Minutes of the Board of Health Regular Meeting
Thursday, May 18, 2017
Videoconference
Board Room/Room C
458 Laurier Blvd., Brockville/25 Johnston Street, Smiths Falls
4:00 p.m. – 5:40 p.m.

Present:

A. Warren, Chair	C. Russell-Julien
A. Churchill	T. Surko
I. Hargreaves	Regrets: P. Deery, J. Gallipeau, D. Malanka, S. Smith
T. Jansman	
C. Kaine	P. Stewart, Medical Officer of Health/CEO
D. Nash	H. Bruce, Executive Assistant
H. Patel	

J. Empey – Business Manager, QCIS	J. Mays – Manager, CHP
S. Gates – Director, QCIS	E. Murkin – Manager, CHP
J. Hess – Director, HLD	
R. Kavanagh – Manager, HLD	Invitees: T. Clow, S. Funnell, C. Robinson, C Shaffer

Agenda Item	Key Discussion Points	Decision	Action
1. Call to Order	A. Warren called the meeting to order at 4:00 p.m. and welcomed everyone.	n/a	n/a
2. Certificate of Appreciation	Deferred.		
3. Introduction of New Members	A. Warren advised that there have been 3 new provincial appointments. Candace Kaine introduced herself advising that she has worked extensively on committees for healthy youth and youth justice and has an interest in encouraging healthy lifestyles. She is looking forward to working with the Board of Health. Sherryl Smith sent her regrets for today's meeting. Toni Surko introduced herself advising that she is retired and the former CEO of Carleton Place Hospital. She has enjoyed working with health unit staff and is pleased to sit on this Board. A. Warren welcomed everyone and reviewed the videoconferencing etiquette with the group.	n/a	n/a
4. Approval of the Agenda	The agenda was reviewed.	It was moved by: C. Russell-Julien Seconded by: D. Nash That: The agenda of the May 18, 2017 Regular Meeting be approved as circulated. Motion Carried.	n/a

Agenda Item	Key Discussion Points	Decision	Action
5. Conflict of Interest Declaration	The question was raised if there were any conflicts of interest to declare. None were raised.	n/a	n/a
6. Consent Agenda			
6.1. Approval of the Minutes from the Board of Health Regular Meeting held on April 20, 2017 6.2. Finance, Property and Risk Management Committee Report 6.2.1. First Quarter Financial Report 6.2.2. Risk Management 6.3. General Correspondence 6.4. Duty of Care Report	The motion was read.	It was moved by: C. Kaine Seconded by: T. Jansman That: The following items on the consent agenda be approved as circulated: 6.1. Approval of the Minutes from the Board of Health Regular Meeting held on April 20, 2017 6.2. Finance, Property and Risk Management Committee Report 6.2.1. First Quarter Financial Report 6.2.2. Risk Management 6.3. General Correspondence 6.4. Duty of Care Report Motion Carried.	n/a
7. Presentation:			
7.1. Emergency Preparedness	T. Clow gave a presentation to the Board on emergency preparedness advising that this is the annual Board of Health training	n/a	n/a

Agenda Item	Key Discussion Points	Decision	Action
	(See Appendix #1). Questions: Does the minister look at it on a provincial level? T. Clow advised that they could, it is up on the website but they have not asked us for the plan. Our plan does follow all of the requirements. Does the Reeve or Mayor declare the public health emergency? T. Clow advised that the Reeve or the Mayor declares it at the municipal level, but if it was provincially possibly the Chief Medical Officer of Health would declare it. P. Stewart stated that the municipality can call the community control group together or she can, as Medical Officer of Health, bring the group together, but the municipality is the only one that declares an emergency for a municipality. Do we test our plan? T. Clow advised that we do. We test sections of it. We do test our fan out list and if there is an actual emergency the ministry counts it as a tabletop. It is a way to handle things when you have a surge. We move into the IMS structure and assign roles – it works. A. Warren thanked T. Clow for her presentation.		
8. Business Arising:			

Agenda Item	Key Discussion Points	Decision	Action
8.1. Lanark County Request to Board of Health: Levy Apportionment	P. Stewart advised that Lanark County brought to our attention that the MPAC Population Data should only be used for municipal enumeration purposes. It is currently being used to apportion the municipal levy among obligated municipalities. A good discussion about this was held at the Finance, Property and Risk Management Committee. (see Briefing Note) P. Stewart advised that the Board must decide how the municipal levy is apportioned between obligated municipalities. Each municipality has to agree to what the Board decides and if they can't agree then the default is the MPAC Population Data. The best quality population data is from Statistics Canada census conducted every 5 years. The motion was read. 2017 budgets have been presented and approved for the municipalities. The motion was amended to be effective 2018. The amended motion was initialed by both movers.	It was moved by: A. Churchill Seconded by: C. Russell-Julien That: The Board of Health recommend to obligated municipalities that the most recent Statistics Canada population census data be used to apportion the municipal levy among obligated municipalities starting in 2018; And That: The Board of Health write a letter to Minister Hoskins, Ministry of Health and Long-Term Care, requesting that the use of the enumeration data under the Assessment Act be removed from the Health Protection and Promotion Act Regulation 489/97 and be replaced with Statistics Canada census data. Motion Carried.	n/a
9. New Business:			
9.1. Health Impact Assessment	P. Stewart advised that the new Ontario Public Health Program and Service Standards have a new standard about		

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	healthy environments. We are directed to analyse how changes to the natural and built environment impact health. C. Shaffer, one of our Public Health Inspectors, is doing her Masters of Public Health, and worked on the development of an Health Impact Assessment program. This is work we will be doing to support municipalities. C. Shaffer gave a power point presentation to give an overview of what health impact assessment (HIA) is and what work she has done in her practicum (See Appendix #2). Questions: How do we get out this to municipalities and let them know we are open for business? A letter sent to municipalities and working with municipal planning departments was suggested. A meeting with the planners - Lanark County and United Counties - was also suggested. It is about opening the dialogue. For smaller municipalities economic development will be contacted as well. A presentation to council and community partners was suggested. This is an excellent initiative that will build awareness with municipalities and the value of work done at the health unit. There is concern about capacity however. C. Shaffer advised that part of our tool is looking through criteria to determine what level		

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	would be appropriate – comprehensive, rapid or not. We thought we would do more rapid than comprehensive ones unless there was additional funding available. A. Warren thanked C. Shaffer for her presentation.		
9.2. Accountability Agreement Indicator Report	P. Stewart advised that the province establishes health promotion and health protection indicators and identifies a target for us to reach. We did very well this year. She reviewed the results with the group.	n/a	n/a
9.2.1. Dental Report	R. Kavanagh presented on the oral health program. The indicators that P. Stewart shared with you on oral health are focused on how well our staff are doing out in the field. We have a couple protocols that we work under and have another obligation to provide indicators regarding oral health status every year. This year the group wanted to share indicators with the Board to showcase what the team does. The 4 main areas of focus are the HSO Ontario program, screening program, oral health education and promotion, and monitoring of fluoride in municipalities. In our mandate we just look after children, but we get calls all the time from older adults that experience pain and don't have access to dental benefits. We don't have anything to offer them but we try and raise	n/a	n/a

Agenda Item	Key Discussion Points	Decision	Action
	money, and last year we were successful at getting a grant from United Way. ($13,500) We can provide them with $300 to get in the door at the dentist, which gets them seen and an x-ray taken. A. Warren thanked R. Kavanagh for her report.		
9.3. alPHa Conference	P. Stewart will not be attending the alPHa conference, but if there are Board members wishing to attend please let her know. She reviewed the advocacy with the group to be discussed at alPHa. If there is one topic that the Board feels strongly about then the Board can write a letter to the Minister of Health and Long-Term Care. Only 40% of people in our area have dental insurance. This means that the emergency rooms are taken up. It doesn't make sense to not have a dental program for adults.	It was moved by: D. Nash Seconded by: I. Hargreaves That: A letter of advocacy be written to the Minister of Health and Long-Term Care supporting a dental program for adults; And That: alPHa be copied on this letter of advocacy. Motion Carried.	n/a
10. Advocacy:			
10.1. Preschool Speech and Language (PSL)	C. Robinson advised that many children in PSL often are diagnosed with autism and she is asking the Board to support making the PSL program part of the Ministry funded autism services. There is little integration between the 2 programs in terms of communication and funding. She would like to build PSL into the autism care pathway.	It was moved by: T. Jansman Seconded by: C. Kaine That: The Board of Health write a letter to the Chairs of the PSL Collaborative endorsing the PSL Collaborative's advocacy efforts to implement a shared care pathway including PSL for children with autism.	n/a

Agenda Item	Key Discussion Points	Decision	Action
		Motion Carried.	
11. MOH Verbal	The MOHLTC Pubic Health Accountability Framework was reviewed (See Appendix #3).	n/a	P. Stewart will send out a copy of the accountability framework to Board members.
12. Time, Date and Location of Next Meeting	The next meeting will be held on Thursday, June 22, 2017. (originally scheduled for June 15, 2017) We now have a full complement with all 13 members. We will have the meeting in Smiths Falls and ask everyone to attend and do a photo of the complete group. The auditor would be in attendance as well.	n/a	n/a
13. Adjournment		It was moved by: D. Nash Seconded by: A. Churchill That: The meeting adjourn at 5:40 p.m. Motion Carried.	n/a

_____ _____

A. Warren, Chair Date

_____ _____

H. Bruce, Executive Assistant Date

c: Board members
Shared Drive

Emergency Preparedness and Response

Board of Health Training
May 18, 2017

Objectives

- Understand the Health Unit's mandate for emergency management
- Define an emergency and differentiate between an emergency and public health emergency
- Understand the basics of HIRA
- Identify the risk to public health in LGL
- Identify the phases in the emergency management cycle
- Understand the basic IMS model
- Understand the role of public health in emergency response
- Be aware of key elements of the Health Unit Emergency Response Plan (ERP)
- Be aware of key elements in a Continuity of Operations Plan (COOP)

Our Mandate for Emergency Management

The Public Health Emergency Preparedness Protocol dictates that Boards of Health:

- Identify hazards and assess the risks to the public within health unit jurisdiction (**HIRA**)
- Develop an emergency response plan
- Have 24/7 coverage to receive and respond to reports of incidents (**ON CALL**)
- Develop and implement notification protocols for staff (**fan out**)
- Provide education and training for staff and board members
- Exercise continuity of operations and emergency response plans

Definition of 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 Management and Civil Protection Act R.S.O 1990)

Definition of A Public Health Emergency

A ***Public Health Emergency*** is defined as:

"The occurrence or imminent threat of a situation such as an **outbreak of an infectious agent, natural disaster, or a large scale environmental hazard** that poses a **substantial risk** of a large number of **deaths** or **serious harm** to a population, and which has the potential to **overwhelm** routine capabilities to address the threat and/or the health consequences "

(PHO, adapted from WHO 2001)

Identification of Hazards

Hazard Identification and Risk Assessment (HIRA) is one of the first steps in emergency planning

HIRA:

- ✓ Identifies hazards
- ✓ Considers probability of occurrence
- ✓ Considers consequences
- ✓ Considers changing risk
- ✓ Ranks risk

HIRA

- Hazard
- Identification
- Risk
- Assessment

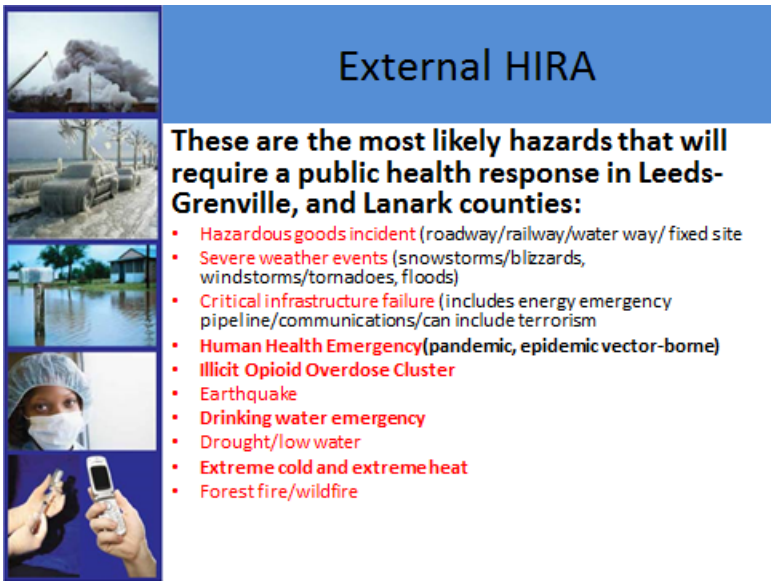
4 Steps in Conducting a HIRA

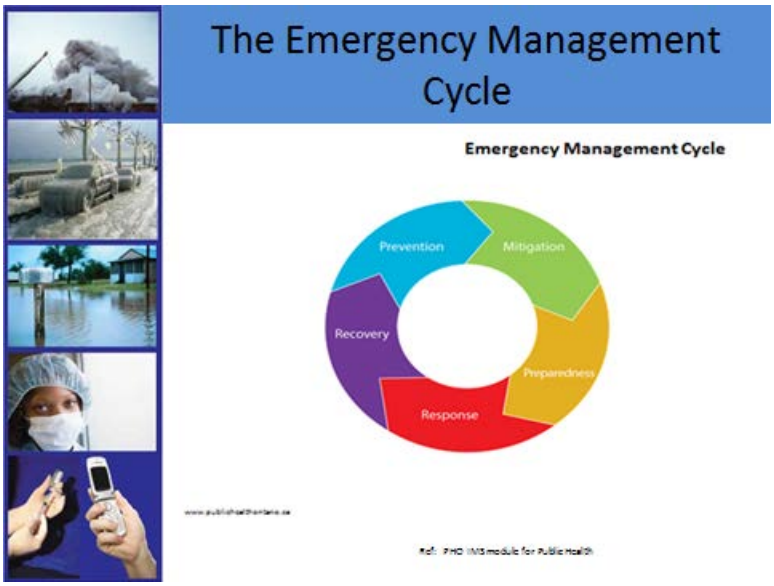
Step 1:
Identifying the risks based on **natural, technological** or **human caused events** and separating out the hazards that could impact your community from those that are likely not to occur.

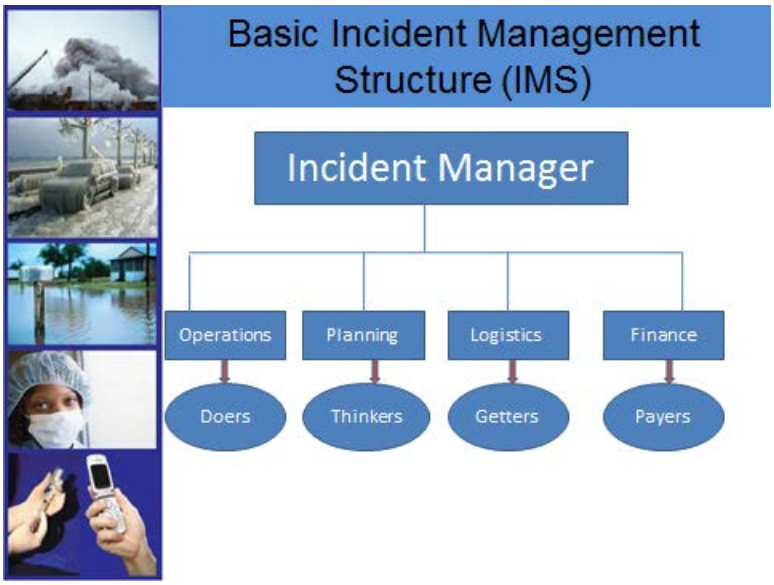
Step 2:
Assessing the **likelihood** of the hazard occurring and the potential impact or **consequences**.

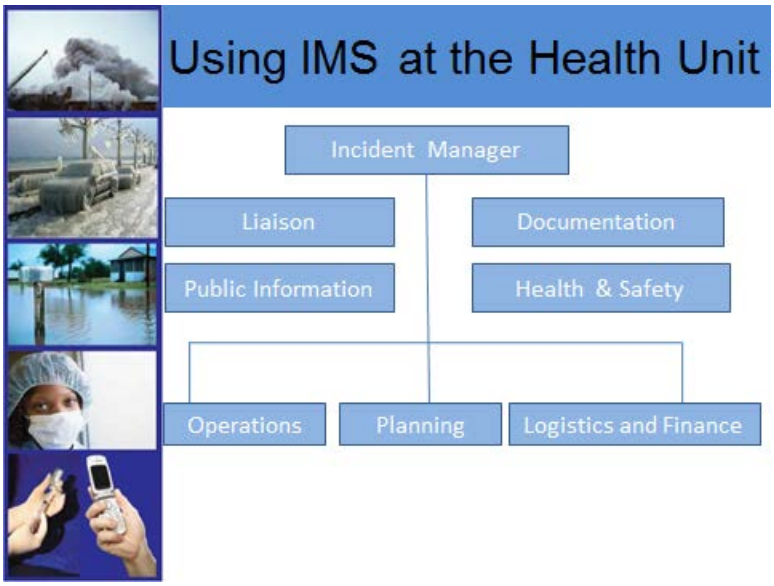
Step 3:
Analyzing the Risk of hazards and prioritizing the hazards that are the most likely to have a significant impact on the population so that resources for prevention and mitigation plans can be put in place to address these hazards.

Step 4:
Monitoring and Reviewing the HIRA on a yearly basis and making adjustments where needed.


External HIRA
These are the most likely hazards that will require a public health response in Leeds-Grenville, and Lanark counties:
Hazardous goods incident (roadway/railway/water way/ fixed site
Severe weather events (snowstorms/blizzards, windstorms/tornadoes, floods)
Critical infrastructure failure (includes energy emergency pipeline/communications/can include terrorism
Human Health Emergency(pandemic, epidemic vector-borne)
Illicit Opioid Overdose Cluster
Earthquake
Drinking water emergency
Drought/low water
Extreme cold and extreme heat
Forest fire/wildfire


The Emergency Management Cycle
Emergency Management Cycle
Prevention
Mitigation
Preparedness
Response
Recovery


Basic Incident Management Structure (IMS)
Incident Manager
Operations
Planning
Logistics
Finance
Doers
Thinkers
Getters
Payers


Using IMS at the Health Unit
Incident Manager
Liaison
Documentation
Public Information
Health & Safety
Operations
Planning
Logistics and Finance


Using IMS in Municipal Incidents
• Municipal Community Control Group (MCCG) activated to support the response to an incident
• Incident Commander
• **Operations**: representatives from Fire, EMS, Police, Public Works
• Emergency Information Officer,
• Health and Safety Officer
• Finance Officer
• Liaison,
• **Documentation**: Scribe
• Medical Officer of Health
• Mayor/ Reeve declare an emergency


Incident Management System
Public Health
Prevention
Mitigation
Recovery
Incident Management System
First Responders

The Leeds Grenville and Lanark District Health Unit Emergency Response Plan

- Provides a framework for a timely and effective mobilization of health unit staff in response to an emergency (how we fan out)
- Defines the role of public health
- Informs staff how the plan is activated
- Provides information on various functions assigned to each IMS manager
- Outlines the roles of all staff, in a community wide response and a response that requires a shelter.
- Provides guidance to staff on assisting people with special needs during an emergency
- Is supported by various appendices ie the Emergency Response Resource Binder

Health Unit Emergency Response Plan

- All staff have a responsibility to be familiar with the Health Unit Emergency Response Plan

You can find a copy on our website under emergencies/disaster, or under South Shared-common- resources- emergency response resources

http://www.healthunit.org/emergency/emergency_response_plan_lgl.pdf

Continuity of Operations Plan (COOP)

- Describes services delivered by program area and the dependencies they rely on (ie IT)
- Assigns time criticality to services
- Documents impact if services are unavailable (on public health, life, safety)
- Identifies roles and responsibilities for response to business disruption and recovery of services within an acceptable time frame and predetermined service levels
- Must be reviewed and exercised annually

Continuity of Operations Plan (COOP)

- Makes advance arrangements to ensure time critical services can continue to function in the event of a business disruption or other emergency

Health Impact Assessment

Courtney Shaffer
Public Health Inspector
Department of Community Health Protection

Leeds, Grenville & Lanark District HEALTH UNIT
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What is HIA?

- World Health Organization Definition:
  - *"A combination of procedures, methods and tools that systematically judges the potential and sometimes unintended effects of a policy, plan, programme or project on the health of a population and the distribution of those effects within the population"*
  - Uses a broad definition of health; considers how the determinants of health could be impacted
  - **The goal of HIA is to identify appropriate actions to manage those impacts**

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The need for HIA

- 2017 Standards for Public Health Programs and Services
  - Healthy Environments Program Standards
    - Identify risk factors and priority health needs in the local physical and natural environments related to building a healthy environment
    - Develop effective strategies in collaboration with community partners to reduce exposure to health hazards and promote healthy natural and built environments
    - Investigate potential health hazards and respond by preventing or reducing exposure
- LGLDHU Strategic Plan 2013-2017
  - Health Goal: Promoting of Healthy Environments
    - The plan recognizes that a healthy environment influences the other three goals: Healthy Infant, Child, Youth Growth and Development; Healthy Living; and Health Equity.
- Health Impact Assessment provides a systematic and evidence based method for drawing conclusions on the health impacts of initiatives that affect the natural and build environments

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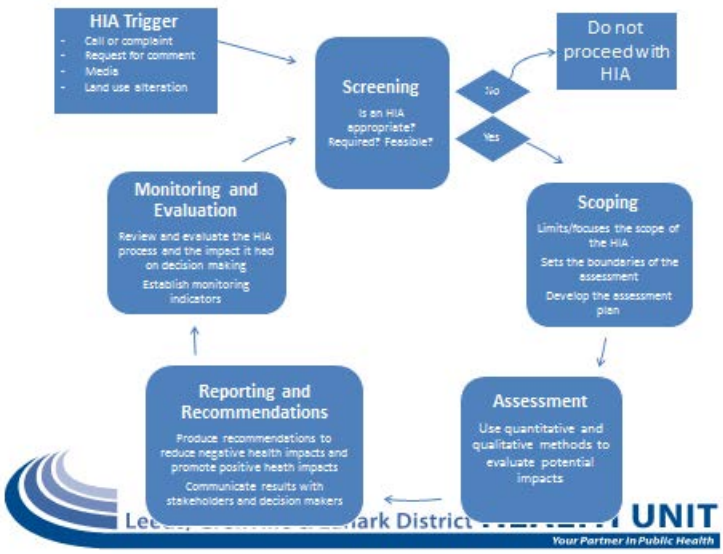

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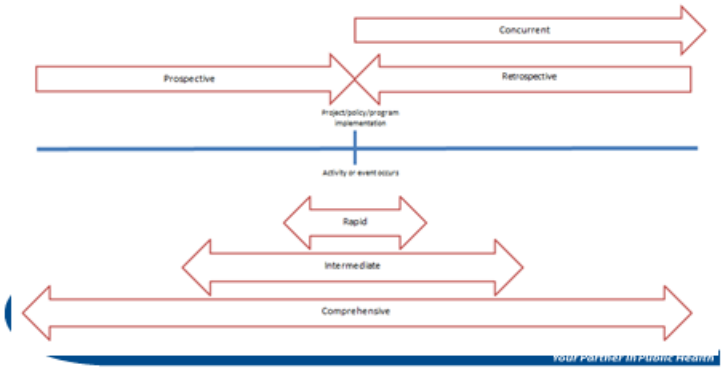
Type and Level of Health Impact Assessment



Examples of events/initiatives that may benefit from the HIA process

- **Opportunity to have influence on a municipal or county official plan**
- **Development or land use alterations.**
  - Residential development or re-development, municipal re-zoning
  - Infrastructure projects (drinking water supply, sewage treatment etc.), transportation projects
  - Land remediation, mining projects, landfill construction, energy generation proposals
  - New/modification to industry (e.g. asphalt plant, landfill, etc.)
  - Projects undergoing provincial or federal Environmental Assessment processes
- **Requests for comment or involvement on projects, policies, programs, bylaws, involving the natural or built environment.**
  - construction of a new trail system,
  - safer routes to schools policy,
  - wood burning furnace bylaw
- **Incidents, such as fires, spills, or floods, that may have long-term health impacts beyond the initial incident response**

Leeds, Grenville & Lanark District **HEALTH UNIT**
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Appendix #3

Leeds, Grenville and Lanark District Health Unit

MOH Verbal Report

May 18, 2017

Organization

The Public Health Branch of the Ministry of Health and Long-Term Care has released the Public Health Accountability Framework for discussion. The Framework includes four domains:

- Delivery of Programs and Services;
- Fiduciary Requirements;
- Good Governance and Management Practices; and
- Public Health Practice.

Many of the requirements in the previous Public Health Organizational Standards that were presented to the Board in the past year have been retained e.g. Risk Management, Information Management, Client Service Standards, and Board Governance. The areas which will need to be reviewed or developed by the Health Unit are:

- Development and submission of an Annual Service Plan along with the budget submission;
- Development and submission of in-year performance reports for programs on request;
- Annual report of programs along with costing information;
- Demonstrating use of a systematic process to plan programs and services;
- Review of financial procedures to ensure they are consistent with the Municipal Act;
- Development of a culture of excellence in professional practice;
- Development of a quality and continuous improvement system.

On June 8, 2017, Corinne Berinstein, Senior Auditor, with the Audit Division, Treasury Board, will be facilitating a discussion with the Management Team about Health Unit wide risks, their consequences, underlying causes, and ways to manage the risk effectively. This will fulfill one of our provincial accountability requirements, and will ensure that significant risks are managed effectively.

Program Update

The Every Kid in our Communities (EKIOC) Coalition (in partnership with the Health Unit) held their third annual "Recognition of Asset Builders" Celebration Sunday, April 30th at the Healthy Kids Day, at the YMCA of Brockville and Area. This event was an opportunity to celebrate and honour organizations and people, who make a difference in the lives of children and youth - in other words they build assets! Two of our employees, Rebecca Shams (Youth Tobacco Program) & Kim Marshall (Public Health Nurse) were recognized for being role models and leaders in the youth engagement process, and for being advocates for our youth.

Youth ages 10-24 across Eastern Ontario were busy this spring making short videos about something important to them. Eight original local films have been nominated as finalists for the 2017 MyView Youth Film Festival. The Awards Ceremony is on Thursday June 8th at 7 p.m. at the Brockville Arts Centre. The Health Unit provides support to the youth in our area to participate in the festival.

The Health Unit has been supporting the Upper Canada District School Board and the Catholic District School Board of Eastern Ontario in their decision to include naloxone in their school first aid kits by developing their naloxone policies and procedures, and training key staff. On May 8th, 169 staff from the UCDSB board (representing elementary and secondary schools in LGL) were trained on opioids and the administration of injectable naloxone. Staff training on intranasal naloxone for the CDSBEO will be taking place on May 26th.

The Public Health Inspectors have begun menu labeling inspections at local food premises. The Health Units from Peterborough and Eastern are meeting every two weeks via teleconference so that a consistent approach can be delivered to franchisees that we share.

The recent floods may have put personal wells at risk of contamination so the Health Unit is strongly advising homeowners to get their well water test.

LHIN

The Health Unit has been invited to a Board to Board governance forum for "Health, Community Care and Social Service Governors and Leaders" which will be held on May 26th near Smiths Falls to discuss "Opportunities to Strengthen Person-Centred Care in Lanark Leeds and Grenville". The forum is organized by Rideau Community Health Services, Perth and Smiths Falls District Hospital, and the Upper Canada Family Health Team.

The South-East LHIN is planning a June 'Setting the Stage' event for the health partners in each sub-region to "create a common foundation from which to launch the Sub-Region planning activity, and initial thinking on priorities". Research will continue during the summer and, in the fall, Sub-Region tables will be formed to "confirm the first priorities on which to work". As outlined in the Patients First Act, I, as Medical Officer of Health, will be involved to bring the population health perspective and a healthy equity lens to the planning discussions.