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

Thursday, June 20, 2024 at 7 p.m.
Microsoft Teams

MISSION - MIDDLESEX-LONDON HEALTH UNIT

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

MEMBERS OF THE BOARD OF HEALTH

Matthew Newton-Reid
Michael Steele
Peter Cuddy
Aina DeViet
Skylar Franke
Michael McGuire
Selomon Menghsha
Howard Shears
Michelle Smibert
Dr. Alexander Summers (Medical Officer of Health, ex-officio member)
Emily Williams (Chief Executive Officer, ex-officio member)

SECRETARY

Emily Williams

TREASURER

Emily Williams

DISCLOSURE OF CONFLICTS OF INTEREST

APPROVAL OF AGENDA

MINUTES

Approve: May 16, 2024 – Board of Health meeting

Receive: May 16, 2024 – 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**	2023 Annual Report and Attestation (Report No. 42-24)	Appendix A	To review the 2023 Annual Report and Attestation and seek approval from the Board of Health for submission to the Ministry of Health. Leads: Emily Williams, Chief Executive Officer and Dr. Alexander Summers, Medical Officer of Health
2			**X**	MLHU 2024 Emergency Response Plan Revisions (Report No. 43-24)	Appendix A	To review the Health Unit's Emergency Response Plan for information. Lead: Sarah Maaten, Director, Public Health Foundations Presenting: Tara MacDaniel, Strategic Advisory, Emergency Management and Marc Resendes, Acting Manager, Strategy, Planning and Performance
3			**X**	Introduction to the MLHU Management Operating System (Report No. 44-24)	Appendix A	To introduce the Middlesex-London Health Unit's Management Operating System (MOS). Leads: Emily Williams, Chief Executive Officer and Dr. Alexander Summers, Medical Officer of Health
4			**X**	Current Public Health Issues (Verbal Report)		To provide an update on current public health issues in the Middlesex-London region. Lead: Dr. Alexander Summers, Medical Officer of Health

5			**X**	Medical Officer of Health Activity Report for May (Report No. 45-24)		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
6			**X**	Chief Executive Officer Activity Report for April and May (Report No. 46-24)		To provide an update on external and internal meetings attended by the Chief Executive Officer since the April Board of Health meeting. Lead: Emily Williams, Chief Executive Officer
Correspondence						
7			**X**	June Correspondence		To receive items a) through c) for information: a) Township of Lucan-Biddulph re: *Recommended Phase Out of Free Water Well Testing in the 2023 Auditor General's Report* b) Public Health Sudbury & Districts re: *Support for Bill C-322 National Framework for a School Food Program Act* c) Middlesex-London Board of Health External Landscape for June 2024

OTHER BUSINESS

The next meeting of the Middlesex-London Board of Health is Thursday, July 18, 2024 at 7 p.m.

CLOSED SESSION

The Middlesex-London Board of Health will move into a closed session to approve previous closed session 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, May 16, 2024, 7 p.m.
MLHU Board Room – CitiPlaza
355 Wellington Street, London ON

MEMBERS PRESENT:	Matthew Newton-Reid (Chair) Michael Steele (Vice-Chair) Selomon Menghsha Skylar Franke Michelle Smibert (attended virtually) Peter Cuddy Michael McGuire Howard Shears Dr. Alexander Summers, Medical Officer of Health (ex-officio)
REGRETS:	Emily Williams, Chief Executive Officer (ex-officio) Aina DeViet
OTHERS PRESENT:	Stephanie Egelton, Executive Assistant to the Board of Health (recorder) Dr. Joanne Kearon, Associate Medical Officer of Health Sarah Maaten, Director, Public Health Foundations Jennifer Proulx, Director, Family and Community Health and Chief Nursing Officer Mary Lou Albanese, Director, Environmental Health, Infectious Diseases and Clinical Services Shaya Dhinsa, Manager, Sexual Health Darrell Jutzi, Manager, Municipal and Community Health Promotion Ryan Fawcett, Manager, Privacy, Risk and Client Relations David Jansseune, Associate Director, Finance and Operations/Chief Financial Officer Megan Cornwell, Manager, Corporate Communications Morgan Lobzun, Communications Coordinator Parthiv Panchal, End User Support Analyst, Information Technology Scott Courtice, Executive Director, London InterCommunity Health Centre Angela Armstrong, Program Assistant, Communications Linda Stobo, Manager, Social Marketing and Health System Partnerships Donna Kosmack, Manager, Oral Health

Chair Matthew Newton-Reid called the meeting to order at **7 p.m.**

It was moved by **M. Steele, seconded by P. Cuddy,** *that the Board of Health appoint an Acting Secretary (Alexander Summers) for the duration of the May 16 Board of Health Meeting per the Middlesex-London Board of Health – By-law No. 3 - Proceedings of the Board of Health.*

Carried

It was moved by **S. Franke, seconded by S. Menghsha,** *that the Board of Health appoint an Acting Treasurer (Alexander Summers) for the duration of the May 16 Board of Health Meeting per the Middlesex-London Board of Health – By-law No. 3 - Proceedings of the Board of Health.*

Carried

Dr. Alexander Summers, Medical Officer of Health introduced Megan Cornwell, Manager, Corporate Communications to the Board.

Chair Newton-Reid welcomed M. Cornwell and noted that the Board of Health looks forward to working with her as a community leader.

DISCLOSURE OF CONFLICT OF INTEREST

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

APPROVAL OF AGENDA

It was moved by **M. Steele, seconded by S. Franke,** *that the **AGENDA** for the May 16, 2024 Board of Health meeting be approved.*

Carried

APPROVAL OF MINUTES

It was moved by **H. Shears, seconded by P. Cuddy,** *that the **MINUTES** of the April 18, 2024 Board of Health meeting be approved.*

Carried

It was moved by **M. Steele, seconded by S. Menghsha,** *that the **MINUTES** of the April 18, 2024 Performance Appraisal Committee meeting be received.*

Carried

It was moved by **M. Steele, seconded by S. Menghsha,** *that the **MINUTES** of the April 18, 2024 Governance Committee meeting be received.*

Carried

NEW BUSINESS

Finance and Facilities Committee Meeting Summary (Verbal Report)

Committee Chair Michael Steele provided an overview of the report heard by the Finance and Facilities Committee at 6 p.m. for the Board of Health's consideration.

M. Steele noted that in summary for Q1, the Health Unit is in a slight surplus position, with vacancies contributing to the gap and the expectation that finances will be balanced at the end of the year.

It was moved by **M. Steele, seconded by P. Cuddy,** *that the Board of Health receive Report No. 09-24FFC re: "2024 Q1 Financial Update, Borrowing Update and Factual Certificate" for information.*

Carried

Delegation from the London InterCommunity Health Centre (Verbal Delegation)

Dr. Summers introduced Scott Courtice, Executive Director, London InterCommunity Health Centre to present as a delegation to the Board of Health.

Dr. Summers noted that the Board had indicated its desire to know more about local partners with which the Health Unit works. The Board of Health will be presented with more local partners at future Board meetings.

Scott Courtice, Executive Director, London InterCommunity Health Centre provided an overview of the London InterCommunity Health Centre and noted its continued close partnership with the Middlesex-London Health Unit.

S. Courtice noted that the London InterCommunity Health Centre opened in 1989. Community health centers are to support those who are marginalized, newcomers and who face barriers in the traditional health system. There are three (3) locations, with a care team including family doctors, nurse practitioners, nurses, social workers, dietitians, community health workers who work with community developers and health promoters to support the population. S. Courtice added that the client base is approximately 12,000.

S. Courtice briefly reviewed the programs that the London InterCommunity Health Centre offers, which are in the categories of Children, Youth, Families and Community, Diabetes and Chronic Diseases and Primary Health Care. S. Courtice noted that the Health Unit has had a strong partnership with the London InterCommunity Health Centre with some of these programs before COVID-19, especially with the safer supply programs and care for those with HIV.

In addition to regular programming, the London InterCommunity Health Centre supports newcomers, vaccination, infectious disease support, health and homelessness, opioids and harm reduction. S. Courtice noted that as the Community Drug and Alcohol Committee has been re-established (and as co-chair), this is an important time to be doing work related to substances due to the loss of members of the community to the toxic drug supply.

Chair Newton-Reid noted that the London InterCommunity Health Centre has 6.5 doctors on staff and inquired what the current waitlist is seeing a doctor within the organization. S. Courtice noted that for the first time, the LIHC has a full roster of doctors on staff and there is currently no open wait list. The London InterCommunity Health Centre identifies clients with high risk factors to be rostered and noted that the community could use more physicians and nurse practitioners.

Chair Newton-Reid inquired on the funding sources for the London InterCommunity Health Centre. S. Courtice explained that 90% of their funding is from the Province of Ontario and do not receive federal funding due to resources being met through provincial funding.

Chair Newton-Reid thanked S. Courtice and Dr. Summers for their collaborative work and alignment to support the community. Vice-Chair Michael Steele added his gratitude for S. Courtice attending the Board of Health meeting and noting that based on the London InterCommunity Health Centre's values and mission that the work between them and the Middlesex-London Health Unit are clearly aligned.

Board Member Selomon Menghsha inquired how many employees work at the London InterCommunity Health Centre and what geographical area it serves. S. Courtice stated that there are 150 employees and the LIHC is focused on serving the City of London due to its complex urban health needs.

It was moved by **S. Franke, seconded by S. Menghsha,** *that the Board of Health receive the verbal delegation from the London InterCommunity Health Centre for information.*

Carried

Collective Action to Address Substance Use and Harms in Middlesex-London (Report No. 36-24)

Jennifer Proulx, Director, Family and Community Health introduced Sarah Maaten, Director, Public Health Foundations and Darrell Jutzi, Manager, Municipal and Community Health Promotion to present on the Health Unit's collective action to address substance use and harms in the community.

D. Jutzi explained that the Chief Medical Officer of Health Annual Report titled "Balancing Act: An All-of-Society Approach to Substance Use and Harms" was released on March 28, 2024. The report focused on tobacco/vaping Products, alcohol, cannabis and opioids along with the factors that drive their use. The Chief Medical Officer of Health in the report calls for a balance between long-term upstream strategies to create healthy communities with short-term actions to respond to substance-specific challenges.

S. Maaten provided information on data associated with the burden of substance use within the Middlesex-London community.

For opioid use causing emergency department visits, there are substantial impacts among males, individuals 25-44 years old, and those in urban areas. This rate is significantly higher among Middlesex-London residents compared to Ontario and peer group. For deaths related to opioid use, there are substantial impacts among males, individuals 25-44 and 45-64 years old. Death rates are significantly higher among Middlesex-London residents compared to Ontario and peer group in 2021 and 2022.

For cannabis use causing emergency department visits, there have been increased visits from 2013 to 2019, primarily among those under the age of 25 years old with hospitalizations significantly higher among Middlesex-London residents compared to Ontario and peer group.

For alcohol use causing emergency department visits, the incident rate is significantly lower than Ontario but higher compared to peer group, with the highest rates among males and individuals 15-24 years old and hospitalizations significantly higher among Middlesex-London residents compared to Ontario and peer group.

D. Jutzi noted that the Health Unit is using a number of interventions to address substance use and harms which closely align with the approach highlighted in the Chief Medical Officer of Health Annual Report. These interventions include:

- Surveillance (e.g., collect, analyze, and interpret population-level health substance related data);
- Clinical Services Delivery (e.g., early childhood home visiting programs);
- Community and Partner Mobilization (e.g., Middlesex-London Community Drug and Alcohol Committee);
- Healthy Public Policy Development (e.g., guidance pertaining to municipal alcohol retailor density);
- Communication and Social Marketing (e.g., regional campaigns such as Rethink your Drinking);
- Inspections (e.g., enforcing legal requirements of the Smoke-Free Ontario Act, 2017);
- Investigations (e.g., progressive enforcement activities related to Cannabis);
- Health Resource Inventory Management (e.g., needle exchange program and naloxone kit distribution and tracking).

The Chief Medical Officer of Health report calls for a whole-of-society, health-first approach in a non stigmatizing manner. Early this year, the former Middlesex-London Community Drug and Alcohol Strategy (CDAS) Steering Committee was re-established as the Middlesex-London Community Drug and Alcohol Committee (CDAC). Next steps for this Committee include reviewing and expanding membership, liaise with other tables to support other strategies and develop a framework to raise and prioritize issues to guide work in this area going forward.

The Health Unit will continue to collect and analyze relevant data to monitor trends over time, emerging trends, priorities and health inequities related to substance use and harms. In addition, the Health Unit will identify recommendations from the report and the previous Community Drug and Alcohol Strategy identify opportunities to enhance existing work or address gaps. The Board of Health will continue to receive updates on this work and through the Community Drug and Alcohol Committee.

Vice-Chair Steele inquired what would trigger an emergency department visit regarding cannabis. S. Maaten noted that this would relate to cannabis poisonings (such as the use of edibles).

Vice-Chair Steele inquired which organizations other than the Health Unit and London InterCommunity Health Centre were involved with the Community Drug and Alcohol Committee. D. Jutzi noted that there is representation from the City of London, London Police and the Canadian Mental Health Association. D. Jutzi added that as the committee is being re-established, there is an opportunity to expand membership. Dr. Summers added that the gap for membership currently is Middlesex County, Indigenous representation and those with living and lived experience.

Board Member Skylar Franke noted that there are 98 actions to combat substance use in the community by the Committee, and inquired if these actions within the strategy will continue or if there will be updates required. Dr. Summers noted that there has been continued significant discussion at Community Drug and Alcohol Committee meetings, and it was determined that at this time, the actions did not need to be changed. The Committee is currently looking at moving forward with reviewing acute issue responses and key strategies to prioritize over years 2 and 3. Dr. Summers concluded that actions may need to be revisited in the future, but at this time, strategic coordination is the goal.

Board Member S. Menghsha inquired on the jump in 2020 for the burden of opioid use and why London differs from peer groups. Dr. Summers noted that broadly speaking, we are in the third wave of the opioid crisis. From 2014 onward, the burden of opioid use was driven by compromised and toxic drug supply. The push to de-prescribe, in conjunction with other variables, resulted in individuals seeking street-available opioids. Dr. Summers added that Southwestern Ontario has had an increase potentially because of its proximity to the 401 and quicker access to the United States borders.

Board Member Howard Shears inquired if Niagara, Windsor and Sarnia are comparable peer groups to Middlesex-London. Dr. Summers explained that peer groups are informed by size and rural and urban mix, and that Hamilton and Waterloo would be comparable peer groups for the region.

Board Member S. Franke inquired on when the Health Unit needs direction on conducting work associated with the Chief Medical Officer of Health Annual Report, as some political figures may not agree with recommendations within the report. Dr. Summers noted that the key next steps for staff is to identify components of the Chief Medical Officer of Health Annual Report and identify how it is actioned in a local context such as what we are identifying, leveraging and mitigating. An example of this is that alcohol retail will be expanded in Province and the report conclusion is that increased availability anticipates increased harms. Dr. Summers added that the Health Unit is exploring tools that public health, partners or local councils can use to minimize the harms associated with this new policy measure.

It was moved by **P. Cuddy, seconded by S. Franke,** *that the Board of Health receive Report No. 36-24 re: "Collective Action to Address Substance Use Harms in Middlesex-London" for information.*

Carried

Harm Reduction, Program Enhancement and Needle Syringe Program Activity (Report No. 37-24)

Mary Lou Albanese, Director, Environmental Health, Infectious Diseases and Clinical Services introduced Shaya Dhinsa, Manager, Sexual Health to provide information on the Health Unit's work with ham reduction and the needle syringe program.

S. Dhinsa noted that the Health Unit reports to the Ministry of Health annually on use of the Harm Reduction Program Enhancement (HRPE) and the Needle Syringe Program (NSP). The reporting notes staffing resources, local opioid or overdose response plans, naloxone distribution, early warning system, surveillance and programs gaps.

S. Dhinsa noted that there were 10,837 naloxone kits distributed in 2023 and 5 new eligible community organizations became part of the program supported by the Health Unit. Staff continue to monitor weekly emergency department opioid overdose reports, and the local and provincial monthly drug alerts, which increase awareness of the toxic drugs circulating in our community. In 2023, one local drug alert was issued. Chippewas of the Thames First Nation Health Centre, Munsee-Delaware Nation Health Services, and Oneida Nation of the Thames Health Services along with the Strathroy Middlesex General Hospital identified the increase in overdoses. Analysis identified that many of the patients were from the identified communities and support was offered at the request and direction of First Nations' partners. The local drug alert information is also distributed through the Ministry of Health provincial monthly drug alert.

S. Dhinsa explained that the Needle Syringe Program currently has the main core site at Regional HIV/AIDS Connection (RHAC)'s Carepoint, with 11 public access satellite locations, 16 client-only satellite sites, and 1 mobile outreach van. There are 23 needle disposal bins located throughout the City of London. In 2023, there were 37,537 visits to these sites, 1,719,589 needles distributed and 828,215 returned with an estimated 48% return rate.

Board Member Michael McGuire noted that in British Columbia, the approach was to decriminalize some drugs (opioid use) and this decision was recently reversed. M. McGuire inquired if this type of policy change is monitored by the Health Unit, as there are conversations within the community that discuss if programs like the needle syringe program are helping or exacerbating a problem. S. Dhinsa noted that the Health Unit often reviews substance policy from other provinces and programs and noted that some staff from the Health Unit visited British Columbia to review their programming on reducing HIV within the community of people who inject drugs. S. Dhinsa further noted that the programming in British Columbia is more for urban residents and does not necessarily need to be replicated in Middlesex-London, noting that it is important regardless to bring the knowledge back to the area. In regard to harm reduction, the needle syringe program reduces harm but does not eliminate them. The program (Carepoint) can provide safe supplies for those who inject drugs and information on addiction support if requested. Dr. Summers noted that harm reduction is a balancing act between destigmatization of those who inject drugs and minimizing harm, while still de-normalizing substances and ensures the population in aware of the harms. Dr. Summers explained that in British Columbia, the act of decriminalizing opioids was intended to move substance use from a legal issue to a medical issue. What appears to have caused significant concern is the use of these substances in public spaces, and a perceived loss of public order. The Health Unit is reviewing substance use policy and minimizing health harms, and that public health supports a legalized, decommercialized, highly regulated drug supply. M. McGuire thanked S. Dhinsa and Dr. Summers for this information, as the Health Unit is taking a "eyes wide open" approach to harm reduction.

It was moved by **M. McGuire, seconded by S. Menghsha,** *that the Board of Health receive Report No. 37-24 re: "Harm Reduction, Program Enhancement and Needle Syringe Program Activity Report" for information.*

Carried

Q1 2024 Risk Register Update (Report No. 38-24)

Ryan Fawcett, Manager, Privacy, Risk and Client Relations presented the Q1 2024 Risk Registry.

R. Fawcett noted that the Health Unit has made progress with mitigating risks for removal from the registry. Ten (10) risks were identified in Q4, and four (4) have been removed due to successful mitigation. One (1) new risk was added to the registry in the People/Human Resources category.

Among the seven (7) risks identified on the registry, four (4) are high risk and three (3) are medium risk.

High risk

Two (2) significant residual risks are within the Financial and People/Human Resources categories. The Financial risk is related to COVID-19 funding and mitigation. The new People/Human Resources risk related to restructuring, as there is a risk of reduced productivity as new teams are forming and learning new work in Q1.

Two (2) moderate residual risks are within Financial and Political categories. The Financial risk is related to budget and funding being stagnant and not sustainable due to contractual obligations and inflation. The Political risk is related to public health modernization and mergers.

Medium risk

One risk (1) carries moderate residual risk related to the Technology category and two (2) carry minor residual risk related to Technology and Legal/Compliance risk categories. These three (3) risks are receiving effective mitigation strategies to minimize organizational risk to an acceptable level.

There were no questions or discussion.

It was moved by **H. Shears, seconded by S. Franke,** *that the Board of Health:*

1) *Receive Report No. 38-24 re: "MLHU Q1 Risk Register" for information; and*
2) *Approve the Q1 Risk Register (Appendix A).*

Carried

Q1 2024 Provisional Strategic Plan Update (Report No. 39-24)

Sarah Maaten, Director, Public Health Foundations presented the Q1 2024 Provisional Strategic Plan Update.

S. Maaten noted that all fourteen (14) projects are on track to proceed as planned, with three (3) additional projects starting in Q1. The three (3) new projects are to:

- Catalog and track MLHU relationships with key local and regional partners, including the assigned MLHU leads / key liaisons for those relationships;
- Develop and implement an evidence-based framework to effectively engage with partners; and
- Integrate public health foundational principles and practices into staff orientation and ongoing training curriculum.

S. Maarten added that one of the tactics among six within the organizational quality management system initiative has not been initiated yet, as it is for the development of a template for programmatic operational plans within the Management Operating System (MOS) work. S. Maaten noted that this will be presented to the Board of Health at an upcoming meeting.

There were no questions or discussion.

It was moved by **P. Cuddy, seconded by S. Franke,** *that the Board of Health receive Report No. 39-24 re: "2023-25 Provisional Plan 2024 Q1 Status Update" for information.*

Carried

Current Public Health Issues (Verbal)

Dr. Summers provided a verbal update on current public health issues within the region.

COVID-19 Vaccine Spring Campaign & Fall National Advisory Concerning Immunization (NACI) Recommendations

The COVID-19 Vaccine Spring Campaign runs from April to June, for the following individuals including:

- Adults 65 years of age and older
- Adult residents of long-term care homes, retirement homes, and other congregate living settings for seniors
- Individuals 6 months of age and older who are moderately to severely immunocompromised
- Individuals 55 years and older who identify as First nations, Inuit, and Metis and their non-Indigenous household members who are 55 years and older

The campaign is targeted for the highest risk individuals, with the rest of the population not being recommended for their vaccine at this time. There is a lower number of COVID-19 positive cases in the community, but it is still present. Looking ahead to the fall, public health still encouraging those considering getting vaccination for COVID-19 and influenza to reduce the burden of illness.

Chair Newton-Reid sought clarification on the recommendation for individuals ages 5 and up who are not vaccinated. Dr. Summers explained that the recommendation is that those ages 5 and up should receive a primary series of COVID-19 vaccinations (3) and an annual booster.

Ontario Blacklegged Tick Risk Areas

There has been an increase in Lyme disease caused by Blacklegged Ticks in Ontario. The Blacklegged Tick was not as prevalent in Ontario 20 years ago.

Blacklegged Ticks can spread four tick-borne diseases of public health significance:

- Anaplasmosis
- Babesiosis
- Lyme Disease
- Powassan virus infection

The estimated risk areas for blacklegged ticks have been increasing throughout Ontario, year over year, with Kingston previously being the main risk area of the province. Blacklegged Ticks are found in London and Middlesex County. With the increase presence of Blacklegged Ticks, treat the Middlesex-London region as a high-risk area. The Health Unit's Vector Borne Disease team conducts surveillance, tick dragging and education. Dr. Summers reminded to take precautions such as educating yourself on outdoor safety from ticks and when returning home, checking for ticks on yourself and your pets.

Health & Homelessness Update

The City of London approved the "Highlight Supportive Housing" Plan on April 2, 2024. Highlights of the plan include:

- 600 Highly Supportive Housing units to be developed in next 3 years;
- Highly Supportive Housing will provide 24/7 on-site support and a continuum of care for those using substances;
- Use of a coordinated intake approach to standardized intake practices; and
- Core, consistent functions will be required to ensure quality and consistency across multiple projects to support those in the housing units.

The City (of London) will also be hosting community engagement opportunities on the Whole of Community Response, the homeless crisis and an encampment to housing strategy.

Hospital Costs of Homelessness

A report from the Canadian Institute for Health Information has explored the hospital admission costs of homelessness in the community. The report highlighted the importance of preventing homelessness due to the amount of costs (twice as much) associated with emergency room visits and those experiencing homelessness.

The key findings of the report include:

- Nearly 30,000 people last year homeless when admitted to hospital and/or discharged from hospital;
- Average length of stay for people experiencing homelessness 15.4 days vs national average 8 days;
- Average cost per stay $16,800 vs national average $7,800; and
- Of patients, 93% admitted to hospital after emergency department visit.

Vice-Chair Steele noted that dogs receive Lyme disease vaccination and treatment, and inquired if there was anything similar for humans. Dr. Summers confirmed that there is no vaccination for Lyme disease for humans.

It was moved by **P. Cuddy, seconded by S. Franke,** *that the Board of Health receive the verbal report re: Current Public Health Issues for information.*

Carried

Medical Officer of Health Activity Report for April (Report No. 40-24)

Dr. Summers presented his activity report for April, noting that he had taken time off during the month and shared appreciation to the Board of Health and colleagues for this time off.

There were no questions or discussion.

It was moved by **S. Franke, seconded by H. Shears,** *that the Board of Health receive Report No. 40-24 re: "Medical Officer of Health Activity Report for April" for information.*

Carried

Board of Health Chair Activity Report for March and April (Report No. 41-24)

Chair Newton-Reid presented his activity report for March and April.

There were no questions or discussion.

It was moved by **S. Franke, seconded by P. Cuddy,** *that the Board of Health receive Report No. 41-24 re: "Board of Health Chair Activity Report for March and April" for information.*

Carried

CORRESPONDENCE

Board Member S. Franke requested that correspondence items d) Peterborough Public Health re: Chief Medical Officer of Health Annual Report and e) Peterborough Public Health re: Recommendation for Federal Restrictions on Nicotine Pouches be endorsed. Further, S. Franke requested that related to item d), that the Health Unit and funders (City of London and County of Middlesex) write a similar letter to the Chief Medical Officer of Health with the London and Middlesex context in mind.

It was moved by **M. McGuire, seconded by S. Franke,** *that the Board of Health receive items a), b), c), f) and g) for information:*

a) Timiskaming Public Health Unit re: Endorsement of Public Health Sudbury & Districts Letter on Gender-based and Intimate Partner Violence (IPV)
b) Public Health Sudbury & Districts re: Recommendations for Government Regulation of Nicotine Pouches (Provincial)
c) Public Health Sudbury & Districts re: Recommendations for Government Regulation of Nicotine Pouches (Federal)
f) Middlesex-London Board of Health External Landscape for May 2024
g) Summary of Association of Local Public Health Agencies' Resolutions for 2024

Carried

It was moved by **S. Franke, seconded by M. McGuire,** *that the Board of Health endorse correspondence item e) Peterborough Public Health re: Recommendation for Federal Restrictions on Nicotine Pouches.*

Carried

It was moved by **S. Franke, seconded by M. McGuire,** *that the Board of Health:*

1) Endorse correspondence item d) Peterborough Public Health re: Chief Medical Officer of Health Annual Report; and
2) Direct staff in coordination with public funders (City of London and County of Middlesex) to write a letter of support grounded in the local Middlesex-London context regarding the Chief Medical Officer of Health Annual Report.

Carried

OTHER BUSINESS

The next meeting of the Middlesex-London Board of Health is Thursday, June 20, 2024 at 7 p.m.

CLOSED SESSION

At **8:20 p.m.** it was moved by **M. McGuire, seconded by M. Steele,** *that the Board of Health will move into a closed session to consider matters regarding litigation or potential litigation, including matters before administrative tribunals, affecting the municipality or local board; advice that is subject to solicitor-client privilege, including communications necessary for that purpose; and to approve previous closed session Board of Health minutes.*

Carried

At **8:26 p.m.,** it was moved by **S. Franke, seconded by M. Steele,** *that the Board of Health return to public session from closed session.*

Carried

ADJOURNMENT

At **8:27 p.m.,** it was moved by **M. McGuire, seconded by M. Smibert,** *that the meeting be adjourned.*

Carried

MATTHEW NEWTON-REID
Chair

ALEXANDER SUMMERS FOR EMILY WILLIAMS
Acting Secretary

PUBLIC SESSION – MINUTES
MIDDLESEX-LONDON BOARD OF HEALTH
FINANCE AND FACILITIES COMMITTEE

Thursday, May 16, 2024, 6 p.m.
MLHU Board Room – CitiPlaza
355 Wellington Street, London ON

MEMBERS PRESENT:	Michael Steele (Chair) Matthew Newton-Reid Selomon Menghsha Michael McGuire Howard Shears Dr. Alexander Summers, Medical Officer of Health (ex-officio)
REGRETS:	Emily Williams, Chief Executive Officer (ex-officio)
OTHERS PRESENT:	Stephanie Egelton, Executive Assistant to the Board of Health (recorder) Dr. Joanne Kearon, Associate Medical Officer of Health David Jansseune, Associate Director Finance and Operations/Chief Financial Officer Morgan Lobzun, Communications Coordinator (entered at 6:43 p.m.) Angela Armstrong, Program Assistant, Communications (entered at 6:43 p.m.)

At **6 p.m.,** Chair Michael (Mike) Steele called the meeting to order.

It was noted that Secretary and Treasurer/Chief Executive Officer, Emily Williams would be absent from this meeting. The Committee will need to appoint a Secretary and Treasurer for the meeting per the Board of Health By-law No. 3 - Proceedings of the Board of Health.

It was moved by **M. McGuire, seconded by M. Newton-Reid,** *that Finance and Facilities Committee appoint Alexander Summers as Acting Secretary for the duration of the May 16, 2024 Finance and Facilities Committee meeting per the Middlesex-London Board of Health – By-law No. 3 - Proceedings of the Board of Health.*

Carried

It was moved by **M. McGuire, seconded by M. Newton-Reid,** *that Finance and Facilities Committee appoint Alexander Summers as Acting Treasurer for the duration of the May 16, 2024 Finance and Facilities Committee meeting per the Middlesex-London Board of Health – By-law No. 3 - Proceedings of the Board of Health.*

Carried

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 **H. Shears, seconded by M. Newton-Reid,** *that the **AGENDA** for the May 16, 2024 Finance and Facilities Committee meeting be approved.*

Carried

APPROVAL OF MINUTES

It was moved by **M. McGuire, seconded by S. Menghsha,** *that the **MINUTES** of the February 15, 2024 Finance and Facilities Committee meeting be approved.*

Carried

NEW BUSINESS

2024 Q1 Financial Update, Borrowing Update and Factual Certificate (Report No. 09-24FFC)

David Jansseune, Associate Director, Finance and Operations/Chief Financial Officer presented the Q1 2024 Financial Update, Borrowing Update and Factual Certificate to the Committee.

D. Jansseune noted that these were non-consolidated results for Q1 (MLHU) and Q4 (MLHU2) and reminded the Committee that the Health Unit has two (2) reporting companies with three (3) financial segments:

- MLHU: Shared Funded Programs
- MLHU: Three (3) 100% Funded Programs
- MLHU2: Four (4) 100% Funded Programs

D. Jansseune noted that the bulk of the Health Unit's budget is under the main company (MLHU) and include both shared funded programs (funded by the Ministry of Health, County of Middlesex and City of London) and three (3) 100% discrete funding for specific program purposes. MLHU2 has four 100% discrete funding programs for specific program purposes. Fiscal reporting for MLHU is from January to December and fiscal reporting for MLHU2 is from April to March. Both companies are audited by KPMG annually.

Committee Member Matthew Newton-Reid inquired if the Health Unit would consider consolidating the two companies into one company in the future for cost saving purposes, particularly related to the auditing process. D. Jansseune noted that the Health Unit is currently undergoing analysis on financial systems (Great Plains) and re-writing accounts to flow better. D. Jansseune explained that one way of analysis is to review the necessity of the second company. For example, the main funder of MLHU2 is the Ministry of Children, Community and Social Services and funds most of the company (approximately $2.5 million). The Ministry (of Children, Community and Social Services) requires a separate audit of their financial statements, and there is a potential at re-adjusting to segmented financial statements in the future.

Chair Steele inquired how much it costs the Health Unit to have two separate financial companies. D. Jansseune noted that from a full time equivalent (FTE) perspective, it is approximately 0.2 FTE to support intercompany journal entries.

Committee Member Howard Shears inquired if the Health Unit completes consolidated statement of companies. D. Jansseune confirmed that the Health Unit conducts annual financial audits and added that auditors are currently working on the Health Unit's audit. The Board of Health will review these draft financial statements in the summer. H. Shears followed up to confirm that the Health Unit had two different financial year ends, which D. Jansseune confirmed. D. Jansseune added that due to the different financial years, that Finance must coordinate accounts for each of the companies at the end of the quarters.

Dr. Summers noted that the funding calendar is different due to the Ministry funders having a fiscal year of March to April, and public health units having a fiscal year of January to December pursuant to the *Municipal Act,* 2001. Dr. Summers noted that public health units struggle with this discrepancy, and it has been noted for the Province.

Committee Member M. Newton-Reid noted that the Board of Health may need to have a broader conversation regarding the financial companies in the future and to discuss funding years as it relates to the

Health Unit's operations. Dr. Summers added that at times, the Health Unit is not aware of funding until August of the year, or with not much notice. The Province of Ontario has signaled a review of the public health funding timelines and will announce in the future.

D. Jansseune added that the Seniors Dental program is funded 100% under MLHU.

MLHU Q1 Results from January to March 2024

D. Jansseune reviewed the Q1 financial information with the Committee and reminded the Committee of the Health Unit's $36 million Annual Budget which includes the shared funded programs at $32 million and three (3) 100% funded programs at $4 million. D. Jansseune noted that the Health Unit has the most flexibility with the shared funding programs, as the Senior Leadership team can move funds where it best makes sense for their programs. This cannot be done with discrete funding or 100% funded programs. D. Jansseune added that overall in Q1, the Health Unit is financially doing well with an approximately $306,000 in favourability and a $106,000 surplus.

D. Jansseune highlighted the approximately $556,000 favourability for salaries, overtime and benefits, and that this favourability will decrease over time. The favourability is high due to the organizational restructuring effective January 1, 2024 and current vacancies that have not been filled. As of January 1, there were 20 vacancies and as of March 31, there were 14. D. Jansseune noted that this favourability will offset the gap.

D. Jansseune noted that general expenses were flat at $1.6 million, as the timing of expenditures vs timing of budget are different. To finish Q1 reporting, the gap is at approximately $253,000 and is an estimate of vacancies, time to fill and pay step differences from April to December. The forecast is flat to budget and salaries will need to maintain an estimated 3.75 FTE vacancy rate from April to December. D. Jansseune concluded that at this time, no reserve entries have been budgeted for 2024.

Committee Member H. Shears inquired on staff impacts if the Health Unit is running 3.75 FTE under budget, and if staff can maintain work levels without more stress or overtime hours. Dr. Summers noted that it is anticipated that some vacancies occur organically through recruitment delays and resignations. The Health Unit anticipates minimal immediate impact on overtime, given how the Health Unit can prioritize different types of work. The restructuring of the Health Unit has resulted in re-prioritization, and the Health Unit is currently managing vacancies by reducing how much work is completed. Dr. Summers noted that overtime is being periodically seen in business lines where work is being conducted reactively as opposed to proactively, such as a case and contact management within the Infectious Disease Control team. The Health Unit is tolerating the 3.75 FTE under budget operationally, but globally are stretched. Teams are collectively feeling strained operationally as the restructuring was the best estimate for the resources required for the work at the time. Dr. Summers concluded that when the Health Unit is preparing for 2025 budget planning, fine tuning will occur with the support of the Senior Leadership Team.

Chair Steele inquired how many staff the Health Unit currently has. D. Jansseune noted that there are approximately 288 FTE.

D. Jansseune reviewed the MLHU 100% Funded Programs. D. Jansseune reminded the Committee that the budget is under $4 million and any surplus needs to be returned to the funders (Ministry of Health and City of London).

COVID-19 Vaccine funding was originally ending on December 31, 2023, however the Health Unit received $100,000 on March 28, 2024 for COVID-19 Vaccine funding to be used by March 31, 2024. Due to the timing of the funding being received, the Health Unit could not extend contracts and could not utilize money very well. D. Jansseune noted that $37,000 was able to be used and $63,000 will be returned to the Ministry of Health.

The Ontario Seniors' Dental Care funding is budgeted at $3.5 million, with a potential risk of overspending due to additional staffing to support the expanded dental clinic at CitiPlaza.

Committee Member M. Newton-Reid inquired on the funding amounts and logistics for funding regarding the Seniors' Dental Care Program at CitiPlaza. Dr. Summers noted that similarly to the Strathroy Dental Clinic, the Health Unit received capital funding for the build of the clinic but did not receive operational funding until after all staff were hired. Dr. Summers added that the Health Unit has received reassuring messages from the Ministry of Health that operational funding will flow to public health units. The Ministry has been signaled that the Health Unit has a waitlist for dental services, and the risk for not receiving funding is low. M. Newton-Reid inquired if municipal funders (County of Middlesex and City of London) could support funding if there was a provincial shortfall. Dr. Summers noted that if funding did not come through, operations of the clinic should be shuttered for a period until funding is provided, but there is a low likelihood that this would need to occur.

Committee Member H. Shears inquired if the dentists at the clinic were employed by the Health Unit. Dr. Summers noted that the dentists at the clinic are hired as staff at the Health Unit.

D. Jansseune reviewed that the City of London Cannabis Legislation (CLIF) funding tends to fluctuate year over year. The program is budgeted at $200,000 and funds may be carried over to following years for future spending.

D. Jansseune reminded the Committee that the School Focused Nurses Initiative funding was discontinued in June 2023 by the Ministry of Health.

D. Jansseune reviewed the Ontario Seniors' Dental Care capital funding. The Ministry of Health approved $408,900 for the expansion of operatories at CitiPlaza to be used by March 31, 2024. The Health Unit were not able to use all the funding but showed progress of spending to the Ministry of Health. CitiPlaza (as the landlord) has approved construction, and the construction was awarded to CCS Construction following the Request for Proposal (RFP) process. Two (2) existing operatories have been retrofitted to increase patient comfort and address staff ergonomics, along with new doors and windows being added to the two (2) new operatories. Equipment for the new operatories has been ordered and is waiting for pick-up, and the London Fire Department has assessed sprinklers, sensors and emergency strobe lighting. The City of London has approved building permits for construction this week. D. Jansseune added that the forecasted expenses range from approximately $320,000 to $375,000 for the project, and there has been a request made to the Ministry of Health for new funding for the remainder of the unpaid project costs after March 31.

Committee Member M. Newton-Reid inquired if based on funding and need, if there is a piece of equipment that the Health Unit could purchase with the funding to meet timeline spending (approximately $35,000). D. Jansseune noted that the deadline for the approval of $408,900 in funding for the dental clinic ended on March 31, and the Health Unit would need to attest to any money spent after. D. Jansseune added that at this time, less than $408,900 has been spent. Dr. Summers noted that there are still outstanding items to be purchased for the dental clinic. At this time, a portion of construction costs to CCS Construction have been paid, and further updates will be provided to the Committee and Board. Dr. Summers concluded that the timing of funding has put the Health Unit in a difficult position. Committee Member H. Shears confirmed for clarity if the Health Unit received approval for spending but not the actual funding. Dr. Summers confirmed this is correct and added that the Health Unit is comfortable forging ahead based on previous experience.

Committee Member H. Shears inquired if the 50% deposit towards the dental clinic construction fixes the contract costs. D. Jansseune noted that that 50% deposit was for construction only costs, and does not include equipment, electrical and subcontractors.

MLHU2 Q4 Results from April 2023 to March 2024

D. Jansseune reviewed the Q4 financial information for the 100% funded programs and are non audited at the time of this meeting. The budget for the 100% funded programs is approximately $3 million, and programs are funded through Public Health Agency of Canada (Smart Start for Babies and FoodNet), Public Health Ontario (Library Shared Services) and the Ministry of Children, Community and Social Services (Best Beginnings). There is a $0 surplus and deficit as it is based on audited expenditure, and that unused funds are returned to the funders.

D. Jansseune noted that programs that share funds between the companies (MLHU and MLHU2) are required to segregate the 100% funded portion. D. Jansseune provided the financial information for these programs:

- Smart Start for Babies (Public Health Agency of Canada) has a budget of approximately $152,000 and shares expenses with Nurse Family Partnership and Early Years Group Programs. Funding has been fully utilized for the year.
- Best Beginnings (Ministry of Children, Community and Social Services) has a larger budget of approximately $2,483,000 and shares funding with Healthy Babies, Healthy Children. Funding has been fully utilized for the year.
- Library Shared Services (Public Health Ontario) has a budget of approximately $108,000 and shares expenses with Library Services under Shared Funded Programs. Funding has also been fully utilized for the year.
- FoodNet Canada (Public Health Agency of Canada) has a budget of approximately $116,000 that is not shared with other programs. There was $15,000 that was unused and will be returned to the funder. The reason for the surplus is lower salary costs and lower travel costs.

D. Jansseune briefly reviewed the Health Unit's cashflow. On January 1, the bank balance was $1.5 million positive and on March 31, the bank balance was $4.4 million positive. Accelerated payments have been made on the bank loans during the quarter. The line of credit was also used for 14 days, with $8,000 in net interest. The Health Unit also received $5.8 million in February for 2023 COVID-19 expenses.

D. Jansseune provided updates from the provincial Ministry of Health. In Q1, the following one-time funding approvals for the Health Unit were received on March 28:

- Capital funding for Seniors Dental Expansion at Citi Plaza for $408,900
- COVID-19 Vaccine Program Enhancement for $100,000
- Respiratory Syncytial Virus (RSV) Adult Prevention Program for $22,000

Dr. Summers noted that the intention of the RSV funds is to be determined, but most likely were for the anticipatory work associated with the RSV vaccination and rollout to long term care homes in the region.

Committee Member M. Newton-Reid inquired if there is a timeline for the Health Unit to pay back the variable bank loan. D. Jansseune noted that he would provide the date to the Committee at a later date. M. Newton-Reid noted the Board's desire to pay the variable loan down. D. Jansseune noted that through the budget process, there would be a review on payments made as minimum payments vs. budgeted through multi-year budgeting. Dr. Summers added that the Senior Leadership Team would be reviewing multi-year budget assumptions, and that the Board would be receiving updates on this matter in the near future.

Committee Member H. Shears inquired on the purpose of the variable loan and if it was for operating purposes. D. Jansseune noted that the purpose of the variable loan was for the move of offices (from King Street to CitiPlaza).

D. Jansseune indicated that the Factual Certificate was enclosed in the agenda package for the Committee's review.

Committee Member Selomon Menghsha inquired what an example of internally generated revenue is, referring to the 2% internally generated revenue within the Health Unit. D. Jansseune noted that the $1.1 million includes approximately $441,000 of funding for the relatively new Infection, Prevention and Control (IPAC) Hub, and approximately $700,000 is COVID-19 vaccination recovery. It is estimated that the remainder is revenue from Sexual Health clinics and user fees. D. Jansseune committed to the Committee that he would provide more information on internally generated revenue. Dr. Summers added that the Health Unit has very few user fees. Fees within the Sexual Health clinics are offset by physician billing through the Ontario Health Insurance Plan (OHIP) and there is a smaller number of birth control sales. The Health Unit used to have a more robust paid vaccine program and travel clinic, but those programs have been stopped.

Committee Member H. Shears inquired if restaurant inspections are a paid service. Dr. Summers confirmed that restaurants do not pay for inspections.

Committee Member M. Newton-Reid inquired if dentists within the Seniors' Dental Program can bill for services (such as how physicians in the Sexual Health clinic can bill to OHIP). Dr. Summers noted that operational funding received from the Ministry of Health includes hiring dentists to work in the dental clinic. Dentists have never had the ability to charge their services to OHIP, however with the introduction of the Canadian Dental Care Plan, dentists will be able to bill their services as applicable to the federal government.

Chair Steele inquired on the reason for the variance on corporate services administration (Schedule A3). D. Jansseune noted that this was most likely offsetting of the gap and flowed through corporate services administration for the Associate Medical Officer of Health's salary.

It was moved by **H. Shears, seconded by M. Newton-Reid,** *that the Finance & Facilities Committee recommend to the Board of Health to receive Report No. 09-24FFC re: "2024 Q1 Financial Update, Borrowing Update and Factual Certificate" for information.*

Carried

OTHER BUSINESS

The next meeting of the Middlesex-London Board of Health (Finance and Facilities Committee) is on Thursday, September 19, 2024 at 6 p.m.

ADJOURNMENT

At **6:50 p.m.,** it was moved by **M. Newton-Reid, seconded by S. Menghsha,** *that the meeting be adjourned.*

Carried

MICHAEL STEELE
Committee Chair

ALEXANDER SUMMERS for
EMILY WILLIAMS
Acting Secretary

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MIDDLESEX-LONDON BOARD OF HEALTH

REPORT NO. 42-24

TO: Chair and Members of the Board of Health

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

DATE: 2024 June 20

2023 ANNUAL REPORT AND ATTESTATION

Recommendation

It is recommended that the Board of Health:

1) *Receive Report No. 42-24 re: "2023 Annual Report and Attestation" for information; and*
2) *Approve the Middlesex-London Health Unit 2023 Annual Report and Attestation.*

Report Highlights

- The Ontario Ministry of Health requires public health units to submit an Annual Report and Attestation.
- The report provides a year-end summary of the achievements of all programs governed under the Accountability Agreement. It includes a narrative on the delivery of programs; fiduciary requirements; good governance and management; public health practice and a Board of Health attestation.
- Insufficient resources, as well as continued recovery from COVID-19, prevented the MLHU from fully operationalizing and meeting all the program and service delivery requirements of the OPHS in 2023. The agency did fulfil its fiduciary, good governance and management, and public health practice requirements.
- Appendix A includes the 2023 Annual Report and Attestation that is due to the Ministry of Health on June 28, 2024.

Background

The Annual Report and Attestation is a funding and accountability reporting tool that Boards of Health are required to submit as per the Ontario Public Health Standards: Requirements for Programs, Services, and Accountability, and the Public Health Funding and Accountability Agreement. This report is required annually and is due to the Ministry by June 28, 2024.

The 2023 Annual Report and Attestation was completed by the MLHU leaders to demonstrate compliance with programmatic and financial requirements during 2023. Key activities and program achievements for 2023 are summarized for Foundational Standards and Program Standards in the narrative tabs. Activities and outcomes achieved are also described for one-

time projects funded by the ministry for the periods of January 1 to December 31, 2023, as well as April 1, 2023 to March 31, 2024. Reporting on program process and outcome indicators are no longer required to be reported on the Annual Report and Attestation. These indicators have been integrated into the Q3 and Q4 Standard Activity Reports (SAR).

2023 Annual Report and Attestation
Insufficient resources, as well as continued recovery from COVID-19, prevented the MLHU from fully operationalizing and meeting all the requirements of the OPHS in 2023. Specifically, with regards to the delivery of public health programs and services, resources were insufficient to comprehensively fulfill the following:

- Undertaking fulsome population health assessment, including the identification of priority populations, social determinants of health and health inequities
- Collecting and analysis of relevant data to monitor trends over time, emerging trends, priorities, and health inequities, and report and disseminate the data and information
- Having a strategic plan that included input from staff, clients, and community partners
- Developing and implementing a program of public health interventions in accordance with the Chronic Disease Prevention and Well-Being Program Standard
- Developing and implementing a program of public health interventions that promoted healthy built and natural environments in accordance with the Healthy Environments Program Standard
- Developing and implementing a program of public health interventions in accordance with the Healthy Growth and Development Program Standard
- Developing and implementing a program of public health interventions in accordance with the School Health Program Standard
- Developing and implementing a program of public health interventions in accordance with the Substance Use and Harm Reduction Guideline
- Developing and implementing a program of public health interventions in accordance with the Injury Prevention Guideline

The agency did fulfil its fiduciary, good governance and management, and public health practice requirements. The financial information is aligned with the 2023 audited results. Expenditures related specifically to COVID-19 amounted to $6.2 million. The “base funding” shows a surplus of $665,404 which was the result of underspending in Seniors Dental – all other shared funded programs balanced to zero with no surplus and no deficit. One-time funding was utilized throughout the year with the report showing a carry-over for the capital expansion of Seniors Dental at Citi Plaza.

Summary and Next Steps
The MLHU’s inability to comprehensively fulfill the program and service delivery requirements of the OPHS reflects insufficient resources. This ongoing challenging was the primary driver of the organizational re-structuring at the end of 2023. The MLHU will continue to prioritize work based on need and impact, and modify services to reflect any future changes to the OPHS once they are known. The agency will also continue implementation of a robust Management Operating System to ensure efficient and effective service delivery.

Upon approval from the Board of Health, the 2023 Annual Report and Attestation (Appendix A) will be submitted to the Ministry of Health by the deadline of June 28, 2024.

This report was prepared from a collaboration of the Strategy, Planning & Performance and Finance teams.

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

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

This report refers to the following principle(s) set out in Policy G-490, Appendix A:

- The Organizational Requirements as outlined in the *Ontario Public Health Standards: Requirements for Programs, Services and Accountability*.
- The following goal or direction from the Middlesex-London Health Unit's Strategic Plan:
  - Define what we do and do it well (Direction under the Program Excellence Priority area)

This topic has been reviewed to be in alignment with goals under the Middlesex-London Health Unit's Anti-Black Racism Plan and Taking Action for Reconciliation, specifically the Foundational Standards section in the Annual Report and Attestation describes activities to coordinate the implementation of both plans.

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MIDDLESEX-LONDON BOARD OF HEALTH

REPORT NO. 43-24

TO: Chair and Members of the Board of Health

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

DATE: 2024 June 20

MLHU 2024 EMERGENCY RESPONSE PLAN REVISIONS

Recommendation

It is recommended that the Board of Health receive Report No. 43-24 re: "MLHU 2024 Emergency Response Plan Revisions" for information.

Report Highlights

- The Ontario Public Health Standards (OPHS) requires that the MLHU prepare for emergencies to ensure 24/7 timely, integrated, safe and effective response to, and recovery from emergencies with public health impacts.
- The previous Board-approved MLHU Emergency Response Plan (ERP) was completed in September 2012.
- As outlined on the 2023-25 Provisional Plan, the MLHU has spent 2023 and 2024 revising the Plan to produce the MLHU 2024 Emergency Response Plan (ERP) (Appendix A).
- This Plan was approved by the MOH and CEO in March 2024.
- The Plan will continue to be updated with approval from the MOH and CEO, and in consultation with key partners and internal stakeholders.

Background

The current Ontario Public Health Standards identify Emergency Management (EM) as a Foundational Standard, which enable public health units to manage emergency situations consistently and effectively. The Emergency Management Guidelines (EMG) (2024), updated in January 2024, provides direction to Boards of Health (BOH) to effectively prepare for emergencies ensuring 24/7, timely, integrated, safe, and effective response to, and recovery from emergencies with public health impacts.

The legal authority for EM in Ontario is defined in the *Emergency Management and Civil Protection Act* (EMCPA) and order in Council 1739/2022, which requires that ministries and municipalities establish emergency management programs that include emergency plans, training and exercise opportunities, and education.

The MLHU's previous ERP was approved by the Board of Health in September 2012. Following the strategic direction as indicated in the 2023-25 Provisional Plan, the MLHU began the process of updating the ERP in early 2023, which was approved by the MOH and CEO in March 2024 (affixed as Appendix A).

Revisions to the ERP

The following principles were considered during the 2023 ERP revisions:

- Take an "all hazard" approach applicable to any emergency and in conjunction with other internal and external plans,
- Undertake a collaborative process, where key partners and internal stakeholders can be engaged,
- Ensure the plan is simple, concise, and accessible for utilization in an emergency,
- Maintain up-to-date comprehensive planning processes for the emergency management program,
- Where possible, maintain consistency with terminology and contents to other community plans (City of London and County of Middlesex) to enhance familiarity between partner ERP's. The intent is to increase comprehension and ability to act by all community partners likely to be called on for support, and
- Recognize that the ERP is to be a living document, that will be continuously updated over time.

With these principles in mind, alongside the updates in expectations from the 2024 EMG, noteworthy revisions to the 2024 ERP include:

- Adoption of the disaster risk reduction approach to prevent and mitigate risk,
- Enhanced alignment with the Emergency Management Framework for Ontario,
- Identification of the MLHU Incident Management Team (IMT) and training program,
- Updated description of the IMT governance and IMS structure for effective, scalable, and flexible emergency preparedness and response,
- Additional context for declaring emergencies,
- A continuum approach to emergency response,
- Improved alignment of the MLHU ERP with community partner ERP's, and
- Reference to annual exercising of the ERP.

Next Steps

The MLHU will continue to operationalize and maintain the 2024 Emergency Response Plan, including:

- Maintaining the ERP as a fluid document, updating as required with approval from the MOH and/or CEO,
- Completing updates from community partner consultations on municipal plans currently in progress,
- Integrating the plan into the MLHU's Administrative Policy Manual,
- Uploading a version of the ERP to the MLHU website (minus personally identifying information) for public access,
- Socializing the updated ERP with key community partners and internal stakeholders, and
- Continuing the development of the ERP appendices and associated plans, such as the Continuity of Operations Plan and specific appendices such as Pandemic and Infrastructure Failure plans.

This report was written by the Strategic Advisor – Emergency Management on the Strategy, Planning and Performance (SPP) Team.

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

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

This report refers to the following principle(s) set out in Policy G-490, Appendix A:

- The Emergency Management Foundational standard as outlined in the *Ontario Public Health Standards: Requirements for Programs, Services and Accountability*.
- The Emergency Management Civil Protection and Protection A*ct EMCPA); and Health Protection and Promotion Act (HPPA).*
- The following goal from the Middlesex-London Health Unit's Strategic Plan: Program Excellence is identified as a priority area within the MLHU 2023-2025 Provisional Plan. An initiative under this priority is to collaboration with health system partners and indigenous leader and service providers, to develop a robust emergency management (EM) plan that facilitates effective and timely response and surge capacity in the event of a public health emergency. Activities and projects to advance the strategic plans related to EM are to (1) refine the Emergency Response Plan, including cross training on public core competencies.

This topic has been reviewed to be in alignment with goals under the Middlesex-London Health Unit's Anti-Black Racism Plan and Taking Action for Reconciliation:

- With support of MLHU's Health Equity and Reconciliation Team (HEART), there is ongoing work on documenting and supporting emergency response as required within the Indigenous communities in our region; and
- Ongoing surveillance of public health hazards and risks that may give rise to a public health emergency, with particular attention to impacts on priority of populations.

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Emergency Response Plan 2024

For information, please contact the
Emergency Management Program:

Middlesex-London Health Unit
110-355 Wellington St.
London, Ontario
N6A 3N7
519-663-5317

email: emergency@mlhu.on.ca

Table of Contents

Record of Amendments

AMENDMENT NO.	DATE	DESCRIPTION OF REVISION	CHANGED BY

1.0 Introduction

1.1 Aim

The Middlesex-London Health Unit (MLHU) Emergency Response Plan (ERP) is the operational guideline for timely and effective organizational management and response to an emergency, disruption, or incident. The ERP intends to (a) protect the public health, safety, and wellbeing of clients of MLHU, the residents of Middlesex County and/or the City of London, and the staff of MLHU itself; and (b) ensure the maintenance and/or restoration of MLHU's functions and services.

This ERP is designed to be flexible and adaptable to any emergency or disruption that impacts the MLHU in whole or in part. For it to be operationally sound, all MLHU employees with identified emergency responsibilities (see Appendix A – MLHU Incident Management Team (IMT) Membership Roles and Contacts) must:

- Maintain familiarity with the ERP's contents and attachments,
- Contribute to the annual review of the ERP to ensure its contents remain current,
- Participate in scheduled emergency preparedness, response, and recovery training, and
- Participate in scheduled emergency drills and exercises as appropriate to their function as described in the ERP.

The ERP was adapted from the City of Hamilton Emergency Plan.

1.2 Authority

The legal authority for the ERP is detailed in the Health Protection and Promotion Act and corresponding Ministry of Health, Emergency Management Guideline, 2024 under the Ontario Public Health Standards (OPHS): Requirements for Programs, Services and Accountability.

Moreover, the ERP has been developed with consideration of broader legislative requirements for emergency management programs as outlined in the Emergency Management and Civil Protection Act.

1.3 Definitions and Relevant Terms

Business Continuity or Continuity of Operations Plan (COOP): a plan that guides an organization's internal response to an emergency to help ensure the delivery of time critical services.

Corrective Action Plan (CAP) - Action plans developed from the learnings of after-action debriefings for enhanced preparedness, response, and recovery.

Disruption - Disruptive events or disruptions are time-limited events that impact, or are likely to impact, the ability of the health system to maintain regular health services and where required, to support individuals hurt because of the disruption.

Emergency - A situation or an impending situation that constitutes a danger of major proportions that could result in serious harm to persons or substantial damage to property and that is caused by the forces of nature, a disease or other health risk, an accident, or an act whether intentional or otherwise.

Emergency Operations Centre (EOC) - A designated facility established by an agency or jurisdiction to centralize management and coordination of the agency or jurisdictional response and support to any emergency.

Emergency Management Guideline (EMG) -Within the Ontario Public Health Standards (OPHS), the EMG details the legislative requirements for public health units to develop their own public health emergency management programs that complement the municipal, provincial, and health sector emergency management programs (2024).

Emergency Reception Centre - Temporary emergency reception and/or lodging service for homeless, situationally vulnerable, or evacuated persons during any emergency.

Emergency Response Plan (ERP) - A set of documents, instructions, and procedures that enable the MLHU to respond to incidents, emergencies, disasters and/or threats in a controlled manner under the direction of the appropriately designated health officials and in cooperation with key external community partner agencies.

Emergency Site - The physical location or space occupied by any emergency event.

Health Hazards Identification and Risk Assessment (HIRA) - The process of identifying the nature and extent of risks from hazards within our community, including the causes and characteristics.

Incident Action Plan (IAP) - The document that contains response objectives, reflecting the overall strategy and specific tactical actions, and supporting information for each operational period. The plan may be oral or written. When written, the IAP may have several attachments (i.e., safety plan, communications plan, evacuation plan, map, etc.) An IAP can be modified as an emergency changes.

Incident Commander (IC) - The person at MLHU who coordinates and manages the overall response to the emergency.

Note: There may be an Incident Commander at another agency that leads the overall community response where MLHU is not the lead agency but supports an aspect of the emergency response depending on the nature of the emergency.

Incident Management System (IMS) - A standardized approach to emergency management encompassing personnel, facilities, equipment, procedures, and communications operating within a common organizational structure.

Incident Management Team (IMT) - The incident management team includes the incident leadership and those who work with them to manage the incident. They provide specialized knowledge, skills, and advice as needed. The roles and responsibilities of the IMT may be different from the regular workplace organizational structure.

Internal Mass Notification System (IMNS) - A method of alerting members of the Incident Management Team (IMT), any MLHU division, or MLHU staff, in whole or in part, to advise them of any emergency and to provide directions or issue orders.

Lower-Tier Municipalities - The inclusive corporations of the municipalities of Adelaide Metcalfe, Lucan Biddulph, Middlesex Centre, Newbury, North Middlesex, Southwest Middlesex, Strathroy-Caradoc, and Thames Centre.

Municipal Emergency Response Plan - An ERP prepared by the City of London, Middlesex-County, or any of the lower-tier municipalities.

Mutual Assistance Agreement - Written agreement between agencies and/or jurisdictions that describes how they will assist one another on request during any emergency by furnishing personnel, equipment, and/or expertise in a specified manner.

Ontario Public Health Standards (OPHS) - Published by the Minister of Health under the authority of Section 7 of the Health Protection and Promotion Act (HPPA) to specify the mandatory health programs and services for public health units (2021).

Operational Period (OP) - The period of time scheduled between IMT meetings for execution of a given set of operational actions as specified in the IAP. The length of time is varied but typically is no longer than 24 hours.

2.0 Emergency Response Plan Implementation

Emergency preparedness requires the ability to prevent, mitigate, respond, and recover from emergencies. In line with the Emergency Management Framework for Ontario, MLHU's Emergency Response Plan categorizes emergency management activities into the following four phases:

2.1 Prevention / Mitigation

It is imperative that all emergency management activities are informed by local needs and risks to build an effective program that protects the health and safety of the MLHU community. The MLHU completes this through:

- maintaining relationships that include collaborating and contributing to local Hazard Identification and Risk Assessment (HIRA) processes within the City of London and Middlesex County,
- where possible, utilizing local HIRA to inform specific sub-plans for emergencies likely to occur in our community, and
- completing ongoing surveillance of public health hazards and risks that may give rise to a public health emergency, with particular attention to impacts on priority populations.

2.2 Plan Activation

In an anticipated emergency, MLHU may activate an IMS structure to implement the ERP. This includes establishing the MLHU Incident Management Team (IMT), which may be assembled in whole or in part, dependent on the expertise and resources required at the time.

An emergency is declared when current programming cannot support the response needed. For more information about the MLHU IMT, see Appendix A: MLHU Incident Management Team (IMT) Roles & Contacts.

2.2.1 Authority to Activate this Plan

An urgent need to respond to a public health matter is different than a public health emergency. In an emergency, the ERP is activated when a hazard or risk impacts, or threatens to impact, the health, safety, and well-being of the Middlesex-London community and/or MLHU staff; and/or (b) additional resources and support beyond that which are available within the agency's regular organizational structure, or procedures are required.

The authority to identify the incident commander, activate the ERP and the associated IMT, occurs at the discretion of the Medical Officer of Health (MOH), Chief Executive Officer (CEO), Associate Medical Officer of Health (AMOH), or designate, based on the situation.

Some factors that impact the decision may include, but are not to:

- Nature of emergency
- Severity of emergency
- Impact on the Middlesex-London community
- Media attention
- Resources available to respond
- Anticipated duration of emergency
- Activation of City or County Emergency Operations Centre
- Provincial or Federal request
- Recommendation from Directors and Leaders
- Legislative requirements

Declaring an official emergency must be made by the **Mayor, Warden, or other senior elected official** in the community.

Consideration should be given to whether the Board of Health and/or the Ministry of Health should be notified in the event of a plan activation.

2.2.2 Procedure for Activation and Assembly

Continuum Approach

In a current or impending emergency, the ERP can be activated. An emergency is deemed when a situation constitutes a danger of major proportions that could result in serious harm to persons or substantial damage to property. The cause of an emergency may be a result of forces of nature, a disease or other health risk, an accident or an act whether intentional or otherwise.

The ERP is activated at the discretion of the Incident Commander and can range from single site or small-scale public health emergencies of a short length (i.e., 6 to 24 hours), through to significant public health emergencies involving multiple sites or municipalities spanning a longer time-period (i.e., several days, weeks or months). An activation of the ERP is based on the determination that normal MLHU processes or resources required to deliver critical and essential public health services, are no longer sufficient, requiring the establishment of the IMT within the IMS for response. At this stage, the Business Continuity or Continuity of Operations Plan (COOP), Appendix C, can be enacted to help guide the organization's response with the goal to maintain the delivery of all other public health time critical services.

Relative to the situation, the Incident Commander determines the MLHU staff resources required to support the emergency response. The Incident Commander may also determine whether the IMT should be activated, in whole or in part. Should the IMT be activated, all members of the IMT deemed to be appropriate for the emergency, will be contacted by the Incident Commander (or designate) and instructed to assemble at a specific location to develop an initial Incident Action Plan (IAP). The IMT members may be contacted during business hours through normal telecommunications channels including e-mail or telephone. For events occurring after hours requiring immediate response, the RAVE Mobile Safety may be used in line with the Internal Mass Notification System (IMNS) Policy (8-210). Where an activation of ERP requires the mobilization of additional human resources, refer to the After-Hours and Coverage Policy.

2.3 Emergency Response

For all emergencies, regardless of scale or complexity, the Incident Management System (IMS) structure requires the implementation of various management functions. These core functions include command, operations, planning, logistics, and finance/administration.

2.3.1 Incident Management Team (IMT)

At the MLHU, the Incident Management Team (IMT) would assume overall strategic direction and decision making for an emergency incident. The IMT utilizes IMS structures, which is the standardized structure and approach in emergency management across Ontario. Appendix D: Tools, Documentation and Resources outlines resources and tools for the IMT, needed to utilize IMS.

IMT Structure (IMS Organizational Chart)

Because emergency responses are meant to be scalable and flexible, the IMS structures can vary, and change frequently depending on the resources needed. Some situations lead to activation of the ERP partially or in full. In all scenarios, the Strategic Advisor – Emergency Management can consult about ERP activation. An example of a partial activation is a single site emergency or small-sized public health event impacting a small amount of people and typically requiring an emergency response expected to last less than 24 hours. Naturally, this situation requires fewer resources. A small-scale measles outbreak is an example; see Figure 1.

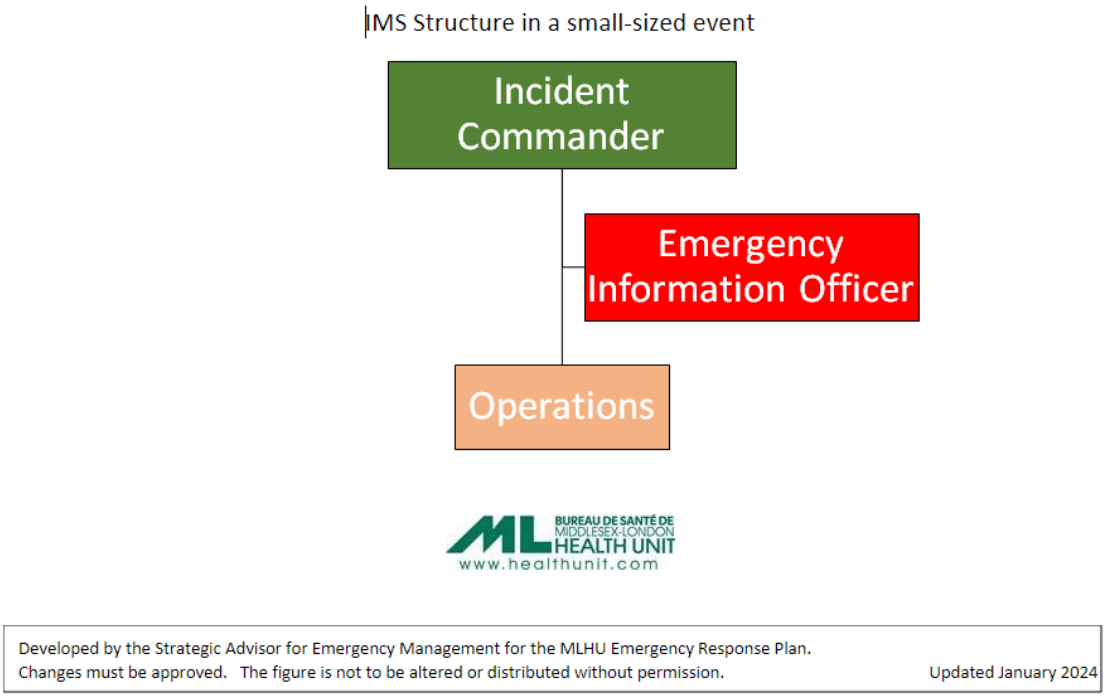

Figure 1: IMS Structure requiring a small-scale response.

As the IMT is structured by the IMS, this again allows for a scalable and flexible emergency response. Consequently, the IMT structure will change relative to the emergency, with positions of command staff activated or deactivated as needed. A relative scenario is during a single site emergency or larger public health event that impacts a single municipality. More MLHU staff are required if the event response is expected to exceed a 24-hour period.

Cross-divisional support may also be necessary leading to the decision toward a partial or full activation of the ERP. In this situation, the following IMS structure may be used to support a medium-sized emergency response requiring additional positions of command, but still not a full activation of the ERP, as shown in Figure 2. An example of a medium-sized event would be in response to an outbreak of Disease of Public Health Significance (DOPHS) where several cases are reported but perhaps the acquisition is known.

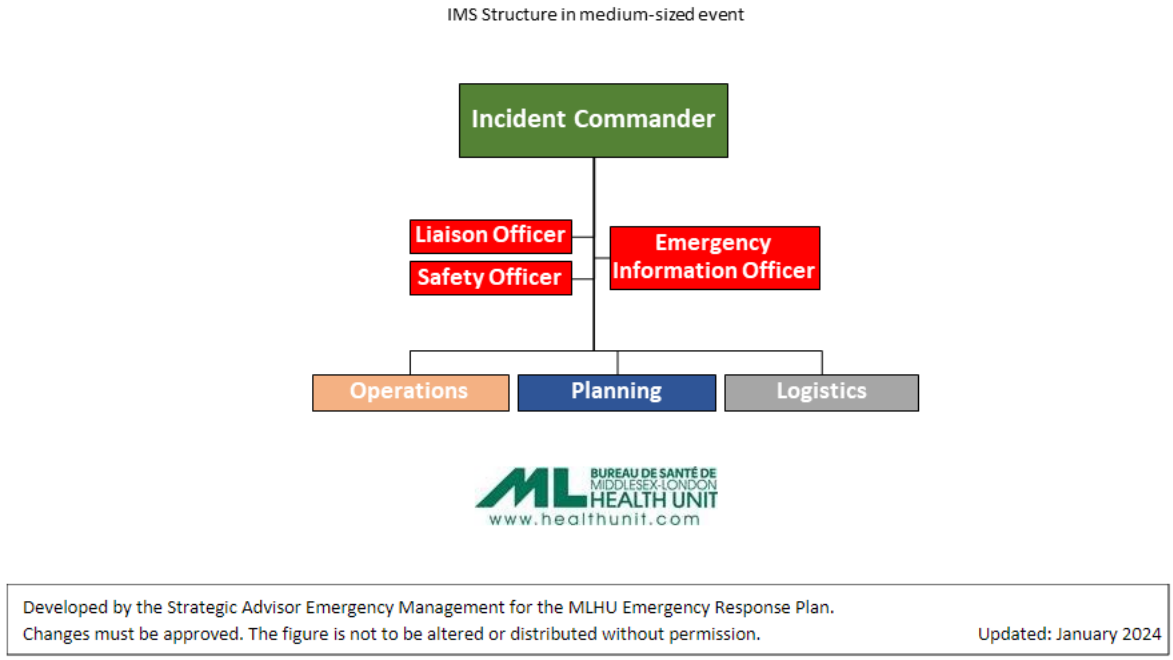

Figure 2: IMS Structure requiring a medium-scale response.

In the event of a major public health emergency, involving multiple sites within the City of London, Middlesex County, or multiple lower-tier municipalities, significant community impact is expected and may require orders to be issued (i.e., Section 22) by the Medical Officer of Health (MOH) or the Associate Medical Officer of Health (AMOH).

A disruption of this magnitude can last several days, requiring full activation of the IMT. Or alternatively, the MLHU could become a supporting partner of the City of London's Emergency Operations Centre (EOC) Policy Group or the County of Middlesex County Emergency Control Group (CECG), as outlined within the respective ERP's. As per the latter scenario, it will be determined if the MLHU's IMT is required or not to support other municipal efforts.

Figure 3 outlines the IMT organizational chart including all potential positions in the IMT, internal to the MLHU, that may be activated as required to respond to a large-sized emergency. Appendix A-MLHU Incident Management Team (IMT) Membership Roles and Contacts outlines the specific individuals that would assume the various positions. An example of a large-scale response would be in response to a pandemic with community-wide spread.

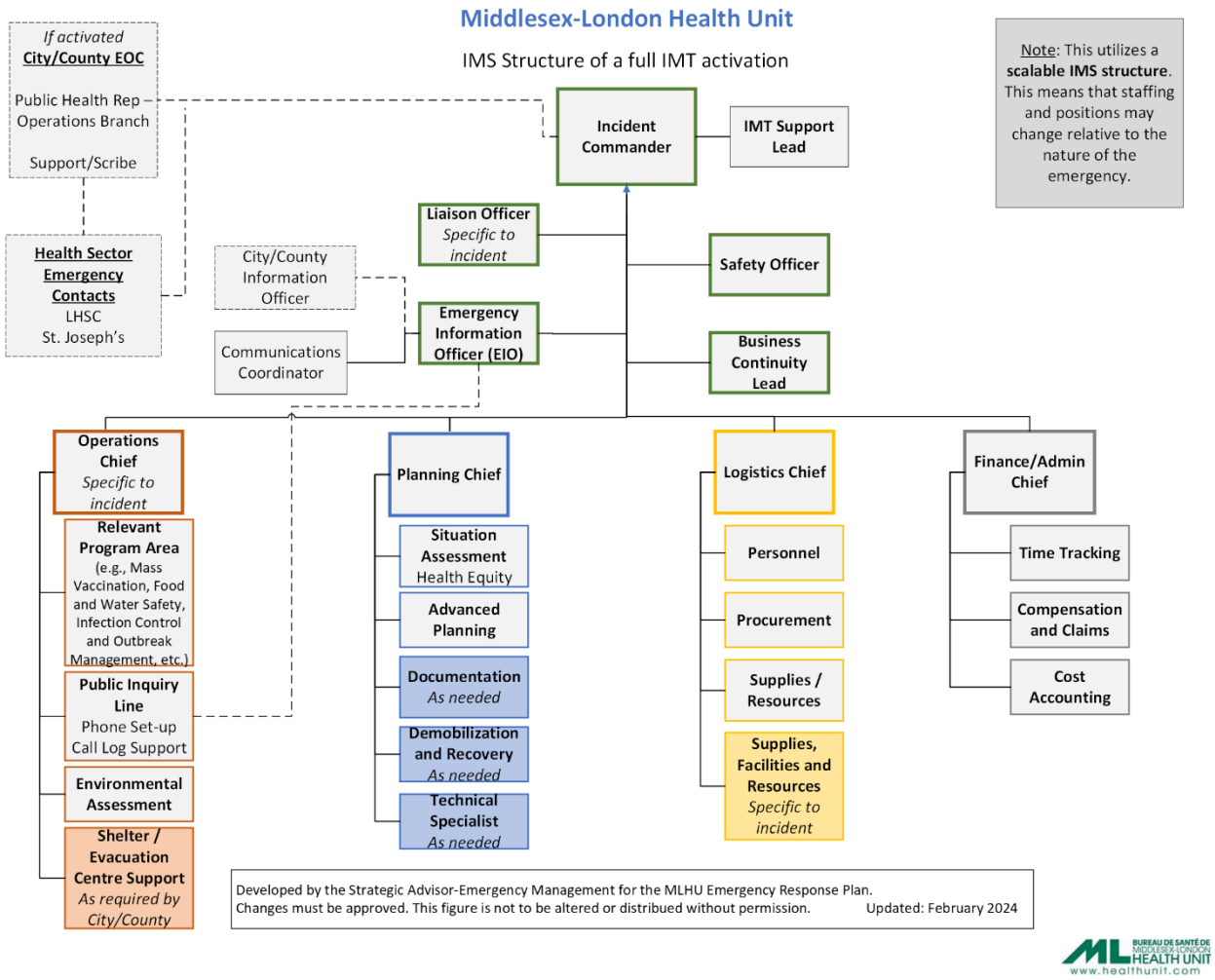

Figure 3: IMS Structure requiring a large-scale response.

IMS Roles and Responsibilities of the IMT

Generally, the roles and responsibilities of the IMT includes the following:

Function	Role
Command Staff	**Incident Commander** Leads and manages the overall public health response to the incident. Acts as the final decision maker for all response initiatives and objectives identified in the Incident Action Plan (IAP). **Safety Officer** Ensure safety of staff, clients, and visitors. Monitors and corrects hazardous conditions. Has authority to halt any operation that poses an immediate threat to life and health. **Emergency Information Officer** Serves as the conduit for information approved by the Incident Commander to internal and external stakeholders, including staff, clients, visitors, and the media. **Liaison Officer** Functions as the incident contact person in the IMT for representatives from other agencies and community groups that may be involved in the emergency response. **Business Continuity Lead** Provides overall direction for business continuity and maintenance of essential public health services while the MOH and other MLHU staff are deployed to emergency response.
Operations	Develops and implements strategy, tactics, and all other emergency operations to carry out the objectives established by the Incident Commander in the IAP.
Planning	Oversees the collecting, analyzing, and dissemination of information regarding the incident. Conducts planning meetings and prepares the IAP for review by the Incident Commander in collaboration with other sections.
Logistics	Organizes and directs operations associated with maintenance of the physical environment and with the provision of human resources, material, technology, equipment, and services, to support the incident activities. Participates in Incident Action Planning.
Finance and Administration	Monitors the use of financial assets and the accounting for financial expenditures. Supervises the documentation of expenditures and cost reimbursement activities.

2.3.2 Governance of the IMT

The Incident Management Team (IMT) functions within the operational structure of the MLHU. This means that despite the Incident Commander (IC) being the strategic decision-maker for the purposes of the emergency or disruption, the regular organizational reporting structure remains. As such, the governance of the IMT is relative to the position that assumes the IC position. For example, if the IC position is assumed by the AMOH, then the IC has accountability to the Medical Officer of Health (see Figure A). However, the IC position can be assumed by the MOH or Chief Executive Officer (CEO), depending on the scale, severity, or context for the emergency. In these situations, the IC role has direct accountability to the Board of Health (BOH), (see Figure B).

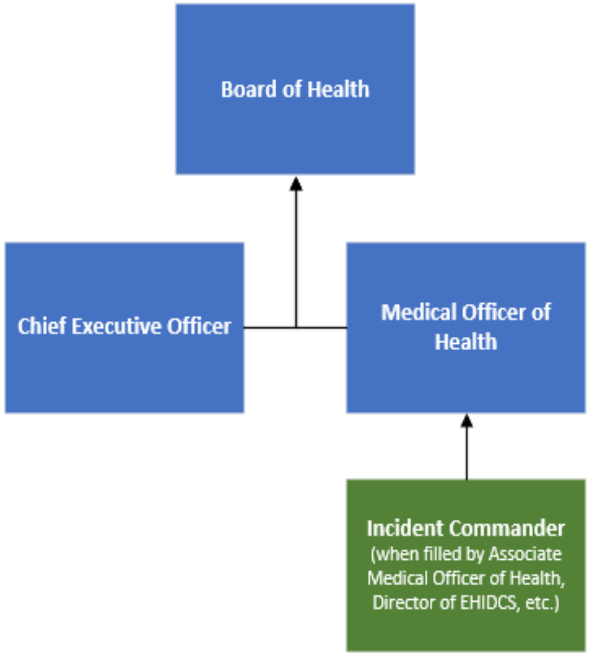

Figure A: Governance Model for Incident Commander as MOH/CEO

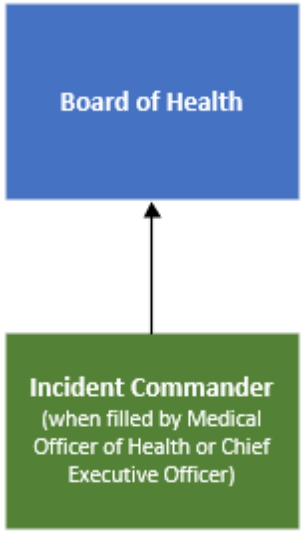

Figure B: Governance Model for Incident Commander

2.3.3 Emergency Operational Planning Cycle

The IMT can utilize the following planning cycle to support the IMT in operating in a unified manner. Appendix D: Tools, Documentation and Resources (i.e., forms, checklists, and templates), are available to support the implementation of the IMT Planning Cycle.

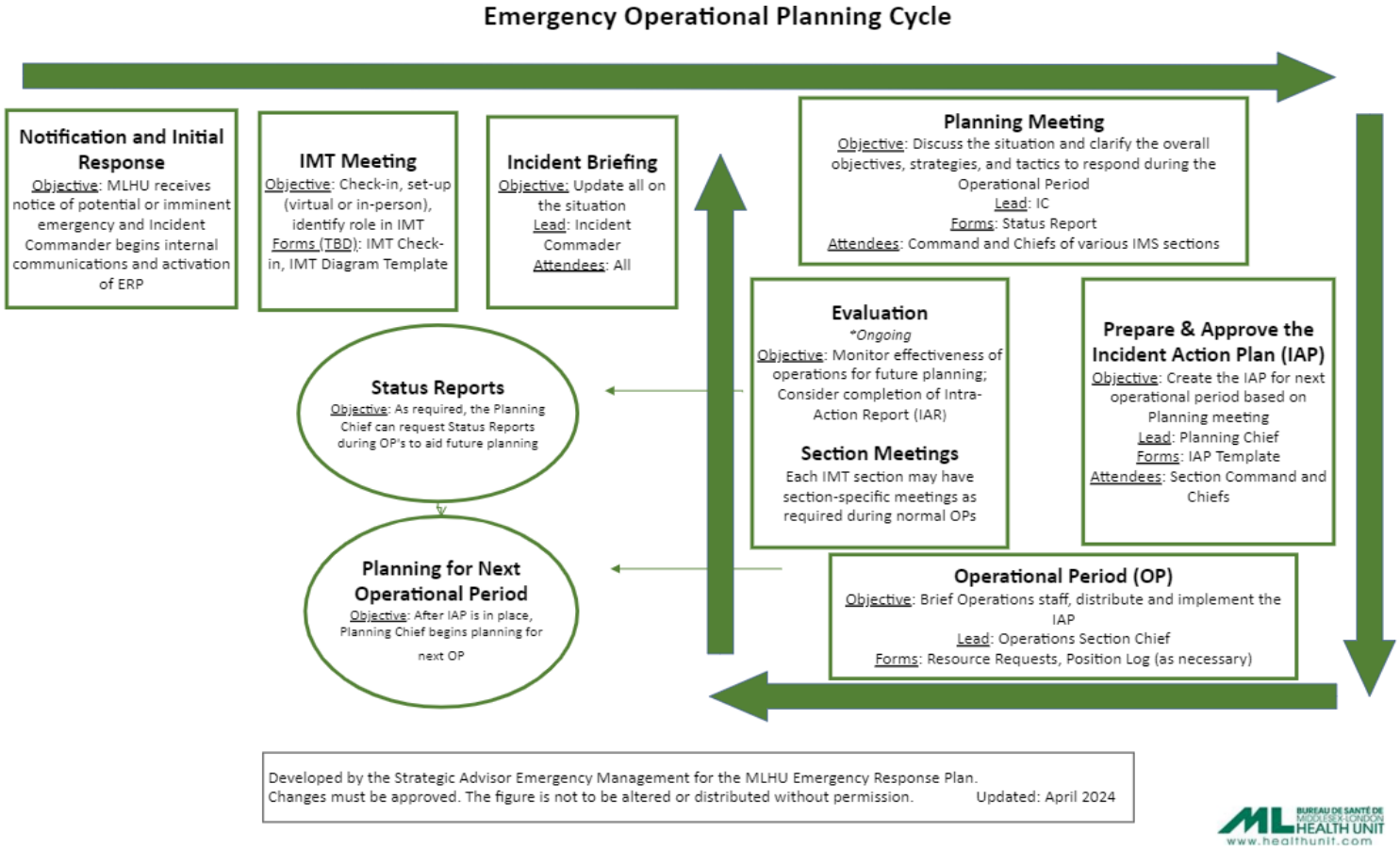

Figure 4: Operational Planning Cycle for the IMT

2.3.4 Staff Deployments

As deemed necessary, MLHU staff may be deployed to support emergency response efforts, particularly within the Operations section. Leaders and staff should be prepared for these response efforts when requested. Staff may be expected to perform a wide variety of roles, including but not limited to:

- case investigation and contact tracing,
- conducting inspections at a site,
- immunization administration,
- administrative support,
- staffing a public inquiry line,
- staff and support the establishing of a Reception Centre (emergency shelter),
- provide technical guidance and advice,
- transport supplies to clinics or other locations, and
- financial cost tracking and operation adjustments (i.e., HR support in scheduling).

All MLHU staff support emergency response and recovery operations, but not all have direct response and recovery responsibilities. Those who are not deployed to the emergency response will continue to play a key role in ensuring continuity of operations for essential public health services (also known as “business continuity”). See Appendix C for the MLHU Continuity of Operations Plan (COOP).

During emergencies that occur outside of normal business hours, additional human resources may be required. The process for calling in staff is articulated in the After-Hours and Coverage Policy.

2.3.5 IMT Activation Meeting Locations

The IMT, upon activation, will assemble at **110-355 Wellington Street (Citi Plaza)** in the **Board Room**. The alternative location will be at **51 Front St (Shops on Sydenham)** in the **Board Room**. As necessary, the Incident Commander may also determine that IMT meetings be held virtually (via Microsoft Teams).

2.3.6 Safety Throughout the Response

It is imperative that MLHU maintains a level of care and concern for staff and clients alike during an incident, and throughout the emergency response.

Critical incident stress occurs in a stressful or traumatic situation that cannot be prevented. Support should be initiated within the organization after a traumatic event and can be instrumental during extended and acute phases of any response.

During an incident, the Safety Officer will be responsible for maintaining critical incident support, as necessary. This may include:

- The provision of counselling services (i.e., Employee and Family Assistance Program (EFAP) and workplace wellness programs) for staff who have witnessed, responded to, been victimized by, or otherwise experienced a traumatic event.

- The provision of education on available resources and self-protection and coping mechanisms.
- Arranging debriefings, formally or informally for affected persons and/or within divisions and/or for all staff, depending on the need or circumstances of the event.

2.4 Termination and Recovery

While coordinated and clear response activities are critical during an emergency, it is equally important to properly terminate and articulate procedures and processes for recovering from a state of emergency.

2.4.1 Procedure for Termination

The termination of the ERP and/or internal emergency may occur as deemed appropriate by the Incident Commander. The following communication activities should be considered once the decision has been made to terminate this Plan:

- The Incident Commander will notify members of the IMT in writing**,** along with the Board of Health and/or Ministry of Health if originally notified of activation.
- The community and staff may be advised of plan termination and/or that the emergency within MLHU has ended and should be distributed by the **Emergency Information Officer** in consultation with the Incident Commander.
- Any termination of an external (and formally declared) emergency must be made by the **Mayor, Warden, or other senior elected official** in the community.
- In provincially declared emergencies, the declaration and termination announcements are made by the **Premier or Deputy Premier** only.

2.4.2 Recovery Roles and Activities

As the emergency or incident concludes, the recovery phase focuses on actions taken to return the MLHU to its pre-emergency condition or to a state of new normal when full recovery is not possible. This includes the process of shutting down response strategies and demobilizing resources to return to business as normal (or a new normal) following any emergency or continuity of operations event.

The role of the IMT upon conclusion of any emergency or continuity of operations event is to set priorities, actions, and timelines for the return to normal business operations, as well as issuing targeted communications to clients, employees, the public at large, and the Board of Health. This could include:

- demobilizing response activities and moving employees back to normal responsibilities,
- returning workspaces usurped for a higher priority function to their normal function,
- moving tools and technology back to their home office or user if moved,
- expanding any functions that were consolidated functionally or geographically,
- reactivating any processes that were ceased or reduced,
- establishing plans to clear any backlogs or recover any lost data,
- providing any employee assistance that may be required to recover post event, and
- establishing a thorough communication strategy for return of services.

2.4.3 Hot Washes and After-Action Reports

Evaluating an emergency, or events leading up to an emergency, enhances MLHU's ongoing state of public health emergency preparedness. Activities like hot washes and after-action reports (AAR) are forms of evaluative actions taken to assess the lessons learned. These activities should be a positive learning process. These evaluations may be undertaken at the direction of the MOH, AMOH, CEO or designate, in consultation with the Strategy, Planning and Performance team.

Hot washes and debriefs are informal and high-level, capturing the strengths and weaknesses of the organizational response, while reflecting on learnings for future response and recovery efforts. The focus is typically on the management of the public health event and completed soon after the emergency has ended. For more information on completing a hot wash or debrief, see Conducting a Hot Wash or Debrief: Common Components for Public Health.

After-Action Reports (AAR) are formal qualitative reviews conducted after the end of an emergency response, usually after a hot wash and/or debrief, which identifies best practices, gaps, and lessons learned. An AAR aims to determine why things worked well or did not. These typically involve opportunities for feedback from stakeholders to identify shared experiences and ways to improve collaboration. Due to the more in-depth nature, they require more time after an event. For more information on completing an AAR, see Best Practices for Conducting In-and After-Action Reviews as part of Public Health Emergency Management.

Different types of evaluations have different resource requirements. Organizational capacity should be assessed when determining what type of evaluation will be conducted.

3.0 Communication and Coordination

3.1 24/7 Notification Procedures

The MLHU is legislatively required to maintain 24/7 notification protocols for communications in an emergency. As such, at any time the ERP is activated, appropriate and accurate information must be communicated to relevant individuals based on the type of emergency, including consideration of clients, staff, the public at large, the Board of Health, and other strategic partners. This information may include issuing action directives, responding to requests for information, and providing information to specific client or stakeholder groups.

Notification procedures and protocols are identified in the Internal Mass Notification System (IMNS) Policy (8-210) for **internal** communications. Broadly, this Policy governs the use of the RAVE Mobile Safety System at MLHU, managed by Emergency Management and Occupational Health and Safety, to notify MLHU staff and leaders in the event of any incident or emergency.

For **external** notification of any potential or imminent public health emergency, the Emergency Information Officer (EIO), often fulfilled by the Communications Manager role, will be responsible for issuing any media releases, social media posts, or other communications strategies as required, in consultation with the Incident Commander.

3.2 Coordination with Community Partners

The MLHU is an active member of our community's Emergency Management Program Committees (EMPC), led by our local municipalities (Middlesex County and City of London). This is where both health and non-health sector agencies gather to conduct ongoing, collaborative, and coordinated emergency planning and preparedness activities for our region.

Memberships include:

- City of London: Emergency Operations Centre (EOC) Policy Group
    - London Police
    - London Fire Department
    - Middlesex-London Paramedic Service (MLPS)
    - London Health Sciences Centre (LHSC)
    - St. Joseph's Healthcare – London (SJHC)
    - London Hydro
    - London Transit Commission (LTC)
    - City of London Emergency Management representatives
- Middlesex County: County Emergency Control Groups (CECG)
    - Various emergency management leads across the lower-tier municipalities, such as Mayors, Deputy Mayors, Councillors, Police and Fire Chiefs, and Public Works.
    - Health sector partners include representation from MLPS, and occasionally, Middlesex Hospital Alliance.
    - Middlesex County's Community Emergency Management Coordinator (CEMC)

The membership of the EMPC's will be reviewed annually in collaboration with MLHU's municipal partners.

Note: With support of MLHU's Health Equity and Reconciliation Team (HEART), there is ongoing work on documenting and supporting emergency response as required within the Indigenous communities in our region.

Agency responses to an emergency or incident can vary depending on the nature and complexity of the event. The lead organization of the emergency response would encompass the Incident Commander (IC) position with General Staff for the organizational structure. An IC can be transferred to another organization where the type or scale of the incident has expanded authority or training of the person in place. As an incident becomes larger and more complex, a supporting organization can be asked to join the organization leading the response to become part of a Unity of Command, reporting to the IC with decisions made jointly by two or more jurisdictions.

A partner organization's participation can also support the IC through activation of their Emergency Control Group (ECG), being the IMT for the MLHU. For specific emergencies, the MLHU's role varies depending on the most appropriate agency to lead the response. Some situations will require the MLHU to lead the response, where other circumstances will require municipal organizations to be the primary lead, with MLHU as a supporting partner. See Table 1 outlining MLHU's typical primary lead role versus supporting partner role.

	MLHU Role	
Emergency / Incident	**Lead Organization in Response**	**Supporting Partner in Municipal Response**
Bioterrorism		✓
Bomb Threat		✓
Chemical • Spill, Explosion		✓
Communicable Disease • Outbreak, Epidemic, Pandemic	✓	
Food • Recall, Contamination	✓	
Industrial • Spill, Explosion, Contamination		✓
Nuclear		✓
Power / Infrastructure • Failure (including telecommunications, and cyberattack)		✓
Radiological		✓
Transportation • Train Derailment, Airplane Crash • Multi-vehicle Collision		✓
Water • Sanitary system failure or breakdown • Contamination	✓	
Weather / Nature • Floods, Winter Storms, Tornadoes • Extreme Temperature (Hot, Cold)* • Air Quality*		✓
Other		✓

Table 1: Lead roles identified for specific emergencies.
*MLHU has the expertise for an enhanced supportive role, having specific topic protocols and for public health education.

3.3 Relationship to Other Plans

3.3.1 INTERNAL

The MLHU has other internal plans that provide additional direction for specific emergencies and disruptions, in which MLHU is more likely to be the lead organization in the response.

These plans must align to the general roles, responsibilities, and processes detailed in the ERP, and include:

- Continuity of Operations Plan (not yet started) (See Appendix C)
- Labour Disruption Plan (Some previous document) (See Appendix E)
- Pandemic Plan (not yet started) (See Appendix F)
- Mass Vaccination Plan (not yet started) (See Appendix G)

The Emergency Management program will also maintain a list of associated policies, procedures, and/or protocols that exist and are managed by teams responsible for those programs that describe MLHU's responses to specific public health scenarios or risks. In most instances, the MLHU's response to these risks does not constitute an emergency and does not require the activation of the ERP. However, in instances when the response to these risks requires additional resources and support beyond that which are available within the agency's regular organizational structure or procedures, the ERP will be activated, and these plans will be critical to informing the Incident Action Plan (IAP).

These include:

Plan, Procedure, or Protocol	**MLHU Team Responsible**
Facility / Infrastructure Failure Plan	Procurement & Facilities/Information Technology
Waterborne Illness Outbreak Response Procedure	Safe Water, Tobacco Enforcement and Vector Borne Disease
Respiratory Season Plan (*to be reviewed annually by the MLHU Respiratory Season Planning Workgroup*)	Infectious Disease Control
Case and Contact Management Protocol	
Outbreak Management Protocol	
Food Recall Procedure	Food Safety and Health Hazards
Foodborne Illness Outbreak Response Procedure	
Extreme Temperature Protocol	
Air Quality Protocol	
Extreme Weather Protocol	

There are other relevant policies that are closely aligned with the Emergency Response Plan, including:

- After-Hours Service and Coverage Policy (*under development*).

3.3.2 EXTERNAL: Municipalities

***CURRENTLY UNDER REVIEW WITH PARTNERS**

The MLHU is required to provide ongoing support and advice to municipal partners on all emergency-related health matters, as well as participate in collaborative planning and preparedness activities.

Specific responsibilities as assigned to MHLU through the MOH or AMOH by the municipalities through their respective ERP's are described below.

3.3.3 EXTERNAL: Hospitals and Primary Care
***CURRENTLY UNDER REVIEW WITH PARTNERS**

While MLHU plays a critical role in supporting the health system's response to emergencies, further efforts are required to formalize this coordination.

3.3.4 EXTERNAL: Indigenous Communities

Work is underway with the MLHU's Health Equity and Reconciliation Team (HEART) to consider how MLHU can support emergency planning and preparedness with our local Indigenous community partners.

3.3.5 EXTERNAL: Conservation Authorities

Conservation Authorities within the Middlesex-London region include the Ausable-Bayfield Conservation Authority (ABCA) and the Upper Thames River Conservation Authority (UTRCA). MLHU has no specific responsibilities in the event of a flooding emergency but will support any emergency response as required and maintain awareness of flood alerts and warnings.

4.0 Maintenance and Testing

4.1 Exercising the Plan

It is the responsibility of the Strategic Advisor – Emergency Management (SA-EM) to test this plan in collaboration with the Senior Leadership Team, either in whole or in part, in compliance with the OPHS (2021) and associated MOH Emergency Management Guideline.

Testing of the ERP normally occurs annually by completing an exercise involving the participation of the members of the IMT. Broadly, the SA-EM will prepare:

1. A discussion-based exercise (e.g., tabletop) to familiarize participants with current plans, policies, and procedures, as well as to develop new plans, or
2. An operations shadow-based exercise to validate plans, policies, and procedures and identify resource gaps.

Upon completion of the exercise, an evaluation, and an after-action report (AAR), including a corrective action plan (CAP), to identify shortfalls and necessary corrective actions will be completed to continuously improve the ERP and MLHU's overall emergency preparedness.

4.2 Staff Training

The SA-EM will maintain a current list of the IMT roles and contacts, see Appendix A, including training achievements. The SA-EM is required to facilitate training opportunities for staff based on the training courses available, role within the IMT structure, need for refresher learning, and based on Public Health Competency requirements related to the COOP, outlined in Appendix A: A1 MLHU Emergency Management Training Program. Dayforce software will be used to track and inform staff regarding required training.

4.3 Review and Amendment

The SA-EM within the Public Health Foundations (PHF) Division is responsible for maintaining the ERP and facilitating all revisions and any amendments, annually or as required. The SA-EM is supported in this task by the members of the Management Leadership Team (MLT), acting as the emergency preparedness designates (program delivery subject matter experts) from each Division. Any revisions to the ERP will be reflected in the Record of Amendments (Page 2).

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

REPORT NO. 44-24

TO: Chair and Members of the Board of Health

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

DATE: 2024 June 20

INTRODUCTION TO THE MLHU MANAGEMENT OPERATING SYSTEM

Recommendation

It is recommended that the Board of Health receive Report No. 44-24 re: "Introduction to the MLHU Management Operating System" for information.

Report Highlights

- The MLHU is implementing a Management Operating System (MOS) in an effort to answer the following key questions:
    1. Are we doing the right things?
    2. Are we doing what we do well?
- The MOS is an integrated system that describes the structure and processes for decision making and accountability to ensure consistent quality in meeting organizational goals.
- The MOS will align and integrate policies and procedures into four core processes: Strategic Planning, Operational Planning and Implementation, Risk Management, and Organizational Performance Management (Appendix A). The core processes are at different stages of development.

Background

Over the past two years, the MLHU has been trying to answer two foundational questions:

1. Are we doing the right things?
2. Are we doing what we do well?

To understand the first question, staff have been documenting and describing the work of the MLHU, categorizing efforts into a suite of common interventions. These are the 'tools in our toolbox' that the MLHU can draw on to achieve public health goals and objectives. To help answer the second question, a Management Operating System (MOS) has been developed.

Management Operating System in development

The MOS is the administrative governance system by which MLHU is directed and managed. It is an integrated system that describes the structure and processes for decision making and accountability that guide behaviour. This framework ensures consistent quality in meeting organizational goals. Foundational aspects of the MOS include:

- Defined accountabilities and decision-making authorities
- Organizational and programmatic structure and design including definitions and documentation of the work we do (our interventions), and the diseases, topics, or populations on or with which we work (our programs)

The MOS will align and integrate our policies and procedures into four core processes (Appendix A):

- Strategic Planning,
- Operational Planning and Implementation,
- Risk Management, and
- Organizational Performance Management.

The core processes are at different stages of development.

Processes and policies exist for strategic planning, which continued during and in the recovery from the pandemic in the form of provisional plans. While the provincial vision for public health is unclear, updates to the Ontario Public Health Standards (OPHS) are anticipated in 2024. This will inform and enable broader strategic planning in 2025 for the 2026-2030 cycle.

Operational planning is an immature component of the MOS. There is currently no consistent, standardized operational planning process. Templates and processes will be developed for teams to utilize. Critical elements include incorporating strategic tactics (that the team is involved in), program related interventions, activities and tasks to meet the OPHS, management related tasks (e.g. budgeting, hiring) and, administrative related tasks (e.g. planning, administration). Once defined, organizational planning will link to all other aspects of the MOS.

Regarding risk management, there are processes in place for documenting risks and connecting leadership staff and the Board of Health in their review. The risk framework is sufficient, however it is currently a “stand alone” process, in that it is not clearly integrated with strategic planning or organizational performance management. There are opportunities to embed a risk-management mindset into the other core processes.

Significant effort has been invested to develop organizational performance management (OPM). This core process is intended to align people, resources, and processes to ensure that we are doing the right things and doing them well. It will help the organization identify risks and create timely solutions, supporting leaders in monitoring interventions and programs. The OPM system will more clearly provide a structure to enable accountability and excellence in the agency, and ensure ongoing learning and improvement.

Next Steps

Significant foundational development has been completed, and is captured in the MOS Policy, which is an anchoring policy of the Administrative Policy Manual. A diverse, internal

implementation working group has guided the development of frameworks, concepts, communication and implementation. Over the past year the evolving MOS has been communicated to leaders and a formal roll-out of the concepts to all staff is planned for mid-June to late July 2024.

The MLHU has initiated organizational performance management with first quarter (Q1) 2024 reporting. Quarterly reports sequence through all leadership levels (i.e., from Managers to Directors, from Directors to MOH and CEO, and from MOH and CEO to the Board of Health). Q1 reports include quantitative measures including financial variance and staffing levels and currently describe public health intervention achievements in narrative form. The OPM process will evolve over time through the gradual incorporation of organizational and programmatic key performance indicators (KPIs). The first round of organizational performance reporting will be shared with the Board of Health in July of 2024.

This report was written by the Public Health Foundations division.

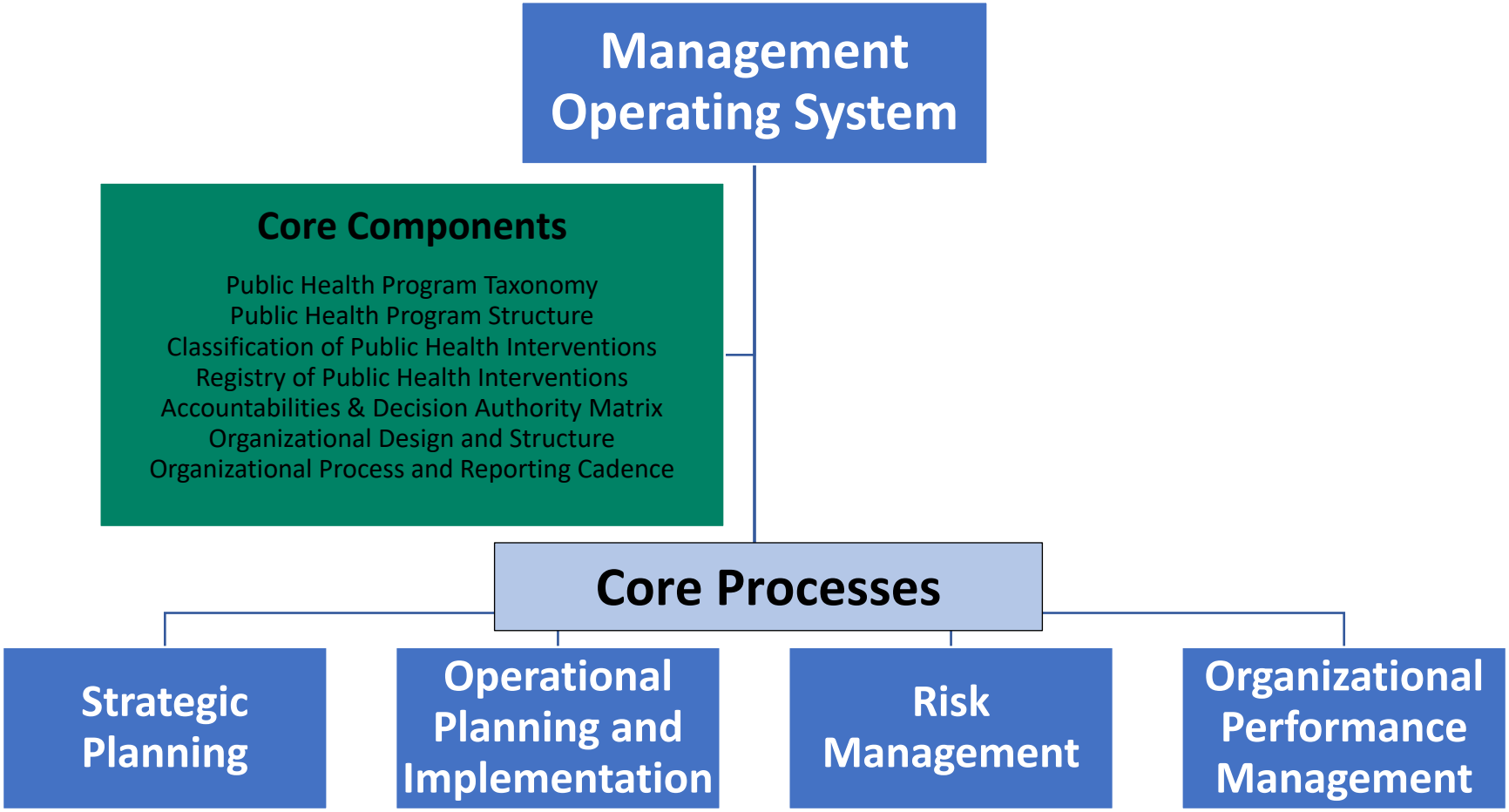
Emily Williams, BScN, RN, MBA, CHE
Chief Executive Officer

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

This report refers to the following principle(s) set out in Policy G-490, Appendix A:

- The organization requirements in the Public Health Accountability Framework outlined in the *Ontario Public Health Standards: Requirements for Programs, Services and Accountability*.
- The following goal or direction from the Middlesex-London Health Unit's Strategic Plan:
  - Our public health programs are effective, grounded in evidence and equity
  - We make effective decisions, and we do what we say we are going to do

This topic has been reviewed to be in alignment with goals under the Middlesex-London Health Unit's Anti-Black Racism Plan and Taking Action for Reconciliation, specifically the broad sets of recommendations related to governance and accountability in both plans.


Management Operating System
Core Components
Public Health Program Taxonomy
Public Health Program Structure
Classification of Public Health Interventions
Registry of Public Health Interventions
Accountabilities & Decision Authority Matrix
Organizational Design and Structure
Organizational Process and Reporting Cadence
Core Processes
Strategic Planning
Operational Planning and Implementation
Risk Management
Organizational Performance Management

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MIDDLESEX-LONDON BOARD OF HEALTH

REPORT NO. 45-24

TO: Chair and Members of the Board of Health

FROM: Dr. Alexander Summers, Medical Officer of Health

DATE: 2024 June 20

MEDICAL OFFICER OF HEALTH ACTIVITY REPORT FOR MAY 2024

Recommendation

It is recommended that the Board of Health receive Report No. 45-24 re: "Medical Officer of Health Activity Report for May 2024" for information.

The following report highlights activities of the Medical Officer of Health for the period of May 2 to June 7, 2024.

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 a wide range of external and internal meetings, along with liaising with community partners and municipal and provincial stakeholders.

The Medical Officer of Health, along with other team members, continues to host a weekly Middlesex-London Health Unit (MLHU) Staff Town Hall.

The Medical Officer of Health also participated in the following meetings:

Public Health Excellence– *These meeting(s) reflect the MOH's work regarding public health threats and issues; population health measures; the use of health status data; evidence-informed decision making; and the delivery of mandated and locally needed public health services as measured by accountability indicators*

May 21 Attended the Public Health Ontario educational session, "Update on Ontario's New Tick-Borne Diseases."

May 22 Participated in a meeting regarding the internal action items from the Community Drug and Alcohol Committee meeting.

May 23 Participated in a meeting regarding the IPAC Hubs.

Attended the Public Health Ontario educational session, "2023 Wildfire Smoke Exposure and Public Health in Ontario."

May 27 Participated in an internal planning meeting regarding Provincial changes in alcohol policy.

May 29 Participated in a meeting regarding the MLHU's submission for public health consultation on the OPHS review.

May 30 Attended the monthly Management Operating System (MOS) Steering Committee meeting.

Community Engagement, Partner Relations, and System Leadership – *These meeting(s) reflect the MOH's representation of the Health Unit in the community and engagement with local, provincial and national stakeholders both in health and community arenas, along with engagements with local media.*

May 10 Participated in the monthly COMOH Executive meeting.

May 13 Co-chaired the meeting of the Community Drug and Alcohol Committee.

May 14 Attended an introductory meeting with the incoming City Manager for the City of London.

Participated in a meeting of the Urban Public Health Network (UPHN) Strategic Planning Sub-Committee.

Participated in the monthly Public Health Sector Coordination Table meeting, facilitated by the Ministry of Health.

May 15 Participated in a call regarding the external program SupportRx.

Participated in a call with the London InterCommunity Health Centre.

May 16 Participated in a call with Dr. Mehdi Aloosh, Medical Officer of Health, Windsor-Essex County Health Unit.

Met with Kelly Ziegner, CEO, United Way Elgin Middlesex.

Attended the monthly meeting of the Strategy and Accountability Table for the Whole of Community System Response, facilitated by the City of London.

May 17 Interview with Arfa Rana, CBC News London, regarding the local measles rate and the report of the first measles death in a child under the age of 5 in Ontario.

Interview with Carly Weeks, Globe and Mail, regarding the local measles rate and the report of the first measles death in a child under the age of 5 in Ontario.

Interview with Ben Harrietha, 980 CFPL, regarding the local measles rate and the report of the first measles death in a child under the age of 5 in Ontario.

May 22 Participated in a webinar regarding the Ontario Public Health Standards Review public health sector consultation process.

May 23 Participated in the monthly meeting of the Middlesex-London Ontario Health Team Coordinating Council.

May 24 Participated in a meeting with the County of Middlesex regarding emergency response plans.

Attended a call facilitated by the Ministry of Health regarding changes in provincial policy.

Participated in a call with Dr. Natalie Bocking, Medical Officer of Health, Haliburton, Kawartha, Pine Ridge District Health Unit.

May 27 Participated in the monthly meeting of the Southwestern Ontario Medical Officers of Health/Associate Medical Officers of Health.

May 28 Attended a meeting of the COMOH Ontario Health Team Working Group.

May 30 Attended the quarterly touch-base meeting with CUPE representatives.

Attended a call facilitated by the Ministry of Health regarding wasterwater testing for infectious diseases.

May 31 Participated in the monthly alPHa Board meeting.

Interview with Randy Richmond, London Free Press, regarding the local opioid crisis.

June 3 Participated in a meeting with the City of London regarding emergency response plans.

June 4 Interview with Devon Peacock, 980 CFPL, regarding the local opioid crisis.

Attended the monthly Middlesex-London Ontario Health Team Governance Sub-Committee meeting.

June 5 Participated in the monthly Public Health Leadership Table meeting, facilitated by the Ministry of Health.

Interview with Kate Dubinski, CBC London, regarding the discontinuation of the Wastewater Surveillance program.

Employee Engagement and Teaching – *These meeting(s) reflect on how the MOH creates a positive work environment, engages with employees, and supports employee education, leadership development, mentorship, graduate student teaching, medical students or resident teaching activities.*

May 13 Attended the Family and Community Health divisional meeting.

May 28 Met with a medical student for mentorship.

May 29 Participated in a meeting with LHSC and a Masters of Public Health student regarding their rotation.

June 3 Participated in a call with a medical student for mentorship.

June 4 Presented at the Public Health 101 agency orientation for new MLHU staff.

Organizational Excellence – *These meeting(s) reflect on how the MOH is ensuring the optimal performance of the organization, including prudent management of human and financial resources, effective business processes, responsive risk management and good governance.*

May 13 Attended the monthly meeting with the Board of Health chair.

May 16 Attended the May Finance and Facilities Committee meeting.

Attended the May Board of Health meeting.

May 22 Participated in a meeting regarding the organization and classification of internal, organizational policies and procedures.

May 30 Participated in a meeting regarding the MLHU's response to alPHa resolutions being discussed at the alPHa annual general meeting.

June 5-7 Attended the alPHa annual general meeting and conference, including a meeting of COMOH.

This report was prepared by the Medical Officer of Health.

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

This report refers to the following principle(s) set out in Policy G-490, Appendix A:

- The Good Governance and Management Practices Domain as outlined in the *Ontario Public Health Standards: Requirements for Programs, Services and Accountability*.

This topic has been reviewed to be in alignment with goals under the Middlesex-London Health Unit's Anti-Black Racism Plan and Taking Action for Reconciliation, specifically the Governance and Leadership (ABRP) section.

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MIDDLESEX-LONDON BOARD OF HEALTH

REPORT NO. 46-24

TO: Chair and Members of the Board of Health

FROM: Emily Williams, Chief Executive Officer

DATE: 2024 June 20

CHIEF EXECUTIVE OFFICER ACTIVITY REPORT FOR APRIL AND MAY

Recommendation

It is recommended that the Board of Health receive Report No. 46-24 re: "Chief Executive Officer Activity Report for April and May" for information.

The following report highlights activities of the Chief Executive Officer (CEO) for the period of April 5 – June 6, 2024.

Standing meetings include weekly Corporate Services leadership team meetings, Senior Leadership Team meetings, MLHU Leadership Team meetings, Virtual Staff Town Hall meetings, bi-weekly R3 meetings, monthly check ins with the Director, Public Health Foundations, and weekly check ins with the Corporate Services leaders and the Medical Officer of Health. The Chief Executive Officer took vacation from April 29 to May 5.

The Chief Executive Officer also attended the following meetings:

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

April 12 Attended the Health Sector Advisory Group meeting hosted by Fanshawe College to discuss and develop an action plan to innovate collaboration between Fanshawe College and the health sector in support of increasing Health Human Resources.

May 6 With the CFO, met with City of London finance representatives to discuss the Q1 MLHU Financial update.

With the CFO, met with the County of Middlesex finance representative to discuss the Q1 MLHU Financial update.

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

April 8 Attended the Canadian Public Health Week Staff Celebration and Coffee Break to recognize the important work of Health Unit staff.

April 10 Initiated the Performance Appraisal process for the Corporate Services leadership team members, piloting a new electronic tool, and beginning with the Associate Director, Human Resources and Labour Relations.

April 11 Attended a meeting to discuss the Management Operating System (MOS) Organizational Performance Reporting to review financial indicators.

April 15 Attended the Management Operating System/Intervention Description Indicator Development Project Steering Committee meeting.

Attended a meeting to discuss the new electronic Public Health Nurse Performance Appraisal Tool.

April 16 Attended the April MLHU Leadership Team meeting.

April 17 Chaired the Corporate Services Division meeting to share important strategic updates, promote collaboration, and build relationships across teams.

Attended the Eid al-Fitr Coffee Break hosted by the Health Equity And Reconciliation Team and the BeWell Committee.

April 18 Attended a meeting to discuss and finalize the Employee Benefits and Employee and Family Assistance Program Request for Proposal (RFP).

Met with the Manager, Corporate Communications to provide a Corporate Services overview in support of orientation to the agency.

April 22 Attended a meeting to discuss an RFP for legal services for the Board of Health and the agency.

Attended the Equity, Diversity and Inclusion Staff Advisory Committee meeting as the Senior Leadership Team representative.

April 23 Chaired the Pride Working Group meeting, to ensure collaboration and an organized plan for the Health Unit's participation in the Pride London Festival. The group determined to meet biweekly until the event.

April 25 Attended a meeting to discuss Management Operating System Organizational Performance Management Reporting and the financial indicators.

Attended a meeting to support the development of a business case (Return on Investment) related to public health programming.

May 6 Attended a meeting to discuss and finalize the RFP for legal services.

May 7 Chaired the Pride Working Group meeting.

May 10 Attended a meeting to finalize the Management Operating System and Organizational Performance Reporting financial indicators.

May 13 Attended a meeting with Associate Director, Human Resources and Labour Relations to review job titles across the agency in order to ensure alignment.

Attended the Employment Systems Review Steering Committee meeting to discuss outstanding items and timelines for completion.

May 15 Attended a meeting with the Coordinator, Human Resources to plan for the second LEADS Self review session.

May 21 Attended the May MLHU Leadership Team meeting.

May 23 Chaired the Pride Working Group meeting.

May 27 Met with the Manager, Corporate Communications to discuss Indigenous Solidarity Day event resources.

Attended a meeting with the Coordinator, Human Resources to plan for the LEADS Engage Others review session.

May 29 Attended the Citi Plaza Dental Operatory Build Steering Committee meeting to review key deliverables and timelines for completion.

May 28 Met with CFO to discuss multi-year budget assumptions and formation of options for SLT review.

May 29 Attended the Centralized Ordering Project Close Out meeting to review activities that transition to sustainability and lessons learned.

May 30 With the Medical Officer of Health and Associate Director, Human Resources and Labour Relations attended the quarterly touch base with union partner Canadian Union of Public Employees.

June 3 Chaired the June MLHU Leadership Team Pre-Planning meeting to determine the agenda for the June meeting.

Attended the Equity, Diversity and Inclusion Staff Advisory Committee Meeting as the SLT Representative.

June 4 Chaired the Pride Working Group meeting.

Participated in the inaugural agency orientation session called ‘Public Health 101’ to provide an overview of the Corporate Services Division and promote understanding of the work to new staff.

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

April 8 Attended the Board of Health April agenda review and Executive meeting.

April 9 Attended the April Public Health Sector Coordination Table meeting hosted by the Ministry of Health.

April 11 Attended the Association of Public Health Business Administrators (AOPHBA) Executive meeting, including presenting an update on the Professional Development pillar of the strategic plan.

April 17 Met with the Board of Health Chair for a monthly one-on-one meeting.

Met with the Board of Health Chair and the Board of Health Executive Assistant to discuss Board of Health orientation.

April 18 Attended the Performance Appraisal Committee meeting.

Attended the April Governance Committee meeting.

Attended the April Board of Health meeting.

April 25 Attended the Middlesex London Ontario Health Team meeting.

With AOPHBA colleagues, attended a meeting to discuss leadership development opportunities for the association group.

May 8 Attended the Board of Health May agenda review and Executive meeting.

May 9 Attended the AOPHBA meeting at Toronto Public Health.

May 13 Met with the Board of Health Chair for a monthly one-on-one meeting.

With AOPHBA colleagues, attended a meeting to discuss the Professional Development pillar from the association strategic plan, and plan additional development opportunities for the association group.

May 14 Attended a meeting to discuss the plan for Association of Municipalities of Ontario conference delegations.

May 15 Co-facilitated the LEADS Self review session to assist leaders in practicing the concepts from the initial training.

May 29 Attended a meeting to review alPHa resolutions with the BOH Executive, in advance of the Annual General Meeting and conference.

May 31 Attended the Association of Public Health Business Administrators meeting at Toronto Public Health.

June 4 Met with the Medical Officer of Health, Associate Medical Officer of Health and

Executive Assistant, Board of Health to finalize the Association of Municipalities Annual Conference Delegations.

June 5-6 Attended the Association of Local Public Health Agencies Annual General meeting and conference in Toronto.

Personal and Professional Development – *This area reflects on how the CEO is conducting their own personal and professional development.*

April 16 With the Senior Leadership team, participated in the LEADS Lead Self Review session to practice concepts learned in the initial training.

April 22 Completed an Introduction to Anti-Black Racism Toronto Academic Health Science Network electronic learning course to improve understanding about the history of Anti-Black Racism in Canada.

May 15 Attended the Positive Psychology at Work with Your Health Space session hosted by Cyno and Be Well to learn about opportunities to promote psychological safety within the agency.

May 22 Attended the Advancing Health Equity for 2SLGBTQUIA+ People webinar hosted by Canadian College of Health Leaders to learn about emerging best practices in this area.

This report was prepared by the Chief Executive Officer.

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

This report refers to the following principle(s) set out in Policy G-490, Appendix A:

- The Good Governance and Management Practices Domain as outlined in the *Ontario Public Health Standards: Requirements for Programs, Services and Accountability*.

This topic has been reviewed to be in alignment with goals under the Middlesex-London Health Unit's Anti-Black Racism Plan and Taking Action for Reconciliation, specifically the Governance and Leadership (ABRP) section.

Correspondence A

Township of Lucan Biddulph

270 Main Street
P.O Box 190, Lucan, Ontario N0M 2J0
Phone (519) 227-4491; Fax (519) 227-4998

May 21, 2024

The Honourable Andrea Khanjin, Ontario Minister of Environment, Conservation and Parks
Honourable Sylvia Jones, Ontario Minister of Health and Long-Term Care
Honourable Shelly Spence, Auditor General of Ontario

VIA Email to: minister.mecp@ontario.ca
sylvia.jones@ontario.ca
comments@auditor.on.ca

RE: Recommended Phase out of free water well testing in the 2023 Auditor General's Report

Please be advised that at their last regular meeting on Tuesday, May 7, 2024, the Council of the Township of Lucan Biddulph passed the following resolution:

Resolution No. 2024 - 123
Moved by J. Hodgins
Seconded by A. Westman

WHEREAS the Ontario Auditor General's annual report on public health from December 2023 indicates that Public Health Ontario is proposing the phasing-out of free provincial water testing services for private drinking water; and

WHEREAS free private drinking water testing services has played a pivotal role in safeguarding public health, particularly in rural communities such as the Township of Lucan Biddulph; and

WHEREAS the removal of free private drinking water testing could lead to a reduction in testing, potentially increasing the risk of waterborne diseases in these vulnerable populations; and

WHEREAS the tragic events in Walkerton, Ontario underscored the critical importance of safe drinking water.

NOW THEREFORE BE IT RESOLVED that The Township of Lucan Biddulph hereby requests that the Province reconsider and ultimately decide against the proposed phasing-out of free private drinking water testing services.

FURTHER BE IT RESOLVED that this resolution be sent to all Ontario municipalities, Minister of Environment Conservation and Parks, Minister of Health, Middlesex-London Health Unit, and MPP Elgin-Middlesex-London.

CARRIED

Please contact our office should you require any further information on this matter.

Sincerely,

Ron Reymer

Ron Reymer
CAO/Clerk

cc: MPP Rob Flack

BOH 06-10-24

Public Health
Santé publique
SUDBURY & DISTRICTS

May 28, 2024

VIA ELECTRONIC MAIL

Viviane Lapointe
Member of Parliament, Sudbury

Marc Serré
Member of Parliament, Nickel Belt

Carol Hughes
Member of Parliament, Algoma-Manitoulin-Kapuskasing

Dear Members of Parliament:

Re: Support for Bill C-322 National Framework for a School Food Program Act

At its meeting on May 16, 2024, the Board of Health carried the following resolution #36-24:

> *WHEREAS the current Ontario student nutrition program only reaches 40% of students and 71% of publicly funded Kindergarten to Grade12 schools due to insufficient funding, rising food costs, inadequate infrastructure and human resources, and an increase in student need for proper nourishment[i]; and*
>
> *WHEREAS the Board of Health for Public Health Sudbury & Districts passed motion 02-20 supporting a universal fully funded healthy school food program, and motion 61-23 supporting a funded national school food program in the 2024 Federal Budget; and*
>
> *WHEREAS although the Government of Canada recently announced an investment of $1 billion over 5 years for the national school food program in the 2024 Budget to help enhance and broaden existing programs throughout Canada, more support is required to ensure a universal fully funded school food program for all students; and*

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phsd.ca

WHEREAS Private Member's Bill C-322 calls for a national framework to establish a school food program that is universal, sustainable and effective, where no child is left out or stigmatized in the program due to their families' ability to pay, fundraise, and volunteer with the program; and

THEREFORE BE IT RESOLVED THAT the Board of Health for Public Health Sudbury & District commend the Government of Canada for prioritizing healthy school food in Budget 2024 and for working in partnership with provinces, territories and Indigenous communities throughout Canada; and

FURTHER THAT the Board of Health urges local Members of Parliament and other key partners to endorse Bill C-322, National Framework for a School Food Program Act and continue to uphold the commitment to the health and well-being of children and youth in Canada.

Evidence has shown that not all schools are able to implement a healthy school food program due to its inconsistent patchwork of funding via public and private contributions, and charitable donations[i,ii,iii]. At the same time, these programs often rely on volunteers to administer the program as the funds are prioritized for covering rising costs of food and maintaining program infrastructure to deliver school meals or snacks[i,ii,iv].

The Board of Health is pleased to witness growing support for prioritizing a national school food policy for Canada. Many individuals from across the country also voiced the importance for programs to "embrace universality" so that a healthy school food program can positively impact student's nourishment, health and wellbeing, and academic achievement, without students, families and schools feeling stigmatized if participating in the program[v]. The proposed National Framework for School Food Program Act would help ensure the development of a universal program in which students have equal opportunity to benefit from healthy meals at school everyday.

Sincerely,

René Lapierre
Chair, Board of Health

M. Mustafa Hirji, MD, MPH, FRCPC
Acting Medical Officer of Health and Chief Executive Officer

cc: Honourable Chrystia Freeland, Deputy Prime Minister and Ministry of Finance
Honourable Jenna Sudds, Ministry of Families, Children and Social Development
Honourable Gary Anandasangaree, Ministry of Crown-Indigenous Relations

Honourable Patty Hadju, Ministry of Indigenous Services
Bruce Bourget, Director of Education, Rainbow District School Board
Danny Viotto, Director of Education, Huron Superior Catholic District School Board
Joanne Bénard, Director of Education, Sudbury Catholic District School Board
Lesleigh Dye, Director of Education, District School Board Ontario North East
Lucia Reece, Director of Education, Algoma District School Board
Paul Henry, Directeur de l'éducation, Conseil scolaire catholique Nouvelon
Sébastien Fontaine, Directeur de l'éducation, Conseil scolaire public du Grand Nord de l'Ontario
Sylvie Petroski, Directrice de l'éducation, Conseil scolaire catholique de district des Grandes Rivières
Debbie Field, Coalition for Healthy School Food
Carol Dodge, Executive Director, Better Beginnings Better Futures
Ontario Boards of Health

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[i] Ruetz, A. T., & McKenna, M. L. (2021). *Characteristics of Canadian school food programs funded by provinces and territories.* Canadian Food Studies, 8(3), 70-106. https://doi.org/10.15353/cfs-rcea.v8i3.483

[ii] Haines, J., & Ruetz, A. (2020, March 01). *School Food and Nutrition. Comprehensive, Integrated Food and Nutrition Programs in Canadian Schools: A Healthy and Sustainable Approach.* Arrell Food Institute. https://arrellfoodinstitute.ca/wp-content/uploads/2020/03/SchoolFoodNutrition_Final_RS.pdf

[iii] Bond, N. (2015, February 01). *Evaluating Universal Student Nutrition Programs: Methods, Indicators, and Outcomes.* Regions. Community Engaged Scholarship Institute. https://atrium.lib.uoguelph.ca/bitstreams/840f461a-78ab-4733-81a3-0c1c0d2ceb12/download

[iv] Ruetz, A.T., Edwards, G., Zhang, F. (2023). *The Economic Rationale for Investing in School Meal Programs for Canada: multi-sectoral impacts from comparable high-income countries.* The Arrell Family Foundation. https://amberleyruetz.ca/assets/uploads/ruetz-consulting_the-economic-rationale-for-investing-in-school-mealprograms-for-canada.pdf

[v] Economic and Social Development Canada. (2023). *National School Food Policy Engagements – What We Heard Report*. Government of Canada. https://www.canada.ca/en/employment-social-development/programs/school-food/consultation-school-food/what-we-heard-report-2023.html

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Middlesex-London Board of Health
External Landscape Review – June 2024

The purpose of this briefing note is to inform MLHU Board of Health members about what is happening in the world of public health and impacts to the work of the MLHU and Board. This includes governance and legislative changes, news from other local public units, external reports on important public health matters, learning opportunities and MLHU events. **Please note that items listed on this correspondence are to inform Board members and are not necessarily an endorsement.**

Local Public Health News

Dr. Eileen de Villa, Toronto's Medical Officer of Health, announces resignation

On May 14, 2024, Dr. Eileen de Villa, Toronto's Medical Officer of Health, announced her resignation. Dr. de Villa will continue in the role until December 31, 2024.

Dr. de Villa has served as Toronto's Medical Officer of Health since 2017, leading Canada's largest local public health unit through a period of significant change and public health challenges. During her tenure, Dr. de Villa has overseen multiple critical public health initiatives including:

- Guiding Toronto's COVID-19 pandemic response and the largest vaccination campaign in the city's history.
- Addressing the ongoing drug toxicity crisis.
- Championing public health initiatives focused on addressing health inequities.

To learn more, please read the media release on the City of Toronto's website.

Impact to MLHU Board of Health
The Board of Health supports collaboration between Boards of Health and supports the networking between Medical Officers of Health. The Board of Health wishes Dr. de Villa all the best in her next endeavours and thanks her for her service to the City of Toronto.

National, Provincial and Local Public Health Advocacy

Ontario Expanding the Sale of Alcoholic Beverages Starting this Summer

On May 24, the Ontario Government announced that consumers will be able to purchase new products like coolers and other ready-to-drink beverages alongside more pack sizes at grocery stores that currently sell wine or beer, followed by new retailers being able to sell an increased selection of local, domestic and international alcohol products. By the end of October 2024, every convenience, grocery and big-box store in Ontario will be able to sell beer, cider, wine and ready-to-drink alcoholic beverages if they choose to do so.

The phased expansion and rollout will begin later this summer and will include the following milestones:

- On August 1, 2024, the up to 450 grocery stores that are currently licensed to sell beer, cider or wine will also be able to sell ready-to-drink beverages. These grocery stores will also be able to start offering consumers large-pack sizes.
- After September 5, 2024, all eligible convenience stores will be able to sell beer, cider, wine and ready-to-drink alcoholic beverages.
- After October 31, 2024, all eligible grocery and big-box stores will be able to sell beer, cider, wine and ready-to-drink beverages, including in large pack sizes.

To learn more, please read the media release from the Ontario Government newsroom.

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Impact to MLHU Board of Health
The Board of Health will be hearing at the July Board of Health meeting about the impacts that this policy will have on the community. By expanding the sale of alcohol in the marketplace, it can further negatively impact the health of the community. The Board previously heard concerns about alcohol on the community in Report No. 36-24 and Report No. 42-23.

2024 Association of Local Public Health Agencies – Annual General Meeting and Conference

From June 5-7, public health units from across Ontario met in Toronto at the Association of Local Public Health Agencies – Annual General Meeting and Conference. Representing the MLHU was Dr. Alex Summers, Dr. Joanne Kearon, Emily Williams, Board Chair Matt Newton-Reid and Vice-Chair Mike Steele.

Topics discussed included:

- Strengthening Public Health
- Proposed Voluntary Public Health Unit Mergers
- Updates from Queen's Park

Impact to MLHU Board of Health
Delegates at the 2024 alPHa Annual General Meeting and Conference (including those from MLHU) supported resolutions which coincide with the Ontario Public Health Standards and program obligations under the Health Protection and Promotion Act. Resolutions that were discussed also included new trends in public health.

New Provincial Cabinet

Legislative Assembly of Ontario

On June 6, Premier Ford announced additional ministries and a cabinet shuffle. The Ontario Legislature will be back in session on October 21, 2024.

The following changes have been made:

- Stan Cho becomes Minister of Tourism, Culture and Gaming, with responsibility for OLG
- Rob Flack becomes Minister of Farming, Agriculture and Agribusiness
- Mike Harris becomes Minister of Red Tape Reduction
- Natalia Kusendova-Bashta becomes Minister of Long-Term Care
- Stephen Lecce becomes Minister of Energy and Electrification
- Neil Lumsden becomes Minister of Sport
- Todd McCarthy becomes Minister of Public and Business Service Delivery and Procurement, with responsibility for Supply Ontario
- Greg Rickford becomes Minister of Indigenous Affairs and First Nations Economic Reconciliation and remains Minister of Northern Development
- Todd Smith becomes Minister of Education
- Graydon Smith becomes Minister of Natural Resources
- Lisa Thompson becomes Minister of Rural Affairs
- Stephen Crawford becomes Associate Minister of Mines as part of the Ministry of Mines
- Trevor Jones becomes Associate Minister of Emergency Preparedness and Response as part of Treasury Board Secretariat
- Sam Oosterhoff becomes Associate Minister of Energy-Intensive Industries as part of the Ministry of Energy and Electrification
- Nolan Quinn becomes Associate Minister of Forestry as part of the Ministry of Natural Resources
- Vijay Thanigasalam becomes Associate Minister of Housing as part of the Ministry of Municipal Affairs and Housing
- Steve Clark has been appointed Government House Leader.

To read the full media release and see the full list of changes, please visit the Ontario Government newsroom.

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Impact to MLHU Board of Health
MPP Rob Flack (Elgin-Middlesex-London) is now Minister of Farming, Agriculture and Agribusiness. Minister Flack was previously the Associate Minister of Housing. There were no changes to the Minister of Health and the Minister of Children, Community and Social Services. This is now the largest cabinet the Ontario government has had to date.

Learning and Networking Opportunities

Public Health Ontario | Santé publique Ontario

Public Health Ontario launches new course: Health Promotion Essentials

Public Health Ontario (PHO) has a variety of Health Promotion education resources designed for different health professionals available on their website. In order to better support those seeking education on Health Promotion, PHO is pleased to announce the release of a new Health Promotion Essentials online course.

This course is free and intended for those working in Health Promotion, but beneficial for all that wish to learn. After completing Health Promotion Essentials, individuals will have a greater knowledge and understanding of:

- health promotion foundational concepts
- the value of health promotion
- how health promotion can contribute to the health of people in Ontario

To take the course or learn more information, please visit Public Health Ontario's website.

Impact to MLHU Board of Health
The Board of Health acknowledges learning and development as a vital part of effective governance. Public health board members can benefit from learning more about the promotion of public health and the contribution it has for the local community.