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

Thursday, May 19 , 2022, 7:00 p.m.
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
Ms. Aina DeViet
Mr. John Brennan
Ms. Kelly Elliott
Ms. Mariam Hamou
Mr. Matt Reid
Mr. Mike Steele
Ms. Tino Kasi
Mr. Selomon Menghsha
Dr. Alexander Summers (Medical Officer of Health, ex-officio member)
Ms. Emily Williams (Chief Executive Officer, ex-officio member)

SECRETARY

Ms. Emily Williams

TREASURER

Ms. Emily Williams

DISCLOSURE OF CONFLICTS OF INTEREST

APPROVAL OF AGENDA

MINUTES

Approve: April 21, 2022 – Board of Health meeting
April 28, 2022 – Special Meeting of the Board of Health

Receive: April 21, 2022 – Governance Committee meeting

Item #	Delegation	Recommendation	Information	Report Name and Number	Link to Additional Information	Overview and Lead
Reports and Agenda Items						
1			**X**	Nurse-Family Partnership Annual Report (Report No. 28-22)		To provide an annual update on the Nurse-Family Partnership. Leads: Ms. Heather Lokko, Director, Healthy Start/Chief Nursing Officer and Ms. Lindsay Croswell, Community Health Nursing Specialist
2			**X**	MLHU 2022 Infectious Disease Control Operational Update (Report No. 29-22)	Appendix A	To provide an update on the Infectious Disease Control Team operational plan. Leads: Ms. Mary Lou Albanese, Director, Environmental Health and Infectious Diseases and Mr. Jordan Banninga, Manager, Infectious Disease Control
3			**X**	Opioid Crisis Update (Report No. 30-22)	Appendix A	To provide an update on the opioid crisis and response in London and Middlesex County. Leads: Ms. Mary Lou Albanese, Director, Environmental Health and Infectious Diseases and Ms. Shaya Dhinsa, Manager, Sexual Health
4			**X**	MLHU School Team's Return to School Health Work (Report No. 31-22)		To provide an update on the School Health Team's work as it returns to schools. Leads: Ms. Maureen MacCormick, Director, Healthy Living, Ms. Anita Cramp, Manager, Young Adult, and Mr. Darrell Jutzi, Manager, Child Health

5			**X**	County of Middlesex Official Plan Review Submission (Review No. 32-22)	Appendix A	To inform the Board of Health about a submission by MLHU to the County of Middlesex with regards to their Official Plan Review. Leads: Ms. Maureen MacCormick, Director, Healthy Living and Ms. Rhonda Brittan, Manager, Healthy Communities and Injury Prevention
6			**X**	Verbal Funding Update		To provide an update on funding. Leads: Ms. Emily Williams, Chief Executive Officer and Mr. Dave Jansseune, Assistant Director of Finance
7	**X**		**X**	Verbal COVID-19 Disease Spread and Vaccine Campaign Update		To provide an update on COVID-19 matters. Lead: Dr. Alexander Summers, Medical Officer of Health
8			**X**	Medical Officer of Health Activity Report for April (Report No. 33-22)		To provide an update on external and internal meetings attended by the Medical Officer of Health since the last Board of Health meeting. Lead: Dr. Alexander Summers, Medical Officer of Health
9			**X**	Chief Executive Officer Activity Report for April (Report No. 34-22)		To provide an update on external and internal meetings attended by the Chief Executive Officer since the last Board of Health meeting. Lead: Ms. Emily Williams, Chief Executive Officer

Correspondence						
10		**X**	**X**	May 2022 Correspondence		To receive item a).

OTHER BUSINESS

The next meeting of the Middlesex-London Board of Health is Thursday, June 16 at 7:00 p.m.

CONFIDENTIAL

The Middlesex-London Board of Health will move into a confidential session to approve previous confidential Board of Health minutes and to discuss matters which pertain to one or more of the following, as per section 239(2) of the *Municipal Act, 2001, S.O. 2001, c. 25*:

(a) the security of the property of the municipality or local board;

(b) personal matters about an identifiable individual, including municipal or local board employees;

(c) a proposed or pending acquisition or disposition of land by the municipality or local board;

(d) labour relations or employee negotiations;

(e) litigation or potential litigation, including matters before administrative tribunals, affecting the municipality or local board;

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

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

(h) information explicitly supplied in confidence to the municipality or local board by Canada, a province or territory or a Crown agency of any of them;

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

(j) a trade secret or scientific, technical, commercial or financial information that belongs to the municipality or local board and has monetary value or potential monetary value; or

(k) a position, plan, procedure, criteria or instruction to be applied to any negotiations carried on or to be carried on by or on behalf of the municipality or local board.

ADJOURNMENT

PUBLIC SESSION – MINUTES
MIDDLESEX-LONDON BOARD OF HEALTH

Thursday, April 21, 2022, 7:00 p.m.
Microsoft Teams

MEMBERS PRESENT:
Mr. Matt Reid (Chair)
Ms. Kelly Elliott (Vice-Chair)
Mr. John Brennan
Mr. Mike Steele
Mr. Selomon Menghsha (joined at 7:18 p.m.)
Ms. Mariam Hamou
Ms. Maureen Cassidy
Ms. Aina DeViet
Ms. Tino Kasi

OTHERS PRESENT:
Ms. Carolynne Gabriel, Executive Assistant to the Board of Health and Communications Coordinator (Recorder)
Dr. Alexander Summers, Medical Officer of Health
Ms. Emily Williams, Chief Executive Officer/Director, Health Organization
Ms. Stephanie Egelton, Executive Assistant, Medical Officer of Health and Associate Medical Officer of Health
Ms. Heather Lokko, Director, Healthy Start/Chief Nursing Officer
Ms. Maureen MacCormick, Director, Healthy Living
Ms. Cynthia Bos, Manager, Human Resources
Ms. Lilka Young, Health and Safety Advisor
Ms. Linda Stobo, Manager, Chronic Disease Prevention and Tobacco Control
Ms. Alison Locker, Manager, Public Health Assessment and Surveillance
Ms. Tracey Gordon, Manager, Vaccine Preventable Diseases
Mr. Dan Flaherty, Communications Manager
Mr. Alex Tyml, Online Communications Coordinator, Communications
Mr. Parthiv Panchal, Information Technology, End User Support Analyst

Chair Matt Reid called the meeting to order at **7:02p.m.**

DISCLOSURE OF CONFLICT OF INTEREST

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

APPROVAL OF AGENDA

It was moved by **Ms. Maureen Cassidy, seconded by Ms. Aina DeViet,** *that the **AGENDA** for the April 21, 2022 Board of Health meeting be approved.*

Carried

APPROVAL OF MINUTES

It was moved by **Ms. Kelly Elliott, seconded by Ms. Mariam Hamou,** *that the **MINUTES** of the March 17, 2022 Board of Health meeting be approved.*

Carried

It was moved by **Ms. Cassidy, seconded by Mr. John Brennan,** *that the **MINUTES** of the April 7, 2022 Finance & Facilities Committee meeting be received.*

Carried

REPORTS AND AGENDA ITEMS

Finance & Facilities Committee Meeting Summary from April 7, 2022 (Report No. 20-22)

Mr. Mike Steele, Chair, Finance and Facilities Committee provided a summary of the proceedings of the April 7, 2022 Finance and Facilities Committee meeting. The Finance and Facilities Committee received five (5) reports from staff.

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

1) *Receive Report No. 06-22FFC, re: "Cyber Security Training" for information;*
2) *Receive Report No. 07-22FFC, re: "Financial Borrowing Update" for information;*
3) *Receive Report No. 08-22FFC, re: "2021 Vendor and VISA Payments" for information;*
4) *Receive Report No. 09-22FFC, re: "2021 Board of Health Remuneration" for information; and*
5) *Receive Report No. 10-22FFC, re: "Q4 Financial Update and Factual Certificate" for information.*

Carried

Mr. Steele updated the Board of Health that the May Finance and Facilities Committee meeting has been cancelled. The next meeting of the Finance and Facilities Committee will occur the first Thursday in June.

Verbal Governance Committee Meeting Summary from April 21, 2022

Ms. Aina DeViet, Chair, Governance Committee provided a summary about the proceedings of the April 21, 2022 Governance Committee meeting, which had four (4) reports presented.

It was moved by **Ms. DeViet, seconded by Ms. Cassidy**, *that the Board of Health receive Report No. 05-22GC, re: "2021 Occupational Health and Safety Report" for information.*

Carried

It was noted that the Governance Committee moved to make the MOH and CEO Performance Review Committee a standing committee instead of an ad hoc committee.

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

1) *Receive Report No. 06-22GC, re: "Governance By-law and Policy Review" for information*
2) *Direct Staff to evenly distribute the governance by-laws and policies to be reviewed over a two-year period.*
3) *Approve the governance policies appended to Report No. 06-22GC.*

Carried

It was moved by **Ms. DeViet, seconded by Mr. Steele**, *that the Board of Health approve the MOH and CEO Performance Review Committee as a standing committee and direct staff to develop the Terms of Reference and reporting calendar for the committee.*

Carried

It was moved by **Ms. DeViet, seconded by Mr. Steele**, *that the Board of Health receive Report No. 07-22GC, re: "2021-22 Provisional Plan Update" for information.*

Carried

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

1) *Receive Report No. 08-22GC, re: "MLHU Q1 2022 Risk Register" for information.*
2) *Approve the Q1 2022 Risk Register (Appendix A to Report No. 08-22GC).*

Carried

Canadian Public Health Week 2022 at Middlesex-London Health Unit (Report No. 21-22)

This report was introduced by Dr. Alexander Summers, Medical Officer of Health. Dr. Summers articulated that the report outlines a real highlight for the Health Unit with the inaugural Canadian Public Health Week happening this year. To celebrate, events were held for staff of MLHU and social media was used to promote the week to the public. A highlight of the week was a coffee break which occurred on the Friday and was in-person for staff as well as attended by some Board of Health members, the Mayor of London, and the Warden of Middlesex County.

The appendix to the report outlines initiatives and activities from across the organization. This information was used to inform staff trivia and social media posts, as well as highlight the work of the organization for the Board of Health.

Ms. Williams stated that, as someone who joined the organization during the COVID-19 pandemic, the coffee break was a chance to meet staff face-to-face and the week was truly a celebration of the work of public health.

It was moved by **Ms. Cassidy, seconded by Ms. DeViet,** *that the Board of Health receive Report No. 21-22 re: "Canadian Public Health Week 2022 at Middlesex-London Health Unit" for information.*

Carried

Feedback on Vaping-Related Provisions of the *Tobacco and Vaping Products Act* (Report No. 22-22)

This report was introduced by Ms. Maureen MacCormick, Director, Healthy Living who introduced Ms. Linda Stobo, Manager, Chronic Disease Prevention and Tobacco Control.

Discussion on this report included:

- At the time the *Tobacco and Vaping Products Act (TVPA)* was passed, evidence around vaping and its health effects was new. To address this, it was included in the legislation that a review would be conducted three years after the enactment of the Act and every two years thereafter. This provides an opportunity to review the evidence on an ongoing basis and determine any changes to ensure the protection of the population.
- Since the enactment of the legislation, a lot more evidence has become available which is concerning, including evidence of harms to respiratory and circulatory systems and significant concerns regarding dual use of vapour products and cigarettes.
- There is also evidence of confusion by the public with regards to the safety of vapour products. When vapour products first became widely available, it was thought they could be a cessation aid for those addicted to tobacco products; however, the way vapour products are regulated as a commodity and not as a cessation aid is not in alignment with the evidence on how vapour products could potentially help with cessation.

- The Middlesex-London Health Unit and the Southwest Tobacco Control Area Network have drafted submissions with recommendations for the Tobacco Control Directorate in response to their request for public input. These submissions on Appendix A and B.
- Since the drafting of these submissions, the Federal Government announced in the 2022 budget the enactment of a federal tax regime for vaping products, as well as a framework for provinces to follow suit which would complement the federal tax regime. This announcement addresses one of the recommendations in the submissions.
- There has been a rapid growth in the marketplace even beyond expectations from 2019-2020. The retail landscape has increased, especially online sales which are harder to enforce.
- Youth feedback to MLHU Enforcement Officers is that vapour products are very easy to obtain, and they believe vaping is safer than using cigarettes.
- Ms. Cassidy articulated that some tactics to sell vapour products seem predatory, similar to historical practices to promote cigarettes. Ms. Stobo noted that many large vapour companies are owned by the tobacco industries, and that records show that tobacco companies see vapour products as an opportunity to hook people on nicotine in a new way as tobacco use is declining. This will require public health to re-do some of the work done in the past to reduce the burdens of tobacco by reframing it as nicotine addiction.
- Ms. Hamou inquired if the Health Unit sees educating parents as a strategy for mitigating the use of vapour products in youth. Ms. Stobo indicated that the Middlesex-London Health Unit is working with School Board partners to work on vapour product use in schools. The Chronic Disease Prevention Team is working closely with the Child Health and Young Adult Teams working in schools. Work initiated in 2019 and early 2020 were interrupted due to the pandemic, but work is resuming. Possible activities are reaching parents through schools with information to have conversations with their children.
- Dr. Summers noted that the fight against the harms of tobacco have made the careers of many medical officers of health and public health staff, and this will continue with the emergence of vapour products. The work of public health to mitigate the burden of tobacco and vapour products will be upstream and a cornerstone of public health going forward.

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

1) *Receive Report No. 22-22 re: "Feedback on Vaping-Related Provisions of the Tobacco and Vaping Products Act" for information;*
2) *Endorse and submit feedback prepared by Middlesex-London Health Unit staff, attached as Appendix A, to the Tobacco Control Directorate of Health Canada, expressing its support and providing its perspective on the operation of the vaping-related provisions of the Tobacco and Vaping Products Act (TVPA); and,*
3) *Endorse and submit feedback prepared by the Southwest Tobacco Control Area Network, attached at Appendix B, to the Tobacco Control Directorate of Health Canada, on behalf of the seven public health units in southwestern Ontario.*

Carried

Update of Urban and Rural Health Indicators within the Middlesex-London Region (Report No. 23-22)

This report was introduced by Dr. Summers who introduced Ms. Alison Locker, Manager, Population Health Assessment and Surveillance.

Dr. Summers shared a PowerPoint presentation.

Discussion on this report included:

- The Middlesex-London Health Unit has previously assessed population health outcomes across different strata of demographic variables, including urban versus rural settings as the risk and health outcomes can differ between regions.

- In February 2020, the Health Unit provided a comparison of health indicators between urban (City of London) and rural (Middlesex County) populations.
- The current report is intended to provide a brief update on this data. The data used for this report is also from 2020 and is from emergency department visits. No new mortality or behavioural risk factor data is available.
- The three indicators for which there is comparative data between the report in 2020 and the current report are emergency department visits for falls, motor vehicle collisions, and opioid poisonings.
- In the report from 2020, the rate of falls and motor vehicle collisions were higher in rural settings than in urban settings while the rate of opioid poisonings was higher in urban settings than rural.
- Using the most up-to-date data, there were not changes in the patterns.
    - Regardless of the year, the rates of falls are significantly higher in rural settings than in urban. There was a decline in both rural and urban settings in 2020, likely due to pandemic public health measures which restricted movement.
    - Motor vehicle collisions continued to be higher in rural settings than urban settings. Similar to falls, there was a sharp drop in 2020, likely due to pandemic public health restrictions
    - The rate of opioid poisonings continued to be higher in urban settings as compared to rural settings. Unlike falls and motor vehicle collisions, the rates in both settings continued to increase year over year with no large decline due to the pandemic.
- Caution is necessary when interpreting data from one year as the trends seen in 2020 may or may not be sustained in the future.
- MLHU will continue to monitor, assess, and report on relevant indicators as they inform interventions and planning. While mortality data has not been updated since 2015, it is anticipated that there will be new data released. As the largest three mortality indicators (ischemic heart disease, dementia and Alzheimer disease, and lung cancer) are generational issues, is it not anticipated that rate will have changed drastically over five years. The Health Unit is currently providing ongoing interventions to reduce chronic disease indicators; however, the impact of these interventions may not be seen for years to come.
- Ms. DeViet inquired how changing community demographics (e.g. people moving from urban settings to more rural communities) is taken into consideration when analyzing and interpreting data trends and using the data to inform interventions. Dr. Summers noted this question speaks to the challenges of measuring health outcomes like lung disease where the exposures that result in the health outcome accumulate over a lifetime, regardless of any movement over the lifetime. It also speaks to the importance of collecting multiple sociodemographic data points to help with interpreting mortality data to help determine contributing factors. Additionally, the challenges with interpreting data speaks to the need to use both population health assessment and surveillance data but also community consultations and demographic forecasting.

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

1) *Receive Report No. 23-22, re: "Update of Urban and Rural Health Indicators within the Middlesex-London Region" for information; and,*
2) *Direct staff to provide a summary of this report to Middlesex County Council.*

Carried

MLHU 2022 Vaccine Preventable Diseases Operational Plan (Report No. 24-22)

This report was introduced by Ms. Mary Lou Albanese, Director, Environmental Health and Infectious Diseases who introduced Ms. Tracey Gordon, Manager Vaccine Preventable Diseases.

Discussion on this report included:

- Prior to the COVID-19 pandemic, the Vaccine Preventable Diseases Team (VPD) was very busy, with the majority of the work focused on school-aged children receiving the mandated and recommended vaccines as indicated in the Ontario Publicly Funded Vaccine Schedule and *Immunizations School Pupils Act*, as well as managing programs prescribed under the Ontario

Public Standards, including the distribution of the annual influenza vaccine and monitoring vaccine adverse effects.

- Due to the COVID-19 pandemic and the introduction of the COVID-19 vaccines, VPD has had to modify its operational plan in order to continue to offer the COVID-19 vaccine in addition to providing its already existing programs.
- The strategy within the Operational Plan is to maintain the COVID-19 vaccination clinics at their baseline levels while leveraging those resources to administer non-COVID-19 Ontario publicly funded vaccines to school-aged children.
- The focus on providing the COVID-19 vaccine during the pandemic has resulted in a decrease in the vaccination of school-aged children with all required and recommended publicly funded vaccines. The plan is to leverage additional resources through COVID-19 funding as well as periodic down time in the COVID-19 vaccination clinics to focus on screening school-aged children for overdue vaccines. By the end of 2022, the hope is to have screened all children from junior kindergarten to grade 12. After just over three weeks, the team has screened and sent letters to over 17 000 overdue grade 9 to grade 12 students as well as 6000 junior kindergarten students.
- MLHU will continue to offer two mass vaccination sites, one in the County at the Caradoc Community Centre, and one in the city of London at the Western Fair District Agriplex. In parallel with these clinics, mobile clinics will continue to be offered, focusing on areas with lower vaccination rates. The provincial GO-Vaxx bus is also being leveraged to assist in providing clinics both in the County and London. Another team is going to all schools to provide non-COVID-19 vaccines as part of the regular grade 7 vaccination program.
- Leaders and staff at mass vaccination clinics are being trained to administer all school-aged vaccines. Students will be able to book appointments for these vaccines at the Caradoc Community Centre clinic every Monday and at the Agriplex clinic every Wednesday, Friday, and Saturday starting May 2, 2022. Online bookings for the school-aged vaccines were opened over a week ago and over 220 students are booked in the first two weeks. COVID-19 vaccine will continue to be offered every day the mass vaccination clinics are open.
- Ms. Cassidy inquired if the clinic at the Western Fair District Agriplex will continue to be available, recognizing that the Western Fair is being planned for this fall. Ms. Gordon noted that recently in April, the mass vaccination clinic at the Agriplex moved from the larger space into the horse arena which is a smaller space. This will permit the clinic to continue to run even as other events are being held at the Agriplex.

It was moved by **Ms. Hamou, seconded by Ms. Elliott**, *that the Board of Health receive Report No. 24-22, re: "MLHU 2022 Vaccine Preventable Diseases Operational Plan" for information.*

Carried

Verbal COVID-19 Disease Spread and Vaccine Campaign Update

Dr. Summers provided a verbal update and shared a PowerPoint presentation.

Discussion on this update included:

- In Ontario, cases of COVID-19 continue to increase among those eligible for testing, but the rate is slowing. There has been some indication over the past four to five days that cases and transmission may be plateauing. Additionally, the percent-positivity also appears to be plateauing. Wave 6 hospitalization rates are trending upward; however, they are not nearly as high as first Omicron wave. Additionally, the proportion BA.2 subvariant COVID-19 cases identified continues to increase and this strain will quickly become the dominant strain in the province.
- Across the world, there continues to be substantial COVID-19 activity, but it is starting to decline.
- Ontario, Quebec, Manitoba, Alberta, and the USA are all seeing a plateauing of the Omicron wave. This may be due to populations reaching a temporary state of herd immunity, which means that enough of the population has either been infected with COVID-19 or vaccinated that the virus is unable to be transmitted to people who are easily infected. As a result of vaccination, there is a

lower rate of mortality and even though there are higher cases than previous waves, cases are more are mild or asymptomatic

- Dr. Summers believes that Wave 6 has likely peaked or very nearly peaked, although the recent long weekend may cause an increase.
- The increase in cases and transmission of COVID-19 in Wave 6 was expected. As the province came out of Wave 5, there was a rolling back public health protections which meant there would be an increase in cases and transmission. What was unknown was how much the cases would increase, which would depend on previous infection rates and immunization. A notable bump in cases was experienced as, with protections lifted, there was increased mobility outside of homes. People are still moderating their out-of-home mobility, but it differs among people as everyone has different risk levels.
- Wastewater testing is suggesting a decline which is indicative of plateauing.
- Hospitalizations, ICU rates, and deaths are lagging indicators, and are not expected to plateau yet.
- The one major limit for the health care system during this sixth wave isn't the case numbers, but the staffing with staff getting or being close contacts of COVID-19 cases. The rate of staff absenteeism due to COVID-19 is starting to plateau.
- Percent-positivity in Southwestern Ontario, including in Middlesex-London is also declining.
- A single vital sign doesn't count for much when interpreting the data; however, when taking into consideration multiple indicators, it is suggestive that cases in Middlesex-London are truly plateauing.
- The COVID-19 vaccine allowed for tolerating rates as high as occurred in Wave 5. Without the vaccine the impact on human suffering, death, and health care capacity would have been profound.
- The risk to the community of transmitting or being exposed to COVID-19 continues to be high. Booster doses are encouraged.
- When making plans, individuals should consider their personal health and risk but also the vulnerabilities of those around them.
- Ms. Cassidy inquired how those who are vulnerable can be protected, especially when they are in the community and not a high-risk setting like long-term care homes where there are still some restrictions. Dr. Summers indicated that when considering the risk of severe outcomes from COVID-19 and any other infectious disease, it is considered how to optimize the immune protection of that individual and also how to reduce the risk of exposure. Those two domains have different strategies. To optimize the immune protection, individuals are vaccinated, for example the availability of fourth dose boosters for those 60 years of age or older. To reduce potential exposure, individuals can wear masks. Individuals and their families can also make decisions about what environments they will go into given the community risk, including those who are more vulnerable who may wish to avoid higher risk settings and activities.
- Mr. Steele inquired how effective wearing a mask is for protecting the person wearing the mask when in a larger group where others are not wearing masks. Dr. Summers indicated that wearing a mask may mitigate the risk of COVID-19 for the person wearing the mask by five to 20 per cent with an N95 respirator having a slightly larger reduction in risk than a cloth or medical mask because of the fit.

It was moved by **Ms. Cassidy, seconded by Mr. Selomon Menghsha,** *that the Board of Health receive the Verbal update re: "COVID-19 Disease Spread and Vaccine Campaign" for information.*

Carried

Medical Officer of Health Activity Report for March (Report No. 25-22)

Dr. Summers provided an overview of his activities since the March 17, 2022 Board of Health meeting.

It was moved by **Ms. Hamou, seconded by Mr. Brennan,** *that the Board of Health receive Report No. 25-22 re: "Medical Officer of Health Activity Report for March" for information.*

Carried

Chief Executive Officer Activity Report for March (Report No. 26-22)

Ms. Williams provided an overview of her activities since the March 17, 2022 Board of Health meeting.

It was moved by **Ms. Cassidy, seconded by Ms. Hamou,** *that the Board of Health receive Report No. 26-22 re: "Chief Executive Officer Activity Report for March" for information.*

Carried

CORRESPONDENCE

It was moved by **Ms. Cassidy, seconded by Ms. Tino Kasi,** *that the Board of Health receive items a) and c) for information and to endorse items b) and d).*

Carried

OTHER BUSINESS

The next meeting of the Middlesex-London Board of Health is a Special Meeting of the Board of Health on Thursday, April 28, 2022 at 6:00 p.m.

The next regular meeting of the Middlesex-London Board of Health is Thursday, May 19 at 7:00 p.m.

CONFIDENTIAL

At **8:35 p.m.,** it was moved by **Ms. Elliott, seconded by Ms. Hamou,** *that the Board of Health will move in-camera to approve previous confidential Board of Health minutes and to consider matters regarding labour relations or employee negotiations and personal matters about identifiable individuals, including municipal or local board employees.*

Carried

At **9:24 p.m.,** it was moved by **Ms. Hamou, seconded by Mr. Steele,** *that the Board of Health return to public session from closed session.*

Carried

ADJOURNMENT

At **9:24 p.m**., it was moved by **Ms. Cassidy, seconded by Ms. Kasi,** *that the meeting be adjourned.*

Carried

MATT REID
Chair

EMILY WILLIAMS
Secretary

PUBLIC SESSION – MINUTES
MIDDLESEX-LONDON BOARD OF HEALTH

Thursday, April 28, 2022, 6:00 p.m.
MLHU Board Room – CitiPlaza
355 Wellington St. London, ON, N6A 5L7

MEMBERS PRESENT:	Mr. Matt Reid (Chair) Ms. Kelly Elliott (Vice-Chair) Mr. John Brennan Mr. Mike Steele Mr. Selomon Menghsha (vis MS Teams) Ms. Maureen Cassidy Ms. Aina DeViet Ms. Tino Kasi (via MS Teams)
REGRETS:	Ms. Mariam Hamou
OTHERS PRESENT:	Ms. Carolynne Gabriel, Executive Assistant to the Board of Health and Communications Coordinator (Recorder) Dr. Alexander Summers, Medical Officer of Health Ms. Emily Williams, Chief Executive Officer/Director, Health Organization Ms. Stephanie Egelton, Executive Assistant, Medical Officer of Health and Associate Medical Officer of Health Ms. Heather Lokko, Director, Healthy Start/Chief Nursing Officer Ms. Mary Lou Albanese, Director, Environmental Health and Infectious Diseases Ms. Kendra Ramer, Manager, Strategy, Risk and Privacy

Chair Matt Reid called the meeting to order at **6:05 p.m.**

DISCLOSURE OF CONFLICT OF INTEREST

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

APPROVAL OF AGENDA

It was moved by **Ms. Aina DeViet, seconded by Ms. Kelly Elliott,** *that the **AGENDA** for the April 28, 2022 Special Meeting of the Board of Health.*

Carried

CONFIDENTIAL

At **6:06 p.m.,** it was moved by **Mr. Michael Steele, seconded by Mr. John Brennan,** *that the Board of Health will move in-camera for the purpose of educating or training the members.*

Carried

At **8:01p.m.,** it was moved by **Ms. DeViet, seconded by Ms. Tino Kasi,** *that the Board of Health return to public session from closed session.*

Carried

ADJOURNMENT

At **8:01p.m**., it was moved by **Ms. Kasi, seconded by Ms. Maureen Cassidy,** *that the meeting be adjourned.*

Carried

MATT REID	**EMILY WILLIAMS**
Chair	**Secretary**

PUBLIC MINUTES
GOVERNANCE COMMITTEE
Microsoft Teams
Thursday, April 21, 2022 6:00 p.m.

MEMBERS PRESENT: Ms. Aina DeViet (Chair)
Mr. Matt Reid
Ms. Kelly Elliott
Mr. Mike Steele
Ms. Tino Kasi (joined 6:03 p.m.)

OTHERS PRESENT: Ms. Carolynne Gabriel, Executive Assistant to the Board of Health (Recorder)
Dr. Alexander Summers, Medical Officer of Health
Ms. Emily Williams, Chief Executive Officer
Ms. Kendra Ramer, Manager, Strategy, Risk and Privacy
Ms. Cynthia Bos, Manager, Human Resources
Ms. Lilka Young, Health and Safety Advisor
Ms. Mariam Hamou, Member, Board of Health

At **6:00 p.m.,** Chair Aina DeViet called the meeting to order.

DISCLOSURES OF CONFLICT OF INTEREST

Chair DeViet inquired if there were any disclosures of conflict of interest. None were declared.

APPROVAL OF AGENDA

It was moved by **Mr. Michael Steele, seconded by Mr. Matt Reid,** *that the **AGENDA** for the April 21, 2022 Governance Committee meeting be approved.*

Carried

APPROVAL OF MINUTES

It was moved by **Ms. Kelly Elliott, seconded by Mr. Steele,** *that the **MINUTES** of the February 17, 2022 Governance Committee meeting be approved.*

Carried

NEW BUSINESS

2021 Occupational Health and Safety Report (Report No. 05-22GC)

This report was introduced by Ms. Cynthia Bos, Manager, Human Resources who introduced Ms. Lilka Young, Health and Safety Advisor.

Discussion on this report included:

- Over the course of 2021, there were 77 employee-reported incidents, a 126% increase from 2020. Possible contributing factors to this increase are the increase in workforce and the promotion of the incident reporting platform conducted during the weekly staff virtual townhalls, which increased awareness of the platform and encouraged staff to report incidents.

- The top three types of incidences reported were violence, struck with/caught by/contact with, and slips/trips/falls.
- All incidents of violence were workplace violence; no cases of domestic violence were disclosed. Of the workplace violence, the incidents were client-to-worker and cases of aggression and verbal or written threats; no MLHU staff members were injured or physically assaulted. A trend of workplace violence against health care workers has been seen globally over the course of the pandemic.
- Examples of struck with/caught by/contact with incidents are contact with sharp edges or pinch points.
- Incidents in slips/trips/falls potentially could be attributed to more work sites with the vaccination clinics, which resulted in more scenarios, for example slipping out of chairs at a clinic. Slipping on ice was also a factor.
- There were five (5) employee needle stick incidents reported and an additional five (5) by non-employees seconded from partner agencies to support the vaccine effort. As the COVID-19 vaccination clinics provided over one million doses, the number of needle stick injuries is not surprising.
- There were two (2) incident investigations into root causes, one for a critical injury and another for a needle stick injury.
- A large focus of 2021 for Occupational Health and Safety was supporting the COVID-19 vaccination effort, including the opening and operation of several COVID-19 vaccination clinics. The Occupational Health and Safety Program was integrated into the planning, operations, and logistics of the clinics and supported training, ensuring proper personal protective equipment, safe workstation set-up, and safety measures for receiving the vaccine.
- The Joint Occupational Health and Safety Committee (JOHSC) increased from nine to 12 members to assist with additional COVID-19 vaccine clinic worksite inspections.
- The Employee Immunization Program was transitioned from Vaccine Preventable Diseases to Occupational Health and Safety, which had an additional workload due to an increase in MLHU staff and additional recording requirements for COVID-19 vaccines.
- Occupational Health and Safety has taken a leadership role in the Be Well program, which is the Health Unit's internal wellness program. Among the accomplishments of Be Well was the launching of a staff membership portal with Employee Wellness Solutions Network.
- The rate of violence incidents in 2022 is trending similar to 2021 with verbal threats and aggression. Safety plans are put in place as appropriate.
- It was noted by Ms. DeViet that two incident types continue to increase year-over-year, motor vehicle incidents and violence, while all others declined in 2020.

It was moved by **Ms. Elliott, seconded by Mr. Reid,** *that the Governance Committee make a recommendation to the Board of Health to receive Report No. 05-22GC, re: "2021 Occupational Health and Safety Report" for information*.

Carried

Governance By-Law and Policy Review (Report No. 06-22GC)

This report was introduced by Ms. Emily Williams, CEO who outlined the changes to the five (5) policies which were appended to the report.

The policies under review were:

- G-020 MOH and CEO Direction
- G-040 MOH and CEO Selection and Succession Planning
- G-290 Standing and Ad Hoc Committees
- G-380 Conflicts of Interest and Declaration

- G-410 Board Member Remuneration and Expenses

The proposed changes to the policies were outlined in Appendix A.

Discussion on this report included:

- G-020 MOH and CEO Direction: the proposed change was to remove the section of the policy which specifically lists the duties of the roles and instead maintain reference to policy G-030 MOH and CEO Position Descriptions.
- G-040 MOH and CEO Selection and Succession Planning: the proposed change was that, in the event the CEO is temporarily unable to fulfill their position (vacation, short leave of absence) the Assistant Director, Finance shall temporarily be in charge of the daily operations and perform the CEO's duties. It was also suggested that the Transition and Selection Committee shall consider appointing a senior leader in an acting role to fulfill a permanent position for either role.
- G-290 Standing and Ad Hoc Committees: it was suggested by a member of the Governance Committee to make the MOH and CEO Performance Appraisal Committee a standing committee instead of an ad hoc committee; however, recommendation from staff was to keep it as an ad hoc committee as it is responsible for the completion of only one (1) task.
    - Mr. Reid suggested that the committee be a standing committee with members and a calendar decided at the inaugural January Board of Health meeting so the committee and its duties are not forgotten later in the year. As well, as the committee is assembled every year, having it as a standing committee would provide some consistency.
    - If the committee is a standing committee it would require a Terms of Reference and reporting calendar to be completed and approved for the inaugural Board of Health meeting in January.

It was moved by **Mr. Reid, seconded by Ms. Elliott**, *that the MOH and CEO Performance Review Committee become a standing committee of the Board of Health and Terms of Reference be developed in consultation with staff.*

Carried

Further discussion on the report included:

- G-380 Conflicts of Interest and Declaration: no changes were recommended.
- G-410 Board Member Remuneration and Expenses: it was recommended by staff to remove section 1.3 which stipulates that Board members can only be paid one fee per day, regardless of how many Board-related events they attended that day. Removing this section will bring the policy in line with current and historical practice. It was acknowledged that not updating this policy to make this change would mean members of the Governance Committee would not receive remuneration for attending their meetings as they are scheduled to occur on the same day as Board of Health meetings.

It was moved by **Ms. Elliott, seconded by Mr. Steele,** *that the Governance Committee make a recommendation to the Board of Health to:*

1) *Receive Report No. 06-22GC re: "Governance By-Law and Policy Review" for information;*
2) *Direct staff to evenly distribute the governance by-laws and policies to be reviewed over a two-year period; and*
3) *Approve the governance policies appended to this report (Appendix B).*
4) *Direct staff to develop the Terms of Reference and reporting calendar for the standing MOH and CEO Performance Review Committee.*

Carried

2021-22 Provisional Plan Update (Report No. 07-22GC)

This report was introduced by Ms. Williams who introduced Ms. Kendra Ramer, Manager, Strategy Risk and Privacy.

Discussion on this report included:

- In the fourth quarter of 2021, the Board of Health approved extending the timelines for the provisional plan due to the Health Unit focusing on pandemic work.
- Over the course of the first quarter of 2022, MLHU has begun repatriating staff to their home teams which has allowed the re-initiation of projects under the Provisional Plan.
- Report No. 07-22GC outlines the projects which have been re-initiated.
- A variety of ongoing activities and tasks associated with achieving the goals identified in the Provincial Plan have been operationalized by programs and teams across the Health Unit during the pandemic.
- A detailed progress report will be prepared and presented at the next Governance Committee meeting.
- Planning is underway to determine timelines for the strategic plan development cycle for 2023.

It was moved by **Ms. Tino Kasi, seconded by Mr. Steele,** *that the Governance Committee make a recommendation to the Board of Health to receive Report No. 07-22GC, re: "2021-22 Provisional Plan Update" for information.*

Carried

MLHU Q1 2022 Risk Register (Report No. 08-22GC)

This report was introduced by Ms. Williams, who noted this report is the first of the new quarterly risk reporting process, which is different than in the past where an annual report was produced. Ms. Williams then introduced Ms. Ramer.

Discussion on this report included:

- The strategy of looking at risks on a quarterly basis and assessing mitigation strategies was the reason for shifting to quarterly reporting.
- In Q4 of 2021 there were 12 risks identified as high risk. Of those 12, seven (7) are now ranked as moderate, which means that mitigation strategies were either effective or highly effective. Three (3) of the 12 are now ranked as minor residual risks and two (2) remain at significant residual risk, particularly due to the inability to assess the mitigation strategies at this time.
- Through this new process, new risks can also be identified throughout the year. Since Q4 of 2021, one (1) medium risk and two (2) new high risks were identified in relation to political and human resource categories, which have partially effective mitigation strategies in place at this time.
- These newly identified risks will be revisited in Q2 to determine if the mitigation strategies continue to be effective or if new strategies are required.
- The medium risk of cyber security is now ranked as moderate due to training which is in place.

It was moved by **Mr. Reid, seconded by Ms. Kasi,** *that the Governance Committee make a recommendation to the Board of Health to:*

1) *Receive Report No. 08-22GC re: "MLHU Q1 2022 Risk Register" for information; and*
2) *Approve the Q1 2022 Risk Register (Appendix A).*

Carried

OTHER BUSINESS

The next meeting of the Governance Committee will be held on Thursday, June 16, 2022 at 6:00 p.m.

CONFIDENTIAL

At **6:31 p.m.,** it was moved by **Ms. Elliott, seconded by Mr. Reid,** *that the Governance Committee will move in-camera to consider matters regarding labour relations or employee negotiations and personal matters about identifiable individuals, including municipal or local board employees.*

Carried

At **6:42 p.m.,** it was moved by **Mr. Reid, seconded by Ms. Kasi,** *that the Governance Committee rise and return to public session*

Carried

ADJOURNMENT

At **6:42 p.m.** it was moved by **Mr. Reid, seconded by Ms. Kasi**, *that the meeting be adjourned.*

Carried

AINA DEVIET
Chair

EMILY WILLIAMS
Secretary

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 28-22

TO: Chair and Members of the Board of Health

FROM: Dr. Alexander Summers, Medical Officer of Health
Emily Williams, CEO

DATE: 2022 May 19

NURSE-FAMILY PARTNERSHIP ANNUAL REPORT

Recommendation

It is recommended that the Board of Health receive Report No. 28-22, re: "Nurse-Family Partnership Annual Report" for information.

Key Points

- Each year, an annual report for the five Ontario sites implementing the Nurse-Family Partnership (NFP) program is generated and submitted by MLHU to the international NFP office.
- The process significantly supports review and reflection on strengths and successes, as well as areas for improvement for the year ahead.
- Areas of focus for 2022 include information system and data/continuous quality improvement (CQI) needs, referrals, early enrollment, retention, reflective supervision, assessment of client experience, and advisory boards.

Background

The Nurse-Family Partnership® (NFP) is an evidence-based intensive home visiting program for young, low-income, first-time parents, with demonstrated positive effects on pregnancy, children's subsequent health and development, and parents' economic self-sufficiency. Since 2008, steps have been taken in Ontario and British Columbia to adapt and evaluate NFP in Canada, with MLHU involved in this work beginning in 2016. In 2019, MLHU became the provincial license holder for five Ontario public health units delivering the NFP program to high-risk clients. Results from the randomized control trial in British Columbia will be publicly available this year.

NFP is a licensed program currently delivered in eight countries (USA, Canada, England, Scotland, Northern Ireland, Bulgaria, Australia, and Norway). Maintaining fidelity to the program's 14 core model elements is critical to realizing expected outcomes. Each year, every license holder is required to submit an annual report to guide discussion of implementation successes and challenges, as well as emergent outcome variations. By using quantitative and qualitative data, the annual report supports reflection on progress and development of quality improvement plans for the following year. The international office provides guidance, research, resources and international networking to support program and quality improvement assessment, planning, and implementation.

The 2021 annual report submitted by MLHU on February 28, 2022 to the international office at the University of Colorado Denver includes information from all five sites implementing NFP in Ontario. After the annual review meeting on March 11, the international office response was received on April 21, 2022.

2021 Annual Report Summary

All sites were able to maintain moderate to significant NFP service delivery throughout 2021. Sites continued to build and improve on providing the program and connecting with one another virtually, despite challenges presented by ongoing redeployment of some staff to pandemic response. The redeployment of NFP supervisors was particularly challenging. Continued restrictions through 2021 limited in-person visits and had a significant negative impact on referral rates. The ongoing support of the Ontario NFP Nursing Practice Lead – a Community Health Nursing Specialist employed by MLHU and cost-shared between implementing sites – was critical throughout the pandemic.

In 2021, 388 clients participated in the program and a total of 4228 visits were completed. Of 182 discharges from the program, 42 percent graduated, 38 percent were considered un-addressable attrition and 14 percent were considered addressable attrition. The final four percent included transfers to other NFP sites and discontinuation in the program after child apprehension. Ontario has the highest rate internationally of enrollments generated from referrals received, at 88 percent. At intake, clients ranged in age from 15 to 24 years, with 86 percent housed securely, 45 percent enrolled in high school, 47 percent completed high school, 15 percent enrolled in post-secondary education, 27 percent participating in the workforce, and 42 percent disclosing challenges with mental illness. Fifty-five percent reported current or recent experience of intimate partner violence.

All clients participated voluntarily, were assigned a single NFP registered nurse, were visited on the standard schedule (with adjustments as needed based on the client's needs), were first-time parents, and met the socioeconomic disadvantage criteria. Three of five sites reported 100 percent compliance with completing first visits before the end of the 28th week of gestation, and there was a three percent improvement in the overall percentage of participants enrolled by 16 weeks gestation. The benchmark for reflective supervision was maintained in three out of five sites throughout the pandemic, although accompanied home visits were not. Existing advisory boards reduced or suspended meetings in 2021, and efforts to establish Community Advisory Boards in other sites were delayed. All nurses and supervisors completed the required education; in 2021, Ontario and British Columbia collaboratively planned and co-facilitated virtual NFP education for nurses and supervisors in British Columbia and Ontario. While process and outcome data collection, analysis, and reporting processes continue to improve, there were additional challenges during the pandemic and need for data support remains evident. In 2021, a SharePoint site was created to share the site data reports, improving consistency and efficiency.

As part of the annual review process, MLHU reported on Ontario's progress related to 2021 priorities and objectives agreed on with the international office. In addition to MLHU's identification of provincial priorities and areas for improvement for 2022, the international office provided feedback on areas of strength and further work. Areas of focus for NFP in Ontario for this year include, but are not limited to, addressing information system and CQI needs, increasing/re-establishing referrals, improving early enrollment and retention rates, resuming adherence to reflective supervision requirements, assessing client experience in the program, and resuming work to establish advisory boards where needed. The Ontario NFP Nursing Practice Lead is in the process of meeting with each implementing site to share annual report data, highlight areas of strength and opportunities for improvement, and begin action planning.

Conclusion

Investment in the early years is a cost-effective approach to improving population health. The Nurse-Family Partnership program continues to grow and improve in Ontario, and MLHU continues to support four other public health units in the province implementing this program. MLHU has begun to explore interest in NFP implementation amongst other health units.

This report was submitted by the Chief Nursing Officer.

Alexander Summers, MD, MPH, CCFP, FRCPC
Medical Officer of Health

Emily Williams, BScN, RN, MBA, CHE
Chief Executive Officer

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 29-22

TO: Chair and Members of the Board of Health

FROM: Dr. Alexander Summers, Medical Officer of Health
Emily Williams, Chief Executive Officer

DATE: 2022 May 19

MLHU 2022 INFECTIOUS DISEASE CONTROL OPERATIONAL UPDATE

Recommendation

It is recommended that the Board of Health receive Report No. 29-22, re: "MLHU Infectious Disease Control Operational Update" for information.

Key Points

- As of April 28, 2022, there have been 36,831 confirmed cases of COVID-19 and 375 total deaths in Middlesex-London region.
- The Infectious Disease Control Program has continued to respond to reports of all other Diseases of Public Health Significance (DOPHS).
- COVID-19 continues to require significant resources for infection prevention and control, case screening, case investigation, outbreak investigation and management.
- The program has undergone and will continue to undergo significant change to reflect local infectious disease epidemiology and provincial policy direction.

Background

The first laboratory-confirmed COVID-19 case in the Middlesex-London region was reported to the Middlesex-London Health Unit (MLHU) on January 24, 2020. As of April 28, 2022, a total of 36,831 confirmed COVID-19 cases were reported to and followed up by the MLHU. Additionally, the Infectious Diseases Control (IDC) Program continues to response to all reported cases of Diseases of Public Health Significance (DOPHS) within Middlesex-London. While some pathogens have seen reduced incidence rates (Salmonellosis, average of 79 episodes per year to 52 in 2021), others have seen increased incidence rates (Tuberculosis, average of 10 episodes per year to 20 in 2022). The Infectious Disease Control Program Description can be found attached as Appendix A.

Program interventions have shifted considerably from what was initially planned for 2022 due to the emergence of the Omicron variant and its related sub-variants in late 2021. Earlier variants allowed MLHU to effectively utilize case and contact management to control the spread of COVID-19 in our community by quickly identifying positive individuals and their contacts to stop the chain of transmission. The original operational planning assumptions for 2022 anticipated that case and contact management of COVID-19 would remain a foundational intervention for the IDC program.

However, the Omicron variant was both highly transmissible and vaccine evasive. Compared to the Delta variant's doubling time of 7.2 days, Omicron had a doubling time of 3.2 days. As a result, community-focused case and contact management was no longer as effective an intervention.

Current Operational Response

Since the emergence of the Omicron variant and provincial direction to only perform case and contact management in high-risk settings, IDC has primarily acted as an outbreak investigation and management team. With community contacts no longer being identified and quarantined by public health, contact tracers have acted as case screeners, identifying individuals who had acquisition or transmission exposures at high-risk outbreak settings (long-term care and retirement homes, acute care, group homes, shelters, detention centres, and First Nation communities and congregate settings). Once high-risk cases are identified, public health nurses or inspectors conduct a case investigation interview to assess each high-risk exposure and trigger outbreak investigations. If an outbreak is subsequently identified, the team works closely with facility operators to implement outbreak control measures for areas at risk.

Local COVID-19 cases peaked on December 30, 2021 at 715 reported cases. The seven-day incidence rate since that time has been no less than 60 cases per day. This has required the entire team complement to be engaged in the triaging of cases and outbreaks.

Expected Q3 and Q4 Operational Response

Barring the emergence of a new and more transmissible and immune-evasive variant, it is expected that there will be a reduced incidence rate of COVID-19 cases and outbreaks through to September 2022. The winter respiratory season will likely see an increased incidence rate of cases and outbreaks due to waning immunity from vaccination and previous infection. Continued uptake of booster doses will be critical to ensure that a sufficient level of population immunity is maintained to avoid severe pressure on the acute care system.

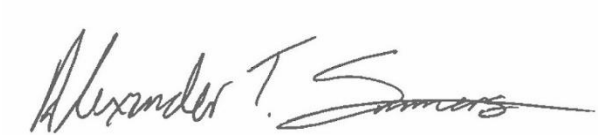
Operational Response for 2023 and Beyond

There is still considerable uncertainty for what COVID-19 endemicity will look like globally and locally. Until a steady state is reached, the delivery of the Infectious Disease Control Program will be variable, responsive to community need with the resources it has available.

Next Steps

Once greater clarity regarding COVID-19 epidemiology emerges, updated program needs for 2023 will be brought forward for Board of Health consideration.

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



Alexander Summers, MD, MPH, CCFP, FRCPC
Medical Officer of Health

Emily Williams, BScN, RN, MBA, CHE
Chief Executive Officer

MLHU 2022
Infectious Disease Control
Program Description

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Program Summary

The Infectious Disease Control (IDC) Program plays an important role in protecting communities from infectious diseases. The program aims to quickly and effectively respond to disease episodes and help implement prevention and control measures across settings. Interventions conducted by IDC include conducting outbreak investigation and management, case and contact management, clinical support, institutional infection prevention and control, inspections, community infection prevention and control, FoodNet Canada, health promotion and communication, tier 2 intake, and surveillance, monitoring and reporting.

Details regarding program management and structure, program mandate, and intended outcomes are the program can be found in Appendix A on page 13.

To be prepared for 2022, certain operational planning assumptions were required to be prepared for the unpredictability of COVID-19 case and contact management. The assumptions were based on the knowledge of the Alpha and Delta variants' infectivity and death rate and the continued management of all cases including contact tracing and ongoing high ICU and hospital admissions. However, although cases have continued with the Omicron variant, the severity, death and hospitalization rates have stabilized. As well, the provincial case and contact direction has transitioned to focus only on high-risk settings (i.e. long-term care and retirement homes, shelters, and other congregate settings). With the stabilization of cases and prioritization of high-risk settings, case and contact management has evolved to primarily outbreak management. Moving forward, it will be critical to continue to make adjustments to the IDC operational model in order to continue to meet the needs of the community and stay within the fiscal envelope which is unknown at this time.

Planning Assumptions

Planned 2022 Operational Response

The planning assumption for 2022 was for a variant of similar transmissibility and severity to the Alpha and Delta variants of COVID-19, along with stable incidence rates of other Diseases of Public Health Significance (DOPHS). The base case scenario projected that there would be, on average, 10 to 20 cases of COVID-19 per day, five associated contacts would be identified, and the IDC team would provide ongoing case and contact management to these individuals. Additionally, the IDC team would be managing between five and 10 outbreaks concurrent to these disease investigations.

Current Operational Response

Since the emergence of the Omicron variant, the IDC Program has primarily acted as an outbreak investigation and management team. With contacts no longer being identified and quarantined by public health, Contact Tracers have acted as case screeners, identifying individuals who had acquisition or transmission exposures at high-risk outbreak settings (long-term care and retirement homes, acute care, group homes, shelters, detention centres, and First Nation communities and congregate settings). Once high-risk cases are identified, Public Health Nurses or Inspectors conduct a case investigation interview to asses each high-risk exposure and trigger outbreak investigations. If an outbreak is subsequently identified, Public Health Nurses or Inspectors work closely with facility operators to implement outbreak control measures for areas at risk.

Local COVID-19 cases peaked on December 30, 2021 at 715 reported cases. The seven-day incidence rate since that time has been no less than 60 cases per day. This has required the entire team compliment to be engaged in the triaging of cases and outbreaks.

Expected Q3 and Q4 Operational Response

Barring the emergence of a new and more transmissible and immune evasive variant, it is expected that there will be a reduced incidence rate of COVID-19 cases and outbreaks through to September. Where necessary, the IDC Program will look to reduce the scheduled hours of its Contact Tracer compliment to align with operational demands. The winter respiratory season will likely see an increased incidence rate of cases and outbreaks due to waning immunity from vaccination and previous infection. Continued uptake of booster doses will be critical to ensure that a sufficient level of population immunity is maintained to avoid severe pressure on the acute care system.

Operational Response for 2023 and Beyond

There is still considerable uncertainly for what COVID-19 endemicity will look like globally and locally. Until a steady state is reached, the delivery of the IDC Program will be variable, and will require MLHU to be responsive to community need with the resources it has available.

Target and Priority Populations

- Hospitals
- Congregate Living Settings
- International Agricultural Workers
- First Nation, Métis, and Inuit Communities

Key Partners and Stakeholders

- First Nation, Métis, and Inuit Community Leaders
- City of London Shelter Operators
- Southwest Infection Prevention and Control HUB
- Ontario Health West
- London Middlesex Triad
- London Health Sciences Centre
- Regional Testing Advisory Committee
- Community Wide Infection Control Committee

Program Interventions

Outbreak Investigation and Management

Outbreak investigation and management is a key intervention to identify the cause of outbreaks within a setting and to implement infection control measures to reduce the risk of ongoing transmission. An outbreak is an increase from the usual number of cases of disease or infection. In the case of a respiratory outbreak, the outbreak is suspected and reported when there are two cases of acute respiratory illness within 48 hours. An enteric outbreak is suspected and reported when there are two cases of gastrointestinal illness within 48 hours.

Outbreaks are reported by facilities as soon as they are suspected or identified, or alternatively, when the health unit has investigated cases that have exposures linked to a particular location, product, or setting.

When the health unit declares the outbreak, outbreak control measures are implemented to stop any ongoing transmission of disease. In the case of long-term care and retirement homes, this may mean isolating residents to their rooms, limiting communal dining, and enhancing cleaning. In the case of an enteric outbreak, there is an investigation of the source. If the investigation identifies a contaminated food product, this could result in an inspection and recall notice being issued at a scope appropriate to the degree of contamination.

Case and Contact Management

Case and contact management are specialized skills that public health staff use in an investigation of any DOPHS that legislatively must be reported to the health unit. Case investigation is the identification of any person with suspect, confirmed, and probable diagnoses. The management of the case is variable depending on the type of pathogen that is reported.

The investigation typically begins with a thorough interview to determine and identify close contacts (contact tracing) using a series of questions and data collecting methods so that information can be documented in a case and contact management tool. Contact investigation or contact tracing is the identification, monitoring, and support of the individuals or contacts who have been exposed to the case and possibly infected themselves. This process prevents further transmission of disease by separating people who have or may have an infectious disease from people who do not.

Clinical Support

Due to the lack of community physicians' available to provide the health care needs to individuals with suspect or active tuberculosis (TB), the Middlesex-London Health Unit provides services through clinics run by the IDC team in partnership with a local Pediatric Infectious Disease Specialist and Respirologist. Currently, the TB clinic routinely sees the following clients: active TB cases with no specialist involved in care at time of diagnosis, immigrants who have been indicated for surveillance under the TB Immigration Surveillance (IMS) Program, contacts of cases with no family physician that are interested in latent tuberculosis infection (LTBI) treatment, Government Assisted refugees (GARs) with positive TB skin tests, GARs with negative TB skin tests and abnormal chest x-rays, referrals, and LTBI clients with no family physician that are interested in treatment.

Institutional Infection Prevention and Control (IPAC)

The IDC program is responsible for supporting infection prevention and control (IPAC) practices in high-risk congregate settings (i.e. long-term care and retirement homes, shelters and other congregate settings) so as to limit the spread of infectious diseases. Some of the activities associated with this intervention include:

- providing education and training, supporting communities of practice;
- learning and networking among IPAC leaders;
- supporting the development of IPAC programs;
- policy and procedures within sites;
- assessments and audits of IPAC programs and practice;
- recommendations to strengthen IPAC programs and practices;
- mentoring of IPAC service delivery within homes;
- working with public health partners and congregate living settings to develop outbreak management plans and
- supporting the congregate living setting to implement IPAC recommendations.

Inspections

Compliance inspections at institutional food kitchens, personal service settings, and child care centres are completed by Public Health Inspectors using risk assessment as per provincial protocols. Re-inspections are required when non-compliance or violations are found. The IDC team ensures that an updated list of premises is entered into the data system for all public health inspections. All inspection results are posted on the MLHU website.

Community Infection Prevention and Control

As per the Ministry of Health and Long-Term Care, *Infection Prevention and Control Protocol*, public health is expected to follow up on certain IPAC complaints related to high-risk settings (e.g. personal service settings, dental and medical offices). In some circumstances, notification of regulatory body is needed. Depending on the type of complaint or investigation, consultation with Public Health Ontario is needed. Similar to inspections, IPAC lapses are disclosed on the health unit website as needed. Some complaints may also generate a case report and sharing of findings with clients.

FoodNet Canada (FNC)

FNC is a multi-partner, enhanced surveillance program for food- and water-borne illnesses with the purpose of determining what foods and other sources are making Canadians ill. FNC is the Public Health Agency of Canada (PHAC) surveillance program with the ability to examine trends in enteric illness and to assess risk over time to determine public health impact. FNC considers enteric illnesses from a unique perspective which integrates enhanced follow-up of human cases of selected enteric diseases, testing of retail food products of interest for infectious agents that can cause illness, and sampling of manure from local farms and surface water for infectious agents that can cause illnesses.

MLHU is responsible for carrying out two of the FNC program's four components: enhanced follow-up of human cases reported among Middlesex-London residents, and the purchase of retail food items to be tested for infectious pathogens.

Health Promotion / Communications

Proactive efforts are made to prevent the spread of infectious diseases. These efforts include health care provider infectious disease articles for MLHU's health care provider e-newsletter, the development of materials for MLHU's health care provider resources binder, and the review and update of paper and electronic resources on the MLHU website.

The program also identifies the intersection between the social determinants of health and the risks of infectious disease transmission associated with these determinants. As an example, during the COVID-19 pandemic, housing has been a significant factor in determining the amount of transmission of infectious diseases. Public health has been able to provide recommendations to decision makers regarding the need for adequate housing for individuals to isolate when infectious or potentially incubating an infectious disease.

Tier 2 Intake

Tier 2 intake is a service provided to the public calling or emailing about issues pertaining to infectious disease control. The IDC tier 2 intake deals with all pathogens except for COVID-19 and has a Public Health Nurse or Public Health Inspector assigned daily to triage calls from the community. The COVID-19 tier 2 intake responds to all inquiries regarding COVID-19 that can not be resolved by tier 1 Client Service Representatives. The IDC tier 2 line operates Monday to Friday, 8:30am to 4:30pm and the COVID-19 tier 2 lines from 9:00am to 8:00pm.

Surveillance, Monitoring, and Reporting

Daily and monthly surveillance reports summarize the DOPHS in the Middlesex -London region. The surveillance reports inform local program planning, prioritization and interventions. A daily outbreak report is generated and distributed to internal and external stakeholders (e.g., Long-term care institutions and hospitals). During influenza season, from November to May, MLHU distributes a weekly a Community Influenza Surveillance Report to local stakeholders which is also posted on the MLHU website.

The Daily Surveillance Report (DSR) is prepared and distributed to key stakeholders to notify them about the current cases being monitored in the community. A Monthly Surveillance Report is prepared by the Population Health Assessment and Surveillance Team and reviewed by the IDC Manager and Associate Medical Officer of Health.

COVID-19 has additional surveillance tools that support daily reporting on the MLHU Dashboard. Reporting through the dashboard is made possible through detailed case reporting from the case screening and investigations processes.

Tuberculosis medical surveillance is a medical check-up for a person who is newly arrived in Canada to check that their inactive tuberculosis has not progressed to active tuberculosis disease. Medical surveillance is required for anyone who was assessed as having inactive tuberculosis on their immigration medical examination (IME). Medical surveillance ensures that proper treatment can be provided, which in turn helps protect the health and safety of people in Canada. Inactive tuberculosis is the only medical condition for which medical surveillance is currently required.

2021 Performance / Service Level Indicators

Case and Contact Management

In 2021, there were a total of 19,306 episodes reported to MLHU for follow-up. This included 18,638 episodes of COVID-19 requiring follow-up.

Other case counts of interest included:

- The number of Carbapenemase-producing Enterbacteriaceae (CPE) cases (n=15) reported in 2021 exceeded 2 standard deviations (SD) (11.0) of the annual average
- The number of Tuberculosis (active) cases (n=20) reported in 2021 exceeded 2SD (16.2) of the annual average from the previous five years (2016-2020)
- The number of Encephalitis/Meningitis cases (n=24) reported in 2021 exceeded 2SD (23.0) of the annual average
- The number of Legionellosis cases (n=26) reported in 2021 exceeded 2SD (25.6) of the annual average
- The number of Lyme disease cases (n=6) reported in 2021 exceeded the annual average (5.20) but did not exceed 2SD (12.6) of the annual average
- The number of Paratyphoid Fever cases (n=1) reported in 2021 exceeded the annual average (0.4) but did not exceed 2SD (2.2) of the annual average
- The number of Tetanus cases (n=1) reported in 2021 exceeded the annual average (0.2) but did not exceed 2SD (1.1) of the annual average.

Outbreak Investigation and Management

- 325 confirmed COVID-19 outbreaks were investigated

Institutional Infection Prevention and Control

- ~1,600 requests for support from congregate settings (i.e. Long-Term Care and Retirement Homes, Shelters, Detention Centres, Group Homes, Child Care Facilities, Hospitals):
    - 750 requests for assistance implementing guidance documents
    - 469 requests for outbreak preparation and planning
    - 299 requests for general education
    - 42 requests for audits and assessments of IPAC practices
    - 99 requests for assistance with IPAC program planning, implementation and evaluation
    - 261 for other requests

Inspections

- 84 required licensing or ownership change inspections
- Five inspections to follow up on complaints
- Routine personal service setting inspections were deferred due to COVID-19 workload
- Routine institutional food inspections were deferred due to COVID-19 workload
- Routine child care inspections were deferred due to COVID-19 workload

FoodNet Canada

Water Sampling

- Among the surface water samples that were positive for toxin-producing E. coli (STEC) in 2021, one sample was serotyped as O111:H8, and another sample was serotyped as O103:H2. O111 and O103 are both included in the seven prioritized STEC serogroups in Canada as they are known to cause human illness.

Retail Sampling

- Four ground beef samples (11.1%, 4/36) were found to be positive for STEC in 2021 Q3. Serotypes identified were 06:H34, O55:H12, O:H29**t**, and O2:H25.

Farm Sampling

- Of the FNC farm and retail isolates that were sequenced and analyzed, 48.8% (39/80) were found to be related to a human whole genome sequence (WGS) cluster. The most matches were among turkey manure (66.7%, 32/48), followed by swine manure (45.5%, 5/11) and chicken breast (25.0% 2/8).

Highlights / Initiatives Planned

De-escalation of Pandemic Response to Sustained Operations

For most of the pandemic, those working on COVID-19 interventions have primarily worked continental shifts to facilitate seven-days-per-week coverage. An initial transition to regular Monday to Friday coverage occurred in March 2022 with an additional transition to come in July 2022. It is the intention of the program to have as few individuals working evenings and weekends as required by the Ministry of Health. A recent communication expressed that only outbreak investigation and management should be prioritized outside of regular business hours.

Resumption of All Routine Inspections

The pandemic response has significantly impaired the IDC Program's capacity to conduct routine inspections. Starting in June 2022, routine inspections will resume with highest-risk locations (e.g. institutional food) being prioritized for first inspections.

Enhanced Institutional Infection Prevention and Control Support

Since the beginning of the pandemic, case load and staff turnover have limited the IDC Program's ability to provide onsite infection prevent and control support to congregate settings and engage in facility liaison work. On-the-ground presence by public health professionals improves the relationship with facilities, provides a more nuanced understanding of the settings in which outbreak control measures may need to be applied, and increases the uptake of infection prevention and control practices. As the incidence rate and outbreaks are reduced through Q2 and Q3, Public Health Nurses and Public Health Inspectors will be conducting site visits to most congregate settings, except group homes.

Program Challenges and Risks

Workload Variability

Entering the summer months, it is anticipated that there will be a decline in respiratory infectious disease activity. In order to be properly prepared for a Fall / Winter respiratory season, the IDC team will need to provide staff with work opportunities but be diligent to ensure there is work to be performed when individuals are scheduled.

Staffing

The staffing needs of the pandemic have been met with numerous strategies like having medical students from Western University or City of London staff assist with contact tracing, integrating workflows with a provincial workforce to conduct some components of case investigation, deploying and redeploying internal staff, and onboarding significant numbers of new team members.

These staffing changes have each brought challenges and limited the IDC team's ability to develop a workforce with a high degree of experience and expertise.

Change Management

The need to respond to ever-changing infectious diseases epidemiology and corresponding provincial guidance has been difficult for team members. Each subsequent change is more difficult to implement given change fatigue. There continue to be changes required for de-escalation from the peak of the pandemic.

Conclusion

The unpredictability of the pandemic and the potential for additional variants makes it very difficult for public health to plan case and contact management for 2023 and beyond. In addition, future fiscal unknowns add more challenges to planning and forecasting. However, maintaining a baseline of case investigators, contact tracers, program assistants and leaders will support the Middlesex-London community through 2022 and enable the IDC team to appropriately plan for 2023 as more information is made available.

Appendix A

Program Management and Structure

Operational Cadence

The IDC program has a seven-day-per-week, 9:00am to 8:00pm operational response with 24-hour on-call.

Most of the team is scheduled Monday through Friday with supplemental staff scheduled on continental shifts to provide evening and weekend coverage. The IDC Manager and Associate Managers have a rotating on-call during evening and weekend hours and are further supported by the on-call Medical Officer of Health.

Staffing Compliment (FTEs)

Role	Pre-Pandemic 2020 Compliment	Budgeted 2022 Compliment	Current Compliment
Manager	1	1	1
Associate Manager	0	7	7
Supervisor	0	4	3
Program Assistant	1	8	6
Public Health Nurse	7	44	55[1]
Public Health Inspector	7	25	9
Health Promoter	0.5	0.5	0.5
Contact Tracer[2]	0	50	48
TOTAL FTE	16.5	139.5	129.5

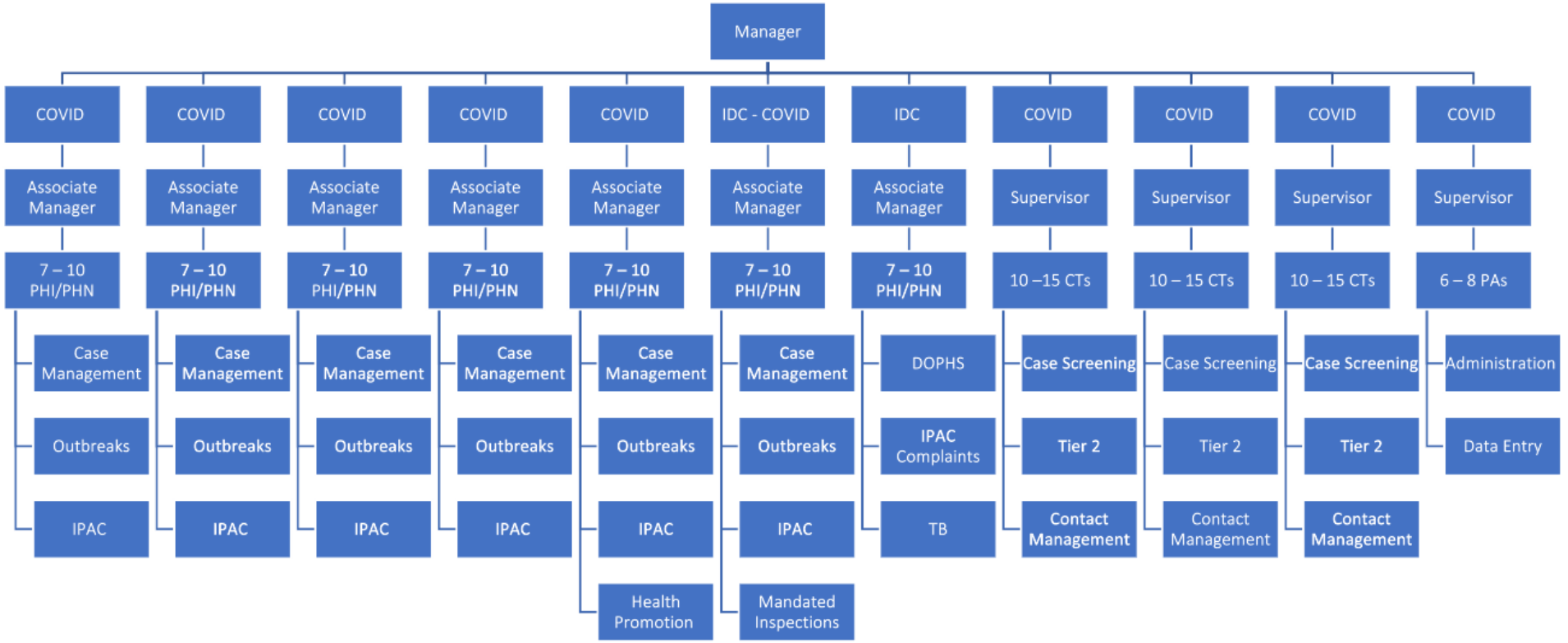
[1] Eleven additional temporary full-time Public Health Nurses have been hired to offset the lack of Public Health Inspectors available from recruitment. Public Health Inspector roles were posted but insufficient candidates were identified to fulfill the 16 temporary contracts.

[2] All Contact Tracers are on temporary casual contracts and are scheduled as workload require.

Roles

Role	Description
Manager	The Manager provides leadership to the IDC Program by setting program strategy, operational goals and objective, monitoring performance, and providing constant oversight of operational objectives. In collaboration with Associate Managers and Supervisors, the Manager will identify and address program issues, challenges, and opportunities. The Manager will also be responsible for ensuring that each intervention is appropriately staffed to reflect changing priorities.
Associate Manager	The Associate Managers are responsible for the delivery of assigned interventions within the IDC Program. The interventions are assigned at the discretion of the Manager and the Associate Manager is responsible for the effective delivery of assigned interventions. This includes regular and robust oversight and reporting on the performance of the intervention and of staff, including performance management. Associate Mangers are responsible for ensuring that program staff are following required documentation and data collection practices through the regular review of case documentation and running reports from case management databases and tools. The Supervisors are also responsible for providing consultative support and guidance to Case Investigators and Contact Tracers who encounter difficult or complex cases and contacts. They will also mentor, coach and provide feedback on performance. The Supervisors are also responsible for the day-to-day scheduling and attendance management of the staff assigned to their interventions.
Supervisor	Supervisors have the same responsibilities as indicated for Associate Managers for the management of program staff but do not supervise individuals performing interventions that require regulated health professionals.
Program Assistant	The Program Assistant supports all administrative needs of the Infectious Disease Control Program which includes, but is not limited to, monitoring lab results being received by fax, reconciling data and preparing lists for team members, and ensuring that reporting to provincial reporting systems are complete.
Public Health Nurse	Public Health Nurses are responsible for outbreak investigation and management, case and contact management, clinical support, institutional infection prevention and control, community infection prevention and control, health promotion, tier 2 intake, and surveillance, monitoring and reporting.
Public Health Inspector	Public Health Inspectors are responsible for outbreak investigation and management, case and contact management, institutional infection prevention and control, inspections, community infection prevention and control, health promotion, tier 2 intake, and surveillance, monitoring and reporting.
Health Promoter	Health Promoters are responsible for developing and implementing health promotion interventions related to infectious disease control.
Contact Tracer	Contact Tracers are responsible for specific components of case and contact management and tier 2 intake.

Organizational Structure



Program Mandate

Legislation

- Health Protection and Promotion Act, R.S.O. 1990 H.7
    - Designation of Diseases O. Reg. 135/18 i) Communicable Diseases – General R.R.O. 1990, Reg. 557
- Mandatory Blood Testing Act, 2006
- Coroners Act, R.S.O. 1990, c. C.37
- Occupational Health and Safety Act, R.S.O. 1990, c.O.1
- Public Hospitals Act, R.S.O. 1990, c. P.40
- Emergency Management and Civil Protection Act, R.S.O. 1990, c. E.9
- Personal Health Information Protection Act, 2004, S.O. 2004, c.3 Sched. A (PHIPA) c) Quarantine Act, S.C. 2005, c. 20

Program Standards

- Ontario Public Health Standards, 2018 or as current
    - Infectious and Communicable Diseases Prevention and Control Standard
    - Infectious Diseases Protocol, 2018 (or as current)
    - Infection Prevention and Control Complaint Protocol, 2018 (or as current)
    - Infection Prevention and Control Disclosure Protocol, 2018 (or as current)
    - Population Health Assessment and Surveillance Protocol, 2018
    - Institutional/Facility Outbreak Management Protocol, 2018 (or as current)
    - Control of Respiratory Infection Outbreaks in Long-Term Care Homes, 2018
    - Tuberculosis Prevention and Control Protocol, 2018 (or as current)
    - Tuberculosis Program Guideline 2018 (or as current)
    - Personal Service Settings Guideline, 2018 (or as current).
    - Healthy Environments and Climate Change Guideline, 2018 (or as current)
    - Ministry Guidance documents and Directives related to COVID-19, as current
    - Emergency Management Guideline, 2018 or as current
- Canadian Tuberculosis Standards
- Planning Guide for Respiratory Pathogen Season, 2018

Intended Program Outcomes

Long-Term / Population Health

- To reduce the burden of respiratory, enteric and other infectious disease of public health significance.

Intermediate

- Analyze and use local data to influence and inform the development of local healthy public policy and its programs and services for the prevention of infectious and communicable disease.
- Design program interventions to address the identified needs of the community, including priority populations, associated with respiratory, enteric and other infectious disease.
- Timely and effective detection, identification, and management of exposures and local cases/outbreaks of respiratory, enteric and other infectious diseases of public health significance, including diseases of public health significance, their associated risk factors, and emerging trends.
- Effective case management results in limited secondary cases.
- Reduced progression from latent tuberculosis infection (LTBI) to active tuberculosis (TB) disease.
- Reduced development of acquired drug-resistance among active TB cases.
- Effective and efficient management and mitigation of public health risks associated with infection prevention and control lapses.
- Increased awareness and use of infection prevention and control practices in settings that are required to be inspected.

Short-Term

- Conduct population health assessment and surveillance regarding respiratory, enteric and other infectious disease and their determinants.
- Communicate, in a timely and comprehensive manner, with all relevant health care providers and other partners about urgent and emerging respiratory, enteric and other infectious diseases.
- Provide timely public health management of cases, contacts, and outbreaks of tuberculosis to minimize the public health risk.
- Provide public education to increase awareness related to infection prevention and control measures, including respiratory etiquette and hand hygiene.
- Notify the public of a lapse according to the Infection Prevention and Control Disclosure Protocol.
- Educate the public about IPAC best practices.
- Raise the awareness of the public of infection control requirements.
- Increase the knowledge of the public about infection prevention and control.
- Work with community partners and service providers to determine and address the need for knowledge translation resources and supports in the area of infection prevention and control.
- Educate stakeholders about IPAC best practices.
- Increase the knowledge of Health Care Providers regarding mandatory reporting requirements and management of infectious diseases.
- Work with appropriate partners to increase awareness among relevant community partners, including correctional facilities, health care, and other service providers, of infection prevention and control practices and reporting requirements for diseases of public health significance.
- Receive reports of complaints regarding infection prevention and control practices and respond to and/or refer to appropriate regulatory bodies.
- Effective and efficient management and mitigation of public health risks associated with infection prevention and control lapses.
- Inspect all required facilities to ensure compliance with the Infectious Disease Protocol, and to educate owner/operators and staff of the inspected facilities on the infection control practices required in each of the specific service settings.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 30-22

TO: Chair and Members of the Board of Health

FROM: Dr. Alexander Summers, Medical Officer of Health
Emily Williams, Chief Executive Officer

DATE: 2022 May 19

OPIOID CRISIS UPDATE

Recommendation

It is recommended that the Board of Health receive Report No. 30-22, re: "Opioid Crisis Update" for information.

Key Points

- For many years, opioid poisonings have represented an important and increasing public health issue, both locally and across the province.
- A local Opioid Crisis Working Group was formed in 2017 to implement a variety of enhanced local interventions.
- Since the COVID-19 pandemic began, opioid-toxicity impacts have increased.
- The use of naloxone for opioid poisonings increased by 60% or more in 2020 and 2021 compared to 2019.
- There has been a recent increase in drug alerts warning individuals at risk of overdose of toxic drugs circulating in the community.

Background

In 2017, the local Opioid Crisis Working Group was formed with community leaders to develop strategies to address the opioid crisis. Today, opioid poisonings continue to pose a significant public health threat in the Middlesex-London Health Unit region. In Ontario, according to a recent report from the Ontario Drug Policy Research Network, the Office of the Chief Coroner for Ontario / Ontario Forensic Pathology Service, and Public Health Ontario, "the COVID-19 pandemic has exacerbated the ongoing opioid overdose crisis, leading to a significant rise in unintentional deaths due to opioid-related toxicity." The report goes on to state that "between February 2020, the month before Ontario declared a State of Emergency due to COVID-19, and December 2020, there was a 79 per cent increase in the number of opioid-related deaths across the province."

Population Health Assessment

Appendix A shows data from the Public Health Ontario (PHO) Interactive Opioid Tool for the Middlesex-London region. It includes data from 2017, when the local crisis was declared, to June 2021, the most recently available data. Prior to the start of the COVID-19 pandemic, both opioid-related emergency department (ED) visits and deaths had been increasing across Ontario and in the Middlesex-London region.

Unfortunately, these patterns of increased ED visits and deaths continued once the COVID-19 pandemic began in 2020. PHO's Interactive Opioid Tool shows that opioid-related ED visits in Ontario increased by 98 per cent between January 2020 and June 2021, from 757 to 1,500 visits. In the Middlesex-London region, the increase in opioid toxicity ED visits was even more dramatic, with visits to local EDs tripling, from 37 in January 2020 to 113 in June 2021.

Opioid-related toxicity deaths have also continued to increase in Ontario since the beginning of the COVID-19 pandemic. There was a 45 per cent increase in deaths across the province between January 2020 and June 2021, from 152 deaths to 220 deaths. Locally, the number of opioid-related toxicity deaths also shows signs of increasing since the start of the pandemic. In 2020, an average of eight opioid-toxicity deaths was reported each month, whereas from January to June 2021, the monthly average was 12 deaths.

Local Interventions

Middlesex-London Health Unit (MLHU) and community partners continue to work together to minimize the adverse effects of the opioid crisis, including opioid toxicity, other negative health outcomes, and death, through the following local interventions:

Needle Syringe Programs (NSP) facilitate the use of a sterile needle and syringe and other equipment for each injection to reduce the risk of acquiring HIV and hepatitis B and C. These programs also provide client-centered counselling, skill-building, and referral to addictions treatment and other health and social services. Utilization of the service has increased, with 1.9 million syringes distributed in 2021, up from 1.7 in 2020 and 1 million in 2019.

Naloxone Distribution provides life-saving naloxone to reverse an opioid overdose. MLHU provides naloxone to 37 eligible community organizations. The number of naloxone kits distributed increased over 60 per cent throughout the pandemic. There were 8,900 naloxone kits distributed and 1,252 used in response to an opioid poisoning in 2021 compared to 2020 when 6,064 kits were distributed, and 1,189 kits were used. In 2019, there were 4,687 kits distributed with 737 used.

Consumption and Treatment Services (CTS) Site in London, Ontario, operated by the Regional HIV/AIDS Connection, provides an essential service to reduce harms associated with drug use, including opioid-related overdoses. Throughout the pandemic there was a slight decrease in visits to the CTS site and an overall increase in opioid overdoses and referrals to services such as primary care, housing, addiction services, mental health, access to food, wound care, and testing. In 2021 there were 14,013 visits, 13,932 referrals and 237 overdoses; in 2020 there were 20,047 visits, 810 referrals and 126 overdoses; and in 2019 there were 28,859 visits, 1,576 referrals and 171 overdoses.

Local Drug Alerts are issued as part of an Early Warning System to share with community partners and those at risk for opioid poisoning. The alerts consist of information about a toxic drug circulating in the community, including identifying the drug or mix, and a prompt to people to have naloxone. The Consumption and Treatment Services sends out the alerts. There were four alerts issued in 2021 and three alerts in 2020 and 2019.

Safer Supply located at London InterCommunity Health Centre (LIHC), with Dr. Andrea Sereda, began the country's first Safer Supply program in 2016. Safer Supply involves the provision of a regulated supply of opioid medication to adults who use criminalized drugs and who are at high risk of overdose and other harms. Funded through Health Canada, LIHC supports over 280 individuals on the Safer Supply Program through an interdisciplinary model of care. Documented positive program outcomes include a 35 per cent reduction in injection drug use, a 32 per cent reduction in emergency department visits, a 30 per cent reduction of survival sex work, a 36 per cent reduction of criminal justice system involvement, and improved food and income security.

Community Drug and Alcohol Strategy (CDAS) is a locally developed long-term strategy aimed at preventing and addressing substance use-related harms in our community. Launched in 2018, the Strategy is the result of the expertise and collaboration of local partners as well as the diverse voices of hundreds of citizens invested in the health and wellness of Middlesex-London. The CDAS is based on broad community actions toward shared goals and a "Four Pillars" approach of prevention, treatment, harm reduction and enforcement, and focused on all substances.

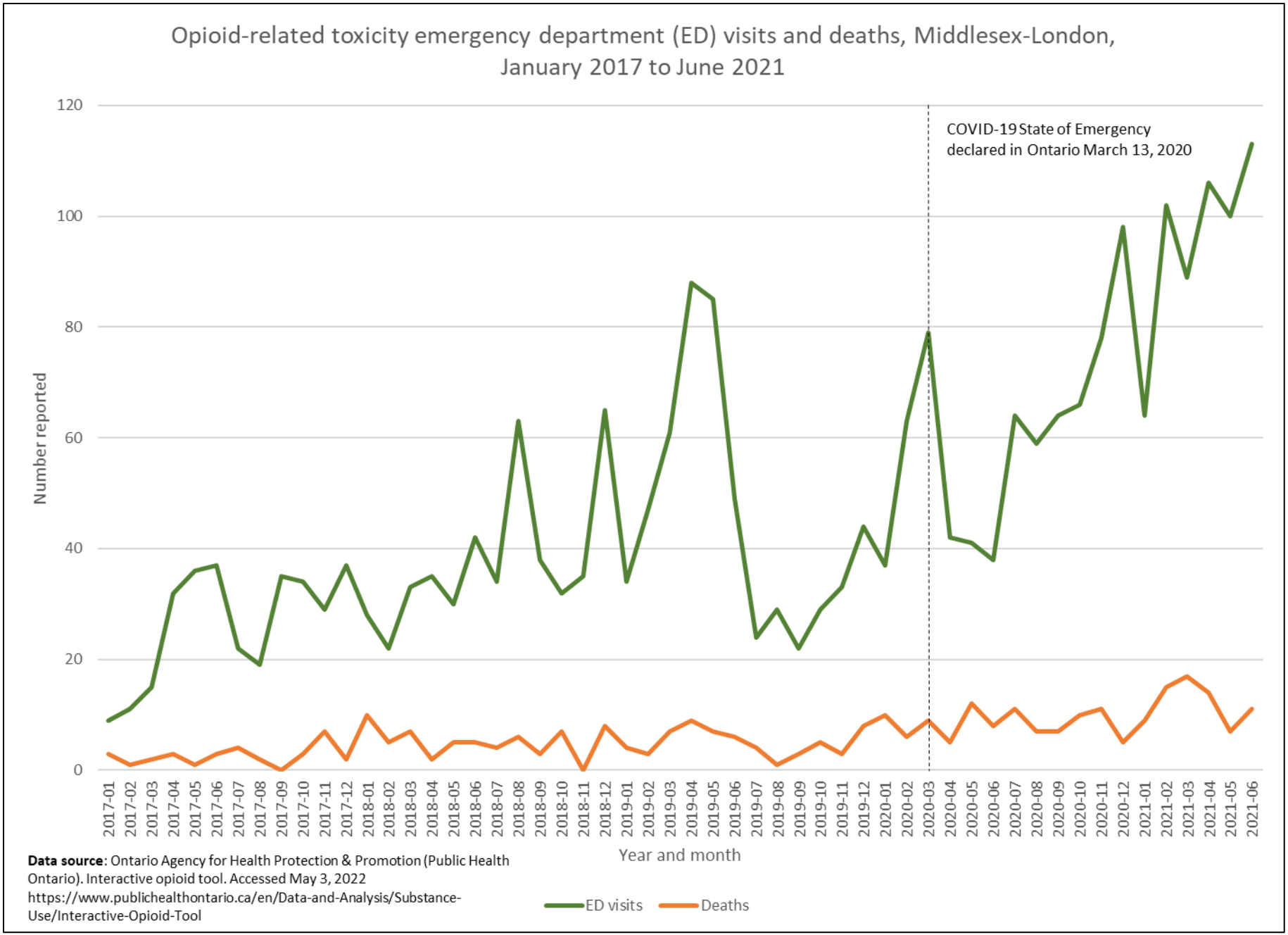
Next Steps

The opioid crisis has continued to escalate through the COVID-19 pandemic, potentially exacerbated by challenges for clients to access many in-person services. As the pandemic hopefully wanes, it is essential to continue efforts to reduce the morbidity and mortality of opioid poisoning by applying a Four Pillar approach with a focus on community collaboration, upstream prevention, and the fulsome consideration of evidence-informed policy options to minimize harms.

This report was prepared by the Environmental Health and Infectious Disease Division, the Healthy Living Division and the Office of the Medical Officer of Health.

Alexander Summers, MD, MPH, CCFP, FRCPC
Medical Officer of Health

Emily Williams, BscN, RN, MBA, CHE
Chief Executive Officer


Opioid-related toxicity emergency department (ED) visits and deaths, Middlesex-London, January 2017 to June 2021
COVID-19 State of Emergency declared in Ontario March 13, 2020
Number reported
Year and month
ED visits
Deaths
Data source: Ontario Agency for Health Protection & Promotion (Public Health Ontario). Interactive opioid tool. Accessed May 3, 2022 https://www.publichealthontario.ca/en/Data-and-Analysis/Substance-Use/Interactive-Opioid-Tool

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 31-22

TO: Chair and Members of the Board of Health

FROM: Dr. Alexander Summers, Medical Officer of Health
Emily Williams, Chief Executive Officer

DATE: 2022 May 19

MLHU SCHOOL TEAM'S RETURN TO SCHOOL HEALTH WORK

Recommendation

It is recommended that the Board of Health receive Report No. 31-22, re: "MLHU School Team's Return to School Health Work" for information.

Key Points

- As school communities return to a new "normal", MLHU school public health nurses have returned to working in schools.
- MLHU school nurses reported being welcomed by school administrators, support staff, educators and students.
- Mental health is the top concern in schools, followed by sexual health/healthy relationships, vaping cessation, and eating disorders. Overall, school staff report that students are lacking a general sense of wellbeing as a result of the pandemic.

Background

Schools are the most immediate settings for promoting lifelong health of children and youth (Pan-Canadian Joint Consortium for School Health, 2018; Seigart, Dietsch, & Parent, 2013). At school, children and youth develop social competencies, such as self-confidence, friendship, empathy, participation, respect, and responsibility, as well as foster healthy habits such as physical activity, proper nutrition, and good personal hygiene (Colao, Piscitelli, Pulimeno et al., 2020; Lancet Editorial, 2022; Zajacova, & Lawrence, 2018).

The overall goal of the School Health Team (SHT), which is comprised of the Child Health and Young Adult Teams, is to achieve the optimal health of school-aged children and youth using a Comprehensive School Health approach. This is an internationally recognized approach that supports improvement in students' educational outcomes while addressing school health in a planned, integrated, and holistic way. This whole-school model builds capacity to incorporate wellbeing as an essential aspect of student achievement. This is done through partnership and collaboration with school boards and schools (OPH School Standard, 2018). To achieve this overall goal, the SHT supports approximately 33 secondary schools and 150 elementary schools in the Middlesex-London region by providing resources, programs and services. The allocation of resources, programs, and services within the SHT is informed by proportionate universalism, whereby the team strives to achieve a blend of universal and targeted interventions to reduce inequities within school communities (Health Equity Guideline, 2018).

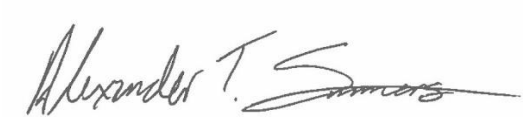
The onset of COVID-19 in February 2020 suspended all health promotion work in schools; however, COVID-19 resulted in school boards and public health units working alongside each other in a new way to navigate the COVID-19 pandemic. Interestingly, public health and school boards report that their working relationship is stronger than ever due to the pandemic. As school communities return to a new "normal", MLHU school public health nurses have returned to working in and with schools. They have been welcomed

by school administrators, support staff, educators and students. School staff have conveyed that "a big piece was missing from the school not having the public health nurse at the school." MLHU staff have been met with many requests and invitations to collaborate on healthy school initiatives and to partner with Guidance Counselors, and Student Success Teachers. The general sentiment is that school staff are thankful to have public health nurses back in schools as a caring adult and essential support for students and the broader school community.

Next Steps

School administrators and staff reported their main concerns to their MLHU school public health nurses. Through these conversations, it was determined that mental health is the top concern in schools, followed by sexual health/healthy relationships, vaping cessation and eating disorders. Overall, school staff report that students are lacking a general sense of wellbeing as a result of the pandemic. The work of the school team is grounded in population health, and the role of staff is focused on health promotion and illness prevention. The school team is pleased to inform the Board of Health that after two years of focusing on COVID-19 prevention and management, the team has returned to school health work and are working alongside school partners.

This report was prepared by the Child Health and Young Adult Team, Healthy Living Division.



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Chief Executive Officer

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MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 32-22

TO: Chair and Members of the Board of Health

FROM: Dr. Alexander Summers, Medical Officer of Health
Emily Williams, Chief Executive Officer

DATE: 2022 May 19

COUNTY OF MIDDLESEX OFFICIAL PLAN REVIEW SUBMISSION

Recommendation

It is recommended that the Board of Health receive Report No. 32-22, re: "County of Middlesex Official Plan Review Submission" for information.

Key Points

- Under the *Ontario Public Health Standards*, the Middlesex-London Health Unit must inform the development of local healthy public policy related to promoting healthy built and natural environments.
- In April 2022, MLHU staff in the Healthy Living and Environmental Health and Infectious Diseases Divisions reviewed and submitted written comment to the County of Middlesex Official Plan Amendment Consultation Draft (Appendix A).

County of Middlesex Official Plan Review

Built and natural environments that are well planned help to create healthy communities with resulting positive impacts on overall physical and mental health, social wellbeing, sense of safety, and reduced exposure to health hazards. Public health has mandate under the *Ontario Public Health Standards* to support the creation of healthy public policy that reduces exposures to health hazards and promotes the development of healthy built and natural environments. Official Plans are an important municipal-level policy framework that can help ensure that land use planning decisions support healthy communities.

Middlesex County is in the process of updating its Official Plan to conform to changes made to the Provincial Policy Statement in 2020 and to set new goals and priorities that will shape future growth and development in the County over the next 25 years. In April 2022, MLHU staff in the Healthy Living and Environmental Health and Infectious Diseases Divisions had an opportunity to review and submit written comment, including potential enhancements for consideration, to the County of Middlesex Official Plan Amendment Consultation Draft. The submission is included in Appendix A. Many existing and amended policies contained within the Official Plan align with and enhance public health's mandate to reduce health inequities, promote healthy behaviours and contribute to the development of safe, supportive and healthy environments. The County of Middlesex Official Plan will provide strong policy support for health-supporting built and natural environments for the next 25 years.

This report was prepared by the Healthy Communities and Injury Prevention team, Healthy Living Division.

Alexander Summers, MD, MPH, CCFP, FRCPC
Medical Officer of Health

Emily Williams, BscN, RN, MBA, CHE
Chief Executive Officer

Explanation of comment format: The comments that follow are organized according to sections of the Official Plan, referencing the Official Plan Amendment Consultation Draft (March 8, 2022) and include the Official Plan headings, sub-headings and numbers. Comments are not provided for all sections of the plan, rather sections and elements of notable public health interest. Recommended additions for consideration are presented in **bolded text** under relevant headings and sub-headings.

Section 2.0 Policy Framework

Preserving and protecting the natural environment has many environmental benefits such as preserving biodiversity, better outdoor air quality, and reducing exposure to potential hazards.[1] As well, "being in and viewing nature has significant physical and mental [health] benefits including increased social well-being and reduced stress." (BC Centre for Disease Control, 2018, p.32)

Natural environments can also help to reduce greenhouse gas (GHG) emissions and help to reduce the negative effects of climate change. Preserving and protecting natural environments is important as health risks from climate change are growing for residents in Middlesex-London and actions are needed to address potential impacts.[2,3]

MLHU supports the strengthened focus in the proposed amendments to the Official Plan that stresses an "ecological systems-based approach" and protection of natural features and ecological functions of the environment. There is a strong connection between the ecosystem and human health and wellbeing (Eco-health, Ecological Determinants of Health). The aim to balance economic development with the protection of natural environments has many co-benefits to the environment, communities and individuals and contributes to climate change mitigation and adaptation. This approach also focuses on sustainability and takes a broader long-term focus on the environment versus what may be of concern in the immediate proximity, or on adjacent lands.

2.2 Resource Management

2.2.2.1 Agriculture: Introduction

MLHU supports protecting agricultural land as it contributes to a stable food system and supports local food production and supply. Purchasing local food helps to reduce the carbon footprint while stabilizing food security. Agricultural practices that seek to reduce greenhouse gas (GHGs) (methane) and fertilizer run-off, should be considered within the context of climate change and health of the environment.

2.2.3.3 Aggregate Resources: New Pits and Quarries

- f) the impact of **environmental hazards** on any existing or potential, **private and/or** municipal water supply resource areas;

2.3 Growth Management

2.3.1 Growth Management: Introduction

MLHU supports directing future growth to Settlement Areas as this facilitates the creation of complete, compact and connected communities, while preserving the natural environment, agricultural land and reducing potential exposure to natural hazards; all of which can increase sense of place or community, physical and mental well-being and contribute to climate change mitigation (i.e., the preserving of green space, and encouraging and facilitating active transportation).[1,2]

2.3.3 Forecasting Growth

Given the projected forecasts in population included in the "Population and Housing Projections Report", noting the average age of the population is getting older, it will be important for municipalities to encourage and support infrastructure, development and design that supports all ages and abilities, and aging in place, in areas such as the transportation system, housing policies and Settlement Areas.

2.3.4 Economic Development

Health is influenced by many factors including individual genetics, lifestyles, and the places where we live, learn, play, work, and age and it is these factors that contribute to the health of individuals and communities. However, there are important social determinants of health which can be barriers to reaching optimal health such as: access to health services; culture, race, and ethnicity; disability; income and income distribution; employment, job security, and working conditions; education; food insecurity; housing; physical environments; and social support networks.[4,5] Many of these barriers also increase vulnerability to climate change for individuals and communities.[2]

Policies and initiatives that aim to address these barriers without causing further inequities are important and can contribute to improving the overall health of individuals and communities.

Recommended enhancements to policies include the following:

- d) encourage local municipalities to promote a high standard of urban design by prioritizing principles such as pedestrianization, **compact form,** mixed-use, **high quality** functional public spaces **that include natural and built features**, accessibility and universal design, to create healthy vibrant communities which attract investment.
- f) support the retention **and creation** of **accessible** educational, health, recreational, cultural and religious facilities to ensure that the County's communities are provided with those opportunities that facilitate growth and well-being. Such facilities provide a vital role in small communities and add economic vitality and a sense of place and community where quality of life is considered a major attraction for growth and development.
- m) encourage, where possible**, equitable and integrated** multi-modal access to employment lands including walking and cycling trails **and public transit**.
- r) promote the development of agri-tourism and work with local municipalities, **municipal food policy councils,** and agricultural representatives to explore options for the development of local agri-tourism, including identifying strengths, unique local attributes, opportunities, and potential links with value-added agriculture, local foods, potential new product markets, local heritage, recreation opportunities, and natural heritage and identifying the facilities, infrastructure, and resources necessary to support an agri-tourism industry. The development of agri-tourism must not interfere with agricultural operations.
- t) require that local municipalities support strong urban design and revitalization **that considers affordable housing, access to healthy food, green space, and transportation** where needed in downtown cores as a means of enhancing the quality of place.

MLHU supports the encouragement of a vibrant, dynamic arts and culture community that contributes to the growth, prosperity and vibrancy of the County as it is important for the social well-being of the community and can lead to a sense of place and community belonging. In addition, MLHU supports the creation of a strong and sustainable local agricultural sector that can increase access to local foods produced through sustainable agricultural practices.

2.3.5 General Policies

MLHU supports the policy statement "Local official plan will promote the creation of resilient communities. As such, development applications should be reviewed with respect to anticipated impacts that may result from a changing climate."

2.3.6 Settlement Capacity Study

Recommended enhancements to policies include the following:

- d) an identification of any existing restrictions to future development, **including any potential hazards.**
- g) an assessment of traffic and transportation services and needs, **including existing infrastructures and their condition.**
- **An assessment of the local food system, including access to healthy, affordable food.**

2.3.7 Housing Policies

As already indicated above under 2.3.4 Economic Development, housing is an important social determinant of health that can affect the ability to reach optimal health.[4,5] The quality of housing can positively or negatively impact the physical, mental and social well-being of individuals; therefore, it is important to ensure that everyone has access to safe, good quality housing.[1] Offering a variety of mixed housing types and forms is also important as it is inclusive and provides quality housing for a range of different incomes, life stages and supports aging in place. Mixed housing types can also reduce social isolation and increase sense of safety, social connectedness, mental health and health equity.[6]

MLHU supports policies that aim to address access to safe, diverse, accessible housing and commends the County's commitment to undertake an "Attainable Housing Review.

Recommended enhancements to policies include the following:

- vii) Policies that encourage **and prioritize** a pedestrian and mixed-use focus, **connectivity and access to green space** in new development

From a climate change perspective, MLHU supports the policy statement: "Policies that promote the reduction of greenhouse gas emissions, improvements in air quality, promotion of compact form, use of green infrastructure and development that maximizes energy efficiency and conservation including the use of alternative and renewable energy sources."

2.3.7.3 Housing Policies: Intensification and redevelopment

Recommended enhancements to policies include the following:

- County Council shall encourage residential intensification and redevelopment in areas designated for residential use which comply with the following criteria;
    - **Current land and/or surrounding land uses do not pose an adverse impact on human health**

2.3.8.1 Settlement Areas: Urban Areas

Recommended enhancements to policies include the following:

- New development should proceed in an integrated, **complete** and compact form.

2.4 Physical Service & Utilities

2.4.2 Transportation System

Recommended enhancements to policies include the following:

- The County encourages the development and maintenance of a sustainable, interconnected and energy efficient transportation system that supports a variety of **safe** transportation modes **for all users.**

2.4.2.2 Transportation System: General policies

Recommended enhancements to policies include the following:

- d) Encourage **the development and maintenance of** an integrated transportation system that supports a variety of safe, sustainable and energy efficient modes of transportation;
- f) Encourage safe, convenient and visually appealing pedestrian and cycling infrastructure **for all ages and abilities;**
- h) Ensure that development proposals that are likely to generate a traffic impact are accompanied by an Engineering Report addressing the potential impact on the transportation system **and its' users** and surrounding land uses to the satisfaction of the County and the local municipality;

2.4.4 Waste Management

MLHU supports the inclusion of this section and the upstream approach towards waste management as identified in the Official Plan. Less waste to landfill through diversion and reduction efforts will result in fewer hazards and contribute to climate change mitigation efforts through reduction in greenhouse gases.

3.0 Detailed Land Use Policies

3.2.3 Detailed Land Use Policies: Local Official Plans

Recommended enhancements to policies include the following:

- j) Transportation **for all users (transit users, pedestrians, cyclist and motorists);**
- **Access to healthy, affordable food, including food retail access and green spaces providing opportunities for local food production;**
- **Green infrastructure.**

3.2.4.1 Urban Areas: Permitted Uses and 3.2.5.1 Community Areas: Permitted Uses
Overall, the MLHU supports the permitted uses in both Urban and Community areas but recommended enhancements to policies include the following:

- **Urban agriculture (e.g., community gardens, farmers markets, roof top gardens, and edible landscaping**)

Summary:
The County of Middlesex Official Plan amendment is an opportunity to revisit and review the County's framework and policies of the current Official Plan. Land use policy can have a positive impact on the health and well-being of Middlesex County residents by influencing the environments in which people live, work, play and age. Both the physical and built environments are important factors in determining the health of a community.

The MLHU respectfully submits the comments and recommendations outlined in this document for consideration of inclusion in the County of Middlesex Official Plan.

References:

1. BC Centre for Disease Control. (2018). Healthy Built Environment Linkages Toolkit: making the links between design, planning and health, Version 2.0. Vancouver, B.C.: Provincial Health Services Authority, 2018. Retrieved from: http://www.bccdc.ca/pop-public-health/Documents/HBE_linkages_toolkit_2018.pdf
2. Berry, P., Paterson, J. and Buse, C. (2014). *Assessment of Vulnerability to the Health Impacts of Climate Change in Middlesex-London.*
3. Middlesex-London Health Unit. (July 2019). Climate Change. [Internet] https://www.healthunit.com/climate-change
4. Middlesex-London Health Unit. (July 2019). Social Determinants of Health. [Internet] https://www.healthunit.com/social-determinants-of-health
5. Ministry of Health and Long-Term Care. (June 2021). Ontario Public Health Standards: Requirements for Programs, Services and Accountability. Toronto, ON: Queens Printer for Ontario 2021. Retrieved from: https://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/protocols_guidelines/Ontario_Public_Health_Standards_2021.pdf
6. Middlesex-London Health Unit. (Feb 2019). Community Design. [Internet] https://www.healthunit.com/community-design
7. Middlesex-London Health Unit. (2013). Linking Health and the Built Environment in Rural Settings: Evidence and Recommendations for Planning Healthy Communities in Middlesex County. London, Ontario: Author.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 33-22

TO: Chair and Members of the Board of Health

FROM: Alexander Summers, Medical Officer of Health

DATE: 2022 May 19

MEDICAL OFFICER OF HEALTH ACTIVITY REPORT FOR APRIL

Recommendation

It is recommended that the Board of Health receive Report No. 33-22, re: "Medical Officer of Health Activity Report for April" for information.

The following report presents activities of the Medical Officer of Health (MOH) for the period of April 1 – May 5, 2022. As of May 5, the formal Minister of Health's appointment of Dr. Alexander Summers as Medical Officer of Health is pending.

The Medical Officer of Health provides oversight of all public health programs at the Middlesex-London Health Unit, and co-chairs the Senior Leadership Team. During the pandemic, the Medical Officer of Health extensively participates in external and internal pandemic-related meetings with municipal and provincial stakeholders, along with liaising with community partners. The MOH, in partnership with MLHU's Communications Team, hosts a weekly virtual media briefing for COVID-19 matters, and includes the Mayor of London, the Warden of Middlesex County and a representative from London Health Sciences Centre.

The Medical Officer of Heath, along with other team members, continues to host a weekly Middlesex-London Health Unit (MLHU) Staff Town Hall (Friday) and presents on many topics, including COVID-19. The MOH also hosts biweekly (Tuesday) healthcare provider outreach and community stakeholder webinars with information regarding COVID-19.

The Medical Officer of Health also attended the following meetings:

Client and Community Impact – *These meeting(s) reflect the MOH's representation of the Health Unit in the community and media:*

April 1 Interview with Jen Bieman (London Free Press) on current opioid situation.
Interview with Jane Sims (London Free Press) on PCR testing**.**

April 6 Attended Western Regional Integrated Vaccination meeting with Dr. Daniel Warshafsky (Associate Chief MOH, Ontario).
Interview with Mike Stubbs (Global News) and Jen Bieman (London Free Press) on fourth doses.

April 7 Interview with Ken Eastwood and Loreena Dickson (Newstalk CJBK) on COVID-19 matters locally.

April 11 Attended Middlesex County Emergency Control Group meeting.
Attended IPAC Hub Working Group meeting.

April 12 Attended City of London Emergency Control Group meeting.

Attended Special Meeting of the Thames Valley District School Board with Dr. Ninh Tran, Acting Medical Officer of Health at Southwestern Public Health Unit.

April 13 Attended Council of Medical Officers of Health (COMOH) meeting.

April 14 Interview with Reta Ismail (CTV London) on the increasing case counts in Middlesex-London.
Hosted Her Honour Lieutenant Governor of Ontario, Elizabeth Dowdeswell, along with the Mayor of London at the Agriplex Vaccination Clinic.

April 19 Attended Ministry of Health COVID-19 Public Health Coordination call.
Met with Western University Leadership on COVID-19 Planning.

April 20 Attended COMOH meeting on "Public Health Priorities".
Attended 2022 Pillar Annual Community Connector.

April 25 Attended Middlesex County Emergency Control Group meeting
Lectured at Western University's Coordinated Professional Development Program (Parkwood Hospital) on "COVID-19 Vaccines and Variants".
Attended Southwest Medical Officers of Health meeting, hosted by Grey-Bruce Public Health Unit.

April 26 Attended City of London Emergency Control Group meeting.
Attended Ministry of Health COVID-19 Public Health Coordination call.

April 27 Attended COMOH meeting.

April 28 Met with Associate Chief Medical Officer of Health, Dr. Wajid Ahmed, on COVID-19 and non-COVID-19 matters.
Interview with Mike Stubbs (Global News) on school vaccinations.

May 4 Attended biweekly London Middlesex Primary Care Alliance meeting.

May 5 Attended Ministry of Health COVID-19 Public Health Coordination call.

Employee Engagement and Learning – *These meeting(s) reflect on how the MOH influences the Health Unit's organizational capacity, climate and culture and the contributions made to enable engaged and empowered staff; thoughtful and responsive leadership and organizational structures that support decision-making, innovation and learning:*

April 1 Attended Program Evaluation meeting.

April 4 Met with CUPE Representatives, with the Chief Executive Officer.

April 5 Attended webinar hosted by the Public Health Association of British Columbia on "Our Planet, Our Health, Our Public Health Responsibility" in honour of Canadian Public Health Week.

April 6 Attended MLHU Leadership Team session on "Joy in Work".

April 8 Hosted Canadian Public Health Week "Coffee Break" at CitiPlaza

April 12 Attended MLHU Leadership Team meeting.

April 13 Attended MLHU Leadership Team session on "Joy in Work".
Attended webinar on "Air and Health" from the Canadian Associations of Physicians for the Environment.

May 3 Attended Health Unit Clinic Physicians' meeting

May 4 Participated in "Crucial Conversations" workshop at the Health Unit.

Governance – *This meeting(s) reflect on how the MOH influences the alignment of management methods and systems to ensure appropriate structures and resources are in place to achieve the HU's mission and vision. This also reflects on the MOH's responsibility for actions, decision and policies that impact the HUs ability to achieve the requirements as set out under the strategic plan, the Ontario Public Health Organizational Standards (OPHOS), other funder requirements and direction provided by the Board of Health:*

April 4 Participated in a meeting with the Executive Director of Thames Valley Health Team, Mike McMahon regarding the Ontario Health Team (OHT).

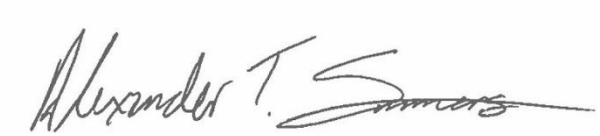
April 7 Attended Finance and Facilities Committee meeting.
Meeting with Ministry of Health regarding funding, with the Chief Executive Officer.

April 21 Attended Governance Committee meeting.
Attended Board of Health meeting.

April 28 Attended Western Ontario Health Team (WOHT) Coordinating Council meeting.
Attended Special Board of Health meeting.

May 5 Meeting with Ministry of Health regarding funding, with the Chief Executive Officer.

This report was prepared by the Medical Officer of Health.



Alexander Summers, MD, MPH, CCFP, FRCPC
Medical Officer of Health

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 34-22

TO: Chair and Members of the Board of Health

FROM: Emily Williams, Chief Executive Officer

DATE: 2022 May 19

CHIEF EXECUTIVE OFFICER ACTIVITY REPORT FOR APRIL

Recommendation

It is recommended that the Board of Health receive Report No. 34-22, re: "Chief Executive Officer Activity Report for April" for information.

The following report highlights activities of the Chief Executive Officer for the period of April 1, 2022 – May 5, 2022

Standing meetings include weekly Healthy Organization leadership team meetings, SLT (Senior Leadership Team), Logistics and R3 (Repatriation, Redeployment and Recruitment), Virtual Staff Town Hall meetings and C3 (COVID Collaborative Committee) meetings.

The Chief Executive Officer also attended the following meetings:

Client and Community Impact – *These meeting(s) reflect the CEO's representation of the Health Unit in the community:*

April 14 The CEO, with the MOH, participated in a visit from the Lieutenant Governor of Ontario, Her Honour the Honourable Elizabeth Dowdeswell at the MLHU Agriplex vaccination clinic.

April 21 The CEO met with Cindy Howard from Middlesex County to discuss the MLHU Budget.

April 22 The CEO met with Anna Lisa Barbon and Kyle Murray from the City of London to discuss the MLHU Budget.

April 28 As part of the CEO's Association of Ontario Public Health Business Administrators (AOPHBA) membership, the CEO met with Cynthia St. John from Southwest Public Health to discuss health unit administrative matters.

May 4 The CEO attended a breakfast meeting with London's City Manager to discuss the close out of the 2019-2023 City Strategic Plan; development of the 2023-2027 City Strategic Plan; the 2023 City Budget Update process; and development of the 2024-2027 Multi-Year Budget.

Employee Engagement and Learning – *These meeting(s) reflect on how the CEO influences the Health Unit's organizational capacity, climate and culture and the contributions made to enable engaged and empowered staff; thoughtful and responsive leadership and organizational structures that support decision-making, innovation and learning:*

April 4 As part of the Employment Systems Review (ESR) recommendations, the CEO met with the ESR Project Steering Committee.

The CEO, with the MOH, met with the CUPE union leadership.

April 6 As part of the Provisional Strategic plan and as a key part of the recovery plan for MLHU, the CEO chaired and attended the first Joy in Work session with the MLHU Leadership Team (MLT).

April 8 The CEO attended the Canadian Public Health Week Coffee Break Celebration.

April 11 As part of the CUPE union negotiation preparation, the CEO attended a negotiations overview meeting with the MLHU Bargaining committee.

April 13 As part of the Provisional Strategic plan and as a key part of the recovery plan for MLHU, the CEO chaired and attended the second Joy in Work session with the MLHU Leadership Team (MLT).

April 14 The CEO, with the MOH met with the ONA union leadership.

April 20 As part of the Employment Systems Review (ESR) recommendations, the CEO met with the ESR Project Steering Committee.

April 25 As part of the CUPE union negotiation preparation, the CEO, attended the Pre-Bargaining meeting with the MLHU Bargaining Committee and the CUPE union Bargaining committee representatives.

As part of the CUPE union negotiation preparation, the CEO attended a Proposal review meeting with the MLHU Bargaining Committee.

The CEO attended and chaired the May MLT (MLHU Leadership Team) planning meeting.

April 29 The CEO, with the MOH met and discussed the Joy in Work sessions feedback in order to finalize action items

May 2 The CEO met with union leadership to discuss a confidential union labour relations matter.

May 3 As part of the Employment Systems Review (ESR) recommendations, the CEO met with the ESR Project Steering Committee.

May 4 As part of the MLHU Safety and Health Week, the CEO attended a Safety Tour.

May 5 The CEO met with union leadership to discuss a confidential union labour relations matter.

Personal Development – *These meeting(s) reflect on how the CEO develops their leadership, skills and growth to define their vision and goals for the Health Unit.*

April 5 The CEO attended the Canadian College of Health Leaders Summit.

April 14 As part of the CEO's McCormick Care Board membership, the CEO attended the McCormick Care Executive Committee meeting.

Governance – *This meeting(s) reflect on how the CEO influences the alignment of management methods and systems to ensure appropriate structures and resources are in place to achieve the HU's mission and vision. This also reflects on the CEO's responsibility for actions, decision and policies that impact the HUs ability to achieve the requirements as set out under the strategic plan, the Ontario Public Health Organizational Standards (OPHOS), other funder requirements and direction provided by the Board of Health:*

April 1 The CEO met with Gallagher to review the ongoing market analysis related to the non-union compensation.

April 7 The CEO attended the Finance and Facilities Committee meeting.

April 11 The CEO attended the MLHU Board of Health April Agenda Review and Executive meeting with the Board Chair and Vice-Chair.

April 20 The CEO attended the MLHU Governance Committee Agenda Review meeting.

April 21 The CEO attended the Board of Health meeting.

April 21 The CEO attended the Governance Committee meeting.

April 25 The CEO attended a meeting to discuss the MLHU Profile Project, including a review of resources and implementation.

April 26 The CEO attended a MLHU software overview meeting in order to advance the IT infrastructure improvement work

April 27 The CEO attended a Board of Health Orientation overview meeting.

April 28 The CEO attended the Board of Health Orientation.

May 5 The CEO attended the monthly Ministry of Health Public Health Funding meeting.

The CEO met with Board Chair to discuss the MLHU funding update.

This report was prepared by the Chief Executive Officer.

Emily Williams, BscN, RN, MBA, CHE
Chief Executive Officer

CORRESPONDENCE – May 2022

a) **Date:** May 2, 2022
Topic: 2022-2023 Ministry of Health Funding for Middlesex-London Health Unit
From: Hon. Christine Elliott, Deputy Premier and Minister of Health
To: Mr. Matt Reid, Chair, Middlesex-London Board of Health

Background:

On May 2, 2022, the Province (Ministry of Health) notified the Middlesex-London Health Unit that the Health Unit will be receiving $528,200 in additional base funding for 2022-2023, up to $793,400 in one time funding for 2021-2022, up to $15,657,200 in one time funding for 2022-2023 and up to $31,800 for one time funding for 2023-2024.

Recommendation: Receive.

Ministry of Health

Office of the Deputy Premier
and Minister of Health

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Ontario

May 2, 2022

eApprove-72-2022-381

Mr. Matt Reid
Chair, Board of Health
Middlesex-London Health Unit
355 Wellington Street, Suite 110
London ON N6A 3N7

Dear Mr. Reid:

I am pleased to advise you that the Ministry of Health will provide the Board of Health for the Middlesex-London Health Unit up to $528,200 in additional base funding for the 2022-23 funding year, up to $793,400 in one-time funding for the 2021-22 funding year, up to $15,657,200 in one-time funding for the 2022-23 funding year, and up to $31,800 in one-time funding for the 2023-24 funding year, to support the provision of public health programs and services in your community.

Dr. Kieran Moore, Chief Medical Officer of Health, will write to the Middlesex-London Health Unit shortly concerning the terms and conditions governing the funding.

Thank you for the important service that your public health unit provides to Ontarians, and your ongoing dedication and commitment to addressing the public health needs of Ontarians.

Sincerely,

Christine Elliott

Christine Elliott
Deputy Premier and Minister of Health

c: Emily Williams, Chief Executive Officer, Middlesex-London Health Unit
Dr. Alexander Summers, Medical Officer of Health (A), Middlesex-London Health Unit
Dr. Kieran Moore, Chief Medical Officer of Health
Alison Blair, Associate Deputy Minister, Pandemic Response and Recovery, MOH