AGENDA
MIDDLESEX-LONDON BOARD OF HEALTH

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

Thursday, 7:00 p.m.
2013 May 16

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

Mr. David Bolton
Ms. Denise Brown (Vice Chair)
Mr. Al Edmondson
Ms. Patricia Fulton
Mr. Marcel Meyer (Chair)
Mr. Stephen Orser
Mr. Ian Peer
Ms. Viola Poletes Montgomery
Ms. Nancy Poole
Mr. Mark Studenny
Ms. Sandy White

SECRETARY-TREASURER

Dr. Christopher Mackie

DISCLOSURE OF CONFLICTS OF INTEREST

APPROVAL OF AGENDA

APPROVAL OF MINUTES

SCHEDULE OF APPOINTMENTS

7:10 – 7:25 p.m.	Mr. John Millson, Director, Finance & Operations, Item #1 – Report No. 067-13 re "Draft Reserve/Reserve Fund Policy"
7:25 – 7:40 p.m.	Mr. Ross Graham, Manager, Special Projects, Item #2 – Report No. 064-13 re "Accountability Agreements: 2012 Performance and 2013 Targets"
7:40 – 7:55 p.m.	Ms. Kim Leacy, Registered Dietitian, Chronic Disease Prevention & Tobacco Control Team, Item #3 – Report No. 065-13 re "Harvest Bucks: A Farmers' Market Vegetable And Fruit Program"

REPORTS

	Report No. and Name	Link to Appendices and Key Additional Information	Delegation	Recommendation	Information	Brief Overview
1	Report No. 067-13 re "Draft Reserve/Reserve Fund Policy"	Appendix A Appendix B Appendix C Appendix D	X	X		To recommend that the Board of Health endorse the Draft Reserve/Reserve Fund Policy (Appendix C) and engage the City and County regarding the Memorandum of Understanding (Appendix D)
2	Report No. 064-13 re "Accountability Agreements: 2012 Performance and 2013 Targets"	Appendix A	X	X		To identify some of the Health Unit's accomplishments in 2012 and review proposed targets for 2013
3	Report No. 065-13 re "Harvest Bucks: A Farmers' Market Vegetable And Fruit Program"		X		X	To provide information about a program to increase access to and consumption of fresh vegetables and fruit
4	Report No. 066-13 re "Community Resources for Newcomers with No Health Insurance"	Appendix A			X	To describe resources available that identify free or low cost health-related services
5	Report No. 068-13 re "Identifying Priority Populations for Reproductive Health"	Identifying Priority Populations			X	To provide information about a research project undertaken by the Health Unit to identify priority populations in London and Middlesex
6	Report No. 069-13 re "Baby-Friendly Initiative"				X	To outline implementation targets that have been achieved related to the orientation to the Baby-Friendly Initiative policy
7	Report No. 070-13 re "Smart Start For Babies: Improving Outcomes"				X	To outline changes made to the 2012 Smart Start for Babies Program
8	Report No. 071-13 re "Creating Healthier Nutrition Environments in Local Group Homes"				X	To provide an update on work done by the Health Unit to improve the nutritional environments in four pilot group homes
9	Report No. 072-13 re "Drug Awareness Events – Child Health Team"				X	To report on Drug Awareness Events organized by the Health Unit's Child Health Team
10	Report No. 073-13 re "Stepping Out Safely: Healthy Aging 2012"				X	To provide information about the 2012 Stepping Out Safely program for older adults
11	Report No. 074-13 re H7N9 Influenza and Novel Coronavirus – Emerging Infections and the Health Unit's Role"				X	To report on the status of H7N9 Influenza and Novel Coronavirus and the Health Unit's role
12	Report No. 075-13 re "Medical Officer of Health Activity Report – May "				X	To outline activities of the Medical Officer of Health in May

CONFIDENTIAL

OTHER BUSINESS

Next scheduled Board of Health Meeting: Thursday, June 20, 2013 7:00 p.m.

Please note: the taking of the Board of Health photo has been tentatively scheduled for Thursday, June 20, prior to the June Board meeting. Please advise the Executive Assistant to the Board of Health if you cannot make it on June 20th at 6:30 p.m.

CORRESPONDENCE

a) Date: 2013 March 6 (Received 2013 March 21)
Topic: Bill C-460
Intent: Acknowledging receipt of correspondence regarding Bill C-460
From: Ms. A. Opalick, Executive Correspondence Officer, Office of the Prime Minister
To: Dr. Bryna Warshawsky, Secretary-Treasurer, Middlesex London Board of Health

b) Date: 2013 April 17 (Received 2013 April 22)
Topic: Potential Health Impacts of a Casino in Peterborough
Intent: A copy of correspondence requesting that the provincial government:
a) Reconsider its plan to expand gambling throughout the province;
b) Direct the Ontario Lottery and Gaming Corporation to implement stronger harm Reduction policies and criteria, including the use of tools such as a casino social contract; and,
c) Plan to commit a larger percentage of its gaming revenues for public awareness, prevention and treatment of gambling disorders and research.
From: Mr. David Watton, Chair, Board of Health Peterborough County-City Health Unit
To: The Honourables Kathleen Wynn, Premier of Ontario; Charles Sousa, Minister of Finance; and Deb Matthews, Minister of Health and Long-Term Care

c) Date: 2013 April 25 (Received 30 April 2013)
Topic: No Time to Wait: The Healthy Kids Strategy Report
Intent: A copy of correspondence endorsing the Healthy Kids Panel and requesting the Working Group to develop a comprehensive action plan to implement the Strategy
From: Mr. Daryl Vaillancourt, Chairperson, North Bay Parry Sound District Health Unit
To: The Honourables Deb Matthews, Minister of Health and Long-Term Care; and Ms. Teresa Piruzza, Minister of Children and Youth Services

ADJOURNMENT

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 064-13

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 May 16

ACCOUNTABILITY AGREEMENTS: 2012 PERFORMANCE AND 2013 TARGETS

Recommendation

It is recommended that Board of Health members receive the 2012 Accountability Agreement Performance Indicators for information, and approve the 2013 targets.

Key Points

- The 2012 Accountability Agreement indicators identify some of the Health Unit's accomplishments in 2012.
- Staff members recommend that the proposed targets for 2013 be accepted.
- The Ministry of Health and Long-Term Care currently has seven working groups exploring possible additional indicators.

Background

Under section 5.2 of the 2011-2013 Public Health Accountability Agreement between the Middlesex-London Board of Health and the Ministry of Health and Long-Term Care (MOHLTC), the Board agreed to "use best efforts to achieve agreed upon Performance Targets… for the Performance Indicators specified…"

There are currently 17 performance indicators reflecting the program areas of food safety, water safety, infectious disease control, vaccine preventable disease, tobacco control, injury prevention, substance abuse and child health. The first year of the agreement, 2011, collected baseline data for each indicator. The second and third years (2012 and 2013, respectively) report the Health Unit's performance against targets that were jointly negotiated and agreed upon by the Board and MOHLTC in 2012. Throughout the process, the Health Unit has submitted data for each indicator on-time, and collaborated with the MOHLTC to resolve any data quality issues.

2012 Performance – Year Two

On April 25, 2013, the MOHLTC published the Health Unit's performance on 9 of the 17 indicators (53%) for which data was available. Data (for all health units) was not reported on 8 of 17 indicators (47%) because of MOHLTC data quality issues. These included inspections of small drinking water systems and personal service settings, vaccination administration, youth smoking rates, falls and high-risk alcohol consumption.

The Health Unit met or exceeded performance targets on seven of the nine indicators reported. On two indicators, the Health Unit was below the negotiated target by 1% or less. The MOHLTC reported being pleased with the Health Unit's performance, and did not require follow-up reporting. See Table 1, Appendix A.

2013 Targets – Year Three

On May 2, 2013 the MOHLTC notified the Health Unit that the Board now has the opportunity re-negotiate 2013 targets for some of the performance indicators. For other indicators, previously negotiated targets will continue to apply. Staff members have reviewed the proposed targets. All targets can be accomplished within existing program budgets. However, staff members are recommending a change to one indicator. If the completion rate for 3 inspections of high risk restaurants could be set at 90% rather than 100%, compliance may be increased for three reasons:

- First, when a high-risk restaurant has been inspected 3 times in a year, some operators may be less attentive to food safety practices knowing they won't be inspected again that year. With the proposed approach, the uncertainty of the timing of the third inspection may improve compliance.
- Second, the small amount of surplus staff time could be used to over-inspect certain restaurants (e.g. 4 times per year or more), again ensuring that an operator would have to maintain compliant food safety practices for the duration of the year.
- Third, the choice to inspect 2, 3 or 4 times could be made rationally based on the record of inspections in current and previous years, allowing more scrutiny of restaurants with poorer compliance and less scrutiny of restaurants that have proven that they maintain acceptable food safety practices.

Results would be monitored to identify impact of this new approach on compliance. See Table 2, Appendix A for the proposed targets.

Conclusion/Next Steps

The MOHLTC currently has seven working groups exploring possible additional indicators (each focused on a different public health program area). The Health Unit is represented on four of these working groups: Chronic disease prevention (Ms. Diane Bewick), tobacco (Mr. Ross Graham), prevention of injury & substance misuse (Ms. Mary Lou Albanese), and reproductive & child health (Dr. Maria Van Harten).

This report was prepared by Mr. Ross Graham, Manager, Special Projects.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

Appendix A

Performance on Reported Indicators in 2012 and Negotiable Indicators for 2013.

	Table 1: Performance on Reported Indicators	Baseline	2012 Target	2012 Performance
1	% of high-risk food premises inspected every 4 months	84%	100%	99%
2	% of Class A pools inspected	78%	≥ 85%	100%
4	% of gonorrhoea cases where follow-up occurred within 0-2 business days	N/A	70%	99%
5	% of iGAS cases where follow-up was same-day as lab confirmation	N/A	100%	100%
7a	% of HPV vaccine wasted that are stored/administered by MLHU	0.0%	Maintain	0%
7b	% of Influenza vaccine wasted that are stored/administered by MLHU	1.2%	Maintain or improve	0%
9c	% of school children who have completed Meningococcus immunizations	87.1%	Maintain or improve	86.7%
11	% of tobacco vendors in compliance with youth access legislation	96.0%	≥ 90%	99%
14	Baby Friendly Initiative (BFI) Status	Preliminary	Intermediate	Intermediate

	Table 2: Indicators with Negotiable Targets	Proposed Target	Staff Recommendation
1	% of high-risk food premises inspected every 4 months	100%	90%*
2	% of Class A pools inspected	100%	Accept
4	% of gonorrhoea cases where follow-up occurred within 0-2 business days	> 70%	Accept
5	% of iGAS cases where follow-up was same-day as lab confirmation	100%	Accept
7a	% of HPV vaccine wasted that are stored/administered by MLHU	Maintain (currently at 0%)	Accept
7b	% of Influenza vaccine wasted that are stored/administered by MLHU	Maintain or improve (currently at 0.1%)	Accept

*Under this approach, certain high-risk food premises would be inspected more than three times a year and certain premises less, based on their performance on inspections to date. Uncertainty of timing of third (or fourth) inspection may increase compliance.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 065-13

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 May 16

HARVEST BUCKS: A FARMERS' MARKET VEGETABLE AND FRUIT PROGRAM

Recommendation

It is recommended that Report No. 065-13 re "Harvest Bucks: A Farmers' Market Vegetable and Fruit Program" be received for information.

Key Points

- In 2009, 63% of Middlesex-London residents aged 12 years and older reported eating less than the recommended daily amount of vegetables and fruit.
- The Harvest Bucks program pilot involved the production and distribution of food literacy resource kits and $8000 worth of vegetable and fruit vouchers ('harvest bucks') to 411 individuals and families.
- Participants reported increased access to and consumption of fresh vegetables and fruit and increased food literacy. The program also resulted in increased exposure and revenue for local vegetable and fruit farmers.
- Program planning is underway for an ongoing Harvest Bucks program including expansion to additional markets and distributing organizations.

Background

Eating the recommended servings of vegetables and fruit each day is one part of a healthy diet that reduces the risk of cancer, heart disease and stroke. In 2009, 63% of Middlesex-London residents aged 12 years and older reported eating less than the recommended daily amount of vegetables and fruit. Increasing access to and consumption of vegetables and fruit for Middlesex-London residents is one of the three-year outcomes identified in the Health Unit Strategic Plan.

The Harvest Bucks Program was a collaborative pilot project with the Health Unit and other members of London's Child and Youth Network. Harvest Bucks involved the production and distribution of food literacy resource kits and vegetable and fruit vouchers ($2 each) redeemable at the Western Fair Farmers' and Artisans' Market.

From November 2012 to January 2013, resource kits and $8000 in harvest bucks were distributed to 411 individuals and families. Materials were distributed to participants through various community organizations targeting those involved in food programming. Participating organizations were Youth Opportunities Unlimited, Mommy and Me (a Childreach Program), London Intercommunity Health Centre, Growing Chefs, the Health Unit's Smart Start for Babies Program and Family Home Visitors, Southern Ontario Aboriginal Health Access Centre, and Crouch Neighbourhood Resource Centre.

Distribution strategies varied by organization, including one-to-one client settings and group classes. Harvest buck recipients received between $10 to $50 of vouchers, varying by distributing organization, and a food literacy resource kit including information about meal planning, vegetable and fruit preparation and food-related community supports.

Evaluation Summary

The feedback from participants, distributing organizations and the Market was very positive. Some evaluation data is presented below organized by the original program objectives.

Increased Access to and Consumption of Fresh Vegetables and Fruit

- The voucher redemption rate was 63% ($5022), ranging from 32 to 93% for individual organizations.
- 83% of participants surveyed reported that the program helped them buy healthy and fresh food.
- 54% reported being able to buy vegetables or fruit they can't usually afford.
- 33% reported buying vegetables and fruit they can't find within their neighbourhood.
- 77% reported eating all vegetables and fruit that were purchased.
- 24% reported trying vegetables or fruit they hadn't tried before.
- 49% reported changing their eating habits (e.g., eating more vegetables and fruit and/or healthy food).

Increased Food Literacy

- 20% of participants surveyed reported learning new ways to cook or store food from the program.
- 49% reported the program changed their eating habits (e.g., getting more ideas for healthy eating, starting to write meal plans, intentionally planning and including healthier snack and meal options).

The primary influencer of participants' food literacy was the distributing organization's process. Increased food literacy was observed when the distributing organizations imbedded the Harvest Bucks program within their own food programming (e.g., using resources from the kit, preparing the recipes provided). For those clients who received the kit with limited program use of the kit's contents, the food literacy impact appeared to be limited.

Increased Exposure and Revenue for Local Vegetable and Fruit Farmers

- 61% of participants surveyed reported spending their own money at the Market in addition to the harvest bucks.
- 37% reported spending $1-19, 22% reported spending $20-39, and 2% reported spending $40 or more, of their own money.

Increased Familiarity with and Comfort Shopping at a Farmer's Market

- 91% of participants surveyed said they would return to the Market.
- 41% reported learning that fresh fruit and vegetables cost less at the Market than they thought.
- 31% reported feeling more comfortable going to the Market.

An unintended positive outcome was an increased sense of community connection; 34% of participants surveyed reported feeling more connected to their community. Distributing organizations noted this was especially evident for some of their most vulnerable clients.

Conclusion

The Harvest Bucks program increased access to and consumption of fresh vegetables and fruit. Distributing organizations were a critical influencer on participant's food literacy, highlighting the importance of engaging those organizations involved in food programming as distributing organizations.

Based on the positive evaluation data, program planning is underway for an ongoing Harvest Bucks program, including expansion to additional markets and distributing organizations. The partnership is exploring alternative program funding through grants and corporate/agency sponsorship. The opportunity for additional distributing organizations to purchase vouchers for client use is also being investigated.

This report was prepared by Ms. Kim Leacy, Registered Dietitian, and Ms. Linda Stobo, Manager, Chronic Disease Prevention & Tobacco Control Team.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

This report addresses the following requirements of the Ontario Public Health Standards (2008): Foundational Standard 4, 11, 12; Chronic Disease Prevention 7, 8, 11, 12

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 066-13

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 May 16

COMMUNITY RESOURCES FOR NEWCOMERS WITH NO HEALTH COVERAGE

Recommendation

It is recommended that Report No. 066-13 re "Community Resources for Newcomers with no Health Coverage" be received for information.

Key Points

- In July 2012, the federal government eliminated a wide range of health services and benefits for refugee claimants from the Interim Federal Health Program. These cuts elicited concerns regarding the health of those seeking refuge in Canada.
- Under the Health Unit's leadership, a group of community partners, local physicians, and medical students worked collaboratively to advocate for additional services for individuals without OHIP, and to develop a tool to help newcomers access health-related services for free or at very low cost in London and Middlesex County.

Identifying the Need

Significant changes were made to the Interim Federal Health Program (IFHP) in July 2012, which resulted in the reduction and/or elimination of a wide range of health services and benefits for refugee claimants. There were numerous concerns regarding the potential negative impacts of these cuts on the health of those seeking refuge in Canada. Family Health Services staff, with two concerned local physicians, formed a Newcomer Resource Working Group comprised of community service providers, physicians, and medical students. This group met several times in an effort to find a way to respond to unmet health care needs of refugees and refugee claimants within our community. The group concluded that providing current and accurate information on free and low cost health-related services in the community to primary health care providers and other community service providers in an easy-to-access format would support these providers in making appropriate and timely referrals, and would ultimately help mitigate some of the potential negative impacts of the IFHP funding changes.

Developing the Resource

Initially, the group identified what free or low cost health-related services were available within London and Middlesex County for people that have no OHIP card. It was decided that information included in the resource should be directly related to health care services affected by the IFHP cuts and should not include resources related to basic needs, as the existing "Help Yourself Through Hard Times" resource directory already includes this information. The group also determined that the resource would not be designed for direct distribution to clients, but would be distributed to staff and volunteers who provide support to newcomers and refugees for the purpose of facilitating awareness of and referral to available services. A Resource Map (attached as Appendix A), or listing, was produced. The listing provides information on services in the following categories: primary health care, medical, prenatal, developmental screening, vision, hearing, dental, speech, mental health/addiction, respite, children, settlement, interpretation, emergency

shelter, sexual assault, telephone help line, and food bank. It also includes information regarding where clients can access free/low cost medical supplies and medications. Based on feedback received from partners such as the London Network for an Inclusive Community and the Physician Champion Group members, the decision was made to develop an accompanying Booklet to provide additional details about resources highlighted on the Map.

Distribution of the Resource Map and accompanying Booklet to physicians and community agencies began in February, and feedback has been very positive. The Map and Booklet are available on the Health Unit website, under "For Professionals", and other agencies are being encouraged to link to these resources.

Benefits of Working Group Formation and Resource Development

A number of benefits have been realized from the formation of this Newcomer Resource Working Group:

- The identification of existing resources and the sharing of experiences related to working with refugees has resulted in expanded knowledge and enhanced practice among the workgroup members.
- Due to advocacy efforts of this group, some agencies made changes to their referral acceptance policies (i.e., some agencies who previously would not accept clients without a health card have changed their policies to now accept these clients), which ultimately resulted in a greater number of services available in our community for individuals without an OHIP card.
- Working together on this initiative has resulted in increased collaboration and networking among the Health Unit, community agencies and medical students.
- As a result of increased knowledge and understanding among professionals making referrals, it is expected that clients will access available services and resources more easily and in a timely manner.

Conclusion/Next Steps

The Health Unit responded to concerns regarding Interim Federal Health Program cuts, in collaboration with community partners, local physicians, and medical students, by developing a resource that outlines services available for individuals with no OHIP card. This initiative has resulted in increased services for newcomers in the community, improved referral practices and strengthened collaborative relationships. Distribution of these resources to health and social service providers in London and Middlesex County will continue on an ongoing basis, with the resource revised annually. There has been significant interest in these resources locally and provincially with opportunities for presenting the resource to large groups and an expression of interest from Best Start (Ontario's Maternal Newborn and Early Child Development Resource Centre) to develop a similar resource reflecting available provincial services. Copies of the Resource Map and the accompanying Booklet will be sent to all members of City and County Council.

This report was prepared by Ms. Heather Lokko, Manager, Reproductive Health Team, and Ms. Joanne Simpson and Ms. Muriel Abbott, Public Health Nurses.

Dr. Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards:
Foundational Standard: Requirements #3 and #4
Strategic Area of Focus: Improved health outcomes in the area of reducing health inequities

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 067-13

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 May 16

DRAFT RESERVE/RESERVE FUND POLICY

Recommendation

It is recommended that the Board of Health endorse Appendix B – Draft Reserve/Reserve Fund Policy and direct staff to engage the City of London and Middlesex County regarding the related Memorandum of Understanding in Appendix C to Report No. 067-13.

Key Points

- Establishment and maintenance of reserves and reserve funds is a responsible business practice used by many health units in Ontario.
- Although Middlesex-London has reserves and reserve funds, it does not have a formal policy to establish them or to maintain them.

Background

During the Board's review and approval of the 2013 cost-shared budget, the Board received Report No. 117-12, "2013 Budget – Protecting the Gains". In the report a number of concerns were raised in meeting the anticipated shortfall of $477,682 as a result of achieving a 0% municipal increase. Generally, these concerns related to the Health Unit's potential inability to meet training requirements, purchase specialized services, manage corporate assets, and to meet unexpected expenditures. It was discussed that a partial solution to mitigate the areas of concern was for the Board of Health to develop a policy for establishing and maintaining reserves and/or reserve funds.

A reserve is an amount set aside by resolution of the Board of Health that is carried year to year mainly as a contingency against unforeseen events or emergencies. A reserve fund is an amount set aside for a specific purpose by resolution of the Board of Health that is carried from year to year unless consumed or formally closed.

Historically, the Board has made contributions to reserves and reserve funds without a formalized approach. The Health Unit currently does have both reserves and reserve funds, the balances of which are included in the annual audited financial statements. Attached as Appendix A is a summary of reserves and reserve funds as at December 31, 2012.

Legislatively, the Middlesex – London Board of Health is a separate autonomous entity, and as such can legally hold reserves and reserve funds. However, the Province of Ontario explicitly prohibits the use of their grants as contributions to reserves and/or reserve funds in their agreements with Boards of Health.

Draft Policy

Attached as Appendix B is a draft Reserve/Reserve Fund policy for the Board's consideration and feedback. The main purpose of the policy is to provide a framework for the Board of Health to establish and maintain reserves and/or reserve funds to protect against predicted and unpredicted liabilities, and to cover contingencies or emergency expenditures. The draft policy answers the following questions:

a) How are reserves and reserve funds established?
b) What are the maximum contributions allowed for a reserve fund?
c) What are the annual and cumulative maximums allowed for reserves?
d) Who authorizes contributions and withdrawals to/ from reserves and/or reserve funds?
e) What are the reporting requirements under the policy?

Finally the draft policy sets out a process whereby an agreement is reached with the City of London and Middlesex County. A draft agreement is attached as Appendix C.

Environmental Scan

A brief and informal survey was conducted to understand if other autonomous Boards of Health utilized reserves and/or reserve funds. Appendix D provides the outcome of the survey. Twenty-four (24) health units were asked if their Boards of Health utilized reserves and/or reserve funds as a financial management tool. Twelve (12) Boards of Health were left out of the survey as they were either from a regional structure or municipally integrated structure where it was assumed they used reserves and reserve funds.
Out of the twenty-four (24) health units surveyed, fourteen (14) responded that they have reserves and/or reserve funds and most had policies governing their use. Five (5) health units responded that they didn't utilize reserve and/or reserve funds and the remaining five (5) did not respond before this report was written. This quick survey revealed that more than half of the health units surveyed utilize reserves and/or reserve funds.

From the health units that provided further information and copies of their policies it would seem that many Boards of Health provide for a maximum level of reserves. However, there was a lot of variability in terms of the maximum set. The maximum ranged from 1.5% of gross revenue to 16.67% (or 2 months of operations) and in some cases there were no maximums.

Next Steps

Reserves and reserve funds are used by many health units, including the Middlesex-London Health Unit. The Board of Health could increase its oversight and standardize the Health Unit's approach by implementing a policy such as that in Appendix B. If this is approved, staff will approach both the City of London and the County of Middlesex with the intent to establish an agreement similar to the draft "Memorandum of Agreement" attached as Appendix C.

This report was prepared by Mr. John Millson, Director, Finance & Operations.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

Appendix A

Middlesex-London Health - Reserve & Reserve Fund balances
As December 31, 2012

	2012	2011
Reserves set aside by the Board:		
Funding stabilization	$ 765,957	$ 899,251
Reserve funds set aside by the Board:		
Accumulated sick leave	307,314	344,164
Environmental – septic tank	6,044	6,044
Dental Treatment reserve	174,169	214,746
Total reserve funds	487,527	564,954
Total reserves and reserve funds	**$ 1,253,484**	**$ 1,464,205**

MIDDLESEX-LONDON HEALTH UNIT

ADMINISTRATION MANUAL

SUBJECT: **RESERVE / RESERVE FUNDS** **POLICY NUMBER:** X**-XXX**
SECTION: Finance

IMPLEMENTATION DATE: TBD **APPROVED BY:** Board of Health
REVISION DATE: N/A **SIGNATURE:**

BACKGROUND

Legislatively the Middlesex-London Board of Health is a separate autonomous entity, and as such can legally hold reserves and reserve funds. However, the Province of Ontario explicitly prohibits the use of their grants as contributions to reserves and/or reserve funds in their agreements with Boards of Health.

Reserves are amounts set aside by resolution of the Board of Health that are carried year to year mainly as contingencies against unforeseen events or emergencies.

Reserve Funds are amounts set aside for specific purposes by resolution of the Board of Health. They are carried from year to year unless consumed or formally closed.

PURPOSE

To provide the process for establishing, maintaining, and using reserves and reserve funds.

To maintain an appropriate level of financial resources to protect against predicted or unpredicted liabilities, cover contingency or emergency expenses, and provide for major future expenditures.

POLICY

Any Reserve and Reserve Funds will be established by resolution of the Board of Health in accordance with the Memorandum of Agreement between the obligated municipalities and the Board of Health which outlines the general parameters for establishing and operating Reserves and Reserve Funds (see Section 1.1 and 1.2).

Contributions to and withdrawals from established reserve or reserve funds will be approved by resolution of the Board of Health.

The maximum contributions to a reserve fund shall be the amount required to fulfill the specific requirement.

The maximum contributions to reserves for any particular operating year shall be 2% of gross revenues found on the annual statement of operations of the audited financial statements.

The maximum cumulative contributions to reserves shall be 10% of gross revenues found on the annual statement of operations of the audited financial statements.

Where possible, the use of reserve and reserve funds should be leveraged to request additional one-time funding grants from the province or other sources.

PROCEDURE

1.0 Establishment of Reserves and Reserve Funds

1.1 A Reserve or Reserve Fund is established in accordance with the Memorandum of Agreement date "TBD" (Appendix A). The Memorandum of Agreement specifies that:

a) A Reserve Fund is used to address a specific obligation or requirement that is planned.
b) A Reserve is used to address one-time or short-term expenditures, either planned or unplanned.
c) Any audited unexpended municipal funds are eligible to be transferred in to a Reserve or Reserve Fund, subject to the limits
d) Maximum contributions to a Reserve Fund are equal to the amount to fulfil the specific requirement.
e) Maximum of total reserves is equal to 10% of gross revenues found on the annual statement of operations of the audited financial statements.
f) Maximum annual contribution to reserves shall be 2% of gross revenues found on the annual statement of operations of the audited financial statements.
g) Any additions or withdrawals are authorized by the Board of Health.
h) The Health Unit will provide an annual reporting to Obligated Municipalities which will be included in the annual audited financial statements.

1.2 Each Reserve Fund is established by a resolution of the Board of Health in keeping with the Memorandum of Agreement and an understanding of the purpose of the Reserve Fund, maximum contribution to the Reserve Fund and expected timelines for contributions to and withdrawals from the Reserve Fund.

1.3 Any Reserve or Reserve Fund is to be held in an interest-bearing account at a Canadian Chartered Bank with the same signing officers as other Health Unit bank accounts.

2.0 Additions

2.1 Annually when the draft audited financial statements are presented to the Board of Health, the following actions take place:

a) The Director of Finance & Operations, or delegate, presents a financial report on the funds available for transfer to Reserves and/or Reserve Funds. The report will specify the current fund balances of the Reserves and/or Reserve Funds, and the limit of allowable transfers according to the limits set by the Memorandum of Agreement for Reserves or Board of Health Resolution in the case of Reserve Funds.
b) The Director of Finance & Operations or delegate makes a recommendation to the Board of Health to transfer the amounts according to the Memorandum of Agreement for Reserves or Board of Health resolution in the case of Reserve Funds.
c) Management and the Auditors revise the draft financial statements to reflect the Board of Health approved contributions.

3.0 Withdrawals

3.1 Withdrawals from a Reserve and/or Reserve Fund are made at any point during the operating year, provided the withdrawal has been approved by the Board of Health.

4.0 Annual Reporting

4.1 Yearly, the Obligated Municipalities are given the annual audited financial statements for the Middlesex-London Health Unit which includes a summary of the balances of the Reserves and/or Reserve Funds.

4.2 At the next Board of Health meeting following the approval of the annual audited financial statements, the Director of Finance and Operations will provide a summary report to the Board of Health outlining the transactions of the Reserve and/or Reserve Funds during the previous fiscal year. This report will be forwarded to the Obligated Municipalities.

5.0 Responsibilities

5.1 Board of Health

a) To establish the Memorandum of Agreement with the obligated municipalities
b) To approve the establishment, maintenance and withdrawal (use) of Reserves and Reserve Funds.

5.2 Secretary-Treasurer

a) To ensure the control of Reserves and Reserve Funds in accordance with applicable legislation, Board of Health resolutions for Reserve Funds, Memorandum of Agreement, and the Reserve / Reserve Fund Policy

5.3 Director, Finance and Operations

a) To ensure annual review of Reserve and Reserve Funds balances is completed
b) To provide and make recommendations for the establishment, maintenance, and withdrawal (use), elimination of Reserves and Reserve Funds based on existing legislation, Memorandum of Agreement(s), sound financial management, or other requirements.
c) To ensure all administrative matters related to the establishment, maintenance and control of Reserves and Reserve Funds are completed.

DRAFT
Memorandum of Agreement

Between

Middlesex-London Health Unit
(Hereinafter Referred to as the "Health Unit")

And

_____
(Name of Obligated Municipality)

It is recognized that the maintenance of a reserve and reserve funds is an acceptable business practice.

In order for the Health Unit to address one-time or short-term expenditures, either planned or unplanned, which arise, it is necessary to maintain reserves and/or reserve funds.

It is understood that the Health Unit will attempt to offset any unexpected expenditures within their annual operating budget for all Health Unit programs, where possible without jeopardizing programs.

Any audited unexpended municipal funds are eligible for transfer to a reserve and/or reserve fund by resolution of the Board of Health.

Any contributions to reserve and/or reserve funds will be made using the same apportionment used for funding public health programs. For clarity, the current apportionment used is the percentage of population method. For every municipal dollar of funding 84% comes from the City of London, and 16% from the County of Middlesex.

It is agreed that any reserves which are presented in the audited financial statements be capped at 10% of the Health Unit's total gross revenues found on the statement of operations of the audited financial statements. It is further agreed that annual contributions will be capped to 2% of the Health Unit's total gross revenues found on the statement of operations of the audited financial statements.

It is agreed that in the case of reserve funds, there is no cap on annual contributions, however, the maximum contributions shall equal the estimated amount of the commitment or requirement specified.

Any excess unexpended municipal funds above the amount transferred annually to a reserve and/or reserve funds, will be returned to the obligated municipality at their respective rate following the approval of the annual financial statements.

Any withdrawal from a reserve and/or reserve fund will be made by a Board of Health resolution.

The Health Unit will provide an annual report to the obligated municipalities outlining the transactions of the reserve and/or reserve funds during the previous year.

IN WITNESS THEREOF, the parties have executed this Agreement, dated at,_____, Ontario this _____ day of _____, 2013.

Obligated Municipality:	**Health Unit:**
_____	Middlesex-London Health Unit
Name of Municipality	Name of Health Unit
1) _____	1) _____
Signature	Signature
_____	Chair, Board of Health
Name, Title	Name, Title
2) _____	2) _____
Signature	Signature
_____	Dr. Christopher Mackie, Secretary-Treasurer
Name, Title	Name, Title

Appendix D

Survey of Public Health Units for Reserves/Reserve Funds

		Public Health Unit	Reserve / Reserve Fund Utilization	Policy Received
Rural Northern Regions	1	Northwestern Health Unit	Yes	Yes
	2	Porcupine Health Unit	Yes	Yes
Mainly Rural	3	The Eastern Ontario Health Unit	Yes	No
	4	Elgin-St.Thomas Health Unit	Yes	Yes
	5	Grey Bruce Health Unit	No	
	6	Haldimand-Norfolk Health Unit	NR	
	7	Haliburton, Kawartha, Pine Ridge District Unit	Yes	Yes
	8	Huron County Health Unit	NS	
	9	Leeds, Grenville and Lanark District Health Unit	NR	
	10	Oxford County Health Unit	NS	
	11	Perth District Health Unit	Yes	No
	12	Renfrew County and District Health Unit	Yes	No
	13	Simcoe Muskoka District Health Unit	Yes	Yes
Sparsely Populated Urban-Rural Mix	14	The District of Algoma Health Unit	Yes	No
	15	North Bay Parry Sound District Health Unit	Yes	Yes
	16	Sudbury and District Health Unit	Yes	No
	17	Thunder Bay District Health Unit	Yes	Yes
	18	Timiskaming Health Unit	NR	
Urban/Rural Mix	19	Brant County Health Unit	No	
	20	Chatham-Kent Health Unit	NR	
	21	City of Hamilton Health Unit	NS	
	22	Hastings and Prince Edward Counties Health Unit	No	
	23	Kingston, Frontenac and Lennox and Addington Health Unit	Yes	Yes
	24	Lambton Health Unit	NS	
	25	Middlesex-London Health Unit	Yes	N/A
	26	Niagara Regional Area Health Unit	NS	
	27	Peterborough County-City Health Unit	No	
Urban Centres	28	Durham Regional Health Unit	NS	
	29	Halton Regional Health Unit	NS	
	30	City of Ottawa Health Unit	NS	
	31	Peel Region Health Unit	NS	
	32	Waterloo Health Unit	NS	
	33	Wellington-Dufferin-Guelph Health Unit	NR	
	34	Windsor-Essex County Health Unit	No	
	35	York Regional Health Unit	NS	
Metro Centre	36	City of Toronto Health Unit	NS	

Summary

14 Yes to utilize reserves and/or reserve funds
5 No to utilize reserves and/or reserve funds
5 (NR) No response received at time of writing the report
12 (NS) Not surveyed due to their structure being either regional or integrated into a municipality

Completed by John Millson, MLHU (May 7th, 2013)

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 068-13

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 May 16

IDENTIFYING PRIORITY POPULATIONS FOR REPRODUCTIVE HEALTH

Recommendation

It is recommended that Report No. 068-13 re "Identifying Priority Populations for Reproductive Health" be received for information.

Key Points

- The Foundational Standards in the Ontario Public Health Standards require Boards of Health to systematically identify populations at risk and to determine priority populations that would benefit from targeted public health programs and services.
- The Reproductive Health team engaged in a research project to identify priority populations in London and Middlesex who would benefit from targeted reproductive health programs and services.
- Women living on low income and those under 24 years of age were identified as priority populations. The outcomes of this work will guide team planning and intervention for several years. The process developed can be used by other program areas, and has been shared with other health units.

Reproductive Health Team Planning

As a new team in January 2012, the Reproductive Health Team (RHT) had the opportunity to engage in significant planning. Using the "Model for Evidence-Informed Decision Making in Public Health" from the National Collaborating Centre on Methods and Tools, the team examined various forms of evidence to support the process of clarifying the team's mandate, to determine topic areas of focus, to identify evidence-informed and/or promising public health strategies, and ultimately, to develop a three-year operational plan for the team.

Health Unit staff members recognized that they needed to invest time in clarifying the priority populations for reproductive health. Requirement #3 of the Foundational Standards in the Ontario Public Health Standards (2008) states:

> *"The board of health shall use population health, determinants of health and health inequities information to assess the needs of the local population, including the identification of populations at risk, to determine those groups that would benefit from public health programs and services (i.e., priority populations)."*

In addition to population-based approaches and universal approaches to improve reproductive health outcomes, outreach to priority populations and targeted programs are important to address the specific needs of the most vulnerable populations.

The Region of Waterloo Public Health had previously developed a process to determine priority populations. Although this information was useful to guide the priority setting work of the RHT, there was a need for a more prescriptive process to determine local priority populations.

Goals and Process of Priority Population Project

A Masters of Public Health student worked collaboratively with the Social Determinants of Health Public Health Nurse on the RHT. The primary goals of this work were to:

1) determine a definition of 'Priority Populations' for the RHT, that could potentially be adopted or adapted for use across the service area or the agency;
2) determine a process for identifying priority populations in Middlesex-London in relation to reproductive health, that could also be used to identify priority populations in relation to other areas as well;
3) determine priority populations in Middlesex-London in relation to reproductive health ; and
4) make recommendations for planning and implementing evidence-informed strategies, programs, and services for populations who are at an increased risk of poor reproductive health outcomes, while still providing universal programs and services to the broader population.

In order to achieve the ultimate goal of determining priority populations and making program recommendations, staff reviewed priority population work done by other health units, determined a definition of 'priority populations' through consultation with team members and consideration of existing definitions, conducted a situational assessment, and identified recommendations. A full report entitled, Identifying Priority Populations, documents the process followed and captures the completed work, with an Executive Summary beginning on page iii.

Outcomes of Identification of Priority Populations for Reproductive Health

'Next steps' were identified as part of the project. The RHT continued with their planning efforts and completed the 'next steps', reviewing strategies and their effectiveness for the identified populations and topic areas, and finalizing planning decisions related to who should receive targeted programming, what topic areas the programming would cover, and what strategies would be most helpful.

After consideration of the evidence, the team selected two populations to focus on for the next few years: 1) women living at or below the low income cut-off, and 2) women $\leq$ 24 years of age.

A process similar to the one developed by the Reproductive Health Team has also been used by the Early Years Team, who are currently working to identify priority populations related to the early years. A number of other health units have become aware of this work and have asked to see the report.

Conclusion/Next Steps

The time spent during planning to determine priority populations through a systematic process will ensure the reproductive health program is based on the best available evidence. The Reproductive Health Team has identified two priority populations to focus on for the next few years. As the Team implements the plan, ongoing evaluation will be conducted to assess the balance between universal and targeted strategies, and to determine whether strategies need to be modified to better meet the needs of the target population.

This report was prepared by Ms. Heather Lokko, Manager, Reproductive Health Team, and Ms. Joanne Simpson, Public Health Nurse.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards: Foundational Standard: Requirements #3 and #4.
Strategic Area of Focus: Improved health outcomes in the area of reducing health inequities.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 069-13

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 May 16

BABY-FRIENDLY INITIATIVE

Recommendation

It is recommended that Report No. 069-13 re "Baby-Friendly Initiative" be received for information.

Key Points

- The Baby-Friendly Initiative (BFI) is a global evidence-based strategy that promotes, protects, and supports the initiation and continuation of breastfeeding. All health units in Ontario are required to work towards achievement of Baby-Friendly designation, and the Middlesex-London Health Unit is in the process of working towards this.

- Implementation targets that have been achieved to date relate to orientation to the Baby-Friendly organization policy, staff education, resource and curricula review for BFI compliance, data collection planning and community outreach.

Background

Breastfeeding increases the health and development of infants and children, and provides health, social, and economic advantages to women, families, and society in general. Current recommendations from the World Health Organization include exclusive breastfeeding for the first six months, with continued breastfeeding up to two years and beyond. The Baby-Friendly Initiative (BFI) is a global evidence-based strategy that promotes, protects, and supports the initiation and continuation of breastfeeding.

The Ministry of Health and Long-Term Care selected Baby-Friendly designation as an Accountability Agreement Performance Indicator for all public health units in Ontario. The Health Unit signed a Certificate of Intent to begin the implementation process in November 2011. The implementation process has clearly defined steps laid out by both the Ministry and the Breastfeeding Committee for Canada, the national designation authority.

Progress Update on the Implementation of the Baby-Friendly Initiative at MLHU

The implementation process for the BFI includes a comprehensive mix of policy development and implementation, staff education, review and revision of curricula and resources, practice changes, data collection and community outreach. The implementation plan identified early in 2012 has been successful in leading the Health Unit through these requirements. Achievements to date:

- The Board of Health (BOH) endorsed the Baby-Friendly Organization Policy 2-080 in October 2012 (see Report No. 119-12). The BOH received an initial orientation to the policy, an overview of the Breastfeeding Committee of Canada's BFI 10 Steps Practice Outcome Indicators, and were informed of BOH responsibilities within the Baby-Friendly Initiative.
- Policy summary posters/plaques have been mounted in most teaching rooms and waiting areas, with the remainder to be mounted by the end of May.

- Orientation to the Baby-Friendly Organization Policy is nearly complete for all staff and volunteers, with 100% completion expected by the end of May.
- All staff working directly with prenatal and postpartum women and families ('direct care providers') have participated in intensive education, with additional skill development sessions planned for June.
- All other staff and volunteers working at the Health Unit ('indirect care providers') are in the process of completing education that will provide basic breastfeeding and BFI information, with the expectation that this education will be completed by the end of June.
- Almost 600 print resources for young families, as well as the Prenatal Education curricula, have been reviewed to determine consistency with Baby-Friendly principles.
- A data collection plan has been developed.
- Community outreach is resulting in growing momentum as community partners are working with nurses to develop capacity related to Baby-Friendly practices and improving the connection between organizations that serve young families.
- The BFI Advisory Group has met twice, with another meeting planned for this spring.
- Health Unit staff members are integrating Baby-Friendly Initiative concepts into their work (e.g., Communications added 'BFI compliance' to their communication checklist; a breastfeeding pamphlet was incorporated into emergency preparedness materials).

Next Steps/Conclusion

Over the coming months, orientation to the organization policy and Baby-Friendly Initiative education for all staff who are indirect care providers will be completed. Policy and education requirements will be integrated into Human Resource processes for new Health Unit employees. The revision of resources for young families will be completed. A Baby-Friendly 'Resource Compliance Checklist' will be disseminated across the whole agency to prompt all service areas to consider Baby-Friendly principles in resource development and acquisition.

The Health Unit will continue to partner with provincial groups, supporting the development of a provincial breastfeeding surveillance system, and implementation of the Baby-Friendly Initiative within many hospitals in the Southwest region. Locally, the Health Unit will continue its work with other London and Middlesex agencies and groups who work with prenatal and young families with an ultimate goal of building more support for breastfeeding in the community.

The Health Unit is progressing toward achieving key requirements set out by both the Ministry of Health and Long-Term Care and the Breastfeeding Committee for Canada.

This report was prepared by Ms. Laura Dueck, Public Health Nurse, and Ms. Heather Lokko, Manager, Reproductive Health Team.

Dr. Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards: Child Health, Requirement #4, #7 and an Area of Focus: Facilitate the effective and efficient implementation of the Public Health Accountability Agreement

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 070-13

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 May 16

SMART START FOR BABIES: IMPROVING OUTCOMES

Recommendation

It is recommended that Report No. 070-13 re "Smart Start for Babies" be received for information.

Key Points

- Smart Start for Babies Program provides prenatal and nutrition education for vulnerable pregnant women and teens in London and Middlesex County.
- Significant changes were made to the program in 2012 and the program continues to evolve.

Background

Smart Start for Babies (SSFB) is a Canada Prenatal Nutrition Program designed for pregnant women and teens who are at risk for poor birth outcomes due to factors such as poor lifestyle habits, abuse, poverty, recent arrival in Canada, and teen pregnancies. The woman's primary support person can also access the program. The program is funded by the Public Health Agency of Canada, and as the sponsor, the Health Unit provides in-kind support in the form of staff to coordinate and facilitate the program. SSFB has been sponsored by the Health Unit for the past eight years with experienced public health nurses and registered dietitians facilitating the sessions. The program also receives significant in-kind personnel support from London Health Sciences Centre, Merrymount Family Support and Crisis Centre, Children's Aid Society London & Middlesex (CAS), and Health Zone Nurse Practitioner-Led Clinics. The program provides access to healthy foods, nutritional counseling, training for life skills, prenatal education, and referrals to available community supports and resources.

Sessions provide prenatal and nutritional education and address priority issues of healthy weights, mental health promotion, and injury prevention. At each SSFB session, participants are provided with a healthy snack. Every three months dietitians engage participants in cooking a healthy meal. Participants in SSFB receive $10 in food vouchers each week to promote access to healthy food, as well as bus tickets, prenatal vitamins, and a variety of kitchen utensils and cookware to support the preparation of healthy meals at home. Special projects held twice a year provide participants with slow cookers and Magic Bullet food processors. The Kiwanis Club of London donated $1500 to SSFB in 2012 to purchase 63 slow cookers. In the fall of 2012, SSFB was able to access the Harvest Bucks program (see Report No 065-13 in this Board of Health package) and participants received vouchers for fresh produce at a local farmers' market.

Program Structure

Following an extensive evaluation process, a number of changes have occurred over the last year in the local SSFB program. Since September 2012, the SSFB program has increased the number of sessions offered to participants by offering sessions weekly instead of twice a month. This allows participants to enter the program later in their pregnancy and still derive nutritional, social, and educational benefits from the program. SSFB is now able to offer 42 sessions per year at seven sites compared to 24 sessions at four sites

in previous years. In the first six months of the new program structure, there were 73 new participants, representing an 89% increase over the same period for the previous year. Promotion of the program through the creation of a new logo, poster, and bookmark has been successful in recruiting new participants to the program. Promotional materials have been distributed to community agencies and to physicians in London and Middlesex County. SSFB has also created a new display which has been used to promote the program at various community events.

The SSFB prenatal and nutrition education curricula have been revised and updated to meet the Baby Friendly Initiative (BFI) criteria (see Report No. 069-13 of this Board of Health package). To further support breastfed infants, participants now receive a $20 voucher to purchase Vitamin D for their breastfed babies.

New Partnerships

Since September 2012, three new partnerships have been established to support SSFB. CAS partnered with SSFB to begin offering sessions to CAS clients. The Health Zone Nurse Practitioner-Led Clinic also began offering sessions in partnership with Chelsea Green Children's Centre Inc. As well, in March 2012, SSFB partnered with three Ontario Early Years Centres and the South London Community Centre to provide space and to hire site coordinators who support participants in the program. Site coordinators offer consistency to participants by being present each week to welcome participants to sessions, to foster relationships, to engage participants in the preparation of healthy snacks and clean up, and to link participants to appropriate community resources.

Recognizing that teens have particular needs, the Health Unit teen prenatal education classes are now linked with SSFB. Two SSFB sessions are held for teens each week. Twice a year, teens are able to attend a Teen Prenatal Fair organized by the SSFB Program Coordinator. Agencies which offer services specifically geared to teens are invited to attend the fair with a display and provide a brief presentation.

Conclusion

Smart Start for Babies has a long history in London and Middlesex County. It has been sponsored by the Health Unit for the past eight years with experienced public health nurses and registered dietitians facilitating the sessions. Pregnant women and teens who face barriers to accessing healthy foods are able to learn valuable life skills and improve their nutritional well-being which results in healthy birth outcomes. The program continues to grow and evolve to provide excellent nutrition and prenatal education to this vulnerable population.

This report was prepared by Ms. Kathy Dowsett, Manager, Family Health Services, and Ms. Nancy Del Maestro, Public Health Nurse and Smart Start for Babies Program Coordinator.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

This report addresses the following requirements of the Ontario Public Health Standards: Reproductive Health Program, to support healthy pregnancies. It also addresses the strategic direction of the Middlesex-London Health Unit to reduce health inequities for vulnerable populations.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 071-13

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 May 16

CREATING HEALTHIER NUTRITION ENVIRONMENTS IN LOCAL GROUP HOMES

Recommendation

It is recommended that Report No. 071-13 re "Creating Healthier Nutrition Environments in Local Group Homes" be received for information.

Key Points

- The goal of the Group Home project is to improve the nutritional environments in four pilot group home sites.
- Community partners collaborated to develop a comprehensive Nutrition Checklist Manual which encourages group homes to consider a healthy physical environment, education and skill building, and community partnerships.
- As a result of this initiative, Fanshawe College has changed its curriculum to include teaching students about a healthy nutrition environment with six hours of class learning which utilizes the Nutrition Checklist Manual.
- Future plans include offering these tools to other group homes within partnering agencies, and quality assurance monitoring of participating programs.

Background

Creating a supportive nutrition environment for groups of youth living together in a community setting can have a positive impact on their eating habits. The Youth on Track for Health Committee was struck in 2011 to assist in improving the nutrition environment in group homes. Advocating for positive role modeling and the development of a safe and sanitary environment for food production, as well as providing food literacy education for staff and youth, are all important components of the comprehensive approach to improving nutritional habits in our local group homes.

Stakeholders working collaboratively on this project include: Western Area Youth Services, Craigwood and Anago. In addition, the committee includes representation from a registered nurse from the Centre for Children and their Families in the Justice System, an instructor from Fanshawe College and two registered dietitians from the Health Unit. The Health Unit is the project lead and works with partners to plan, implement and evaluate the various strategies.

Project Description

The Committee has developed and implemented several activities in the four pilot group homes. They include:

- The development of a comprehensive Nutrition Checklist Manual that was based on the evidence-based Nutrition Tools for Schools. This document includes four main areas: Healthy Physical

Environment; Healthy Supportive Environment; Education and Skill Building and Community Partnerships. The goal is for the homes to use the checklist to identify what is working well and to identify priority areas to work on to improve the nutrition environment. The Manual is now used at Fanshawe College in the course curriculum for Child and Youth Workers. The integration of this information into the curriculum allows students to be better prepared in terms of nutrition knowledge and have the necessary food preparation and food safety skills they need to work in group homes. The instructor involved in this project has also partnered with the Health Unit and created opportunities for students to receive their Food Handler Certification prior to graduation.

- The Public Health Registered Dietitians have provided opportunities for at-risk youth living in these homes to practice and enhance their food skills. The youth have engaged in cooking sessions in community-based settings. They have been empowered to learn how to make nutritious, economical, easy meals that require minimal equipment and time. These sessions have also built self-efficacy, self-esteem and confidence in participants' cooking abilities.
- Quarterly newsletters have been developed by the Health Unit and shared with the group homes and partners. Topics have included healthy eating information, role modeling and creating supportive nutrition environments.

Success Stories from Local Pilot Agencies

Success stories from local agencies have been captured:

- Fanshawe College reported that "*the second (2nd) year curriculum now includes 12 hours dedicated to teaching students about a healthy nutrition environment with 6 hours in-class learning including an overview of the Checklist and resources and 6 hours devoted to food skills development".*
- One student stated "*I have never made a meal from scratch and it really isn't that hard and tastes so much better."*
- Another agency reported that previously *"they used only white flour based grain products and switched to whole grain products [because of this project]. Initially youth were upset but with time and teaching they have accepted the change and disclosed they don't mind whole wheat now or notice a difference."*
- Annotated comments from a third home revealed "*the salt shaker is no longer placed on the table, youth didn't appreciate this but with time and teaching they have come to accept this, we have also changed from serving fruit punch to 100% fruit juice, staff have been purposefully enrolled in food safety certification classes, and the grocery shopping lists have been tweaked to ensure ingredients to support menu items are purchased to decrease menu substitutions."*

Next Steps and Conclusion

Creating healthier nutrition environments through collaboration with local champion agencies using the Nutrition Checklist Manual and other strategies can have a positive impact on eating habits and the lives of youth living in group settings. Next steps for this project include disseminating these tools to additional homes within our community, monitoring practices using the audit tool, continuing skill building opportunities and sharing these successes with our provincial partners.

This report was prepared by Ms. Christine Callaghan and Dr. Heather Thomas, Registered Dietitians, and Ms. Christine Preece, Manager, Young Adult Team.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards: Chronic Diseases and Injuries Program Standards: Child Health Standard 4,5,7 and Chronic Disease 11

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 072-13

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 May 16

DRUG AWARENESS EVENTS – CHILD HEALTH TEAM

Recommendation

It is recommended that Report No. 072-13 re "Drug Awareness Events – Child Health Team" be received for information.

Key Points

- According to the Centre for Addiction and Mental Health (CAMH) and the Ontario Student Drug Use and Health Survey, 54.9% of grade 7-12 students report the use of alcohol and 22% of grade 7- 12 students report the use of cannabis.
- Six hundred and twenty-six (626), grade 7 & 8 students in London and Middlesex County participated in school Drug Awareness Events.

Background

According to the Centre for Addiction and Mental Health (CAMH) and the 2011 Ontario Student Drug Use and Health Survey, 54.9% of grades 7-12 students in Ontario report the use of alcohol. Next to alcohol, cannabis is the second most commonly used drug in this age group, with 22% of students reporting usage. In response to these statistics and concern from parents, community professionals, teachers and school support staff, the Health Unit Child Health Team, with input from local police departments, developed a series of Drug Awareness Events (DAE).

Since the initiation of these events, students from London and Middlesex County have received enhanced education on alcohol and marijuana misuse. At each DAE, groups of fifteen or twenty students in grade 7 and 8 and their teachers rotate through four to five interactive stations. These engaging and interactive stations are staffed by Public Health Nurses, Mothers Against Drunk Driving (MADD) volunteers, a Youth Addiction and Mental Health Counselor from Addiction Services Thames Valley, and local police agencies. Depending on the locale of the school the police agencies involved are the OPP (Middlesex County), Strathroy-Caradoc Police Services, or the RCMP.

2012-13 School Year

During the school year 2012-13, the Child Health Team organized and facilitated eight Drug Awareness Events for over 626 grade 7 and 8 students in London and Middlesex County. Two county schools participated, Our Lady Immaculate and St. Vincent de Paul. In London, six schools were involved: Northbrae, St. David, C.C. Carothers, Princess Elizabeth, Bonaventure Meadows and Fairmont. During these events, students participated in interactive stations where they learned about decision making skills and law enforcement. These stations which were titled, Jeopardy, Think Twice, The Law, and Walk the Line allowed students to gain information and practice skills they may need when dealing with the many drug influences in our society. Jeopardy involves an interactive computer game where teams of students are given an opportunity to answer drug related questions. At the 'Think Twice' station students watch a DVD

called “Marijuana and Cancer” and discuss the harmful effects that smoking marijuana has on the human body. “Walk the Line” is an interactive station that provides an opportunity for students to test their gross and fine motor skills while wearing a pair of fatal vision goggles, which simulate the decrease in capabilities when a person is intoxicated. At the Addiction Services station, students are provided with skills to help them make informed decisions. Finally, “The Law” is staffed by a police service member who informs students of current laws regarding alcohol and marijuana use including enforcement and consequences.

It is recognized that one event is only the beginning of student education about drugs. Repeated messages and answers to students’ questions are invaluable. To that end, Public Health Nurses on the Child Health Team support schools by directing them to the Ontario Health and Physical Education Curriculum. Follow-up resource packages are also provided to each teacher in attendance to encourage continued education in the classroom. Packages include CAMH publications on alcohol and marijuana, highlights from the Ontario Student Drug Use and Health Survey, discussion questions, internet resources, poster and essay contests from the Knights of Columbus and MADD, as well as other community resources.

Conclusion

In the early stages of implementation, feedback from teachers, parent volunteers and students indicated this is an effective delivery method. Changes based on student and teacher feedback have been made to further increase the impact of Drug Awareness Events. A more intensive evaluation is planned for the 2013-14 school year. Collaborative initiatives like Drug Awareness Events provide Public Health Nurses with an excellent opportunity to partner with community agencies to deliver health messages to a large number of students in a short period of time.

This report was prepared by Ms. Susan Luciani, Public Health Nurse, and Ms. Suzanne Vandervoort, Manager, Child Health Team.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 073-13

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 May 16

STEPPING OUT SAFELY: HEALTHY AGING 2012

Recommendation

It is recommended that Report No. 073-13 re "Stepping Out Safely: Healthy Aging 2012" be received for information.

Key Points

- Falls are the leading cause of injury-related deaths, hospitalizations, and Emergency Room visits among older adults in London and Middlesex.
- With the aging of the population, a focus on health promotion and injury prevention, particularly preventing falls, is important to enable older adults to maintain quality of life as they age.
- The Stepping Out Safely: Healthy Aging 2012 initiative has provided health promotion information to over 4,000 older adults in London and Middlesex. Feedback has been positive, with 93% of participants rating their experience as good or excellent.

Background

Falls in older adults remain a significant health issue. Similar to national and provincial statistics for unintentional injuries, falls are the leading cause of injury-related deaths, hospitalizations, and Emergency Room visits among older adults in London and Middlesex.

A broad set of health determinants influences the risk of falling and fall-related injuries in older adults. These fall risk factors are categorized into biological/intrinsic, behavioral, socio-economical, and environmental. Many of these risk factors are modifiable with appropriate interventions.

The first wave of baby boomers turned 65 in 2011 and the number of older adults will increase significantly over the next two decades. Research findings indicate that older adults are very receptive to positive health promotion messages. A focus on health promotion and injury prevention, particularly preventing falls, is important to enable older adults to maintain quality of life as they age.

The initial Stepping Out Safely event was implemented in 2005 with two goals; to raise awareness about falls related risk factors and to educate older adults on falls prevention strategies. In 2005, 70 older adults participated and by the ninth event in 2012, the event was at capacity by the end of the first registration day, with 135 participants. The event is organized to be fun and interactive, including presentations, displays and activities related to specific themes such as bone health, nutrition and physical activity. Free bus transportation was offered to registrants from various locations.

Partnership - Key Element

The Stepping Out Safely Committee was formed in late 2004 to plan the first Stepping Out Safely event. The working group had representatives from the Council for London Seniors, Kiwanis Seniors Community Centre, Middlesex-London Health Unit, and Third Age Outreach of St. Joseph's Health Care. Since then, the partnership has expanded to include both non-profit organizations and area businesses. Older adult volunteers also participated on the committee. This committee has no stable funding and depends upon in-kind contributions and sponsorships. The continued support from community partners working in a collaborative manner has sustained an annual Stepping Out Safely event. By 2012, the partnership table had grown to 79 members.

Stepping Out Safely: Healthy Aging 2012

In 2011, the community partners wanted to organize an event on a larger scale, and the seven month-long Stepping Out Safely: Healthy Aging 2012 initiative was developed. From April to October 2012, over 100 local activities were delivered connecting over 4,000 older adults with healthy aging information. Activities were organized under monthly themes that included: leisure and the arts; celebrating aging; safety; physical activity; nutrition; and medicine clean out. Over 200 seniors participated in the Stepping Out Safely event in October, a successful wrap-up 'party' celebrating healthy aging.

Feedback from the participants who attended the Stepping Out Safely: Healthy Aging 2012 activities was positive. At the Stepping Out Safely: Healthy Aging wrap-up event, a participant commented,

> *"I had so much fun! The presenters are wonderful. I have learned a lot on ways to keep going and active. Keep up the good work!"*

An online survey was sent to the community partners for their feedback. Of community partners who completed the online survey, 93% rated the participation experience as good or excellent, and that the Stepping Out Safely: Healthy Aging 2012 initiative fulfilled their organizational mandates. Eighty percent were "highly likely" to participate in future Stepping Out Safely activities.

Conclusion

Collaboration is the key element in the successful implementation of the Stepping Out Safely: Healthy Aging 2012 initiative. Under the leadership of the Steering Committee and with the support of many community partners and volunteers, this seven month-long project provided healthy aging information to many older adults. It also has fostered networking opportunities for community partners. Plans are underway to continue the annual Stepping Out Safely event for 2013.

This report was prepared by Ms. Amy Mak, Public Health Nurse, and Ms. Mary Lou Albanese, Manager, Healthy Communities and Injury Prevention Team.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

This report addresses the following requirement of the Ontario Public Health Standards**:** Prevention of Injury and Substance Misuse Health Promotion and Policy Development requirement #4: The board of health shall increase public awareness of the prevention of injury in falls across the lifespan.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 074-13

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 May 16

H7N9 INFLUENZA AND NOVEL CORONAVIRUS – EMERGING INFECTIONS AND THE HEALTH UNIT'S ROLE

Recommendation

It is recommended that Report No. 074-13 re "H7N9 Influenza and Novel Coronavirus – Emerging Infections and the Health Unit's Role" be received for information.

Key Points

- H7N9 influenza is a new strain of influenza causing human infection in eastern China. From February 19, 2013, when the first identified case occurred, to May 2, 2013, 128 cases have been reported, of whom 26 have died.
- In a separate outbreak of a different virus, the novel coronavirus has resulted in infection in five countries since April 2012. This virus is from the same family of viruses that caused the SARS outbreak and has resulted in 30 cases as of May 6, 2013, of whom 18 have died.
- While no cases of either virus have been reported in Canada as of May 6, 2013, the Health Unit is involved in monitoring these international outbreaks, providing information to local health care providers, and preparing for a local response should this be required.

Overview

Infections and outbreaks that arise around the world are monitored closely by national, provincial and local public health officials. This report will provide a brief overview of the recent H7N9 influenza and the novel coronavirus outbreaks, and describe the Health Unit's responses.

H7N9 Influenza

H7N9 influenza is a new strain of influenza affecting humans. The first case developed symptoms on February 19, 2013 in eastern China and was first reported internationally on March 31, 2013 when three cases had been identified. As of May 2, 2013, 128 cases have been reported, of whom 26 have died.

The outbreak remains confined to eight adjacent provinces and two municipalities in eastern China. One person with the infection was identified in Taiwan but acquired their infection in eastern China. The virus appears to be causing severe illness as indicated by the fact that 20% of infected individuals have died, although some milder infections have also been reported.

It is suspected that the H7N9 virus is spreading to people from infected poultry, in part related to live bird markets; however this spread may be occurring indirectly as not all infected individuals have known contact with poultry or live bird markets. The virus does not appear to be resulting in sustained spread from one person to the other, although there have been reported clusters of cases in three families where limited transmission may have occurred. The conclusion that the virus is not easily spread from one person to another is based on the follow-up of almost 1700 people who have had close contact with those who are

infected; almost no H7N9 infections among these close contacts have been identified. As well, lack of efficient human-to-human spread is indicated by the fact that the virus has infected only a very small number of people relative to the population size in the affected areas. There is concern that the H7N9 virus will develop the ability to be efficiently spread from person-to-person. However, it is not possible to determine if, or when, this will occur.

Unlike past influenza infections from birds (e.g., H5N1 influenza), the H7N9 strain does not cause symptoms in birds. Testing of 68,060 birds from affected areas has identified only 46 infected birds (chicken, ducks and pigeons) as of April 26, 2013. Control measures in China have included closing live bird markets in numerous cities and culling birds from live bird markets where infected birds have been identified.

Based on recommendations from the Ministry of Health and Long-Term Care, travelers returning from China with respiratory symptoms compatible with influenza should be tested to determine if they may have the H7N9 virus. Information regarding the virus, diagnosis, treatment and reporting have been distributed to local health care providers by the Health Unit.

Additional information can be found on the following web pages:

- Ministry of Health and Long-Term Care
- Public Health Agency of Canada
- World Health Organization

Novel Coronavirus

The novel coronavirus is from the same family of viruses that caused the SARS outbreak in 2003. The novel coronavirus was first identified in September 2012 in two patients, one from Saudi Arabia who became ill in June and the other from Qatar who became ill in September. In looking back at a cluster of 11 ill individuals from Jordan in April 2012, two additional patients with the virus were identified. As of May 6, 2013, 30 confirmed cases of human infection have been reported, of whom 18 have died. These cases have been identified from five countries (United Arab Emirates, United Kingdom, Jordan, Qatar, Kingdom of Saudi Arabia). Thirteen of these cases have occurred since April 14 in the same eastern area of Saudi Arabia and have resulted in eight deaths.

The novel coronavirus causes severe respiratory and kidney problems. The virus is closely related to a virus found in bats, however, it is currently unclear how it is spreading to people. Although it does not appear that the virus can easily spread from person-to-person, a few family clusters have been identified including a family cluster in the United Kingdom. This finding indicates that the virus can spread among people with substantial close contact. The source of infection for the 13 recent cases appears to be related to transmission within a health care facility, although the exact mechanism of spread is still under investigation.

Additional information can be found on the following web pages:

- Ministry of Health and Long-Term Care Health
- Public Health Agency of Canada
- World Health Organization

The Health Unit's Response to these International Outbreaks

The Health Unit's response to these international outbreaks consists of the following:

- Monitoring the information as it becomes available, including the websites listed above. In addition, a listserve called ProMED provides regular email updates on evolving infectious diseases;

- Participate on Ministry of Health and Long-Term Care teleconferences designed to ensure all Ontario health units are adequately informed of the situation and are aware of the response that is expected in Ontario;
- Communicate information to local health care providers through two listserves that reach over 800 health care providers. Alerts and updates that are sent to health care providers are subsequently posted on the Health Unit's web site.
- Prepare for a local response should this be required.

Conclusion

International outbreaks, such as the recent H7N9 influenza and novel coronavirus outbreaks, are monitored closely to determine the local implications. Relevant information is communicated to local health care providers through two listserves and the Health Unit's website.

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

Dr. Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards: Infectious Disease Prevention and Control

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 075-13

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 May 16

MEDICAL OFFICER OF HEALTH ACTIVITY REPORT – MAY

Recommendation

It is recommended that Report No. 075-12 re "Medical Officer of Health Activity Report – May" be received for information.

The following report highlights activities of the Medical Officer of Health since his start on May 1, 2013, up to May 8.

Supporting PricewaterhouseCoopers (PWC) in the final stages of preparation of their report to the Board of Health has been an important focus to date. The Medical Officer of Health, Mr. John Millson, Director, Finance & Operations and Dr. Bryna Warshawsky, Associate Medical Officer of Health met with representatives from PWC on April 30 to discuss the Draft Interim Report of the Shared Services Review. The MOH, Mr. Millson and Dr. Warshawsky also met with representatives from the County of Middlesex and City of London and PWC on May 1 to discuss the Draft Interim Report.

Another major focus has been meeting with internal staff. On May 1, the MOH met with all directors. On May 2, the MOH spoke at a meeting of the Non Union Management staff. On May 3, the MOH spoke at a meeting of all Environmental Health and Chronic Disease Prevention staff. On May 8, the MOH spoke at a meeting of all Health Unit nursing staff in celebration of National Nursing Week. Over the period from May 1 to May 8, the MOH met one-to-one with each direct report, including all Health Unit directors and all managers in the Office of the MOH.

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

- On May 8, met with Organizational Health and Vitality Strategic Achievement Group
- May 3 and May 8, met with Board Chair, Mr. Marcel Meyer, to discuss the agenda for the May 9th and May 16th Board of Health meetings.

Note: As the MOH seeks to expand engagement beyond internal staff to meet with partners and stakeholders in the Middlesex and London communities, recommendations from members of the Board of Health would be welcome regarding key groups or individuals with whom to meet. These can be made through Sherri Sanders (Sherri.Sanders@mlhu.on.ca) or directly to the MOH.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health