
Jim Pine, Special Advisor, Public Health Modernization
Ontario Boards of Health
Association of Local Public Health Agencies (alPHa)

Attachment

alPHa
Association of Local PUBLIC HEALTH Agencies

Public Health Modernization Discussion Paper Response Submitted to the Public Health Modernization Team

The Association of Local Public Health Agencies (alPHa) is pleased to present the following response to the Public Health Modernization Discussion Paper. We invited our members to provide answers to the questions that are posed in the paper to help us identify themes common to the local public health sector throughout the province. This feedback has been synthesized and presented within the framework of themes and questions laid out in the consultation survey.

alPHa's response is intended to be complementary to the individual responses of its members, not a summary or a substitute. alPHa urges the Public Health Modernization team to take the unique local circumstances and perspectives presented in its members' and partners' direct feedback to the survey and in-person consultations into careful consideration as it formulates its advice to the Minister.

PREAMBLE and PRINCIPLES

alPHa agrees with the Ministry's vision of a "coordinated public health sector that is nimble, resilient, efficient and responsive to the province's evolving health priorities". alPHa also agrees with improving consistency where it makes sense to do so and improving clarity and alignment of the related roles and responsibilities of the province, Public Health Ontario (PHO), and local public health. alPHa certainly agrees that enhanced investment in health promotion and prevention will be critical to the success of Ontario's plan to end hallway health care.

In November of 2019, alPHa transmitted its Statement of Principles for Public Health Modernization to the Minister and the Public Health Modernization Team and these remain the foundation of alPHa's present response. These principles are incorporated into the responses to the survey questions as appropriate and the full document is attached.

The foundational principle is that any and all changes must serve the goal of strengthening the Ontario public health system's capacity to improve population health in all of Ontario's communities through the effective and efficient local delivery of evidence-based public health programs and services. Public health unit (PHU) realignments, identification of efficiencies, clarification of roles and strengthening of institutional relationships must all have that central aim as their starting point.

It must be recognized that Ontario already has an enviable public health system, based on a network of 34 PHUs with expert staff, strong partnerships and a clear and authoritative mandate to protect and promote health within their local communities. These are supported by the central research and evidence functions of PHO and the oversight of the Chief Medical Officer of Health (CMOH) within the Ministry. Building on the Ontario system's existing strengths must be the strategic foundation for any proposed changes.

Theme: Insufficient Capacity

What is currently working well in the public health sector?

- Actions taken in response to the Walkerton and SARS crises in the early 2000s (e.g., increased provincial responsibility for funding, strengthened role of the Chief Medical Officer of Health (CMOH), creation of PHO) have led to measurable improvements to the Ontario public health sector's capacity to detect and respond to emerging threats. The swift collective and thorough response to the developing Novel Coronavirus (2019-nCoV) epidemic is a clear application by Ontario's public health sector of the lessons learned from the 2003 SARS outbreak.

- Ontario's public health sector is already an effective network of 34 local public health units (PHUs)with a strong and detailed mandate to identify and meet the health protection and promotion needs of their communities. That mandate is clearly spelled out in the Health Protection and Promotion Act (HPPA) and the Ontario Public Health Standards (OPHS), with explicit flexibility built in to ensure that programs and services can be adapted according to local circumstances.

- Within each of the existing PHUs' boundaries, strong partnerships have been forged with local municipalities, social services, school boards and health care providers among others to support this work.

- The sector benefits from the collaborative work of province-wide professional (e.g., alPHa, COMOH, ASPHIO, ODPH, OPHNL, APHEO) and topic-specific (e.g. TCAN, LDCP) groups. These groups provide ongoing opportunities for collaboration and information exchange across PHU boundaries throughout Ontario.

- There is clear public and political recognition of the critical importance of investments in health protection and promotion to improving population health and ensuring the sustainability of the health care system.

- There is an invaluable range of professional, political and technical expertise resident in the public health sector (public health physicians, elected officials, epidemiologists, nurses, public health inspectors, health promoters, policy analysts, dentists, dietitians, business administrators, lawyers and highly skilled support staff).

- Local representation on boards of health (in a variety of models that includes elected municipal officials in all cases, with provincial appointees and citizen representatives serving in many) reflects community characteristics and values within the PHU boundary and provides direct accountability.

- Collaboration among PHUs including the development of consistency of practice (e.g., HIV case management, immunization enforcement in schools and child care centres, infection prevention and control inspections in the health care sector, electronic medical record use, records retention policies), mutual aid agreements, cross-coverage, outbreak management, and voluntary mergers (Southwestern and Huron-Perth).

- PHO is a unique and invaluable resource within the sector that has strong roles in research, professional development, ethics review, knowledge translation and response to emerging threats.

- The cost-sharing model provides the framework to ensure a stable and predictable source of adequate funding for public health programs and services while ensuring accountability at both the provincial and municipal levels.

- PHUs with large populations have budgets that allow them to deliver services efficiently and cost-effectively while also ensuring surge capacity.

- PHUs that are integrated with Regions (e.g., Halton, Durham) and cities (e.g., Toronto, Ottawa) benefit from support services (e.g. administrative, IT) embedded within those structures. This integration also facilitates coordination among public health, social services, emergency health services and public works.

What are some changes that could be considered to address the variability in capacity in the current public health sector?

- Formal mechanisms and commitment at both the provincial and municipal levels to ensure that the total annual public health funding envelope is stable, predictable, protected and sufficient to cover all costs for the full delivery of all public health programs and services in all PHUs whether they are mandated by the province or developed to serve unique local needs as authorized by Section 9 of the HPPA.

- Provincial support for voluntary mergers of PHUs with complementary characteristics where it can be demonstrated that functional capacity will be improved. Any realignments of present PHU boundaries must be considered only to ensure critical mass to efficiently and equitably deliver public health programs and services. As a general rule, existing PHUs should be left intact, particularly with regard to municipal boundaries, and complementary geographic, demographic and organizational characteristics should be key factors in deciding which mergers should be considered. Evidence about the relationship between critical population mass and the effective allocation of public health resources should also be examined.

- Enhance centralized provincial supports, to increase efficiency and the capacity of all public PHUs to deliver the full scope of the OPHS. PHO already has important research and evidence roles but is also well-positioned to coordinate the strengths of different PHUs. Provincial-level strategic and topic-specific advisory tables that include PHO, the CMOH and local public health leadership have also proven very useful in the past.

- In partnership with local public health, educational institutions and other relevant organizations, develop a provincial public health human resources strategy to build on the successful recruitment and retention of a skilled and competent public health workforce. Maintaining the visibility of the public health sector, demonstrating its stability and importance, presenting the wide range of opportunities within it, providing incentives to work in remote areas and keeping salaries competitive will be vital components.

- Increase decision-making flexibility at the local level to develop their own models for the provision of mandated services according to local circumstances and resources, as well as to develop more formal arrangements to share resources if surge capacity is needed (e.g. epidemiology, analysis, evaluation).

What changes to the structure and organization of public health should be considered to address these challenges?

- alPHa does not believe that systemic structural and organizational changes are necessary to address capacity challenges. As we have demonstrated in our answers to the other discussion questions, any capacity issues can be appropriately addressed within the existing framework by building on its strengths.

- Capacity for most PHUs has been steadily eroding over the years largely due to the Ministry putting caps (often 0%) on annual budget increases that are necessary to cover the costs of delivery of new programs, annual Consumer Price Index (CPI) increases and honouring collective agreements. This erosion will be significantly magnified by the Province's decision to shift 5% of the cost-shared and 30% of previously 100% provincially funded public health programs to municipalities. More details on this were presented by alPHa to the Standing Committee on Finance and Economic Affairs on January 17, 2020 as part of its pre-budget consultation. Speaking notes and the transcript of this presentation are linked above and attached below.

- The autonomy of each local board of health (BOH) must be maintained and stronger mechanisms should be considered to reinforce their sole focus on and local decision-making authority over public health matters as well as to protect them from intrusive policies (e.g., municipal hiring freezes, vacancies on local boards and Associate Medical Officer of Health (AMOH) positions due to inappropriate delays in the provincial appointment and approval processes).

- Several organizational considerations are outlined in the attached alPHa Statement of Principles.

Theme: Misalignment of Health, Social, and Other Services

What has been successful in the current system to foster collaboration among public health, the health sector and social services?

- alPHa respectfully observes that the use of the term "misalignment" in the wording of this theme is misleading, as it creates the false impression that misalignments are a significant systemic problem. On the contrary, PHUs are very well aligned with municipalities, social services, school boards and other community-based services and partners. Previous proposals to align PHU boundaries with those of the health sector (i.e., LHINs) has threatened these existing local relationships without demonstrating the necessity for doing so. If misalignments in certain areas are identified, they must be measured against and prioritized in context of existing alignments in others.

- The reciprocal mandate between the local MOH and LHIN CEO became an important enabler for public health's relationship with the health care sector and this is being expanded upon with most PHUs having direct involvement in the new Ontario Health Teams (OHTs).

- Our members provided us with many specific examples of successful local collaborations with the health care sector related to such topics as injury prevention, substance use, perinatal health, infectious disease prevention and health equity in program design. These will surely be presented in more detail in their individual submissions to the present survey.

- Our members provided us with many specific examples to demonstrate the strength of local collaboration with social services, boards of education and community agencies. The existing geographical alignments of these different groups was cited as critically important. Where public health is integrated within a municipal or regional government, links to their social services

departments are particularly strong. In other cases, formal service agreements and partnerships are highly dependent on shared community boundaries and characteristics.

- The OPHS are explicit in their requirement of all boards of health to carry out their mandated obligations in partnership with local stakeholders. Public health is in turn seen as a credible broker within the local community that can support multi-stakeholder engagement and community mobilization for healthy public policy.

How could a modernized public health system become more connected to the health care system or social services?

- Strengthen the health and social services sectors' focus on prevention and the social determinants of health. Explore the implementation of a "health in all policies" approach with parallel mandates, clear role expectations and accountability for protecting population health across related provincial government ministries and government-funded agencies.

- The Ministry of Health (Ministry) could provide a reciprocal and clearly defined mandate for PHUs and OHTs to utilize public health's surveillance and analysis expertise to conduct population-based needs assessments to inform the effective local allocation of primary health care resources and build capacity among health service providers to offer evidence-based health promotion and prevention interventions.

- Improvements to information technology to support interoperability and data standards to accelerate the appropriate inclusion of public health information into electronic health records and facilitate public health's receipt of vital information from primary care and the broader health care system. This collaboration would support disease prevention and health promotion at the individual to population-level to end hallway health care. More details on digital modernization will be provided in a separate submission by the COMOH Digital Health Committee.

What are some examples of effective collaborations among public health, health services and social services?

- Our members provided us with many specific examples of successful local collaborations among public health, health services and social services. These will surely be presented in more detail in their individual submissions to the present survey.

- The mandated reciprocal relationship between the local Medical Officer of Health (MOH) and Local Health Integration Network (LHIN) CEO was cited as instrumental in promoting a better understanding of public health's mandate, focus and functions to the health care conversation. Direct involvement of public health in local OHTs is expected to increase the momentum.

- The partnership between the Council of Ontario Directors of Education and COMOH (CODE-COMOH) is expected to contribute to the well-being of Ontario's children and students through enhancing PHU and school board partnerships in order to achieve optimal delivery of services and ongoing supports for children and students.

Theme: Duplication of Effort

As with the previous theme, alPHa would argue that the use of the term "Duplication of Effort" suggests that it is a systemic problem that underlies widespread inefficiencies. While we agree that

there are public health functions that could in fact be carried out jointly, regionally or centrally, the local nature of public health requires certain programs and services with similar aims to be developed and implemented in different ways to meet unique local needs.

Care must therefore be taken in defining the term and in identifying and eliminating duplication that is in fact redundant. Care must also be taken when examining alleged duplication of effort between sectors. Public health has a unique set of roles and responsibilities and it would be a mistake to assume that they are transferrable. For example, health promotion in public health differs fundamentally from health promotion in primary care. Only public health focuses on upstream population-level approaches to prevent injuries and illnesses before they occur, and success often depends on strong existing relationships with community partners.

What functions of public health units should be local and why?

- The health protection functions of public health are local by definition. Health hazard investigation and response, infection prevention and control, communicable disease outbreak management, water quality and food safety are examples of areas where local public health has clearly prescribed and detailed roles and responsibilities under the HPPA and OPHS. Carrying these out relies heavily on interaction with individuals, institutions, businesses and service providers throughout the local community. Timeliness and efficiency are supported by preexisting positive relationships.

- Health promotion work is also informed in large part by understanding the local population's characteristics, identifying local priorities and strategically developing approaches for policy development and program and service delivery that will be most responsive to local population health needs. Ongoing population health assessment and surveillance ensures that local data are at the root of program planning as well as healthy public policy development through public health's relationship with municipalities.

- Some public health services (e.g. harm reduction, screening programs, prenatal education, Healthy Babies Healthy Children, neighbourhood groups) focus on individuals and families with high needs. Public health's knowledge of the community and partnerships are a valuable resource for connecting clients with necessary services, which are also primarily local.

What population health assessments, data and analytics are helpful to drive local improvements?

- The epidemiological capacity to collect and access data to conduct detailed local population health assessments within local contexts must be enhanced. Public health programs and services benefit from solid data at the sub-health unit level (e.g., priority neighbourhoods, planning zones, ER admissions). Local epidemiologists have a keen understanding of the local context and are well positioned to collaborate with stakeholders to gather data, conduct analysis and inform recommendations for action and priority setting.

- The CMOH's 2017 Annual Report recommended a provincial population health survey to collect data at the local community and neighbourhood levels to contribute to a better understanding of community wellness. The survey would need to be flexible and nimble, with the ability to customize questions to local needs.

- The Rapid Risk Factor Surveillance System is an ongoing local health telephone survey conducted collaboratively since 2001 by numerous PHUs and the Institute for Social Research at York

University. Information is gathered using questionnaires on a wide variety of health topics to inform service planning for the broad range of public health programs that are required by the OPHS, to advocate for healthy public policy development and to improve community awareness of health risks.

- Strategies to identify and address gaps in data and information must be considered. The Children Count Locally Driven Collaborative Project is an important current example of a strategy to improve available data and interventions to improve child and youth health in Ontario.

What changes should the government consider to strengthen research capacity, knowledge exchange and shared priority setting for public health in the province?

- alPHa believes that the most important development in this regard was the establishment of the Ontario Agency for Health Protection and Promotion, a.k.a. PHO. PHO has been instrumental in supporting our health protection activities with excellent standards of practice developed in communicable disease control, vaccination, and infection prevention and control. We believe that there is an important opportunity to reinforce PHO's capacity to strengthen similar work in the areas of environmental health and non-communicable diseases (which account for over 70% of ill health in Ontario) by focusing on evidence, translating it into recommended practice, and setting common implementation standards. PHO is the key agency for scientific expertise, research and knowledge exchange and is one of the Ontario public health sector's strongest assets. This is one of the strengths that needs to be built upon as the Ministry seeks to achieve the outcomes outlined in this discussion paper.

What are public health functions, programs or services that could be strengthened if coordinated or provided at the provincial level? Or by Public Health Ontario?

- As noted above, the existing roles and responsibilities of PHO should be reinforced and expanded.

- Increased centralized supports, provided by PHO or the Ministry, have the potential to reduce duplication of effort, and contribute to increased consistency and improved delivery of public health programs and services. Examples include a provincial immunization registry, provincial electronic medical records, centralized digital supports including facilitation of data sharing, provincial health communication campaigns, continuing professional education opportunities, centralized reviews of evidence, bulk purchasing, access to data repositories, provincial advisory committees etc. Centralized supports must be designed to sustain the local capacity to develop and implement innovative and locally relevant campaigns.

- Developing provincial leadership on surveillance and population health assessment, technical direction (especially on emerging public health issues), emergency management, healthy policy development and chronic disease prevention coordination. Setting provincial population health goals with targets and cross-sectoral strategies would be a useful foundation upon which to carry out these functions.

- The Ministry, likely via the independent authority of the CMOH, needs to be more active in providing local public health with guidance and / or direction when asked to ensure consistent approaches where there is agreement that they are required. There have been instances (ISPA enforcement, IPAC investigations and HIV Case management for recent examples) where local public health asked for direction to address disparate and sometimes conflicting local practices. With none provided, local MOHs were compelled to work together to develop their

own recommendations for a collective approach.

Beyond what currently exists, are there other technology solutions that can help to improve public health programs and services and strengthen the public health system?

- The COMOH Digital Health Committee will be making a detailed submission to the Public Health Modernization consultation. It will call on the Province to develop a digital strategy for public health; provide sufficient resources to support aligned and necessary information systems and common applications; work with public health partners to facilitate the incorporation of public health information into a provincial electronic health record; centralized coordination and technical support for digital solution integration and Provincial leadership on data standards and interoperability.

- Other suggestions put forth by our members included bulk purchasing of information technology hardware and software, a centralized website with important public health information, a seamless provincial immunization registry, a centralized online inspection disclosure system, enhanced technology to reduce travel requirements (e.g., video calls for client interactions and videoconferencing for health unit staff in rural areas). Inequities in access to technology solutions and tech-mediated opportunities for collaboration were also raised. We expect that many other suggestions will be made in other submissions to the survey question.

Theme: Inconsistent Priority Setting

As with previous themes, alPHa would argue that the use of the term "Inconsistent Priority Setting" suggests a systemic problem that underlies widespread inefficiencies. The existence of different public health priorities in different parts of the province is a feature of the system, not a bug, and is one of its strengths. Local authority over priority setting must be preserved to ensure that the unique health needs of each community can be served. This should include the authority to adapt programs and services to address province-wide public health priorities according to the local context.

What processes and structures are currently in place that promote shared priority setting across public PHUs?

- PHUs are required, through the HPPA, to meet the requirements of the OPHS. These standards provide a framework to support consistent priority setting across Ontario and the related Accountability Agreements ensure provincial approval and awareness of each BOH's plan for the delivery of mandated programs and services each year.

- Ontario's 34 PHUs are connected to a wide range of networks that provide opportunities for sharing of information, priority setting and collective action. alPHa, including COMOH, BOHs and Affiliate Sections, is the most important of these at the systemic level as it brings the governance, medical and programmatic aspects of the entire system together at a single table, which in turn provides an ideal point of contact for government and other stakeholders.

- Profession-specific associations such as ASPHIO, OPHNL, APHEO, AOPHBA, OAPHD, ODPH and HPO provide similar opportunities for the collective identification of priorities within their purview. Each of these groups is represented at the alPHa table.

- Topic-specific collaboratives, spanning regions or the province, provide opportunities to share information and resources, and to collectively address common goals. For example, regional

TCANs allow for shared priority setting and planning related to reducing smoking behavior in regions spanning multiple PHUs. Similar collaborative groups have addressed cannabis, alcohol and opioids.

- Regional PHU groupings (South West, Central West, Central East, North East, North West, East) are networks that provide similar opportunities for neighbouring PHUs that share geographic and demographic characteristics.

- 100% provincially funded public health programs (e.g. Universal Influenza Immunization Program, Ontario Seniors Dental Care Program (OSDCP)) are a clear demonstration of priorities that are shared province wide.

What should the role of Public Health Ontario be in informing and coordinating provincial priorities?

- PHO's mandate is to provide a foundation of sound information, knowledge and evidence to support policy, action and decisions of government, public health practitioners, front-line health workers and researchers. Centralized and timely evidence reviews, provision of provincial and local data, guidance documents and best practices, research ethics, and coordination of tables to address significant province-wide needs (e.g., Healthy Human Development table, Provincial Infectious Disease Advisory Committee) are key functions that underlie evidence-based setting of priorities throughout the public health sector. Reinforcing PHO's capacity to perform these functions in the areas of health promotion and non-communicable disease prevention should be considered.

- PHO's "hub and spoke" model, which was the basis for the former Regional Infection Control Networks, could be used to establish collaborative regional tables in the various public health areas of focus to inform common priorities and joint projects. Such an approach would be valuable in setting province-wide priorities as common themes emerge.

- PHO would be instrumental in providing the evidentiary basis for the establishment of provincial population health goals as proposed above.

What models of leadership and governance can promote consistent priority setting?

- A model of leadership and governance to promote consistent priority setting is already in place. The HPPA provides a clear, detailed and specific framework for the organization and delivery of public health programs and services, including the composition, authority and duties of boards of health. The HPPA is in turn the enabling legislation for the OPHS, which set out clear, detailed and specific requirements for the delivery of public health programs and services in each of the province's 34 PHUs.

- The Office of the CMOH is responsible for ensuring that the OPHS continue to be relevant and based on evidence, and for supporting local public PHUs in meeting the requirements of the standards. Each BOH is required to submit annual business plans to the Ministry through this office as part of the budget and accountability processes.

- Leadership and governance principles are outlined in the attached alPHa Statement, including preserving the autonomy and authority of the local MOH and reinforcing local boards' autonomy, skill sets, effective governance and public health focus.

Theme: Indigenous and First Nation Communities

What has been successful in the current system to foster collaboration among public health and Indigenous communities and organizations?

- PHUs with significant indigenous populations long ago identified the importance of improving their access to public health programs and services, especially in First Nations communities. Many have independently entered into formal agreements with local bands under Section 50 of the HPPA for the provision of programs and services.

- The 2018 OPHS added a requirement for boards of health to engage with First Nations and Indigenous communities and organizations under the Health Equity Standard. The *Relationship with Indigenous Communities Guideline, 2018* was developed to support this work and a *Relationship with Indigenous Communities Toolkit* is said to be under development by the Ministry.

- The widespread acceptance of and commitment to the Truth and Reconciliation Calls to Action throughout the public health sector. Staff training in cultural awareness / competency /safety, the local involvement of Indigenous leaders in decision making, program planning and relationship development, and local partnerships and initiatives have sprung forth from that commitment in all of Ontario's PHUs.

Are there opportunities to strengthen Indigenous representation and decision- making within the public health sector?

- In its Statement of Principles, alPHa notes the necessity of special consideration being given to the effects of any proposed organizational change on Ontario's many Indigenous communities, especially those with a close relationship with the boards of health for the PHUs within which they are located. It is further notes that opportunities to formalize and improve these relationships must be explored as part of the modernization process. alPHa recommends that this exploration, including consideration of the above question, be conducted in full consultation with Indigenous communities and organizations as well as boards of health that have already demonstrated commitment to and experience with Indigenous engagement and service delivery to these populations.

- In its Statement of Principles, alPHa recommends that local BOHs be reflective of the communities that they serve. In areas with large indigenous populations and / or First Nations communities, consideration should be given to appointing one or more members of those communities to the BOH itself. This has already been done, for example, in Peterborough. This could be reinforced with the formation of local Indigenous health advisory committees with more widespread stakeholder involvement. These committees would be especially important for identifying and addressing the health needs of Indigenous people living off-reserve in a culturally sensitive way.

- Provincially, the Office of the CMOH should ensure that central resource and policy supports are in place to facilitate local engagement with Indigenous communities and reinforce pathways to increasing representation and decision-making. The Health Equity requirements of the OPHS that are specific to improving the health of First Nations, Métis, and Inuit people living in Ontario should be the foundation of these supports. The CMOH will also have an important role to play as a liaison with the Government of Canada (through the Public Health Agency of Canada) to ensure that it abides by its complementary obligation to contribute to the improvement of health care and health outcomes for these communities.

Theme: Francophone Communities

What has been successful in the current system in considering the needs of Francophone populations in planning, delivery and evaluation of public health programs and services?

- alPHa's members have extensive experience in providing programs and services aimed at different cultural and linguistic groups within their communities, including Ontario's significant Francophone population. PHUs with significant Francophone populations are best equipped to share what has been successful, identify the gaps and provide advice on how to address them. This is in fact a good example of the importance of ensuring that local boards of health retain decision-making authority over program planning and service delivery to best serve local needs.

What improvements could be made to public health service delivery in French to Francophone communities?

- The provision of a 100% provincially funded centralized translation service that is accessible to all boards of health was cited repeatedly in our members' feedback to this question, as was support for French-language training programs for health unit staff.

Theme: Learning from Past Reports

What improvements to the structure and organization of public health should be considered to address these challenges?

- Most past reports have recommended PHU mergers, and alPHa is not opposed to this in principle, as long as such mergers are of entities with complementary community characteristics and values, will lead to a demonstrable positive impact on capacity, are worth the extraordinary cost and disruption, and are favoured by all concerned parties. The Simcoe-Muskoka, North Bay-Parry Sound, Southwestern and Huron-Perth PHUs are the results of mergers that have taken place since 2005, and valuable insights on the process, including the identification of driving forces, key success factors and challenges, are readily available.

- As noted above, alPHa does not believe that structural and organizational changes are necessary to address capacity challenges. While we agree that health unit mergers as a means to finding efficiencies and reducing duplication of efforts are worth considering, we have not been presented with a clear and convincing argument that a wholesale restructuring of the Ontario's public health system – with its concomitant major costs and disruptions - is a prerequisite for making it nimble, resilient, efficient and responsive.

What about the current public health system should be retained as the sector is modernized?

From alPHa's Statement of Principles:

- Ontario's public health system must remain financially and administratively separate and distinct from the health care system.

- The strong, independent local authority for planning and delivery of public health programs and services must be preserved, including the authority to customize centralized public health programming or messaging according to local circumstances.

- Parts I-V and Parts VI.1 – IX of the HPPA should be retained as the statutory framework for the purpose of the Act, which is to "provide for the organization and delivery of public health programs and services, the prevention of the spread of disease and the promotion and protection of the health of the people of Ontario".

- The OPHS should be retained as the foundational basis for local planning and budgeting for the delivery of public health programs and services.

- The leadership role of the local MOH as currently defined in the HPPA must be preserved with no degradation of independence, leadership or authority.

What else should be considered as the public health sector is modernized?

- Any and all changes must serve the goal of strengthening the Ontario public health system's capacity to improve population health in all of Ontario's communities through the effective and efficient local delivery of evidence-based public health programs and services.

- Achieving efficiencies must be defined in terms of improvements to service delivery and not cost savings. Each of the completed health unit mergers for example has had the former as their central aim but the merger process itself has always been costly.

- Provincial supports (financial, legal, administrative) must be provided to assist existing local PHUs in their transition to any new state without interruption to front-line services. Any costs associated with Public Health Modernization should be fully covered by the Ministry, including additional funding to address technology changes associated with any structure or governance changes.

- alPHa is very pleased with the format and process of the current consultation. That said, in the period between the initial 2019 budget announcement and the formal launch of this consultation (a period of over seven months), there was an unacceptable scarcity of information available to Ontario's considerable public health workforce. This has had a measurable and possibly irreversible negative impact on culture and morale within Ontario's public health workplaces. It has also put a considerable hindrance on the working relationship between local public health leadership and its partners within the Ministry. We hope that the transparency, comprehensiveness and reciprocity of this consultation will continue throughout the analysis and implementation phases to restore trust and demonstrate that the Government of Ontario values the public health professionals that are the foundational strength of the system.

ABBREVIATIONS

alPHa	Association of Local Public Health Agencies
AOPHBA	Association of Ontario Public Health Business Administrators
APHEO	Association of Public Health Epidemiologists in Ontario
ASPHIO	Association of Supervisors of Public Health Inspectors of Ontario
BOH	Board of Health
CMOH	Chief Medical Officer of Health
COMOH	Council of Ontario Medical Officers of Health
HPO	Health Promotion Ontario
HPPA	*Health Protection and Promotion Act*
HIV	Human Immunodeficiency Virus
IPAC	Infection Prevention and Control
ISPA	*Immunization of School Pupils Act*
LDCP	Locally Driven Collaborative Project
OAPHD	Ontario Association of Public Health Dentistry
OPHNL	Ontario Association of Public Health Nursing Leaders
ODPH	Ontario Dietitians in Public Health
OPHS	Ontario Public Health Standards
PHO	Public Health Ontario
PHU	Public Health Unit
TCAN	Tobacco Control Area Network

Enclosures:

alPHa Statement of Principles (November 2019), also attached.
alPHa Deputation, Standing Committee on Finance and Economic Affairs (January 17, 2020), also attached

BACKGROUND

On April 11, 2019 the Minister of Finance announced the 2019 Ontario Budget, which included a pledge to modernize "the way public health units are organized, allowing for a focus on Ontario's residents, broader municipal engagement, more efficient service delivery, better alignment with the health care system and more effective staff recruitment and retention to improve public health promotion and prevention".

Plans announced for this initiative included regionalization and governance changes to achieve economies of scale, streamlined back-office functions and better-coordinated action by public health units, adjustments to the provincial-municipal cost-sharing of public health funding and an emphasis on digitizing and streamlining processes.

On November 6, 2019, further details were presented as part of the government's Fall Economic Statement, which reiterates the Province's consideration of "how to best deliver public health in a way that is coordinated, resilient, efficient and nimble, and meets the evolving health needs and priorities of communities". To this end, the government is renewing consultations with municipal governments and the public health sector under the leadership of Special Advisor Jim Pine, who is also the Chief Administrative Officer of the County of Hastings. The aim of the consultation is to ensure:

- Better consistency and equity of service delivery across the province;
- Improved clarity and alignment of roles and responsibilities between the Province, Public Health Ontario and local public health;
- Better and deeper relationships with primary care and the broader health care system to support the goal of ending hallway health care through improved health promotion and prevention;
- Unlocking and promoting leading innovative practices and key strengths from across the province; and
- Improved public health delivery and the sustainability of the system.

In preparation for these consultations and with the intent of actively supporting positive systemic change, the alPHa Board of Directors has agreed on the following principles as a foundation for its separate and formal submissions to the consultation process.

PRINCIPLES

Foundational Principle

1) Any and all changes must serve the goal of strengthening the Ontario public health system's capacity to improve population health in all of Ontario's communities through the effective and efficient local delivery of evidence-based public health programs and services.

Organizational Principles

2) Ontario's public health system must remain financially and administratively separate and distinct from the health care system.

3) The strong, independent local authority for planning and delivery of public health programs and services must be preserved, including the authority to customize centralized public health programming or messaging according to local circumstances.

4) Parts I-V and Parts VI.1 – IX of the Health Protection and Promotion Act should be retained as the statutory framework for the purpose of the Act, which is to "provide for the organization and delivery of public health programs and services, the prevention of the spread of disease and the promotion and protection of the health of the people of Ontario".

5) The *Ontario Public Health Standards: Requirements for Programs, Services, and Accountability* should be retained as the foundational basis for local planning and budgeting for the delivery of public health programs and services.

6) Special consideration will need to be given to the effects of any proposed organizational change on Ontario's many Indigenous communities, especially those with a close relationship with the boards of health for the health units within which they are located. Opportunities to formalize and improve these relationships must be explored as part of the modernization process.

Capacity Principles

7) Regardless of the sources of funding for public health in Ontario, mechanisms must be included to ensure that the total funding envelope is stable, predictable, protected and sufficient for the full delivery of all public health programs and services whether they are mandated by the province or developed to serve unique local needs as authorized by Section 9 of the Health Protection and Promotion Act.

8) Any amalgamation of existing public health units must be predicated on evidence-based conclusions that it will demonstrably improve the capacity to deliver public health programs and services to the residents of that area. Any changes to boundaries must respect and preserve existing municipal and community stakeholder relationships.

9) Provincial supports (financial, legal, administrative) must be provided to assist existing local public health agencies in their transition to any new state without interruption to front-line services.

Governance Principles

10) The local public health governance body must be autonomous, have a specialized and devoted focus on public health, with sole oversight of dedicated and non-transferable public health resources.

11) The local public health governance body must reflect the communities that it serves through local representation, including municipal, citizen and / or provincial appointments from within the area. Appointments should be made with full consideration of skill sets, reflection of the area's socio-demographic characteristics and understanding of the purpose of public health.

12) The leadership role of the local Medical Officer of Health as currently defined in the Health Protection and Promotion act must be preserved with no degradation of independence, leadership or authority.

DESIRED OUTCOMES

- Population health in Ontario will benefit from a highly skilled, trusted and properly resourced public health sector at both the provincial and local levels.
- Increased public and political recognition of the critical importance of investments in health protection and promotion and disease prevention to population health and the sustainability of the health care system.
- Local public health will have the capacity to efficiently and equitably deliver both universal public health programs and services and those targeted at at-risk / vulnerable / priority populations.
- The geographical and organizational characteristics of any new local public health agencies will ensure critical mass to efficiently and equitably deliver public health programs and services in all parts of the province.
- The geographical and organizational characteristics of any new local public health agencies will preserve and improve relationships with municipal governments, boards of education, social services organizations, First Nations communities, Ontario Health Teams and other local stakeholders.
- The geographical and organizational characteristics of any new local public health agencies will reflect the geographical, demographic and social makeup of the communities they serve in order to ensure that local public health needs are assessed and equitably and efficiently addressed.
- Local public health will benefit from strong provincial supports, including a robust Ontario Agency for Health Protection and Promotion (Public Health Ontario) and a robust and independent Office of the Chief Medical Officer of Health.
- The expertise and skills of Ontario's public health sector will be recognized and utilized by decision makers across sectors to ensure that health and health equity are assessed and addressed in all public policy.

Association of Local Public Health Agencies
Speaking Points
Standing Committee on Finance and Economic Affairs
Re: 2020 Ontario Budget
Friday, January 17, 2020

- Good afternoon, Chair and Members of the Standing Committee on Finance and Economic Affairs.

- I am Dr. Eileen de Villa, Vice-President of the Association of Local Public Health Agencies, better known as alPHa, and Toronto's Medical Officer of Health and with me is Loretta Ryan, alPHa's Executive Director.

- alPHa represents all of Ontario's 34 boards of health and medical officers of health (MOHs).

- As you may know, in essence, the work of public health is organized in the Ontario Public Health Standards as follows:

    - Chronic Disease Prevention and Well-Being
    - Emergency Management
    - Food Safety
    - Health Equity
    - Healthy Environments
    - Healthy Growth and Development
    - Immunization
    - Infectious and Communicable Diseases Prevention and Control
    - Population Health Assessment

- Safe Water
- School Health
- Substance Use and Injury Prevention

- Last January, in the alPHa Pre-Budget Submission, alPHa noted that:

  - Public Health is on the Front Line of Keeping People Well
  - Public Health Delivers an Excellent Return on Investment
  - Public Health is an Ounce of Prevention that is Worth a Pound of Cure
  - Public Health Contributes to Strong and Healthy Communities
  - Public Health is Money Well Spent

- Furthermore, alPHa recommended that:

  - The integrity of Ontario's public health system be maintained
  - The Province continue its funding commitment to cost-shared programs
  - The Province make other strategic investments, including in the public health system, that address the government's priorities of improving services and ending hallway medicine

- As regards to this last point, Public Health's contribution to ending hallway medicine is summarized in alPHa's Public Health Resource Paper .

- Despite this advice, the 2019 Ontario Budget announced that the Government would be changing the way the public health system was organized and funded.

- On October 10, 2019, Ontario named Jim Pine as its Advisor on Public Health (and Emergency Health Services) consultations.

- Subsequently, on November 18, the Ministry of Health launched renewed Public Health consultations and released a Discussion Paper.

- alPHa was pleased with these recent announcements and has been fully engaged with the consultation.

- For example, on November 15, alPHa released a Statement of Principles respecting Public Health Modernization.

- On a funding note, as was reported by alPHa on September 11, the Ministry of Health confirmed the cost-sharing formula for public health will change to 70% provincial/30% municipal to be applied to almost all mandatory public health programs and services.

- That said, as the Premier announced on August 19 at the AMO Conference, and which alPHa welcomed, municipalities would be receiving one-time transitional funding to limit the increase in costs borne by municipalities in 2020 to no more than 10%.

- Despite this, many boards of health have reported that they have had to draw on their reserves to ease the financial burden that this decision has placed on their obligated municipalities .

- A more positive announcement in the 2019 Ontario budget was the decision to proceed with a new 100% provincially funded, public health unit delivered Ontario Seniors Dental Care Program (OSDCP), which was officially launched on November 20.

- alPHa believes that a modernized, effective and efficient public health system that is adequately resourced is needed more than ever.

- alPHa agrees, for example, with the Standing Committee on Public Accounts Report about the importance of addressing key chronic disease risk factors such as physical inactivity, unhealthy eating, alcohol consumption and

tobacco use of which the attributable burden of illness places huge demands on the health care system.

- Moreover, in its presentation to the Standing Committee on Social Policy, alPHa warned about the unforeseen consequences of the legalization of cannabis and the promotion of vapour products, such as e-cigarettes and other similar products.

- Finally, as the Office of the Chief Medical Officer of Health has recently noted, the Public Health Agency of Canada is tracking a novel coronavirus outbreak in Wuhan, China; as our experience with SARS demonstrated, infectious diseases "know no borders".

- With all the foregoing in mind, alPHa respectfully recommends the following:

    - Led by Ontario's Advisor, the Ministry of Health continue to pursue meaningful consultations with key stakeholders, including alPHa, respecting Public Health Modernization
    - Any changes to the public health system be implemented in accordance with alPHa's Statement of Principles and pending response to the Public Health Modernization discussion paper
    - The public health system receives sufficient and sustainable funding to address population health needs
    - Ontario preferably restore the previous provincial-municipal cost-sharing (75/25) formula for Public Health and, at the very least, make no further changes to the current (70/30) formula
    - Ontario continue to invest in Public Health operations and capital, including 100% funding for priority programs, such as OSDCP

- Thank you for your attention. We would be pleased to answer any questions.

STANDING COMMITTEE ON FINANCE AND ECONOMIC AFFAIRS
FRIDAY 17 JANUARY 2020
PRE-BUDGET CONSULTATIONS

Full Transcript **(all presentations)**

Association of Local Public Health Agencies

The Chair (Mr. Amarjot Sandhu): Next, I would like to call upon the Association of Local Public Health Agencies. Please state your name for the record. You have seven minutes for your presentation.

Dr. Eileen de Villa: Thank you very much. Good afternoon, Chair and members of the Standing Committee on Finance and Economic Affairs. I'm Dr. Eileen de Villa, vice-president of the Association of Local Public Health Agencies, better known as ALPHA, and I'm also Toronto's medical officer of health. I'm joined today by my colleague Loretta Ryan, ALPHA's executive director.

ALPHA represents all of Ontario's 34 boards of health and medical officers of health. As you may know, in essence, the work of public health is organized in the Ontario Public Health Standards as follows: chronic disease prevention and well-being, emergency management, food safety, health equity, healthy environments, healthy growth and development, immunization, infectious and communicable diseases prevention and control, population health assessment, safe water, school health, substance use, and injury prevention.

Last January, in the ALPHA pre-budget submission, ALPHA noted that public health is on the front line of keeping people well. Public health delivers an excellent return on investment. Public health is an ounce of prevention that is worth a pound of cure. Public

health contributes to strong and healthy communities, and public health is money well spent.

Furthermore, ALPHA recommended that the integrity of Ontario's public health system be maintained, that the province continue its funding commitment to cost-shared programs and that the province make other strategic investments, including in the public health system, that address the government's priorities of improving services and ending hallway health care. In regard to this last point, public health's contribution to ending hallway health care is summarized in ALPHA's public health resource paper.

Despite this advice, the 2019 Ontario budget announced that the government would be changing the way the public health system was organized and funded.

On October 10, 2019, Ontario named Jim Pine as its adviser on public health and on emergency health services for the consultations. Subsequently, on November 18, the Ministry of Health launched renewed public health consultations and released a discussion paper. ALPHA was pleased with these recent announcements and has been fully engaged with the consultation. For example, on November 15, ALPHA released a statement of principles respecting public health modernization.

On a funding note, on September 11, the Ministry of Health confirmed that the cost-sharing formula for public health will change to 70% provincial and 30% municipal, to be applied to almost all mandatory public health programs and services. This said, as the Premier announced on August 19 at the AMO conference—and which ALPHA welcomed—municipalities would be receiving one-time transitional funding to limit the increase in costs borne by municipalities in 2020 to no more than 10%. Despite this, many boards of health have reported that they have had to draw on their reserves to ease the financial burden that this decision has placed on their obligated municipalities.

A more positive announcement in the 2019 Ontario budget was the decision to proceed with a new, 100% provincially funded, public-health-unit-delivered Ontario Seniors Dental Care Program, or OSDCP, which was officially launched on November 20.

ALPHA believes that a modernized, effective and efficient public health system that is adequately resourced is needed more than ever. ALPHA agrees, for example, with the Standing Committee on Public Accounts report about the importance of addressing key chronic disease risk factors, such as physical inactivity, unhealthy eating, alcohol consumption and tobacco use, of which the attributable burden of illness places huge demands on the health care system. Moreover, in its presentation to the Standing Committee on Social Policy, ALPHA warned about the unforeseen consequences of the legalization of cannabis and the promotion of vapour products, such as e-cigarettes and other similar products.

Finally, as the Office of the Chief Medical Officer of Health has recently noted, the Public Health Agency of Canada is tracking a novel coronavirus outbreak in Wuhan, China. As our experience with SARS demonstrated, infectious diseases know no borders.

With all the foregoing in mind, ALPHA respectfully recommends the following:

—led by Ontario's adviser, the Ministry of Health continue to pursue meaningful consultations with key stakeholders, including ALPHA, respecting public health modernization;

—any changes to the public health system be implemented in accordance with ALPHA's statement of principles and pending response to the public health modernization discussion paper;

—that the public health system receive sufficient and sustainable funding to address population health needs—

The Chair (Mr. Amarjot Sandhu): One minute.

Dr. Eileen de Villa:—that Ontario preferably restore the previous provincial-municipal cost sharing 75-25 formula for public health and, at the very least, make no further changes to the current 70-30 formula; and

—that Ontario continue to invest in public health operations and capital, including 100% funding for priority programs such as the Ontario Seniors Dental Care Program.

I'll thank you for your attention, and we would be very pleased to address any questions you might have.

The Chair (Mr. Amarjot Sandhu): Thank you. We'll go to the opposition side this time. MPP Shaw.

Ms. Sandy Shaw: Thank you very much for your presentation. I commend you for your work. I would say that people didn't understand what public health did previous to these abrupt changes; we understand it now.

I would also like to say, we remember when SARS happened, and Dr. Sheela Basrur—the heroic efforts that we took to prevent that from being a full-blown crisis. It was 15 or 16 years ago; how quickly we forget, right? So I think we need to keep reminding ourselves that when we need public health to be able to mobilize, we really, really need it.

So I want to commend you. I understand the work that you do. I always did. I want to say that we're fully supportive of what you do. There's no misunderstanding on the part of the New Democrats of what you do.

My question is very specific because we've got a short time. About the changes to the public health unit, the geographic deployment—so 35 units that are going to now, perhaps, be shrunk down to 10. This is a question about my riding in Hamilton, where our medical officer of health, Dr. Richardson, has expressed some of her concerns, particularly now that we are an Ontario health team and we do not know how the Ontario health team is trying to get on with their work without any direction—really clear direction, I would say—from the government and without the understanding that this public health unit will now maybe be beyond the geographic area of the Ontario health team.

So there's a lot of confusion out there in terms of what's happening. I'm wondering if you have any understanding of that or any advice around what the impact will be when these health units shrink.

1620

Dr. Eileen de Villa: Thank you for the question. At this stage of the game and as alluded to in my remarks, there are ongoing consultations right now in respect of public health modernization as proposed by the current provincial government. My understanding at this stage is that there is still open discussion with respect to what will be the configuration of local public health units. You're right: Right now, there are currently 34. There were some original proposals made last year. We're understanding at this stage of the game that there is some revisiting, a "reset," I believe, is the word that has been used. So we don't know yet where the discussions will land.

However, I would say that there are some important questions to ask here and some important considerations for the committee. First public health as a system is separate from the health care system. There are important areas of interaction that we need to have between public health and health care, but they are in fact distinct and separate. The Ontario health teams fall more within the context of health care, and that's a very important role that needs to be played. I think there are certainly some questions as to how that will manifest itself in the future. However, it is in fact separate from public health.

The Chair (Mr. Amarjot Sandhu): One minute.

Dr. Eileen de Villa: That's not to take away from its importance.

Ms. Sandy Shaw: Thank you.

The Chair (Mr. Amarjot Sandhu): MPP Arthur.

Mr. Ian Arthur: Thank you so much for your presentation. I echo the sentiments of my colleague.

Just very quickly: The upstream causes of health care costs were talked about for a long time. It seems to have receded a bit in terms of the discussion. With skyrocketing health care costs, do you see any avenue other than dealing with those upstream causes for bringing those expenditures under control?

Dr. Eileen de Villa: Thank you for the question. As a public health practitioner, we are all about the upstream. That is our focus. That is where we live, and that's where we provide the most value to the system. There will always be some need for health care, which is downstream. However, we know that what constitutes and what maintains

health are the social determinants of health, the conditions within which people live and the environments within which they live—

The Chair (Mr. Amarjot Sandhu): Thank you. I apologize to cut you off. We'll have to move to the government side now. MPP Skelly.

Ms. Donna Skelly: Thank you for your presentation. This year our government committed over $700 million—close to $800 million—in funding for public health units right across Ontario. Yes, we believe that there is an opportunity and several challenges moving forward in the restructuring and modernization of delivery of those services, and we are consulting, I believe under the leadership and direction of Jim Pine. He is the emergency health services adviser. He is leading the dialogue, meeting with representatives from municipalities, meeting with health service sector representatives from right across the province, in order to understand what the challenges are, in order to identify perhaps some of the duplication of services. We have seen examples that have been brought forward to our government.

I'm just wondering if maybe you could, while we have this opportunity at this committee hearing, share with this committee some of the areas that you have identified as duplication in the delivery of health care services under these current boards.

Dr. Eileen de Villa: Thank you for the question. I'm going to talk about duplication in respect of public health as opposed to health care.

Ms. Donna Skelly: I should say "public health." Thank you.

Dr. Eileen de Villa: Yes, because they are quite distinct, as I indicated earlier. You're quite right around the consultations; I think that there is an opportunity to engage in conversation around what's best for public health. The public health system, however, does require the co-operation and collaboration of several partners. There's certainly a

role for provincial entities. There's a role for local entities, some of which are governmental and some of which are community-based.

Where are there areas that we could improve? There are always areas for improvement, whether we're talking about public health or health care. When it comes to public health, I think what we have seen through the various reports—some of which emanated from local public health; some of which have come through Auditor General-type reports—would include areas like research.

I think there is an opportunity, as well, to confer across the province around what are some of the directions and priorities that we should be seeking together, because we know that where we have had success in public health in the past, most of the successes have come through the collaborative efforts of a variety of local or regional public health entities, as well as the province.

I think those are just a few examples of some areas where we could collaborate better and perhaps reduce duplication.

Ms. Donna Skelly: One of the programs that you raised involves dental care for seniors, which is, of course, something I think most of us really believe is long overdue.

The Chair (Mr. Amarjot Sandhu): One minute.

Ms. Donna Skelly: Can you speak to some of the limitations, some of your observations, since we've started introducing that program?

Dr. Eileen de Villa: It's a relatively new program, launched in November and currently being delivered through public health units. I would say that for many of my colleagues around the province, one of the challenges is that they did not have pre-existing seniors'

dental care programs, or facilities through which to deliver such clinical services. Certainly, establishing those facilities is one of the challenges that exist right now.

But as mentioned in our remarks, we at ALPHA are extremely pleased. This was certainly one of the positives in respect of recent funding announcements when it came to public health and public health delivery programs.

Ms. Donna Skelly: Thank you.

The Chair (Mr. Amarjot Sandhu): Thank you so much for your presentation.

July 16, 2020

The Honourable Christine Elliott
Minister of Health
5th Floor, 777 Bay Street
Toronto, ON M7A 2J3
email: christine.elliottco@ola.org

Dear Minister Elliott,

Re: Endorsement of correspondence regarding the 2020 Municipal Cost Share of Public Health Funding from Eastern Ontario Health Unit and correspondence regarding COVID-19 and Reconsiderations Related to Public Health Modernization from the Association of Local Public Health Agencies

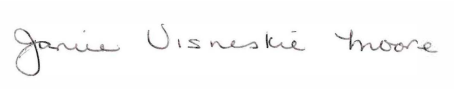
At the Regular Board meeting held on June 30, 2020, the Board of Health for Renfrew County and District Health Unit agreed to support the following motion by the Haliburton, Kawartha, Pine Ridge District Health Unit (HKPR District Health Unit):

"THAT the correspondence sent by the Eastern Ontario Health Unit to the Minister of Health regarding the 2020 Municipal Cost Share of Public Health Funding (attached), and the correspondence sent by the Association of Local Public Health Agencies to the Minister of Health requesting consideration of a pause on the Public Health Modernization initiative (attached) be endorsed; and THAT the provincial share of public health funding be reinstated to its previous level; and THAT a letter of support be sent to The Honourable Christine Elliott".

The Board of Health for Renfrew County and District Health Unit agrees with the Eastern Ontario Health Unit and the Association of Local Public Health Agencies that the Public

Health Modernization process should be deferred until after the COVID-19 response is examined and that public health funding should be restored to its previous level for 2020.

Sincerely,



Janice Visneskie Moore
Chair, Board of Health

cc: Dr. David Williams, Ontario Chief Medical Officer of Health
Alison Blair, Executive Lead for Public Health Modernization
Jim Pine, Special Advisor, Public Health Modernization
Association of Municipalities of Ontario (AMO)
Ontario Boards of Health
Association of Local Public Health Agencies (alPHa)

HALIBURTON, KAWARTHA, PINE RIDGE DISTRICT HEALTH UNIT

www.hkpr.on.ca • info@hkpr.on.ca
1-866-888-4577

June 19, 2020

The Honourable Christine Elliott
Minister of Health
5th Floor, 777 Bay St.
Toronto, ON M7A 2J3
(Sent via email to: christine.elliottco@ola.org)

Dear Minister Elliott

RE: Endorsement of correspondence regarding the 2020 Municipal Cost Share of Public Health Funding from Eastern Ontario Health Unit and correspondence regarding COVID-19 and Reconsiderations Related to Public Health Modernization from the Association of Local Public Health Agencies

At its meeting held on June 18, 2020, the Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit (HKPR District Health Unit) passed the following motion:

"THAT the correspondence sent by the Eastern Ontario Health Unit to the Minister of Health regarding the 2020 Municipal Cost Share of Public Health Funding (attached), and the correspondence sent by the Association of Local Public Health Agencies to the Minister of Health requesting consideration of a pause on the Public Health Modernization initiative (attached) be endorsed; and THAT the provincial share of public health funding be reinstated to its previous level; and THAT a letter of support be sent to The Honourable Christine Elliott".

The Board Health agrees with the Eastern Ontario Health Unit and the Association of Local Public Health Agencies that the Public Health Modernization process should be deferred until after the COVID-19 response is examined and that public health funding should be restored to its previous level for 2020.

Sincerely

BOARD OF HEALTH FOR THE HALIBURTON,
KAWARTHA, PINE RIDGE DISTRICT HEALTH UNIT

D. J. F. Elmslie

Doug Elmslie
Chair, Board of Health
DE/aln/ed

Cc (via email): Dr. David Williams, Ontario Chief Medical Officer of Health
Alison Blair, Executive Lead for Public Health Modernization
Jim Pine, Special Advisor, Public Health Modernization
Association of Municipalities of Ontario (AMO)
Jennifer Moore, CAO, Northumberland County
Mike Rutter, Chief Administrative Officer, County of Haliburton
Ron Taylor, Chief Administrative Officer, City of Kawartha Lakes
Ontario Boards of Health
Association of Local Public Health Agencies (alPHa)

Attachments: 2

EOHU Eastern Ontario Health Unit | BSEO Bureau de santé de l'est de l'Ontario

Cornwall, February 12, 2020

The Honorable Christine Elliott
Minister of Health and Deputy Premier
Hepburn Block, 10th Floor, 80 Grosvenor Street
Toronto ON M7A 1E9

Dear Minister Elliott:

RE: 2020 Municipal Cost Share of Public Health Funding

At its meeting on January 30, 2020, the Eastern Ontario Health Unit (EOHU) Board of Health unanimously passed the following motion number 2020-1393:

> ***WHEREAS*** *the Ontario Government's Public Health Modernization Consultation process is still ongoing and in fact delayed;*
>
> ***WHEREAS*** *the Public Health Modernization Consultation process does not address public health funding models including municipal cost-share;*
>
> ***WHEREAS*** *without prior consultation nor discussion with health units or municipalities and before a new public health structure model has been devised and implemented, the municipal public health funding share for 2020 has been increased to 30% and now extends to include programs not previously cost-shared with municipalities;*
>
> ***WHEREAS*** *the 30% share across all programs, including those previously not cost-shared will result in significant and likely unsustainable increase of close to 50% to the EOHU's 3 obligated, mostly rural municipalities which have a limited tax base;*
>
> ***WHEREAS*** *the EOHU's obligated municipalities have planned for a 2020 modest overall contribution increase of up to 2% which is less than their new 30% cost-share formula 2020 contribution, even offset by verbally confirmed one-time transitional funding by the Ministry of Health;*
>
> ***THEREFORE, BE IT RESOLVED THAT*** *for the calendar year of 2020 the provincial Ministry of Health reverse the 30% cost-share formula and return to previous years' municipal share of 25% applicable only to previously shared mandatory programs;*
>
> and
>
> ***FURTHERMORE THAT*** *copies of this motion be forwarded to local municipalities, the Wardens Caucus of Eastern Ontario, the Association of Municipalities of Ontario (AMO), ROMA, local MPPs, MPP Steven Clark, all Ontario Boards of Health, the Association of Public Health Agencies (alPHa) in request for their support to urge the provincial Ministry of Health not to change the 2019 cost-share formula.*

…/2

Thank you for your attention to this important public health issue.

Sincerely,

Dr. Paul Roumeliotis, MD, CM, MPH, FRCP(C)
Medical Officer of Health/CEO
Secretary, Board of Health

Copy: Municipalities of Stormont, Dundas, Glengarry, Prescott & Russell
Warden's Caucus of Eastern Ontario
Association of Municipalities of Ontario (AMO)
ROMA
City of Cornwall
Ontario Boards of Health
Association of Public Health Agencies (alPHa)
Office of the Chief Medical Officer of Health
Jim McDonell, MPP, Stormont - Dundas - South Glengarry
Amanda Simard, MPP, Glengarry - Prescott-Russell
Steven Clark, Minister of Municipal Affairs

alPHa
Association of Local PUBLIC HEALTH Agencies

480 University Ave., Suite 300
Toronto, Ontario M5G 1V2
Tel: (416) 595-0006
E-mail: info@alphaweb.org

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

alPHa Sections:

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

Affiliate Organizations:

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

March 6, 2020

Hon. Christine Elliott
Minister of Health
5th Floor
777 Bay St.
Toronto, ON M7A 2J3

Dear Minister Elliott,

Re: COVID-19 and Reconsiderations Related to Public Health Modernization

On behalf of the Association of Local Public Health Agencies (alPHa) and its member Medical Officers of Health, Boards of Health and Affiliate organizations, I am writing today to urge you to consider pausing the Public Health Modernization initiative until the COVID-19 emergency is declared over in order to ensure that the response can be analysed, evaluated and incorporated into the consultations.

After a long period of uncertainty within the public health sector, we were indeed very grateful for your January 31 news release that included your praise of public health's "remarkable responsiveness" to the 2019 novel coronavirus and your expression of confidence that dedicated public health professionals are keeping Ontarians safe.

As we noted in our submission to the Public Health Modernization consultation paper, commitments to strengthening Ontario's public health system in response to the Walkerton, SARS and H1N1 health emergencies (including increased provincial responsibility for funding, strengthened role of the Chief Medical Officer of Health and creation of The Ontario Agency for Health Protection and Promotion) have led to measurable improvements to the Ontario public health sector's capacity to detect and respond to emerging threats. The swift collective and thorough response to the COVID-19 epidemic is a clear application by Ontario's public health sector of the lessons learned from the 2003 SARS outbreak.

This is not to say that activating our emergency response mechanisms has become a simple matter. Emergency response is by its very nature incredibly resource intensive and requires a high degree of ingenuity and nimbleness to adapt the response to a constantly evolving situation. Unfortunately, this can have a measurable impact on the equally important health protection and promotion activities that Ontario's dedicated public health professionals carry out every day to keep Ontarians well.

As we also noted in our submission to the Public Health Modernization team, the capacity for most public health units has been steadily eroding over the years largely due to the Ministry putting caps (often 0%) on annual budget increases that are necessary to cover the costs of delivery of new programs, annual CPI increases and honouring collective agreements. This erosion will be significantly and immediately compounded by the Province's abrupt and unjustified decision to immediately shift 5% of the cost-shared and 30% of previously 100% provincially funded public health programs to municipalities.

It is often said that public health is at its best when it's invisible to the public. In other words, its most important and effective contributions to population health are in fact those day-to-day health promotion, disease prevention and surveillance activities that we know will protect people from ever-present threats to their health and well being. In the Ontario Public Health Standards, this province has one of the world's strongest foundations for these contributions. The chronic inadequacy of resources to meet our daily obligations is regrettably brought into stark relief when they need to be diverted to emergency response duties.

As the response to COVID-19 has progressed, the PH-EMS Modernization team has recognized the need for local public health to focus on its work without distraction and postponed further face to face consultations with local public health in addition to extending the deadline for written submissions. We are respectfully asking that you reinforce this by providing official direction to pause the modernization process at least until the COVID-19 emergency is declared over, a full analysis of the response has been conducted and the lessons learned have been applied.

In addition, we are asking you to immediately reverse the download of the provincial portion of the public health funding envelope to restore the degree of financial certainly required to ensure that the both the extraordinary response and routine public health activities remain robust.

We see this test of public health as an important opportunity to take a collective step back and reconsider the approach that is being taken towards Ontario's public health sector, as a keener understanding of its purpose is re-entering the public and political discourse. We are eager to assist you in achieving your vision of a "coordinated public health sector that is nimble, resilient, efficient and responsive to the province's evolving health priorities" and we look forward to continuing the vital Public Health Modernization discussions that have already begun.

In the meantime, we are once again asking that the public health aspect of the PH-EMS Modernization endeavour be deferred until such a time as the COVID-19 response can be examined in retrospect and inform those discussions, and that the provincial share of public health funding be restored to its previous level at least until the discussions have concluded.

We would be pleased to discuss this with you further. To schedule a meeting, please have your staff contact Loretta Ryan, Executive Director, alPHa, at loretta@alphaweb.org or 416-595-0006 x 222.

Yours sincerely,

Carmen McGregor,
alPHa President

COPY: Dr. David Williams, Chief Medical Officer of Health
Alison Blair, Executive Lead for Public Health Modernization
Jim Pine, Special Adviser, Public Health Modernization

simcoe muskoka
DISTRICT HEALTH UNIT

August 19, 2020

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

Dear Minister Elliott:

On behalf of the Board of Health for the Simcoe Muskoka District Health Unit I commend the provincial government for its leadership in bringing COVID-19 under control throughout Ontario. Through the definitive leadership of the provincial government, and with the concerted action of local public health units, Ontario has achieved a cumulative incidence of disease that is less than half of our neighbouring states, and a daily incidence at present that is less than 10% of theirs. The rapid action of the province putting in place public health measures in March, and their careful withdrawal since that time have been essential to our success. Also essential has been the redirection of almost all the resources within local health units to enable the timely identification of cases and their contacts for home isolation, management of outbreaks in workplaces, Long Term-Care facilities and retirement homes, and the provision of guidance and direction to municipalities, businesses, organizations and the general public supporting physical distancing, hand hygiene, and face coverings. All of these actions have enabled our communities to flatten the curve without which we would have had the same experience as our neighbouring jurisdictions to the south.

Local public health units, with the leadership of their boards of health, are completely dedicated to the successful control of COVID-19 moving forward until our provision of mass vaccination and with it the hoped-for end to the pandemic. If necessary, we will continue this struggle for years.

In order to continue to be successful, additional resources are needed, and the promise of additional resources by the province has been very much appreciated. This includes the $100 million to public health communicated earlier in the year (the *COVID-19 Extraordinary Expenses*), and recently the $50 million (500 nurses) for the public health support to the recommencement of the schools (the *School-Focused Nurses*).

This additional funding will be essential to enable the success of the local public health response to the pandemic; however, its timely provision is also critical to our success. Through communication with Ministry of Health staff we have learned that the *COVID-19 Extraordinary Expenses* will be provided late in 2020 as reimbursement for extraordinary expenditures related to the pandemic response. This approach requires boards of health to take on these expenditures throughout the year without certainty as to the actual amount that they will be reimbursed. Some boards do not have reserve funds, and others have depleted their reserves

already in their response (including our Board of Health). Without the provision of the funds at this time, these boards will not be able to maintain the level of their response needed to fully control COVID-19. In addition, the boards have been instructed to proceed with hiring the additional *School-Focused Nurses* without having the additional funding at this time required to do so; those boards that do not have remaining reserve funds will not be in a position to do so until they receive these additional funds.

Local public health has performed extraordinary work with the province to flatten the curve, and to enable the opening of the economy and soon the school system. This is a critical time for us all as we strive to maintain these achievements while avoiding a resurgence of cases that would threaten these gains. Therefore, the Board of Health urges the immediate provision of the funding allocations to local boards of health regarding the *COVID-19 Extraordinary Expenses* and for the *School-Focused Nurses* in order to enable a response by local public health units that is unobstructed by local financial shortfalls.

Thank you for your consideration of this request, and for your exemplary leadership.

Sincerely,

ORIGINAL Signed By:

Anita Dubeau, Chair
Simcoe Muskoka District Health Unit Board of Health

AD:CG:cm

cc. Dr. David Williams, Chief Medical Officer of Health
Loretta Ryan, Executive Director, Association of Local Public Health Agencies
Ontario Boards of Health
Mayor and Council of Simcoe and Muskoka
Members of Provincial Parliament for Simcoe and Muskoka

Municipality of Chatham-Kent
CK Public Health
PO Box 1136, 435 Grand Avenue West, Chatham, ON N7M 5L8
Tel: 519.352.7270 Fax: 519.352.2166
Email ckpublichealth@chatham-kent.ca

July 30, 2020

The Honourable Patty Hajdu. P.C., M.P.
Minister of Health
House of Commons
Ottawa, ON K1A 0A6
Sent via email: Patty.Hajdu@parl.gc.ca

The Honourable David Lametti
Minister of Justice and Attorney General of Canada
Department of Justice Canada
284 Wellington Street
Ottawa, ON K1A 0H8
Sent via email: David.Lametti@parl.gc.ca

Dear Minister Hajdu and Minister Lametti:

RE: The Decriminalization of Personal Possession of Illicit Drugs

This builds on the Board's September 2018 endorsement of a similar motion from Toronto Public Health. In making this endorsement, the Board joins a growing movement to pursue a public health approach to drug policy.

Opioid use and its related harms is a growing problem here in Chatham-Kent. From 2003 to 2017 the rate of emergency room visits for opioid poisoning among Chatham-Kent residents increased 225% and the rate of hospitalizations increased by 45%. Since the declaration of the COVID-19 pandemic, there have been an increasing number of calls to local EMS and emergency department visits related to opioid overdoses.

Evidence from other countries that have pursued decriminalization, demonstrate, that in order for it to be effective, this approach must be accompanied by investments in harm reduction, treatment, and mental health supports and services. [1]

The Board strongly supports the decriminalization of personal possession of illicit drugs together with comminuted commitment of resources to effectively address problematic substance use and reduce related harms in our community and calls on the federal government to create a national task force to research drug policy reform.

Sincerely,

Joe Faas
Chair, Chatham-Kent Board of Health

C: Association of Local Public Health Agencies
Ontario Association of Chiefs of Police
Honourable Dave Epp, MP, Chatham-Kent-Leamington
Honourable Rick Nicholls, MPP, Chatham-Kent-Leamington
Honourable Monte McNaughton, MPP, Lambton-Kent-Middlesex
Chatham-Kent Municipal Council

[1] Hughes, C. and Stevens, A. (2011). Harm Reduction Digest (44) A resounding success or a disastrous failure: Re-examining the interpretation of evidence on the Portuguese decriminalization of illicit drugs. Drug And Alcohol

Municipality of Chatham-Kent
CK Public Health
PO Box 1136, 435 Grand Avenue West, Chatham, ON N7M 5L8
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Email ckpublichealth@chatham-kent.ca

July 27, 2020

The Right Honourable Justin Trudeau, P.C., MP
Prime Minister of Canada
Office of the Prime Minister
80 Wellington Street Ottawa, ON K1A 0A2
Sent via email: justin.trudeau@parl.gc.ca

The Honourable Chrystia Freeland, P.C., M.P.
Deputy Prime Minister
Privy Council Office
Room 1000
80 Sparks Street Ottawa, ON K1A 0A3
Sent via email: chrystia.freeland@parl.gc.ca

The Honourable Bill Morneau, P.C., M.P.
Minister of Finance
90 Elgin Street, 17th Floor
Ottawa, ON K1A 0G5
Sent via email: bill.morneau@parl.gc.ca

Dear Prime Minister Trudeau, Deputy Prime Minister Freeland, and Minister Morneau:

RE: Basic Income for Income Security during COVID-19 Pandemic and Beyond

At its meeting held on June 17, 2020, the Chatham-Kent Board of Health received correspondence to the federal government from Simcoe Muskoka District Health Unit, dated May 20, 2020, Timiskaming Health Unit, dated June 9, 2020, Haliburton, Kawartha, Pine Ridge District Health Unit, dated June 19, 2020. These letters request that the federal government transition the Canada Emergency Response Benefit (CERB) into a basic income for all Canadians during the COVID-19 response and beyond. The Board also endorses the May 11, 2020 resolution by the City of Kitchener to establish a universal basic income.

Income is one of the strongest predictors of health, and it makes sense that focusing on population health interventions to address socioeconomic factors will impact health outcomes far greater than individual focused interventions.

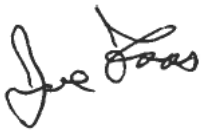
…/2

Previous to COVID-19, Chatham-Kent residents have experienced lower median household incomes, higher rates of poverty (with more than one in four children living in low income), lower rates of post-secondary education, higher proportions of the population working in lower wage manufacturing, retail, and service occupations, as well as higher rates of lone-parent families, seniors, and people living alone. Socio-economic factors vary across the Municipality with some communities and neighbourhoods facing a higher degree of material deprivation than others. An examination of local chronic disease health inequities has shown significantly higher rates of chronic disease-related health care utilization and death in the most materially deprived areas compared to the least deprived areas of Chatham-Kent. Annual analysis of the local cost of a nutritious food basket has continued to illustrate how little money a family of four on a social assistance budget would have left to cover the costs of childcare, rural transportation, and other basic needs, after paying for shelter and healthy food. Furthermore, the most recent calculation of Chatham-Kent's living wage well exceeded $16 per hour, and local costs of living have increased since that time.

As a result of the COVID-19 pandemic, we can anticipate the exacerbation of existing disparities, creating an even wider gap between those with opportunity and those without. Local concerns around homelessness, poverty, food insecurity, transportation, mental health and addictions, child and partner violence, and the needs of Indigenous people have been amplified.

The Board strongly recommends your government take immediate action to evolve CERB into legislation for a basic income as an effective long-term response to the issues of income security, poverty, food insecurity, and overall community health and well-being.

Sincerely,



Joe Faas
Chair, Chatham-Kent Board of Health

C: Honourable Doug Ford, Premier of Ontario
Dr. David Williams, Chief Medical Officer of Health
Pegeen Walsh, Executive Director, Ontario Public Health Association
Association of Local Public Health Agencies
Ontario Boards of Health
Honourable Dave Epp, MP, Chatham-Kent-Leamington
Honourable Rick Nicholls, MPP, Chatham-Kent-Leamington
Honourable Monte McNaughton, MPP, Lambton-Kent-Middlesex
Chatham-Kent Municipal Council

Elizabeth Milne

From: [redacted]
Sent: Friday, July 17, 2020 7:59 AM
To: Elizabeth Milne
Subject: Make Masks Mandatory

Attention Ms.Milne,

Please circulate this email to all MLHU Board Of Health Members.
Thank you.

[redacted]

Dear Ms. Cassidy and MLHU Board of Health,

I am writing to express my concern around the July 2 COVID Order from the MLHU and why the Mayor, City Council, the Warden, Middlesex County Council and the MLHU Board of Health are siding with Dr. Mackie in NOT making a mandatory mask policy in all indoor public places, as many other municipalities across Ontario have ordered.

Dr. Mackie's and Mr. Holder's recommendation that we wear masks in public indoor places is not working. For example, the staff at Food Basics, Commissioners Rd. West where I often shop, do not wear masks. While there this week, a shopper standing beside me sneezed. I suggested to her that she should wear a mask. She answered, "I only sneezed once." With airborne COVID-19 spread now seen as very possible, I became anxious. When shopping at Tuckey's Home Hardware my husband never sees their staff wearing masks. He notes many younger shoppers don't wear masks either. While shopping at Metro in Byron a week ago I had to jump back against the canned goods shelf behind me to get farther away from an unmasked young mom with her baby and stroller as she ambled by me, not adhering to the 6 feet social distancing requirement. A friend has stopped shopping at Remark as their staff do not wear masks and don't social distance as the aisles there are quite narrow.

About 5 weeks ago Rebecca Zandbergen on CBC Radio's London Morning program questioned Dr. Brian Fisman, Professor of Epidemiology at the University of Toronto Dalla Lana School of Public Health on Dr. Mackie's lukewarm stance to the seriousness of COVID-19 and the need to introduce precautionary measures. Dr. Fisman said, "He has some funny ideas. He needs to start looking at the data."

Dr. Mackie said that "If we do reach higher disease levels at or near the peak levels we saw in April then we will certainly reconsider the order to more, all the way up to indoor spaces." Dr. Mackie's reactionary timing will put more medical front line workers in jeopardy and would cause those with cancelled elective surgeries to anxiously wait longer as more COVID-19 cases fill hospital beds.

Mandating mandatory masks in London-Middlesex is the right thing to do as an added proactive and precautionary layer to help us not go back to lockdown as we open up the economy and prepare for Stage 3. Going back to lockdown would increase the City's and Middlesex County's already high debt load. Please don't be so short sighted. We can't rule out a second wave.

I look forward to your response.

Sincerely,

[redacted]

Elizabeth Milne

From: [redacted]
Sent: Thursday, July 16, 2020 10:52 PM
To: Elizabeth Milne
Subject: Mandatory masks - a request for thoughtful consideration and prompt action

Dear Ms. Milne,

Could you kindly forward this strong request to the Middlesex London Health Unit Board Members at your earliest convenience?

Your cooperation is highly appreciated.

Dear Board Members of the Middlesex London Health Unit:

I am contacting you to ask that you use your leadership to influence **mandating the use of masks in indoor public spaces** in our community to help fight COVID-19. This is especially crucial now, as we begin Stage 3 of reopening businesses.

There is enough evidence that masks can limit the spread of droplets and aerosols entering into the surrounding environment. Health Canada, the CDC, and the WHO have long recommended the use of masks in places where physical distancing is difficult, such as inside stores.

The Middlesex-London Health Unit (MLHU) is among only a few regions (of the 34 Health Units in Ontario), to not mandate this essential safety measure. Currently in London masks are only 'recommended'. This approach to masking is not working, as not enough Londoners are wearing them. This poses an increased risk for our entire community.

We appreciate that currently our COVID-19 numbers are low, but we need to be proactive and do all that we can to keep them that way, especially as we enter Stage 3.

Sincerely,

[redacted]

Elizabeth Milne

From: [redacted]
Sent: Thursday, July 16, 2020 3:13 PM
To: Elizabeth Milne
Subject: Masks indoors at public places

Dear Ms. Milne: I am contacting you to ask that you use your leadership to influence **mandating the use of masks in indoor public spaces** in our community to help fight COVID-19. This is especially crucial now, as we begin Stage 3 of reopening businesses.
There is enough evidence that masks can limit the spread of droplets and aerosols entering into the surrounding environment. Health Canada, the CDC, and the WHO have long recommend the use of masks in places where physical distancing is difficult, such as inside stores.

The Middlesex-London Health Unit (MLHU) is among only a few regions (of the 34 Health Units in Ontario), to not mandate this essential safety measure. Currently in London masks are only 'recommended'. This approach to masking is not working, as not enough Londoners are wearing them. This poses an increased risk for our entire community.

We appreciate that currently our COVID-19 numbers are low, but we need to be proactive and do all that we can to keep them that way, especially as we enter Stage 3.
Please forward to all Board Members. Thank you.

[redacted]

Elizabeth Milne

From: [redacted]
Sent: Thursday, July 16, 2020 8:19 AM
To: Elizabeth Milne
Subject: London needs mandatory indoor mask mandate

Dear Ms Milne,

Please pass this message to the Board members of the London Health Unit: London needs a mandatory indoor mask mandate.

Taiwan, with a population of almost 24 million people, has had only 7 deaths from COVID 19 since January because everyone wears a mask indoors, and whenever social distancing is not possible; along with other protocols. There is need for protection, not lack of it. The statistics are clear in Canada, and around the world. Where masks are NOT worn, the disease spreads.

What benefit can there be to not placing this protocol in place? This concerned citizen requests a mandatory indoor mask mandate.

Thank you for your consideration of this serious concern.

Sincerely,

[redacted]

Elizabeth Milne

From: [redacted]
Sent: Thursday, July 16, 2020 12:03 AM
To: Elizabeth Milne
Subject: Mandatory masking from a home mask maker

Dear Elizabeth Milne,

Could you please ensure that my email (below) is forwarded to ALL Board members of the Middlesex-London Health Unit. Thank you in advance.

[redacted]

Dear Middlesex-London Health Unit Board Members,

I was disappointed to learn on the news tonight that Dr. Chris Mackie is only **recommending** the use of masks in indoor public spaces instead of **mandating** them. I started making masks early on and have a special interest in watching people everywhere I go to see if they are abiding by this recommendation. I would say that they are not. Now that we are set to enter Stage 3 there will be an increased risk for Londoners, particularly at a time when many are becoming more complacent due to fatigue and a false sense of security, particularly the young.

Worldwide, the general recommendation to wear masks was a long time coming despite how obvious it seemed that it helped reduce coronavirus emissions. Just think where we might have been in the pandemic had people been encouraged to wear them earlier. In the same way, I think the time is already here to make masking mandatory in the London area, not down the road after the inevitable spikes increase suffering for people (and affect the economy if things had to tighten up again).

Please bring your influence to bear on Dr. Mackie to change his recommendation to an official mandate to help keep us safe. Lives depend on this measure.

Thank you for your time,

Sincerely,

[redacted]