A G E N D A

MIDDLESEX-LONDON BOARD OF HEALTH

399 RIDOUT STREET NORTH
SIDE ENTRANCE, (RECESSED DOOR)
Board of Health Boardroom

THURSDAY, 7:00 p.m.
2011 January 20

MISSION - MIDDLESEX-LONDON BOARD OF HEALTH

The mission of the Middlesex-London Health Unit is to promote wellness, prevent disease and injury, and protect the public's health through the delivery of public health programs, services and research.

MEMBERS OF THE BOARD OF HEALTH

Ms. Denise Brown	Ms. Viola Poletes Montgomery
Ms. Patricia Coderre	Ms. Nancy Poole
Mr. Al Edmondson	Mr. Don Shipway
Dr. Francine Lortie-Monette	Mr. Mark Studenny
Ms. Doreen McLinchey	Mr. Joe Swan
Mr. Marcel Meyer	Dr. Graham Pollett

DISCLOSURE OF CONFLICTS OF INTEREST

APPROVAL OF MINUTES

APPROVAL OF AGENDA

SCHEDULE OF APPOINTMENTS

7:10 -7:40 Dr. Jean Clinton, MD FRCP (C), Associate Clinical Professor, Department of Psychiatry and Behavioural Neuroscience at McMaster University, Division of Child Psychiatry re Item #6.

7:40 – 7:50 Mr. John Millson, Director, Finance and Operations re Item #2.

ACTION REQUIRED

1) Election of 2011 Board of Health Executive (Report No. 001-11)

2) 2011 Cost-Shared Budget (Report No. 002-11)

3) Healthy Living Champions Award 2009-2010 and Healthy School Celebration (Report No. 003-11)

4) Record Retention Schedule (Report No. 004-11)

FOR INFORMATION

5) Medical Officer of Health Activity Report – January (Report No. 005-11)

6) The Early Years – Critical to the Future (Report No. 006-11)

7) Working with Newcomer Populations (Report No. 007-11)

8) Caring for Families in the Limberlost Neighbourhood (Report No. 008-11)

9) Dietary Reference Intakes: Calcium and Vitamin D (Report No. 009-11)

10) Healthy Eating Group Home Project (Report No. 010-11)

11) Canada's Healthy Workplace Month (Report No. 011-11)

12) Provincial Bed Bug Initiatives (Report No. 012-11)

CONFIDENTIAL

That the Board of Health rise and go into Committee of the Whole In Camera for the purpose of considering a matter pertaining to reports, advice and recommendations of officers and employees of the Health Unit concerning labour relations and employee negotiations in regard to one of the Health Unit's associations or unions.

OTHER BUSINESS

Next Board of Health Meeting – Thursday, February 17, 2011, 7:00 PM

CORRESPONDENCE RECEIVED

a) Dated 2010 November 20 (Received 2010 December 1) Correspondence from Mr. Dennis Roughley, Chair, Board of Health, Simcoe Muskoka District Health Unit to Premier Dalton McGuinty requesting that the Provincial Government reinstate the proposed "Human Development and Sexual Health" content of the 2010 Health and Physical Education Curriculum for Grade 1-8 prior to May 2011.

b) Dated 2010 November 23 (Received 2010 December 9) Correspondence from Dr. Penny Sutcliffe, Medical Officer of Health/Chief Executive Officer, Sudbury and District Health Unit to the Honourable Leona Aglukkaq, Minister of Health, advising that Sudbury and District Board of Health carried the following resolution #55-10:

WHEREAS immunization is one of the most effective public health strategies, saving more lives in Canada in the last 50 years than any other single health intervention; and

WHEREAS immunization coverage rates are important indicators of health, estimating the proportion of individuals who have completed a recommended immunization series; and

WHEREAS the Ontario Public Health Standards (OPHS) require that Boards of Health undertake activities to reduce or eliminate the burden of vaccine preventable diseases; and

WHEREAS in the absence of mandatory immunization reporting by all health care providers, public health has inaccurate immunization coverage information upon which to base important vaccine preventable disease program decisions;

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health advocate to the federal government for a national vaccine registry to collect, analyse (by geographic and socio-demographic variables), share and report immunization information, particularly in early childhood; and

FURTHER THAT the Sudbury & District Board of Health urge the Ministry of Health and Long-Term Care (MOHLTC) to develop legislation, beyond the Day Nurseries Act, that assists public health units in monitoring the vaccine coverage rates of infants, toddlers and preschool children; and

FURTHER THAT the Sudbury & District Board of Health urge the MOHLTC to develop legislation that requires the reporting of all publicly funded immunizations provided by health care providers; and

THAT a copy of this motion be forwarded to the Ontario Public Health Association, the Association of Local Public Health Agencies, and all Ontario boards of health.

c) Dated 2010 November 25 (Received 2010 December 16) Correspondence from Mr. Kidd, Chair Board of Health for the Timiskaming Health Unit re: Resolution #08-2010, Bill 100 Paved Highway Shoulders advising that the following resolution was passed:

***WHEREAS** Bill 100 requires the Minister of Transportation to construct, during resurfacing, one-meter (minimum) paved shoulders on prescribed highways and provide signage that warns vehicles to watch for and share the road with pedestrians and cyclists.*

***WHEREAS** Bill 100 will make it possible for people to cycle and walk more safely on Ontario's secondary highways. Increased cycling and walking for recreation, commuting and as a general means of getting around, has major health and environmental benefits.*

***WHEREAS** physical environment is a social determinant of health and we know that the way our roads and communities are designed directly affects health. Also as a means of injury prevention, safe road design, along with active transportation features such as cycling lanes and sidewalks, which translates into more walkers and cyclists being on the street, results in lower rates of vehicle-pedestrian collisions.*

***WHEREAS** the availability of paved shoulders on our highways, along with appropriate signage and other safety features, would therefore serve to enhance active transportation opportunities across the province. I believe that the passage of Bill 100 would signify a very sound societal investment.*

***WHEREAS** this would build on active transportation initiatives at the municipal levels.*

***BE IT RESOLVED THAT** the Board of Health supports the recommendations of the Simcoe Muskoka District Health Unit, to encourage the Legislative Assembly of Ontario to adopt Bill 100.*

***THEREFORE, BE IT FURTHER RESOLVED THAT** a copy of this resolution be forwarded to the Legislative Assembly of Ontario and Ontario Boards of Health.*

d) Dated 2010 December 7 (Received 2010 December 9) Correspondence from Ms. Valerie Sterling, President, Association of Local Public Health Agencies (alPHa) to Dr. Arlene King, Chief Medical Officer of Health, expressing appreciation for Dr. King's commitment to engaging in productive substantive discussions with alPHa over the past five months.

e) Dated 2010 December 7 (Received 2010 December 9) Correspondence from Ms. Valerie Sterling, President, Association of Local Public Health Agencies (alPHa) to Dr. Arlene King, Chief Medical Officer of Health, expressing appreciation for Dr. King's commitment to engaging in productive substantive discussions with alPHa over the past five months.

f) Dated 2010 December 16 (Received 2010 December 21) Correspondence from Mr. Jim Grieve, Assistant Deputy Minister of Education, re information on regulatory amendments that will enable and support the second year of implementation of the Full-Day Learning Kindergarten Program.

g) Dated 2010 December 17 (Received 2010 December 22) Correspondence from Dr. Penny Sutcliffe, Medical Officer of Health /Chief Executive Officer, Sudbury and District Health Unit advising that the Sudbury District Board of Health carried the following resolution #62-10:

WHEREAS the Sudbury & District Health Unit (SDHU) has been a Teaching Health Unit for more than 20 years, fostering innovation, training future public health practitioners and improving public health practice; and

WHEREAS the current Teaching Health Unit Program, the Public Health Research, Education and Development (PHRED) Program, will be dissolved December 31, 2010; and

WHEREAS the Sudbury & District Board of Health is committed to continuous public health practice improvement through evidence-informed decision making, practice-relevant research and professional development, as reinforced by the Foundations of the Ontario Public Health Standards (OPHS); THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health will leverage its more than 20 year history as a Teaching Health Unit and continue its commitment to the principles of a Teaching Health Unit, seeking funding and partnership opportunities to further enrich its capacity in a post-PHRED era; and

FURTHER THAT the Sudbury & District Board of Health formally acknowledge the historical contributions of the provincial and health unit PHRED programs, including the provincial and local leaders and staff, and the program's advisory bodies, for their significant contribution to the advancement of public health practice locally and across Ontario; and

FURTHER THAT this motion be forwarded to the current PHRED program boards of health, the PHRED Steering Committee, the Ministry of Health and Long-Term Care, the Ministry of Health Promotion and Sport, the Chief Medical Officer of Health, the Ontario Agency for Health Protection and Promotion and other partners including the Public Health Agency of Canada, the Canadian Institutes of Health Research, the Ontario Public Health Association and the Association of Local Public Health Agencies.

h) Dated 2010 December 23 (Received 2011 January 6) Correspondence from the Honourable Deb Matthews, Minister of Health and Long-Term Care, re approval of one-time funding to support Middlesex-London Health Unit's Needle Exchange Program.

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 001-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 January 20

Election of 2011 Board of Health Executive

Recommendations

1. ***It is moved by _____, seconded by _____that _____ be elected Chair of the Middlesex-London Board of Health for the year 2011; and further***

2. ***It is moved by _____, seconded by _____that _____ be elected Vice-Chair of the Middlesex-London Board of Health for the year 2011; and further***

3. ***It is moved by _____, seconded by _____that _____ be elected Secretary-Treasurer of the Middlesex-London Board of Health for the year 2011; and further***

4. ***It is recommended that the Board of Health establish Standing Committees for 2011; and further***

5. ***That the schedule of regular Board of Health meetings for 2011 highlighted in Appendix D of Report No. 001-11 be approved.***

Background

City Council and County Council have recently appointed their representatives to the Board of Health. Representing City Council (Appendix A) are: Councillor Denise Brown, Councillor Joe Swan and Ms. Patricia Coderre (Lay Appointee). Representing County Council (Appendix B) are: Councillor Al Edmondson, Councillor Marcel Meyer and Councillor Don Shipway. The appointments in each instance are for four years, i.e., the term of municipal council.

Bylaw No. 3 of the Board of Health (Appendix C) regulates the proceedings of the Board. Section 18.0 of this Bylaw addresses Elections and Appointment of Committees. It reads as follows:

18.1 *At the first meeting of each calendar year, the Board shall elect by a majority vote a Chair and a Vice-Chair for that year.*

18.2 *The Chair of the Board shall rotate on an annual basis to one of the representatives of the City of London, the County of Middlesex and the Province of Ontario.*

18.3 *At the first meeting of each calendar year, the Board shall appoint the representative or representatives required to be appointed annually at the first meeting by the Board to other boards, bodies or commissions where appropriate.*

18.4 *The Board may appoint committees from time to time to consider such matters as specified by the Board. (e.g., Human Resources, Planning, etc.).*

Inaugural Meeting Decisions

(a) Election of Executive Officers

As per Bylaw No. 3, the positions of Chair and Vice-Chair are elected positions which serve a one year term. These positions are rotated sequentially among the three constituent groups represented on the Board as follows: County of Middlesex, City of London and Provincial Appointees. The outgoing Chair, Mr. Al Edmondson, is a County of Middlesex appointee. Last year's Vice-Chair, Mr. Walter Lonc, was a City of London appointee.

Consequently, to comply with Bylaw No. 3, the Chair for 2011 should be elected from one of the three City of London representatives (usually the preceding year's Vice-Chair) and the Vice-Chair from one of the five Provincial Appointees. The Medical Officer of Health is usually appointed Secretary-Treasurer of the Board.

(b) Establishment of Standing Committees

Subsequent to the Election of Officers and consistent with Board of Health Policy No. 2-10, Section 1.3 (ii) Structure and Responsibilities of the Board of Health (Appendix D), the Board determines whether it wishes to establish one or more Standing Committees. Historically, the Board of Health has not operated with Standing Committees but has had all matters dealt with directly by the Board.

(c) Approval of 2011 Meeting Schedule

The Board then confirms the meeting schedule for the coming year. Traditionally, Board meetings have been held the 3rd Thursday of each month with the exception of the December meeting which has been held on the 2nd Thursday. Meetings for the months of July and August have been held on an as needed basis, at the call of the Chair. On this basis, a proposed meeting schedule for 2011 is presented in Appendix E.

(d) Board of Health Members' Appointment Terms

Appendix F, Provincial Appointee Reappointment Process (an Appendix of Board of Health Policy No. 2-10), calls for the Secretary-Treasurer to annually provide a listing of all Board Members term expiration dates. This list is provided in Appendix G.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

This report addresses Bylaw #3 as outlined in the MLHU Administration Policy Manual.

Appendix A

300 Dufferin Avenue
P.O. Box 5035
London, ON
N6A 4L9

London
CANADA

December 14, 2010

Chair and Members
Board of Health
Middlesex-London Health Unit
50 King Street
London, ON N6A 5L7

I hereby certify that the Municipal Council, at its session held on December 7, 2010 resolved:

30. That the following **BE APPOINTED** to the Board of Health of the Middlesex-London Health Unit for the term December 1, 2010 to November 30, 2014:

Councillor D. Brown
Councillor J. Swan
Patricia L. Coderre (30/1/CW)

C. Saunders
City Clerk
/hw

cc: P. Coderre, 127 Wakefield Crescent, London, ON N5X 1Z6

CORPORATION OF THE COUNTY OF MIDDLESEX

County Building, 399 Ridout Street N., London, Ontario N6A 2P1
(519) 434-7321 FAX: (519) 434-0638

Appendix B

January 12, 2011

Dr. Graham Pollett
Medical Officer of Health
Middlesex-London District Health Unit
50 King Street
London, Ontario N6A 5L7

Dear Graham:

RE: REPRESENTATION ON THE MIDDLESEX-LONDON BOARD OF HEALTH

Middlesex County Council appointed the following members to the Middlesex-London Board of Health:

1. Councillor Al Edmondson
Mayor
Municipality of Middlesex Centre
14484 Eight Mile Road
Arva, Ontario N0M 1C0
Telephone: 519-660-0559 (Residence)
E-mail: edmondson@middlesexcentre.on.ca

2. Councillor Marcel Meyer
Deputy Mayor
Municipality of Thames Centre
5100 Westchester Bourne, R.R.#2
Belmont, Ontario N0L 1B0
Telephone: 519-644-1029 (Residence)
E-mail: mmeyer@thamescentre.on.ca

3. Councillor Don Shipway
Mayor
Municipality of North Middlesex
179 Ailsa Craig Main St., P.O. Box 122
Ailsa Craig, ON N0M 1A0
Home: 519-293-3219
E-mail: donshipway@execulink.com

Sincerely,

Kathy Bunting, AMCT
County Clerk

RECEIVED
JAN 12 2011
MEDICAL OFFICER OF HEALTH

/kb

APPENDIX A
To Policy 2-10

MIDDLESEX-LONDON HEALTH UNIT

MIDDLESEX-LONDON BOARD OF HEALTH

BYLAWS

IMPLEMENTATION DATE: September 25, 1986

REVISED and RE-ENACTED on November 21, 1996
REVISED and RE-ENACTED on February 19, 1998
REVISED and RE-ENACTED on March 16, 2000
REVISED and RE-ENACTED on March 15, 2001
REVISED and RE-ENACTED on November 18, 2004
REVISED and RE-ENACTED on February 21, 2008

Bylaws for the Board of Health will be reviewed in the calendar year following a municipal election (every 3 years).

MIDDLESEX-LONDON HEALTH UNIT

Board of Health**: Bylaw No. 1**

Pursuant to Section 56(1)(a) of the *Health Protection and Promotion Act*, R.S.O. 1990, as amended, chapter H.7, the Board of Health for the Middlesex-London Health Unit enacts Bylaw No. 1 to provide for the **management of property.**

1. In this bylaw:

   (a) "Act" means the *Health Protection and Promotion Act*, R.S.O. 1990 (as amended), Chapter H.7.

   (b) "Agreement" means an agreement between the Board and the Councils for the Corporation of the City of London and the Corporation of the County of Middlesex.

   (c) "Board" means the Board of Health for the Middlesex-London Health Unit.

2. The Board shall hold title to any real property acquired by the Board for the purpose of carrying out the functions of the Board and may sell, exchange, lease, mortgage, or otherwise charge or dispose of real property owned by it, subject to Section 52(4) of the Act.

3. (a) In accordance with the Agreement, the Secretary-Treasurer shall be responsible for the care and maintenance of all properties as required by the Board.

   (b) The Secretary-Treasurer shall keep a written inventory of all properties possessed by the Board and shall update this inventory list annually.

4. Pursuant to the Act and the terms of any leasing or rental agreements, the responsibility of the Secretary-Treasurer shall include, but not be limited to, the following:

   (a) the replacement of, or major repairs to, capital items such as the heating, cooling, and ventilation systems; roof and structural work; plumbing; lighting & wiring;

   (b) the maintenance and repair of the parking areas and the exterior of the building;

   (c) the care and upkeep of the grounds of the property;

   (d) the cleaning, maintaining, decorating and repairing of the interior of the building;

   (e) the maintenance of up-to-date insurance including both property and personal liability coverage, fire, theft, malpractice, errors and omissions and automobile insurance.

5. The Board shall ensure that all such properties comply with applicable statutory requirements contained in local, provincial, and/or federal legislation (e.g., Building Code and Fire Code).

First Reading - February 21, 2008
Second Reading - February 21, 2008
Third Reading - February 21, 2008

This Bylaw to be in force and effect from February 21, 2004, and to remain in force and effect until otherwise amended by enactment by the Board.

Executed in London, in the Province of Ontario, on this **21st day of FEBRUARY, 2008**.

_____ _____

Susan Eagle
Chair

Graham L. Pollett
Secretary-Treasurer

MIDDLESEX-LONDON HEALTH UNIT

Board of Health: **Bylaw No. 2**

Pursuant to Section 56(1)(b) of the *Health Protection and Promotion Act*, R.S.O. 1990(as amended), chapter H.7, the Board of Health for the Middlesex-London Health Unit enacts Bylaw No. 2 to provide for **banking and finance.**

1. In this bylaw:

   (a) "Act" means the *Health Protection and Promotion Act*, R.S.O. 1990, as amended, Chapter H.7;

   (b) "Board" means the Board of Health for the Middlesex-London Health Unit.

2. The Board through the Secretary-Treasurer will enter into an agreement with a recognized chartered bank or trust company which will provide the following services:

   (a) a current chequing or savings account(s) for the Board;

   (b) provision for cancelled cheques on a monthly basis, together with a statement showing all debits and credits;

   (c) payment of interest at a rate to be negotiated between the Board and the bank or trust company for all surplus funds temporarily held in such account(s);

   (d) provide advice and other banking services as required by the Board.

3. The Board will maintain a formal list of names, titles, and signatures of those individuals who have signing authority.

4. Two signatures shall be required on each cheque, comprising one Board Member and the Secretary-Treasurer. These signatures shall be on a signature plate in the keeping of the Finance and Operations Manager.

5. Notwithstanding item 4 of this bylaw, signing authorities shall be restricted to the Chair of the Board of Health, Medical Officer of Health, Associate Medical Officer of Health, and Finance and Operations Manager, any two of whom may sign cheques in the absence of the Chair and/or Secretary-Treasurer.

6. The Secretary-Treasurer is hereby authorized on behalf of the Board to:

   (a) deposit or negotiate or transfer to the bank or trust company (but only for the credit of the Board) all or any cheques, promissory notes, bills of exchange or orders for payment of monies;

   (b) receive all paid cheques and vouchers and to arrange, settle, balance and certify all books and accounts at the bank or trust company;

(c) sign the bank's or trust company's form of settlement of balances and releases;

(d) receive all monies and to give acquittance for the same;

(e) invest excess or surplus funds in interest-bearing accounts or short-term deposits.

7. The Secretary-Treasurer of the Board, shall:

(a) prepare and control the Annual Budget under the jurisdiction of the Board for submission to the Board;

(b) prepare financial and operating statements for the Board in accord with established Ministry policies indicating the financial position of the Board with respect to the current operations;

(c) act as custodian of the books of account and accounting records of the Board required to be kept by the laws of the Province;

(d) in conjunction with the Auditor, arrange for an annual audit of all accounting books and records;

(e) report to the Board on all financial and banking matters;

(f) perform other duties as the Board may direct.

First Reading - February 21, 2008
Second Reading - February 21, 2008
Third Reading - February 21, 2008

Dated in London, in the Province of Ontario, on this **21st day of FEBRUARY, 2008**.

This Bylaw to be in force and effect from February 21, 2008, and to remain in force and effect until otherwise amended by enactment by the Board.

_____
Susan Eagle
Chair

_____
Graham L. Pollett
Secretary-Treasurer

MIDDLESEX-LONDON HEALTH UNIT

Board of Health: **Bylaw No. 3**

Pursuant to Section 56(1) (c) of the *Health Protection and Promotion Act*, R.S.O. 1990, c. H.7, the Board of Health for the Middlesex-London Health Unit enacts Bylaw No.3 to regulate **the proceedings of the Board of Health.**

1. In this bylaw:

   (a) "Act" means the *Health Protection and Promotion Act*;

   (b) "Board" means the Board of Health for the Middlesex-London Health Unit;

   (c) "Chair" means the person presiding at the meeting of the Board;

   (d) "Chair of the Board" means the Chairperson elected under Section 57(2) of the Act;

   (e) "City" means the Corporation of the City of London;

   (f) "County" means the Corporation of the County of Middlesex;

   (g) "Committee" means a committee of the Board, but does not include the Committee of the Whole;

   (h) "Committee of the Whole" means all the members present at a meeting of the Board sitting in Committee;

   (i) "Council" means the Council of the City of London and/or the Council of the County of Middlesex;

   (j) "Majority" means a simple majority of members present;

   (k) "Meeting" means a meeting of the Board;

   (l) "Member" means a member of the Board;

   (m) "Quorum" means a majority of the members of the Board;

   (n) "Secretary-Treasurer" means the Secretary-Treasurer of the Board.

   (o) “In-camera” means deliberations of the Board are closed to the public and the media.

1.0 General

1.1 In all the proceedings at or taken by this Board the following rules and regulations shall be observed and shall be the rules and regulations for the order and dispatch of business at the Board, and in the Committees thereof.

1.2 Except as herein provided, Robert's Rules of Order shall be followed for governing the proceedings of the Board and the conduct of its members.

1.3 A person who is not a member of the Board shall not be allowed to address the Board except upon invitation of the Chair or the members.

1.4 No persons shall smoke in the Board meeting room.

2.0 Convening Meeting

2.1 The regular meetings shall be held at a date and time as determined by the Board at its first regular meeting of the year.

2.2 The Board may, by resolution, alter the time, day or place of any meeting.

3.0 Special Meetings

3.1 A special meeting may be called by the Chair of the Board of Health.

3.2 Any three Board members by written communication to the Secretary-Treasurer may initiate a special meeting.

3.3 A special meeting shall not be summoned for a time which conflicts with a regular meeting or a meeting previously called of the Council(s) of the City of London and/or the County of Middlesex.

4.0 Notifying Board Members of Meetings

4.1 The Secretary-Treasurer shall give notice of each regular and special meeting of the Board and of each Committee to the members thereof.

4.2 The notice shall be accompanied by the "Agenda" and any other matter, so far as known, to be brought before such meeting.

4.3 The notice shall be delivered or sent by ordinary mail to the residence or place of business of each member so as to be received no later than the Friday of the week before the scheduled Board meeting.

4.4 Lack of receipt of the notice shall not effect the validity of holding the meeting or any action taken thereat.

4.5 The notice calling a special meeting of the Board shall state the business to be considered at the special meeting and no business other than that stated in the notice shall be considered at such meeting except with the unanimous consent of the Members present and voting.

5.0 Notifying the Public of Board Meetings

5.1 The Board shall give reasonable notice to the public of every of its meetings by posting in a publicly accessible location and by publishing on its website or any other print or electronic medium of mass communication:

(a) the date, time and location of the meeting;

(b) a clear, comprehensive agenda of the items to be discussed at the meeting.

5.2 If an electronic or telephone meeting is to be held, the Board will ensure that the public can exercise, without difficulty, their right to attend the meeting.

6.0 Meetings Open to the Public

6.1 The Board shall ensure that its meetings are open to the public except where a closed meeting is permitted by law. See Item 7.0 re Convening In-Camera (Closed) Meeting(s).

7.0 Convening In-Camera (Closed) Meeting(s)

7.1 Pre-requirements for in-camera sessions

Before holding a meeting or part of a meeting that is closed to he public, the Board shall state by resolution,

(a) the fact of the holding of the closed meeting and the general nature of the matter to be considered at the closed meeting; or

(b) in the case of a meeting for education or training, the fact of the holding of the closed meeting, the general nature of its subject-matter and that it is to be closed under that subsection.

7.2 Criteria for in-camera meetings

In accordance with Section 239 (2) of the *Municipal Act,* R.S.O ,as amended, a meeting or part of a meeting may be closed to the public if the subject matter being considered is:

(a) the security of the property held by the Middlesex-London Board of Health;

(b) personal matters about an identifiable individual, including Board employees;

(c) a proposed or pending acquisition of land by the Middlesex-London Board of Health;

(d) labour relations or employee negotiations;

(e) litigation or potential litigation, including matters before administrative tribunals; affecting the Middlesex-London Health Unit;

(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.

7.3 Criteria for in-camera voting

A meeting shall not be closed to the public during the taking of a vote, except:

(a) When item 7.2 permits or requires the meeting to be closed to the public; and/or

(b) The vote is for a procedural matter or for giving directions or instructions to officers, employees or agents or persons retained under contract of/with the Board.

7.4 In-camera record keeping requirements

The Board shall record without note or comment all resolutions, decisions and other proceedings at a meeting, whether it is closed to the public or not.

8.0 Preparation of the "Agenda"

8.1 The Secretary-Treasurer shall prepare for the use of members at the regular meetings the "Agenda" as follows:

(a) Call to Order and Declarations of Interest;

(b) Minutes of Previous Meeting;

(c) List of Items to be dealt with in open session including delegations;

(d) List of Items to be dealt with in-camera;

(e) Other Business from the Floor;

(f) Date of Next Meeting;

(g) Adjournment

8.2 For special meetings, the "Agenda" shall be prepared when and as the Chair may direct or, in default of such direction, as provided in the last preceding section so far as applicable.

8.3 The business of each meeting shall be taken up in the order in which it stands on the "Agenda", unless otherwise described by the Board.

9.0 Commencement of Meetings

9.1 As soon as there is a quorum after the hour fixed for the meeting, the Chair or Vice-Chair, or person appointed to act in their place and stead, shall take the chair and call the members to order.

9.2 If the person who ought to preside at any meeting does not attend by the time a quorum is present, the Secretary-Treasurer shall call the members to order and a presiding officer shall be appointed by the members present, to preside during the meeting or until the arrival of the person who ought to preside.

9.3 If there is no quorum within ten minutes after the time appointed for the meeting, the Secretary-Treasurer shall call the roll and take down the names of the members then present, and the meeting shall then adjourn until the next day of meeting unless the Board otherwise decides.

9.4 Upon any member directing the attention of the Chair, to the fact that a quorum is not present, the Secretary-Treasurer, at the request of the Chair, shall within three minutes following such request, record the names of those members present and advise the Chair if a quorum is, or is not, present.

10.0 Rules of Debate and Conduct of Members of the Board

10.1 The Chair shall preside over the conduct of the meeting, including the preservation of good order and decorum, ruling on points of order and deciding all questions relating to the orderly procedure of the meetings, subject to an appeal by any member to the Board from any ruling of the Chair.

10.2 Each delegation will be allowed a maximum of 10 minutes, but a member of the Board may introduce a delegation in addition to the speaker or speakers. Normally, a delegation will not be heard on an item unless there is a report from staff on the item.

10.3 The Board shall render its decision in each case no later than the day following the next meeting where possible.

10.4 When a member finds it impossible to attend any meeting, the onus is upon the member to advise the Secretary-Treasurer prior to the holding of such meeting, and to advise of his wishes with respect to having an agenda item tabled.

10.5 If the Chair desires to leave the chair for the purpose of taking part in the debate or otherwise, the Chair shall call on the Vice-Chair or another member in his absence, or refusal to fill his place until he resumes the chair.

10.6 Every member, previous to speaking to any question or motion, shall respectfully address the Chair.

10.7 When two or more members ask to speak, the Chair shall name the member who, in his opinion, first asked to speak.

10.8 A member may speak more than once on a question, but after speaking shall be placed at the foot of the list of members wishing to speak.

10.9 No member shall speak to the same question at any one time for longer than five minutes except that the Board upon motion therefore may grant extensions of time for speaking of up to five minutes for each time extended.

10.10 Any member may require the question or motion under discussion to be read at any time during the debate, but not so as to interrupt a member while speaking.

10.11 When a member desires to address the Board upon a matter that concerns the rights or privileges of the Board collectively or of himself as a member thereof, he shall be permitted to raise such matter of privilege, and a matter of privilege shall take precedence over other matters.

10.12 When a member desires to call attention to a violation of the rules of procedure, he shall ask leave of the Chair to raise a point of order and after leave is granted, he shall state the point of order with a concise explanation and then not speak until the Chair has decided the point of order.

10.13 Unless a member immediately appeals to the Board the decision of the Chair shall be final.

10.14 If the decision is appealed, the Board shall decide the question without debate and its decision shall be final.

10.15 When the Chair calls a member to order, he shall immediately cease speaking until the point of order is dealt with and he shall not speak again without the permission of the Chair unless to appeal the ruling of the Chair.

11.0 Motions and Order of Putting Questions

11.1 Every motion shall be deemed to be in possession of the Board for debate after it is presented by the Chair, and seconded, but may, with permission of the Board, be withdrawn at any time before amendment or decision.

11.2 When a matter is under debate, no motion shall be received other than a motion:

(a) to adopt;

(b) to amend;

(c) * to table;

(d) to refer;

(e) to receive;

(f) * to adjourn the meeting; or

(g) * that the vote be now taken.

* these items are to be voted on without debate.

11.3 A motion to refer or table shall take precedence over any other amendment.

11.4 When a motion that the vote be now taken is presented, it shall be put to a vote without debate, and, if carried by a majority vote of the members present, the motion and any amendments thereto under discussion shall be submitted to a vote forthwith without further debate.

11.5 A motion relating to a matter not within the jurisdiction of the Board shall not be in order.

12.0 Voting

12.1 Only one amendment at a time can be presented to the main motion and only one amendment can be presented to an amendment, but when the amendment to the amendment has been disposed of, another may be introduced, and when an amendment has been decided, another may be introduced.

12.2 The amendment to the amendment, if any, shall be voted on first, then if no other amendment to the amendment is presented, the amendment shall be voted on next, then if no other amendment is introduced, the main motion, or if any amendment has carried, the main motion as amended, shall be put to a vote.

12.3 Nothing in this section shall prevent other proposed amendments being read for the information of the members.

12.4 When the question under consideration contains distinct propositions, upon the request of any member, the vote upon each proposition shall be taken separately.

12.5 After the Chair commences to take a vote, no member shall speak to or present another motion until the vote has been taken on such motion, amendment or subamendment.

12.6 Every member present at a meeting of the Board when a vote is taken on a matter shall vote thereon unless prohibited by statute; and, if any member present persists in refusing to vote, he shall be deemed as voting in the negative.

12.7 If a member disagrees with the announcement by the Chair of the result of any vote, he may object immediately to the Chair's declaration and require that the vote be retaken.

12.8 After any matter has been decided, any member may move for a reconsideration at the same meeting or may give notice of a motion for reconsideration of the matter for a subsequent meeting in the same year, but no discussion of the question that has been decided shall be allowed until the motion for reconsideration has carried, and no matter shall be reconsidered more than once in the same calendar year.

13.0 Minutes

13.1 Minutes shall be taken at all regular and special meetings by the Secretary-Treasurer/Designate.

13.2 The names of all Board members and Health Unit employees who attend the meeting shall be recorded.

13.3 All Board motions shall become effective immediately upon approval, unless otherwise stated. All approved and defeated motions shall be recorded.

13.4 There shall be a motion to approve the minutes or amended minutes of each Board meeting.

13.5 All Board of Health minutes shall be ratified by signature of the Board Chair and Secretary-Treasurer.

14.0 Adjournment

14.1 A motion to adjourn the Board Meeting or adjourn the debate shall be in order, except:

(a) when a member is in possession of the floor;

(b) when it has been decided that the vote be now taken;

(c) during the taking of the vote; but no second motion to the same effect shall be made until after some intermediate proceedings shall have taken place.

15.0 Communications

15.1 Every communication intended to be presented to the Board must be written dated and signed.

15.2 Every such communication shall be delivered to the Secretary-Treasurer before the commencement of the meeting of the Board.

16.0 Proceedings on Bylaws

16.1 Every bylaw shall be introduced by a member upon motion for leave specifying the title of the bylaw, and a bylaw shall not be in form blank or incomplete.

16.2 Every bylaw shall receive three readings at different meetings before being passed, except that the Board may by a majority vote provide for two or more readings at one meeting.

16.3The question "shall this bylaw be now read for a first time" shall be decided without amendment or debate.

16.4Every bylaw may be considered by the Committee of the Whole after the second reading thereof.

16.5All amendments made in the Committee of the Whole shall be reported by the Chair thereof to the Board which shall receive the same forthwith without debate.

16.6The Secretary-Treasurer shall endorse on all bylaws read at the Board the dates of the several readings and of the passing thereof and shall be responsible for the correctness of such bills should they be amended.

16.7Every bylaw which has been passed by the Board shall be sealed with the seal of the Board, signed by the Chair of the Board or by the Chair of the meeting at which the bylaw was passed and by the Secretary-Treasurer and deposited with the Secretary-Treasurer for custody.

16.8All bylaws adopted by the Board shall be kept in a separate volume.

17.0 Secretary-Treasurer and Board Solicitor

17.1 It shall be the duty of the Secretary-Treasurer:

(a) to attend or cause an assistant to attend all meetings of the Board;

(b) to keep or cause to be kept full and accurate minutes of the meetings of all the Board meetings, text of Bylaws and Resolutions passed by it;

(d) to forward a copy of all resolutions, enactments and orders of the Board to those concerned in order to give effect to the same; and

(e) to forward all reports of the Board requiring City/County Council approval to the appropriate official so that the same may be considered by the Council at the next regular meeting.

17.2 It shall be the duty of the Board Solicitor:

(a) To examine reports of the Board on request and to report whenever any matter contained therein is beyond the power of the Board or otherwise illegal.

(b) To advise the Board and Committees as to the legality of all matters considered by the same bodies of which he shall have notice.

(c) To act on other matters as decided by the Board.

18.0 Elections and Appointment of Committees

18.1At the first meeting of each calendar year the Board shall elect by a majority vote a Chair and a Vice-Chair for that year.

18.2The Chair of the Board shall rotate on an annual basis to one of the representatives of the City of London, the County of Middlesex, and the Province of Ontario.

18.3At the first meeting of each calendar year the Board shall appoint the representative or representatives required to be appointed annually at the first meeting by the Board to other boards, bodies, or commissions where appropriate.

18.4 The Board may appoint committees from time to time to consider such matters as specified by the Board(e.g. Human Resources, Planning, etc.).

19.0 Conduct of Business in Committees

19.1The rules governing the proceedings of the Board shall be observed in the Committees insofar as applicable.

19.2It shall be the duty of the Committee:

(a) to report to the Board on all matters referred to them and to recommend such action as they deem necessary;

(b) to forward to the Board the minutes of meetings;

(c) to forward to the incoming Committee for the following year any matter undisposed of.

19.3The procedures of the Board with respect to:

(a) incurring of liabilities and paying of accounts;

(b) contracts and expenditures;

(c) petty cash;

(d) tenders and quotations;

shall be in accordance with the Agreement.

20.0**Corporate Seal**

20.1The corporate seal of the Board shall be in the form impressed hereon and shall be kept by the Executive Officer or the Secretary-Treasurer of the Board.

21.0Execution of Documents

21.1The Board may at any time and from time to time direct the manner in which and the person or persons who may sign on behalf of the Board and affix the corporate seal to any particular contract, arrangements, conveyance, mortgage, obligation, or other document or any class of contracts, arrangements, bylaw, conveyances, mortgages, obligations or documents.

22.0Duties of Officers

22.1The Chair of the Board shall:

(a) preside at all meetings of the Board;

(b) represent the Board at public or official functions or designate another Board member to do so;

(c) be ex-officio a member of all Committees to which he has not been named a member;

(d) perform such other duties as may from time to time be determined by the Board.

22.2 The Vice-Chair shall have all the powers and perform all the duties of the Chair in the absence or disability of the Chair, together with such powers and duties, if any, as may be from time to time assigned by the Board.

23.0 Amendments

23.1 Any provision contained therein may be repealed, amended or varied, and additions may be made to this bylaw by a majority vote.

24.0 **General**

24.1 In this bylaw, words importing the singular number or the masculine gender only shall include more persons, parties or things of the same kind than one and females as well as males and the converse.

First Reading - February 21, 2008
Second Reading - February 21, 2008
Third Reading - February 21, 2008

This Bylaw to be in force and effect from February 21, 2008, and to remain in force and effect until otherwise amended by enactment by the Board.

Executed in London, in the Province of Ontario, on this **21st day of FEBRUARY, 2008**.

_____
Susan Eagle
Chair

_____
Graham L. Pollett
Secretary-Treasurer

MIDDLESEX-LONDON HEALTH UNIT

Board of Health: **Bylaw No. 4**

Pursuant to Section 56(1)(d) of the *Health Protection and Promotion Act*, R.S.O. 1990, c. H.7, the Board of Health for the Middlesex-London Health Unit enacts Bylaw No. 4 to provide for the **duties of the Auditor** of the Board of Health, namely:

1. (a) The Board shall appoint an Auditor who shall not be a member of the Board and shall be licensed under the *Public Accountancy Act,* R.S.O. 1990, c. P.37.

   (b) The Auditor shall be the same Auditor as the City of London may from time to time appoint.

2. The Auditor shall:

   (a) audit the accounts and transactions of the Board of Health;

   (b) perform such duties as are prescribed by the Ministry of Municipal Affairs and Housing with respect to local boards under the *Municipal Act*, S.O. 2001, c. 25 and the *Municipal Affairs Act*, R.S.O. 1990, c. 25;

   (c) perform such other duties as may be required by the Board that do not conflict with the duties prescribed by the Ministry of Municipal Affairs and Housing as set out in clause (b) of this bylaw;

   (d) have a right of access at all reasonable hours to all books, records, documents, accounts and vouchers of the Board and is entitled to require from the members of the Board and from the Officers of the Board such information and explanation as in his/her opinion may be necessary to enable him/her to carry out such duties as are prescribed by the Ministry of Municipal Affairs and Housing and under the *Health Protection and Promotion Act*.

First Reading - February 21, 2008
Second Reading - February 21, 2008
Third Reading - February 21, 2008

This Bylaw to be in force and effect from February 21, 2008, and to remain in force and effect until otherwise amended by enactment by the Board.

Executed in London, in the Province of Ontario, on this **21st day of FEBRUARY, 2008**.

_____
Susan Eagle
Chair

_____
Graham L. Pollett
Secretary-Treasurer

MIDDLESEX-LONDON HEALTH UNIT

Board of Health: BYLAW No. 5

Being a Bylaw to designate a head of the Middlesex-London Board of Health for the purposes of the ***Municipal Freedom of Information and Protection of Privacy Act***, R.S.O. 1990 (as amended), c. M. 56.

WHEREAS under Section 3(1) of the *Municipal Freedom of Information and Protection of Privacy Act*, the Board may by bylaw designate from among its members an individual or a committee of the Board to act as head of the Middlesex-London Board of Health for the purposes of the Act;

AND WHEREAS the Board deems it necessary and expedient to designate a head for the purposes of the Act;

NOW THEREFORE THE MIDDLESEX-LONDON BOARD OF HEALTH ENACTS AS FOLLOWS:

1. The Chair of the Board to be designated as "Head" for the purposes of the *Municipal Freedom of Information and Protection of Privacy Act*.

2. The Chair of the Board to provide for all other institutional requirements regarding access and privacy as set out in *the* ***Municipal Freedom of Information and Protection of Privacy Act*** and the ***Personal Health Information and Protection Act 2004,*** *R.S.O. 2004*, c.3 Sched. 4.

First Reading - February 21, 2008
Second Reading - February 21, 2008
Third Reading - February 21, 2008

This Bylaw to be in force and effect from February 21, 2008, and to remain in force and effect until otherwise amended by enactment by the Board.

Executed in London, in the Province of Ontario, on this **21st day of FEBRUARY, 2008.**

_____
Susan Eagle
Chair

_____
Graham L. Pollett
Secretary-Treasurer

BOARD OF HEALTH DESIGNATION OF "HEAD" FOR THE PURPOSES OF THE
MUNICIPAL FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT

I, **Susan Eagle**, Chair of the Middlesex-London Board of Health, having been designated "Head" per Board of Health Bylaw No. 5 for the purposes of the *Municipal Freedom of Information and Protection of Privacy Act*, R.S.O. 1990, c. M. 56, delegate all powers and duties under the Act to the Medical Officer of Health and Chief Executive Officer of the Middlesex-London Health Unit. I understand that as "Head" for the purposes of the Act, I remain accountable for actions taken and decisions made under the Act.

Executed in London, in the Province of Ontario, on this **21st day of FEBRUARY, 2008.**

This designation to be in force and effect from February 21, 2008, and remain in force and effect until otherwise amended by the Board of Health.

_____

Susan Eagle
Chair

MIDDLESEX-LONDON HEALTH UNIT

MIDDLESEX-LONDON HEALTH UNIT

ADMINISTRATION MANUAL

SUBJECT: **STRUCTURE AND RESPONSIBILITIES OF THE BOARD OF HEALTH** **POLICY NUMBER: 2-010**

SECTION: Board of Health Page 1 of 3

IMPLEMENTATION DATE: July 8, 1992 **APPROVED BY:** Board of Health
REVISION DATE: June 1, 1995 **SIGNATURE:**
December 18, 1996
July 20, 2000
November 18, 2004
June 21, 2006 (Directors Committee)
2008 October 16 (Board of Health)
2010 January 21 (Board of Health)
2010 November 18 (Board of Health)

PURPOSE

To outline the structure and responsibilities of the Board of Health.

POLICY

The Board of Health is an autonomous body responsible for the governance of the Health Unit in accordance with Section 49 (1), (2), (3) of the *Health Protection and Promotion Act (HPPA)*, R.S.O.1990 as amended, which outlines the composition of boards of health and R.R.O. 1990, Regulation 559 re Designation of Municipal Members of Boards of Health

The Board of Health will serve as an advocacy body for public health.

PROCEDURE

1.0 Board of Health Structure

1.1 Board of Health Appointments

The Board of Health consists of municipal and provincial appointees. Each member's term of office is determined by the appointing body.

The number of Board members and their representation is as follows:

- City of London – 3 appointees
- County of Middlesex – 3 appointees
- Province of Ontario – 5 appointees

1.2 Vacancies and Re-appointments

Vacancies on the Board will be filled by appointment by the body represented, that is the municipality or province.

Terms of office for provincial appointees may be renewed by applying to the Public Appointments Unit of the Ministry of Health and Long-Term Care. **Appendix B, Provincial Appointee Reappointment Process**, will be followed with respect to reappointment of provincially appointed board members.

1.3 Committee Structure

Each year at its inaugural meeting, the Board will:

i. Elect a Chair, Vice Chair and Secretary-Treasurer

ii. Decide whether to operate as a committee of the whole or whether to establish standing committees.

The Chair of the Board rotates on an annual basis to one of the appointees of the County of Middlesex, the City of London or the Province of Ontario.

The Board will enact bylaws (See **APPENDIX A**) to provide for the management of property; banking and finance; Board of Health proceedings; the duties of the Auditor and power designation related to the Municipal Freedom of Information and Protection of Privacy Act.

Bylaws will be reviewed by the Board of Health in the calendar year following a municipal election (every four years).

2.0 Responsibilities

The Board of Health oversees the interpretation, implementation, management and advocacy for the health programs and services described in the HPPA for persons in the City of London and County of Middlesex.

The Board of Health is accountable to the Minister of Health and Long-Term Care for interpretation of policies, the local administration and implementation of public health programs. The Board of Health appoints a Medical Officer of Health (MOH) who has been approved by the Minister of Health and Long-Term Care. The Board delegates responsibility to administer these programs to the MOH in his/her capacity as the Executive Officer (HPPA, 1990, S.67(1)). The MOH reports regularly to the Board at monthly meetings on the conduct of the programs of the Board.

Individual Board members will represent the decision of the Board of Health to their respective appointing bodies. The Board of Health advocates for the health unit, which includes programs and services, budgetary issues and broader public health issues.

3.0 Access to the Board of Health

The Medical Officer of Health (MOH)/CEO prepares the agenda for all Board meetings. Requests for community or staff presentations to the Board are made to the MOH.

Directors may attend all Board of Health meetings.

Agendas, reports and minutes of all regularly scheduled meetings of the Board are available to all staff and the public and are posted to the Health Unit website at the universal resource locator (URL) of www.healthunit.com.

Board meetings are open to the public. Whenever practicable, the Board of Health will provide appropriate alternate means of public attendance at Board meetings, including but not limited to internet streaming of meetings through the Health Unit website, www.healthunit.com. Further details regarding public presentations to the Board are documented under Bylaw No. 3 (See **APPENDIX A**).

The Board of Health believes that physical presence of members at meetings greatly enhances its deliberations. Physical attendance is therefore the desirable, usual and expected method of participation in meetings. However, the Board also recognizes the usefulness and effectiveness of providing for electronic meetings and electronic participation in Board meetings by individual board members. Electronic participation at regularly scheduled board meetings is at the discretion of the Chair and is considered an exceptional measure intended to cater for unavoidable conflicts and emergencies.

Board meetings may also be conducted electronically (i.e., by videoconference or teleconference) where time or circumstances make this a better means of conducting Board of Health business, provided that the proceedings ensure public access and otherwise comply with the provisions of Board of Health By-law No.3. (See APPENDIX A, Middlesex-London Board of Health By-laws). At the subsequent meeting of the Board of Health after any meeting(s) that had been held by teleconference or video conference, the Board will approve the minutes of any preceding electronic meeting(s).*

Further details regarding electronic participation in Board meetings are documented in APPENDIX C, Electronic Participation in Board Meetings.

*** A meeting is determined to have been conducted electronically when a majority of board members in attendance are not physically present.**

Appendix E

PROPOSED MIDDLESEX-LONDON BOARD OF HEALTH
MEETING DATES FOR 2011

DATE OF MEETING		
January	20	
February	17	
March	17	(Week of March break for the School Boards)
April	21	
May	19	
June	16	
July		(at call of Chair)
August		(at call of Chair)
September	15	
October	20	
November	17	
December	8	(Early due to Year End Holidays)

MIDDLESEX-LONDON HEALTH UNIT
www.healthunit.com

Appendix B
To Policy 2-10

Provincial Appointee Reappointment Process

Purpose and Application

The purpose of this procedure is to set the requirements, criteria and process for Board of Health reappointment requests. This procedure applies to provincially appointed Board of Health members whose terms of appointment are expiring within six months.

Notification

Incumbent appointees who are eligible for reappointment will notify the Chair of their intentions with respect to requesting reappointment not less than six months prior to the expiration of their term. The Secretary-Treasurer of the Board will provide a listing of all Board Members with term expiration dates annually, usually at the first meeting of the year.

Term of Appointment

The term of appointment for provincial appointees is set by the Public Appointments Secretariat and may be for one, two or three years. The term of appointment for a municipal appointee is the term of office of the council unless otherwise specified by the Council.

Criteria to be Considered

In considering the reappointment endorsement/recommendation, the Board of Health will consider:

a) Commitment to the Mission, Vision and goals of the Middlesex-London Health Unit (MLHU)
b) Commitment to and an understanding of the policies and programs of the MLHU
c) Ability to work collegially with other Board Members and the Medical Officer of Health/CEO
d) Representation of MLHU in the community
e) Regularity of attendance at Board of Health meetings
f) Participation in and contribution at Board of Health meetings
g) Ability to make a continued commitment to monthly involvement in Board of Health meetings and related activities.

Limits on Consecutive Length of Service

Acknowledging the value of experience and the need for continuity, as well as the benefits of new and fresh perspectives on the Board of Health, incumbents may seek reappointment, subject to the following limits on length of service:

A Board of Health member who has served eight (8) or more years may only be considered for endorsement/recommendation for an additional term under special circumstances, such as

a) When an insufficient number of new appointments have been received, or
b) Reappointment requests from incumbents who are eligible to be re-appointed are insufficient, and the Board would suffer from a lack of continuity.

Any recommendation to reappoint an incumbent shall identify these special circumstances and recommend a waiver of the limit on length of service.

Consideration of Reappointment Requests

The Board of Health will consider endorsements/recommendations relating to Board reappointment in a closed session, under **Board of Health: Bylaw No. 3**, section 7.2, Criteria for in-camera meetings, subsection (b) personal matters about an identifiable individual, including Board employees.

The Board members will absent themselves from the portion of the session during which their reappointment request is considered. The remaining members may, at their discretion, request the member to return to provide information or answer questions. A motion regarding endorsement/recommendation, if any, will be made in camera.

Letter of Endorsement/Recommendation

The Chair will submit a letter of endorsement by regular mail addressed to the Minister of Health and Long Term Care listing the names of all interested appointees that are being supported for reappointment along with the completed *Reappointment Information Form(s)* to

The Ministry of Health and Long Term Care
10th Floor Hepburn Block, 80 Grosvenor Street
Toronto, ON M7A 2C4

Or by email or fax to
Minister's Special Assistant for Public Appointments
Fax: 416-326-1571

A copy of all above-mentioned documentation must also be sent to the Manager, Public Appointments Unit, Ministry of Health and Long Term Care, by fax to 416-327-8496 or by email.

MIDDLESEX-LONDON HEALTH UNIT

Middlesex-London Board of Health (BOH)
Date of Member Appointments/Expirations

	Name of Board Member	Appointed By	First Appointed to BOH	Expiration Date
1	Dr. Francine Lortie-Monette	Province of Ontario	February 3, 2006	February 2, 2012
2	Ms. Viola Poletes Montgomery	Province of Ontario	March 1, 2006	February 29, 2012
3	Mr. Mark Studenny	Province of Ontario	April 11, 2006	April 10, 2012
4	Ms. Doreen McLinchey	Province of Ontario	August 11, 2004	August 10, 2012
5	Ms. Nancy Poole	Province of Ontario	July 28, 2010	July 27, 2013
6	Ms. Patricia Coderre	City of London - Community Appointee	December 1, 2006	November 30, 2014
7	Ms. Denise Brown	City of London	December 1, 2010	November 30, 2014
8	Mr. Joe Swan	City of London	December 1, 2010	November 30, 2014
9	Mr. Al Edmondson	County of Middlesex	December 1, 2002	December 31, 2014
10	Mr. Marcel Meyer	County of Middlesex	January 1, 2011	December 31, 2014
11	Mr. Don Shipway	County of Middlesex	January 1, 2011	December 31, 2014

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 002-11

TO: Chair and Members of the Board of Health

FROM: Graham L. Pollett, MD, FRCPC
Medical Officer of Health

DATE: 2011 January 20

2011 BUDGET

Recommendation

It is recommended that the Board of Health approve the 2011 Mandatory & Related Programs budget (Cost-Shared Programs) at the net amount of $22,424,593 representing an increase of $215,580.

Background

Each year the Board of Health reviews and approves the Health Unit's Cost-Shared Programs budget. This budget accounts for approximately 75% of the total Board of Health net expenditures. The remaining 25% of net expenditures are made up of 100% programs. The Mandatory & Related Programs budget is cost-shared between the Ministry of Health & Long-Term Care (MOHLTC), Ministry of Health Promotion and Sport (MHPS), City of London, and County of Middlesex.

Consistent with past practice, the City of London's budget submission is the first required of the funding agencies. Table 1 below, summarizes the relevant steps in the City's budget process and the anticipated completion dates.

Table 1 – 2011 City of London Budget Timetable

	Due Date
Financial Planning & Policy Technical Review	October 22nd , 2010
Tabling of the City of London Budget to Board of Control	December 20th , 2010
Budget Orientation and Strategic Planning	January 25th , 2011
Public Participation Sessions	February 2nd , 2011
Committee of the Whole	February 16th , 2011
Council Approval	February 28th , 2011

2011 Cost-Shared Programs Budget

Senior management, in preparing this budget, was guided by the following:

1) Current economic environment – In the province's 2010/11 budget, it announced a variety of restraint measures to contain costs. Earlier in the Fall of 2010, provincial staff indicated that health units should expect no more than a 1.5% increase for mandatory programs. Accordingly, the proposed budget includes a 1.5% increase to the provincial share.

2) Board of Health's commitment to maintain the municipal funding at the 2004 level or a 0% increase over 2010 funding amount.

It can be seen from Table 2 (Appendix A) that these assumptions would yield an additional $215,580 in provincial grants or an increase of 1.0% over the 2010 net budget for Mandatory Programs. In addition, the Vector Borne Disease program would receive no increase in funding over the amount provided in 2010. Table 3 (Appendix A) provides the 2011 net budget by funding body.

Table 4 (Appendix A) provides an overview of budget changes for cost-shared programs across the entire organization. It can be seen that the increase is needed primarily to fund anticipated changes in pension and employment insurance costs, job reclassifications, and equipment related costs.

Subsequent Events

Since the development of the budget, there have been a number of events that may impact the final outcome of the 2011 budget, namely:

1) Municipal Elections – initial budget targets provided to City departments and boards/commissions may be altered to achieve an overall 0% increase in municipal taxes.

2) New Provincial programs/funding – at the end of 2010, there were a number of funding announcements that potentially could impact this budget.

3) Contract Negotiations – Both Ontario Nurses Association (ONA) and Canadian Union of Public Employees (CUPE) contract negotiations are still underway.

The outcomes of the above events may prompt further budget adjustments prior to the budget submission to the province this spring. Staff will endeavor to keep the Board of Health apprised of these and all events affecting the operating budget.

Summary

The 2011 cost-shared budget has been prepared on the assumption that the Board of Health will receive a 1.5% increase in the provincial share of the cost-shared programs, with a 0% increase to the municipal component. Under this scenario, the anticipated changes to pension and employment insurance costs, and job reclassifications can be accommodated, along with some marginal software charges.

Mr. John Millson, Director, Finance and Operations, will make a budget presentation at the January 20, 2011, Board of Health meeting.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

Appendix A

Table 2 – 2011 Gross Cost Shared Budget – By Program

	2010 Board of Health Approved Budget	2011 Budget	Increase / (Decrease)
Mandatory Programs (67:33)	$ 21,593,057	$ 21,808,637	$ 215,580
Vector Borne Disease (75:25)	615,956	615,956	0
Total Cost Shared	**$ 22,209,013**	**$ 22,424,593**	**$ 215,580**

Table 3 – 2011 Cost Shared Budget – By Funding Body

	Total	Province	City	County
Mandatory Programs	$ 21,808,637	$ 14,587,556	$ 6,065,708	$ 1,155,373
Vector Borne Disease	615,956	461,967	129,351	24,638
2011 Total Cost Shared	**$ 22,424,593**	**$ 15,049,523**	**$ 6,195,059**	**$ 1,180,011**
2010 Total Cost Shared	**$ 22,209,013**	**$ 14,833,943**	**$ 6,195,059**	**$ 1,180,011**
Increase/(Decrease)	**$ 215,580**	**$ 215,580**	**$ 0**	**$ 0**

Table 4 – Overview of 2011 Budget Changes

Description	2011 Increase/(Decrease)
• Salaries and benefits as a result of: 1) Increase in pension benefits (OMERS & CPP = $144,000) 2) Increase in Employment Insurance costs. ($12,000) 3) Job reclassifications ($35,000)	$ 191,580
• Computer software costs relating to the Food Safety program and e-learning	$ 24,000
Total Increase over 2010 Budget	**$ 215,580**

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 003-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 January 20

Healthy Living Champions Award 2009-2010 and Healthy School Celebration

Recommendation
It is recommended that Report No. 003-11 re Healthy Living Champions Award be forwarded to the Thames Valley District School Board, the London and District Catholic School Board, the Conseil Scolaire de District du Centre-Sud-Ouest and the private schools.

Background
Schools have a significant impact on the health behaviours and outcomes of children and youth. Schools can play a key role in supporting students' health and wellbeing, and by extension, the health of families and communities. In Ontario, it has been demonstrated that an increased focus on students' health in schools leads to positive changes in academic performance, as measured by Education Quality and Accountability Office (EQAO) test scores.

In an effort to create healthier school environments and to address childhood overweight and obesity, the Healthy Living Champions Award was introduced to elementary schools in Middlesex-London in 2007. This award recognizes elementary schools in London and Middlesex County for their commitment to promoting physical activity and healthy eating. The Award is based on the Ministry of Education's 'Foundations for a Healthy School' framework. The framework addresses the components of Comprehensive School Health, which include: 1) High Quality Instruction and Programs, 2) Healthy Physical Environment, 3) Supportive Social Environment, and 4) Community Partnerships. In the 2009/2010 school year, the Healthy Living Champions Award included strategies to promote physical activity and healthy eating under each of these categories. To be eligible for the Award, schools needed to earn a minimum of 4000 points in both the physical activity and healthy eating categories. The Award levels included Gold (20,000 + points), Silver (15,000 + points) and Bronze (10,000 + points).

Participation
For the 2009/2010 school year, 78 of the 147 elementary schools in Middlesex-London were successful in receiving the Healthy Living Champions Award; this represents a little over 50% of schools participating in the Award. Of the 78 schools that were successful, 45 of these schools were from the Thames Valley District School Board (TVDSB); 23 were from the London District Catholic School Board (LDCSB); 7 were Private and 3 were French first language from the Conseil Scolaire de District du Centre-Sud-Ouest (Appendix A). Of the 78 schools that received the Award, 51 received Gold, 18 received Silver and 9 received Bronze. Successful schools represented various socioeconomic status and geographic areas of London and Middlesex County.

Programming Related to Healthy Living Champions Award
The Healthy Living Champions Award encourages schools to promote healthy eating and physical activity. The Award criteria list activities that schools can engage in, such as: the 'Big Crunch', 'Eating Through the Alphabet', non-food item fundraising, intramural physical activities and staff role-modeling. Schools often develop their own creative strategies, engaging in campaigns and activities such as a family barn dance, 'Lunch Bunch' cooking club, 'Boot Camp', a 'Snow Tower' contest, and aerobic dance classes at lunch.

Over 100 people were involved in documenting school activities that met the award criteria. This Award is truly an example of students, staff, administration, parents, and public health professionals working collaboratively to create a healthier school setting to improve educational and health outcomes for children and youth.

Recognition
The Child Health Team hosted a Healthy Schools 15th Anniversary and 2010 Healthy Living Champions Award Winners Celebration at the TVDSB Main Office. All schools in Middlesex-London were invited to attend the celebration, regardless of whether or not they had a Healthy School Committee or had participated in the Healthy Living Champions Award. Healthy School Committees were recognized for the important work they do and Healthy Living Champion Award Winners were recognized for their accomplishments with a plaque and monetary incentive that reflected the schools' level of achievement. For the first time, staff was also able to provide each winning school with a collection of physical activity

equipment. During the celebration, schools were given the opportunity to network and share success stories, allowing schools to recognize that there are many strategies to promote a healthy school environment. The afternoon was a great success with over 70 teachers, administrators, parents, students, and public health practitioners in attendance.

Funding

The Healthy Living Partnership Middlesex-London has provided financial assistance in past years; however, this was the last year that they are able to support the Award due to a change in direction from the province. For 2009/2010, the Healthy Living Champions Award Committee was extremely pleased to receive support from three new funders. First time funding was gratefully received from London Life – The Key to Giving, TVDSB, and LDCSB.

Conclusion

The Healthy Living Champions Award encourages elementary schools to enhance their school environments to better support children to engage in physical activity and make healthier food choices. The Award creates partnerships between schools and community agencies and can improve student outcomes. The Award is growing - the number of participating schools continues to increase, and Award content and criteria are expanding. For 2010/2011, safety and dental health (as they relate to healthy eating and physical activity) have been added to the Award criteria, and further modifications of the Award are expected for 2011/2012.

This report was prepared by Christine Callaghan, Public Health Dietitian, Family Health Services; Denise Walsh, Public Health Nurse, Child Health Team; and Heather Lokko, Manager, Child Health Team.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards: Chronic Disease Standard 3 and 11, Child Health Standard 4, 5 and the Foundational Standard.

Healthy Living Champions

Congratulations to the 2010 Award Winners!

GOLD

Académie de la Tamise
Al-Taqwa Islamic School
Ashley Oaks Public School
Blessed Kateri Catholic School
Blessed Sacrament Catholic School
Brick Street Public School
Byron Woods Montessori
Caradoc North Public School
Chippewa Public School
Clara Brenton Public School
Eagle Heights Public School
East Williams Memorial Public School
École Sainte-Jeanne d'Arc
Evelyn Harrison Public School
F.D. Roosevelt Public School
Holy Family Catholic School
Jack Chambers Public School
Jean Vanier Catholic School
London Islamic School
Lord Elgin Public School
Lorne Avenue Public School
M.B. McEachren Public School
Matthews Hall
Montessori House of Children
Notre Dame Catholic School
Our Lady Immaculate Catholic School
Our Lady of Lourdes Catholic School
Oxbow Public School
Parkhill-West Williams Public School
Riverside Public School
Sir Arthur Carty Catholic School
St. Anne Catholic School
St. Anthony Catholic French Immersion School
St. Catherine of Siena Catholic School
St. Charles Catholic School
St. David Catholic School
St. Francis Catholic School
St. George Catholic School
St. George's Public School
St. John French Immersion Catholic School
St. Patrick Catholic School
St. Paul Catholic School
St. Theresa Catholic School
St. Vincent de Paul Catholic School
Victoria Public School
Victory Christian Academy
Westdale Public School
Westminster Central Public School
White Oaks Public School
Wilberforce Public School
Wilfrid Jury Public School

SILVER

Adelaide-W.G. MacDonald Public School
A. E. Duffield Public School
Bishop Townshend Public School
Caradoc Central Public School
Delaware Central Pubic School
Glen Cairn Public School
Huron Heights Public School
Mosa Central Public School
Northbrae Public School
Northridge Public School
Orchard Park Public School
Sir Isaac Brock Public School
Sir John A. MacDonald Public School
St. Marguerite d'Youville Catholic School
St. Robert Catholic School
St. Sebastian Catholic School
Tecumseh Public School
Wilton Grove Public School

BRONZE

Caradoc South Public School
Ealing Public School
École Marie-Curie
Kensal Park French Immersion Public School
Masonville Public School
North Meadows Public School
Strathroy Community Christian School
Tweedsmuir Public School
Westmount Public School

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MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 004-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 January 20

Record Retention Schedule

Recommendation
It is recommended that the Board of Health approve the proposed Record Retention Schedule (Appendix A).

Background
The Health Unit is updating its Records and Information Management Program to ensure that the program is compliant with public health standards, legislation or where no legislative requirements exist, best practices are followed. The overall goals of such a program are to:

- Ensure efficiency and accountability by facilitating the timely retrieval of information
- Provide consistent direction through the lifecycle of a record from creation to disposition, and
- Meet Freedom of Information and privacy requirements.

Defining a Record
A record is defined as any recorded information however recorded, whether in printed form, on film, by electronic means or otherwise, including correspondence, memoranda, plans, maps, drawings, graphic works, photographs, film, microfilm, sound recordings, videotapes, machine readable records and any documentary material regardless of physical form or characteristics.

Record Retention Schedule
The Retention Schedule, which itemizes the different types of records held by an organization, specifies how long records must be kept. The schedule is a key component of a Records and Information Management Program. Some records such as Board of Health minutes must be retained permanently; others for a specified period or only for as long as the information is relevant.

Records that contain confidential or personal/health information are shredded, while others may be destroyed without shredding. The schedule applies to both paper and electronic records. Protocols to ensure the destruction of electronic records will be developed.

The updated Retention Schedule (Appendix A) was developed following a review of Retention Schedules from eight Ontario health units and builds heavily on the work of the Sudbury & District Health Unit (SDHU). SDHU has granted staff permission to use and to modify their work to meet the needs of MLHU. Appendix A has been vetted by Directors Committee and Managers and is recommended to replace Schedule A (Appendix B), which is part of Policy 6-030, a Board of Health approved policy.

The Retention Schedule is a critical document in advancing the Records and Information Management Program. The schedule will allow staff to review its current holdings as well as inactive records that are housed in the basement of 50 King Street and off site at Command Services. Such actions are intended to ensure records are retained only for as long as necessary. This will decrease on site storage requirements as well as the cost of storing records off site that have exceeded their destruction date.

Approval of the proposed Retention Schedule will allow this work to proceed while other components of the Records and Information Management Program are being updated. Staff orientation will be planned to ensure a consistent and successful implementation of the schedule.

Retention Schedules are considered “ever green” documents in that the schedule needs to be monitored on a regular basis and some changes are expected as the document is used in practice.

Future Developments
The proposed Retention Schedule is currently organized under general headings. These headings will be refined in the coming weeks; such edits are not expected to affect the retention periods. Other sections of Policy 6-030 “Health Unit Records – Establishment, Security, Retention Schedules & Disposal” will be updated for the Board’s consideration at a future meeting.

This report was prepared by Ms. Charlene Beynon, Manager, Special Projects-Records Management, Office of the Medical Officer of Health.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

This report addresses the Information Management requirement in the draft Ontario Public Health Organizational Standards and requirements of the Ontario Council of Community Health Accreditation.

Appendices available upon request.

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 005-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 January 20

Medical Officer of Health Activity Report – January

Recommendation
It is recommended that Report No. 005-11 re Medical Officer of Health Activity Report – January be received for information.

The following report highlights activities of the Medical Officer of Health since the last Board of Health meeting.

December 2010 will be known as the "Snow Month" given the record amount of snow which fell in the Middlesex-London area and the havoc it wreaked. In addition to the closure of the 402 Highway between London and Sarnia for a number of days, the Health Unit was closed an unprecedented four days (December 6, 7, 8, 15). In addition the Strathroy office was closed the afternoon of December 13th. Both Middlesex County and Lambton County Councils declared emergencies. The Medical Officer of Health participated in a number of teleconference meetings of the Middlesex County Community Control Group. This overall experience provided an opportunity to implement the Health Unit's Adverse Weather Protocol which proved most useful. In a follow-up review, Directors identified a number of areas to strengthen the protocol, and these changes have been made.

The Strategic Planning process is well underway. Seven Staff Discovery Sessions involving 120 staff have been held. Approximately 90 feedback surveys from Community Partners have been received, and the Client Survey component of the process began January 10, 2011. Advertisements have been placed in City and County newspapers. Business cards were prepared which highlight the Client Survey web address. These cards are being distributed by staff as they interact with clients in the community. The Client Survey Tool has been translated into seven languages. A Board of Health Discovery Session was held January 11.

Other meetings involving the Medical Officer of Health since the last Board of Health meeting included: Attendance at the inaugural meeting of Middlesex County Council at which Strathroy-Caradoc Mayor Joanne Vanderheyden was re-elected Warden; Board of Health orientation sessions for new Board members Ms. Denise Brown, Mr. Don Shipway and Mr. Marcel Meyer; participation in a Middlesex Municipal Association executive teleconference; presentation to Middlesex Centre County Council (together with Mr. Jim Reffle and Mr. Dave White), on the introduction of the Food Premises Inspection Disclosure System (DineSafe - Middlesex-London); attendance at the Thames Valley District School Board Anti-Bullying Taskforce meeting; attendance at the Regional HIV/AIDS Connection Board Meeting; and attendance at the 9th Canadian Immunization Conference.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 006-11

TO: Chair and Members of the Board of Health

FROM: Graham L. Pollett, MD, FRCPC
Medical Officer of Health

DATE: 2011 January 20

THE EARLY YEARS: CRITICAL TO THE FUTURE

Recommendation

It is recommended that Report No. 006-11 re The Early Years: Critical to the Future be received for information.

Background

This report provides an outline of current initiatives to help children achieve their developmental potential. Included is an overview of the provincial recommendations regarding the Enhanced 18-Month Well-Baby Visit and highlights of the local Early ID Strategy implemented by the Health Unit in collaboration with physician champions and community partners.

The skills necessary to achieve full potential in life begin to form in the first months and years of life. Brain development in the first three years will affect learning, behaviour and health throughout life. Seventy per cent of parents have concerns about the social and mental development of their child and about their parenting skills, but only 28% actually discuss these concerns with their primary care provider. Recent studies show that 25-30% of children are arriving at school without the skills necessary to learn.

Enhanced 18-Month Well-Baby Physician Visit

The 18-Month Well Baby Visit is the last of a series of scheduled primary care visits and potentially the last time a child is seen by a primary care provider before school entry. The Ontario Ministry of Children and Youth Services convened an Expert Panel on the 18-Month Well-Baby Visit to develop a provincial strategy to support standardized developmental assessment and evaluation at 18 months for each child in Ontario. The initiative introduces a process, using standardized tools such as the Nipissing District Developmental Screen (Nipissing) and the Rourke Baby Record, that encourages discussion with parents, identifies children who will require referral to specialized services, and raises awareness about local resources. The Offord Centre for Child Studies plays a lead role in supporting communities to move this initiative forward and has chosen Middlesex-London as one of four provincial pilot sites.

Local Early ID Strategy

The Health Unit recognizes the importance of building strong partnerships among parents, primary care providers, public health, child development services and community agencies to create a culture that enhances the developmental health and well-being of children. A multi-strategy and multi-disciplinary approach to promoting child well-being and early identification of developmental concerns is being implemented. The current and planned implementation strategies are summarized as follows:

- Provide parents and caregivers with education and resources – Strategies include a social marketing campaign, development and distribution of information resources through the Ontario Early Years Centres (OEYCs), libraries and other parenting/family services; articles in parent focused magazines; community health fairs; and community screening clinics. The "As We Grow Together Journal" is a new resource for parents that provides anticipatory guidance from birth to 18 months of age about normal growth and development. Use of the Nipissing Tool is encouraged to promote dialogue between primary care providers, parents and Public Health Nurses (PHNs) that provide service at Well Baby and Child Clinics. Families are encouraged to schedule an Enhanced 18-Month Well-Baby Visit.

- Build partnerships with parents and community resources – The Early ID Community Partnership Committee was formed which presently consists of 37 members including Physician Champions, Nurse Practitioners, tykeTALK, Thames Valley Children's Centre, Child Parent Resource Institute, Madame Vanier, All Kids Belong, OEYCs, Literacy Specialists, London Health Sciences Centre, Community Resource Centres, Children's Aid Society (CAS), Merrymount, YMCA Child Care Services, Investing in Children, London Public Libraries and various Health Unit programs. All partners are involved in program planning and delivery.

- Provide education for primary care providers – A Physician Outreach initiative has been implemented resulting in over 300 physicians being visited by a PHN to discuss the Enhanced 18-Month Well-Baby Visit and to provide a binder of community resources and a local referral pathway resource map. Presentations by PHNs have been given at City Wide Physician Rounds, Family Practice Rounds, 10 Family Health Teams, 3 First Nation Reserves, NICU/Developmental Follow Up clinic staff and paediatricians, Family Practice Nurses, Emergency Department, Family Practice Residents, Licensed Child Care Centres, Family Physician network, CAS and individual physician practices. A subcommittee of physician champions and primary care providers provides coaching/mentoring and helps plan educational opportunities.

- Encourage timely access/manage wait times – The Early ID Community Partnership Committee and Physician Champion Subcommittee are in the process of developing a one point of entry system for families with children suspected of a developmental concern. Advanced screening will be provided with appropriate referral recommendations being made in collaboration with primary care providers. This will allow for early intervention with appropriate community resources while the family is waiting for a referral to a developmental specialist. A standardized form for the collection of data has been recommended for use by all participating agencies.

Conclusion

The Ontario Public Health Standards require that children at risk of poor health and developmental outcomes receive support and referral to services prior to school entry. The willingness of the community to work together to promote optimal growth and development throughout the early years continues to advance staff efforts. The Health Unit will continue to exemplify the true meaning of interdisciplinary capacity building in its role as a pilot site.

This report was written by Ms. Ruby Brewer, Family Health Services Manager.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards: Child Health 4b, 5a, 5b, 7, 8, 1

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 007-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 January 20

Working with Newcomer Populations

Recommendation
It is recommended that Report No. 007-11 re Working with Newcomer Populations be received for information.

Background
The City of London has become increasingly multicultural during the past two decades. Although Middlesex County has had some increase in immigration during this time, it has not been to the same extent. The 2006 Census indicates that the total visible minority population in London has increased to 14%. Additionally, it states that 19% of London's population is made up of immigrants and one-quarter of these are from Asia and the Middle East. The top two non-official languages that are spoken are Spanish and Arabic.

The definitions of "immigrant", "refugee" and "newcomer" have important distinctions when it comes to accessing many governmental services related to settlement. Since public health programs generally are more universally-based, such distinctions are usually not necessary. For the purposes of this report, "newcomer" is used broadly to denote those community members who self-identify as a newcomer, whether immigrant, refugee or permanent resident, and without limits on their length of time in Canada.

Health Unit staff works with newcomer populations in many settings and in a variety of initiatives. This report highlights two specific aspects of the work of the Young Adult Team within Family Health Services: participation in the London & Middlesex Local Immigration Partnership; and a parenting program, "Understanding Your Teen", for Arabic-speaking newcomer parents of teens.

London and Middlesex Local Immigration Partnership Council
Based on community consultation meetings during 2009 and 2010, the London and Middlesex Local Immigration Partnership Council (LMLIP) was formed. The LMLIP is funded by Citizenship and Immigration Canada with leadership from the City of London and the United Way of London and Middlesex. It is structured with a Central Council and six sub-councils. Health Unit staff have been involved since the beginning of this consultative process. Currently, the LMLIP is in the implementation phase of the strategic plan. A Public Health Nurse (PHN) from the Young Adult Team is part of the education sub-council whose direction includes the development of strategies focused on the fostering of relationships between parents, schools and community agencies for the benefit of students, parents and staff, and the promotion of cross-cultural peer mentoring to increase mutual cultural awareness, understanding and respect.

"Understanding Your Teen" Parenting Program
"Understanding Your Teen" is a program designed to meet an identified community need in South London. During 2009, The South London Neighbourhood Resource Centre (SLNRC) conducted focus groups with their clientele which demonstrated a strong interest in parenting issues related to teens and expressed the following concerns:

- Feelings of less parenting support now that they were away from extended family
- Unfamiliarity with effective communication skills
- Teens being exposed to information that they did not understand, and
- How to maintain home culture while adapting to "Canadian ways."

Since programs to support "positive parenting" are mandated within the Ontario Public Health Standards, the decision was made to partner with the SLNRC to offer "Understanding Your Teen" to Arabic speaking newcomer parents. This four week program has been developed to work with newcomer parents to help them learn about parenting styles, teen growth and development, values and beliefs, and communication skills within the context of bi-cultural parenting. SLNRC provided a meeting location within the neighbourhood, support with recruitment and attendance, childcare and refreshments. The Health Unit provided a PHN as a group facilitator, translation of existing print resources into Arabic, and interpretation services.

This program was extremely well-received by parents with consistent attendance during the series. The evaluations indicated that the co-operation and exchange of ideas along with discussion and interaction among participants were highly valued. All indicated that they would recommend these sessions to a friend. The most frequently mentioned suggestion for change was for a greater number of sessions in the series, and to have more series or workshops offered.

Summary

The Young Adult Team is actively involved with newcomers through its participation in the LMLIP and the provision of teen parenting programs and resources. Collaboration with community partners, as part of the ongoing relationship building with newcomer populations, is an important aspect of these activities. Further activities and initiatives will be based on ongoing community assessment and identified need.

This report was prepared by Ms. Muriel Abbott, PHN, Young Adult Team, and Ms. Christine Preece, Manager, Young Adult Team, Family Health Services.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards: Child Health 1,4,5,6,7,8.

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 008-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: January 20, 2011

Caring for Families in the Limberlost Neighbourhood

Recommendation
It is recommended that Report No. 008 -11 re Caring for Families in the Limberlost Neighbourhood be received for information.

Background
Limberlost is a geared-to-income family housing complex managed by the London Middlesex Housing Corporation and is comprised of 160 townhouse units. London Housing provides space on Wednesday morning for the Health Unit, Childreach, and the Limberlost Chaplaincy to provide support services for the families in the neighbourhood. A Public Health Nurse (PHN) has been present one morning each week since 1995 providing a Well Baby/Child Clinic and Ask-a-nurse Clinic. More recently, the Nurse Practitioner has provided care to those families without a family physician.

The Limberlost community is multicultural in nature and the composition of families from various cultures is constantly changing. Approximately half of the families now living in Limberlost are Canadian born and the remaining families are comprised of families who have immigrated to Canada from Eastern and Northern Africa, Eastern Europe and South America. The majority of these families arrived in Canada as refugees.

Services Provision
In 2010, a total of 56 discrete families were seen at Ask-a-Nurse Clinics (total of 34 clinics) in the Limberlost community. There were a total of 443 new and return visits by adults, 51 infant visits and 155 visits with children over the age of one year. On average, 14 adults and 6 children were seen at each clinic in 2010. Since 2001, these averages have remained consistent with 15.6 adults and 6.5 children seen weekly at the Limberlost Clinic. The Health Unit's Nurse Practitioner (NP) also held 9 clinics and 1 flu clinic in the Limberlost neighbourhood in 2010 with 110 clients benefiting from her care. Another 405 clients, primarily residents from the Limberlost community, were seen at the Health Unit NP clinic at Sherwood Forest Mall.

As part of the work of the Clinic, 23 formal referrals were made in 2010 by the PHN to outside agencies including child care subsidy, London Housing and the Health Unit's Healthy Babies Healthy Children program. The Children's Aid Society is also involved with many Limberlost families. The families have significant challenges and as a result, a number of organizations are often involved in order to support the families in meeting their basic needs.

Families attend the Clinic for a variety of health needs including prenatal teaching and care, reproductive health teaching, breastfeeding support, sexual health care, acute episodic care, health promotion, advocacy, life skills, parenting skills, growth and development teaching, parenting, immunization teaching, linking to supports and services, substance use information, and mental health support.

How Do Families Benefit from Staff Involvement?
The Health Unit provides Public Health Nursing to families within the Limberlost housing complex including children, youth and adults. It is easy for families to access these services and often they are referred to other service agencies. Many times, bus tickets and taxi vouchers are provided to families as transportation is often a barrier to seeking medical care.

Families living in Limberlost who are involved in the Healthy Babies Healthy Children home visiting program benefit from seeing the same public health nurse in their home as well as in the Clinic. This provides for continuity of care, ensures efficient follow-up, and takes advantage of the already established rapport between the nurse and the family.

The PHN at the Limberlost Clinic functions in a liaison role with other community partners to provide the best services for families. As a result of her long standing work in this community, the PHN is aware of and understands the many challenges and barriers facing these families. She advocates for enhancement of supports and services for individuals and for the community at large. Service provider

meetings provide an opportunity to review the needs of the families and the broader community and identify gaps in service.

Conclusion

Families living in the Limberlost housing complex are living in poverty. They face multiple barriers to accessing health care including transportation, stigma and discrimination, and lack of social supports. By providing services to families living in Limberlost, they are able to more easily access care, receive support and information, develop a trusting nurse-client relationship, and benefit from a professional assessment and referral to appropriate supportive services.

This report was prepared by Ms. Nancy Summers, Manager, Home Visiting (West Team), Family Health Services.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards: Reproductive Health Standard Requirements 4 and Child Health Standard Requirement 6

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 009-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 January 20

Dietary Reference Intakes: Calcium and Vitamin D

Recommendation
It is recommended that Report No. 009-11 re Dietary Reference Intakes: Calcium and Vitamin D be received for information.

Background
On March 8, 2006, international delegates met for a groundbreaking conference with the purpose of clarifying the health risks and benefits of unprotected sun exposure and influence of vitamin D on health. At this conference, the North America UV, Vitamin D and Health Steering Committee recommended the United States Institute of Medicine (IOM) assess the current research on health outcomes associated with calcium and vitamin D. The review of the evidence would inform whether there was a need to update the nutrient reference values, also known as Dietary Reference Intakes (DRIs). Board Report No. 070-06 (Appendix A) provides additional context of the relationship among unprotected sun exposure, vitamin D and health.

Calcium, Vitamin D, and Ultraviolet Radiation (UVR)
Vitamin D is a fat-soluble vitamin stored in fat tissue and the liver. This vitamin has been known for many years to be of critical importance in the maintenance of healthy bones. Vitamin D can be obtained through diet and dietary supplements, and can be synthesized through incidental skin exposure to ultraviolet radiation (UVR). Calcium plays an important role in nerve transmission, muscle contraction, blood clotting and affects blood pressure. Along with vitamin D, adequate Calcium levels ensure bone health. Calcium is primarily obtained from calcium-rich food sources such as milk products (e.g., fluid or powdered milk, yogurt, cheese), fortified milk alternatives (e.g., rice and soy beverages), spinach, kale, almonds, and some legumes. Calcium from plant-based sources is not as well absorbed as that from dairy sources. Vitamin D assists in the absorption of calcium.

IOM Findings
On November 30, 2010, the IOM released a report which based upon review, recommended updating the DRIs for calcium and vitamin D. The IOM Committee undertook an exhaustive review of studies on potential health outcomes and found that the evidence supported a role for vitamin D and calcium in bone health but not in other health conditions (e.g., cancer, cardiovascular disease, hypertension, diabetes, metabolic syndrome, falls, immune response, neuropsychological functioning, physical performance, preeclampsia, and reproductive outcomes). Additionally, it was found that the majority of Canadians receive adequate amounts of these nutrients and there is emerging evidence that too much vitamin D and Calcium may be detrimental to health. It should be noted that DRIs are established to meet the needs of the majority of the healthy population and are not relevant for special populations such as those in therapy for chronic diseases. DRIs are established to maintain health and not to reduce risk of developing adverse health conditions. Appendix B outlines the updated DRIs for Calcium and Vitamin D. In the table, upper level intakes are established from the combination of food and dietary supplements.

The IOM determined that vitamin D synthesis in the skin through unprotected exposure to UVR from sunlight is difficult to standardize because it varies greatly from individual to individual. The recommendation to avoid unprotected UVR from sunlight remains unchanged. Specifically, people are advised against trying to obtain adequate levels of vitamin D from unprotected sun exposure because doing so increases their risk of developing skin cancer. The evidence reviewed took into consideration individuals who are known to have lower level vitamin D synthesis (e.g., those over 50 years, people with dark skin, people who remain indoors, and those who wear clothing covering most of their skin). Also, DRIs for vitamin D were recommended taking into consideration seasonal differences that would reflect an individual's minimal sun exposure, for instance during winter at extreme northern latitude. Therefore, the new DRIs for vitamin D will ensure the Canadian population achieves Vitamin D needs regardless of seasonal changes.

Summary

Although the DRIs are established to meet the needs of the majority of the healthy population, there is still the need for the individual who may be at risk for inadequate calcium and vitamin D intake, to review their health status with a health professional.

Across the wealth of literature, there are inconsistencies connecting vitamin D with reducing risk for the development of non-bone health indicators (e.g., cancers). The current data are not sufficient to support a benefit of intakes greater than the revised upper level. Higher levels of vitamin D have not demonstrated greater health benefits; in fact, they have led to other health problems (e.g., increased incidence of fractures related to falls, cancers, and acute adverse affects). As such, the IOM recommends additional research to enhance the precision and knowledge regarding the plausible link between vitamin D and non-bone health conditions.

This report was prepared by Ms. Heather Thomas, Public Health Dietitian and Ms. Kaylene McKinnon, Public Health Nurse, Chronic Disease Prevention and Tobacco Control Team., Environmental Health and Chronic Disease Prevention Services.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards (2008): Foundational Standard 4, 5, 8, 9, 11, 13; Chronic Disease Prevention 7, 11, 12.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 009-11

TO: Chair and Members of the Board of Health

FROM: Graham L. Pollett, MD, FRCPC
Medical Officer of Health

DATE: 2011 January 20

DIETARY REFERENCE INTAKES: CALCIUM AND VITAMIN D

Recommendation

It is recommended that Report No. 009-11 re Dietary Reference Intakes: Calcium and Vitamin D be received for information.

Background

On March 8, 2006, international delegates met for a groundbreaking conference with the purpose of clarifying the health risks and benefits of unprotected sun exposure and influence of vitamin D on health. At this conference, the North America UV, Vitamin D and Health Steering Committee recommended the United States Institute of Medicine (IOM) assess the current research on health outcomes associated with calcium and vitamin D. The review of the evidence would inform whether there was a need to update the nutrient reference values, also known as Dietary Reference Intakes (DRIs). Board Report No. 070-06 (Appendix A) provides additional context of the relationship among unprotected sun exposure, vitamin D and health.

Calcium, Vitamin D, and Ultraviolet Radiation (UVR)

Vitamin D is a fat-soluble vitamin stored in fat tissue and the liver. This vitamin has been known for many years to be of critical importance in the maintenance of healthy bones. Vitamin D can be obtained through diet and dietary supplements, and can be synthesized through incidental skin exposure to ultraviolet radiation (UVR). Calcium plays an important role in nerve transmission, muscle contraction, blood clotting and affects blood pressure. Along with vitamin D, adequate Calcium levels ensure bone health. Calcium is primarily obtained from calcium-rich food sources such as milk products (e.g., fluid or powdered milk, yogurt, cheese), fortified milk alternatives (e.g., rice and soy beverages), spinach, kale, almonds, and some legumes. Calcium from plant-based sources is not as well absorbed as that from dairy sources. Vitamin D assists in the absorption of calcium.

IOM Findings

On November 30, 2010, the IOM released a report which based upon review, recommended updating the DRIs for calcium and vitamin D. The IOM Committee undertook an exhaustive review of studies on potential health outcomes and found that the evidence supported a role for vitamin D and calcium in bone health but not in other health conditions (e.g., cancer, cardiovascular disease, hypertension, diabetes, metabolic syndrome, falls, immune response, neuropsychological functioning, physical performance, preeclampsia, and reproductive outcomes). Additionally, it was found that the majority of Canadians receive adequate amounts of these nutrients and there is emerging evidence that too much vitamin D and Calcium may be detrimental to health. It should be noted that DRIs are established to meet the needs of the majority of the healthy population and are not relevant for special populations such as those in therapy for chronic diseases. DRIs are established to maintain health and not to reduce risk of developing adverse health conditions. Appendix B outlines the updated DRIs for Calcium and Vitamin D. In the table, upper level intakes are established from the combination of food and dietary supplements.

The IOM determined that vitamin D synthesis in the skin through unprotected exposure to UVR from sunlight is difficult to standardize because it varies greatly from individual to individual. The recommendation to avoid unprotected UVR from sunlight remains unchanged. Specifically, people are advised against trying to obtain adequate levels of vitamin D from unprotected sun exposure because

doing so increases their risk of developing skin cancer. The evidence reviewed took into consideration individuals who are known to have lower level vitamin D synthesis (e.g., those over 50 years, people with dark skin, people who remain indoors, and those who wear clothing covering most of their skin). Also, DRIs for vitamin D were recommended taking into consideration seasonal differences that would reflect an individual's minimal sun exposure, for instance during winter at extreme northern latitude. Therefore, the new DRIs for vitamin D will ensure the Canadian population achieves Vitamin D needs regardless of seasonal changes.

Summary

Although the DRIs are established to meet the needs of the majority of the healthy population, there is still the need for the individual who may be at risk for inadequate calcium and vitamin D intake, to review their health status with a health professional.

Across the wealth of literature, there are inconsistencies connecting vitamin D with reducing risk for the development of non-bone health indicators (e.g., cancers). The current data are not sufficient to support a benefit of intakes greater than the revised upper level. Higher levels of vitamin D have not demonstrated greater health benefits; in fact, they have led to other health problems (e.g., increased incidence of fractures related to falls, cancers, and acute adverse affects). As such, the IOM recommends additional research to enhance the precision and knowledge regarding the plausible link between vitamin D and non-bone health conditions.

This report was prepared by Ms. Heather Thomas, Public Health Dietitian and Ms. Kaylene McKinnon, Public Health Nurse, Chronic Disease Prevention and Tobacco Control Team., Environmental Health and Chronic Disease Prevention Services.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards (2008): Foundational Standard 4, 5, 8, 9, 11, 13; Chronic Disease Prevention 7, 11, 12.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 070-06

Appendix A

TO: Chair and Members of the Board of Health

FROM: Graham L. Pollett, MD, FRCPC
Medical Officer of Health

DATE: April 20, 2006

NORTH AMERICAN CONFERENCE ON UV, VITAMIN D AND HEALTH

Recommendation

It is recommended that Report No. 070–06 re North American Conference on UV, Vitamin D and Health be received as information.

Background

On March 8, 2006, international delegates met for a groundbreaking conference with the purpose to clarify the health risks and benefits of unprotected sun exposure. The collaborative effort between Canada and the United States gathered research experts, public health and health care practitioners, policy makers, and interested members of the public, to review the current research, address pertinent challenges, and strategize toward acceptable risk reduction strategies for the general public based on current scientific evidence. Of the 152 registered participants, 8 self identified as indoor tanning industry representatives, and 2 self identified as pharmaceutical/vitamin supplement industry representatives.

The Conference Steering Committee invited experts in the areas of cancer, dermatology, nutrition, autoimmune diseases and bone health from Canada and the United States to participate in a workshop the following day, March 9, 2006. The purpose was to develop consistent public health messaging about skin cancer prevention, sun exposure and health; establish a network maintaining open communication between experts on this issue; and identify research gaps and opportunities. A Consensus Statement is being finalized from this day's proceedings.

The Issues: Vitamin D

Vitamin D is a fat-soluble vitamin stored in fat tissue and the liver. This vitamin has been known for many years to be of critical importance in the maintenance of healthy bones and recent research suggests other potential roles in maintenance of human health. We produce vitamin D in the body through ultraviolet (UV) exposure, diet, and dietary supplements. Appendix A provides an overview of how vitamin D is generated in the body. It is clear from the literature that current United Sates and Canadian dietary intakes (in the absence of some UV exposure) will not produce adequate vitamin D levels in the blood to obtain health benefits. In fact, vitamin D inadequacy is a common problem in the United States and in Canada. Additionally, some researchers at the conference challenged the current dietary reference intakes (DRIs) and acceptable upper limits (UL) of vitamin D indicating that both values were grossly inadequate to maintain appropriate levels of serum vitamin D. The recommendations for vitamin D are currently under review and will likely be revised upwards.

The Issues: Unprotected UV Exposure

Some vitamin D research demonstrates a plausible link between unprotected sun exposure, subsequent vitamin D production and the prevention of a variety of chronic diseases such as cancer (specifically breast, prostate, and digestive system cancers), multiple sclerosis, type 1 diabetes, and cardiovascular disease. The research implies that some level of UV exposure and vitamin D may exhibit a protective effect reducing the potential risk of developing certain chronic diseases. However, there are few studies currently available that have investigated the amount of UVB required to synthesize adequate vitamin D levels. Direct links cannot confidently be made at this time because the biological pathways causing the effect are not clearly identified in the literature. Consequently, additional research is needed before recommendations to the general public can be made with confidence.

Recommendations

The North America UV, Vitamin D and Health Steering Committee is currently preparing a consensus statement of the risks and benefits of sun exposure. This document will reflect a balance between avoiding an increase in the risk of skin cancer and achieving enough ultraviolet radiation exposure to maintain adequate vitamin D levels. It will be specific to regions of latitude throughout North America. Appendix B provides a sample consensus statement developed in consultation with multidisciplinary health experts and released in 2005 by the Cancer Council of Australia. The current *Mandatory Health Programs and Services Guidelines* (1997) Program Standards for Chronic Diseases and Injuries provide a prudent course of action (see below). Chronic diseases, including cancers, diabetes, and osteoporosis, continue to be the leading causes of death in Ontario. These conditions that cause premature death, disability and health care costs, chronic diseases require measures that reflect prevention, early detection, and treatment. Until specific recommendations around ultraviolet radiation exposure and vitamin D recommendations are released, the staff will continue to promote information that identifies the health risks and benefits of unprotected sun exposure.

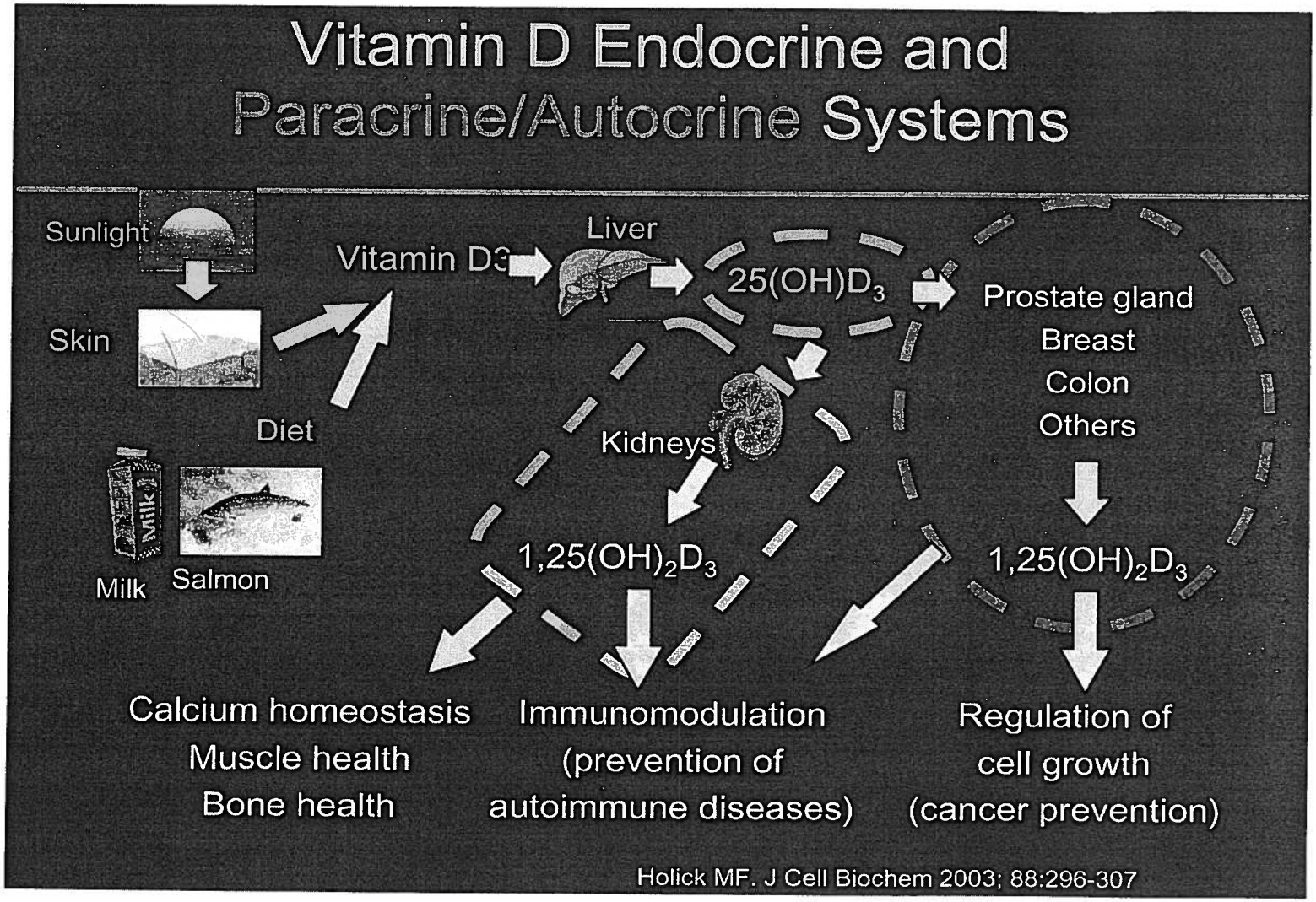
This report was prepared by Ms. Heather Thomas, Public Health Dietitian and Ms. Kaylene McKinnon, Public Health Nurse, Chronic Disease and Injury Prevention Team, Environmental Health and Chronic Disease Prevention Services.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Mandatory Health Programs and Services Guidelines:
Chronic Disease Prevention:

1. To increase the proportion of the population of all ages who limit sun exposure, use protective clothing and sunscreens when exposed to sunlight, and avoid artificial sources of ultraviolet light (i.e. sun lamps, tanning booths) when exposed to sunlight, and avoid artificial sources of ultraviolet light (i.e. sun lamps, tanning booths).

Requirements and Standards:
15 a., b., c. The Board of Health shall work with local groups and individuals to provide education and promote policies which reduce the risk of skin cancers.


Vitamin D Endocrine and Paracrine/Autocrine Systems
Sunlight
Skin
Vitamin D3
Liver
25(OH)D3
Prostate gland
Breast
Colon
Others
Diet
Kidneys
Milk
Salmon
1,25(OH)2D3
1,25(OH)2D3
Calcium homeostasis
Muscle health
Bone health
Immunomodulation
(prevention of
autoimmune diseases)
Regulation of
cell growth
(cancer prevention)
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Appendix B

RISKS AND BENEFITS OF SUN EXPOSURE
POSITION STATEMENT

APPROVED BY THE AUSTRALIAN AND NEW ZEALAND BONE AND MINERAL SOCIETY, OSTEOPOROSIS AUSTRALIA, AUSTRALASIAN COLLEGE OF DERMATOLOGISTS AND THE CANCER COUNCIL AUSTRALIA

Summary statement
A balance is required between avoiding an increase in the risk of skin cancer and achieving enough ultraviolet radiation exposure to maintain adequate vitamin D levels.

Sun exposure is the cause of around 99% of non-melanoma skin cancers and 95% of melanoma in Australia1, however, ultraviolet radiation B (UVB) exposure in small amounts is essential to good health. In Australia, where ultraviolet radiation levels are in the high to extreme range for most of the year, sun protective measures to reduce the incidence of skin cancer must continue as a high public health priority.

The majority of Australians generally have sufficient ultraviolet radiation exposure to enable adequate vitamin D production – serum 25-hydroxy vitamin D levels >50 nanomole/Litre (nmol/L) – to form and maintain healthy, strong bones.

It is well established that Vitamin D forms in the skin as a result of UVB exposure. However, there are few studies currently available that have investigated the amount of UVB that people require to synthesise adequate vitamin D2. There is evidence to suggest that prolonged or excessive sun exposure has no benefit in health outcomes related to Vitamin D3. Therefore, people should continue to protect themselves from overexposure, especially during peak ultraviolet radiation periods (10 am to 3 pm). Further scientific investigation of the amount of ultraviolet radiation exposure required to ensure adequate vitamin D levels in Australia is warranted.

People are at risk of vitamin D deficiency and may need vitamin D supplementation if their exposure to ultraviolet radiation is not adequate. People living in the southern parts of Australia have a higher risk of vitamin D deficiency, particularly during the winter months.

Recommendations

1. In most situations, sun protection to prevent skin cancer is required during times when the UV index is moderate or above (>3). At such times when the UV index is higher than or equal to 3, sensible sun protection behaviour is warranted and is unlikely to put people at risk of Vitamin D deficiency.

2. Most people achieve adequate vitamin D levels through the UVB exposure they receive during ypical day-to-day outdoor activities. As an example, it has been estimated that adequate vitamin D levels (>50 nmol/l) can be achieved in summer by the face, arms and hands or the equivalent surface area being exposed to as little as an average of 5 minutes of sunlight either side of the peak UV periods on most days of the week. In winter, in the southern states of Australia where UV radiation levels are less intense, Vitamin D levels may be maintained by approximately 2-3 hours of sunlight exposure accumulated over a week to the face, arms and hands or equivalent surface area.

3. Certain people are at high risk of skin cancer. They include individuals who have had skin cancer, have received an organ transplant or are highly sun sensitive. These people need to have more rigorous sun protection practices and therefore should discuss their vitamin D requirements with their medical practitioner to determine if dietary supplementation rather than sun exposure is necessary.

4. Some groups in the community are at increased risk of vitamin D deficiency. These include the elderly, babies of vitamin D deficient mothers, people who are housebound or are in institutional care and dark skinned people, particularly those who cover their skin for religious or cultural reasons. These people should discuss their vitamin D status with their medical practitioner.

Vitamin D deficiency

Certain groups within the community are at higher risk of moderately severe vitamin D deficiency (indicated by serum vitamin D levels <25 nmol/L) if their sun exposure is inadequate. These include the elderly, babies (especially those of vitamin D deficient mothers), people who are housebound or are in institutional care, dark skinned people and those who cover their skin for religious or cultural reasons. Vitamin D levels between 25 and 50 nmol/L are classified as 'mild deficiency'.

Vitamin D status in Australia has not been widely studied in the general population, however some studies have shown that up to 80% of people in 'at-risk' populations display evidence of deficiency4. Mild vitamin D deficiency (25–50 nmol/L) was noted in 43% of females and moderately severe vitamin D deficiency (<25nmol/L) in 11% of females during winter in the Victorian population of Geelong (latitude 38°S)5.

Vitamin D production decreases during winter when the intensity of ultraviolet radiation is lower. The body can rely on tissue stores of vitamin D for between 30 and 60 days4 assuming vitamin D levels are adequate prior to winter. In most cases, any vitamin D reduction during winter is corrected in summer when more sunlight is received with more time spent outdoors. While this correction may occur, it is still important to prevent deficiency during winter as fracture rates increase with deficiency, particularly with older adults.

Vitamin D deficiency in children can result in rickets, characterised by bone and muscle weakness and bone deformities. For adults with low vitamin D, problems may include osteoporotic fractures, bone and joint pain, falls, muscle and bone weakness, and difficulty in walking.

Bone and musculoskeletal health

There is evidence that sun exposure may be beneficial in reducing the risk of osteoporosis. The human body needs vitamin D to regulate calcium levels in the blood and to make and maintain healthy, strong bones.

Vitamin D is produced in the skin by exposure to UVB (wavelength 290–320 nm) from sunlight. It can also be obtained from foods such as milk, margarine, oily fish, eggs, liver and cheese, but is generally only present in small amounts in these foods. Most vitamin D is produced as a result of ultraviolet radiation exposure.6

Most people achieve adequate vitamin D levels through typical day-to-day outdoor activities. As an example, it has been estimated that adequate vitamin D levels (>50 nmol/l) can be achieved in summer by the face, arms and hands or the equivalent surface area receiving as little as 5 minutes of sunlight exposure either side of the peak UV periods on most days of the week7. In winter, in the southern states of Australia where UV radiation levels are less intense, Vitamin D levels may be maintained by approximately 2-3 hours of sunlight exposure accumulated over a

week to the face, arms and hands or equivalent surface area. In northern states, the amount of sunlight exposure required to receive adequate vitamin D levels is significantly less than this. Most people would achieve these levels of sunlight exposure with normal outdoor activities without needing to deliberately seek additional sun exposure.

Other health conditions

Recently, some studies have been published that suggest possible beneficial effects of sun exposure in the prevention or improvement in outcome of a number of other diseases including breast, prostate, and colorectal cancer, non-Hodgkin lymphoma and multiple sclerosis8,9,10. However the biological pathways underlying these observed associations are far from clear and it is not known how much sun exposure is necessary, and when. Thus there is insufficient evidence for any definitive action to be taken on these findings or make any recommendations, as more research is needed.

Older adults

Vitamin D deficiency is a problem in frail, housebound or institutionalised older Australians. It is related to increasing age (which is linked to reduced capacity to create vitamin D), and low levels of exposure to sunlight4. As the human body ages, it also becomes less efficient at synthesising new bone and making vitamin D, adding to the problem11. Older adults who are vitamin D deficient increase their risk of osteoporosis, falls, and fractures12.

The National Health and Medical Research Council recommends that older adults boost their vitamin D intake through dietary means or by taking a daily supplement as prescribed by a medical practitioner13.

Older adults who are not at high risk of skin cancer and who are mobile should ensure they have incidental exposure to sunlight, especially at times when ultraviolet radiation is less likely to cause other health problems.

Skin type

People with dark skin require more ultraviolet radiation exposure to produce adequate levels of vitamin D than people with fair skin, as the pigment in their skin reduces ultraviolet radiation absorption14. When people with dark skin cover themselves this further reduces the ultraviolet radiation available for vitamin D production. Children of mothers with inadequate vitamin D levels are also likely to be deficient15. Vitamin D supplementation is likely to be required for these population groups.

Babies

Australia's high ultraviolet radiation levels mean that even when babies are outdoors for very short periods before 10 am and after 4 pm with small amounts of skin exposed, they are likely to receive enough ultraviolet radiation exposure to maintain healthy vitamin D levels even with the use of sun protection.

Southern regions of Australia

For regions south of 37 degrees latitude (includes the southern parts of Victoria and Tasmania) there are relatively low levels of ultraviolet radiation for the months of June and July16. For this reason people in southern regions do not normally require sun protection during winter months unless they are at high altitudes or near highly reflective surfaces such as snow or water or unless they have a high risk of skin cancer.

Can being sunsmart increase your risk of vitamin D deficiency?

Sensible sun protection behaviour should not put people at risk of vitamin D deficiency.

While sun exposure is important for the production of vitamin D, it is important to keep in mind that unprotected sun exposure in Australia carries a significant risk of skin and eye damage and skin cancer. Consistent and deliberate sun exposure without any form of sun protection when the UV index is above 3 is not recommended, even for those diagnosed with vitamin D deficiency. The small amount of sunlight received on the face, hands, arms or legs during normal outdoor daily activities is usually all that is required to absorb appropriate levels of ultraviolet radiation at these times.

What are the alternatives?
Where there is vitamin D deficiency, oral vitamin D supplementation – rather than relying on sun exposure – may be necessary. A medical practitioner should be consulted about whether there is need for vitamin D supplementation. Given the risks associated with the use of solaria and the amount of ultraviolet radiation they emit, Cancer Council organisations do not recommend the use of solaria in boosting vitamin D levels17.

8 March 2005

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Dietary Reference Intakes for Calcium and Vitamin D APPENDIX B

	Calcium			Vitamin D		
Life Stage Group	**Estimated Average Requirement (mg/day)**	**Recommended Dietary Allowance (mg/day)**	**Upper Level Intake (mg/day)**	**Estimated Average Requirement (IU/day)**	**Recommended Dietary Allowance (IU/day)**	**Upper Level Intake (IU/day)**
Infants 0 to 6 months	*	*	1000	**	**	1000
Infants 6 to 12 months	*	*	1500	**	**	1500
1-3 years old	500	700	2500	400	600	2500
4-8 years old	800	1000	2500	400	600	3000
9-13 years old	1100	1300	3000	400	600	4000
14-18 years old	1100	1300	3000	400	600	4000
19-30 years old	800	1000	2500	400	600	4000
31-50 years old	800	1000	2500	400	600	4000
51-70 years old	800	1000	2000	400	600	4000
51-70 year old females	1000	1200	2000	400	600	4000
71+ years old	1000	1200	2000	400	800	4000
14-18 years old, pregnant/breastfeeding	1100	1300	3000	400	600	4000
19-50 years old, pregnant/breastfeeding	800	1000	2500	400	600	4000

* For infants, Adequate Intake is 200 mg/day for 0-6 months of age and 260 mg/day for 6 to 12 months of age.
** For infants, Adequate Intake is 400 IU/day for 0 to 6 months of age and 400 IU for 6 to 12 months of age.

Source: Institute of Medicine of the National Academies, Report Brief, November 2010.

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 010-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 January 20

Healthy Eating Group Home Project

Recommendation

It is recommended that Report No. 010 -11 re Group Home Healthy Eating Project be received for information.

Background

Healthy food, in appropriate amounts, according to Eating Well with Canada's Food Guide provides children and youth with important nutrients and fuels healthy growth and development. Providing children and youth with healthy foods and role modeling healthy habits related to food sets a foundation for lifelong good health. Group Homes have the ability to make a positive impact on youth living in their care. Creating a supportive nutrition environment in Groups Homes that provides healthy foods at all meals and snacks, role modeling and skill building related to cooking and meal preparation can have a positive effect on the lives and future of youth living in these Homes.

Participation

The stakeholders who have come together to work collaboratively on this project include a representative from the following agencies: Western Area Youth Services (WAYS), Craigwood, and Anago. In addition, the committee consists of representation from a Registered Nurse from the Centre for Children & their families in the Justice System of the London Family Court Clinic and the Health Unit. Health Unit staff is facilitating as the lead for this project. The ultimate mission of this group is to create a healthy nutrition environment in identified group homes by influencing the nutritional quality of meals and snacks served, advocating for a safe and sanitary environment where food is prepared and served, and providing food literacy education for staff and youth.

Description of Project

A stakeholder identified the need to improve the nutrition environments in area Group Homes and, as a result, area personnel from the respective Group Homes and associated agencies came together to address this gap. Listed below is a synopsis of the activities and work to date related to this project:

- A literature review was conducted to determine if similar projects had been undertaken previously. Findings were very limited. Only one study by Evans et al (2009) was remotely related to this project. Specifically, the study examined the relationship between food environments and fruit and vegetable consumption in adolescents. Results from this study demonstrated that adolescents residing in residential homes with more conducive food environments ate more fruit and vegetables compared to those living in homes with less support. Although this is only one study with a sample size of 246, it does illustrate that nutrition environment is important in fostering healthier food choices.
- Staff and Youth Surveys for dissemination at the respective agencies were developed by the working group. The goal of the surveys was to obtain baseline data regarding the practices, thoughts, and skill building needs of staff and youth in area group homes. The surveys have been disseminated, completed by staff and youth and returned to the Health Unit. The data for all agency group homes have been entered and analysis of the data is forthcoming.
- Following the survey, each agency identified a pilot site within their organization that will participate in the pilot roll out of this project. The following pilot sites were identified: Belton House and Waterloo (WAYS), St. George (Craigwood) and Parkhill (Anago).
- The group worked on the development of Healthy Eating Guidelines for Group Homes under four broad categories: Healthy Physical Environment; Supportive Environment; Education and Skill Building and Partnerships. For each Healthy Eating Guideline a definition of success was developed. The goal is to have the pilot sites implement these Healthy Eating Guidelines within their respective agency.

Next Steps

Based on the work completed to date, the vision for the future includes the following steps:

- Complete the data analysis of the staff and youth surveys and report findings to all group homes.

- Based on the Healthy Eating Guidelines developed, the working group plans to create a checklist that can be used by the pilot group homes to take an inventory of which Healthy Eating Guidelines are currently being implemented well and also identify priority areas that need to be addressed. The goal is to have each pilot group home implement the Healthy Eating Guidelines one at a time and experience success and to share these successes with one another and create a culture of support and sharing of ideas and resources.
- Provide the pilot group homes with support in the form of workshops, education, and direct skill building opportunities and also provide a forum for group homes to share and learn from each other.
- Have the pilot group homes share their success with other group homes and act as champions for these standards to be implemented and embraced in all group homes.
- Act as a vehicle for advocacy in terms of adequate funding to ensure healthy food choices are available.
- Partner with other agencies and institutions to address issues related to educational needs and skills when working within the group home setting.

Conclusion

The goal is to create healthier nutrition environments in select pilot group homes via the introduction of Healthy Eating Guidelines and to have these group homes share their successes and become champions of the guidelines. Ultimately, the expectation is to have these guidelines adopted as "Best Practices" by these agencies so that a healthy eating environment in group homes becomes the norm.

This report was prepared by Ms. Christine Callaghan, Public Health Dietitian and Ms. Christine Preece, Manager, Young Adult Team.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Mandatory Health Programs and Services Guidelines: Child Health Standard 4, 5, 7 and Chronic Disease 11

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 011-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 January 20

Canada's Healthy Workplace Month

Recommendation
It is recommended that Report No. 011-11 re Canada's Healthy Workplace Month be received for information.

Background
The Workplace Wellness and Fun (WWAF) Committee is comprised of staff and management representatives from throughout the Health Unit and is currently chaired by the Healthy Workplace Coordinator from the Chronic Disease Injury Prevention Team. The primary goal of the Committee is "to encourage healthy living among Middlesex-London Health Unit employees." Members of the Committee consist of: Ms. Mary Lou Albanese, Chronic Disease and Injury Prevention Manager; Ms. Cynthia Bos, Human Resources Assistant; Ms. Hayley Brown, Public Health Nurse, Vaccine Preventable Diseases; Ms. Cassandra Brubacher, Public Health Nurse, Infectious Disease Control Team; Ms. Joan Carrothers, Oral Health Services Manager; Ms. Sandy Richardson (Chair), Healthy Workplace Coordinator; Ms. Trudy Sweetzir, Communications Assistant; and Ms. Shirley VanderHeide, Program Assistant, tykeTALK.

Healthy Workplace Month - October 4 to 31, 2010
Canada's Healthy Workplace Month (CHWM) is presented by Great-West Life and managed by the National Quality Institute (NQI) in collaboration with the Canadian Centre for Occupational Health and Safety. The tenth annual CHWM was four weeks long and was designed to celebrate employees, their successes, and their accomplishments. The WWAF Committee facilitated the participation of MLHU staff in Canada's Healthy Workplace Month and the Committee Chair submitted weekly reports to the NQI web-site.

The theme for CHWM 2010 was Healthy Mind, Healthy Body, Healthy Work… A Positive Workplace Works! Each week, organizations were challenged to plan activities based on the weekly themes that promoted fostering a workplace culture of trust and respect where people are happy and healthy at work. Following the designated weekly themes during CHWM, the Health Unit WWAF Committee promoted (through weekly e-mail and voice-mail messages) and facilitated (provided funding and resources) the following activities for Health Unit staff.

<u>Week 1 – Being a Positive Workplace</u>

- Bowls of Hershey "Hugs and Kisses" were placed on administrative assistants desks throughout all offices and service areas and employees were invited to enjoy one themselves for all their hard work but also to give one to a coworker as they told them how much they enjoyed working with them and/or how they inspire you.
- Six Tim Horton's gift certificates were awarded through a random draw of employees and winners were asked to take a coworker out for a coffee break with them.
- A Give Back with Your Soul(s) drive was announced. Employees were encouraged to donate gently used footwear (slippers, boots, shoes, socks etc. for men, women and children) to a community shelter for women and families. During the month of October, designated boxes were placed in strategic locations throughout the Health Unit offices and employees were asked to make donations as they could throughout the month. Reminders of the footwear drive were sent with weekly announcements.

<u>Week 2 – Being Positive with Family and Friends</u>

- Employees were encouraged to make plans to attend a family flu clinic day so their families are protected and remain healthy during the upcoming flu season.
- A healthy recipe was distributed prior to the Thanksgiving weekend.
- Six Tim Horton's gift cards were distributed through a random draw and that week's winners were encouraged to give it to, or share it with, a friend or family member who is important to them.

<u>Week 3 – Being Positive About Work/Life Harmony</u>

- Employees were sent a page of desk exercises to do several times per day and they were reminded to take a break, to rejuvenate themselves, to do some deep breathing and relaxation exercises – to make themselves a priority.
- Team and service areas photographs were done and employees were encouraged to display pictures of their work teams and family members on their desks to remind themselves of what brings "balance" to their lives.
- Employees were encouraged to try a "no work at home" week (turn off the blackberry, cell-phone etc), go to bed a ½ hour earlier (to get more sleep) and to try a new physical activity with their families (bowling, skating, Frisbee etc).
- Six Tim Horton's gift cards were distributed and winners were encouraged to keep them for themselves and enjoy a reward for all the hard work they do.

Week 4 – Being Positive About Community

- The boxes of footwear collected during the month were delivered to 2 local shelters (Rotholme and The Women's Rural Resource Centre). The Health Unit van was filled with donations and delivered by Committee members as employees gave back to their communities with SOUL(s)!
- The WWAF Committee encouraged employees to consider such activities as donating blood at a local blood donor clinic, organ donation or volunteering at a local food bank.
- Six Tim Horton's gift cards were distributed through a random draw and winners were encouraged to give it to, or share it with, a stranger or someone in need.

In the category of "251+" employees, the Health Unit received an overall 2nd place and will receive a certificate stating this ranking from the National Quality Institute. It should be noted that MLHU is the only health unit in Canada to place in any of the ranking categories in all 4 weeks of the month. The weekly winners and the overall winners can be viewed at: http://www.healthyworkplacemonth.ca/winning_teams. The WWAF Committee will continue to meet throughout 2011, to plan participation in the alPHa Challenge as well as Canada's Healthy Workplace Month. The Committee is making plans to bring more innovative and novel employee health initiatives to fellow employees in 2011.

This report was prepared by Ms. Sandy Richardson, Chair WWAF Committee and Healthy Workplace Coordinator, Chronic Disease Injury Prevention Team.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards:
Chronic Disease Prevention Requirement # 4 "The board of health shall use a comprehensive health promotion approach to increase the capacity of workplaces to develop and implement health policies and programs, and to create or enhance supportive environments to address the following topics, health eating, healthy weights, comprehensive tobacco control, physical activity, alcohol use, work stress and exposure to ultraviolet radiation."

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 012-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health and CEO
DATE: 2011 January 20

Provincial Bed Bug Initiatives

Recommendation
It is recommended that Report No. 012-11 re Provincial Bed Bug Initiatives be received for information.

Background
At the October 21, 2010, Board of Health meeting, Board members reviewed Report No. 128-10 re Bed Bugs (attached as Appendix A).

Announcement of Provincial Initiatives
Attached as Appendices B, C and D are materials that the Ontario Provincial Government announced on Monday January 10, 2011, regarding funding opportunities for local health units to apply for implementation of local bed bug initiatives that will focus on education, awareness and supports for those vulnerable populations in dealing with bed bug issues.

Staff in Environmental Health and Chronic Disease Prevention Services are awaiting the application process details and funding approval criteria that are currently being prepared by the Ministry of Health and Long-Term Care.

Conclusion
Currently, there are no known cases or evidence of infectious disease(s) being transmitted by a bed bug bite. Bed bugs have been generally deemed as nuisances and have not posed any major known health risks. However, bed bug infestations can cause affected individuals anxiety, secondary infections, allergic reactions and potential financial hardships.

Mr. James Reffle, Director, Environmental Health and Chronic Disease Prevention Services, will update the Board on any emerging information about this process at the January 20, 2011, Board meeting.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health and CEO

This report addresses the following requirements of the Ontario Public Health Standards:
Section 2) a) ii) of the *Identification, Investigation and Management of Health Hazards Protocol* requiring the Board of Health to liaise and maintain partnerships with the community and relevant local, provincial and federal agencies with an interest in and mandate for prevention of health hazards in the environment through committees, meetings and/or regular communications for the purpose of sharing expertise and information.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 128-10

12.2

Appendix A

TO: Chair and Members of the Board of Health

FROM: Graham L. Pollett, MD, FRCPC
Medical Officer of Health

DATE: 2010 October 21

BED BUGS

Recommendation

It is recommended that Report No. 128-10 re Bed Bugs be received for information.

Background

On September 28, 2010, a letter co-signed by the Ontario Minister of Health and Long-Term Care, The Honourable Deb Mathews, and the Ontario Minister of Municipal Affairs and Housing, The Honourable Rick Bartolucci, was sent to Board of Health Chairs and Medical Officers of Health outlining the growing issue of bed bugs (Appendix A). The letter summarized the various measures in place under current Ontario legislation such as the Residential Tenancies Act, the Building Code Act and the Health Protection and Promotion Act to help address concerns such as bed bugs. The Ministers requested local health units to ensure that coordinated measures are put in place in order to respond to this issue with a focus on prevention and education.

Local Measures

Since 2008, staff has received an increase in calls regarding bed bugs. It is possible for anyone to become infested with bed bugs, which are small biting insects that multiply quickly and travel easily. The Environmental Health Team has worked with a number of local groups to assist them with addressing bed bug issues in residential and other settings in order to facilitate effective strategies for pest control and prevention through the use of Integrated Pest Management (IPM) approaches.

Staff has been working with City of London staff responsible for enforcing the Property Standards By-law. Section 4.10.1 of the Bylaw requires that, "All buildings shall be kept free of rodents, vermin and insects at all times and methods used for exterminating rodents or insects or both shall be in accordance with the provisions of the Pesticides Act, R.S.O. 1990, Chapter P.11, as amended, and all regulations enacted pursuant thereto."

Environmental Health Team Public Health Inspectors are handling bed bug complaints/inquiries coming from residents by explaining the nature of bed bug infestations and providing the fact sheet information (Appendix B) either verbally, by linking the caller to information on the website or by mailing information to them.

Investigation of problems in multi-unit residential buildings can be followed up in a similar fashion. Ideally, the owner/landlord/property management company would be asked to participate from the outset of any follow-up investigation. Both the landlord and the tenant are encouraged to work together to resolve the problem as it is in the best interest of both parties to expedite the necessary actions required to eradicate the infestation and take preventive measures against any recurrence. Professional pest control companies are available and trained to complete an IPM approach to resolve these problems in individual units and can investigate the possibility that the infestation has spread to other units.

Provincial Meeting

The resurgence of bed bugs across North America and other parts of the world has led to an influx of calls for action at local, provincial and national levels.

Health Unit staff attended the Bed Bug Summit in Toronto that was held at Queens Park on September 29, 2010. Several hundred participants from a wide range of stakeholders attended the Summit that included presentations from public health, community groups, pest control management industry, housing and property management groups and provincial and municipal political officials.

Health Unit staff, along with those from other Health Units, will also be participating with the Ontario Agency of Health Protection and Promotion in looking at provincial approaches to this issue.

Conclusion

Bed bugs have recently reappeared as a significant public concern and nuisance. Staff has been responding to an increased number of calls for assistance.

Currently, there is no evidence of infectious disease transmission by a bed bug bite. Bed bugs have been generally deemed as nuisances and have not posed any major known health risks. However, bed bug infestations can cause affected individuals anxiety, secondary infections, allergic reactions and potential financial hardship. Staff will apprise the Board as provincial and local approaches to this issue evolve.

This report was prepared by Mr. James Reffle, Director of Environmental Health and Chronic Disease Prevention Services.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health and CEO

This report addresses the following requirements of the Ontario Public Health Standards:

Section 2) a) ii) of the *Identification, Investigation and Management of Health Hazards Protocol* requiring the Board of Health to liaise and maintain partnerships with the community and relevant local, provincial and federal agencies with an interest in and mandate for prevention of health hazards in the environment through committees, meetings and/or regular communications for the purpose of sharing expertise and information.

Ministry of Health and Long-Term Care

Office of the Minister

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80 Grosvenor Street
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Tel 416-327-4300
Fax 416-326-1571
www.health.gov.on.ca

Ministère de la Santé et des Soins de longue durée

Bureau du ministre

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80, rue Grosvenor
Toronto ON M7A 2C4
Tél : 416 327-4300
Téléc : 416 326-1571
www.health.gov.on.ca

Ministry of Municipal Affairs and Housing

Office of the Minister

777 Bay Street, 17th Floor
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Ontario

September 28, 2010

Dear Board of Health Chair / Medical Officer of Health / Associate Medical Officer of Health:

Our government understands that bed bug infestations are a growing concern in communities across the province.

The issue of beg bugs represents a significant challenge. Bed bugs cause a variety of negative physical health, mental health and economic consequences. In particular, the impact on our vulnerable and marginalised groups is concerning.

As you may know, the Province already has various measures in place to help combat concerns such as bed bugs. Under the *Residential Tenancies Act, 2006* (RTA) landlords are required to keep their buildings and rental units in a good state of repair while ensuring that all health, safety and maintenance standards are met.

In addition, the *Building Code Act* (BCA) gives municipalities the authority to adopt by-laws that prescribe standards for the maintenance and occupancy of property. The BCA further authorizes municipalities to order a property owner to comply with the standards prescribed in its by-law for property standards.

Further, the *Health Protection and Promotion Act* (HPPA) establishes broad authority for public health units to prevent, eliminate and decrease the effects of health hazards within their jurisdictions.

However, we recognize that there is more work to be done. The public expects a strong and coordinated response to this issue. We would like to request your support in order to ensure appropriate measures exist at the local level to tackle the apparent increase in bed bug infestations. We encourage you to focus on prevention and education in order to reduce the number of people affected.

Our government is committed to working with you to find available solutions. Our current plan includes:

- Dr. Arlene King, the Chief Medical Officer of Health, conducting a province-wide assessment of the scope of the problem;
- working with our municipal partners in public health units and housing departments on the development of appropriate educational materials to raise public awareness; and
- working with our partners in the tourism and consumer services industries to minimize possible impact on these sectors.

We sincerely appreciate your attention to this issue.

Sincerely,

Deb Matthews

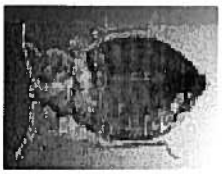
Deb Matthews
Minister of Health
and Long-Term Care

R. Bartolucci

Rick Bartolucci
Minister of Municipal
Affairs and Housing

MIDDLESEX-LONDON HEALTH UNIT

BEDBUGS



FACT SHEET fact sheet

What is a bedbug?

The adult bedbug (*Cimex lectularius)* is a flattened wingless oval body shaped insect, normally brownish in colour. Size ranges from 5mm to 10 mm in length.

Juvenile bedbugs known as nymphs, are shaped similar to the adult bedbug, but are smaller and their colour can range from near colourless to yellowish white. Size can be as small as 1.6 mm in length.

Bedbugs are nocturnal and feed during the night, preferably human blood. After feeding, they become dark red in colour and become bloated from a blood meal.

Can bedbugs transmit a disease?

Currently, there are no known cases or evidence of infectious disease(s) being transmitted by a bedbug bite.

Bedbugs are deemed as nuisances and do not pose any major known health risks.

However, bedbug infestations can cause affected individuals anxiety, secondary infections, allergic reactions and potential financial hardships.

How do bedbugs get into my home?

Bedbugs are transferred to the home accidently by hitch hiking on objects from a site that has bedbugs. These objects can include luggage, clothing, and used furniture.

What can I do if I have bedbugs in my home?

The most effective method of control in dealing with bedbugs, is implementing an effective Integrated Pest Management (IPM) approach, which requires collaboration of all parties involved with a variety of techniques and products to maximize effective control and minimize risk to human health and environment. This includes:

1. Consult the Middlesex-London Health Unit or a Professional Pest Control Operator.

Cont'd p.2

London Office
50 King St., London, ON N6A 5L7
tel: (519) 663 - 5317 fax: (519) 663 - 9581

Strathroy Office - Kenwick Mall
51 Front St. E., Strathroy, ON N7G 1Y5
tel: (519) 245 - 3230 fax: (519) 245 - 4772

2. Inspect your mattress and bed frame including resting areas, especially the seams, creases, folds, crevices, underside and any other locations where bedbugs can hide for evidence of live, dead or bedbug fecal spots.
3. Using a nozzled vacuum with detachable disposable bag, vacuum all crevices on your mattress, bed frame, baseboards and any objects near the bed area to collect bedbugs and their eggs. Vacuum daily and empty and discard vacuum bag after each use.
4. Wash all linens in the hottest water possible and place them in the hot dryer.
5. Remove all unnecessary clutter.
6. Seal all cracks and crevices between baseboards, bed frames, floors and walls with caulking. Repair or remove any damaged, exposed, loose fixtures, and openings where bedbugs can hide.
7. Monitor daily and examine closely any items brought into your home.

How do I control bedbugs from coming into my home?

1. Regular house cleaning, including vacuuming your mattress, can help prevent an infestation. Cleaning up clutter will reduce the number of places bedbugs can harbour.
2. Be cautious when buying, receiving or picking up used furniture or clothing. Inspect all used items for bedbugs.
3. When travelling take the following precautions:

    - Inspect the room, the bed and furniture for bedbug activity.
    - Protect your luggage: keep luggage on the shelf or away from the floor.
    - Protect your home: upon return to your home, isolate your luggage from your home such as the garage. Inspect the luggage and clothing. Wash all clothing in the hottest water possible and then in a hot dryer.

For Further Information Contact:
Environmental Health Team
Environmental Health & Chronic Disease Prevention Services
519-663-5317 ext. 2300 (phone)
519-663-9276 (fax)

Ontario

NEWS

Ministry of Health and Long-Term Care

Supporting The Fight Against Bed Bugs

McGuinty Government Invests In Local Public Health Unit Programs

NEWS

January 10, 2011
2011/nr-002

Ontario is supporting local initiatives that are aimed at preventing and managing infestations of bed bugs.

The province's 36 public health units will be able to apply for funding to support bed bug-related programs that emphasize coordination with other local services, education and awareness and/or provide supports to vulnerable populations. A total of $5 million will be invested by the province to support these programs.

In addition, a new public education website featuring tools has been launched to give Ontarians a one-stop-shop to get accurate information and simple, easy-to-use tips to combat infestations. The province is also distributing a guide, *An Integrated Pest Management Program for Managing Bed Bugs,* to stakeholders on how to identify bed bug infestations, perform inspections properly, prepare living areas for treatment and carry out pest treatments.

The province and the public health units are also working to develop better ways to assess bed bug activity and infestations.

Today's announcement responds to recommendations from a Bed Bug Summit hosted by MPP Mike Colle on September 29, 2010.

QUOTES

"Our government recognizes that bed bug infestations are a problem affecting Ontarians throughout the province. We are investing in local solutions aimed at preventing and managing these pests as well as providing thorough education and awareness to the public and stakeholders."
- Mike Colle, MPP for Eglinton-Lawrence

QUICK FACTS

- Toronto Public Health has seen a dramatic increase in infestation reports – from 46 in 2003 to more than 1,500 in 2009.
- Adult bed bugs are 3mm - 5mm in size - about the size and shape of an apple seed – and a reddish brown color.

LEARN MORE

For information on bed bugs and how to prevent or get rid of them, see www.bedbugsinfo.ca.

For public inquiries call ServiceOntario, INFOline at 1-866-532-3161 (Toll-free in Ontario only)

Media Contacts:
Neala Barton, Minister's Office, 416-327-4388
David Jensen, Ministry of Health and Long-Term Care, 416-314-6197

Ontario

Appendix C

BACKGROUNDER

Ministry of Health and Long-Term Care

Bed Bug Initiatives

January 10, 2011

Like many jurisdictions, including the United States, United Kingdom, Australia and other Canadian provinces, Ontario is seeing a growing number of bed bug infestations being reported.

The province is responding with a number of initiatives aimed at preventing and managing bed bugs, including:

- Funding up to $5 million for local education and awareness initiatives and to support vulnerable populations
- Launching a new public education campaign that features a new website to inform Ontarians how to identify bed bugs and what actions they can take
- Distributing an integrated pest management best practices guide on how to identify bed bugs, perform inspections properly, prepare living areas for treatment, and carry out pest control treatments.

Local Initiatives

The government is providing up to $5 million in funding to support public health units in addressing bed bugs in their communities. The province's 36 public health units can apply for funding to support bed bug-related programs that emphasize coordination with other local services, education and awareness and/or provide supports to vulnerable populations.

New Website: www.bedbugsinfo.ca

The new website is a one-stop-shop for the public to get accurate information and simple, easy-to-use tips to combat infestations. The site will also include resources, templates and pre-prepared materials for different organizations to use in various settings to bring information to their own members.

Integrated Pest Management Program for Managing Bed Bugs

A guide, *An Integrated Pest Management Program for Managing Bed Bugs* is being distributed on how to identify bed bug infestations, perform inspections properly, prepare living areas for treatment and carry out pest treatments. The guide stresses bed bug prevention through education of residents, facility managers and landlords. It also provides an educational resource for service providers such as visiting nurses, social workers, tradespersons and others who must, as part of their job, visit or come into contact with people who may have bed bug infestations.

Neala Barton, Minister's Office, 416-327-4388
David Jensen, Ministry of Health and Long-Term Care, 416-314-6197

Appendix D

Bed Bugs Website
Qs and As

THE WEBSITE

What is this website all about?

With reports of increasing bed bug infestations and stakeholders expressing concern that people need guidance, the provincial government has developed a public education program to help Ontarians fight bed bugs. The website – www.bedbugsinfo.ca – will help the public do three key things effectively: Prevent, Identify and Act.

The website is a one-stop-shop for accurate information and simple, easy-to-use tips to combat infestations. It will also include resources, templates and pre-prepared materials for different stakeholders to use in various settings to bring the prevent/identify/act message to their own members.

Why did you feel you had to create this site? A lot of this information already exists on Toronto Public Health's (TPH) website as well as others.

The provincial government partnered with Toronto Public Health in the initial development of the website's content, as TPH had already done great work in this field due to local need. However, a central site is needed with content that is applicable across the whole province and with resources and information that would be able to serve residents and stakeholders, in different parts of the province.

How much did you spend to create this site?

The development costs of the web site are about $100,000

Who was involved in the creation of the site?

Bed bug infestation is an issue that cuts across the jurisdiction of many provincial ministries. The following were involved in developing and vetting content for the website:

Ministry of Health and Long-Term Care
Ministry of the Environment
Ministry of Municipal Affairs and Housing
Ministry of Community and Social Services
Ministry of Tourism and Culture
Ministry of Consumer and Business Services
Ministry of Health Promotion and Sport
Ministry of Children and Youth Services

GENERAL QUESTIONS / $5M FUND

How big a problem are bed bugs in Ontario?

In part because there is not a requirement to report bed bug infestations to any central authority and because there is a high level of stigma associated with them, it is very difficult to gather reliable data on the volume and occurrence of infestations. Health units have reported to the ministry both formal and anecdotal evidence of infestations in a wide range of settings including low-income/subsidized housing, shelters, rooming houses, private residences and long-term care homes.

To get a handle on this question however, collaborative work has been initiated between Ontario Agency for Health Protection and Promotion (OAHPP) and public health units to discuss how to better understand distribution of bed bugs, as well as causal linkages.

In September 2010, a public opinion poll conducted by IPSOS Reid showed that 2% of Ontario respondents reported they were currently experiencing a bed bug infestation and 4% reported having experienced a bed bug infestation in the past.

Can you get sick from bed bugs? Do bed bugs cause disease?

Although bed bugs and their bites are a nuisance, they are not known to spread disease in humans. Bed bug bites can be very itchy and irritating. Most welts heal in a few days but in unusual cases, the welt may persist for several weeks. The most significant health effects appear to be psychological, including stress, anxiety, depression, and fatigue caused by the presence of bed bugs in the home. Anxiety about being bitten can lead to sleeplessness, which can affect one's wellbeing. Properly and effectively responding to bed bugs helps reduce anxiety.

Aren't bed bugs more of a problem when people live in unsanitary conditions?

Even the cleanest homes or hotels can have bed bugs but regular inspection and housecleaning can prevent or help discover infestation in its early stages. Clean up clutter to help reduce the number of places bed bugs can hide. Sealing cracks and crevices with caulking can also help prevent bed bugs from coming into your home.

Is the Province offering any help to Ontarians who have problems with bed bugs? Any assistance to populations particularly vulnerable to infestations and who may not be able to afford the services of pest management companies?

The government is providing $5 million in funding to support public health units in addressing bed bugs in their communities with a special emphasis for vulnerable populations.

What kinds of projects will this money be used for?

The province's 36 public health units can apply for funding to support bed bug-related programs along with local partners that emphasize education and awareness and/or provide supports to vulnerable populations.

What criteria will be used to evaluate a health unit's application to determine if funding will be allocated?

A process for applying for funding and for evaluating the applications will be developed early in 2011 and will be communicated to the public health units.

Is this $5M funding going to be available to health units every year to fight bed bugs?

The $5 million is being offered as one-time funding, available to public health units to support bed bug-related programs that emphasize education and awareness and/or provide supports to vulnerable populations.

Is there a cap for the amount that an individual health unit can apply for out of the total $5 million fund?

A process for applying for funding and for evaluating the applications will be developed early in 2011 and will be communicated to the public health units. Each application will be evaluated in accordance with pre-determine criteria and the appropriate level of funding will be determined.

Is there an expectation that the $5 million will be evenly distributed across the province?

No. The degree of bed bug infestations varies across the province. It is expected that the applications submitted by the public health units will reflect the degree of bed bug infestations in their health unit areas.

Why do you think that $5 million in one-time funding for the whole province will be enough?

In part because there is not a requirement to report bed bug infestations to a central authority and because there is a high level of stigma associated with them, it is very difficult to gather reliable data on the volume and occurrence of infestations. Therefore, we do not know the exact extent of bed bug infestations across the province and are not able to estimate the exact cost of addressing this

issue provincially. Up to $5 million is currently available on a one-time basis to support public health units in addressing this issue provincially. Funds will be allocated to public health units based on an assessment of need in their communities and the submission of an application to request necessary funds to support bed-bug related programs.

Toronto Public Health requested funding early in 2010 and this request was declined, why are you providing this funding now?

The issue of increasing bed bug infestations is being reported by various jurisdictions across the province. The government views this as a provincial issue that impacts many public health units. Therefore, the ability to request funding to support bed bug-related programs is being made available to all public health units across the province.

If a facility (e.g., a long-term care home or a subsidized housing facility) needs funds to get rid of bed bugs, can it apply to access funds out of the $5 million?

The funding will be made available to public health units to support bed bug-related programs based on an assessment of need in their communities. The obligation of owners of buildings to keep their sites pest-free is not diminished.

Are you planning any other initiatives to deal with bed bugs?

The government is also launching a new website to inform Ontarians on how to identify bed bugs and what actions they can take. As well, the government is distributing the document *An Integrated Pest Management Program for Managing Bed Bugs* to stakeholders on how to identify bed bugs, perform inspections properly, prepare living areas for treatment, and carry out pest control treatments.

Once the OAHPP and other public health units get a better understanding of the prevalence of bed bug infestations, will the province look towards making the bed bud funding a yearly allocation?

Up to $5 million is currently available on a one-time basis to support public health units in addressing this issue provincially. It is hoped that this funding will make a significant contribution to limiting and preventing new and worsening infestations.

ENVIRONMENT

What is *An Integrated Pest Management Program for Managing Bed Bugs* about?

An Integrated Pest Management Program for Managing Bed Bugs covers the fundamental components of an integrated pest management (IPM) program that include planning, education, identification, inspection, record keeping, preparation, treatments and evaluation. It is applicable to all stakeholders who live in or manage residential and commercial dwellings, the pest management industry and other industry and government agencies and the most vulnerable people in society. This document stresses bed bug prevention through education of clients, residents, facilities managers, and landlords and provides an educational resource for professionals and service providers such as visiting nurses, social workers, tradespersons and others who must, as part of their job, visit or come into contact with persons who have a bed bug infestation. The document includes as an appendix an IPM Decision Flow Chart for Bed Bugs and a web-linked Additional Reading resource.

Does this information exist already?

There are numerous publications available on the internet that provide basic biology, inspection, prevention and control best practices for bed bugs. Some of these publications provide inaccurate or misleading information especially as it relates to control measures and pesticide use. The document *An Integrated Pest Management Program for Managing Bed Bugs* outlines the principles of IPM to prevent and manage bed bugs in all types of residential settings as it relates to Ontario pesticide legislation.

How are pest management operators regulated in Ontario?

A business that provides a service to manage pests and uses pesticides to do so must hold an Operator licence and have appropriate insurance coverage as prescribed in Ontario's Pesticides Act and Ontario Regulation 63/09. Also, employees of the company that use pesticides to manage bed bugs must be certified and licensed as a Structural licensed exterminator.

Can the province issue a list of the pest management companies it recommends so landlords, tenants and homeowners can know whom to trust?

No, the province can not provide a list of recommended companies. The document *An Integrated Pest Management Program for Managing Bed Bugs* provides information on what to look for when selecting a pest management company.

Can the province advise how much these pest management services should fairly cost so the public does not over-pay?

No, the province cannot advise the public as to what they should pay for a service call from a pest management company. The document recommends that customers obtain several quotes and compare what is being service is being provided for that cost and consult the document *An Integrated Pest Management Program for Managing Bed Bugs* as it provides information on what to look for when selecting a pest management company.

Where can the public complain and get their money back if they feel they have been provided an ineffective pest management service?

Complaints regarding the misuse of a pesticide by a pest management company or a landlord should be directed to the Ministry of the Environment local district offices. After business hours, call the Ministry of the Environment's Pollution Hotline at 1-866-MOE-TIPS (1-866-663-8477). Issues regarding contracts, failure to honour guarantees or other service related issues should be addressed to the Ministry of Consumer Services.