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 February 17

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 (Vice-Chair)
Ms. Patricia Coderre (Chair)	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 (Secretary-Treasurer)

DISCLOSURE OF CONFLICTS OF INTEREST

APPROVAL OF MINUTES

APPROVAL OF AGENDA

SCHEDULE OF APPOINTMENTS

ACTION REQUIRED

1) Promoting Eye Health in Children (Report No. 013-11)

2) Fluoridation of the City of London's Drinking Water (Report No. 014-11)

3) Board of Health Policy 2-010 and Bylaw Amendments (Report No. 015-11)

4) Board of Health Policy 2-020 Amendments (Report No. 016-11)

5) 2010 Remuneration Report (Report No. 017-11)

FOR INFORMATION

6) Medical Officer of Health Activity Report – February (Report No. 018-11)

7) Summary of Lead Flushing and Sampling at Schools, Private Schools and Day Nurseries (Report No. 019-11)

8) Final Strategy of Shaken Baby Syndrome, "Period of Purple Crying," Implementation Program (Report No. 020-11)

9) Emergency Preparedness Exercise (Report No. 021-11)

10) Connecting Children and Youth to Lifelong Physical Activity and Sport (Report No. 022-11)

11) 2010 Vendor Payments (Report No. 023-11)

CONFIDENTIAL

OTHER BUSINESS

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

CORRESPONDENCE RECEIVED

a) Dated 2010 December 20 (Received 2011 January 11) Correspondence from the Honourable Jim Bradley, Minister of Community Safety and Correctional Services, thanking the Health Unit for the work staff undertook during the weather emergency Lambton County experienced December 13 and 14, 2010.

b) Dated 2010 December 31 (Received 2011 January 11) Correspondence from Ms. Allison Stuart, Assistant Deputy Minister of Health and Long-Term Care, re one-time capital and administrative funding for the Healthy Smiles Ontario program may be spent until March 31, 2011.

c) Dated 2011 January 5 (Received 2011 January 12) Correspondence from Ms. Penny Nelligan, Director, Standards, Programs and Community Development, Ministry of Health Promotion and Sport re 2011 (Calendar Year) CINOT Expansion Budgets.

d) Dated 2011 January 6 (Received 2011 January 17) Correspondence from Ms. Allison Stuart, Assistant Deputy Minister of Health and Long-Term Care, re one-time funding to support Safe Water may be spent until March 31, 2011.

e) Dated 2011 January 11 (Received 2011 January 11) Correspondence from Mr. Jim Embrey, Chair, Peterborough County-City Health Unit to The Right Honourable Stephen Harper, Prime Minister of Canada, stating At its November 10, 2010, meeting, the Board of Health of the Peterborough County-City Health Unit passed the following resolution:

> *That the Peterborough County-City Board of Health call on our federal government to do the following:*
> *• Urge the Prime Minister to encourage his U.S. counterpart to work towards full licensing of all U.S. manufacturers of tobacco products; and*
> *•Urge the federal government to prohibit the sale of raw materials to unauthorized manufacturers in Canada.*

f) Dated 2011 January 11 (Received 2011 January 11) Correspondence from Mr. Jim Embrey, Chair, Peterborough County-City Health Unit to The Honourable Leona Aglukkaq, P.C., M.P., Minister of Health, stating At its November 10, 2010, meeting, the Board of Health of the Peterborough County-City Health Unit passed the following resolution:

> *That the Peterborough County-City Board of Health call on our federal government to do the following:*
> *• Urge Health Minister Aglukkaq to fund local smoking cessation programs targeted at pregnant and postpartum mothers.*

g) Dated 2011 January 11 (Received 2011 January 11) Correspondence from Mr. Jim Embrey, Chair, Peterborough County-City Health Unit to The Honourable Margarett R. Best, Minister of Health Promotion and Sport, stating At its November 10, 2010, meeting, the Board of Health of the Peterborough County-City Health Unit passed the following resolution:

> *Be it resolved that the Peterborough County-City Health Unit…Congratulate the Ministry of Health Promotion and Sport for continuing its support of local youth engagement in tobacco use prevention and request funding for a pilot project of the "Reward and Reminder" approach with interested local partners to strengthen existing prohibition of sales and retail promotion to youth under 19 years of age.*

h) Dated 2011 January 11 (Received 2011 January 11) Correspondence from Mr. Jim Embrey, Chair, Peterborough County-City Health Unit to The Honourable Dalton McGuinty, Premier of Ontario, stating At its November 10, 2010, meeting, the Board of Health of the Peterborough County-City Health Unit passed the following resolution:

> *Be it resolved that the Peterborough County-City Board of Health call upon Premier McGuinty and his provincial Cabinet Ministers to work closely with the federal government in efforts to reduce the prevalence of tobacco use through a comprehensive tobacco strategy.*

i) Dated 2011 January 18 (Received 2011 January 31) Correspondence from The Honourable Deb Matthews, Minister of Health and Long-Term Care, re one-time funding to support activities related to World Tuberculosis Day on March 24, 2011.

j) Dated 2011 January 19 (Received 2011 January 27) Correspondence from The Honourable Chris Bentley, Attorney General and MPP, London West, thanking the Health Unit for the copy of Report No. 133-10 re Cost of Basic Needs Middlesex-London 2010 and that he would share it with his colleagues at Queen's Park.

k) Dated 2011 January 21 (Received 2011 January 28) Correspondence from Dr. Hazel Lynn, Medical Officer of Health, Grey Bruce Health Unit to The Honourable Brad Duguid, Ontario Minister of Energy and The Honourable John Wilkinson, Ontario Minister of the Environment, stating that the Board of Health of the Grey Bruce Health Unit passed the following resolution:

> ***WHEREAS*** *the Operational Roles and Responsibilities for Boards of Health as identified in the Identification, Investigation and Management of Health Hazards Protocol of the Ontario Public Health Standards states:*
>
> *a) In collaboration with the lead government agencies with primary responsibility for the environmental health issue and/or other relevant agencies, experts and interested parties as applicable, the Board of Health shall manage identified health hazards in the environment by:*
>
> *i) Developing options and implementing action plans, including strategies for corrective actions for controlling and where possible mitigation exposure, based on a risk assessment approach. These options many include healthy public policy;*

ii) Developing and implementing risk communication strategies for the public and stakeholders specific to the environmental health issues;
iii) Providing educational material and/or information to the public about health hazards in the environment and actions to minimize the hazards and/or reduce exposure;
iv) Monitoring corrective actions pertaining to identified health hazards in the environment; and
v) Addressing non-compliance with the Health Protection and Promotion Act and taking action where appropriate.

***WHEREAS** the sound made by industrial wind farm technology is, by its nature, difficult to measure and predictive models do not always accurately reflect the many factors influencing the nature of the sound, resulting in an incomplete hazard characterization;*

***WHEREAS** the effect of this noise on people living nearby is not well quantified, resulting in poor or non-existent exposure assessment;*

***WHEREAS** people in Grey Bruce have voiced concern with respect to the negative impacts from the proximity of industrial wind farms to their residence;*

***THEREFORE BE IT RESOLVED THAT** the Board of Health for the Grey Bruce Health Unit request the Province of Ontario to undertake **s**tudies to explore and research in the following areas:*

1. Determining the prevalence of susceptibility – what portion of exposed people suffer distress.
2. Comparisons of the prevalence of susceptibility between various Industrial Wind Turbine technologies, designs, size and siting.
3. Improving field measurement of the broad band noise including low frequency noise.
4. Finding a biomarker for susceptible individuals.
5. Collecting econometric data to assess the real costs of the new technology.
6. Examining technological changes in design, operation and maintenance of Industrial Wind Turbine installations to reduce the noise and impact on residents.
7. Community and social research to determine the best way to introduce new technology to a variety of communities so that the community and social disruption is lessened.
8. Looking at what specific community research and consultation should be undertaken before installation of an Industrial Wind Turbine development in order to ensure that everyone in the community can tolerate the new technology and all will benefit.

All with the goal to eliminate the individual distress and community disruption by:

i. *reducing the uncertainties related to exposure by improving measurement*
ii. *improving the technology and thus reducing exposure*
iii. *improving the process of introducing new technology into communities by developing appropriate public policy*

***FURTHER THAT** a copy of this resolution be forwarded to the Honourable Dalton McGuinty, Premier of Ontario; our local members of Provincial Parliament, Dr. Arlene King, Chief Medical Officer of Health, the Association of Local Public Health Agencies, Ontario Boards of Health; and all Ontario Medical Officers of Health.*

l) Dated 2011 January 25 (Received 2011 January 25) Correspondence from Mr. Andy Sharpe Chair, Peterborough County-City Health Unit to The Honourable Leona Aglukkaq, P.C., M.P., Minister of Health; The Honourable Deb Matthews, Minister of Health and Long-Term Care; and The Honourable Margarett R. Best, Minister of Health Promotion and Sport, requesting the Ministers to consider the following:

1. That advertising and sale of energy drinks to children and youth be restricted; and,

2. Premixed alcohol and energy drinks not be sold in liquor outlets as follow-up from the Health Canada Media Advisory in March 2010 that stated "An energy drink containing alcohol would be subject to different regulations under the Food and Drugs Act, and would be evaluated differently - as a food, and not as a natural health product…Health Canada will be following up with liquor boards and other relevant bodies to ensure that the regulations and their implications for energy drinks containing alcohol are appropriately understood… Health Canada continues to advise consumers not to mix energy drinks with alcohol."

m) Dated 2011 January 26 (Received 2011 January 28) Correspondence from Ms. Linda Stewart, Executive Director, Association of Local Public Health Agencies, re Call for Board of Health Representative to alPHa Board of Directors from the South West region.

Copies of all correspondence are available for perusal from the Secretary- Treasurer.

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 013-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 February 17

Promoting Eye Health in Children

Recommendations

It is recommended:

1. That the Board of Health endorse the discontinuance of the school vision screening program to be replaced by a comprehensive strategy to promote preschool screening as described in Report No. 013-11; and further
2. That a letter of appreciation be sent from the Board of Health to each Volunteer who assisted with vision screening in the schools.

Issue

The Health Unit has offered vision screening in schools for many decades. What has come into question is whether or not screening after a child has entered school is too late. That is, should the focus be on screening prior to school entry. This report describes the Health Unit's current screening program and makes the case for changing to a practice of implementing comprehensive strategies to promote vision screening by Optometrists prior to school entry.

Background

There is a vital connection between good vision and children's ability to learn, as more than 80% of learning occurs through the eyes. One in six children (17%) has a vision problem significant enough to impair learning ability. Children with poor vision often find it difficult to focus and may be misdiagnosed as having a learning or behavioural disability. Often, there are no signs that a child has a vision problem. If vision problems are undetected, they can, in some instances, lead to permanent sight loss.

Identifying vision problems early can improve learning outcomes. An expected Ontario Public Health Standards outcome is to increase the proportion of children beginning school ready to achieve success; eye examinations are a key step in this. The Ontario Association of Optometrists recommends eye exams at 6 months and 3 years of age, then annually or as recommended. Although the Ontario Health Insurance Plan (OHIP) covers annual eye exams for children 19 years of age and under, in 2009, only 7% of 0-4 year olds had their eyes examined by an Optometrist.

Current Vision Screening Program

A Registered Nurse has coordinated the Health Unit's vision screening program for many years, training volunteers, assisting with screening and making referrals for further assessment. During the 2009/10 school year, 29 volunteers offered screening in 76 schools, with 4162 JK and SK children screened; 213 children were referred to a Physician or Optometrist for more comprehensive evaluation. Follow-up information was obtained for 85 children. Of the 85, 62 children received glasses or were diagnosed with other eye conditions. In extrapolating these follow-up results to the total of 213 referrals made, 4% of all screened children required glasses or were diagnosed with other eye conditions. The London Central Lions Club has provided eyeglasses to children in need. During the past school year, 10 children received glasses. A letter of thank you was sent to the Club for its support.

Vision screening has been offered every year (1/2 of schools each year), with all children being screened in either Junior Kindergarten (JK) or Senior Kindergarten (SK). Based on the past two years of statistics, it is estimated that the Health Unit's vision screening program resulted in the identification of vision problems in about 4% of JK/SK children. This is considerable; however, 17% of children have significant vision problems that impair learning ability

To determine what other Ontario health units are doing regarding vision screening in schools, a survey was conducted; 34 health units responded (2 health units conduct vision screening, 2 offer limited vision testing, and 29 do not conduct vision screening/testing. 19 health units do not engage in eye health promotion activities, while 13 are involved in some activities promoting children's eye health.

Proposed Vision Screening Program

Research is inconclusive regarding school vision screening program benefits. The specific test(s) used, the age and underlying health of children, and the personnel administering the test(s) all influence the

effectiveness of preschool vision screening. Children with vision problems are more accurately identified by comprehensive eye examinations by an Optometrist or Ophthalmologist. Health Unit staff is proposing a shift from the provision of individual vision screening to a focus on comprehensive strategies that would optimize children's readiness for school success. These strategies would aim to increase the proportion of children having eye examinations prior to school entry and to ensure families in financial need have access to eyeglasses. The Child Health Team (CHT) plans to use the following strategies:

- Raise Awareness
  - Conduct a social marketing campaign emphasizing eye examinations prior to school entry
- Provide Education
  - Inform parents, childcare providers, school staff, and physicians of the link between vision and learning, common lack of signs of visual impairment, need for eye exams prior to school entry, and OHIP coverage for children's annual eye exams.
- Increase Environmental Support
  - Maintain a current list of available and appropriate resources and service providers
  - Assess barriers that prevent children from undergoing eye examinations and address them
  - Engage physicians, child care providers, school staff and public health nurses to increase the number of interactions during which preschoolers' parents are prompted to seek an eye exam for their child
  - Increase the availability of free or nearly-free children's eyeglasses for those in financial need
- Create Policy
  - Advocate for a policy requiring eye examinations for children prior to school entry.

The full-time equivalent position which has been dedicated to school vision screening will reallocated to carry out the above plan, as well as engage in community outreach, parent engagement and work with schools/boards.

Conclusion
Replacing the current school vision screening program with a comprehensive approach to promoting preschool eye health in children is anticipated to result in an increased proportion of children that achieve school readiness and optimize their developmental, learning and health outcomes.

This report was prepared by Heather Lokko, Program Manager, CHT, 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, Requirements 4, 5, 7 and 8.

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 014-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 February 17

Fluoridation of the City of London's Drinking Water

Recommendation
It is recommended that the Board of Health support the ongoing fluoridation of the City of London's drinking water supply as a measure to achieve optimal dental/oral health for all residents, which is an important component of total health.

Introduction
The Board of Health has considered water fluoridation in several past Board of Health Reports including: Report No. 043-07 re Ontario Fluoridation Office (March 2007), Report No. 107-07 re Request to Establish an Ontario Fluoridation Office (June 2007), Report 111-08 re Water Fluoridation (September 2008) and Report No 006-09 re Water Fluoridation (January 2009) (Appendix A). As well, on October 16, 2008, the Board of Health heard a presentation by Mrs. Carole Clinch, Research Coordinator for the People for Safe Drinking Water, entitled "To Stop Water Fluoridation."

The purpose of this current Board of Health Report is to seek the Board of Health's support for the ongoing fluoridation of London's drinking water. This report will provide an overview of water fluoridation in London including background information on fluoride such as how it works, how its benefits were discovered and its importance as a public health strategy; the process for fluoridating and monitoring London's water and the cost of this process; and the benefits and safety of water fluoridation.

Background
It is increasingly recognized that oral/dental health is an important component of total health. Cavities (also known as tooth decay or dental caries) are holes in the teeth that if left unchecked can lead to pain, infection in the mouth and occasionally in the body, and loss of the tooth. To prevent or alleviate the pain, the hole in the tooth must be filled or the tooth extracted. Despite significant declines in tooth decay over the past decades, it remains a very common chronic childhood disease. A survey of dental indices among Ontario Health Units from 1979 to 2008 revealed that 34% of 5-year-olds had evidence of decay, with even higher rates in older children. Similarly, results from Middlesex-London in 2007-2008 indicated that 35% of 1,264 5-years olds had evidence of ever having tooth decay.

Fluoride is a naturally occurring mineral that has been proven to prevent tooth decay. Fluoride affects the enamel of the teeth such that it stops, or potentially reverses the tooth decay process. Fluoride's main effect occurs after the tooth has erupted into the mouth, as small amounts of fluoride in saliva frequently bathe the tooth. Ingesting high levels of fluoride when the teeth are being formed may cause fluorosis, a cosmetic condition where the teeth have white spots, and in severe cases the teeth can be pitted or have brown stains.

The benefits of fluoride in preventing tooth decay were discovered in the 1930s and 1940s. It was noted that communities with high rates of fluorosis also had low rates of tooth decay. Both the fluorosis and lack of decay were attributed to high levels of natural fluoride in the drinking water. In the 1940s, studies were conducted to assess the effect of low levels of fluoride in drinking water on tooth decay. When comparing cities with fluoride added to the water and non-fluoridated water, it was determined that cities receiving fluoridated water had 50-70% lower rates of tooth decay. Based on amounts of water consumed, a safe level of fluoride was determined that decreased tooth decay without increasing the risk of fluorosis.

By the 1980s, the difference in decay rates between communities with fluoridated and non-fluoridated water had narrowed, in part due to the fact that non-fluoridated cities were also receiving fluoride through foods and beverages that are bottled and processed in areas with fluoridated water (referred to as the "halo effect") and also due to the widespread use of toothpaste with fluoride. Nonetheless, studies have still continued to demonstrate the benefits of fluoridation of the water, and studies where fluoridation is stopped demonstrate an increase in rates of tooth decay, approaching the levels in the non-fluoridated

group. Fluoridation ensures benefit to all those who drink the water, regardless of socioeconomic status, age, ability to regularly brush teeth, or access to dental care.

The Ontario Ministry of the Environment (MOE) estimates that 70% of Ontario residents receive water that is fluoridated, either naturally or by adding fluoride to the water. As of 2005, community fluoridated drinking water was provided to 43% of Canadians. In the United States, approximately 67% of the population receives optimally fluoridated water. Fluoridation of drinking water is less common in European countries although some countries fluoridate their salt.

Fluoride has been recognized by the United States Center for Disease Control and Prevention as one of the ten great public health achievements of the twentieth century and is supported by numerous public health and oral/dental health organizations. It is estimated that for every $1 invested in community water fluoridation, $38 in dental treatment costs are avoided. In Middlesex-London alone, $596,045 was spent in 2009 to cover the cost of urgent dental treatment for children aged 0-17 years whose families could not afford the cost. For many individuals, particularly those over 17 years of age, financial limitations present a major barrier to accessing basic dental care, making strategies that focus on prevention of dental disease, such as fluoride, very important.

Fluoridation in London

The MOE stipulates that where fluoride is added to drinking water, the concentration be adjusted to 0.5 - 0.8 mg/L, the optimum level for control of tooth decay. The City of London receives its water from two sources – about 85 % from Lake Huron and 15% from Lake Erie. The natural level of fluoride in both these water sources is approximately 0.1 mg/L. This level is too low to prevent tooth decay. As per Ontario's Fluoridation Act, a plebiscite was held in London in 1966 through which residents voted to have fluoride added to the water. Beginning in 1967, Lake Huron water has been fluoridated at the Arva Pumping Station before distribution within London. In 1996, the City of London connected to the Lake Erie system which adds fluoride at the Elgin Area Water Treatment Plant. It should be noted that fluoride is not added to water in any jurisdiction in Middlesex County, although fluoride levels are naturally higher in the Thorndale area.

The level of fluoride in London's water is maintained at 0.7 mg/L to provide optimal protection against tooth decay without increased risk of dental fluorosis. The level is continually monitored by the City of London and monthly summaries are provided to the Health Unit. Health Unit staff also provides advice to residents of Middlesex-London on other measures to prevent dental fluorosis such as: not using fluoridated toothpaste for the first two years of life and after that, using only a pea-sized amount of fluoridated toothpaste under adult supervision without swallowing and not using fluoride supplements such as pills or drops. A screening conducted by Health Unit staff in 2006 revealed that London had very low rates of fluorosis of cosmetic concern; of note, the rate in London, where the water is fluoridated (5%), was similar to Strathroy, where the water is not fluoridated (4.6%).

To add fluoride to London's drinking water, hydrofluorosilicic acid is used. The source of this product is an ore that is mined and processed in Florida which is rich in fluoride and phosphorus. The processing involves separating the fluoride from the phosphorus, with the fluoride being used to create hydrofluorosilicic acid and the phosphoric acid being used to create chemical fertilizer. Any substance that is added to drinking water is required to pass rigorous testing to ensure that it meets the high standards that are legislated for the water industry such as the National Sanitation Foundation and American National Standards Institute (NSF/ANSI) Standards for purity. The NSF/ANSI Standards for fluoride products added to drinking water are even more stringent than the US standards that apply to fluoride products used in pharmaceuticals.

A detailed costing of the fluoridation of London's water was done by Mr. Dan Huggins, Water Quality Manager for the City of London. Including annual operating costs and amortized capital costs, the fluoridations of London's water costs approximately $133,000 per year, or about 38¢ per each London resident.

Benefits and Safety of Water Fluoridation

Many research articles have been written with regard to the benefits and safety of water fluoridation. Several systematic reviews (where experts review the scientific papers and draw conclusions based on the papers that are judged to be scientifically sound) have been published. These review papers provide

strong support for the ongoing fluoridation of water for the prevention of tooth decay. A summary of the key findings of these reports and the position of credible scientific organizations can be found in Appendix B which is a memo from Dr. David Williams, the Associate Chief Medical Officer of Health for Ontario. Aside from fluorosis, which is very infrequent when levels of fluoride are kept at 0.7 mg /L as in the City of London, the papers also provide no evidence of harm from fluoridation of the water. To quote the most recent review entitled "Fluoride in Drinking Water," which was conducted by Health Canada and issued for public comment on November 27, 2010:

> *"The weight of evidence from all currently available studies does not support a link between exposure to fluoride in drinking water at 1.5 mg/L and any adverse health effects, including those related to cancer, immunotoxicity, reproductive/developmental toxicity, genotoxicity and/or neurotoxicity. It also does not support a link between fluoride exposure and intelligence quotient deficit, as there are significant concerns regarding the available studies, including quality, credibility, and methodological weaknesses."*

There is also no evidence that fluoride in water has any negative effects on the environment.

Conclusion

The scientific evidence strongly supports the fluoridation of water to prevent tooth decay. The evidence also provides reassurance as to the safety of this important public health strategy. It is recommended that the Board of Health endorse the recommendation to support the ongoing fluoridation of London's water supply as a public health measure to achieve optimal dental/oral health, which is an important component of total health.

This report was prepared by Dr. Bryna Warshawsky, Associate Medical Officer of Health and Director, Oral Health, Communicable Disease and Sexual 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

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 043-07

TO: Chair and Members of the Board of Health

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

DATE: March 15, 2007

ONTARIO FLUORIDATION OFFICE

Recommendation

It is recommended:

1. ***That the Board of Health support the formation of an Ontario Fluoridation Office funded by the province; and further***

2. ***That the Board of Health seek the support of other Ontario Boards of Health for the establishment of an Ontario Fluoridation Office; and further***

3. ***That letters be sent by the Middlesex-London Board of Health to the Minister of the Environment, the Minister of Health and Long-Term Care, the Minister of Health Promotion and the Chief Medical Officer of Health for Ontario to seek support.***

Oral health is an important part of total health. The Centers for Disease Control and Prevention (CDC) in Atlanta identified community water fluoridation as one of the 10 most important public health measures of the 20th century. Although recent data indicate that approximately 70% of the Ontario population has access to fluoridated water, the opposition to fluoridation persists and challenges continue to be presented. Those opposed to fluoridation are more organized than ever. In Southwestern Ontario, there have been at least 4 challenges to fluoridation in the last 4 or 5 years including a recent lawsuit.

Community water fluoridation is a complicated and emotional topic. An example of how concern and confusion can be created is the syndicated column (60 newspapers) by Dr Gifford Jones which appeared in the 2007 January 20 London Free Press (Appendix A)

Given the importance of water fluoridation, Ontario public health dentists convened to discuss the topic from an Ontario perspective. A number of recommendations were discussed including the establishment of an Ontario Fluoridation Office by the provincial government. The Office should be provided resources and be empowered to:

- constantly assemble and review current scientific evidence on fluorides and water fluoridation
- monitor and maintain an inventory of the fluoridation status and fluoride challenges in Ontario and keep track of the arguments and concerns presented and what the outcomes were
- evaluate Ontario data for evidence of the effectiveness of water fluoridation

The Ontario Association of Public Health Dentistry (OAPHD) has addressed the topic before and approached the provincial government for their support. In a 2005 September 16 letter to Dr Butler-Jones, the Chief Medical Officer for Canada, Ontario's chief medical Officer of Health at that time, Dr. Basrur, asked that there be a federal initiative in this area. It is the OAPHD's position that Ontario needs a unified effort on community water fluoridation. The OAPHD will be seeking support from a number of organizations in Ontario. The Council of Ontario Medical Officers of Health has endorsed this position (Appendix B).

This report was prepared by Dr. Neil Farrell, Director of Dental 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: (Family Health-Child Health)

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 107-07

TO: Chair and Members of the Board of Health

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

DATE: June 21, 2007

REQUEST TO ESTABLISH AN ONTARIO FLUORIDATION OFFICE

Recommendation

It is recommended that Report No. 107-07 re the current status of the Middlesex-London Board of Health's request to establish an Ontario Fluoridation Office be received for information.

This is a summary of what is perceived to be the current status of the response to the requests to a number of Ontario Ministries (Health Promotion, Health and Long Term Care, Environment) and the Chief Medical Officer of Health to create an Ontario Fluoridation Office. Requests were forwarded to them from a number of organizations including the Ontario Association of Public Health Dentistry (OAPHD), the Council of Ontario Medical Officers of Health (COMOH), the Middlesex-London Board of Health and many public health units.

It was requested that the Fluoridation Office be created and provided the resources to:

- constantly assemble and review current scientific evidence on fluorides and water fluoridation
- monitor and maintain an inventory of the fluoridation status and fluoride challenges in Ontario and keep track of the arguments and concerns presented and what the outcomes were
- evaluate Ontario data for evidence of the effectiveness of water fluoridation

Dr. Pasut, the Acting Chief Medical Officer of Health, responded in writing (2007, April 30) to the Middlesex-London Board of Health and essentially stated that on 2006 December 12 the government introduced Bill 171, the Health System Improvement Act which, if passed, could create an Ontario Agency for Health Protection and Promotion. This agency, if created, could be a centre for specialized research and knowledge in public health and it may consider the issues that the proposed Fluoridation Office was intended to address.

Therefore, at this time, it appears that the creation of an Ontario Fluoridation Office is uncertain. Its future creation, or a body serving a similar purpose, would seem to depend on:

- the passing of the Health Systems Improvement Act;
- the creation of an Ontario Agency for Health Protection and Promotion subsequent to the Act's being passed;
- determining if the Ontario Agency would address Fluorides and Fluoridation as part of its mandate.

This report was prepared by Dr. Neil Farrell, Director, Dental 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: Child Health Program-Monitoring the Fluoridation of Local Municipal or Regional Water Supply Protocol.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 111-08

TO: Chair and Members of the Board of Health

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

DATE: 2008 September 18

WATER FLUORIDATION

Recommendation

It is recommended that Report No. 111-08 re Water Fluoridation be received for information.

Considerable attention continues to be directed to water fluoridation by a small, organized group of individuals, primarily members of the Fluoridation Action Networks (FAN). A significant amount of time is devoted in communities addressing these concerns and responding to the same questions.

Often municipalities are approached by individuals with the view to having the local council discontinue fluoridation or to ask that a plebiscite be held on its removal. The City of London has been approached on several occasions including over the past summer.

In early 2007, the Ontario Association of Public Health Dentistry (OAPHD), as well as the Council of Ontario Medical Officer of Health (COMOH) requested the Ministers of Health Promotion, Health and Long Term Care and Environment to establish an Ontario Fluoridation Office (Appendix A). The Middlesex London Board of Health also supported this request.

The response dated 2007 April 30 from the then acting Chief Medical Officer of Health is attached. (Appendix B). No Ontario Fluoridation Office has been established.

A letter dated 2008 February 22 from the Regional Public Works Commissioners of Ontario to Ontario Acting Chief Medical Officer of Health and the Chief Drinking Water inspector is also attached (Appendix C) to indicate there are more groups than just public health involved with the issue.

Many respected organizations, including Health Canada, the World Health Organization and the Centre for Disease Control in the USA support water fluoridation.

Mr. Satish Deshpande of the Drinking Water Standards Section of the Ontario Ministry of the Environment has indicated that Health Canada hopes to commence, within this calendar year, a national consultation process on the Technical Support document for the Canadian Drinking Water Quality Guideline for "Fluoride in Drinking Water". This document is being revised by the Federal-Provincial-Territorial Committee on Drinking Water on which Mr Deshpande represents Ontario. It is the Ontario Ministry of the Environment's intent to also carry out a public consultation on this document on Ontario's Environmental Bill of Rights Environmental Registry.

This should provide the opportunity for groups which both support and oppose water fluoridation to present their arguments. It is not certain when the report will be finalized.

In areas where persons are pressing for cessation of fluoridation, elected officials should be informed of the above. It is recommended that any decisions on discontinuing or having a plebiscite on discontinuing fluoridation be deferred until the results of the public consultation and the final report are available.

Dr. Neil Farrell is a member of the ad hoc Fluoride Subcommittee of the Ontario Association of Public Health Dentistry.

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 Program -Monitoring the Fluoridation of Local Municipal or Regional Water Supply Protocol.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 006-09

TO: Chair and Members of the Board of Health

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

DATE: 2009 January 15

WATER FLUORIDATION

Recommendation

It is recommended that the Board of Health continue to support water fluoridation for optimal oral health.

Background

The fluoridation of drinking water has been the subject of a number of Board of Health reports and presentations over the past months. Following a presentation by a group opposed to fluoridation at the October Board Meeting, staff were directed to prepare a report on the issue for the new year. This report addresses the Board direction and begins with a chronology of recent events.

Chronology of Events

At the 2008 September 18 Board of Health meeting, an information report on Water Fluoridation was presented (Appendix A).

In 2008 October, Mr. Pat McNally, Acting General Manager of Environmental and Engineering Services and City Engineer, presented the report, “Requests To Discontinue Water Fluoridation In London” to the Environment and Transportation Committee (Appendix B). Dr. Neil Farrell, Dental Director, was directly involved in the drafting of that report.

At the 2008 October 16 Board of Health meeting, a presentation “To Stop Water Fluoridation” was made by Mrs. Carole Clinch, Research Coordinator for the People for Safe Drinking Water.

In 2008 November, after approximately 1.5 years of discussion and review, the Region of Hamilton Council approved the continued use of drinking water fluoridation for that community. That same month Region of Halton Council deferred a decision on continued support of water fluoridation until after the results of the consultation and review on “Fluoride in Drinking Water” being undertaken by Health Canada is available.

Government Action

The document “Fluoride in Drinking Water” is currently being revised by the Federal-Provincial-Territorial Committee on Drinking Water. It is the Ontario Ministry of the Environment's intent to also carry out a public consultation on this document. Persons with concerns about fluoridation are encouraged to submit their concerns during this consultation process. The report is expected to be finalized in early 2010.

In addition, the Chief Medical Officer of Health for Ontario has indicated that his office and the Ontario Ministry of Health Promotion will collaborate with the Council of Medical Officers of Health of Ontario, other relevant Ministries and the Ontario Agency of Health Promotion and Health Protection on water fluoridation.

Staff will closely monitor all reports and recommendations from these groups on fluoridation.

Summary

As stated in the report to the City of London Environment and Transportation Committee:

> *"Fluoridation of drinking water for the promotion of dental health is practiced by thousands of water systems in over 30 countries. Research into the health effects of water fluoridation has been ongoing for over 70 years and the world foremost dental and medical organizations support and promote the practice. Regardless, there is opposition to water fluoridation and organized lobbyists are now seeking to end the practice of water fluoridation in the City of London. To properly evaluate the multiple arguments put forward by groups opposed to water fluoridation requires a tremendous commitment of time and effort by informed medical professionals. Health Canada will soon be conducting such an exercise, seeking input from all concerned parties."*

It is therefore recommended that:

1. Any citizens or organizations making requests for London to cease fluoridation should be encouraged to present their arguments to the upcoming Health Canada review of the Canadian Drinking Water Guideline for Fluoride in Drinking Water, and

2. City officials should reserve any decisions regarding the cessation of drinking water fluoridation, including conducting a public plebiscite, until after the results of the aforementioned review have been published.

This report was prepared by Dr. Neil Farrell, Director, Dental Services.

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

This report addresses the following requirement(s) of the Ontario Public Health Standards:
Standard: Child Health - Protocol For The Monitoring of Community Water Fluoride Levels

Ministry of Health and Long-Term Care

Chief Medical Officer of Health

Public Health Division
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May 26, 2009

MEMORANDUM

TO: Medical Officers of Health, Associate Medical Officers of Health

RE: Value of Water Fluoridation

The Office of the Chief Medical Officer of Health has been asked to provide expertise and advice to Medical Officers of Health on the value of water fluoridation.

The practice of water fluoridation is one of the greatest public health achievements of the 20th century. More than 90 national and international professional health organizations including Health Canada, the Canadian Public Health Association, the Canadian Dental Association, the Canadian Medical Association, the U.S. Centers for Disease Control and Prevention, the National Institutes of Health and the World Health Organization have endorsed the use of fluoride at recommended levels to prevent tooth decay.

The use of fluoride in drinking water is a safe, effective, economical means of preventing dental cavities. The studies are clear and unequivocal and the benefits of fluoridation are well documented:

- where fluoride has been added to municipal water supplies, there has been a marked decline in the rates of tooth decay;
- water fluoridation reduces dental care expenditures, with an estimated $38 in avoided costs for dental treatment for every $1 invested in community water fluoridation; and
- the health benefits extend to all residents in a community regardless of age, education, or socio-economic status; the practice is particularly beneficial to seniors, underprivileged people, those living in conditions of material privation, and the hardest to reach poor for whom other preventive measures may be inaccessible.

Fluoride additives themselves are required to meet rigorous standards of quality and purity before they can be used, and, when added to water at levels recommended in Ontario and across the country, studies have determined that fluoride, is not harmful.

.../2

It is important to note that credible scientific organizations and associations continue to review the evidence and assess the benefits and harms of fluoridation. Their reports are publicly available and constitute the basis for the continuing support of water fluoridation. The most recent review is that of Health Canada. In 2007, a Health Canada-appointed panel of experts concluded that community drinking water fluoridation remains an effective public health method to reduce the prevalence of dental cavities and that there is no evidence of risks detrimental to the health of Canadians at the current recommended levels.

The value of water fluoridation should not be underestimated. Tooth decay is the single most common chronic childhood disease, one that is highly preventable. According to sound research, fluoridated drinking water greatly reduces the number of cavities in children's teeth, which contributes to their healthy development.

Therefore, I find no reason for Ontarians to avoid drinking fluoridated water at the recommended levels in Ontario's drinking water. Through Ontario's Child Health Program, public health units across the province are required to review drinking water quality reports for their municipal drinking water where fluoride is added, and to take action in accordance with provincial legislation and guidelines.

As you know, the decision to fluoridate local drinking water is made by each municipality in consultation with local residents. It is an effective public measure that reduces social inequalities in health. It helps to contain the costs of health care in Ontario. It benefits all residents in a community, and for these reasons we fully expect that this important practice will continue for many years to come so that Ontarians can enjoy lasting health benefits.

It is often difficult to communicate the information about this well-studied intervention amid misinformation and controversy generated by misinterpretation of data and results of studies. We are attaching a series of Q's and A's and a list of website references to related scientific studies and other areas of research and information that we hope you will find useful.

In my capacity as CMOH for the Province of Ontario and with the support of the Ministry of Health Promotion, my office will continue to monitor this issue and review the information as provided by the scientific reviews.

David C. Williams, MD, MHSc, FRCPC
Chief Medical Officer of Health (A)
Associate Chief Medical Officer of Health, Health Protection

Attachment

Supporting Scientific Studies

Health Canada
http://www.hc-sc.gc.ca/hl-vs/iyh-vsv/environ/fluor-eng.php
"The use of fluoride for the prevention of dental cavities is endorsed by over 90 national and international professional health organizations including Health Canada, the Canadian Public Health Association, the Canadian Dental Association, the Canadian Medical Association, the Food and Drug Administration of the United States and the World Health Organization.

Fluorides protect tooth enamel against the acids that cause tooth decay. Many studies have shown that fluoridated drinking water greatly reduces the number of cavities in children's teeth. Fluoride is used in many communities across Canada, spanning most provinces and territories. About 40 percent of Canadians receive fluoridated water."

Findings and Recommendations of Health Canada's Fluoride Expert Panel (January, 2007)
http://www.hc-sc.gc.ca/ewh-semt/pubs/water-eau/2008-fluoride-fluorure/index-eng.php\
"The current Maximum Acceptable Concentration (MAC) of 1.5 mg/L of fluoride in drinking water is unlikely to cause adverse health effects, including cancer, bone fracture, immunotoxicity, reproductive/developmental toxicity, genotoxicity, and/or neurotoxicity...Under modern conditions of exposure, Heller *et al.* (1997) concluded that 0.7 mg/L of fluoride in drinking water provides a suitable trade off between the risk of dental fluorosis and the protective effect against dental caries...From a health perspective, there is no reason to be concerned about the actual prevalence of very mild and mild dental fluorosis in Canada. In addition, the actual prevalence of moderate dental fluorosis in Canada is low, and all evidence suggests that since 1996 there has been an overall decreasing trend of dental fluorosis in Canada...Community drinking water fluoridation is still an effective public health method to reduce the prevalence of dental caries in the Canadian population."

Health Canada - Chief Dental Officer's letter on water fluoridation
http://www.hc-sc.gc.ca/hl-vs/oral-bucco/care-soin/fluor-eng.php
"The big advantage of water fluoridation is that it benefits all residents in a community, regardless of age, socioeconomic status, education, or employment. Health Canada continues to support water fluoridation as a safe, cost effective public health measure, and encourages Canadians to review respected and credible sources of information to reach their own conclusions about water fluoridation."

The Canadian Dental Association
http://www.cda-adc.ca/en/oral_health/faqs_resources/faqs/fluoride_faqs.asp
List of commonly asked questions about fluoride with answers in lay language.

National Health and Medical Research Council of Australia. 1999
"Water Fluoridation at optimal levels continues to provide significant benefits in the prevention of dental caries for both deciduous (baby) and permanent (adult) teeth. It remains the most effective means of achieving community-wide exposure to the caries preventive effects of fluoride and should remain unchanged."

National Health and Medical Research Council of Australia. 2007: The Efficacy and Safety of Fluoridation is a report on the review of the latest scientific evidence in relation to fluoride and health.
"The existing body of evidence strongly suggests that water fluoridation is beneficial at reducing dental caries."
http://www.nhmrc.gov.au/publications/synopses/_files/eh41.pdf

Oral Health in America: A Report of the Surgeon General. 2000
"Community Water Fluoridation is 'safe and effective' in preventing dental caries" in both children and adults. Water fluoridation benefits all residents serviced by community water supplies regardless of their social or economic status
http://www.cdc.gov/fluoridation/fact_sheets/sg04.htm

Systematic Review of Water Fluoridation. UK/International study. 2000
"Fluoridation of drinking water supplies does reduce caries prevalence, both as measured by the portion of children who are caries free and by the mean change in deft/DMFT Score." The deft Score determines the dental caries status for primary teeth decayed.
(d= decayed, e = extracted due to caries, f = filled t = teeth)
http://www.york.ac.uk/inst/crd/pdf/fluorid.pdf

Water Fluoridation. US Department of Health and Human Services Centers for Disease Control and Prevention. 2001
"Fluoride has contributed profoundly to the improved dental health of persons in the United States and other countries. Fluoride is needed regularly throughout life to protect teeth against tooth decay. To ensure additional gains in oral health, water fluoridation should be extended to additional communities."
http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5014a1.htm

European Fluoridation Forum. 2002
"Water fluoridation has been very effective in improving the oral health of the Irish population, especially of children, but also of adults and the elderly" ...."The prevalence of dental decay is approximately 30-50% lower in fluoridated areas of the Republic of Ireland compared with non fluoridated areas in Northern Ireland."
http://www.dohc.ie/publications/pdf/fluoridation_forum.pdf?direct=1


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Fluoridation and Oral Health

Board of Health

February 17, 2011

Bryna Warshawsky
Associate Medical Officer of Health

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Outline

- Discovery of fluoride
- How fluoride works
- Benefits and safety
- Treatment versus prevention
- Indicators of oral health and access to dental care

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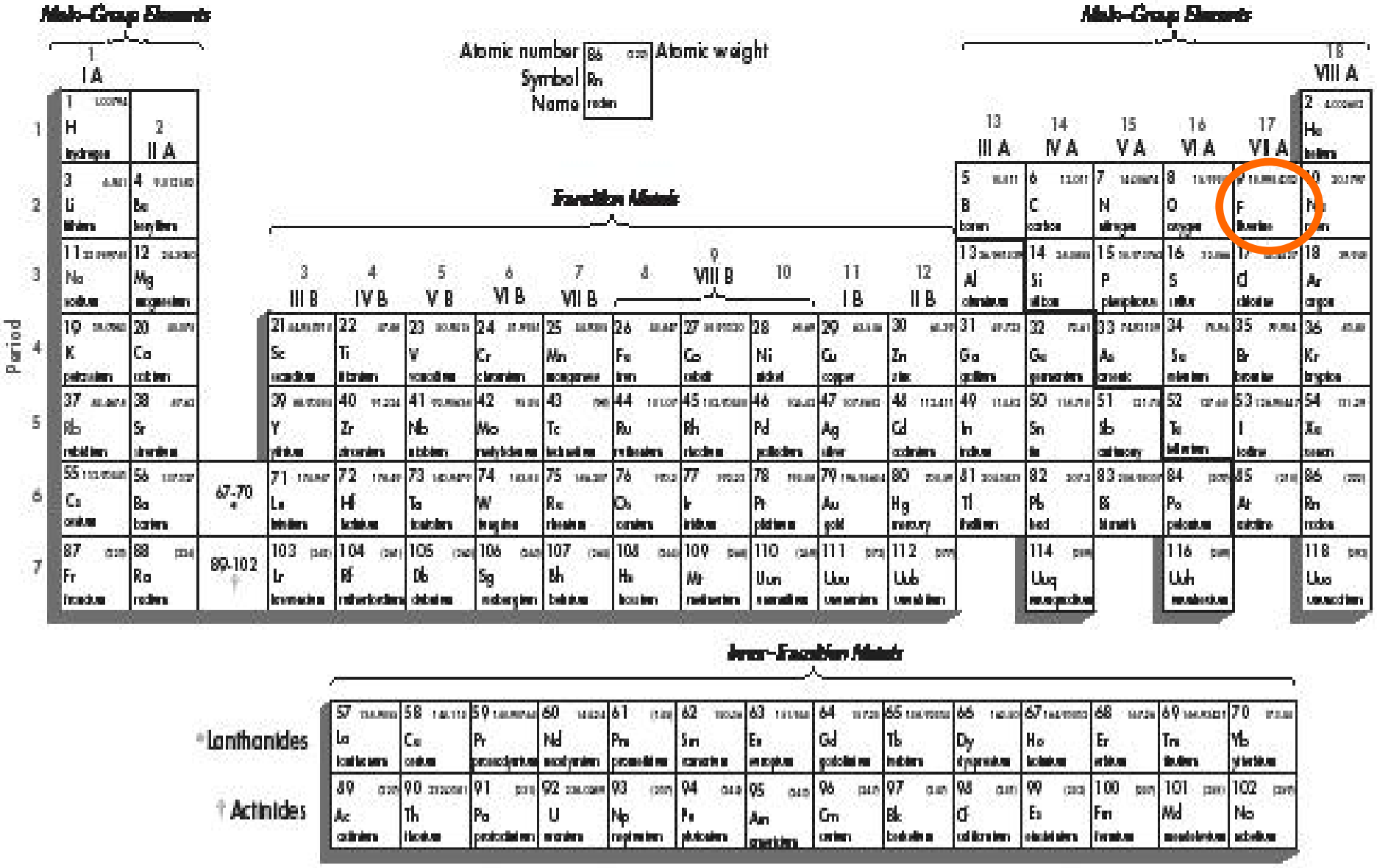

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Discovery of Fluoride

- Early 1900s - High rates of mottling of teeth (fluorosis) noted in some cities
- 1930s – Fluoride identified as the cause
- Cities with high rates of fluorosis also had little dental decay
- Determined optimal fluoride level to prevent decay with minimal fluorosis – 1 ppm
- Conducted experiment by adjusting fluoride levels in 4 sets of cities

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What Can Fluoride Do?

- Prevents decay
- Causes fluorosis
- At very high levels, skeletal fluorosis which causes bone to be brittle

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How Does Fluoride Work?

- To prevent decay
  - After tooth erupts
  - Incorporated into the tooth as it repairs itself from “acid attacks”
  - Fluoride incorporated into the surface of the tooth makes it more resistant to acid
- Fluorosis
  - Before tooth erupts
  - Less than 6 years of age; 22-26 months highest risk period

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Fluoride Numbers

- 0.5 to 0.8 mg/L (ppm)
- 0.7 mg/L (ppm)
  - Optimal level to adjust fluoride in drinking water

- 1.5 mg/L (ppm)
  - Maximum Acceptable Concentration (MAC) of fluoride in drinking water
  - Between 1.5 and 2.4 mg/L (ppm) raise professional and public awareness to control excess fluoride exposure

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Fortification

- Vitamin D in milk and soy products to support healthy bones and teeth
- Iodine in salt to prevent thyroid disease
- Folic acid in flour to prevent neural tube defects
- Vitamin C in some beverages for healthy tissues

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How Do We Know that Fluoride in Drinking Water is Safe and Effective?

- Systematic reviews of published literature
  - Published literature retrieved
  - Reviewed for quality
  - Summarized by experts
  - Results synthesized to draw conclusions by groups of experts

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Systematic Reviews

- 2000, UK - University of York
  - http://www.york.ac.uk/inst/crd/fluores.htm
- 2001, US - Centers for Disease Control and Prevention
  - http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5014a1.htm
- 2007, Australia - Government of Australia
  - http://www.nhmrc.gov.au/publications/synopses/eh41syn.htm
- 2009, Canada - Health Canada – Document for comment
  - http://www.hc-sc.gc.ca/ewh-semt/consult/_2009/fluoride-fluorure/draft-ebauche-eng.php#t4

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Systematic Reviews Conclude

Benefit

- Fluoride prevents tooth decay
- Still effective when other sources of fluoride available, although effect less pronounced and so more difficult to detect

Safety

- Fluorosis
- Evidence does not indicate increased risk of any other health concern including:
  - cancer, impact on IQ, thyroid problems, fractures, skeletal fluorosis

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Fluoride Effective in Other Ages

- Original studies in children
- Adults and elderly prone to root decay
- Studies have demonstrated protection in adults
- More important as adults and seniors keep their teeth

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Fluorosis Prevention

- Maintain fluoride levels in water at or below 0.7 ppm
- No toothpaste or non-fluoridated toothpaste for young children
- After that, pea size amount with parental supervision and spitting out
- No fluoride supplements in the form of pills or drops

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Prevention Versus Treatment

- **Prevention**
- Treatment
  - Pain of cavity
  - Infection from cavity, local or systemic
  - Cosmetic concerns, self esteem issues, chewing problems
  - Procedures, including general anesthesia
  - Lost time from work and school
  - Cost of dental work

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Prevention Particularly Important When Treatment Not Available

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Programs for Children 0-17 Years

- Children in Need of Dental Treatment (CINOT)
  - Urgent needs for low income children
  - $596,000
- Healthy Smiles Ontario – Began in fall 2010
  - Prevention and treatment for low income children (< $20,000 net family income)
  - $870,000
- Ontario Works - Prevention and Treatment
- Prev-OH – at Health Unit Clinic
  - Prevention for low income children 0-17 years
  - $63,000

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Programs for Adolescents and Adults

- Ontario Works – limited treatment
- Basically no other public programs available
- So need private insurance or ability to pay

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Canadian Health Measures Survey

- Health Canada Survey; 2007 – 2009; 15 locations in Canada
- 5,600 participants; ages 6 to 79 years

- Percent of Canadians with no dental insurance
- 32%
  - 20% higher income
  - 36.5% middle income
  - 50% lower income

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Percent avoiding a dental visit in past year due to cost

- 17%

- 9% high income
- 20% middle income
- 35% low income

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Percent of children who have ever had at least one cavity

6 – 11 year olds		12-19 year olds
• 57%		• 59%
• 52%	higher income	• 51%
• 61%	middle income	• 58%
• 61%	lower income	• 70%

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Percent brushing teeth at least twice a day

- 73%

- 76% higher income
- 72% middle income
- 66% lower income

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Percent with fluorosis in children ages 6 -11 years

- No moderate or severe
- 6% all mild – all high income

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Conclusions

- Fluoride reduces tooth decay
- Fluorosis is known risk and rates are low in London due to policies and educational messages
- Evidence does not indicate any other health risk
- No evidence of impact on the environment
- Infrastructure and expertise to adjust fluoride in water are in place and well-established
- Cost is low

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Conclusions

- Access to dental care for low income adolescents and adults is a problem
- Caries rates are higher in children with lower income
- Adjusted fluoride in drinking water provides equitable access to tooth decay prevention regardless of age, socioeconomic status, compliance with dental practices or access to dental care

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Recommendation

That the Board of Health support the ongoing fluoridation of the City of London's drinking water supply as a measure to achieve optimal dental / oral health for all residents, which is an important component of total health.

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Acknowledgements

- Mr. Wally Adams, Manager, Environmental Health
- Ms. Joan Carrothers, Manager, Oral Health
- Dr. Neil Farrell, Former Dental Director
- Mr. Dan Flaherty, Communications Manager
- Mr. Dan Huggins, Water Quality Manager, City of London
- Mr. Jim Reffle, Director, Environmental Health and Chronic Disease Prevention
- Dr. Graham Pollett, Medical Officer of Health

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 015-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 February 17

Board of Health Policy 2-010 and Bylaw Amendments

Recommendation
It is recommended:

1. That the Board of Health endorse the proposed revisions identified in Report No. 015-11 to Policy 2-010 re Structure and Responsibilities of the Board of Health; and further

2. That the Board of Health review Board of Health Bylaw Nos. 1, 2, 3, 4 and 5 and adopt the proposed amendments identified in Report No. 015-11; and further

3. That the Board of Health approve that the amended Bylaws attached to Report No. 015-11 receive all three readings at one meeting.

Introduction
Policy 2-010 re Structure and Responsibilities of the Board of Health (Appendix A) states that the "Bylaws will be reviewed by the Board of Health in the calendar year following a municipal election (every four years)." The Bylaws were last reviewed and re-enacted by the Board of Health on February 21, 2008. With the completion of the municipal elections in October of last year, the Bylaws are due to be reviewed.

Policy 2-10 was last amended on November 18, 2010, at which time, Appendix C - Electronic Participation in Board Meetings was added.

Policy Revisions
The proposed change to the Policy is to replace "Committee of the Whole" with "to have the Board deal with all matters directly" to use proper terminology from Roberts's Rules of Order. The proposed change is highlighted.

Bylaw Revisions
At its November 18, 2010, meeting, the Board of Health endorsed the implementation of the Board of Health Performance Assessment Tool (Appendix B - Report No. 135-10 re Pilot Testing a Board of Health Performance Tool). Therefore, proposed changes to Bylaw 3 include Board of Health Performance Assessment.

Other proposed changes to the Bylaws relate to typographical corrections, formatting and a position title change. The position of Manager, Finance and Operations in Bylaw 2 (#4 and #5) is changed to Director, Finance and Operations, to reflect the Board of Health organizational restructuring which occurred in June 2010.

The proposed changes are highlighted.

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

This report addresses Policy 1-60 re Policy Development and Review and Standard 1 D and E of the Accreditation Principles and Standards of the Ontario Council of Community Health Accreditation.

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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)
2011 February 17 (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 establish standing committees or to have the Board deal with all matters directly.

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/Chief Executive Officer (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 B to
Report 015-11

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 135-10

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2010 November 18

Pilot Testing a Board of Health Performance Assessment Tool

Recommendation

It is recommended:

1) That the Board of Health endorse the implementation of the Board of Health Performance Assessment Tool; and further
2) That the Performance Assessment Tool be completed three times per year, i.e., March, June, and November, with implementation starting in March 2011; and further
3) That the process be reviewed one year after implementation.

Background

In September 2010, the Board of Health accepted the recommendation of the Board Governance Working Group comprised of Board Chair, Mr. Al Edmondson, and Board members Mr. Tom McLaughlin and Mr. Mark Studenny that Board members pilot test a Board of Health Performance Assessment Tool and provide feedback (Report No. 102-10). Staff was directed to report back the results of the pilot at the November Board of Health meeting. This report summarizes the pilot survey process and findings.

Pilot Testing

In order to provide feedback based on their experience of completing the tool, Board members were invited to complete the proposed Self-Assessment of Board Functioning (Appendix A) and to provide their comments on the Pilot Feedback Survey (Appendix B). These two surveys and the Performance of Individual Board Members (Appendix C) which Board Members were encouraged to complete for their own reference were provided in the September 2010 Board package. Following the Board's endorsement of a pilot, the tools were distributed as email attachments on September 17, 2010, and a link was provided for respondents to complete the survey and provide their feedback either on-line or by mail. The deadline for responses was extended from September 24, 2010, until October 4, 2010.

Results

Six Board Assessments and six Feedback Surveys were returned. Four Board Members completed the survey on-line while two returned their surveys by mail. None of the respondents who completed the surveys on-line experienced any technical difficulties.

It was estimated that the Board of Health Performance Assessment Tool would take approximately 10-15 minutes to complete. The time required to complete the tool ranged from 10 to 20 minutes with five of the six respondents completing the tool in 10 to15 minutes; the sixth respondent indicated 20 minutes was required. Few responses were provided to the open ended questions; four of the six respondents indicated that they had completed the Performance of Individual Board Members for their own reference.

The majority indicated that the Board Assessment Tool was comprehensive (no additions or deletions required), questions were worded appropriately and clearly stated and instructions were clear. Two revisions are warranted:

1. Include instructions indicating that the response scale is from "strongly <u>disagree</u>" to "strongly <u>agree</u>".

2. Question A10 – "The Board has adequate information to monitor organizational performance, e.g. … " provided a number of examples which made it challenging to "evaluate in one box". This question should be streamlined.

The intent of this evaluation was to critique the merits of the tool in its ability to assess Board performance, not to provide a summary of the results related to Board functioning. It is recognized that participation is voluntary yet the value and outcomes of the assessment are enhanced with full participation.

Next Steps

It is recommended that the two proposed revisions noted above be made to the Board Performance Assessment Tool and that the tool be used three times per year in March, June and November with Board members having the option to complete their assessments on-line or by hard copy.

This report was prepared by Ms. Charlene Beynon, Manager of Special Projects.

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

This report addresses the Foundational Standard of the Ontario Public Health Standards and the draft Ontario Public Health Organizational Standards.

Appendices available upon request.

MIDDLESEX-LONDON HEALTH UNIT
www.healthunit.com

Appendix C
To Report 015-11

Electronic Participation in Board Meetings

A. Principles

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. Electronic participation at regularly scheduled board meetings is considered an exceptional measure intended to cater for unavoidable conflicts and emergencies and is at the discretion of the Chair.

B. Purpose and Application

The purpose of this procedure is to set the requirements, criteria and process for electronic participation of members in meetings of the Board of Health, including regular meetings, special meetings and closed (in-camera) sessions or portions of meetings.

1. **Compliance with Board of Health By-laws**

   Electronic participation will comply with the provisions of By-law No. 3 re proceedings of the Board of Health. Should compliance not be possible, electronic participation for a member or members will not be implemented.

2. **Discretion of Chair**

   In the absence of a resolution by the Board of Health, implementation of electronic participation/electronic meeting is at the discretion of the Chair.

   Capability for Real Time Communication

   Real time communication that enables the exchange of information, opinions and discussion of issues between all the participants to the meeting is a required element of electronic meetings and electronic participation in meetings by individual board members. This will require, at a minimum, that board members hear and be heard by each other and all others physically present at the meeting or attending by electronic means. Accordingly, meetings conducted by electronic mail or other non real-time communication methods are not permissible. This requirement for communication and public participation may be achieved through “auditory only” methods (e.g. teleconference) or “visual/auditory” methods (e.g. videoconference).

3. **Electronic Participation Same as Personal Attendance**

   Participation by electronic means is the same as personal attendance for the purposes of the proceedings, including but not limited to establishing quorum, attendance, putting forward motions and amendments, debating and voting.

4. **Confidentiality and Conflict of Interest**

   A member participating electronically is bound by the same requirements with regard to conflict of interest and confidentiality as if he or she were physically present at the meeting. In addition, in a closed meeting of the Board, the member undertakes and is responsible to ensure that no unauthorized person is given access to the proceedings or any documents pertaining thereto, and will not record, videotape or transcribe in any way the proceedings or any part of the meeting.

5. **Limits on Electronic Participation**

   If a Board member will not be physically present for more than two consecutive Board meetings, authorization for electronic participation is to be sought by resolution of the Board of Health.

6. **Public Attendance – Meetings Held Entirely by Electronic Means**

   If the meeting is held by electronic means[1], or the designated meeting location is not one that will allow the public to attend without difficulty, the Board will provide alternate means for the public to exercise its right to attend, unless the meeting is permitted to be closed by law. (See By-law No.3, Sections 5.0 re Notifying the Public of Board Meetings and 7.0 re Convening In-Camera (Closed) Meeting(s)).

C. Member Request Process

Board members are to make a request to participate electronically in a regularly scheduled Board meeting to the MOH or designate five or more working days prior to the date of the meeting. In the case of inclement weather, dangerous road conditions or other unforeseeable situation, the request should be made not less than three hours before the start of the meeting. The MOH or designate will notify the Board Chair of the request.

The MOH or designate, usually the Executive Assistant to the Board of Health, will coordinate the means of electronic participation (e.g. by teleconference) and will provide details and instructions to the Board member.

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

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 016-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 February 17

Board of Health Policy 2-020 Amendments

Recommendation
It is recommended that the Board of Health endorse the proposed revisions to Policy 2-020 re Orientation for Board of Health Members as identified in Report No. 016 -11.

Introduction
Policy 2-020 re Orientation for Board of Health Members (Appendix A) was created to ensure new members to the Board of Health are provided with a comprehensive orientation to the Board, the role of public health and the mandate of the Health Unit. The Ontario Public Health Organizational Standards of the Ministry of Health & Long-Term Care and the Ministry of Health Promotion and Sport identify Board member orientation and training as a requirement.

On June 1, 2010, A Working Group comprised of Board members was struck to undertake the following:

1. Review the current orientation binder and orientation process used for new Board members, and

2. Develop strategies for addressing continuing education needs relevant to the role and responsibilities of Board of Health members.

The recommendations of the Working Group were highlighted in Report No. 101-10 re Orientation and Continuing Education for Board of Health Members (Appendix B). The Board of Health endorsed the recommendations of the Working Group.

Policy Revisions
As a result, the following revisions are proposed to Policy 2-020:

1. That Appendix A of Policy 2-020 (Board of Health – Orientation Handbook Table of Contents) be revised by adding Board of Health Role Description to Section 1 (see attached Appendix C).

2. That the Procedure to Policy 2-020 be revised to include the following:
    a. A follow-up orientation session six to eight months after the initial orientation.
    b. A half to full day Board of Health retreat be held annually in March or April with the focus being on a Board identified continuing education topic.

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

This report addresses Policy 1-60 re Policy Development and Review and Standard 1 D and E of the Accreditation Principles and Standards of the Ontario Council of Community Health Accreditation.

MIDDLESEX-LONDON HEALTH UNIT

MIDDLESEX-LONDON HEALTH UNIT

ADMINISTRATION MANUAL

SUBJECT: **ORIENTATION FOR BOARD OF HEALTH MEMBERS** **POLICY NUMBER: 2-020**

SECTION: Board of Health Page 1 of 1

IMPLEMENTATION DATE: **APPROVED BY:** Board of Health
REVISION DATE: July 8, 1992 **SIGNATURE:**
July 20, 2000
June 17, 2004
February 17, 2011

PURPOSE

To ensure new members to the Board of Health are provided with a comprehensive orientation to the Board, the role of public health and the mandate of the Health Unit.

POLICY

The Medical Officer of Health (MOH) orients individual Board members to the policies, procedures, legislation and programs of the Board. The MOH reports on the state of the Health Unit with respect to programs and services, the staff complement and management.
Upon appointment to the Board of Health, each new Board member will be provided with an orientation session and receive materials that provide an overview of the organization (Appendix A re Orientation Handbook Table of Contents).

PROCEDURE

1. Upon appointment, each new Board member will be contacted by the Office of the Medical Officer of Health to arrange for orientation to the Board of Health.

2. The MOH will arrange a follow-up session with each new Board Member six to eight months after the initial orientation.

3. The Secretary-Treasurer notifies each Board member of upcoming events which may be attended by Board members for the purposes of public health orientation, planning and policy discussion e.g., Association of Local Public Health Agencies (alPHa) and the Ontario Public Health Association (OPHA).

4. The MOH will arrange a half to full day Board of Health retreat be held annually in March or April with the focus being on a Board indentified continuing education topic.

5. Throughout the calendar year, each Director may report to the Board of Health on programs and services.

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 101-10

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2010 September 16

Orientation and Continuing Education for Board of Health Members

Recommendations

It is recommended that the Board of Health endorse the recommendations of the Working Group on Board of Health Orientation and Continuing Education as highlighted in Report No. 101-10.

Background

In follow-up to earlier discussions by the Board of Health, a Working Group comprised of Board members Mr. Vance Blackmore, Dr. Francine Lortie-Monette and Ms. Doreen McLinchey was struck to undertake the following:

1. Review the current orientation binder and orientation process used for new Board members
2. Develop strategies for addressing continuing education needs relevant to the role and responsibilities of Board of Health members.

The Working Group met on June 1, 2010. This report summarizes the outcome of this meeting.

Subsequent to the meeting, the Ministry of Health & Long-Term Care and the Ministry of Health Promotion released draft Public Health Organizational Standards which identify Board member orientation and training as a requirement.

Review of Current Orientation Materials

Current orientation materials were reviewed and described as being thorough and informative. The opportunity to ask questions during the orientation session was valued. The following additions were identified for inclusion in the orientation binder:

1. Ontario Public Health Standards
2. Provincial performance management framework
3. Accreditation
4. Expectations re: annual outcome reports of programs and services and
5. New policies e.g., electronic participation and Board meetings, internet streaming and Board meetings, privacy legislation and requirements.

Based on the Working Group's direction, staff has updated the orientation binder (see Appendix A for the Table of Contents) and will continue to revise and inform Board members as new resources become available (e.g., on-line modules for Board members focusing on the Ontario Public Health Standards are being piloted by the Public Health Division, Ministry of Health and Long-Term Care.)

The Working Group recommended that an orientation session on chairing protocols and Robert's Rules of Order be held as early in the calendar year as feasible for the incoming Board Chair, Vice-Chair, Secretary-Treasurer and Recorder and that the session be open to all Board members.

Also, it was the Working Group's opinion that the funding orientation presentation, included as part of the 2010 budget approval process, was most helpful, and the Group recommended that it should be part of each year's process.

A role description was recommended as one strategy to articulate expectations of Board members. A draft role description is attached as Appendix B.

Ongoing Continuing Education

To address ongoing continuing education needs, the Working Group recommended the following:

1. A follow-up session be held six to eight months after the initial orientation;
2. A half to full day Board of Health retreat be held annually in March or April with the focus being on a Board indentified continuing education topic. It is recommended this occur at a mutually agreed

upon time during the week versus on the weekend or immediately prior to a regular Board meeting;

3. Board members attend provincial workshops such as those sponsored by alPHa (Association of Local Public Health Agencies, OPHA (Ontario Public Health Association) and the MOHLTC.

A possible topic identified for the first Board retreat was Board of Health liability.

This report was prepared by Ms. Charlene Beynon, Manager, Special Projects.

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

This report addresses Board direction given to Board Working Group # 2 and the draft Ontario Public Health Organizational Standards.

Appendices available upon request.

MIDDLESEX-LONDON HEALTH UNIT

APPENDIX A
Policy 2-020

Board of Health – Orientation Handbook
Table of Contents

Section 1 - Structure and Responsibilities of the Board of Health

- Board meeting dates
- List of current Board members and contact information
- Board of Health Remuneration and Expense Reimbursement Form
- Board of Health – Role Description
- Policy 2-10 Structure and Responsibilities of the Board of Health
    - Appendix A – Bylaws
    - Appendix B – Provincial Appointee Reappointment Process
    - Appendix C – Electronic Participation in Board Meetings
- Board of Health Reporting and Policy Approvals

Section 2 - Organizational Background and Planning Documents

- Strategic Plan
- Planning Cycle
- Organizational Charts
- Brief Biography of the Executive Officer
- Management Staff and Contact Information
- Executive Summary of Emergency Response Plan

Section 3 - Budget Information

- Budget Summary

Section 4 - Legal Documents

- Summary of Legislation
- The Health Protection and Promotion Act
- Ontario Public Health Standards
- The Immunization of School Pupils Act
- Smoke Free Ontario Act
- Safe Drinking Water Act
    - Chapter 32 – Bill 195
    - Regulation 170/03 – Drinking Water Systems
    - Regulation 169/03 – Ontario Drinking Water Quality Standard

Section 5 - Recommended Reading

- Initial Report on Public Health - August 2009 Public Health Division, MOHLTC
- The Development of Public Health in London and Middlesex County

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 017-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 February 17

2010 Board of Health Remuneration

Recommendation
It is recommended that the 2010 Remuneration Report attached as Appendix A to Report No. 017-11 be forwarded to the Treasurers for the City of London and Middlesex County to be included in their respective annual reports.

Each year both the City of London and Middlesex County Administration are required to report on the remuneration paid to Council members, including remuneration paid to members of Council by Boards and Commissions. The Remuneration Report includes stipends paid for meetings, reimbursements provided for travel and related expenses. Attached as Appendix A, is the remuneration, travel and conference costs that the Health Unit provided in 2010 to each Board of Health member. All reported remuneration and expenditures are in-line with the projected budget. Board member Mr. Vance Blackmore's level of remuneration reflects his active involvement on the Association of Local Public Health Agencies (alPHa) Board of Directors and as Chair of the Board of Health Section.

Mr. John Millson, Director, Finance and Operations, will be in attendance at the February 17th Board meeting to address any questions regarding this report.

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

Appendix A

MIDDLESEX-LONDON BOARD OF HEALTH
2010 REMUNERATION REPORT

Board Member	Board Meetings	Board Mtg. Travel	Other Mtgs./ Conferences	Other Travel & Accomm.	Total
Mr. John Balmer	$ 397.50	$ -	$ -	$ -	$ 397.50
Mr. Vance Blackmore	1,457.50	616.00	6,545.00	3,176.70	11,795.20
Ms. Patricia Coderre	927.50	54.45	3,095.14	1,345.87	5,422.96
Mr. Al Edmondson (Chair)	1,291.91	137.45	1,045.00	354.67	2,829.03
Dr. Francine Lortie-Monette	1,457.50	45.63	265.00	11.28	1,779.41
Mr. Tom McLaughlin	1,192.50	239.19	132.50	27.06	1,591.25
Ms. Doreen McLinchey	1,457.50	502.10	397.50	148.41	2,505.51
Ms. Viola Poletes Montgomery	1,325.00	95.12	1,722.50	104.63	3,247.25
Ms. Nancy Poole	530.00	64.89	265.00	47.30	907.19
Mr. Mark Studenny	1,325.00	230.43	1,425.00	334.72	3,315.15
TOTAL	**$ 11,361.91**	**$ 1,985.26**	**$ 14,892.64**	**$ 5,550.64**	**$ 33,790.45**

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 018-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 February 17

Medical Officer of Health Activity Report – February

Recommendation
It is recommended that Report No. 018-11 re Medical Officer of Health Activity Report – February be received for information.

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

Presentations continued to Municipal Councils regarding the DineSafe Middlesex-London Program. Mr. James Reffle, Director, Environmental Health and Chronic Disease Prevention Services; Mr. Dave White, Manager, Environmental Health; and the Medical Officer of Health (MOH) presented to Thames Centre Council and Strathroy-Caradoc Council. Mr. Reffle and Mr. White also presented to Newbury Council. Thames Centre passed a Bylaw making that Council the third to do so after Lucan-Biddulph and Middlesex Centre Councils.

The 2011 budget approval process included attendance at two City Council meetings. In both instances, Council was sitting as Committee of the Whole. One session was for Council budget orientation purposes. The second was for reviewing the 2011 draft budget. A verbal update will be provided at the February 17, 2011, Board of Health meeting.

As of the writing of this report, Board of Health Members, Ms. Denise Brown and Mr. Al Edmondson, together with the Medical Officer of Health, are registered to attend the Association of Local Public Health Agencies (alPHa) Winter Symposium meeting held in Toronto on February 10 and 11. One focus of the Symposium will be fluoridation of drinking water.

Orientation sessions were held for new City Councilors, Mr. Dale Henderson (Ward 9) and Mr. Matt Brown (Ward 7). Each had a tour of the office at 50 King Street as part of the orientation.

There were many activities related to violence prevention over the past month. A recent announcement of an upcoming Mixed Martial Arts (MMA) event at the John Labatt Centre resulted in numerous interview requests for response by the MOH. It will be recalled that at the June 2010 Board of Health meeting, the Board petitioned the Provincial Government not to legalize MMA events. However, in August, sanction of such events was announced. The focus of the MOH's comments to the media was making the connection between violence which occurs in the Middlesex-London community and the frequent exposure of children and adults to violence through a variety of forms of entertainment including MMA.

The MOH attended a planning meeting for an upcoming forum on pornography to be hosted by the London Abused Women's Centre. He also attended a Coaching Boys to Men meeting. This is a group whose purpose is to engage boys and men in violence prevention especially the prevention of violence against women and children. The MOH also attended an Ontario Public School Boards Violence in the Media Coalition Meeting.

The release of the 2010-2011 Influenza Surveillance Report Update of Current Status and Issues for the January 28 to February 3 period resulted in many media requests. Included in the report was acknowledgement of three deaths during this interval, two of whom were children. The report highlighted increasing influenza activity in the Middlesex-London area.

Activities continue on the implementation of the strategic planning process. The client, volunteer and community stakeholder surveys have been completed and the data are being analyzed.

Progress is being made on the implementation of a records management system. It will be recalled that the Board endorsed a records retention schedule at the January Board meeting. The Records Management Steering Committee, on which the MOH sits, is currently drafting a classification system to complement the records retention schedule.

Other meetings involving the MOH since the last Board of Health meeting included: attendance at a Middlesex-London CEO/CAO meeting; a meeting with Mr. Bill Rayburn, CAO, Middlesex County, to discuss operational issues at 50 King Street; attendance at a Board of Directors meeting for thehealthline.ca; participation in a Community Medicine Seminar for University of Western Ontario medical students; participation in a Ministry of Health and Long-Term Care – Ontario Medical Association Technical Working Group teleconference and face to face meetings and attendance at the London Chamber of Commerce Mayor's State of the City Breakfast.

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

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 019-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 February 17

Summary of Lead Flushing and Sampling at Schools, Private Schools and Day Nurseries

Recommendation
It is recommended that Report No. 019-11 re Summary of Lead Flushing and Sampling at Schools, Private Schools and Day Nurseries be received for information.

Background
The Board of Health previously received Report No. 114-07 on September 20, 2007 (Appendix A) re Lead in Drinking Water – Update, which included information on the development and release of the Protocol for Implementation of Ontario Regulation 243/07 – Schools, Private Schools and Day Nurseries (the Protocol). The Protocol was developed to assist the staff of boards of education, private schools and day nurseries in complying with the newly enacted Regulation 243/07. The protocol was disseminated to members of the Thames Valley District School Board (TVDSB), London District Catholic School Board (LDSCB), Ministry of the Environment (MOE), Ministry of Education, Ministry of Children and Youth Services, neighboring health units, and operators of schools, private schools and day nurseries. Since then, staff of the Environmental Health Team has been working closely with all of these partners to ensure that facility water flushing and annual testing are conducted in accordance with the legislation, and that any concerns are addressed and resolved in accordance with the Protocol.

Amendments to Ontario Regulation 243/07
On December 14, 2009, Regulation 243/07 was amended to expand the sampling window for schools and private schools, to allow co-located facilities to submit only one sample so long as the water distributed throughout the building is from the same plumbing system and to allow a facility to conduct lead sampling once every three years if certain regulatory requirements are met. The Protocol was amended at that time to reflect these legislative changes and the updated version was re-distributed to all stakeholders.

Summary of Activities
Since 2007, both the LDCSB and TVDSB have retained the professional engineering consulting firm, Stantec, to oversee the legislated flushing and sampling activities at all of their schools. As well, the MOE conducts routine inspections of schools, private schools and day nurseries to ensure regulatory compliance with the legislated requirements. Environmental Health Team staff work closely with Stantec and the MOE whenever an adverse lead report is received to ensure proper follow-up activity occurs in accordance with the Protocol.

In cases where only pre-flush samples exceed the provincial standard of 10 µg/L, the importance of proper and thorough flushing is reviewed and emphasized with facility staff. The situation of most concern occurs when post-flush samples exceed the standard. In those cases, a more detailed review and investigation takes place. Flush times are reviewed and adjusted, plumbing fixtures are investigated, in some cases additional sampling takes place, and other remedial measures are taken where necessary to ensure that post-flush samples do not exceed the standard. These corrective actions are confirmed to be successful by acquiring two consecutive post-flush samples, taken a week apart, that are below the prescribed standard.

A summary of the 2007 school and private school results was contained in Report No. 114-07. Later in the fall of 2007, three day nurseries reported elevated post-flush sample results.

In 2008, six schools in the TVDSB, two schools in the LDCSB, two private schools, and seven day nurseries had post-flush samples exceeding the provincial standard.

In 2009, three schools in the TVDSB, zero schools in the LDCSB, zero private schools, and two day nurseries had post-flush samples that exceeded the provincial standard.

In 2010, eight schools in the TVDSB, zero schools in the LDCSB, zero private schools, and five day nurseries had post-flush samples that exceeded the provincial standard.

Again, in every case where post-flush samples exceeded the provincial standard, follow-up activities proceeded in accordance with the Protocol to ensure that flushing times were refined and all necessary remedial actions were taken to confirm post-flush drinking water was below the provincial standard. Also in accordance with the Protocol, where children were present in a facility while the follow-up actions were taking place, access to the water system was suitably restricted and the children were provided with an alternate supply of potable water. Parents were fully informed until the matter was resolved.

Conclusion
Environmental Health Team staff has worked collaboratively with local partners to ensure the proper implementation of Ontario Regulation 243/07 and the Protocol for Implementation of Ontario Regulation 243/07 – Schools, Private Schools and Day Nurseries. Moving forward, the Health Unit aims to continue this work with the goal of reducing and minimizing children's exposure to lead from the drinking water in schools, private schools and day nurseries.

This report was prepared by Mr. Chris Walsh, Public Health Inspector, and Mr. Wally Adams, Manager, Environmental Health. Mr. Adams will be in attendance at the February 17th Board of Health meeting to address any questions regarding this report.

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

This report addresses the following requirement(s) of the Ontario Public Health Standards:
Management and response to drinking water-related reports in accordance with the *Drinking Water Protocol* under the Safe Water Program Standard.
Engage in activities within the community that increase the safety of drinking water and decrease potential for adverse effects on health in accordance with the *Drinking Water Protocol* under the Safe Water Program Standard.

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 114-07

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: September 20, 2007

Lead In Drinking Water - Update

Recommendations

It is recommended:

1. That the Board of Health endorse the Protocol for Implementation of Ontario Regulation 243/07 - Schools, Private Schools an Day Nurseries, attached as Appendix A to Report No. 114-07; and further
2. That the Protocol for Implementation of Ontario Regulation 243/07 - Schools, Private Schools and Day Nurseries, be forwarded to all Ontario Boards of Health.

The Board received Report No. 087-07 re Lead in London Drinking Water on May 17, 2007 and Report No. 101-07 re Lead in London Water – Update on June 21, 2007. This report will update the Board on follow-up activities by Health Unit staff and emerging actions that have taken place over the summer at the local and provincial level.

Provincial Legislation

On June 7, 2007, the Ontario Legislature enacted Ont. Reg. 243/07 *Schools, Private Schools and Day Nurseries* under the *Safe Drinking Water Act*. The new regulation contained several new requirements for the operators of schools, private schools, and day nurseries aimed at reducing children's' exposure to lead from the drinking water at these facilities. Operators of these facilities must now flush their plumbing systems daily, rather than the previously required weekly flushing, and test their water for lead annually. The flushing is intended to clear the plumbing of water that may have accumulated dissolved lead during the night. The flushing must be for at least 5 minutes and longer if necessary to ensure that fresh water from the street main has filled the plumbing system. The sampling procedure requires two samples: a pre-flush sample - one taken immediately after the water has been sitting stagnant for at least 6 hours; and a post-flush sample – one taken between 30 and 35 minutes after the system has been flushed as described above. The second sample is intended to be representative of water the children will consume during the day and must therefore have a lead concentration below the provincial standard of 10 micrograms per litre. Any sample, either pre-flush or post-flush, that exceeds the provincial standard must be reported and the operator of the water system must then take whatever corrective action the Medical Officer of Health requires.

Protocol Development

The Medical Officer of Health arranged a stakeholders' meeting, which was held on July 13, 2007, to develop a Protocol that all involved parties could follow to ensure proper compliance with the new regulation. Representatives from both the Thames Valley District School Board and London and District Catholic School Board, the City of London, the Ministry of Environment, and the Elgin, Oxford, and Middlesex-London Heath Units attended. From that meeting came the original draft of the *Protocol For Implementation Of Ontario Regulation 243/07 Schools, Private Schools, and Day Nurseries* (Appendix A). Subsequent meetings were held in July and August with private school and day nursery operators to clarify the protocol and to receive feedback. The local protocol was shared in its draft form with the MOHLTC and other Health Units in Ontario. Mr. James Reffle, Director of Environmental Health and Chronic Disease Prevention Services was a member of the expert panel that was formed to provide the MOHLTC with recommendations for a suitable public health response to lead exceedances in drinking water in schools, private schools and day nurseries.

School, Private School, and Day Nursery Activities

Schools and private schools must sample their water for lead between June 15th and August 15th of each year. Over the course of the summer, the Thames Valley District School Board (TVDSB) and the London District Catholic School Board (LDCSB) sampled all of their schools in accordance with the requirements of Ont. Reg. 243/07. Seven TVDSB and seven LDCSB schools had initial post-flush samples that exceeded the provincial standard. Follow-up occurred in accordance with the Protocol and, after adjusting flush times at the affected schools, re-sampling resulted in all schools having two consecutive post-flush samples, taken 24 hours apart, with lead concentrations below the provincial standard. Private School sampling was also completed over the summer months and two out of the total 21 private schools had initial post-flush samples exceeding the provincial standard. Again, after adjusting flush times, two consecutive sets of resample results were satisfactory. Day Nurseries must sample between May 1st and October 31st each year. Sampling at these facilities is currently underway and follow-up will occur where necessary in accordance with the Protocol, as the results become available.

Development of Lead in Drinking Water Information Brochure

City of London and Health Unit staff collaborated on the development of an information brochure (See Appendix B) which was delivered door to door during the early part of August in areas of the City where lead service pipes were likely to still exist. City staff continued throughout the summer months to follow-up with residents who had requested water samples for lead testing. Requests had tapered off to a few per day but increased again after delivery of the brochure. As of September 7th, City staff have received 6,568 requests for testing and have collected 6,542 residential tap water samples for lead analysis. So far 1,568 samples out of 6,338 (24.7%) have been found to be greater than the Ontario Drinking Water Standard for lead of 10 ug/L. Public Health Inspectors on the Environmental Health Team continue to contact some recipients of elevated lead results to assist with understanding the Lead Health Messages.

Corrosion Control Activities

The City of London water system staff have been preparing to make changes to the pH of the drinking water to make it less corrosive, thereby reducing its ability to dissolve lead from pipes and plumbing fixtures. Health Unit staff have been advised that scheduling to gradually adjusting the pH upwards will begin on October 1st. It is expected to take until the end of November before the process is complete. The change must be made slowly to avoid creating any undesirable and unintended consequences associated with the change in water chemistry. In conjunction with the pH changes, the sentinel water-sampling program has been ongoing and will continue in order to measure the effectiveness of the changes at reducing the ability of the water to dissolve lead.

Conclusion

The lead in drinking water issue has continued its high profile throughout the summer with the introduction of new provincial legislation. Health Unit staff have worked diligently with their local partners to ensure the proper implementation of the new regulations governing schools, private schools and day nurseries. Staff have also played a leading role provincially in this area by regularly sharing their experiences and resources with their colleagues throughout Ontario. Health Unit staff continue to partner with City of London staff and Ministry of the Environment officials as part of London's three-phased action plan to address lead issues.

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

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

This report addresses the Mandatory Health Programs and Services Guidelines: Safe Water Program Goal "to reduce the incidence of water-borne illness in the population".

Appendices available upon request.

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 020-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 February 17

Final Strategy of Shaken Baby Syndrome, "Period of Purple Crying," Implementation Program

Recommendation

It is recommended that Report No. 020-11 re Final Strategy of Shaken Baby Syndrome, "Period of Purple Crying," Implementation Program be received for information.

Background

Shaken Baby Syndrome (SBS), also known as the Period of Purple Crying, is a form of violent child abuse. It is the leading cause of traumatic infant death in North America. Up to 30 % of abused infants die from their injuries. In order to address this situation, staff partnered with London Health Science Centre (LHSC) to plan and implement a series of community initiatives focused on the prevention of SBS.

In 2008, a Regional Shaken Baby Syndrome Forum was held as a kick off for a series of activities. In January 2009, staff entered into a Memorandum of Understanding with the United States National Center on Shaken Baby Syndrome. As part of the agreement, the Health Unit's responsibility was to implement the program using the Triple Dose Approach. Dose one occurs in the hospital with education provided to both mothers and fathers following the birth of a baby. Dose two provides follow up by public health nurses, family home visitors, pediatricians, and family doctors who reinforce the message by talking to parents about the concepts taught in The Period of Purple Crying program. Dose three is the media campaign. In 2010, the third and final Dose of the strategy was completed.

Dose Three - Media Campaign

In 2010, the Health Unit and LHSC collaborated on the development of a media campaign for the Period of Purple Crying Campaign. The campaign's objective was to reinforce and raise awareness of PURPLE messages (SBS prevention); target parents of newborns and future parents, family, friends and caregivers; and to drive the community to visit www.purplecrying.info for additional information.

Methodology

The National Centre on SBS provided and tested all the materials used in the campaign. The campaign was launched in April 2010 and extended over a period of six to eight weeks. To get a sense of community awareness of the campaign, the Health Unit and LHSC (Trauma Program) collaborated on the development of a survey module as part of the Rapid Risk Factor Surveillance System (RRFSS). RRFSS is an ongoing telephone survey of the general adult population ages 18+ in Middlesex-London. Data obtained from 404 randomly selected adults from May 5 to September 2, 2010, were analyzed.

Results showed that the campaign was successful in garnering the attention of about 43% of the main target group, 25 to 44 year-olds, who reported having either seen or heard of the campaign. Younger adults, ages 18 to 24, were somewhat less aware at 35%. Older adults were significantly less aware (17% for 45 to 64 year-olds, 5% for those over 65). Over two-thirds of those surveyed recalled that the main message was about either crying babies or shaking babies. The media campaign consisted of advertisements on the backs of city buses, strategically located billboards and transit shelters, public service announcements (PSAs) at Rainbow and Western movie theatres, radio PSAs and interviews. The most commonly cited source of recognition by far was radio, reported by 42%. It appears that the campaign was not successful in getting people to visit the Period of Purple Crying website as only 1% reported having done so.

A more formal evaluation has been conducted by the LHSC Trauma Program Epidemiologist over the past year which includes follow up phone calls with clients who participated in the PURPLE education. The final work will be available in the near future.

Next Steps

The Southwestern Ontario Maternal Newborn Child and Youth Network has recently agreed to take SBS on as one of its strategic directions. Health Unit staff is taking a lead role in this working group. The goal is to engage 100% of the hospitals and public health units in the region in the implementation of SBS. Part of this plan will be to develop a regional media campaign for the fall of 2011.

This report was prepared by Evelyn Crosse, Epidemiologist, FHS, and Bonnie Wooten, Manager, Family Health Services HBHC East Team.

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

This report addresses the following requirement(s) of the Ontario Public Health Standards: Family Health Services, Child Health.

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 021-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 February 17

Emergency Preparedness Exercise

Recommendation
It is recommended that Report No. 021-11 re Emergency Preparedness Exercise be received for information.

Background
Throughout 2010, Ms. Patricia Simone, Manager, Emergency Preparedness, coordinated a schedule of monthly small scale exercises, testing such things as the panic/duress alarm and the public address systems, fax notifications to community stakeholders, an awareness campaign of the colour code system, distribution of the revised Emergency Response Plan, participation in the County and City emergency exercises, and set-up of the incident command room. These events culminated in the Health Unit's first tabletop emergency preparedness exercise held on November 30, 2010.

Members of the Non-Union Management Staff, Directors and Administrative Assistants were invited to come together to work through six scenarios (Appendix A), each offering a different yet possible public health emergency situation. These scenarios were specifically designed to engage staff to problem-solve using the Incident Management System (IMS) (Appendix B).

IMS is a widely recognized, interdisciplinary, systematic approach for establishing a command and control system at an incident. Although integrating the concept of IMS into public health was at one time novel, it is widely accepted as the norm now. The Emergency Management Unit of the Ministry of Health and Long-Term Care supports the use of IMS and has sections dedicated to the topic in the Pandemic Plan and in the 2008 Public Health Emergency Preparedness Standards. The IMS structure has also been adopted as accepted practice within the Ontario Hospital Association since 2006.

As preparation for the emergency exercise, staff members were asked to complete an informational on-line course managed by Emergency Management Ontario which gave a baseline review of the core concepts of IMS, namely: (1) Command, (2) Communication, (3) Safety, (4) Liaison, (5) Planning, (6) Operations, (7) Logistics and (8) Finance.

Each of the six breakout teams had a different scenario, and two advisors/auditors were there to coach the team on the specific roles within IMS. The advisors/auditors were community partners, representing police, fire, ambulance, hospital, college, municipality and non-governmental organizations.

Evaluation forms were completed and yielded helpful comments which formed follow-up recommendations and will influence planning for the next exercise scheduled for June 2, 2011. These recommendations have also now been endorsed by the Directors Committee.

Next Steps
A number of items were identified from the exercise for follow up. These included:

(1) During the exercise, the need for training to go "3 deep" was stressed. Future awareness projects will focus on the need to identify and train two additional people to fulfill the same role.
(2) The Administrative Assistants who had previously taken the Scribe course asked for the course to be held again as a refresher. It was also recommended that all Administrative Assistants receive this training. Scribe training has been booked for February 17, 2011.
(3) All members of the Non-Union Management team will be encouraged to complete the Provincial Incident Management Course online (register for the certificate).
(4) Members of the IMS team and their alternates are to become familiar with and use the Job Action Sheets for exercises and real situations.
(5) All Directors and their designated alternates will be encouraged to attend the Provincial Basic Emergency Management course when it is offered in 2011.

Photos of the November 30, 2010, emergency exercise are attached as Appendix C.

This report was prepared by Ms. Patricia Simone, Manager, Emergency Preparedness.

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

This report addresses the following requirement(s) of the Mandatory Health Programs and Services Guidelines:
Emergency Preparedness Protocol (Requirements #2 & #3)

Appendices available upon request.

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 022-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 February 17

Connecting Children and Youth to Lifelong Physical Activity and Sport

Recommendation
It is recommended that Report No. 022-11 re Connecting Children and Youth to Lifelong Physical Activity and Sport be received for information.

Background
Physical activity, recreation activities and sports play an important role in a child's healthy growth and development, but recently, physical activity has suffered serious decline among Canadian children. Being physically active later in life depends on feeling confident in an activity setting. That confidence as an adult most often comes from having learned fundamental movement and sport skills as a child. For this reason, it is critical that children develop the knowledge, skills and attitudes that give them the very best chance of staying active throughout their lives. Parents, teachers, coaches, community volunteers and recreation leaders play a very important role in developing children and youth who are confident in performing physical activity skills. In order to create an active and healthy population, children and youth need a sound foundation of movement and sport skills to build on later in life. This foundation is called Physical Literacy. The Canadian Sport for Life Program (CS4L) is aimed at increasing children and youth physical literacy skills across the ages and is designed for parents, educators, community coaches and recreation leaders. CS4L is a framework that focuses on the child and adolescent life stages, considers the whole child and recognizes differences in growth and development between females and males.

Hosting a Local Physical Literacy Forum
On November 29, 2010, the Health Unit partnered with the London Boys and Girls Club, Thames Valley District School Board (TVDSB), London Catholic District School Board, London Sports Council, London In Motion Committee, Ministry of Health Promotion and Sport, London YMCA, and Ontario Basketball Association to host a forum to educate parents, teachers, youth, coaches and recreation leaders on the CS4L framework and physical literacy methods (Appendix A). Ms. Christine Preece, Manager, Young Adult Team, chaired the local planning committee (Appendix B). The goal of this partnership was to host a quality, multi-sectoral forum that provided parents, educators, recreation leaders, youth and community coaches with the knowledge and skills to teach physical literacy and understand the CS4L Foundational Standards.

Over 100 participants registered for this evening event held at the TVDSB Education Centre. Dr. James Mandigo, world renowned leader in physical literacy, from Brock University was the keynote speaker. Dr. Mandigo provided an interactive session and addressed ways to incorporate physical literacy into teaching and coaching methods for children and youth. He provided practical teachings in which forum registrants participated and learned how to teach these same activities to the children and youth they work/volunteer with on a daily basis.

Ms. Christine Callaghan, Registered Dietitian, Young Adult Team, gave an overview of healthy eating as it relates to physical activity. Ms. Callaghan provided participants with practical ideas for promoting healthy eating within settings such as recreation centres, schools, sporting events and home.

Mr. Derrek Stryker, Director of Sport Development, from the Ontario Basketball Association, provided a practical demonstration by engaging ten year old female players from a local basketball team. Mr. Stryker demonstrated cutting edge techniques to encourage children to learn physical literacy skills through fun, non-traditional activities that are not solely focused on sport specific skills (e.g. doing a layup).

Evaluation
At the end of the evening, registrants were encouraged to complete evaluations to enter for draw prizes. The evaluation results were positive. Themes which emerged from the evaluation included: focusing on the whole child is better than just teaching the physical, fun games can teach complex skills, healthy eating needs to be offered in all settings, everyone can use the physical literacy and CS4L approach, and more forums are needed to educate people to make changes in thinking and teaching.

The forum provided an excellent opportunity for parents, teachers, coaches and leaders to learn about new ways of encouraging children and youth to become physically active into the adult years.

One participant summed up the outcome of this forum by writing*, "Thank you for a fantastic night. It was very informative and worthwhile. The variety of information, speakers and activities/examples were very helpful. It was an amazing experience and I encourage you to provide more like this."*

The organizing committee felt the forum was well received. It is the intention to follow up with a "train the trainer" session to build capacity in the community to develop physical literacy teachers, leaders, coaches and role models.

This report was prepared by 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: Chronic Disease Prevention Standard 3,4 and 11. Child Health Standard 4 and 8.

Appendix B

CANADIAN SPORT FOR LIFE COMMITTEE MEMBERS

Chair

- Christine Preece - Middlesex-London Health Unit

Committee Members

- Arlene Morrell Thames Valley - Thames Valley District School Board Parent Involvement Committee
- Chris Harvey – London Boys and Girls Club
- Christine Callaghan - Middlesex-London Health Unit
- Darlene Charuk - Thames Valley District School Board
- Don Pollock – London Sports Council
- Dorothy McCann - Middlesex-London Health Unit – London In Motion Committee
- Heather Lokko - Middlesex-London Health Unit
- Jo-Ann Hutchison – Ministry of Health Promotion
- Joy Knott - Middlesex-London Health Unit
- Ricardo Mathison - London YMCA
- Rob Hurtubise – Ontario Basketball Association
- Stephanie Howlett – City of London
- Sue McMahon - London District Catholic School Board
- Vinda Holtby – London YMCA

"Connecting Children and Youth to Lifelong Physical Activity and Sport"

- **Learn Cutting-Edge Coaching through 'Canadian Sport for Life' Fundamentals**
- **Teaching Games for Understanding**

Cost Is Free

Includes Supper

Come Dressed to be Active!

Great Draw Prizes

Smile

Fun

Learn

Together

CS4L Canadian Sport For Life
www.canadiansportforlife.ca

Featuring Dr. Jamie Mandigo, PhD

Known nationally and internationally for his work on Physical Literacy
Brock University - Dept. of Physical Education & Kinesiology

Who Should Attend? Parents, Educators, Recreation Leaders, Students, and Coaches

Date: Monday, November 29, 2010
Time: 5:00-8:45 p.m. (includes supper)
Location: Thames Valley District School Board Office
1250 Dundas Street

Register By November 23, 2010
Call 519-663-5317 ext. 2255
or e-mail: janice.ramer@mlhu.on.ca

For more information go to: www.healthunit.com

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT www.healthunit.com
Thames Valley
TVPIC Thames Valley District School Board Parent Involvement Committee
London District Catholic School Board
Boys & Girls Club of London A good place to be
in motion Physical Activity - do it for life! | Middlesex-London Building Canada's Healthiest Community
www.inmotion4life.ca
YMCA of Western Ontario
Ontario Basketball
Sport for all London Sports Council

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 023-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 February 17

2010 Vendor Payments

Recommendation
It is recommended that Report No. 023-11 re 2010 Vendor Payments be received for information.

In accordance with Section 5.17, of the Procurement Policy, the Director of Finance & Operations is to report annually the suppliers who have been invoiced a cumulative total value of $100,000 or more in a calendar year. Attached as Appendix A is a list of such vendors for 2010.

Mr. John Millson, Director, Finance and Operations will be in attendance at the February 17th Board meeting to address any questions regarding this report.

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

This report addresses the following requirement(s) of Policy #4-025, Procurement Policy, as outlined in the MLHU Administration Policy Manual.

Appendix A

2010 Vendor Payment Summary > $100,000

Vendor Name	Total Invoiced	Comments
OMERS	$ 2,449,370.15	Pension payments (includes employee share)
Manulife Financial	$ 1,188,511.88	Employer Health Benefits (includes LTD paid by employees)
County of Middlesex	$ 939,969.03	Lease related payments
Thames Valley Children's Centre	$ 849,853.08	Service contracts – tykeTalk / Infant Hearing Program (IHP)
University of Western Ontario	$ 394,927.26	Service contracts (tykeTalk / IHP)
AIDS Committee of London	$ 278,184.73	Contract for Needle Exchange Program
Richmond Block London Corp	$ 265,570.20	Rent of 201 Queens
Woodstock General Hospital	$ 237,353.92	Service contracts (tykeTalk / IHP)
Protek Systems	$ 210,571.59	IT Hardware & Consulting Costs
Workplace Safety & Insurance	$ 169,030.44	WSIB premiums
Merrymount Children's Centre	$ 167,598.41	Service contracts – Family Networks program
Xerox Canada Ltd.	$ 156,345.41	Copier rental and printing
Elgin Audiology Consultants	$ 143,286.29	Service contracts - IHP
Metropolitan Maintenance	$ 142,692.94	Cleaning of 50 King Street premises
The Canadian Centre for Mosquito Control	$ 141,972.52	Mosquito control contract for Vector-Borne Disease program
Metaphore	$ 133,013.09	Software / Hardware IT purchases
Natus Medical Inc.	$ 132,885.80	Hearing equipment & warranties - IHP
London Health Sciences Centre	$ 124,995.36	Service contracts (tykeTalk / IHP)
Dr. Jeffrey H. Richmond	$ 119,519.44	Dental Services – CINOT
CANBA Investments Limited	$ 101,323.98	Lease related payments – Strathroy office