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

Thursday, July 14 , 2022, 6:00 p.m.
MLHU Board Room – CitiPlaza
355 Wellington Street, London ON

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: June 16, 2022 – Board of Health meeting
July 7, 2022 – Special Meeting of the Board of Health

Receive: June 16, 2022 – Governance Committee meeting
July 7, 2022 – Finance and Facilities Committee meeting

Item #	Delegation	Recommendation	Information	Report Name and Number	Link to Additional Information	Overview and Lead
Reports and Agenda Items						
1	**X**		**X**	Finance & Facilities Committee Meeting – July 7, 2022 (Report No. 43-22)	July 7, 2022 Agenda	To provide an update from the July 7, 2022 Finance and Facilities Committee meeting. Lead: Chair Michael Steele
2	**X**		**X**	Performance Appraisal Committee Meeting – July 7, 2022 (Verbal)	July 7, 2022 Agenda	To provide an update from the July 7, 2022 Performance Appraisal Committee meeting. Lead: Chair Maureen Cassidy
3		**X**	**X**	MLHU Q2 2022 Risk Register (Report No. 44-22)	Appendix A	To provide an update about the MLHU Q2 2022 Risk Register. Leads: Ms. Emily Williams, Chief Executive Officer and Ms. Kendra Ramer, Manager, Strategy, Risk, and Privacy
4			**X**	MLHU's Anti-Black Racism Plan: Implementation Update (Report No. 45-22)		To provide an update on the implementation of MLHU's Anti-Black Racism Plan. Leads: Ms. Heather Lokko, Chief Nursing Officer, and Mr. Christian Daboud, Manager, Health Equity
5		**X**	**X**	Feedback on Proposed Disclosure Requirement for Vaping Product Manufacturers Under the *Tobacco and Vaping Products Act* (Report No. 46-22)	Appendix A	To provide proposed feedback to Health Canada with regards to the proposed disclosure requirements for vaping product manufacturers. Leads: Ms. Maureen MacCormick, Director, Healthy Living and Ms. Linda Stobo, Manager, Chronic Disease Prevention and Tobacco Control

6	**X**		**X**	Current Public Health Issues Update (Verbal)		To provide an update on current public health issues in the Middlesex-London region. Lead: Dr. Alexander Summers
7			**X**	Medical Officer of Health Activity Report for June (Report No. 47-22)		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
8			**X**	Chief Executive Officer Activity Report for June (Report No. 48-22)		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						
9				July 2022 Correspondence		Endorse items a) and b) and receive item c).

OTHER BUSINESS

The next meeting of the Middlesex-London Board of Health is Thursday, August 18 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, June 16, 2022, 7:00 p.m.
MLHU Board Room – CitiPlaza
355 Wellington Street, London ON

MEMBERS PRESENT:	Mr. Matt Reid (Chair) Ms. Kelly Elliott (Vice-Chair) Mr. John Brennan Mr. Selomon Menghsha (attended Virtually) Ms. Mariam Hamou Ms. Maureen Cassidy (arrived 7:08 p.m.) Ms. Aina DeViet
REGRETS:	Ms. Tino Kasi Mr. Michael Steele
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 Ms. Stephanie Egelton, Executive Assistant, Medical Officer of Health and Associate Medical Officer of Health Ms. Mary Lou Albanese, Director, Environmental Health and Infectious Diseases Ms. Cynthia Bos, Manager, Human Resources Ms. Ronda Manning, Manager, Early Years Mr. David Jansseune, Assistant Director, Finance Mr. Dan Flaherty, Manager, Communications Ms. Lilka Young, Health and Safety Advisor Ms. Heather Bywaters, Public Health Nurse Ms. Nathalie Vandenheuvel, Public Health Nurse Mr. Alex Tyml, Online Communications Coordinator Mr. Parthiv Panchal, Information Technology, End User Support Analyst

Chair Matt Reid called the meeting to order at **7:00p.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. Kelly Elliott, seconded by Ms. Aina DeViet,** *that the **AGENDA** for the June 16, 2022 Board of Health meeting be approved.*

Carried

APPROVAL OF MINUTES

It was moved by **Ms. Mariam Hamou, seconded by Ms. DeViet,** *that the **MINUTES** of the May 19, 2022 Board of Health meeting be approved.*

Carried

It was moved by **Ms. Elliott, seconded by Mr. John Brennan,** *that the **MINUTES** of the June 2, 2022 Finance and Facilities Committee meeting be received.*

Carried

REPORTS AND AGENDA ITEMS

Finance & Facilities Committee Meeting – June 2, 2022 (Report No. 36-22)

This report was introduced by Ms. Elliott. Mr. David Jansseune, Associate Director, Finance was present to assist with answering any questions.

It was moved by **Ms. Elliott, seconded by Ms. Hamou,** *that the Board of Health receive Report No. 11-22FFC, re: Information Technology Services - Asset Management for information.*

Carried

It was moved by **Ms. Elliott, seconded by Ms. Hamou,** *that the Board of Health receive Report No. 12-22FFC, re: Q1 Financial Update and Factual Certificate for information.*

Carried

Verbal Governance Committee Meeting Summary from June 16, 2022

Ms. DeViet, Chair, Governance Committee provided a summary about the proceedings of the June 16, 2022 Governance Committee meeting, which had three (3) reports presented.

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

1. *Receive Report No. 10-22GC, re: "Governance By-law and Policy Review" for information; and*
2. *Approve the governance policies appended to this report (Appendix B) as amended.*

Carried

It was moved by **Ms. DeViet, seconded by Ms. Elliott,** *that the Board of Health receive Report No. 11-22GC, re: "2021-22 Provisional Plan Progress Update" for information.*

Carried

It was moved by **Ms. DeViet, seconded by Mr. Brennan,** *that the Board of Health strike the Performance Appraisal Committee for 2022.*

Carried

Chair Reid indicated that, due to the number of Board Members unable to attend, or not yet in attendance, at the meeting, he would not invite members to express interest in joining the Performance Appraisal Committee and move to appoint the membership at this meeting. He instructed Ms. Carolynne Gabriel, Executive Assistant to the Board of Health, to email members of the Board of Health to solicit interest for membership in the Performance Appraisal Committee and, in doing so, adhere to the Terms of Reference for the Committee in beginning the work of the Committee in a timely manner.

Ms. DeViet provided a summary of the proposed changes to the Board of Health By-law #3 and indicated that these changes would provide flexibility for members of the Board to attend meetings virtually or in person.

It was moved by **Ms. DeViet, seconded by Ms. Maureen Cassidy,** *that the Board of Health By-law #3 be now read for the first time.*

Carried

It was moved by **Ms. Elliott, seconded by Mr. Brennan,** *that the Board of Health By-law #3 be now read for a second time.*

Carried

It was moved by **Ms. Hamou, seconded by Ms. DeViet,** *that the Board of Health By-law #3 be now read for a third time and adopted.*

Carried

Middlesex-London Health Unit Be Well Program Update (Report No. 37-22)

This report was introduced by Ms. Emily Williams, CEO who introduced Ms. Cynthia Bos, Manager Human Resources. Ms. Bos introduced Ms. Lilka Young, Health and Safety Advisor who is co-chair of the Be Well Committee.

Highlights of this report included:

- In response to the COVID-19 pandemic, the Be Well Committee pivoted to virtual programming in order to keep staff engaged in its programming. As MLHU staff begin returning to the office in a hybrid model, Be Well will continue offering hybrid programming.
- Examples of programs provided by Be Well include: live virtual exercise classes, which were also recorded and made available on the Be Well website for staff to view when convenient; access to fitness videos on demand through Employee Wellness Solutions Network (EWSN); mental health workshops through Homewood Health, MLHU's employee and family assistance program (EFAP); nutrition sessions; group blood donations; and monthly virtual coffee breaks, which provide an opportunity for staff to gather virtually on Microsoft Teams and play games or have discussions.
- The EFAP program has been promoted frequently through townhalls and usage has seen an uptake in both telephonic counselling and proactive programming.
- The organization will continue to solicit feedback from staff on Be Well programming and incorporate the feedback into program offerings.

Ms. Hamou inquired if there were supports for those cycling to work. Ms. Young outlined the following:

- Staff with a parking pass at Citi Plaza also have access to a secure bike cage located in the parking garage.
- Staff without a parking pass at Citi Plaza can receive an access pass to the secure bike cage subsidized completely by Be Well. Those who would prefer to take the bus can submit for $20.00 per month subsidized by Be Well.
- These options and local cycling infrastructure were promoted by Be Well on townhalls and through Wellness Wednesday emails.
- Showers are available in the MLHU's basement at Citi Plaza.

Ms. Cassidy inquired about the participation rate of the survey outlined in the report and whether it was indicative of staff participation in Be Well programming. Ms. Young indicated that the survey was a new personal health assessment tool which was promoted to staff but participation in which is completely voluntary.

Ms. Cassidy inquired how Ms. Young would gauge overall participation. Ms. Young indicated that because Be Well provides such a variety of different activities, it is hard to speak to participation rates as some staff prefer passive activities such as reading articles, while others prefer more active, social activities like exercise classes and virtual coffee breaks. The testimonials included in the report speak to feedback provided to Be Well expressing appreciation for Be Well, especially during the pandemic.

Ms. DeViet commented on the utilization rate for Homewood Health included in the report, noting that it exceeds the 20 per cent originally budgeted. She commented that this increased use indicates that staff are comfortable requesting help when they need it, but inquired how exceeding the contracted 20 per cent affects the organization and the contract. Ms. Bos responded that MLHU's contract with them elapsed during the pandemic and Homewood Health renewed the contract at the same rate without another request for proposal. The cost in the contract is based on the number of potential users. Given the increase in staffing, it is expected that the contract will be more next renewal.

It was moved by **Ms. Hamou, seconded by Ms. Cassidy**, *that the Board of Health receive Report No. 37-22 re: "Middlesex-London Health Unit (MLHU) Be Well Program Update" for information.*

Carried

Joy In Work Update (Report No. 38-22)

This report was introduced by Ms. Emily Williams, CEO who shared a PowerPoint presentation.

Highlights of this report included:

- Burnout has taken a toll on MLHU staff and leaders.
- Leadership turnover has increased at MLHU with leaders citing heavy workload, struggles with work-life balance, and stress as contributing factors to their decision to leave the organization.
- Burnout negatively impacts staff engagement and subsequently client experience, quality, and safety.
- Supporting staff to deliver public health services while addressing staff well-being and mental health was made a strategic direction within the provisional strategic plan. Initiatives have included regular communications through townhalls, enhanced mental health benefits, and implementing the Joy In Work framework.
- The Joy In Work Framework will address the priorities of developing strategies to mitigate or address staff stress and/or burnout and executing a plan to value and recognize staff contributions in all MLHU programs, including opportunities to enhance staff connectedness and belonging.
- Joy In Work is a framework developed by the Institute for Healthcare Improvement. The framework includes the drivers found to improve Joy In Work as well as a high-level methodology for engaging staff in discussion. The tool serves as a conversation guide with staff. Staff must define "joy in work" for themselves. Staff engage in identifying what makes a good day at work and what impedes them from having a good day at work, and that feedback is refined into action items for implementation, which are then subject to daily improvement and real-time measurements to determine whether the interventions are having a positive impact.
- The framework has seven (7) main domains and two (2) methodology domains for quality improvement. The seven (7) main domains are: physical and psychological safety, meaning and purpose, choice and autonomy, recognition and rewards, participative management, camaraderie

and teamwork, and wellness and resilience. Improvement in all domains has been shown to improve joy in work.

- Steps to date to solicit feedback to inform mitigating staff burnout include: a staff survey which yielded fifty-four (54) recommendations related to organizational and individual wellness and sustaining positive organizational changes; intentional debriefing sessions with a third-party consultant and members of the leadership team which used the Joy In Work framework as a guide; "all feelings welcomed" session offered to staff during the Omicron wave and facilitated by a psychotherapist-trained leader within the organization; and structured and formal debriefing sessions offered to leaders through Homewood Health. All this feedback was mapped to the Joy In Work framework and validated by the leadership team.
- The Senior Leadership Team (SLT) determined that the leadership team (MLT) would be the first cohort to engage in the Joy In Work framework because leaders have significant influence over their direct reports' levels of engagement. Multiple sessions with the leadership team were held to clarify and theme the feedback received to align with the domains of the framework. This resulted in a comprehensive list of action items which would improve joy in work for leaders at MLHU. Directors worked with their divisions to further define approaches for engagement of leaders in each of the action items and to clarify realistic timing for implementation to ensure the required work does not further contribute to burnout. This resulted in a 12-month work plan.
- The Joy In Work framework will be rolled out to all staff in September.

It was moved by **Ms. Elliott, seconded by Ms. DeViet**, *that the Board of Health receive Report No. 38-22, re: "Joy in Work Update" for information.*

Carried

Implementation of the Early Years Outreach (EYO) Initiative (Report No. 39-22)

This report was introduced by Dr. Alexander Summers, Medical Officer of Health, who introduced Ms. Jennifer Proulx, the Acting Director for Healthy Start for the remainder of the year as Ms. Heather Lokko is seconded to the Chief Nursing Officer position full time.

Ms. Proulx introduced Ms. Ronda Manning, Manager, Early Years Community Health Promotion team. Ms. Manning thanked the Board for the opportunity to provide an update on the implementation of the Early Years Outreach Initiative. She then introduced Ms. Heather Bywaters, Public Health Nurse and Ms. Nathalie Vandenheuvel, Public Health Nurse.

Highlights of this report included:

- The relationship, experiences, and environment for children in their early years impacts their development long into adulthood. The protective factors in early years can improve the trajectory for them throughout their lives and for society as a whole. Childcare centres are key environments for early year development.
- It was identified that childcare providers needed more support during the pandemic. This led to the introduction of the Early Years Outreach Initiative.
- One activity of the initiative is an Early Years Outreach email which made it easier for early childhood educators to contact the Health Unit with questions. COVID-19 was a prominent topic, but questions were also received about child abuse, appropriate food, child development, etc.
- Another activity was the Childcare Educators webpage which provided a single location for information specific to early childhood educators as opposed to some information being included on webpages meant for schools.
- An e-newsletter was also developed and sent out monthly in both English and French. Alerts were sent out as needed as well as.
- An additional outcome from these initiatives is increased direct contact with childcare centres which has resulted in increased invitations to join community discussions.

Ms. Cassidy commented that there has been much dialog at City Hall about childcare, especially since the announcement of the National Child Care Strategy. It is anticipated that demand for childcare centres will increase when the funding comes into effect; however, it is unknown if there are sufficient childcare spaces in London to meet that demand. Similar to the health care field, early childhood educators have also been leaving the industry over the course of the pandemic. Ms. Bywaters indicated she has attended several meetings which have discussed this issue. She commented that early childhood educators are leaving the industry, and this has been exacerbated after the National Child Care Strategy was signed because they were expecting recognition as vital frontline workers and this did not happen. If they do not get more support and investment, early childhood educators could continue to leave the industry. London and Middlesex County have increased financial support for childcare centres; however, this means they will not get as much support through the National Child Care agreement. There is a lot of pressure for childcare centres to sign onto the agreement, but some are unsure.

Ms. Bywaters commented that she is grateful to be working in London and Middlesex because there is a network in London which provides advocacy as well as a recruitment and retention group in the county. MLHU is involved with both to provide support.

Ms. Elliott commented that Middlesex County falls well below the provincial average for licensed childcare sports. As a result, unlicensed and home daycares are used more. She inquired if any outreach to unlicensed providers had been done to provide them with information and add them to the e-newsletter distribution list. Ms. Bywaters responded that when the Early Years Initiative was started, the goals were kept small due to the size of the team. Outreach to unlicensed and home daycares has been identified as a next step of the initiative. COVID-19 prevented the team from conducting outreach in the community. Such outreach can be important for reaching unlicensed places as some do not like to be known to the Health Unit because they are unlicensed. Ms. Vandenheuvel added that word of mouth through community partnership meetings has resulted in some unlicensed centres signing up for the e-newsletter.

It was moved by **Ms. Elliott, seconded by Ms. Cassidy,** *that the Board of Health receive Report No. 39-22, re: "Implementation of the Early Years Outreach (EYO) Initiative)" for information.*

Carried

FoodNet Canada Ontario Sentinel Site Update and Memorandum of Agreement (Report No. 40-22)

This report was introduced by Ms. Mary Lou Albanese, Director, Environmental Health and Infectious Diseases.

Highlights of this report included:

- The Middlesex-London Health Unit has been involved with FoodNet Canada since 2014 and is the Ontario sentinel site. British Columbia, Alberta, and Quebec also have sentinel sites.
- The goal of the program is to monitor enteric illnesses and their associated risks. The program includes testing retail food, sampling manure and surface water, and following up with human cases. MLHU participates in all but manure sampling.
- MLHU is moving forward with renewing the memorandum of understanding for another two years. The partnership has been productive. An example is the investigations into human outbreaks of salmonella. It was determined that frozen chicken nuggets which were not fully cooked were the source of the salmonella. This evidence was presented to the Federal Government, and it is now required that the product has been fully cooked in order to be sold.

It was moved by **Ms. Cassidy, seconded by Ms. Hamou**, *that the Board of Health receive Report No. 40-22, re: "FoodNet Canada Ontario Sentinel Site Update and Memorandum of Agreement" for information.*

Carried

Verbal COVID-19 Disease Spread and Vaccine Campaign Update

This verbal report was presented by Dr. Summers. Highlights included:

- COVID-19 data continues to show a persistent decline although wastewater data is denoting an increase. Due to immunization coverage and natural immunity, which have decoupled severity of outcomes from the number of cases, hospitalization and ICU numbers continue to decline.
- The number of reported cases reflect the numbers seen in July of last year; however, in July 2021 testing eligibility was much more broad so the numbers cannot be directly compared, but they are showing a persistent decline.
- With warmer weather limiting indoor activities as well as high immunization rates and natural immunity, the rate of COVID-19 and risks are likely to be as low as they will ever be.
- COVID-19 is endemic, but its impact on the healthcare system will likely be less than in the past. It is likely that COVID-19 will be seasonal in the future along with influenza; how the healthcare system and society adjusts to this remains to be seen.
- With the shift into summer and being mindful that rates and risks are as low as they are likely to get, MLHU has changed its recommendations on masking. Universal masking is still recommended in high-risk settings such as healthcare settings, clinical spaces, and facilities with immunocompromised individuals. Universal eye protection is not required at this time.
- In the community, masking is becoming a personal decision relative to an individual's risk. Masking remains protective, but given the low rates of COVID-19, it is a personal choice. Vaccination remains the best way to reduce personal risk to adverse outcome from COVID-19.
- Businesses may continue to require masking, and this should be respected.
- When autumn comes or a new variant rises, masking recommendations may need to be altered.
- At MLHU, internal policies have been aligned with community recommendations. Medical masks are still required in clinical spaces, but masks are optional in non-clinical spaces. Active screening of all staff and clients remains required.
- Vaccination efforts continue. It is anticipated that there will be a fall booster campaign in which MLHU will play a significant role along with pharmacies and primary care providers. The timeline for second booster doses for those under the age of 60 is not yet clear but is not anticipated during the summer unless there is a new variant or a change in trends. The timeline for vaccinations for those under the age of five is unclear. Moderna has submitted an application to Health Canada.
- MLHU plans on having the capacity to meet the anticipated vaccination needs in the fall and winter, as outlined in Report No. 29-22, "MLHU 2022 Infectious Disease Control Operational Update."

Ms. Cassidy inquired if the wastewater data is a lagging indicator. Dr. Summers replied that in the Middlesex-London region, the wastewater data has historically followed the case trends, this is not happening now, likely due to the decoupling of the number of cases from those cases which are severe enough to require testing, hospitalization, and ICU admission. Wastewater data needs to be contextualized by other indicators as it can be affected by natural factors such as drought or heavy rains.

Ms. Cassidy inquired if Dr. Summers anticipates new variants of concern will increase locally due to the increase in international travel. Dr. Summers responded that the variants currently being seen in Ontario are sub-lineages of the Omicron variant. What these sub-lineages mean for the population is not yet clear, although it is likely that some variants may increase the risk of re-infection. At this time, a truly new variant which will completely change the population response due to immune variation has not been detected. Travel does affect the mixing of populations across the globe so hypothetically the risk of new variant spread could go up; however, travel restrictions are only effective if they are a true lockdown. Restrictions at a softer level have not appeared to impact the spread of new variants.

Ms. Cassidy inquired if there is any indication of a change in the rate of childhood vaccination. Prior to the pandemic there had been an increase in vaccine hesitancy among parents. Are parents more willing due to COVID-19? Dr. Summers responded that prior to the pandemic the Middlesex-London community

continued to see a fairly robust vaccine uptake. There is a lack of a comprehensive vaccine registry prior to children attending school. There is currently such a register for the COVID-19 vaccine but not for other childhood vaccines. This lack of a comprehensive registry for children under the age of five is a gap. With regards to whether vaccination rates in children have increased, it is too early to say. There has been little opportunity to update vaccination information as a Health Unit and families have not had as many opportunities to get vaccinated. MLHU has been screening every child enrolled in schools in the region to determine if their vaccines are up to date, and if they are not, letters are being sent to provide parents with an opportunity to submit vaccine records or to have children vaccinated at "catch-up clinics." There has been tremendous response to these letters with the "catch-up clinics" being fully booked. Additionally, in the next school year, the Health Unit can use the *Immunization Schools Pupil Act* to suspend those who do not have the required vaccinations. MLHU is one of a few Health Units which has had the capacity to do this work during the COVID-19 pandemic.

Ms. DeViet inquired if the second booster dose, anticipated to be available in the fall for the general public, would provide protection against any future variant which may arrive in Ontario. Dr. Summers indicated that the fall booster dose campaign could go in one of two directions. If the predominant variant continues to be Omicron and Omicron-specific vaccines have been approved, those vaccines would be provided during the campaign. Otherwise, existing vaccines will be provided. Existing vaccines provide some protection against Omicron and much better protection against severe outcomes. While they were originally developed to protect against the Alpha strain, they have been effective against the subsequent strains, so existing vaccines could be effective against any future variants as well.

Ms. DeViet commented that she knows individuals who are eligible for a second booster dose but who have not received it yet because it is summer and they want to put it off until the fall when there is potentially higher risks. She inquired what Dr. Summers advise would be. Dr. Summers indicated that he continues to advise that those who are eligible get the vaccine when they become eligible. COVID-19 is still in the community and if individuals wait to get the vaccine, they are still at risk during that delay. Those who are eligible are so because they are at a higher risk of severe outcomes and so should be up to date with their vaccines.

It was moved by **Ms. Cassidy, seconded by Ms. DeViet,** *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 May (Report No. 41-22)

This report was introduced by Dr. Summers. In addition to the content of the report he apprised the Board that as of two days ago, he is now the COMOH Representative, South West Region.

It was moved by **Mr. Brennan, seconded by Ms. Hamou,** *that the Board of Health receive Report No. 41-22 re: "Medical Officer of Health Activity Report for May" for information.*

Carried

Chief Executive Officer Activity Report for May (Report No. 42-22)

This report was introduced by Ms. Williams. In addition to the content of the report she apprised the Board that the collective agreement negotiated with CUPE has now been ratified.

It was moved by **Ms. Cassidy, seconded by Ms. Elliott,** *that the Board of Health receive Report No. 42-22 re: "Chief Executive Officer Activity Report for May" for information.*

Carried

CORRESPONDENCE

No correspondence was received in May.

OTHER BUSINESS

The next meeting of the Middlesex-London Board of Health is Thursday, July 14 at 6:00 p.m.

CONFIDENTIAL

At **8:17 p.m.,** it was moved by **Ms. Elliott, seconded by Ms. Cassidy,** *that the Board of Health will move in-camera to approve previous confidential Board of Health minutes, and to consider matters regarding personal matters about an identifiable individual, including municipal or local board employees, labour relations or employee negotiations, and litigation or potential litigation, including matters before administrative tribunals, affecting the municipality or local board.*

Carried

At **8:24 p.m.,** it was moved by **Ms. Elliott, seconded by Ms. DeViet,** *that the Board of Health rise and return to public session.*

Carried

ADJOURNMENT

At **8:25 p.m**., it was moved by **Ms. Elliott, seconded by Ms. Cassidy,** *that the meeting be adjourned.*

Carried

MATT REID
Chair

EMILY WILLIAMS
Secretary

PUBLIC SESSION – MINUTES
MIDDLESEX-LONDON BOARD OF HEALTH

Thursday, July 7, 2022, 10:00 a.m.
Microsoft Teams

MEMBERS PRESENT:	Mr. Matt Reid (Chair) Ms. Kelly Elliott (Vice-Chair) Mr. Selomon Menghsha Ms. Mariam Hamou Ms. Maureen Cassidy Ms. Aina DeViet Mr. Michael Steele Ms. Tino Kasi
REGRETS:	Mr. John Brennan
OTHERS PRESENT:	Ms. Carolynne Gabriel, Executive Assistant to the Board of Health and Communications Coordinator (Recorder) Dr. Alexander Summers, Medical Officer of Health

Chair Matt Reid called the meeting to order at **10:00 a.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. Mariam Hamou, seconded by Ms. Maureen Cassidy** *that the **AGENDA** for the July 7, 2022 Special Meeting of the Board of Health be approved.*

Carried

REPORTS AND AGENDA ITEMS

Appointment of membership to the Performance Appraisal Committee for 2022

Chair Reid noted that the Performance Appraisal Committee Terms of Reference state: The membership of the Performance Appraisal Committee will consist of the members of the Governance Committee and other Board of Health members as may be deemed appropriate.

As members of the Governance Committee, the following members are by default on the Performance Appraisal Committee: Chair Reid, Ms. Kelly Elliott, Ms. DeViet, Mr. Michael Steele, and Ms. Tino Kasi.

Chair Reid invited Board members to express their interest in being a member of the Performance Appraisal Committee for 2022. Ms. Hamou had previously expressed interest. Ms. Cassidy also expressed her interest.

Chair Reid inquired if any other member was interested. None were declared.

It was moved by **Ms. Hamou, seconded by Mr. Selomon Menghsha,** *that Mr. Reid, Ms. Elliott, Ms. DeViet, Ms. Kasi, Mr. Steele, Ms. Cassidy and Ms. Hamou be appointed to the Performance Appraisal Committee for 2022.*

Carried

ADJOURNMENT

At **10:02 a.m**., it was moved by **Ms. Elliott, seconded by Mr. Steele,** *that the meeting be adjourned.*

Carried

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

PUBLIC MINUTES
GOVERNANCE COMMITTEE
Microsoft Teams
Thursday, June 16, 2022 6:00 p.m.

MEMBERS PRESENT: Ms. Aina DeViet (Chair)
Mr. Matt Reid
Ms. Kelly Elliott

REGRETS: Ms. Tino Kasi
Mr. Michael Steele

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. Mariam Hamou, Member, Board of Health
Ms. Kendra Ramer, Manager, Privacy, Risk and Governance
Ms. Cynthia Bos, Manager, Human Resources
Ms. Lilka Young, Health and Safety Advisor

At **6:01 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. Matt Reid, seconded by Ms. Kelly Elliott,** *that the **AGENDA** for the June 16, 2022 Governance Committee meeting be approved.*

Carried

APPROVAL OF MINUTES

It was moved by **Ms. Elliott, seconded by Mr. Reid,** *that the **MINUTES** of the April 21, 2022 Governance Committee meeting be approved.*

Carried

NEW BUSINESS

Governance By-law and Policy Review (Report No. 10-22GC)

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

Highlights of this report included:

- Four (4) policies were included for review: G-080 Occupational Health and Safety, G-290 Standing and Ad Hoc Committees, G-340 Whistleblower, and G-500 COVID-19 Immunization.
- There were no changes of note to policy G-340 Whistleblower.

- Policies G-080 Occupational Health and Safety and G-500 COVID-19 Immunization were updated to align with staff policies.
- Minimal changes were made to policy G-290 Standing and Ad Hoc Committees to include Terms of Reference and a reporting calendar for the Performance Appraisal Committee. A recommendation was also made to recommend to the Board of Health to strike the Performance Appraisal Committee and appoint members for this committee at the June 16, 2022 or July 14, 2022 Board of Health meeting.
- Currently there are no by-laws or policies coming up for review in Q3 or Q4 of 2022. It is recommended that the Governance Committee continue its review cycle to more evenly distribute the workload for committee members.

Chair DeViet noted in Appendix E of Policy G-290, Performance Appraisal Committee Terms of Reference, under the header "Frequency of Meetings", it says "The Governance Committee will meet three (3) times per year or at the call of the Chair of the Committee." She inquired if it should say "Performance Appraisal Committee" instead of "Governance Committee."

Mr. Reid agreed it should be changed to "Performance Appraisal Committee" and recommended changing the sentence to read "at least three (3) per year or at the call of the Chair of the Committee."

It was moved by **Mr. Reid**, **seconded by Ms. Elliott,** *that the Governance Committee recommend to the Board of Health to:*
1) Receive Report No. 10-22GC, re: "Governance By-law and Policy Review" for information; and
2) Approve the governance policies appended to this report (Appendix B) as amended.

Carried

It was moved by **Ms. Elliott, seconded by Mr. Reid,** *that the Governance Committee recommend to the Board of Health to strike the Performance Appraisal Committee for 2022.*

Carried

2021-22 Provisional Plan Progress Update (Report No. 11-22GC)

This report was introduced by Ms. Williams who introduced Ms. Ramer.

Highlights of this report included:
- Seven (7) projects were initiated or resumed during Q2 2022.
- Two goals associated with projects had problems surface which are causing delays, highlighted at a high level in Appendix B:
    1) Funding was not approved to move forward with the expansion of electronic client records. This problem is not unique to MLHU as this funding was not provided to all health units requesting it. Despite this challenge, there is still a plan to move forward as highlighted in Appendix C.
    2) The Anti-Black Racism Plan will fall behind schedule due to resource capacity and allocation within the Health Equity team. Due to the breadth of recommendations in the Anti-Black Racism Plan and the limited capacity currently within the Health Equity team, focus is being placed on recommendations which have a dependency on other strategic projects, for example the Employment Systems Review led by the Human Resources team.
- A report card on the goals of the Provisional Strategic Plan will be presented to the Governance Committee in Q3.
- One of the projects identified in the Provisional Strategic Plan, Joy In Work, is being brought forward to the Board of Health in a separate report and therefore is not detailed in this report.

Chair Reid confirmed with Ms. Ramer that the Provisional Strategic Plan will carry into 2023 due to its timelines being elongated with Board approval in February 2022.

Ms. Ramer informed the Board that the consultation phase with internal and external stakeholders will begin in Q3 of 2022 as part of the next strategic planning cycle.

Chair DeViet inquired about the information contained in the report about the transition to the SharePoint file system. Under the heading "Top Risks" it states "resistance to change". Chair DeViet inquired if any change management protocols or steps have been put in place to mitigate this risk. Ms. Williams informed the Board that the transition to SharePoint has begun with groups which have expressed interest and these groups are piloting the transition and sharing their lessons learned. Those who are less eager to transition will be offered training and an opportunity to meet with the teams who have already gone through the process.

It was moved by **Ms. Elliott**, **seconded by Mr. Reid,** *that the Governance Committee recommend to the Board of Health to receive Report No. 11-22GC, re: "2021-22 Provisional Plan Progress Update" for information.*

Carried

Board of Health By-Law #3 Review (Verbal)

Ms. Williams introduced this verbal report.

Highlights of the report included:

- Board of Health By-law #3 currently has limitations on attending Board of Health and committee meetings electronically outside of a declaration of emergency. As of last week, all local emergency orders have been rescinded. The limitations included that members attending electronically did not count towards quorum and could not attend in-camera meetings.
- Following research into the matter, it was determined that in 2020, the *Municipal Act* was updated to allow for boards to include in their by-laws that members could meet virtually outside of an emergency declaration and, while doing so, count towards quorum and attend in-camera meetings.
- Presuming the Board members would like the option to continue to meet virtually, changes to By-law #3 were proposed. If the changes are approved, the Board will have the flexibility, at the call of the Chair and under the advisement of the Medical Officer of Health, to meet virtually.
- The proposed changes to the wording of the by-law included:
    - 6.2 In accordance with Section 238(3.1) of the *Municipal Act*, R.S.O., the Board shall ensure that members can participate electronically in a meeting which is open to the public. Any such member shall be counted in determining whether or not a quorum of members is present at any point in time. Board members shall also be permitted to participate electronically in a meeting which is closed to the public.
    - 6.3 A member who is participating electronically in a meeting shall be able to vote on any matter that is before the Board, subject to restrictions contained elsewhere in this policy, and otherwise at law.
    - Section 6.4, which refers to declarations of emergency, is removed.

Mr. Reid noted that other Boards, including the London Police Board, are continuing to implement a hybrid model. He indicated that having the flexibility of attending in person or virtually would be an asset to accommodate for the preferences of the individual Board members, for example those having to travel far distances to attend in person.

Ms. Elliott requested if the language could be updated to clearly indicate a hybrid model such that both virtual and in-person attendance can occur during the same meeting.

Ms. Williams suggested beginning section 6.2 with "In order to support a hybrid model…".

Ms. Elliott suggested adding to section 6.2 "…the Board, meeting in a hybrid model, shall ensure…". Dr. Alexander Summers, Medical Officer of Health, suggested changing the wording to "…the Board shall ensure that members may participate electronically…". He also stated that the intention for MLHU staff is to attend in person if the meeting is in person, except for exceptional circumstances.

Chair DeViet indicated that the ability to attend any meeting virtually, even an in-person meeting, would be an asset to ensure quorum. For example, members would still be able to count towards quorum if they felt ill and could not come in-person, but felt well enough to attend virtually.

It was agreed to change the language as suggested by Dr. Summers.

It was moved by **Mr. Reid, seconded by Ms. Elliott,** *that the Governance Committee receive the Verbal "Board of Health By-Law #3 Review" for information.*

Carried

It was moved by **Mr. Reid, seconded by Ms. Elliott,** *that the Governance Committee recommend to the Board of Health to amend Board of Health By-Law #3.*

Carried

OTHER BUSINESS

The next meeting of the Governance Committee will be held on Thursday, September 15, 2022 at 6:00 p.m.

ADJOURNMENT

At **6:24 p.m.,** it was moved by **Ms. Elliott, seconded by Mr. Reid**, *that the meeting be adjourned.*

Carried

AINA DEVIET
Chair

EMILY WILLIAMS
Secretary

PUBLIC MINUTES
FINANCE & FACILITIES COMMITTEE
Microsoft Teams
Thursday, July 7, 2022 at 9 a.m.

MEMBERS PRESENT: Mr. Mike Steele (Chair)
Mr. Matt Reid
Ms. Kelly Elliott
Mr. Selomon Menghsha
Ms. Maureen Cassidy (arrived at 9:25)

OTHERS PRESENT: Ms. Stephanie Egelton, Senior Executive Assistant to the Medical Officer of Health (Recorder)
Ms. Emily Williams, Chief Executive Officer
Dr. Alexander Summers, Medical Officer of Health
Mr. David Jansseune, Assistant Director, Finance
Ms. Carolynne Gabriel, Communications Coordinator and Executive Assistant to the Board of Health
Ms. Katie denBok, Partner, Audit, KPMG LLP
Ms. Aina DeViet, Board Member
Ms. Lil Marinko, Associate Manager, Vaccine Preventable Disease

At **9:03 a.m.,** Chair Mike Steele called the meeting to order.

DISCLOSURES OF CONFLICT OF INTEREST

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

APPROVAL OF AGENDA

It was moved by **Ms. Kelly Elliott, seconded by Mr. Matt Reid,** *that the **AGENDA** for the July 7, 2022 Finance & Facilities Committee meeting be approved.*

Carried

APPROVAL OF MINUTES

It was moved by **Mr. Reid, seconded by Ms. Elliott,** *that the **MINUTES** of the June 2, 2022 Finance & Facilities Committee meeting be approved.*

Carried

CONFIDENTIAL

At **9:04 a.m**., it was moved by **Mr. Reid, seconded by Ms. Elliott,** *that the Finance & Facilities Committee move into a confidential session to consider matters regarding 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;*

Carried

At **9:10 a.m.,** it was moved by **Mr. Reid, seconded by Ms. Elliott,** *that the Finance & Facilities Committee rise and return to public session from closed session.*

Carried

NEW BUSINESS

2021 Draft Financial Statements (Report No. 13-22FFC)

Ms. Emily Williams, Chief Executive Officer introduced Mr. David Jansseune, Assistant Director, Finance. The work of the Finance Team at the Health Unit and the partnership with KPMG during the audit process was acknowledged.

Ms. Katie denBok, Partner, Audit, of KPMG presented highlights of the audit:

- The financial audit of the Health Unit was completed on June 13, 2022. It is noted that the following matters are still pending: Obtaining updated legal responses, obtaining the signed management representation letter, completing discussions with the Finance and Facilities committee and obtaining evidence of the Board's approval of the financial statements.
- 5 days after the Board approves these financial statements (after July 14, 2022), KPMG will issue a clean financial statement/auditors report.
- KPMG, in accordance with Canadian Accounting Standards, are independent to the Health Unit.
- There are no significant changes to the audit plan, no going concerns, significant risks, uncorrected audit misstatements, significant accounting policy and procedures or control deficiencies to report.
- It is noted under materiality that the Health Unit's audit misstatement posting threshold has been set at $58,850 (2020 - $53,800).
- It is noted that there was a reclassification of financial position made, related to an amount of funds owing to the City of London ($2,189,701).
- Under risks, it was noted that KPMG rebutted the fraud risk from revenue recognition as this is not applicable to the Health Unit.
- It is noted that in 2023, there will be changes to Canadian Accounting Standards regarding asset retirement obligations and financial instruments.

Further, Ms. denBok presented highlights of the draft 2021 financial statements:

- It is noted that increased work of the Health Unit during the pandemic increased overall operations, cash, revenues and expenditures.
- Benefits/salaries increased due to operations needed to support the pandemic effort.
- Accumulated surplus is $549,917 – including $789,355 related to amortization, less tangible capital assets of $260,000.
- Revenue and expenses increased due to COVID spending and COVID funding, with the largest increase in expenditures being in salaries and materials for vaccination clinics, resulting in a small deficit of $256,494.

Mr. Jansseune noted that the deficit of $256,494 does not represent a true deficit, and is considered an accounting deficit, not a cash deficit due to differences in Public Sector Accounting Standard requirements. During Q4, the Health unit demonstrated a to the Board a balanced budget. This difference can be accounted for by the non-cash amortization of $789,355, less the purchase of capital assets, the principal payments on the bank loan, and a CitiPlaza tenant incentive.

It is noted that benefits did not increase, due to many employees being hired on contracts during the pandemic. A committee member thanked the finance team and audit partners for managing the uncertainty associated with the pandemic and ensuring appropriate financial tracking processes remained in place.

It was moved by **Ms. Maureen Cassidy, seconded by Mr. Reid,** *that the Finance & Facilities Committee make a recommendation to the Board of Health to review and approve the audited Financial Statements for the Middlesex-London Health Unit for the year ending December 31, 2021.*

Carried

Chair Steele thanked the Finance Team and Ms. denBok for their support and presentation.

OTHER BUSINESS

The next meeting of the Finance and Facilities Committee will be communicated at the call of the Chair.

It was also reminded to the Committee that there is a Special Meeting of the Board of Health at 10 a.m.

ADJOURNMENT

At **9:31 a.m.,** it was moved by **Mr. Reid, seconded by Ms. Elliott,** *that the meeting be adjourned.*

Carried

MICHAEL STEELE
Chair

EMILY WILLIAMS
Secretary

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 43-22

TO: Chair and Members of the Board of Health

FROM: Emily Williams, Chief Executive Officer

DATE: 2022 July 14

FINANCE & FACILITIES COMMITTEE MEETING – July 7, 2022

The Finance & Facilities Committee (FFC) met at 9 a.m. on Thursday, July 7, 2022.

Reports	Recommendations for Information and Board of Health Consideration
2021 Draft Financial Statements **(Report No. 13-22FFC)**	It was moved by **Ms. Maureen Cassidy, seconded by Mr. Matt Reid,** *that the Finance & Facilities Committee make a recommendation to the Board of Health to review and approve the audited Financial Statements for the Middlesex-London Health Unit for the year ending December 31, 2021.* Carried

This report was prepared by the Chief Executive Officer.

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

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 44-22

TO: Chair and Members of the Board of Health

FROM: Emily William, CEO
Alexander Summers, MOH

DATE: 2022 July 16

MLHU Q2 2022 RISK REGISTER

Recommendation

It is recommended that the Board of Health:

1) ***Receive Report No. 44-22 for information; and***
2) ***Approve the Q2 2022 Risk Register (Appendix A).***

Key Points

- MLHU has shifted to quarterly risk reporting using the new Risk Register approved by the Board of Health on February 17, 2022.
- Thirteen (13) of the 14 high risks identified on the Risk Register were mitigated to achieve either a moderate or low residual risk rating in Q2 2022.
- One (1) high risk will be removed in Q3 due to successful risk mitigation during Q2.
- Two (2) medium risks and one (1) low risk continue to be mitigated to remain at minor residual risk in Q2.
- One (1) new high risk has been reported in Q2.

Background

At its meeting on February 17, 2022, the Board of Health approved the new MLHU Risk Management Plan and Risk Register to address the gaps in the risk reporting process. The Risk Register (Appendix A) is a repository for all risks identified across the organization and includes additional information about each risk (priority rating, mitigation strategies, and residual risk). It captures MLHU's actions taken to address risks which are monitored on a quarterly basis and reported to the Board.

Q2 2022 Risk Register

A total of 12 high risks were identified in Q4 2021 and two (2) new high risks were identified in Q1 2022. Through the implementation of effective/partly effective mitigation strategies, six (6) of these high risks are now ranked as moderate residual risk and seven (7) are ranked as minor residual risk. There is one (1) high risk that has now been eliminated due to successful mitigation and will be removed from the Risk Register in Q3.

There are two (2) medium risks and one (1) low risk reported in Q4 2021 and Q1 2022 that are all ranked at minor residual risk for Q2.

There is one (1) medium risk and one (1) low risk identified on the Risk Register with effective mitigation strategies, both ranking as minor residual risk.

There is one (1) new high risk identified in Q2, categorized as Political, due to the most recent provincial election that highlights additional uncertainty related to public health modernization. Effectiveness of the mitigation strategies to address this risk cannot be assessed as this time.

Next Steps

It is recommended that the Board of Health review and approve the Q2 2022 Risk Register (Appendix A) included with this report.

This report was prepared by the Manager, Privacy, Risk and Project Management.

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

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

RISK MANAGEMENT PLAN

Area:	
Date:	
Version:	

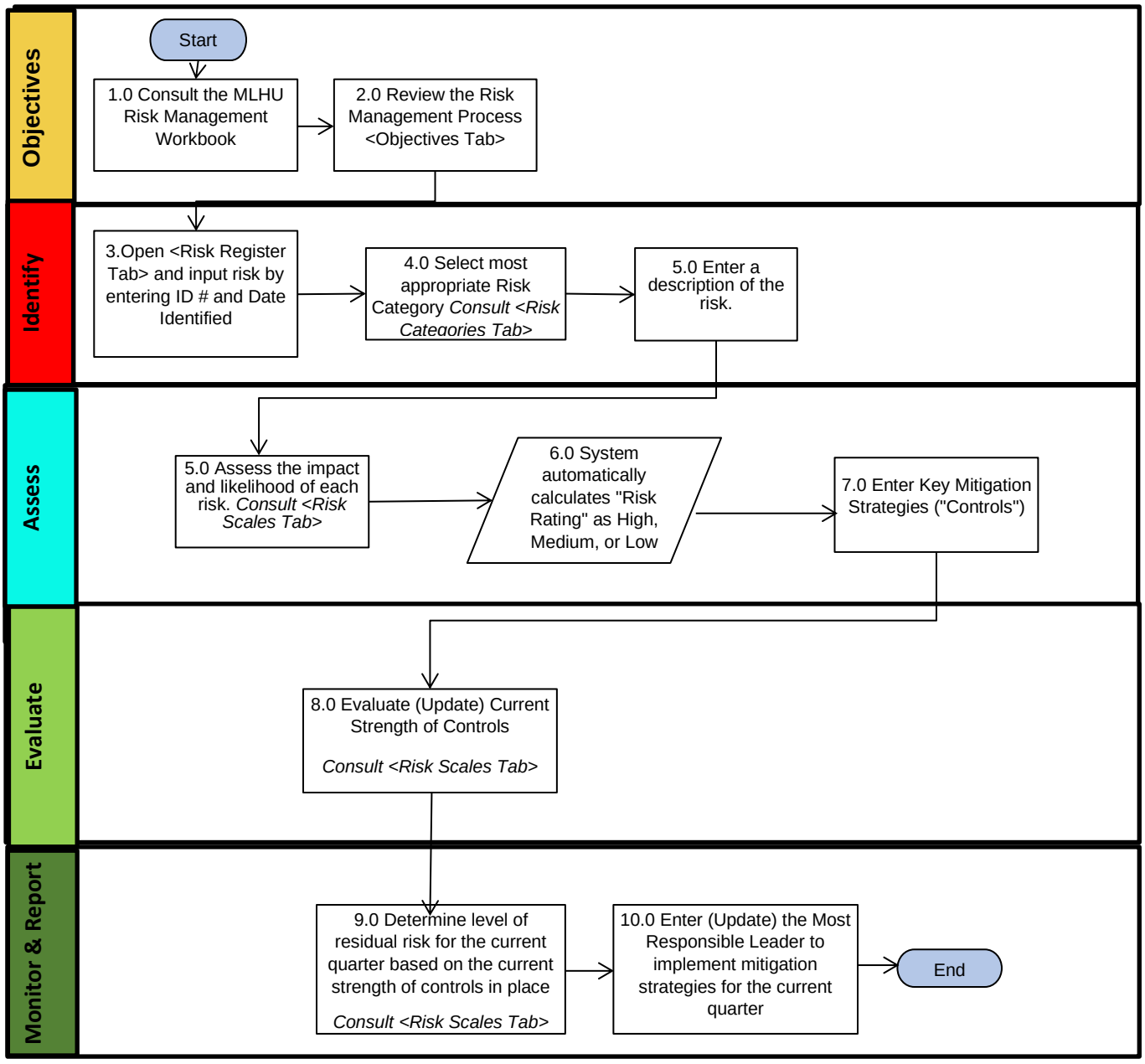
Purpose:	*This tool is designed to identify, assess and evaluate the risks facing MLHU and provide a comprehensive report on a quarterly basis.*

Background:	*This tool is designed to create a risk register that is consistent with the annual Standard Activity Report that is submitted annually to the Ministry.*

Workbook Index

Worksheet Name	Description
Overview	This worksheet provides the overview of the project and a table of contents to navigate the workbook.
Instructions	This worksheet provides users with the instructions for using this workbook. This tab should be reviewed prior to executing the risk assessment workbook. A process flowchart and detailed user guide are included.
Risk Categories	This worksheet provides the definitions of the risk categories used to identify risks.
Objectives	This worksheet highlights the risk management process.
Risk Register	This worksheet is used to identify potential risk categories, assess risks and mitigation strategies, evaluate strenth of controls, monitor and report residual risks on a quarterly basis.
Risk Matrix	This worksheet displays the results of the risk assessment into graphics for reporting and decision making purposes.
Risk Charts	This worksheet displays the results of the risk assessment into summary tables and charts.
Risk Scales	This worksheet provides the ranking models used to conduct the risk assessment.
Reference	This worksheet displays the drop down lists utilized in the risk register.

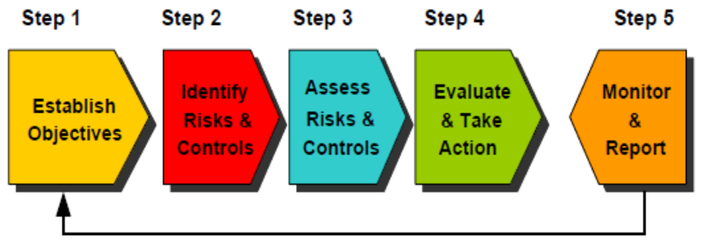
The MLHU Risk Management Process



RISK CATEGORIES

Financial	Operational or Service Delivery	Strategic/Policy
Uncertainty around obtaining, committing, using, losing economic resources or not meeting overall financial budgets/commitments.	Uncertainty regarding activities performed in carrying out the entity's strategies or how the entity delivers services.	Uncertainty around strategies and policies achieving required results; or that old and/or new policies, directives, guidelines, legislation, processes, systems, and procedures fail to recognize and adapt to changes.
Stakeholder/Public Perception	**People/Human Resources**	**Legal Compliance**
Uncertainty around managing the expectations of the public, other governments, Ministries, or other stakeholders and the media to prevent disruption or criticism of the service and a negative public image.	Uncertainty as to the capacity of the entity to attract, develop and retain the talent needed to meet the objectives.	Uncertainty regarding compliance with laws, regulations, standards, policies, directives, contracts, MOU's and the risk of litigation.
Security	**Information/Knowledge**	**Governance/Organizational**
Uncertainty relating to breaches in physical or logical access to data and locations (offices, warehouses, labs, etc.)	Uncertainty regarding access to, or use of, inaccurate, incomplete, obsolete, irrelevant or untimely information, unreliable information systems; inaccurate or misleading reporting.	Uncertainty about maintenance or development of appropriate accountability and control mechanisms such as organizational structures and systems processes; systemic issues, culture and values, organizational capacity, commitment and learning and management systems, etc.
Political	**Technology**	**Privacy**
Uncertainty that events may arise from or impact the Minister's Office/Ministry, e.g. a change in government, political priorities, or policy direction.	Uncertainty regarding alignment of IT infrastructure with technology and business requirements; availability of technological resources.	Uncertainty with regards to exposure of personal information or data; fraud o identity theft; unauthorized data.
Environmental	**Equity**	
Uncertainty usually due to the external risks facing an organization including air, water, earth, forests. An example of an environment, ecological risk would be the possible occurrence of a natural disaster and its impact on an organization's operations.	Uncertainty that policies, programs or services will have a disproportionate impact on the population.	

The risk management process



Step 1: Establish objectives

- Risks must be assessed and prioritized in relation to an objective
- Objectives can be at any level; operational, program, initiative, unit, branch, health system
- Each objective can be general or can include specific goals, key milestones, deliverables and commitments

Step 2: Identify risks & controls

Identify risks - What could go wrong?

- Consider each category of risk
- Obtain available evidence
- Brainstorm with colleagues and/or stakeholders
- Examine trends and consider past risk events
- Obtain information from similar organizations or projects
- Increase awareness of new initiatives/ agendas and regulations

Identify existing controls – What do you already have in place?

- Preventive controls
- Detective controls
- Recovery / Corrective controls

Step 3: Assess Risks & Controls

Assess inherent risks

- *Inherent likelihood* – Without any mitigation, how likely is this risk?
- *Inherent impact* – Without any mitigation, how big will be the impact of the risk on your objective?

Assess controls

- Evaluate possible preventive, detective, or corrective mitigation strategies.

Reassess residual risks

- Re-assess the impact, likelihood and proximity of the risk with mitigation strategies in place.
- *Residual likelihood* – With mitigation strategies in place, how likely is this risk?
- *Residual impact* – With mitigation strategies in place, how big an impact will this risk have on your objective?

Step 4: Evaluate & Take Action

- Identify risk owners.
- Identify control owners.
- Have mitigation strategies reduced the risk rating (Impact x Likelihood) enough that the risk is below approved risk tolerance levels?
- Do you need to implement further mitigation strategies?
- Develop SMART (Specific, Measurable, Achievable, Realistic, Time-specific) actions that will either reduce the likelihood of the risks or minimise the impact.
- Develop detailed action plans with timelines, responsibilities and outline deliveries.

Step 5: Monitor & Report

- Have processes in place to review risk levels and risk mitigation strategies as appropriate.
- Monitor and update by asking:
  - Have risks changed? How?
  - Are there new risks? Assess them
  - Do you need to report or escalate risks? To whom? When? How?
- Develop and monitor risk indicators

Risk Tolerance

- The amount of risk that the area being assessed can manage

Risk Appetite

- The amount of risk that the area being assessed is willing to manage

The tolerance and risk appetite values may differ e.g. Staff can afford to lose email capabilities for five hours (risk tolerance) but only be willing to lose email capabilities for one hour (risk appetite).

VALUE	LIKELIHOOD	IMPACT	PROXIMITY	*SCALE*
1	Unlikely to occur	Negligible Impact	More than 36 months	*Very Low*
2	May occur occasionally	Minor impact on time, cost or quality	12 to 24 months	*Low*
3	Is as likely as not to occur	Notable impact on time, cost or quality	6 to 12 months	*Medium*
4	Is likely to occur	Substantial impact on time, cost or quality	Less than 6 months	*High*
5	Is almost certain to occur	Threatens the success of the project	Now	*Very High*

Update Risk Matrix

MLHU RISK REGISTER

IDENTIFY				ASSESS				EVALUATE		MONITOR & REPORT					Comments
ID	Date Identified	Risk Category	Risk Description	Impact (1-5)	Likelihood (1-5)	Risk Rating (H,M,L)	Key Mitigation Strategies ("Controls")	Actions Taken	Current Strength of Controls	Q1 Residual Risk	Q2 Residual Risk	Q3 Residual Risk	Q4 Residual Risk	Most Responsible Leader	Comments
1	Dec-21	Operational/Service Delivery	Core public Health services below essential levels due to pandemic response	4	4	H	Strategic planning in the midst of the pandemic will help to focus on what priorities the organization should start, stop or continuing doing in order to meet the evolving needs of the community. Adapting the strategic priorities and roadmap to be more agile, flexible, and directional will be crucial for service delivery planning. The likelihood of core public health services falling below essential levels is expected to decrease after Q1 2022 with continued implementation of the risk mitigation strategies mentioned.	Significant repatriation of staff, expanded hiring, stabilization of leadership and reengagement with community partners in non COVID areas. Putting efforts into planning to be able to resume our core public health services took place during Q1. A majority of public health services have resumed in Q2.	Effective	Moderate Risk	Minor Risk			CEO MOH	
2	Dec-21	Equity	Lack of resources to respond to emerging and exacerbated public health issues as a result of the pandemic, including food insecurity, domestic violence, racism, substance misuse and mental health	4	5	H	Efforts to address emerging and exacerbated public health issues have been underway in MLHU programs since the outset of the pandemic (e.g., COVID Care packages provided to clients in quarantine/self-isolation, enhanced mental health screening in home visiting programs, Harvest Bucks and food cards provided to HBHC clients, mobile vaccine clinics offered in collaboration with Black-led organizations, etc.). Our website has up-to-date information about community resources related to these issues, and staff will continue to make referrals. As the COVID response evolves MLHU will strive to ensure these efforts are comprehensive and universal at a system level. MLHLU has prioritized anti-Black racism work; an organizational plan has been created and implementation will begin in January 2022.	Established an advisory committee and additional planning work that has been undertaken in Healthy Living. Repatriation of staff back to their programs provides the resources to address the planning needs. Pivoting planning to focus on emerging local public health issues, including homelessness and substance use has been a key action during Q2.	Partly Effective	Moderate Risk	Moderate Risk			CNO	
3	Dec-21	People/Human Resources	Staff burnout due to high workload and demands related to pandemic response, (e.g operation of the mass vaccination clinics and continued redeployment to COVID work) including role and scheduling changes (type of work, length of shifts, seven day/week extended hours).	4	5	H	MLHU has implemented partnerships with different organizations such as City of London, Thames Valley Family Health team, London Health Sciences Centre, etc. to help address large short term staffing needs for vaccination clinics. Ongoing recruitment efforts to hire temporary staff for COVID to replace redeployed staff. HR and Operations are reviewing hours of work, schedule rotations and staffing levels to determine where adjustments can be made to align with staff preference.	Decommissioning and reduction of hours at the mass vaccination clinics has taken place, decreasing the demands placed on staff. Restructuring of COVID-19 teams, reprioritization of work and recruitment of additional temporary staff has allowed staff redeployed for 2 years to be repatriated back to their original teams. There have been changes made to the COVID team scheduling allowing for shift rotations to be based on employee preference, in addition to operational needs. MLHU continues to provide resources on mental health supports that are available to all staff and leaders, including group debrief/support sessions. MLHU continues to investigate programs that will support staff. Reports of change fatigue, as well as overall fatigue, continue as regular public health programming resumes. HR continues to collaborate with the Unions to obtain staff feedback and look for resolution and communication strategies to support staff through ongoing change. Implementation of the corporate 'Joy in Work' framework has been a key strategy during Q2 as well as minimization of overtime for staff experiencing burnout.	Effective	Moderate Risk	Minor Risk			CEO	
4	Dec-21	People/Human Resources	High demand for limited pool of public health professionals	4	4	H	Implementation of advanced hiring by posting full-time roles for some of the temporary funding based on projected attrition in order to attract external candidates. Hiring of student PHNs and PHIs following their practicums under a temporary licence. Posting for general public health professional roles to build a pool of qualified candidates for when positions are available.	Collaborated with Nursing program contacts at Western to promote temporary Case Investigator roles to graduating nursing students to begin the recruitment process before they complete practicums at other organizations to have them work under a 6 month temporary licence until they complete their NCLEX. Continue to hire PHI students following their practicums, but are limited by the number of students we are able to support (usually 2-3). AMOH recruitment has been initiated and engaging with an external consultant to assist with this work. The temporary contracts support opportunities for public health staff to gain public health experience, thus creating a pool of candidates for permanent job postings.	Effective	Moderate Risk	Moderate Risk			CEO	
5	Dec-21	People/Human Resources	Collective agreement negotiations in 2022 could have potential impacts on business continuity in the event of a labour disruption	5	3	H	Business continuity/labour disruption planning is underway in preparation for CUPE negotiations. SLT has already prioritized the key public health work that needs to be covered. Regular prioritization of labour relations issues through weekly collaboration with the union partners.	Collective bargaining with CUPE in May was successful and the new collective agreement was ratified by CUPE members on June 7, 2022.	Very Effective	Moderate Risk				CEO	It is recommended that this risk be removed from the Risk Register at the end of Q2. Successful risk mitigation means it is no longer an organizational risk.
6	Dec-21	Financial	Uncertainty as to whether the Ministry will provide recovery funding for 2022 will impact staffing requirements during the budget creation and program delivery.	4	4	H	Programs that were previously budgeted will remain in the 2022 budget with the same staffing and funding as previous years. These programs will undergo robust review processes during 2022 to ensure each is aligned with mandated services as described in the Health Protection and Promotion Act and with Board of Health priorities.	The 2022 budget was developed as per strategy with the exception that funding was adjusted for cost of living inflation and step increases. Program review will begin in 2022 for the 2023 budget. Recovery funding had been budgeted at $1,570,039 (18.25 FTE) and was not approved by the Ministry (similar with other Health Units across the province). The funding and related expenses have been removed from forecast. MLHU must continue to right-size the COVID response to make sure that overspending does not occur; this is underway. The Ministry will allow the Health Unit to direct surplus from Mandatory Programs to Recovery Initiatives before supporting COVID-19 efforts. This is an important strategic consideration and a very effective way to offset unapproved funding.	Very Effective	Significant Risk	Minor Risk			CEO	

Update Risk Matrix

MLHU RISK REGISTER

IDENTIFY				ASSESS				EVALUATE		MONITOR & REPORT					Comments
ID	Date Identified	Risk Category	Risk Description	Impact (1-5)	Likelihood (1-5)	Risk Rating (H,M,L)	Key Mitigation Strategies ("Controls")	Actions Taken	Current Strength of Controls	Q1 Residual Risk	Q2 Residual Risk	Q3 Residual Risk	Q4 Residual Risk	Most Responsible Leader	Comments
7	Dec-21	Financial	Ministry is funding at 2019 levels and caps on City/County contributions will increase financial strain and the health unit's ability to generate a balanced budget while absorbing record inflationary adjustments.	4	5	H	The Health Unit will unite with the City and County to lobby the Ministry to recognize, and fund, inflation. Budgeted contingency will be pooled and shown at the corporate level to offset unknown events. Programs will undergo robust review processes and zero-based budgeting to ensure alignment and potentially identify efficiencies.	Inflation has been a discussion point with the County, City and Ministry. The Ministry did increase funding by 1% for the 2022 budget to recognize some, but not all, inflationary pressures. Zero-based budgeting will be the basis of the 2023 budget. The first quarter results generated $2.1 million surplus in expenses, which covers our annual gap of $1.6 million with $0.5 million true surplus. Finance leadership and the CEO meet regularly with the City and County to share financial updates. Inflation is a topic of discussion from both sides.The 2023 budget will highlight inflationary costs to improve transparency.	Partly Effective	Significant Risk	Moderate Risk			CEO	
8	Dec-21	Financial	Financial reporting is not frequent enough to provide managers and directors with the necessary information to make informed decisions in a timely manner.	3	5	H	The Finance department is reviewing structure and staffing requirements to meet the demands associated with monthly reporting. The budget will be developed and shared to increase transparency and awareness. Forecasting will be introduced to improve financial management and overs	The department review is on-going and is currently employing contract staff to assist with the workload. Monthly reporting will require further review as to how effective it will be due to related challenges of monthly closings. Budget has been modified to improve transparency, but more is planned for 2023 (to cover key balance sheet items and cashflow). The level of forecasting will be assessed based on available finance resources. The financial reporting has been recreated and was issued for Q1. The last piece was the financial placemat which was completed in June and will be incorporated in Q2 reporting. Both forecasting and cashflow models have been created and ready to use. Q1 was issued in early June and Q2 is anticipated to be issued within 2 to 3 week of closing - a significant turn around on having timely reporting.	Effective	Moderate Risk	Minor Risk			CEO	
9	Dec-21	People/Human Resources	Targeting of program staff and leadership responsible for implementing public health measures (e.g. section 22 orders, masking, operating mass vaccination clinics, etc.) including threats made in-person, over the phone and social media.	4	4	H	Safety plans have been put in place for staff, leaders and specific clinic sites. Police have been involved in some cases when staff have been threatened. Security is present at Citi Plaza and at the vaccination clinics. Regular communication at Town Hall meetings to provide support to staff and direction on how to call for help.	Clinic operating hours and locations are reported to London police daily, given the shift in focus to mobile clinics. Security is in place at all clinic locations. De-escalation training has been provided to vaccine clinic leadership and select front-line staff. The province's removal of most public healh measures and mandates has decreased the level of anger in the community.	Effective	Minor Risk	Minor Risk			CEO	
10	Dec-21	People/Human Resources	Retention and recruitment of leadership roles in public health.	4	5	H	Focus groups held with leadership staff internally as well as led by an external facilitator to understand what keeps managers at MLHU and reasons they may be leaving. Targeted exit interviews conducted by HR for leaders leaving the organization. Working with an external compensation consultant to conduct a market compensation review with comparator health units and similar sectors.	SLT is committed to working through the "Joy in Work" framework to address the feedback received from staff and leaders through various mechanisms and conducted sessions in April with Leaders to prioritize action items that will be implemented over the short term and long term. The introduction of Associate Manager and Supervisor positions as First Line Leaders has attracted internal candidates to Leadership roles. The market compensation review has been completed by external consultant but changes to rates may not be implemented until 2023. SLT has an ongoing committment and engagement on this topic.	Partly Effective	Moderate Risk	Moderate Risk			CEO	
11	Dec-21	Technology	MLHU physical servers/SAN are past end of life (8+ Years) and in need of replacement.	4	5	H	Completion of migration expected by end of Q1 2022.	Transition of servers continues and the risk is actively being addressed.	Effective	Minor Risk	Minor Risk			CEO	
12	Dec-21	Stakeholder/Public Perception	Ensuring the right leadership and organizational structure is in place to support the evolving needs of the health unit.	4	4	H	The 2021 Provisional Plan goal specifically addresses this risk and the Board has examined the need to leverage skill sets to advance the strategy of the organization. There is commitment to achieving the goals as articulated on the Provisional plan that includes assessing and refining decision-making practices across the organization.	The Board has appointed a permanent CEO and a new MOH who are jointly providing effective leadership and continue to partner on organizational culture transformation through the roll out of the Joy in Work Framework. Continuing to clarify roles and responsibilities of CEO and MOH positions is an ongoing process. Rengagement of external partners by both MOH and CEO is underway while resuming connections with key stakeholders. Communication plan has been in place to help navigate attention from the media related to leadership changes.	Effective	Minor Risk	Minor Risk			CEO	
13	Dec-20	Financial	Uncertainty around timing and allocation of additional funding to cover COVID-related expenditures (staffing and technology costs) creates a risk of cash shortfall that may exceed our line of credit limit	3	3	M	Temporary use of the line of credit will help offset the timing of transfers from the province. Non-COVID program spending is reduced due to limited services provided in the community.	The line of credit was implemented in 2021 to reduce the risk. MLHU received about half of our approved COVID-19 funding in June and anticipating the other half in early fall. This is still a concern as there continue to be significant swings on cash balances. MLHU will continue to do its best to align with operational capacity with COVID demand.	Partly Effective	Minor Risk	Moderate Risk			CEO	
14	Dec-20	Privacy	Rapid implementation of new technology and applications to facilitate pandemic response introduces new privacy and information security risks	3	2	L	Implementation of biennial privacy education program for staff. Agency privacy and information security policies reviewed and updated, including implementation of new virtual care policy. Encrypted tools to support remote work and data transfer. Cyber risk insurance in place. Assessment and mitigation of identified risks ongoing.	Controls implemented in 2021 to reduce the risk. Privacy and IT continue to consult on regular basis and are collaborating on a number of software management implementation projects to ensure that privacy and information security risk are identified, assessed and properly mitigated.	Effective	Minor Risk	Minor Risk			CEO	

Update Risk Matrix

MLHU RISK REGISTER

IDENTIFY				ASSESS				EVALUATE		MONITOR & REPORT					Comments
ID	Date Identified	Risk Category	Risk Description	Impact (1-5)	Likelihood (1-5)	Risk Rating (H,M,L)	Key Mitigation Strategies ("Controls")	Actions Taken	Current Strength of Controls	Q1 Residual Risk	Q2 Residual Risk	Q3 Residual Risk	Q4 Residual Risk	Most Responsible Leader	Comments
15	Jan-22	Political	The potential for rapid turnover on the Board of Health, including Chair/Vice-Chair roles as a result of the 2022 provincial and municipal elections. Turnover at the municipal level may drive a change in the key relationships we establish in the community. Changes at the provincial level can lead to potential changes in policy direction.	4	4	H	Advocating to the Ministry for longer appointment of provincial representatives and focusing on updated Board Orientation plans.	Board orientation session was held in April 2022. A formal package is being prepared for board members that will made available electronically in Q3 2022. The orientation package and materials will mirror the resources provided by Association of Local Public Health Agencies (alPHa).	Effective	Moderate Risk	Minor Risk			CEO	
16	23-Mar-22	Technology	The potential for cyber attack to occur, including phishing scams	4	2	M	Training has been rolled out for all staff related to cyber security.	Implementation of all 4 training modules is now mandatory for all staff. Regular reminders are issued to staff to complete training. Upgrade to new cyber security software.	Partly Effective	Moderate Risk	Minor Risk			CEO	
17	23-Mar-22	People/Human Resources	Increased challenges with work related to staff transition and reorientation as staff move from COVID back into other public health work. These changes also include restructuring of teams which may continue to add to the emotional strain on staff. Potential challenge of having to redeploy staff should there be a need to increase support for case and contact management.	3	5	H	Investigating providing debrief sessions for staff with EFAP provider to acknowledge their experiences through COVID over the past 2 years. Managers are working with teams who are re-joining or newly formed to have these debrief conversations. Leaders were provided a workshop on Change Management with Homewood Health to support them in leading these transitions.	More sessions will be offered throughout the year to support leaders. Implementation of the Joy in Work Framework and cascading to the front line staff. Engaging with staff in decision-making whenever possible and ensuring clear and transparent communication to staff on a regular basis, using change management principles. This will be important as the Healthy Living review is completed and implemented.	Partly Effective	Moderate Risk	Moderate Risk			CEO	
18	June 30, 2022	Political	The return of Public Health Modernization agenda as a result of the Provincial election and the uncertainty it will have on the structure and future of public health in Ontarion.	5	3	H	MLHU will strive to mitigate this risk by preparing Board members to be engaged in conversation with provincial leadership, demonstrating high-quality integration and partnership with local and regional partners such as Ontario Health Team and Ontario Health West leadership, as well as developing a communication plan with staff that ensures that they are not distracted from their core public health work.		Not able to rate		Significant Risk			CEO MOH	

RISK MATRIX

Risk Priority Risk Map

Risk Matrix Interpretation

Risk maps provide an effective, means of identifying and prioritizing risks. Risks with a high Probability, and a medium to high Impact are the highest priority, however risk strategies should be developed to deal with all identified risks.

Impact	5 Threatens the success of the project					
	4 Substantial Impact on time, cost or quality					
	3 Notable impact on time, cost or quality					
	2 Minor impact on time, cost or quality					
	1 Negligible impact					
	Ranking	1 Unlikely to occur	2 May occur occasionally	3 Is as likely as not to occur	4 Is likely to occur	5 Is almost certain to occur
		Likelihood				

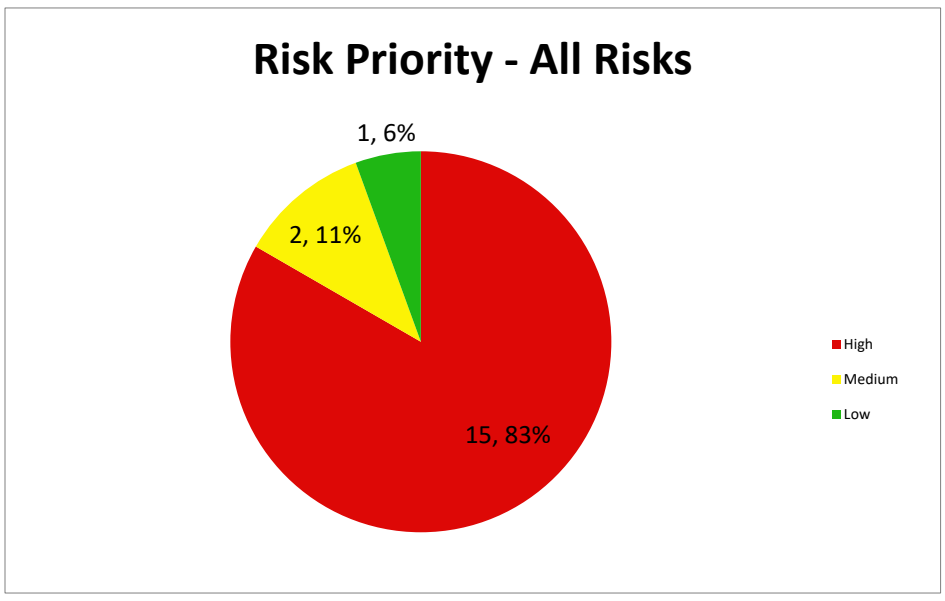
Legend	
	High Risk Priority
	Medium Risk Priority
	Low Risk Priority

RISK CHARTS

Summary Tables and Charts:

Risk Response Tactic	Total	
Risk Priority	Count	Percent
High	15	83%
Medium	2	11%
Low	1	6%
Total	18	100%

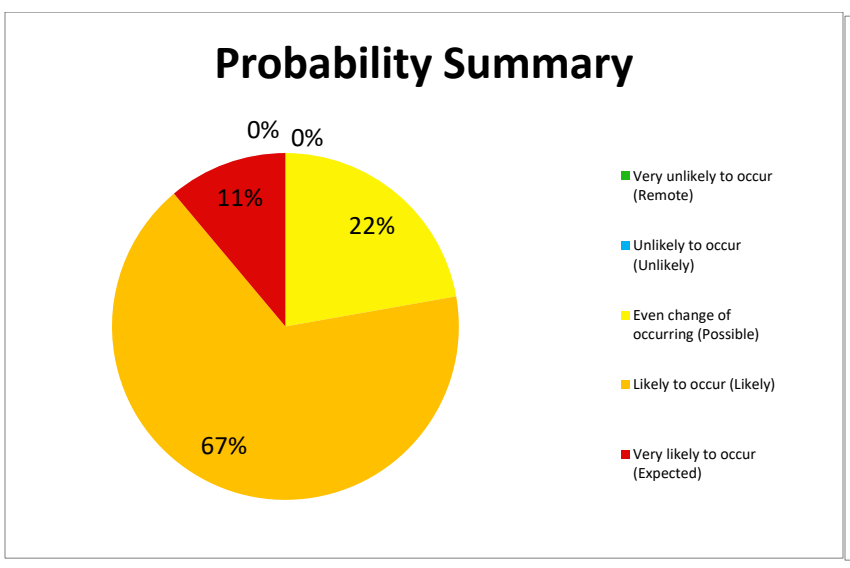
Note that the charts are based on the subtotals and exclude risks that were "Not Assessed (NA)", except Risk Priority

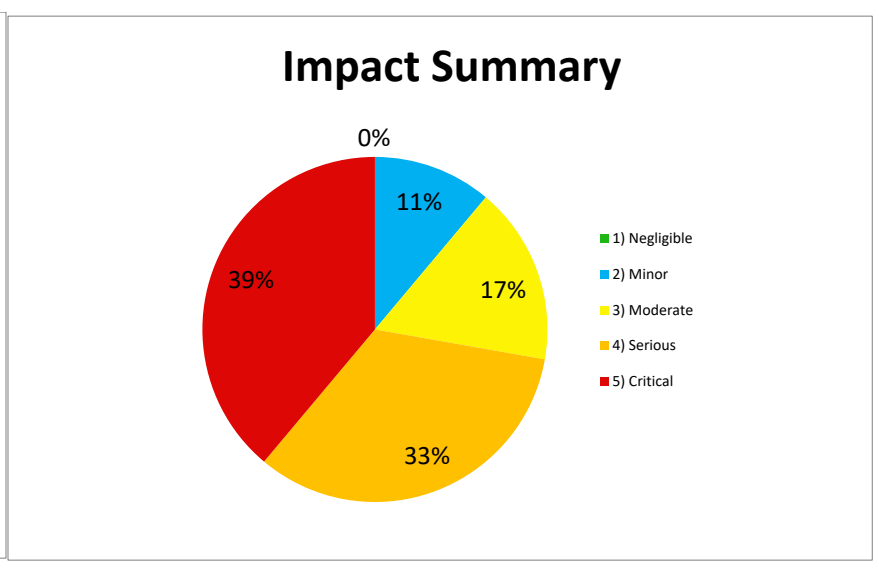


Other Summary Information:

Probability Summary		Total	
Score	Rank	Count	Percent
1	Very unlikely to occur (Remote)	0	0%
2	Unlikely to occur (Unlikely)	0	0%
3	Even change of occurring (Possible)	4	22%
4	Likely to occur (Likely)	12	67%
5	Very likely to occur (Expected)	2	11%
Total		18	100%

Impact Summary		Total	
Score	Rank	Count	Percent
1	1) Negligible	0	0%
2	2) Minor	2	11%
3	3) Moderate	3	17%
4	4) Serious	6	33%
5	5) Critical	7	39%
Total		18	100%





RISK SCALES

Risk Rating Scale:

VALUE	LIKELIHOOD	IMPACT	SCALE
1	Unlikely to occur	Negligible Impact	Very Low
2	May occur occasionally	Minor impact on time, cost or quality	Low
3	Is as likely as not to occur	Notable impact on time, cost or quality	Medium
4	Is likely to occur	Substantial impact on time, cost or quality	High
5	Is almost certain to occur	Threatens the success of the project	Very High

Current Strength of Controls Scale:

SCORE	RANK	PRESENSE OF CONTROL	EFFECTIVENESS	RESIDUAL RISK
0	Not able to rate	There are no controls in place to assign a rating		Significant
1	Very ineffective (Virtually no controls)	Very few, if any, controls are in place	Controls are ineffective at mitigating the risk	Significant
2	Ineffective (Low control effectiveness)	Limited controls are in place	Only a limited number of the controls are effective	Moderate
3	Partly effective (Moderate control effectiveness)	A moderate number of controls are in place	The controls are adequate at mitigating part of the risk	Moderate
4	Effective (High control effectiveness)	The majority of controls are in place	The controls mitigate the majority of the risk	Minor
5	Very effective (Very high control effectiveness)	Nearly all of the required controls are in place	The controls are effective at mitigating the risk	Minor

Residual Risk:

RESIDUAL RISK	DESCRIPTION
Significant	Represents the highest residual risk exposure as the assessed level of risk control effectiveness is insufficient for the level of risk. Management should consider improving risk control plans for these risks.
Moderate	Represents additional residual risk exposure that could be investigated further as the assessed risk control effectiveness is not propitiate with the level of risk. Control plans should be documented and reviewed or appropriateness.
Minor	Areas where the risk control effectiveness is proportionate with the level of risk.

Strength of Controls
Not able to rate
Very Ineffective
Ineffective
Partly Effective
Effective
Very Effective

Residual Risk
Significant Risk
Moderate Risk
Minor Risk

Risk Categories
Environment
Equity
Financial
Governance/Organizational
Information/Knowledge
Legal/Compliance
Operational/Service Delivery
People/Human Resources
Political
Privacy
Security
Stakeholder/Public Perception
Strategic/Policy
Technology

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 45-22

TO: Chair and Members of the Board of Health

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

DATE: 2022 July 14

MLHU's Anti-Black Racism Plan: Implementation Update

Recommendation

It is recommended that the Board of Health receive Report No. 45-22, re: "MLHU's Anti-Black Racism Plan: Implementation Update" for information.

Key Points

- After declaring racism a public health crisis in 2020, the MLHU Board of Health endorsed an Anti-Black Racism Plan (ABRP) for public health action in April 2021.
- Several strategically prioritized recommendations have been completed or are in progress.
- An overarching ABRP Project Charter will be completed within the next quarter, and implementation of additional recommendations, prioritized with input from the ABRP Advisory Group, will be initiated in 2022.

Background

In 2020, racism was declared a public health crisis by the MLHU Board of Health. Following this declaration, MLHU engaged a consultancy firm for the development of the MLHU Anti-Black Racism Plan (ABRP). In April 2021, the MLHU Board of Health endorsed the ABRP for public health action.

The Anti-Black Racism Plan was developed through the engagement of the African, Caribbean, and Black (ACB) communities in London and Middlesex County. The inclusive process engaged a total of 375 members of the ACB community of different ages, cultural, and linguistic backgrounds to ensure the plan reflected the views and priorities of the diverse ACB communities. From a literature review, jurisdictional scan, and the findings from the community consultation, a list of recommendations was developed. The ABRP contains a total of 45 recommendations (see ABRP). Implementation of these recommendations are an important step to dismantling anti-Black racism within and perpetuated by the public health system.

April to December 2021

By early June 2021, a health promoter had been recruited to assist with the engagement of diverse ACB community members and organizations. As a member of the Health Equity and Indigenous Reconciliation Team (HEART), this health promoter supported the coordination, engagement and delivery of pandemic response strategies including: an ACB-focused "Town Hall" event with health care experts from the Black community, engagement and consultation with ACB individuals and organizations, and delivery of five (5) mobile vaccination clinics in collaboration with ACB groups and community partner agencies. This health promoter has also supported other work related to implementation of the Anti-Black Racism Plan.

In the fall of 2021, HEART conducted a community consultation event to obtain feedback on the creation of an Advisory Committee to guide the ABRP implementation. Based on feedback from the community, the development of a draft ABRP Advisory Committee Terms of Reference and recruitment of committee members was initiated and completed by the last quarter of 2021.

January to May 2022

In January of 2022, the first ABRP Advisory Committee meeting took place, with two additional meetings since. The draft Terms of Reference were considered, further revised, and confirmed, and a community co-chair was identified. The Advisory Committee provided feedback on the development of MLHU's new Employment Equity Policy and on its initiative related to the collection of race-based and other social determinants of health (SDOH) data.

After an internal co-chair recruitment process, Dr. Gani Braimoh, C. Psych., (Lecturer Dept. of Psychiatry, Adjunct Assistant Professor, Dept. of Family Medicine Schulich School of Medicine and Dentistry, UWO, and Adjunct Clinical Professor, Faculty of Education, UWO) has been accepted by the committee as its first community co-chair. He will serve for a two-year term.

In collaboration with Human Resources, HEART has developed an Employment Equity Policy that will support the future recruitment of ACB and other equity deserving community members into the workforce of MLHU at all levels. This policy, and associated procedures, will also support the advancement of a more inclusive and welcoming work environment for black employees at MLHU.

Next Steps – June to December 2022

The Anti-Black Racism Plan contains several recommendations related to data collection. To this end, HEART has been working with internal partners (Population Health Assessment and Surveillance Team, and Program Planning and Evaluation Team) to finalize a consistent race-based and other SDOH data set and to develop processes for collection of this data across MLHU programs and services that align with existing provincial standards. It is expected that this work will be completed by the end of 2022. Implementation of these data collection processes will be a crucial first step towards understanding who MLHU does and does not serve, positioning the organization to modify and orient its programs and services to better meet the needs of and reduce barriers experienced by the ACB community. This will also inform population health assessment and surveillance efforts to ensure an evidence-based public health response.

HEART will work with Human Resources to develop an implementation plan for the new Employment Equity Policy, and engagement activities with key stakeholders will be conducted in the next few months.

All the remaining ABRP recommendations will be prioritized with input from the ABRP Advisory Committee. The prioritized recommendations will then be organized within an overarching project charter that will outline timelines, deliverables and sub-projects as required for full implementation of the ABRP over the next few years. Implementation of additional recommendations prioritized for this year will be initiated and/or completed.

Conclusion

Implementation of the recommendations of the Anti-Black Racism Plan has been initiated. Ongoing and sustained support, engagement, and action from all levels of the organization will be critical to the success of implementation, as will ongoing meaningful and authentic engagement with ACB community members in a direct and respectful way. The Health Equity and Indigenous Reconciliation Team will continue to play a critical role in recommendation implementation.

This report was submitted by the Health Equity and Indigenous Reconciliation Team.

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. 46-22

TO: Chair and Members of the Board of Health

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

DATE: 2022 July 14

FEEDBACK ON PROPOSED DISCLOSURE REQUIREMENT FOR VAPING PRODUCT MANUFACTURERS UNDER THE *TOBACCO AND VAPING PRODUCTS ACT*

Recommendation

It is recommended that the Board of Health:

1. ***Receive Report No. 46-22 "Feedback on Proposed Disclosure Requirement for Vaping Product Manufacturers under 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 feedback on the proposed regulations regarding vapour product manufacturer reporting requirements; and***
3. ***Send a copy of the Middlesex-London Health Unit submission, attached as Appendix A, to the Honourable Carolyn Bennett, Minister of Mental Health and Addictions and Associate Minister of Health, recommending that Health Canada publish peer reviewed evidence regarding product safety and health consequences from the use of vaping products within six months.***

Key Points

- On June 18, 2022, Health Canada opened a public consultation to gather feedback on the proposed *Vaping Products Reporting Regulations* which would require vaping product manufacturers to disclose sales data and ingredient information to Health Canada.
- Health Unit staff prepared a submission for Board of Health approval, attached as Appendix A, to express its support and to offer additional recommendations to address the issues underlying the public health concerns related to vaping in Canada.
- On June 23, 2022, the US Food and Drug Administration (FDA) issued orders to ban the sale of JUUL vapour products in the US due to concerns regarding product safety and their disproportionate role in the rise of youth vaping.
- The actions employed by the FDA warrant careful analysis and review by Health Canada.

Consultation on Proposed Vaping Products Reporting Regulations under the *Tobacco and Vaping Products Act*

On June 18, 2022 proposed regulations concerning vaping product reporting requirements and an accompanying Regulatory Impact Analysis Statement were published in *Canada Gazette, Part I*. This publication opened a 45-day consultation period that will close on August 2, 2022. The proposed Regulations would require vaping products manufacturers and importers to disclose the following information to Health Canada:

- **Report on sales** – information on sales of vaping products by brand sold in Canada and for export.
- **Report on ingredients** – information on the ingredients of vaping substances by brand sold in Canada.

The proposed regulations were described as the first step of a gradual approach to introducing vaping product reporting requirements. Ensuring that government, non-government and health organizations remain informed of vapour product industry practices is important to supporting the efforts of health, non-governmental, and governmental agencies to be able to respond to an evolving vapour product market. British American Tobacco plc, Altria Group Inc., Japan Tobacco Inc., Imperial Tobacco Group, Philip Morris International Inc., VMR Products LLC, NJOY Inc., International Vapor Group, Nicotek LLC, VMR Products LLC, MCIG Inc., ITC Limited, and J WELL France are the predominant companies that are operating in the e-cigarette market. The tobacco industry has a long history of deceptive marketing and advertising practices and authoring reports with inaccuracies as to the addictive nature and health consequences of commercial tobacco use. For this reason, vapour product manufacturers should be held to the same standard of accountability and scrutiny as tobacco product manufacturers through the enactment of the proposed regulations.

US Food and Drug Administration Orders Ban on Sale of JUUL Products

Public health concerns about health consequences from vapour product use and the creation of a whole new generation of people addicted to nicotine have reached new levels. On June 23, 2022, the United States Food and Drug Administration (FDA) issued market denial orders (MDOs), with immediate effect, to all JUUL products in the United States. These MDOs require that the company must immediately stop selling and distributing its products in the US, and that in addition, JUUL products currently on the US market must be removed or face enforcement action. The FDA stated in a release that JUUL's application to market their products "lacked sufficient evidence regarding the toxicological profile of the products to demonstrate that marketing of the products would be appropriate for the protection of the public health", and further, that JUUL products "have played a disproportionate role in the rise in youth vaping". While a US federal appeals court has issued a temporary stay blocking the nationwide ban until the matter proceeds through the court system, the action employed by the FDA warrants careful consideration and analysis by Health Canada. A more rigorous approach requiring vapour product manufacturers to prove the safety and efficacy of their products prior to sale may be warranted. Considering this recent development, it is recommended that Health Canada takes meaningful action to determine the health harms from vapour product use through the completion of a comprehensive study of peer-reviewed evidence. Health Canada is encouraged to publish the results of this evidence review within six (6) months, and based on the growing scientific body of research, Health Canada's regulatory approach and vapour product safety messaging may require further revision.

This report was submitted by the Healthy Living Division.

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

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

Appendix A to Report 46-22

Manager, Scientific Regulations Division
Tobacco Products Regulatory Office
Tobacco Control Directorate
Controlled Substances and Cannabis Branch, Health Canada
0301A-150 Tunney's Pasture Driveway
Ottawa, ON K1A 0K9
Email: pregs@hc-sc.gc.ca

Middlesex-London Health Unit (Ontario) Submission to the Proposed Vaping Product Reporting Regulations

The Middlesex-London Health Unit (MLHU) welcomes the opportunity to submit feedback on proposed legislative and regulatory amendments to require vapour product manufacturers to report ingredients and sales data to Health Canada. Since March 2019, the MLHU has made several submissions providing comments and feedback on the *Tobacco and Vaping Products Act* (*TVPA*) and Regulations. The proposed regulations to require vaping product manufacturers to disclose information to Health Canada about sales and ingredients used in vaping products is an important measure to allow Health Canada to keep informed about the rapidly evolving vapour product market. The Middlesex-London Health Unit supports this measure and applauds the federal government for proceeding with this regulatory measure. This submission offers additional comments pertaining to more stringent regulatory and legislative amendments that are required to address the real issues underlying the current impact of vaping in Canada, within the context of the existing legal framework provided by the federal *Tobacco and Vaping Products Act*

PROPOSED REGULATIONS – DISCLOSURE REQUIREMENT FOR MANUFACTURERS

Local public health units, non-governmental organizations, health care practitioners and all levels of government across Canada need to be responsive to the social and health impacts that the use of vapour products have on individual and population health. Ensuring that Canadians remain informed of vapour product industry practices is important to supporting the efforts of health, non-governmental, and governmental agencies to be able to respond to an evolving vapour product market. British American Tobacco plc, Altria Group Inc., Japan Tobacco Inc., Imperial Tobacco Group, Philip Morris International Inc., VMR Products LLC, NJOY Inc., International Vapor Group, Nicotek LLC, VMR Products LLC, MCIG Inc., ITC Limited, and J WELL France are the predominant companies that are operating in the e-cigarette market (2022). In 2018, the global e-cigarette market was valued at about US$14.05 Billion, and in just five years, has reached a market value of US$20.4 Billion (2021) and is projected to reach US$30 Billion by 2027 (Business Wire, 2022). The tobacco industry has a long history of deceptive marketing and advertising practices and authoring reports with inaccuracies as to the addictive nature and health consequences of commercial tobacco use. (Ontario Agency for Health Protection and Promotion, 2017). The proposed regulations would require manufacturers of vaping products to provide Health Canada with the following information:

- Report on vaping product sales – information on sales of vaping products by brand sold in Canada and for export.
- Report on ingredients – information on the ingredients of vaping substances by brand sold in Canada.

In addition to the required product reporting, it is important for Canadians to have an accurate picture of tobacco and vapour product industry non-compliance with all mandated federal regulations through annual reports and a public disclosure system. More importantly, vapour product manufacturers should also be required to submit toxicological or other health impact data. **The Middlesex-London Health Unit recommends that vapour product manufacturers be held to the same standard of accountability and scrutiny as tobacco product manufacturers through the enactment of the proposed regulations. Further, the Middlesex-London Health Unit strongly recommends the implementation of a public non-compliance disclosure system and mandated submissions of toxicological and health impact data by vapour product manufacturers regarding their products.**

FURTHER ACTION REQUIRED TO ADDRESS HEALTH CONSEQUENCES FROM VAPING

The Need for Revised Health Canada Messaging and Urgent Review of Evidence

Vaping prevalence rates have skyrocketed in recent years, particularly among youth and young adults. The nation-wide prevalence of vaping among students (grades 7-12) has doubled, rising from 10% in 2016-2017 to 20.2% in 2018-2019. (Health Canada, 2018; 2019). Since the 2018 publication of the assessment of vaping ("Public Health Consequences of E-Cigarettes") by the US National Academy of Science, Engineering and Medicine (NASEM), scientific understanding of the various harms now known to be associated with e-cigarette use by young people has significantly increased. As noted by colleagues at Physicians for a Smoke-Free Canada (PSC), the NASEM assessment was based on only one-third of the evidence available today (PSC, 2022). PSC's blogpost on the current status of Health Canada's messaging on vaping and its impact on younger users reads, in part, as follows:

> In its 2018 assessment, the NASEM panel of experts explored the scientific evidence behind 47 conclusions finding that there was conclusive or substantial scientific evidence for only 18, moderate evidence for 8, and limited or no evidence for 21 of the conclusions. Fifteen of the 18 conclusions for which there was strong or substantial level of confidence confirmed potential harms from these products and only two conclusions related to potential benefits of vaping. (PSC, 2022)

The NASEM panel of experts concluded that e-cigarette users who entirely quit using tobacco products and transition to vapour products were exposed to fewer of the chemicals found in cigarette smoke and they experienced short-term health consequences in some organ systems (PSC, 2022).

The amount of available scientific evidence regarding the safety and dangers of vapour products is growing and since 2018 other governments have tasked scientists to conduct reviews. There is a building scientific consensus that warns that vaping is dangerous and not particularly useful as a cessation method, especially when purchased and regulated as a consumer product as it is in Canada (PSC, 2022). At present, there is no updated authoritative document that has brought together available systematic reviews, meta-analyses and reports from researchers and pertinent health/government agencies; however, according to Physicians for a Smoke-Free Canada (2022), some conclusions can be drawn that warrant significant consideration when considering public health messaging and government legislation:

1. E-cigarettes have increased the number of young nicotine users in some countries;
2. Young people who use e-cigarettes are more likely to smoke conventional cigarettes;
3. Dual use is common and harmful;
4. When purchased as consumer products, e-cigarettes are not effective cessation aids;
5. E-cigarettes cause damage to respiratory and circulatory systems;
6. Other governments have provided more recent scientific assessments.

Concerns about health consequences from vapour product use and the creation of a whole new generation of people addicted to vaping nicotine have now reached a point that on June 23, 2022, the US Food and Drug Administration (FDA) issued market denial orders (MDOs), with immediate effect, to all JUUL products in the United States of America (US). These MDOs require that the company must immediately stop selling and distributing its products in the US, and that in addition, JUUL products currently on the US market must be removed or face enforcement action. The FDA stated that JUUL's application to market their products "lacked sufficient evidence regarding the toxicological profile of the products to demonstrate that marketing of the products would be appropriate for the protection of the public health", and further, that JUUL products "have played a disproportionate role in the rise in

youth vaping" (FDA, 2022). While a US federal appeals court has issued a temporary stay blocking the nationwide ban until the matter proceeds through the court system, the action employed by the FDA warrants careful consideration and analysis by Health Canada. A more rigorous approach, requiring vapour product manufacturers to prove the safety and efficacy of their products prior to sale, may be warranted. **In light of this recent development, the Middlesex-London Health Unit recommends that Health Canada determine the health consequences that may be caused by vapour products, and that Health Canada's messaging and regulatory approach be reviewed and revised to reflect the results of this review. Health Canada is encouraged to publish the results of this evidence review within six (6) months as timely action would be beneficial.**

Vapour Product Flavouring and Additives

The plethora of flavours in vapour products has posed significant challenges in public health efforts to halt vapour product uptake, especially by young people. Youth consider the flavour of vaping products to be the most important factor when trying e-cigarettes, and vaping initiation is more likely to occur with fruit, sweet, menthol and cherry flavoured products (Zare et al. 2018). Additionally, when non-traditional flavours are restricted and mint and menthol remain on the market, young people shift their purchasing and consumption preferences toward mint and menthol flavour (Morean et al., 2018; Diaz et al., 2020). Therefore, MLHU encourages Health Canada to reconsider regulations on the exclusion of menthol and mint flavours from the pending ban on flavours under the *Tobacco and Vaping Products Act.* According to Al-Hamdani, Hopkins, and Davidson (2021) and the 2020-2021 Youth and Young Adult Vaping Project, almost all vapour product users consumed a flavoured vape juice both at initiation (91.9%) and at present (90.3%). In addition, in most provinces, berry, mango and mint/menthol were the most reported flavours being used (Al-Hamdani, et al., 2021). Section 30.41 of the *Tobacco and Vaping Products Act* states:

> No person shall promote or sell a vaping product that has an appearance, shape or other sensory attribute or function for which there are reasonable grounds to believe that it could make the product appealing to young persons.

It is anticipated that the amendments to Schedules 2 and 3 to the *Tobacco and Vaping Products Act* (Flavours) and Standards for Vaping Products' Sensory Attributes Regulations could come into effect by late 2022. **The Middlesex-London Health Unit highly recommends that Health Canada implements the regulation to ban all vapour product and e-substance flavours, including mint and menthol or a combination of mint/menthol, except for tobacco flavoured products, without delay.**

Vapour Product Promotion and Advertising

The current restrictions on advertising and promotional activities are inadequate. At present, all advertising for vapour products is permitted, unless specifically prohibited; whereas, the reverse is true for tobacco products. Vaping products should be brought under the same advertising and promotion control framework as tobacco. Advertising at such places as recreational facilities, restaurants, places of entertainment, post-secondary institutions, broadcast media, in print publications and online/social media should be strictly prohibited given the potential for youth exposure. A 2019 national Leger poll found that 86% of Canadians believe that the government should apply the same advertising restrictions to vaping products with nicotine as it does to tobacco products in order to protect youth (Leger, 2019). Additionally, there should be a complete ban on offering free or discounted vaping products. There is a substantial body of evidence that supports price control measures and strong taxation regimes for reducing youth and young adult smoking initiation as they are more sensitive to price increases (Public Health Ontario, 2017). According to Huang, Tauras and Chaloupka (2013) and research conducted by Corrigan and colleagues (2021), policies increasing the price of vapour products through a taxation regime and by limiting rebates, discount pricing, and coupons/bulk buying incentives would be highly effective at preventing youth and young adults from initiating the use of vapour products. **The Middlesex-London Health Unit highly recommends that Health Canada implement a comprehensive framework that strictly regulates advertising and promotional activities in**

alignment with current controls in place for tobacco products. Further, the inclusion of product pricing measures and prohibitions on incentive and bulk buying programs are required.

Nicotine Concentration and Uniform Dosing Levels

Data from the 2018-19 Canadian Student Tobacco Alcohol and Drugs (CSTADS) survey showed that 20.2% of Canadian students (approximately 418,000) had used an e-cigarette (with or without nicotine) in the past 30 days (Health Canada, 2019). Students that reported vaping (with or without nicotine) in the past 30 days were vaping regularly with approximately 40% reporting daily or almost daily use (Health Canada, 2019). CSTADS also showed that vaping had led to an overall increase in nicotine use by youth, which suggested that vaping had not replaced smoking behaviours among young people. In fact, the total prevalence of vaping and smoking among young people was much higher than the prevalence of smoking in that population a decade ago. By far, most of the youth in Canada who vaped were using devices that contained nicotine, with 87.6% of all current grade 7-12 students vaping nicotine (Health Canada, 2019). In addition, according to the 2020-2021 Youth and Young Adult Vaping Project, of the 3000 individuals between the ages of 16 and 24 who were interviewed, 64.3% reported using vape juice containing the highest possible concentrations of nicotine (50-60 mg/ml) (Al-Hamdani et al., 2021).

Nicotine is a highly addictive substance that poses significant risk, especially to young people. The brain continues to develop until an individual reaches the approximate age of 25. Exposure to nicotine during brain development can result in nicotine addiction, mood disorders, permanent lowering of impulse control, and changes to attention and learning (NASEM, 2018). Other health impacts include increased blood pressure, increasing risk of heart disease and stroke (Gonzalez and Cooke, 2021), and the potential for increased risk of the spread of breast cancer to the lungs (Huynh et al., 2020). The adverse effects from the use of high concentrations of nicotine include vomiting, headaches, dizziness, nausea and in extreme cases, fainting and nicotine poisoning (NASEM, 2018).

As the Middlesex-London Health Unit noted within its submission in January 2020 to Health Canada's consultation on the *Vaping Products Promotion Regulations*, federal regulation of nicotine levels offers consistent protection from nicotine addiction for youth across Canada, by bringing the current patchwork of provincial regulations into alignment across Canada. Nicotine is a highly addictive substance and reported youth preferences for products with the highest levels of nicotine (Al-Hamdani et al., 2021) justifies the requirement for Health Canada to monitor the scientific evidence on an ongoing basis and adjust product limits accordingly.

Another important factor related to nicotine concentration levels is the application of vapour product design standards to ensure the consistent and uniform dosing of nicotine to vapour product users. According to the European Union's (EU) Commission investigating the latest available evidence on vapour products, at present, vapour products are not held to design and manufacturing standards that ensure that the device delivers the same amount of nicotine per puff by the user (European Union SHEER, 2021). Given that cigarettes are engineered to deliver consistent doses of nicotine, it appears logical that e-cigarettes should do the same if they are to effectively replace nicotine delivered from cigarettes.

The Middlesex-London Health Unit commends the Federal Government's enactment of the 20 mg/ml nicotine concentration level maximum for vapour products but encourages Health Canada to publish peer-reviewed evidence of the safety of all types of vaping products within six (6) months. Further, if the products are deemed to be safe for continued sale, the Middlesex-London Health Unit recommends Health Canada to develop a process that would allow for downward adjustments to maximum nicotine concentration levels. Further, if the products are deemed to be safe for continued sale, it is recommended that Health Canada impose product engineering standards to ensure uniform nicotine dosing so that users know how much nicotine they are inhaling.

Rethinking Retailer Regimes for the Sale of Tobacco and Vaping Products

Between 2020 and 2022, MLHU observed an increase in the number of tobacco youth access test shopping failures, as well as an all-time high rate of vapour product youth access test shopping failures. Prior to 2020, MLHU's tobacco and vapour product youth access compliance rates were ~99.9%. Tobacco Enforcement Officers (TEOs) within Middlesex-London are noting an alarming trend. Between October 2021 and June 2022, TEOs and youth test shoppers have completed 265 youth access checks for vapour products that have resulted in 28 failures (89.4% compliance rate). Most of the youth access failures were at non-specialty vape stores, including convenience stores and gas stations, using youth test shoppers who are between 15 and 16 years of age -- well below the legal age of 19 years in Ontario. Other public health units in Ontario are reporting similar rates of non-compliance with the youth access provisions of the *Smoke-Free Ontario Act, 2017*.

Under the *Smoke-Free Ontario Act, 2017 (SFOA, 2017)*, vapour products flavoured with mint, menthol and tobacco can be sold in non-specialty vape stores (e.g. convenience stores, gas station kiosks, grocery stores, etc.); whereas, vapour products that contain other flavours may only be sold in age-restricted specialty vape stores. Furthermore, under the *SFOA, 2017*, vapour products that have a nicotine concentration of greater than 20 mg/ml can only be sold in age-restricted specialty vape stores. In the Middlesex-London area, during this latest round of youth access inspections, many of the vapour products that were sold to youth test shoppers from non-specialty vape stores were flavoured with fruit and candy-flavoured additives and had a nicotine concentration of greater than 20 mg/ml, despite the provincial legislation. Vapour products with nicotine concentrations greater than 20 mg/ml continue to be sold at retail, both in brick and mortar stores and online despite federal legislation. The illegal sale of these products has resulted in the issuance of charges for the sale of prescribed vapour products in a prohibited place and the seizure of these products. Between June 2021 and June 2022, public health units, including the Middlesex-London Health Unit were stretched to capacity, engaged in the local public health unit response to the COVID-19 pandemic; therefore, most, if not all *Smoke-Free Ontario Act, 2017* public health unit enforcement programs were operating at only base levels. Many Health Units were unable to continue to educate and inspect all tobacco and vapour product retailers, and most were forced to pause youth access test shopping inspections. Despite the reduced enforcement officer presence within the Middlesex-London community, between June 2021 and June 2022, tobacco enforcement officers (TEOs) for MLHU have conducted a total of eight vapour product seizures, with estimated values ranging from $200 to $25,000 from each establishment, totaling approximately $37,000 (1251 products**). Provincially, 12 public health units reported that between June 2021 and June 2022, a total of 13,061 prohibited vapour products (flavoured and for sale in a non-specialty vape store, and/or nicotine concentrations >20 mg/ml) were subject to seizure (retail value of $234,050)**. **Additionally, two public health units reported that they had two inspections that resulted in finding 2200 prohibited products valuing $380,000 but were unable to complete the seizure because the volume of product exceeded local seizure capacity**. **At least 15 referrals to Health Canada were made by Ontario public health units for infractions related to the *Tobacco and Vaping Products Act*.** Despite the loss of merchandise through seizures and the fines that are being issued under the *SFOA, 2017* by Ontario Public Health Unit inspectors, it has become apparent that the fines and seizures of vapour products are an insufficient deterrent to influence retailer compliance. Anecdotally, Enforcement Officers have been told that for products that are approximately $20 per unit, the retailer profits between $5.00 to $9.00 per item. The available supply of these products seems endless and the potential for profit exceeds the risks of being caught.

Under the *SFOA, 2017*, routine non-compliance with tobacco sales offences results in the issuance of an automatic prohibition order under Section 22. At present, there is no automatic prohibition lever that can be applied to retailers who continue to sell vapour products to persons under the age of 19 years, nor for non-specialty vape stores that continue to sell vapour products that should only be available for sale in age-restricted stores in Ontario. Operators have shared with MLHU TEOs that the total revenue from sales of vapour products alone far exceeds both the fine amounts and the risk of product seizures and is viewed as a cost of doing business. Based on the current compliance rate and reported retailer behaviors, current vapour product retail regulations are insufficient.

It may be warranted for Health Canada to consider retail reforms. **The Middlesex-London Health Unit recommends that Health Canada implement an automatic prohibition regime for both tobacco and vaping products under the *TVPA* modelled after Section 22 of the *Smoke-Free Ontario Act, 2017,* for repeated convictions against retailers including those who:**

- **sell tobacco and/or vaping products to persons under the legal age;**
- **sell flavoured tobacco and vaping products prohibited by law; and,**
- **sell vaping products with nicotine concentration levels that exceed 20 mg/ml.**

In addition, due to the pervasive retail availability of tobacco and vapour products and the continued availability of prohibited vapour products in brick and mortar stores across Ontario, **the Middlesex-London Health Unit recommends that Health Canada should consider limiting the sale of tobacco and vapour products to age-restricted stores only.**

Reciprocal Relationships and Cooperation Between Federal and Provincial Inspectors

In Ontario, the display, promotion and sale of tobacco and vaping products at retail are regulated by both provincial and federal legislation. The *TVPA* is enforced by Health Canada Inspectors exclusively, who are responsible for monitoring and ensuring compliance with the *Act* and the Regulations. In Ontario, public health unit staff are designated by the authority outlined under the *Smoke-Free Ontario Act, 2017,* to enforce the requirements and restrictions at retail under provincial legislation exclusively, with no authority under the *TVPA.*

Given the size and scope of jurisdiction that falls to the Health Canada Inspectorate, it is difficult for their Inspectors to respond to the referral in a timely matter. This means that in many cases, vapour products, prescribed by federal law to be "illegal" and subject to federal seizure, remains within the store for continued sale. There is significant consumer demand for this product; therefore, despite warnings issued by provincial inspectors, product will remain on store shelves available for sale or for distribution through other illegal means. In Ontario, there has been some success with reciprocal relationships and collaboration between Ontario Ministry of Finance Inspectors (enforcement of the *Tobacco Tax Act*) and public health staff (enforcement of the *SFOA, 2017*). For example, if illegal tobacco products (under the *Tobacco Tax Act*) are found within a retailer, and a Ministry of Finance Inspector is not within the jurisdiction, under direction of the Ministry of Finance Inspector, the Health Unit Inspector will safely secure the product off site until the Ministry of Finance Inspector can attend to seize the product for their investigation. Not only does this reciprocal and collaborative relationship help to remove illegal products from the marketplace, but it also increases public and retailer perception of a greater enforcement presence, which contributes to greater compliance overall. It is recommended that a similar arrangement be explored between federal and provincial enforcement agencies given the continued availability of flavoured and high nicotine concentration products. Alternatively, the cross designation of provincial and federal inspectorate for sections of the *TVPA* and Regulations that pertain to retail could also be explored.

The Middlesex-London Health Unit recommends that Health Canada engage with provincial Ministries of Health and representatives from local public health enforcement to explore how best to collaboratively implement retail reforms, and to discuss options that exist to support collaborative and more timely enforcement action.

Tighten Restrictions for Online Retail Marketing

Besides the availability of vapour products at retail outlets such as convenience stores, gas stations, grocery stores, and specialty vape stores, vapour products are widely available for sale through websites and social media (Hammond, et al., 2015). While many online vendors use age-verification measures during online purchase, people under the age of 18 years are still able to purchase vapour products online (Hammond et al., 2015). In 2017, the Canadian Tobacco and Drug Survey (CTADS) indicated that more than 75% of youth age 15 to 19 years who tried a

vaping product borrowed, shared or bought it from a friend or relative (Health Canada, 2018). In 2019, the Canadian Tobacco and Nicotine Survey showed that social access of vaping products among those aged 15 to19 years had dropped to 58%, and 43% of this age group purchase from retail sources, including online vendors (Health Canada, 2019).

Underage youth who purchase vaping products online either falsely claim to be of legal age when they access the website, or they are not required to show proof of age. A content analysis of internet e-cigarette vendor practices discovered that most vape vendors (over 60%) did not require age verification or relied on ineffective strategies such as checking a box to verify legal age (Williams et al., 2018). Similarly, Gaiha and colleagues (2020) found that more than a quarter of underage e-cigarette users surveyed were not required to verify their age when purchasing e-cigarettes online.

The local experience within Middlesex-London is in congruence with the evidence. Since resuming in-person learning within Middlesex-London schools in the fall of 2021, approximately 80% of youth are telling TEOs they buy vapour products online. Young people are reporting that they find it easy to get vaping products through online sources. One youth stated that the vapour products are delivered to their mailbox and that he can easily conceal the purchase from his parents because it is his responsibility to pick up the mail after school.

Some specialty vape stores that formerly operated brick and mortar stores in Ontario have shifted to manufacturing and wholesale, and/or to online-based operations to continue to sell flavoured and high nicotine concentration products to all ages, with less enforcement scrutiny. These products are shipped directly to customers' houses or offered through curbside pickup. This process applies the obligation of age verification to the agents/agencies used for delivery. Enforcement agencies, at both the federal and provincial levels, are challenged to be able to effectively monitor retailer compliance with youth access provisions.

Industry brand-incentive programs, like the "Vuse – Click and Collect" program, are also operating in communities across Ontario. This program allows customers to place their orders online and then pick up the vapour products, including all flavours and nicotine concentrations, at select convenience stores. Programs like this appear to have been able to find legislative loopholes and they contribute to the erosion of progress that had been made to prohibit youth access to tobacco and vapour products and to restrict access to flavoured and high nicotine concentration vapour products.

The *TVPA* prohibits youth access to vaping products in a public place or in a place to which the public has access, which includes online retailing. The *Act* specifies that a person, including a retailer, must verify the age of a person purchasing vaping products, however it does not specify how age verification is to be implemented. The current system on many websites of clicking a box to attest to being of age has obvious pitfalls.

The Middlesex-London Health Unit recommends that Health Canada works with provincial Ministries of Health to implement consistent and strict requirements to regulate online sales, including the following measures:

- **Require online retailers to post information advising prospective customers that the sale of vaping and tobacco products are restricted to persons of legal age;**
- **Require two-step age verification for online retailing - the two-step process should involve two authentication methods performed one after the other to verify identity;**
- **Require online retailers to utilize third-party verification services;**
- **Require tobacco and vapour products to contain a label that states that age verification is required at delivery;**

- **Upon delivery, require that a signature be obtained from the person who ordered the package, confirming they are of legal age, and packages must not be left on doorsteps;**
- **Require that delivery be restricted to prescribed carriers.**

Enactment of a Vapour Product Pre-Tax Set Price Minimum

There is unequivocal evidence documented in the tobacco control literature that price increases result in decreased demand and use of cigarettes, and increased intentions to quit smoking (SFO-SAC, 2017). Many provinces have proposed or passed legislation to tax vapour products, including British Columbia, Alberta, Prince Edward Island, Saskatchewan and Newfoundland and Labrador. The Federal Government's announcement of the national tax regime on vapour products as a measure to reduce the consumption of vapour products by youth and young adults is commendable, as they tend to be more price sensitive than adults (U.S. Department of Health and Human Services, 2000). The revenue from taxes from tobacco products along with the revenue from the taxation regime applied to vapour products could be used to fund comprehensive tobacco and vapour product control programming, including prevention and cessation efforts, increased compliance monitoring and enforcement, and ongoing research. A complementary measure to increase the retail price of tobacco and vapour products is to mandate a minimum pre-tax set price minimum (Feighery, et al., 2005). Setting minimum price limits inhibits the manufacturers' ability to use discount pricing and the retail sale of low-cost brands or devices to offset the price increases from taxation (SFO-SAC, 2010). Minimum price polices are effective and widely used to reduce alcohol consumption and harms (Anderson, et al., 2009). The taxation level and the set price minimums for vapour products should be set independently from tobacco products, with careful consideration being given to ensure that e-cigarettes do not become more expensive than cigarettes but set high enough to deter youth, young adults and non-smoker initiation. **The Middlesex-London Health Unit recommends that Health Canada enact a minimum pre-tax set price minimum for vapour products to reduce youth and young adult consumption and associated harms from vapour product use. Further, it is recommended that Health Canada discuss the establishment of complementary vapour product taxation regimes with provincial governments**

Appealing Vapour Product Marketing and Unsubstantiated Health Claims

Websites selling vapour products online are ubiquitous and use marketing tactics that are appealing to youth. In 2019, the Ontario Tobacco Research Unit (OTRU) collected samples of flavoured vaping products from online Canadian vape stores and found several examples of flavoured vaping products with attractive packaging, design elements, names and descriptors with youth-appeal (O'Connor, et al., 2019). Furthermore, researchers who conducted a systematic content and legal analysis of the claims made by e-cigarette manufacturers and retailers on their websites concluded that the vast majority of websites made at least one health-related claim, focusing on potential health benefits while minimizing or eliminating information about possible harmful effects of vaping products (Klein, et al., 2016). Grana and Ling's (2014) content analysis of e-cigarette retail websites also discovered that health claims and cessation messages that are unsupported by current scientific evidence are frequently used by vapour product retailers to sell vaping products (Grana and Ling, 2014). Vaping products have not been approved by Health Canada as a smoking cessation aid because they are not currently tested, manufactured, and regulated as such in Canada. Therefore, claims about vapour product efficacy as a cessation tool should be strictly prohibited.

Enforcement reports from Health Canada inspectors reinforce the lack of compliance by online retailers with current promotion and advertising restrictions under the *TVPA*. Between July 2020 and March 2021, Health Canada inspectors conducted inspections of Instagram social media accounts to assess vapour product industry compliance, with a focus on publicly accessible online promotions. Inspectors reviewed 304 accounts on Instagram and observed non-compliance on 53% of the accounts, resulting in the issuance of a warning letter (Health Canada, 2021). Increased enforcement (issuance of fines) and stricter prohibitions on vapour product advertising are required.

The Middlesex-London Health Unit recommends that Health Canada prohibits online vapour product retailers from making health claims, using celebrity and medical professional endorsements, and promoting e-cigarettes as a cessation aid. Increased compliance monitoring and the use of progressive enforcement measures (Part I charges and Part III summonses) are recommended.

Vapour Product Appearance, Packaging Design and Health Warnings

In November 2019, Canada implemented plain and standardized tobacco product packaging regulations, and at present, have a public consultation process open seeking feedback on proposed amendments to the Tobacco Product and Packaging Regulations. If enacted, the regulations would strengthen and update current health-related messages, extend labelling requirements to all tobacco product packages, implement periodic rotation of messages (every 24 to 36 months) and introduce text health warnings on individual cigarettes, little cigars that have a filter, and tubes, among other measures. Further, the proposal would consolidate all tobacco product labelling and packaging requirements in a single set of regulations -- the *Tobacco Products Packaging and Labelling Regulations*. According to Moodie, Mackintosh, Hastings and Ford, (2011), studies have determined that the colour, shape and size of a package can influence consumer behaviour and contributes to consumer perceptions of the product. Package design can make its contents appear safe to use, undermining the visibility, credibility and effectiveness of health warnings. The same body of evidence can be applied to the regulation of vapour products and packaging. As proposed, the requirement for health warning messages on individual cigarettes will help to reach youth who are being supplied individual cigarettes by social sources; however, with youth vaping rates escalating, attention to vapour product design, packaging and health warnings require similar priority. **The Middlesex-London Health Unit recommends that Health Canada apply a similar plain and standardized packaging regime to vapour products that Health Canada has already applied to commercial tobacco and cannabis products. Additionally, updated health warnings that reflect the latest scientific evidence are recommended for vapour products and their packaging so that health harms are communicated effectively.**

Comprehensive Review of Available Scientific Evidence Required

There has been a concerted effort to increase the body of scientific evidence available to assess the potential harms and potential benefits associated with vapour products, in an attempt to keep up with the ever-expanding vapour product market. The increase in the availability of vapour products by youth and young adults combined with the apparent belief and pervasive messaging found online that "less harmful" means that vapour products are safe is a significant public health concern. Since the release of the 2018 NASEM publication, researchers have developed a greater understanding of the potential harms associated with e-cigarette use, including health harms from dual use of vapour products and cigarettes, and greater clarity regarding vapour products and their role in smoking cessation. Messaging available on Health Canada web pages require review and revision to incorporate findings from the growing body of scientific evidence, and this scientific evidence should be used to inform Health Canada's regulatory approach to vapour products.

- ***Dual use of combustible cigarettes and e-cigarettes is common and harmful.***

  Health Canada's webpage on Vaping and Quitting Smoking (2020) states that if an individual completely switches from smoking cigarettes to using vapour products, the individual will experience short-term general health improvements. The challenge with this messaging is that research has shown that in Canada, 38% of Canadian vapers are people who both smoke cigarettes and vape (PSC, 2021). In addition, the 2020 Canadian Tobacco and Nicotine Survey results showed that although youth and young adults between the ages of 15 and 24 made up only 15% of the surveyed population, they represented 40% of those who reported that they vape. The emphasis on the harm reduction approach clouds the fact that there is scientific consensus that using both vapour products and conventional cigarettes is likely more harmful than only smoking or only using vapour products (PSC, 2022), and youth and young adults are then more susceptible to trying vapour products because 'they aren't as bad as smoking'.

- ***E-cigarettes cause damage to respiratory and circulatory systems.***

  The available scientific evidence regarding the impact of vapour product use on respiratory and circulatory systems has increased substantially, with hundreds of studies examining the health harms in laboratory studies of both animals and humans.

  - Researchers have concluded that the damage caused by vapour products leads to lung and heart disease and stroke (Keith and Bhatnagar, 2021). Vapour product use may also compromise the ability to remove microbial pathogens, increasing the risk of infection from viruses, fungi and bacteria (Keith and Bhatnagar, 2021).
  - In another comprehensive review of cardiovascular effects, findings from Buchanan and colleagues (2020) suggest that vapour product use is associated with inflammation, oxidative stress and haemodynamic imbalance increasing the risk of cardiovascular disease (Buchanan et al., 2020).
  - In a review of 38 studies measuring cardiovascular effects of e-cigarettes, "most studies suggest potential for cardiovascular harm from electronic cigarette use, through mechanisms that increase risk of thrombosis and atherosclerosis" (Kennedy et al, 2019).
  - A 2020 review and meta-analysis of vapour product impact on lung health showed that e-cigarette use was associated with a 39% increase in the risk of asthma and a 51% increase in the risk of developing chronic obstructive pulmonary disease; studies conducted within laboratories showed influence on biological processes that contribute to respiratory harm and illness (Wills et al., 2020).
  - According to Lauren Davis and colleagues (2022), based upon a review of the pulmonary effects of long-term vaping product use, they conclude that e-cigarette use is "…likely to result in irreversible parenchymal lung tissue damage and impaired gas exchange, contributing to chronic lung conditions in long-term vapers".

- ***There is insufficient evidence to support/promote vapour products as a cessation tool when sold and regulated as a consumer product.***

  Health Canada's web page on Vaping and Quitting Smoking reads that "quitting smoking can be difficult, but it is possible. Vaping products and e-cigarettes deliver nicotine in a less harmful way than smoking cigarettes". The web page further states that "while evidence is still emerging, some evidence suggests that using e-cigarettes is linked to improved rates of success" (Health Canada, 2020). There has been a growing body of scientific evidence to evaluate the effectiveness of vapour products to help those addicted to tobacco to quit, with mixed results. Physicians for a Smoke-Free Canada (2021) compiled a summary of scientific reports published after both the release of NASEM (2018) and the release of the European Union's scientific advisors "Final Opinion on Electronic Cigarettes" (2021). The following conclusions were drawn that warrant further investigation by Health Canada:

  - Published studies to date, including longitudinal data analysis, randomized control trials and meta-analysis of e-cigarettes as consumer products (i.e. not regulated or monitored in a clinical setting), when dual use of smoking and vaping was assessed, found high levels of dual use. Further, those that successfully quit smoking had a high prevalence of sustained use of e-cigarettes (PSC, 2021).
  - Vapour products may be helpful as smoking cessation aids, but the available evidence indicates that this is only observed in clinical settings with strict product oversight. Vapour products may have the potential to be as effective as other approved methods for cessation (e.g. nicotine replacement therapy, varenicline, buproprion, etc.); however, they do not meet minimum threshold levels for safety for widespread use. In Canada, vapour products are regulated, marketed and sold as a consumer product, not a drug. Due to the high risk of dual use, sustained addiction to vapour products, growing scientific consensus regarding respiratory and cardiovascular harms associated with use, and the high risk of uptake of vapour products by never smokers, a precautionary approach remains prudent (PSC, 2021).

At present, vaping products have not been approved by Health Canada as a smoking cessation aid because they are not currently tested, manufactured, and regulated as such in Canada. Therefore, until an intensive review of the latest evidence is completed, Health Canada's messaging is confusing and contributing to misperceptions of perceived product safety.

- **FDA action against JUUL raises public health concerns about product safety and the industry role in creating a new generation of people addicted to nicotine.**

  On June 23, 2022, the FDA issued market denial orders (MDOs) banning the sale of all JUUL products in the United States of America. This announcement makes clear that the US government is not satisfied that JUUL products are safe enough to remain on the market without damaging US public health generally, and that the government is convinced that JUUL products have played a lead role in the dramatic increase in youth vaping. The action employed by the FDA warrants careful consideration and analysis by Health Canada. Given JUUL's dominance within the vapour product market in Canada and the attention that JUUL products have had by the FDA, it calls into question the safety of the other vapour products available for sale that have not had careful analysis or government review. A more rigorous approach, requiring vapour product manufacturers to prove the safety and efficacy of their products prior to sale may be warranted.

The Middlesex-London Health Unit recommends that Health Canada takes meaningful action to determine the exact consequences on public health that may be caused by the use of vapour products. The Middlesex-London Health Unit encourages Health Canada to publish peer-reviewed evidence of the safety of all types of vaping products within six (6) months. Based on the results of the comprehensive evidence review, Health Canada's messaging on vaping and the safety of vapour products requires review and revision to incorporate all available evidence for public consumption and comprehension. If vapour products are deemed to be safe for continued sale, it is recommended that Health Canada reconsider its regulatory approach, implementing reforms to meaningfully prevent youth, young adult and non-smoker uptake and to prevent health harms from vapour product use and nicotine addiction.

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MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 47-22

TO: Chair and Members of the Board of Health

FROM: Alexander Summers, Medical Officer of Health

DATE: 2022 July 14

MEDICAL OFFICER OF HEALTH ACTIVITY REPORT FOR MAY

Recommendation

It is recommended that the Board of Health receive Report No. 47-22, re: "Medical Officer of Health Activity Report for June" for information.

The following report presents activities of the Medical Officer of Health (MOH) for the period of June 3 – June 30, 2022. As of June 30, 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. The Medical Officer of Health participates in external and internal pandemic-related meetings, along with liaising with community partners, and municipal and provincial stakeholders.

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 Medical Officer of Health also participated in the following:

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

June 3	Participated in Ministry of Health (MoH) teleconference on Monkeypox in Ontario.
June 6	Worked evening Sexually Transmitted Infection (STI) Clinic at CitiPlaza.
June 7	Attended Ministry of Health COVID-19 Public Health Coordination call.
June 8	Participated in media event on the London Care Curb Hunger Food Drive.
June 9	Met with Ministry of Health on local public health planning initiatives. Interview with Jennifer Bieman (London Free Press) and Scott Taylor (The Dorchester Signpost) on COVID-19 and influenza. Met with representatives from MNP Consultants (Ministry of Health) on IPAC Hubs.
June 10	Interview with Gary Ennett (CBC London) on the lifting of mask mandates in Ontario.
June 13	Hosted Community Stakeholder and Healthcare Provider webinars, with the Healthcare Provider Outreach team. Participated on a panel at the Governor General's Leadership Conference at CitiPlaza.

June 15 Attended Association of Local Public Health Agencies (alPHa) Annual Conference and Annual General meeting.
Attended Council of Medical Officers of Health (COMOH) meeting.

June 15 Attended Canadian Public Health Association Conference (Day 1).

June 16 Attended Canadian Public Health Association Conference (Day 2).
Met with representatives from MNP Consultants (Ministry of Health) on IPAC Hubs.

June 20 Participated in workshop for London Health Sciences' Strategic Plan.
Attended Southwest Medical Officer of Health meeting, hosted by Huron-Perth Public Health.
Worked evening Sexually Transmitted Infection (STI) Clinic at CitiPlaza.

June 22 Met with leadership at Western University to discuss fall planning.

June 23 Participated in the Warden's Annual Charity Golf Tournament.

June 24 Interview with Jennifer Bieman (London Free Press) on monkeypox.

June 25 Interview with Kelly Wang (980 CFPL) on monkeypox.

June 27 Participated in workshop for the City of London's Strategic Plan.
Interview on Rogers TV's "Food Bites" on collaboration between MLHU and the London Food Bank.

June 28 Interview with Ken Eastwood and Loreena Dickson (1290 CJBK) on monkeypox
Hosted Healthcare Provider webinar with the Healthcare Provider Outreach team.
Met with representatives from the Office of the Solicitor General on opioid use locally.
Attended Ministry of Health COVID-19 Public Health Coordination call.

June 29 Met with Barbara Daly, Executive Director of Downtown London.
Attended Urban Public Health Network (UPHN) Annual General Meeting (Day 1).
Presented information on the MLHU to residents of Ward 5 at the Masonville Public Library.

June 30 Attended Urban Public Health Network (UPHN) Annual General Meeting (Day 2).

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:*

June 20 Attended Healthy Organization's division meeting.
Attended MLHU Leadership Team meeting.

June 22 Facilitated Office of the Medical Officer of Health (OMOH) division's "Planning Day".

June 24 Attended MLHU Staff Summer BBQ at Springbank Park.

June 27 Began mentoring a medical student for their public health rotation.

June 28 Attended Population Health Assessment and Surveillance (PHAS) Team meeting.

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:*

June 9	Attended Board of Health Agenda Review and Executive meeting with the Chief Executive Officer.
June 15	Attended alPHa Board of Health meeting, as the newly appointed Southwest Region Representative (COMOH).
June 16	Attended Governance Committee meeting. Attended Board of Health meeting.
June 23	Attended Western Ontario Health Team's Coordinating Council

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. 48-22

TO: Chair and Members of the Board of Health

FROM: Emily Williams, Chief Executive Officer

DATE: 2022 July 14

CHIEF EXECUTIVE OFFICER ACTIVITY REPORT FOR JUNE

Recommendation

It is recommended that the Board of Health receive Report No. 48-22, re: "Chief Executive Officer Activity Report for June" for information.

The following report highlights activities of the Chief Executive Officer for the period of June 3, 2022-June 30, 2022.

Standing meetings include weekly Healthy Organization leadership team meetings, SLT (Senior Leadership Team) meetings, MLT (MLHU Leadership Team) meetings, Virtual Staff Town Hall meetings and C3 (COVID Collaborative Committee) meetings.

As part of the MLHU on-call leadership system, the CEO provided on-call coverage from June 20 to June 26. 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:*

June 13 The CEO met with the CEO of the London Health Sciences Centre (LHSC) to discuss the LHSC Master Planning Consultation.

As part of the Governor General's Canadian Leadership Conference visit to the MLHU, the CEO met the group to offer greetings.

June 16 The CEO, with the MOH, met with Reg Ash, CEO of the Western Fair District, to discuss the future of the Agriplex vaccination clinic.

June 17 The CEO, with the Procurement and Operations manager, toured the MLHU Strathroy office.

June 23 The CEO, with the Procurement & Operations manager and Project Management manager, toured the MLHU Citi Plaza Office with the Southwest Public Health leadership group.

June 27 The CEO, with the MOH, attended the City of London Strategic Plan meeting to review the Community Profile.

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:*

June 8 The CEO attended and chaired the June MLT Planning meeting.

The CEO, with the MOH, attended a meeting to discuss the Electronic Client Record project.

June 9 The CEO, with the MOH, attended and chaired the Leadership On-Call system Process Touch Base meeting.

June 13 The CEO, with the MOH, met with the ONA union leadership.

The CEO, with the MOH, met with Legacy Executive Search Partners to discuss the Associate Medical Officer of Health (AMOH) recruitment.

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

June 20 The CEO attended and chaired the Healthy Organization division meeting.

The CEO attended the June MLT meeting.

June 22 The CEO attended a meeting to discuss the Electronic Client Record project.

The CEO, with the MOH, and members of leadership, met to discuss the Agriplex vaccine clinic availability changes.

June 23 The CEO attended the MLHU Welcome Back Staff BBQ.

June 27 The CEO attended and greeted MLHU staff at their orientation session.

The CEO, with the MOH, met with Legacy Executive Search Partners to discuss the Associate Medical Officer of Health (AMOH) recruitment.

The CEO attended a meeting to discuss the Electronic Client Record project.

June 29 The CEO attended and chaired the July MLT planning meeting.

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.*

June 3 The CEO attended the MLHU Finance Information Session: Management Reporter Overview.

June 7 The CEO attended the 2022 National Health Leadership Conference – 'Leveraging Leadership and People Capacity for Better Health Outcomes'.

June 9 As part of the CEO's McCormick Care Board membership, the CEO attended the McCormick Care Executive Committee meeting.

The CEO attended the MLHU Finance Information Session: Variance Analysis and Forecasting.

June 13 As part of the CEO's McCormick Care Board membership, the CEO attended the McCormick Care Board Strategic Planning Workshop.

June 14 The CEO attended the Association of Local Public Health Agencies (alPHa) Annual General Meeting and the alPHa BOH section meeting.

June 15 The CEO attended the Canadian Public Health Association Conference.

June 16 The CEO attended the Canadian Public Health Association Conference.

June 28 The CEO attended the Association of Ontario Public Health Business Administrators AOPHBA SharePoint Site Orientation meeting.

As part of the CEO's McCormick Care Board membership, the CEO attended the McCormick Care Annual General Meeting.

As part of the CEO's McCormick Care Board membership, the CEO attended the McCormick Care Special Meeting of the Board of Directors.

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:*

June 9 The CEO attended the MLHU Board of Health June Agenda Review and Executive meeting with the Board Chair and Vice-Chair.

June 16 The CEO attended the Governance Committee meeting.

The CEO attended the Board of Health meeting.

June 22 The CEO met with Board Chair as part of their monthly update.

This report was prepared by the Chief Executive Officer.

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

CORRESPONDENCE – July 2022

a) **Date:** June 9, 2022
Topic: Response to COVID-19 – April 2022 Update (Item HL36.1) (see Part 10 of the Toronto Board of Health's decision on page 2 which is addressed to all Boards of Health in Ontario and the Association of Local Public Health Agencies)
From: Toronto Board of Health
To: Boards of Health in Ontario and the Association of Local Public Health Agencies

Background:

On June 9, 2022, the Toronto Board of Health sent via email a notice of adoption of Item HL36.1 as amended at its April 11, 2022 meeting. Part 9 of this item included a request to "the Province of Ontario to work with relevant stakeholders and communities to expand the collection of sociodemographic data in the health system (which may include, for example, optimizing the linkage of existing Census data with health data) to ensure that resources are deployed to the populations with the greatest need and to ensure equitable and culturally-safe access to health and social services." Forwarding Part 9 to all Boards of Health in Ontario was included as Item 10.

Recommendation: Endorse.

b) **Date:** June 21, 2022
Topic: Healthy Babies Healthy Children Funding
From: Dr. Penny Sutcliffe, Medical Officer of Health and Chief Executive Officer, Public Health Sudbury & Districts
To: Ministry of Children, Community and Social Services

Background:

On June 21, 2022, Dr. Penny Sutcliffe wrote to the Minister of Children, Community and Social Services to request, as carried by the Board of Health, that the Ministry to review base-funding needs for the Healthy Babies Healthy Children Program to ensure this essential program is sufficiently resourced to meet the current and growing needs of children and a healthy start in life.

Recommendation: Endorse.

c) **Date:** June 21, 2022
Topic: Simcoe Muskoka District Health Units 2020 and 2021 Annual Report
From: Anita Dubeau, Chair, Simcoe-Muskoka District Health Unit
To: Ontario Boards of Health

Background:

On June 21, 2022, Chair Anita Dubeau shared the link to Simcoe Muskoka District Health

Unit's ***2020 & 2021 Annual Report*****,** which highlights the SMDHU's work and accomplishments in 2020 and 2021. Most of their work over the two years of the report was concentrated on the response to the COVID-19 pandemic, which had a significant impact on the delivery of regular public health services and programs. Priority programs were maintained with restricted capacity, which are also highlighted in the report.

Recommendation: Receive.

TORONTO

John D. Elvidge
City Clerk

City Clerk's Office

Secretariat
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Toronto Board of Health
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June 9, 2022

SENT VIA E-MAIL

To: Boards of Health in Ontario and the Association of Local Public Health Agencies

Subject: Response to COVID-19 - April 2022 Update (Item HL36.1) (see Part 10 of the Toronto Board of Health's decision on page 2 which is addressed to all Boards of Health in Ontario and the Association of Local Public Health Agencies)

The Toronto Board of Health, during its meeting on April 11, 2022, adopted Item HL36.1, as amended, and:

1. Expressed its full support to the Medical Officer of Health to implement additional measures to address the harm of COVID-19, as needed.

2. Requested the Medical Officer of Health, in partnership with Ontario Health and the City's community and health sector partners, to accelerate the integration of the delivery of on-site COVID-19 vaccination, testing, treatment, and health and social services.

3. Requested the Medical Officer of Health to continue using the VaxTO program for the COVID-19 3rd- and 4th-dose campaign, and to scale up live calling in support of vaccine booster dose uptake.

4. Requested the Province of Ontario to re-enable local Medical Officers of Health to issue letters of instruction as part of the local toolkit to reduce the impact of COVID-19 and help keep people safe.

5. Requested the Medical Officer of Health to implement a public health promotion campaign to inform the public of COVID-19 risks and provide guidance for risk mitigation.

6. Requested the Medical Officer of Health and the Province of Ontario to provide additional focused guidance to help the public discern how best to employ layers of protection against COVID-19 and to provide support to those at greatest risk for severe outcomes from COVID-19, including priority access to testing, personal protective equipment, and other resources to support safer public interactions.

7. Requested the Medical Officer of Health to explore innovative and accessible ways to use data to communicate with the public to enable informed decisions about how best to mitigate the risk of COVID-19.

8. Requested the Ministry of Health and Ontario Health to work with Toronto Public Health, primary care, pharmacies, other health care practitioners, and any other relevant stakeholders, to facilitate access to and increase appropriate uptake of COVID-19 treatments, incorporating core elements such as:

    a. an information campaign to raise awareness among health care providers and the public of the availability of this effective treatment;

    b. resources to support health care providers and the public to use available COVID-19 treatments; and

    c. a strategy to leverage existing community vaccine distribution infrastructure to ensure effective, equitable access to COVID-19 treatment.

9. Requested the Province of Ontario to work with relevant stakeholders and communities to expand the collection of sociodemographic data in the health system (which may include, for example, optimizing the linkage of existing Census data with health data) to ensure that resources are deployed to the populations with the greatest need and to ensure equitable and culturally-safe access to health and social services.

10. Forwarded Part 9 above, concerning the collection of sociodemographic data, to all Boards of Health in Ontario and the Association of Local Public Health Agencies.

11. Requested the Medical Officer of Health to provide public reporting on, and consider for potential inclusion in dashboard changes, the following:

    a. COVID-19 related hospitalizations among school-aged children and youth;

    b. transmission of COVID-19 in schools; and

    c. health workforce absentee data.

To view this item and background information online, please visit: http://app.toronto.ca/tmmis/viewAgendaItemHistory.do?item=2022.HL36.1.

Yours sincerely,

JAAmoroso

Julie Amoroso
Board Secretary
Toronto Board of Health

Sent (via e-mail) to the following Boards of Health in Ontario and the Association of Local Public Health Agencies:

- Algoma Public Health Board of Health, c/o Mayor Sally Hagman, Chair
- Brant County Board of Health, c/o Councillor John Bell, Chair
- Chatham-Kent Board of Health, c/o Councillor Joe Faas, Chair
- City of Hamilton Board of Health, c/o Mayor Fred Eisenberger, Chair
- Durham Region Board of Health (Health and Social Services Committee), c/o John Henry, Durham Regional Chair
- Eastern Ontario Health Unit Board of Health, c/o Councillor Syd Gardiner, Chair
- Grey Bruce Health Unit Board of Health, c/o Mayor Sue Paterson, Chair
- Haldimand-Norfolk Health Unit Board of Health, c/o Mayor Kristal Chopp, Chair
- Haliburton, Kawartha, Pine Ridge District Health Unit Board of Health, c/o Councillor Doug Elmslie, Chair
- Halton Region Board of Health (Regional Council), c/o Gary Carr, Halton Regional Chair
- Hastings Prince Edward Public Health Board of Health, c/o Mayor Jo-Anne Albert, Chair
- Huron Perth Public Health Board of Health, c/o Councillor Kathy Vassilakos, Chair
- Kingston, Frontenac, Lennox & Addington Public Health Board of Health, c/o Deputy Warden and Mayor, Denis Doyle, Chair
- Lambton County Board of Health (County Council), c/o County Warden and Mayor, Kevin Marriott, Chair
- Leeds, Grenville & Lanark District Health Unit Board of Health, c/o Mayor Doug Malanka, Chair
- Middlesex-London Health Unit Board of Health, c/o Councillor Maureen Cassidy, Chair
- Niagara Region Board of Health (Regional Council), c/o Jim Bradley, Regional Chair
- North Bay Parry Sound District Health Unit Board of Health, c/o Nancy Jacko, Chair
- Northwestern Health Unit Board of Health, c/o Mayor Doug Lawrance, Chair
- Ottawa Board of Health, c/o Councillor Keith Egli, Chair
- Peterborough Public Health Board of Health, c/o Deputy Warden and Mayor Andy Mitchell, Chair
- Porcupine Health Unit Board of Health, c/o Mayor Sue Perras, Chair
- Public Health Sudbury & Districts Board of Health, c/o Councillor René Lapierre, Chair
- Region of Peel Board of Health (Regional Council), c/o Nando Iannicca, Regional Chair and Chief Executive Officer
- Region of Waterloo Board of Health (Region of Waterloo Council), c/o Karen Redman, Regional Chair
- Renfrew County and District Health Unit Board of Health, c/o Ann Aikens, Chair
- Simcoe Muskoka District Health Unit Board of Health, c/o Deputy Mayor and Councillor Anita Dubeau, Chair
- Southwestern Public Health Board of Health (Oxford, Elgin and St. Thomas), c/o Warden Larry Martin, Chair
- Thunder Bay District Health Unit Board of Health, c/o Councillor James McPherson, Chair
- Timiskaming Health Unit Board of Health, c/o Mayor Carman Kidd, Chair

- Wellington-Dufferin-Guelph Public Health Board of Health, c/o Mayor and Councillor George Bridge, Chair
- Windsor-Essex County Health Unit Board of Health, c/o Warden and Mayor Gary McNamara, Chair
- York Region Board of Health (York Regional Council), c/o Wayne Emmerson, York Region Chairman and Chief Executive Officer
- Dr. Paul Roumeliotis, Association of Local Public Health Agencies, President, COMOH Representative, East Region

cc (via e-mail):
- Dr. Eileen de Villa, Medical Officer of Health, Toronto Public Health

Public Health
Santé publique
SUDBURY & DISTRICTS

June 21, 2022

VIA ELECTRONIC MAIL

Ministry of Children, Community and Social Services
Government of Ontario
438 University Avenue, 7th Floor
Toronto, ON M5G 2K8

Dear Honourable Minister:

Re: Healthy Babies Healthy Children Funding

The Board of Health for Public Health Sudbury & Districts remains wholly committed to the critical Healthy Babies Healthy Children program, however, has longstanding and increasing concerns about the Board's ability to meet clients' growing needs with current program funding. Please be advised that at it's meeting on June 16, 2022, the Board of Health for Public Health Sudbury & Districts carried the following resolution #19-22:

> *THAT the Board of Health for Public Health Sudbury & Districts request the Ministry of Children, Community and Social Services (MCCSS) to review base-funding needs for the Healthy Babies Healthy Children Program to ensure this essential program is sufficiently resourced to meet the current and growing needs of children and a healthy start in life.*

The Board of Health recognizes that the Healthy Babies Healthy Children (HBHC) program provides a critical prevention/early intervention program and is designed to ensure that all Ontario families with children (prenatal to age six) who are at risk of physical, cognitive, communicative, and/or psychosocial problems have access to effective, consistent, early intervention services. Since 1997 the province has committed to resourcing the Healthy Babies Healthy Children program at 100%. Unfortunately, the HBHC budget has not been increased since 2015, resulting in significant erosion in capacity due to fixed cost increases such as collective agreement commitments and steps on salary grids, travel and accommodation costs, and operational and administrative costs.

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This has been further compounded by the increased intensity of need in our communities pre-dating but further exacerbated by the COVID-19 pandemic.

The HBHC program has made every effort to mitigate the effects of the funding shortfalls over the years and to protect programming. The program, however, is not sustainable and significant service reductions will be required without increased to base funding.

It remains our priority to ensure that the HBHC program can effectively identify and support children and families most in need throughout the Sudbury/Manitoulin District. To this effect, we are submitting a revised 2022/23 HBHC program budget based on current needs and requesting consideration by the Ministry staff.

The Board of Health for Public Health Sudbury & Districts is respectfully requesting the Minister's commitment to carefully review base-funding needs for the HBHC program to ensure this essential program is sufficiently resourced to meet the current and growing needs of children and a healthy start in life.

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

Sincerely,

Penny Sutcliffe, MD, MHSc, FRCPC
Medical Officer of Health and Chief Executive Officer

cc: Dr. Kieran Moore, Chief Medical Officer of Health, Ministry of Health
Loretta Ryan, Executive Director, Association of Local Public Health Agencies
Ontario Boards of Health
Dr. Jackie Schleifer Taylor, Chair, Governing Council of Provincial Council for Maternal and Child Health
Sanober Diaz, Executive Director of Provincial Council for Maternal and Child Health