AGENDA
MIDDLESEX-LONDON BOARD OF HEALTH

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

Thursday, 7:00 p.m.
2015 October 15

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. Patricia Fulton
Mr. Jesse Helmer (Vice Chair)
Dr. Trevor Hunter
Mr. Marcel Meyer
Mr. Ian Peer (Chair)
Ms. Viola Poletes Montgomery
Ms. Nancy Poole
Mr. Kurtis Smith
Mr. Mark Studenny
Mr. Stephen Turner
Ms. Joanne Vanderheyden

SECRETARY-TREASURER

Dr. Christopher Mackie

DISCLOSURE OF CONFLICTS OF INTEREST

APPROVAL OF AGENDA

APPROVAL OF MINUTES

DELEGATIONS

7:05 – 7:15 p.m. Ms. Trish Fulton, Chair, Finance and Facilities Committee re Item # 1- Finance and Facilities Committee Meeting

Item #	Report Name and Number	Link to Additional Information	Delegation	Recommendation	Information	Brief Overview
Committee Reports						
1	Finance and Facilities Committee Meeting – October (59-15)	Appendix A	x	x		To receive information and consider recommendations from the October 1, 2015 FFC meeting
Delegations and Recommendation Reports						
2	City of London Cycling Master Plan (60-15)	Appendix A		x		To request the Board of Health to endorse the City of London Cycling Master Plan
Information Reports						
3	Internal Scan of Programs and Services Offered to Local First Nations Communities (61-15)	Appendix A			x	To provide a summary of information about working with local First Nations communities to improve their social determinants of health
4	Influenza: 2014/2015 Season Report and 2015/2016 Season Plans (62-15)	Appendix A			x	To provide a summary of the 2014/2015 Influenza season and information about the plans for 2015/2016
5	Middlesex-London 2014/2015 School-Based Dental Screening Results (63-15)	Appendix A			x	To provide a summary of the 2014/2015 school-based dental program
6	Summary Information Report for October 2015 (64-15)				x	To provide a summary of information from Health Unit programs
7	Medical Officer of Health Activity Report - October (65-15)				x	To provide an update on the activities of the MOH for October 2015

CONFIDENTIAL

The Board of Health will move in camera to discuss matters concerning identifiable individuals.

OTHER BUSINESS

- Next Finance and Facilities Committee Meeting: Thursday, November 5, 2015 @ 9:00 a.m.
- Board of Health Governance Education Session: Thursday, November 19, 2015 @ 4:30 p.m.

PUBLIC SESSION – MINUTES

MIDDLESEX-LONDON BOARD OF HEALTH

2015 September 17

MEMBERS PRESENT:
Mr. Ian Peer (Chair)
Mr. Jesse Helmer (Vice Chair)
Dr. Trevor Hunter
Mr. Marcel Meyer (observing via telephone)
Ms. Nancy Poole
Mr. Kurtis Smith
Mr. Stephen Turner
Ms. Joanne Vanderheyden

REGRETS:
Ms. Trish Fulton
Ms. Viola Poletes Montgomery
Mr. Mark Studenny

OTHERS PRESENT:
Dr. Christopher Mackie, Medical Officer of Health & CEO (Secretary Treasurer of the Board)
Ms. Sherri Sanders, Executive Assistant to the Board of Health (Recorder)
Ms. Mary Lou Albanese, Manager, Healthy Communities and Injury Prevention
Mr. Jordan Banninga, Manager, Strategic Projects
Ms. Vanessa Bell, Manager, Privacy and Occupational Health and Safety
Ms. Lindsay Dako, Nutritious Food Basket Volunteer
Ms. Laura Di Cesare, Director, Human Resources and Corporate Strategy
Mr. Dan Flaherty, Manager, Communications
Dr. Jason Gilliland, Director, Urban Development Program, Western University
Ms. Amanda Goarley, Brescia College Student
Dr. Gayane Hovhannisyan, Associate Medical Officer of Health
Dr. Paul Kershaw, School of Population and Public Health, University of British Columbia
Ms. Ellen Lakusiak, Registered Dietitian
Ms. Kim Leacy, Registered Dietitian
Ms. Heather Lokko, Associate Director, Oral Health, Communicable Disease & Sexual Health Services
Ms. Meghan Lucassen, Nutritious Food Basket Volunteer
Ms. Salma Mahmoud, Nutritious Food Basket Volunteer
Ms. Stephanie McKee, Public Health Nurse, Family Health Services
Mr. John Millson, Director, Finance and Operations
Ms. Karen Sevong, Nutritious Food Basket Volunteer
Ms. Linda Stobo, Manager, Chronic Disease Prevention and Tobacco Control
Mr. Alex Tyml, Online Communications Coordinator
Ms. Suzanne Vandervoort, Acting Director, Family Health Services
Ms. Emily Van Kesteren, Public Health Nurse, Healthy Communities and Injury Prevention
Ms. Sara Michelle Weinman, Nutritious Food Basket Volunteer

Board of Health Chair, Mr. Ian Peer, called the meeting to order at 7:00 p.m.

DISCLOSURES OF CONFLICT(S) OF INTEREST

Mr. Peer inquired if there were any disclosures of conflict of interest to be declared. None were declared.

APPROVAL OF AGENDA

It was moved by Ms. Vanderheyden, seconded by Mr. Smith *that the **AGENDA** for the September 17, 2015 Board of Health meeting be approved.*

Carried

APPROVAL OF MINUTES

It was moved by Dr. Hunter, seconded by Mr. Helmer *that the **MINUTES** of the July 16, 2015 Board of Health meeting be approved.*

Carried

BUSINESS ARISING FROM THE MINUTES - none

DELEGATIONS

Generation Squeeze Community Forum

Dr. Mackie introduced Dr. Paul Kershaw, Associate Professor, University of British Columbia School of Population & Public Health.

Dr. Kershaw explained the concept of Generation Squeeze that he presented at the community forum in the afternoon at BMO Centre in London. Dr. Kershaw recommended that the Health Unit collaborate to encourage awareness about Generation Squeeze and to prescribe Canadians in their 20s, 30s, and 40s to join generation squeeze to increase their collective influence over policy related to child care, parental leave, housing, postsecondary, saving for retirement and minimizing the risks of climate change, etc.

It is free to join Generation Squeeze at www.gensqueeze.ca

Discussion ensued about the end result of Generation Squeeze. Dr. Kershaw responded that funding for those aged 65 and over is higher than for younger demographics ($40,000 versus $12,000). Although younger generations are involved in political efforts, they are sceptical and lack the power necessary to facilitate change. Canada needs to balance the needs of all generations.

It was moved by Ms. Poole, seconded by Mr. Helmer *that the Board of Health set up an ad hoc committee to study the Generation Squeeze concept and how it aligns with Health Unit initiatives.*

Carried

Active and Safe Routes to School (Item #4 on agenda) (Report 51-15)

Dr. Mackie introduced Dr. Jason Gilliland, Associate Professor, Department of Geography, Western University and Ms. Emily Van Kesteren, Public Health Nurse, Healthy Communities and Injury Prevention Team. Ms. Van Kesteren and Dr. Gilliland described the Active and Safe Routes to School (ASRTS) program and the findings of the Human Environments Analysis Lab at Western University (HEAL). Dr. Gilliland explained that HEAL contributes to ASRTS by studying the pros and cons of the structural environment on active transportation, mapping risky spaces for youth, monitoring exposure to pollution and identifying barriers to walking and biking to school.

The City of London is going to be discussing its winter snow removal program shortly, therefore, it was recommended that ASRTS contact the City as soon as possible to arrange a meeting. In response to a question about how the research influences the accommodation review process of the school boards, Ms. Van Kesteren reported that they have met with school trustees and will use this new data in future meetings.

COMMITTEE REPORTS

1. Finance and Facilities Committee Meeting – September 3rd (Report 49-15)

Mr. Ian Peer, Member of the FFC, reported on the outcomes of the Finance and Facilities Committee.

MLHU – March 31st Draft Financial Statements (Report 21-15FFC)

It was moved by Mr. Helmer, seconded by Mr. Turner *that the Board of Health approve the audited Consolidated Financial Statements for the Middlesex-London Health Unit, March 31st, 2015 as appended to Report No. 21-15FFC.*

Carried

50 King Street Verbal Report

Mr. Bill Rayburn attended the FFC meeting and clarified the status of the 50 King Street property. His comments were interpreted as the Health Unit being welcome to stay as long as desired.

2015 Budget – MOHLTC Approved Grants (Report 49b-15)

Dr. Mackie and Mr. John Millson, Director, Finance and Operations, assisted Board members with their understanding of this revised report and how the provincial grant impacts the cost-shared programs and the 100% funded programs.

It was moved by Dr. Hunter, seconded by Ms. Vanderheyden *that the Board of Health:*

1) *Approve the Board Chair to sign the Public Health Funding Accountability Agreement as appended to Report No. 49b -15; and*

2) *Approve additional investments of $176,000 for 2015 as outlined in Appendix C to Report No. 49b-15; and further*

3) *Write a letter to the Minister of Health & Long-Term Care expressing the Health Unit's appreciation for implementing a new public health formula for mandatory programs that supports a more equitable approach to public health funding.*

Carried

Report No. 22-15FFC re 2016 Board of Health Budget – Financial Parameters was tabled at the FFC meeting. The report will be revised and discussed at a future FFC meeting.

2. Governance Committee Meeting - September 17th (verbal report)

Mr. Peer reported that the Governance Committee approved an education session that will take place in lieu of the November 19th Board of Health meeting. Health Unit staff will invite the Chairs and Vice-Chairs of other Southwest Ontario Boards of Health to attend. This event will commence around 4:30 p.m. More information will follow.

2015-2020 Middlesex-London Strategic Plan (Report 14-15GC)

It was moved by Mr. Turner, seconded by Ms. Vanderheyden *that the Board of Health:*

1) *Receive Report No. 14-15GC re 2015-2020 Middlesex-London Strategic Plan for information, and further;*

2) *Approve the Middlesex-London Health Unit 2015-2020 Strategic Plan.*

Carried

RECOMMENDATION REPORTS

3. 2015 Nutritious Food Basket Survey Results and Implications for Government Public Policy (Report 50-15)

Ms. Linda Stobo, Manager, Chronic Disease Prevention and Tobacco Control, and Ms. Kim Leacy, Registered Dietitian, introduced the must-appreciated volunteers from Brescia College who assist with the collection of data for the mandated Nutritious Food Basket program.

It was moved by Mr. Helmer, seconded by Mr. Turner *that the Board of Health:*

1) *Send a letter to the Prime Minister of Canada, the Premier of Ontario and the Ontario Minister Responsible for the Poverty Reduction Strategy requesting they prioritize consideration and investigation into a joint federal-provincial basic income guarantee.*

2) *Send a letter to the Premier of Ontario requesting the province increase social assistance rates to reflect the rising cost of nutritious food & safe housing.*

3) *Send a letter to all London and Middlesex County federal election candidates requesting they take Food Secure Canada's Eat Think Vote candidate pledge.*

4) *Forward Report No. 50-15 re 2015 Nutritious Food Basket Survey Results and Implications for Government Public Policy to the City of London, Middlesex County & appropriate community agencies*.

Carried

INFORMATION REPORTS

4. Active and Safe Routes to School (Report 51-15) - Discussed under 'Delegations' starting on page 2 of these minutes.

5. Working Towards the Vision of a Healthy and Sustainable Local Food System (Report 52-15)

6. Regulatory Compliance Update: Workplace Violence Prevention (Report 53-15)

7. 2014 Year End Performance on Accountability Indicators (Report 54-15)

8. Summary Information Report for September (Report (Report 55-15**)**

9. Medical Officer of Health Activity Report – September (Report 56-15)

Ms. Mary Lou Albanese reported on the *in motion*™ Community Partnership program that takes places over the month of October and invited the Board of Health members to participate.

Dr. Mackie highlighted that the Naloxone Program was announced as a finalist for the 2015 Pillar Community Innovation Award in the Community Collaboration category, which recognizes outstanding examples of collaboration within the community.

It was moved by Ms. Vanderheyden, seconded by Mr. Smith *that Reports 51-15 through 56-15 be received for information.*

Carried

CONFIDENTIAL

At 8:30 p.m. it was moved by Mr. Helmer, seconded by Mr. Turner *that the Board of Health move in camera to discuss matters concerning an identifiable individual.*

Carried

At 9:00 p.m., it was moved by Ms. Vanderheyden, seconded by Mr. Kurtis *that the Board of Health rise and return to public session to report that progress was made in matters concerning an identifiable individual.*

Carried

CORRESPONDENCE

It was moved by Mr. Turner, seconded by Dr. Hunter *that correspondence items a, c and e through j be received for information.*

Carried

It was moved by Mr. Helmer, seconded by Dr. Hunter *that the Board of Health endorse correspondence items b, d and the new item forwarded to Board members re Request for Changes to Municipal Act to Authorize the Use of Electronic Means of Participation of Local Boards and Committees of Local Boards.*

Carried

OTHER BUSINESS

Upcoming meetings:

a) Finance and Facilities Committee – Thursday, October 1, 2015 @ 9:00 a.m.
b) Board of Health – Thursday, October 15, 2015 @ 7:00 p.m.

ADJOURNMENT

At 9:05 p.m., it was moved by Mr. Turner, seconded by Ms. Vanderheyden *that the meeting be adjourned.*

Carried

IAN PEER
Chair

CHRISTOPHER MACKIE
Secretary-Treasurer

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 59-15

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2015 October 15

FINANCE AND FACILITIES COMMITTEE MEETING OCTOBER

The Finance and Facilities Committee met at 9:00 a.m. on October 1, 2015 (**Agenda**). The draft public minutes are attached as Appendix A. The following items were discussed at the meeting and recommendations made:

Reports	Recommendations for Board of Health's Consideration
2016 Board of Health Budget – Financial Parameters (Report 23-15FFC)	*That the Board of Health recommend an assumption of a 2% provincial increase on cost-shared funding and a 0% change to the municipal request for the 2016 Board of Health budget*
2015 Budget Adjustments (Report 24-15FFC)	*That the Board of Health approve $201,000 in additional 2015 expenditures as outlined in Appendix A to Report No. 24-15FFC*

The Finance and Facilities Committee moved in camera to discuss a matter concerning an identifiable individual.

The next meeting of the Finance and Facilities Committee has been scheduled for Thursday, November 5, 2015 at 9:00 am..

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

PUBLIC MINUTES
Finance and Facilities Committee
50 King Street, Room 3A
MIDDLESEX-LONDON BOARD OF HEALTH
2015 October 1 9:00 a.m.

COMMITTEE MEMBERS PRESENT:	Ms. Trish Fulton (Committee Chair) Mr. Marcel Meyer Mr. Ian Peer Ms. Joanne Vanderheyden
REGRETS:	Mr. Jesse Helmer
OTHERS PRESENT:	Dr. Christopher Mackie, Medical Officer of Health and CEO Ms. Laura Di Cesare, Director, Human Resources and Corporate Strategy Mr. John Millson, Director, Finance and Operations Ms. Sherri Sanders, Executive Assistant to the Board of Health (Recorder)

At 9:00 a.m., Ms. Trish Fulton, Committee Chair, welcomed everyone to the meeting.

1. DISCLOSURES OF CONFLICT(S) OF INTEREST

Ms. Fulton inquired if there were any disclosures of conflict of interest to be declared. None were declared.

2. APPROVAL OF AGENDA

It was moved by Mr. Peer, seconded by Ms. Vanderheyden *that the **AGENDA** of the October 1, 2015 Finance and Facilities meeting be approved.*

Carried

3. APPROVAL OF MINUTES

It was moved by Ms. Vanderheyden, seconded by Mr. Peer *that the **MINUTES** from the September 3, 2015 Finance and Facilities Committee Meeting be approved.*

Carried

4. NEW BUSINESS

4.1. 2016 Budget Parameters (No. 23-15FFC)

It was moved by Mr. Peer, seconded by Ms. Vanderheyden *that the Finance & Facilities Committee make recommendation to the Board of Health for an assumption of a 2% provincial increase on cost-shared funding and a 0% change to the municipal request for the 2016 Board of Health budget.*

Carried

Mr. Meyer arrived at 9:17 a.m.

4.2. 2015 Budget Adjustments (No. 24-15FFC)

Mr. Millson reviewed the report and its appendix A with the Committee which outlines additional investments for the 2015 Board of Health budget. Discussion ensued about the additional investments provided in the report.

It was moved by Mr. Peer, seconded by Mr. Meyer *that the Finance & Facilities Committee review and make recommendation to the Board of Health to approve $201,000 in additional 2015 expenditures as outlined in Appendix A to Report No. 24-15FFC.*

Carried

5. CONFIDENTIAL

At 9:35 a.m., it was moved by Ms. Vanderheyden, seconded by Mr. Meyer *that the Finance and Facilities Committee move in camera to discuss a matter concerning an identifiable individual.*

Carried

At 9:40 am, it was moved by Mr. Peer, seconded by Ms. Vanderheyden *that the Finance and Facilities Committee return to public forum and report that a matter was discussed concerning an identifiable individual.*

Carried

6. OTHER BUSINESS

The next scheduled meeting of the FFC is Thursday, November 5, 2015 at 9:00 a.m. in Room 3A.

7. ADJOURNMENT

At 9:42 a.m., it was moved by Ms. Vanderheyden, seconded by Mr. Meyer *that the meeting be adjourned.*

Carried

_____ _____

TRISH FULTON
Committee Chair

CHRISTOPHER MACKIE
Secretary-Treasurer

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 60-15

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2015 October 15

CITY OF LONDON CYCLING MASTER PLAN

Recommendations

It is recommended that the Board of Health:

1) ***Endorse Report No. 60-15 re City of London Cycling Master Plan, and***

2) ***Submit the attached letter of support and recommendations to the City of London for consideration in the development of the Cycling Master Plan (Appendix A).***

Key Points

- Cycling is an increasingly popular mode of active transportation used not only for recreation and transportation.
- The inclusion of the safety, engineering standards, and provincial guidelines as outlined in the *Ministry of Transport Book 18 - Cycling Facilities* will enhance and strengthen London's Cycling Master Plan.
- The efforts of the City of London to develop a new Cycling Master Plan align with the Health Unit's mandate to support and promote physical activity.

BACKGROUND

The City of London Cycling Master Plan – *London ON Bikes* - is undergoing a comprehensive review. The previous version was completed in 2005. The plan is meant to provide connected, comfortable and safe cycling facilities and to increase cycling use. Increasing the use of cycling will maximize environmental, health and social benefits. The Cycling Master Plan review process seeks to identify implementation priorities, to build upon existing programs and to increase awareness about cycling.

The project has included many phases of consultation with the public and key stakeholders through such strategies as information provided on the City's website, working group sessions, public events and outreach, workshops, surveys, and presentations. Utilizing this multi-pronged approach enables organizations such as Middlesex London Health Unit to provide input to a community matter that has public health implications on many levels: injury prevention; chronic disease prevention; mental health promotion; and the promotion of healthy environments.

In particular, under the Ontario Public Health Standards, public health units are mandated to support and promote physical activity. Having infrastructure such as bicycle facilities, and mobility choices that are convenient and well connected, help to support physically active lifestyles.

CYCLING

Cycling is an increasingly popular mode of active transportation used not only for recreation but also for utilitarian purposes, such as travel to and from home to places of work, school or shopping. According to the 2012 Office of the Chief Coroner for Ontario, Cycling Death Review report, cyclists are considered vulnerable road users.

To improve safety, meeting the engineering standards and provincial guidelines as outlined in the *Ministry of Transport Book 18 - Cycling Facilities* will enhance and strengthen the London Cycling Master Plan.

In keeping with these guidelines and best practices, Middlesex London Health Unit recommends City staff ensure that the plan:

- Provides clarity for both cyclists and drivers regarding the roles and responsibilities of each when sharing the road.
- Prioritizes and provides appropriate cycling facilities on roads and intersections that have the highest cyclist-vehicle collision rates.
- Maximizes continuity in the types of bicycle facilities along road ways in order to reduce confusion of both cyclists and drivers.
- Enhances connectivity of on-road and off-road facilities that coincides with current and anticipated future use of various cycling routes.
- Provides appropriate on-road bicycle facilities to increase safety and help reduce the number of cyclists who ride on sidewalks.
- Provides clarity at prioritized intersections to both cyclists and drivers as to where bicycles should be positioned and how they should proceed through the intersection, e.g. chevrons, bike boxes, surface treatment, staggered stop bar, left turn queue box, bicycle-level traffic lights, etc.
- Provides way finding that is clear and includes names of particular key routes and distances to destination points. Incorporate this into a revised Bike & Walk Map.
- Provides an ongoing variety of education strategies using multi-media approaches (e.g. website, Facebook, Twitter, email, radio, television, newspaper, Bike & Walk Map, etc.) directed at both cyclists and drivers to increase mutual understanding and respect of roles and responsibilities when sharing the road.
- Incorporates consultation with Middlesex County and respective municipalities to coordinate bicycle facility connections between London and Middlesex county roadways.

CONCLUSION

Middlesex-London Health Unit supports and acknowledges the efforts of the City of London to develop a new Cycling Master Plan and recommends that the Board send the attached letter of support and recommendations (Appendix A) to the City of London for consideration in their review of the plan.

This report was written by Ms. Bernie McCall, 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

October 15, 2015

Doug MacRae, P.Eng.
Division Manager, Transportation Planning & Design
City of London
300 Dufferin Ave.
P.O. Box 5035
London, ON
N6A 4L9

Dear Mr. MacRae:

Under the Ontario Public Health Standards, the Middlesex London Health Unit (MLHU) promotes physical activity as a means of working towards the goal of reducing the burden of preventable chronic diseases which are the main cause of death and disability in Canada[1,2]. This public health goal aligns with the City of London's 2015 – 2019 Strategic Plan area of focus of Building a Sustainable City. Having infrastructure and mobility choices that are convenient and well connected help to support physically active lifestyles. Development of the Cycling Master Plan - *London ON Bikes*, identifies that improvements to the current cycling infrastructure and cycling facilities will provide health, environmental and social benefits.

Cycling is an increasingly popular mode of active transportation used not only for recreation but also for utilitarian purposes, such as travel to and from home to places of work, school or shopping. According to the 2012 Office of the Chief Coroner for Ontario, Cycling Death Review report, cyclists are considered vulnerable road users[3]. For this reason there is a need to consider safety issues when developing this master plan. We see the Cycling Master Plan - *London ON Bikes* as being well positioned to play a significant role in improving the health and safety of cycling Londoners and improving the cycling environment.

Designing an effective Cycling Master Plan for the City of London is a complex undertaking and we acknowledge the expertise of city staff & consultants involved directly in this project. MLHU commends the efforts undertaken to consult the public and to inform and engage stakeholders.

The need to meet engineering standards and provincial guidelines as outlined in the *Ministry of Transport Book 18 – Cycling Facilities* is an important part of this process. Specifically, MLHU recommends the following:

Cont'd p.2

- That the cycling facilities along with programs, initiatives and policies provide clarity for both cyclists and drivers regarding the roles and responsibilities of each when sharing the road.
- Prioritize and provide appropriate cycling facilities on roads and intersections that have the highest cyclist-vehicle collision rates.
- Maximize continuity in the types of bicycle facilities along road ways in order to reduce confusion of both cyclists and drivers.
- Enhance connectivity of on-road and off-road facilities that coincides with current and anticipated future use of various cycling routes.
- Provide appropriate on-road bicycle facilities to increase safety and help reduce the number of cyclists who ride on sidewalks.
- At prioritized intersections, provide clarity to both cyclists and drivers as to where bicycles should be positioned and how they should proceed through the intersection, e.g. chevrons, bike boxes, surface treatment, staggered stop bar, left turn queue box, bicycle-level traffic lights, etc.
- Provide way finding that is clear and includes names of particular key routes and distances to destination points. Incorporate this into a revised Bike & Walk Map.
- Provide an ongoing variety of education strategies using multi-media approaches (e.g. website, Facebook, Twitter, email, radio, television, newspaper, Bike & Walk Map, etc.) directed at both cyclists and drivers to increase mutual understanding and respect of roles and responsibilities when sharing the road.
- Consult with Middlesex County and respective municipalities to coordinate bicycle facility connections between London and Middlesex county roadways.

The Middlesex London Health Unit supports the City of London Transportation Planning services in its efforts to provide Londoners with a Cycling Master Plan that will improve the cycling environment in the City of London. Having a Cycling Master Plan that supports health, safety and overall quality of life are of particular importance from a public health perspective.

Sincerely,

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health & Chief Executive Officer

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[1] Toronto Public Health, City of Toronto Planning, City of Toronto Transportation Services and Gladki Planning Associates. *Active City: Designing for Health*, May 2014 City of Toronto.

[2] Warburton, DE, Katzmarzk, PT, Rhodes, RE, Shephard, RJ. (2007). *Evidence –informed physical activity guidelines for Canadian adults.* Canadian Journal of Public Health, 98:Suppl 2:S16-68.

[3] Office of the Chief Coroner for Ontario (2-12). *Cycling death review: A review of all accidental cycling deaths in Ontario from January 1st, 2006 to December 31, 2010.* Province of Ontario.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 61-15

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2015 October 15

INTERNAL SCAN OF PROGRAMS AND SERVICES OFFERED TO LOCAL FIRST NATIONS COMMUNITIES

Recommendation

It is recommended that Report No. 61-15 re Internal Scan of Programs and Services Offered to Local First Nations Communities" and attached Appendix be received for information.

Key Points

- Working with our local First Nations communities to address health issues and improve social determinants of health is an important Public Health strategy.
- Forty-nine services were provided to local First Nations communities and sixteen partnerships were created over the past three years.
- Currently, MLHU does not have an official memorandum of agreement with any of the local band councils, but will be exploring this and other options in the future.

Purpose

The attached report provides a summary of programs that were offered to local First Nations communities from Middlesex London Health Unit program teams. Additional information is available upon request.

Background

Overall, First Nations communities have limited access to resources due to multiple factors including limited funding, jurisdictional complexities, and lack of transportation. Determinants of health are a key challenge to the health status of the population.

In addition to those who live off reserves, there are three local First Nations communities within Middlesex County: the Oneida Nation of the Thames, the Chippewa of the Thames, and the Munsee-Delaware Nation.

The Ontario Health Promotion and Protection Act allows health units to develop an *"Agreement with council of band"* with local First Nations communities, including representation on the Board of Health. Currently, MLHU does not have an official memorandum of agreement.

Report Highlights

An internal environmental scan was completed to determine the nature of MLHU programs and services to local First Nations communities (see Appendix for the full report). In total, eighteen teams were surveyed to obtain information.

Forty-nine services were provided to the local First Nations communities such as dental screening and education at schools; support to health care professionals working with children under the age of six; cold chain inspections; publically-funded vaccines; health fairs; and injury prevention education and booster seat

distribution. Staff work in collaborative partnerships with First Nations agencies in the areas of increasing access to healthy foods, fluoride varnish application training, and promotion of literacy and breastfeeding.

Two teams are in the process of enhancing the services they offer the local First Nations communities; three teams would like to enhance their services; and five teams will maintain their current level of service. The majority of staff feel an enhanced understanding of necessary processes for cross-jurisdictional collaboration is important, as well as better internal coordination.

Conclusion

Middlesex London Health Unit provides public health programs to local First Nations communities to address identified health needs. MLHU employees are interested in providing ongoing support to local First Nations communities as a measure to address health inequities. The Health Unit will be exploring options for greater collaboration with both on- and off-reserve representatives of our local indigenous communities.

This report was prepared by Ms. Brooke Clark, Public Health Nurse, Early Years Team; and Ms. Brenda Marchuk, Acting Chief Nursing Officer.

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

Internal Scan of Programs and Services Offered to Local First Nations Communities

Report

MIDDLESEX-LONDON HEALTH UNIT

September, 2015

For information, please contact:

Brooke Clark, RN, BScN
Middlesex-London Health Unit
50 King St.
London, Ontario
N6A 5L7
phone: 519-663-5317, ext. 2369
fax: 519-663-9581
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Middlesex-London Health Unit
50 King Street
London, Ontario
N6A 5L7

Cite reference as: Middlesex-London Health Unit (2000).
Name of Report.
London, Ontario: Author.

Prepared by: Brooke Clark, RN, BScN, Public Health Nurse, Early Years Team
Reviewed and Edited by: Brenda Marchuk, RN, BScN, MN, Acting Chief Nursing Officer

Table of Contents

Acknowledgements

Acting Chief Nursing Officer: Brenda Marchuk, RN, BScN, MN, CCHN(C)

Early Years Program Manager: Ruby Brewer, RN, BScN, MHST

Introduction

The First Nations population has many risk factors that contribute to their poor health outcomes including low education/employment, poverty, obesity, lack of preventative oral health, environmental health concerns, childhood injuries and negative effects on child development (Best Start, 2011). Public Health Ontario (2014), states that aboriginal children are more likely to experience vulnerabilities in early child development that will impact the rest of their life course. Working with our local First Nations communities to improve their social determinants of health is an important Public Health strategy.

There are three First Nations communities west of London: Oneida Nation of the Thames, Chippewa of the Thames, and Munsee-Delaware Nation. Each community has its own culture, strengths, and challenges.

Oneida Nation of the Thames has a population of 1293, with 503 households. They have a total of 446 children under the age of 25, with 100 children under 5. Approximately, 28.02% of the band has a high school certificate or equivalent and 58.38% are employed. The average household income is $84,547 (Environics Analytics, 2015).

Chippewa of the Thames has a population of 827, with 294 households. They have a total of 339 children under the age of 25, with 43 children under 5. Approximately, 24.17% of the band has a high school certificate or equivalent and 57.71% are employed. The average household income is $42,526 (Environics Analytics, 2015).

Munsee-Delaware Nation has a population of 196, with 82 households. They have a total of 58 children under the age of 25, with 14 children under the age of 5. Approximately, 15.15% of the band has a high school certificate or equivalent and 47.27% are employed. The average household income is $44,011 (Environics Analytics, 2015).

Background Information:

The Health Promotion and Protection Act, states in section 50 that a health unit can develop, in partnership, with each band an *"Agreement with council of band"* to determine programs and services the health unit will offer to band members. See Appendix A for the agreement template.

This agreement also states that a member from the band, or if two or more bands enter into the agreement together, can jointly appoint a member of the band to sit on the Board of Health.

Peterborough County-City Health Unit and Eastern Ontario Health Unit each have an agreement in place with their local First Nations communities. In Peterborough, the Chief of Curve Lake First Nation is a member of the Board of Health, and was the chair of the board in 2014. Peterborough County-City Health Unit offers all of their programs and services to their local First Nations communities. The administration determines whether they want the health unit or Health Canada to provide the services.

Middlesex-London Health Unit (MLHU) does not currently have a formalized agreement with either Oneida Nations of the Thames, Chippewa of the Thames, or Munsee-Delaware Nation.

Internal Environmental Scan:

MLHU has a history of providing some program supports to the local First Nations communities upon request. However, lacking is an understanding of the current nature of the supports, as well as a common understanding of what is possible. An internal scan was conducted between May 25 and July 22, 2015 by a Public Health Nurse (PHN) from the Early Years Team to determine:

- What teams are interacting with local First Nations communities,
- What program and services are offered,
- Are such activities done in partnership with communities or to address a gap in services,
- Did the communities request the support or was it initiated by the Health Unit,
- Is there a desire to enhance Health Unit program and services to the population?

In total, 19 managers were contacted through email to setup a meeting time, and 17 managers responded. One large program with three managers sent a single manager to represent them; therefore all programs participated. One manager completed the survey for two teams. Most of the meetings consisted of the manager of the team and the Public Health Nurse conducting the survey. Several of the meetings included the manager and team members who work(ed) with the First Nations population.

In total, 14 teams stated they provide services to the local First Nations communities. Of these 14 teams, 6 specifically stated they work in-directly with the local First Nations communities. Two teams stated they do not provide services to the local First Nations communities because Health Canada provides these services. Two teams explained they have work with the local First Nations communities in the past.

In total, 49 services were provided to the local First Nations communities as well as several First Nations agencies in London. A total of 16 partnerships were created. See Appendix B for a full list of programs and services offered. A majority (n=28) of the programs and services were offered to the local First Nations communities by MLHU compared to the local First Nations communities requesting services (n=20) from MLHU.

Five teams indicated they have key contact times, either as “on-going” or “annually”, which they work with the local First Nations communities. Eleven teams stated they work with the local First Nations communities on an “as needed” basis.

All of the teams were asked if they planned or wanted to enhance their teams programs or services to the local First Nations communities. Two teams explained they are in the process of enhancing services. Three teams would like to enhance their services, five teams stated they will continue with the work they are already doing, and seven teams stated they do not plan on enhancing services at this time. Internal guidance about what is possible when working with the local First Nations communities is desired by teams.

A majority of teams felt MLHU would benefit from an internal coordinated approach to working with the First Nations communities. Teams felt that by working together, staff can be more effective and efficient, reduce duplication of services, and provide better services to our local First Nations communities.

See Appendix B for a summary of all of the findings.

References

Best Start Resource Centre. (2011). *A Sense of Belonging: Supporting healthy Child Development in Aboriginal Families.* Toronto, Ontario, Canada: author.

Environics Analytics. (2015). *Executive Trade Area Report Prepared for: Chippewa of the Thames First Nation.* Retrieved January 7, 2015.

Environics Analytics. (2015). *Executive Trade Area Report Prepared for: Munsee-Delaware Nation.* Retrieved January 7, 2015.

Environics Analytics. (2015). *Executive Trade Area Report Prepared for: Oneida.* Retrieved January 7, 2015.

Ontario Government. (1990). *Health Protection and Promotion Act, R.S.O., c. H.7* . Retrieved from: http://www.ontario.ca/laws/statute/90h07#BK57

Public Health Ontario. (2014). *The First 5 Years: A Foundation for Life.* Retrieved from: http://www.publichealthontario.ca/en/eRepository/OHP_infog_FirstFiveYears_2014.pdf

Appendix A – 'Agreement with Council of Band' template

Memorandum of Agreement

Between

----- First Nation Council
(hereinafter referred to as "the council")

And

Board of Health for the -----
(Hereinafter referred to as "the Board of Health")

The parties hereto agree as follows:

1. The Board of Health will make available to ----- First Nation the programs and services offered by the ----- as detailed in Schedule 1.
2. ----- First Nation will pay the Board of Health for the services according to the formula detailed in Schedule 2.
3. This agreement will be in effect until is superseded or replaced by a subsequent agreement or until it is terminated by either party by giving twelve (12) months written notice.
4. All the terms and conditions of the Schedules are incorporated in to this agreement. This agreement and the attached Schedules embody the entire agreement and supersede any other understanding or agreement, oral or otherwise, existing between the parties at the date of execution and relating to the subject matter of this agreement.

In witness whereof the parties hereto have duly executed this agreement as of the _____day of _____, 20**XX.**

On behalf of the Board of Health for the ----- Health Unit:

_____ By: _____
Witness **Name**
Position: Chairperson, Board of Health

_____ By: _____
Witness **Name**
Position: Medical Officer of Health

On behalf of ----- First Nation Council:

_____ By: _____
Witness **Name**
Position: Chief of ----- First Nation

_____ By: _____
Witness **Name**
Position: General Manager

Schedule 1

Programs and Services

Offered to

----- First Nation

By the

Board of Health

For the

----- Health Unit

In general, all of the programs and services provided by the ----- Health Unit through-out **area (e.g. city, county)** are made available to ----- First Nation Band members including the programs and services mandated by the Ontario Public Health Standards published by the Minister of Health for Ontario, pursuant to the Health Protection and Promotion Act, 1998, R.S.O. 1990, c. H.7, s. 7(1). These programs and services also include the program standards (including the protocols, and supportive guidance and best practice documents) for the following areas: **Chronic Diseases and Injuries** (Chronic Disease Prevention, Prevention of Injury and Substance Misuse)**; Family Health** (Reproductive Health, Child Health)**; Environmental Health** (Food Safety, Safe Water, Health Hazard Prevention and Management)**;** and **Infectious Diseases** (Infectious Diseases Prevention and Control; Rabies Prevention and Control; Sexual Health**,** Sexually Transmitted Infections, and Blood-borne Infections; Tuberculosis Prevention and Control, and Vaccine Preventable Diseases); and local needs programs.

The four principles of Need, Impact, Capacity, and Partnerships and Collaboration underpin all mandated programs and services and are meant to be used by Ontario boards of health to guide the assessment, planning, delivery, management, and evaluation of public health programs and services. In addition, the four principles from the Royal Commission on Aboriginal Peoples will be integrated into all board-First Nation collaboration: that is, Mutual Recognition, Mutual Respect, Sharing, and Mutual Responsibility.

Schedule 2

The allocation of the Board of Health's Budget for public health programs and services between the **names of municipal partners** and **-----** First Nation is based on population data.

Population figures for the **names of municipal partners** are based on federal census data. ***For 1999,*** census data was adjusted for Statistics Canada's estimate of population growth. Population figures for **-----** First Nation are provided by **-----** First Nation as at December 31st of each year.

Appendix B- Summary of Findings from the Internal Environmental Scan

1. Does your team provide services to local First Nations communities?

In total, 14 teams stated they provide services to the local First Nations communities. Of these 14 teams, 6 specifically stated they work in-directly with the communities. Examples of in-direct services include:

- Providing publically funded vaccines, upon request
- Completing of cold chain inspections if the health centres order vaccines
- Providing private well water safety testing kits
- Attending Sexual Health Clinics
- Receiving comprehensive school health programming if attending primary and secondary schools in London and Middlesex County

Two teams (Food Safety and Health Hazard Prevention and Management, and Vector-Borne Disease Team) do not provide services to the local First Nations communities because Health Canada provides these services. The Food Safety team does, however, provide Food Safety Inspections at special events in London or Middlesex County where First Nations vendors could attend.

Two teams (Screening, Assessment, and Intervention team and Southwest Tobacco Control Area team) have worked with the local First Nations communities in the past.

2. Which local First Nations communities do you target?

In total, 13 teams identified Oneida Nation of the Thames and Chippewa of the Thames as their target audiences. Eight teams identified Munsee-Delaware Nation as their target audience. All of the teams indicated they work with First Nations clients who live in London or Middlesex County.

*teams could identify more than one community they target

3. Please indicate all of the local First Nations agencies you work with, the programs/services you offer, and the way you work with them (committee member/partnership, staff education/train the trainer approach, health promotion activities (campaigns etc.), one-on-one direct service/support to clients).

Agency	Team	Partnership	Service	Outcome
Antler River Elementary School	Oral Health		X	Dental screening and educational lessons for all of the children (one-on-one direct service, group teaching) in the school.
	Sexual Health Promotion Team		X	Sexual health education group session to grade 7-8 students
At^losha o Zhaawanong o St. George Street Housing	Best Beginnings Team		X	One-on-one counselling with clients and professional education to staff
	Best Beginnings Team		X	One-on-one counselling with clients
Chippewa of the Thames Health Centre	Early Years Team		X	Healthcare Provider Outreach to Community Health Nurse
	Best Beginnings Team		X	A one-time professional educational session was held to all First Nations Health Centres. NCAST information: • Keys to Caregiving • Promoting Maternal Mental Health during pregnancy
	Healthy Communities and Injury Prevention Team-Kids Need a Boost		X	Group & one-on-one education with parents, staff education, resources offered to clients (pamphlets and booster seats)
	Rabies and Safe Water Team		X	Provides private well water sampling kits
	Infection Disease Control Team/Vaccine Preventable Disease Team		X	Cold chain inspections and staff education
	Vaccine Preventable Disease Team		X	Provides publically funded vaccines
	Chronic Disease Prevention and Tobacco Control Team		X	Community of practice-emails to the Community Health Nurses
Health Weights Connection	Early Years Team	X		Committee member
Munsee- Delaware Health Centre	Early Years Team		X	Healthcare Provider Outreach to Community Health Nurse

Agency	Team	Partnership	Service	Outcome
	Best Beginnings Team		X	A one-time professional educational session was held to all First Nations Health Centres. NCAST information: • Keys to Caregiving • Promoting Maternal Mental Health during pregnancy
	Southwest Tobacco Control Area Network Team	X		Provided support and funds to run a youth program in 2013 which was to discuss the concerns of tobacco use and the effects on the environment
	Rabies and Safe Water Team		X	Provides private well water sampling kits
	Healthy Communities and Injury Prevention Team -Kids Need a Boost		X	Group & one-on-one education with parents, staff education, resources offered to clients (pamphlets and booster seats)
	Infection Disease Control Team/Vaccine Preventable Disease Team		X	Cold chain inspections and staff education
	Vaccine Preventable Disease Team		X	Provides publically-funded vaccines
	Chronic Disease Prevention and Tobacco Control Team		X	Organized a tobacco group for youth
N'Amerind Friendship Centre	Food Safety Team		X	Food Safety Inspections
	Sexual Health Promotion Team		X	Attended a health fair
	Chronic Disease Prevention and Tobacco Control Team	X	X	Attended a health fair, group education sessions, provide resources, worked with staff to staff to implement Harvest Bucks program
Oneida Health Centre	Early Years Team		X	Healthcare Provider Outreach to Community Health Nurse
			X	Professional education sessions to the staff
		X	X	Developmental Screening Clinic in partnership with Developmental Pediatricians
	Best Beginnings Team		X	A one-time professional educational session was held to all First Nations Health Centres. NCAST information: • Keys to Caregiving • Promoting Maternal Mental Health

Agency	Team	Partnership	Service	Outcome
				during pregnancy
	Rabies and Safe Water Team		X	Provides private well water sampling kits
	Healthy Communities and Injury Prevention Team -Kids Need a Boost		X	Group & one-on-one education with parents, staff education, resources offered to clients (pamphlets and booster seats)
	Healthy Communities and Injury Prevention Team - Workplace		X	Consultation for workplace, staff have attended a workplace workshop
	Sexual Health Promotion Team		X	Education session to parents and youth
	Infection Disease Control Team/Vaccine Preventable Disease Team		X	Cold chain inspections and staff education
	Vaccine Preventable Disease Team		X	Provides publically funded vaccines
	Chronic Disease Prevention and Tobacco Control Team		X	Community of practice-emails to the nurses, have attended a health fair
Southwest Ontario Aboriginal Health Access Centre (SOAHAC) o City	Reproductive Health Teams	X		Developed a prenatal needs assessment
	Early Years Team		X	Healthcare Provider Outreach
	Oral Health	X		Worked in partnership with SOAHAC (city and reserve) and 3M to arrange fluoride varnish application training to the SOAHAC staff and arranged for screening, education in the schools.
	Infection Disease Control Team/Vaccine Preventable Disease Team		X	Cold chain inspections and staff education
	Chronic Disease Prevention and Tobacco Control Team	X	X	Community of practice-emails to the Nurse Practitioners. PHN has been in communication with SOAHC to determine if they would like to be listed as a resource on a new handout, worked with staff to implement Harvest Bucks program.
o Munsey	Early Years Team		X	Healthcare Provider Outreach

Agency	Team	Partnership	Service	Outcome
	Healthy Communities and Injury Prevention Team - Fentanyl Patch Program		X	Education to the Healthcare Providers about the Patch 4 Patch Return program
	Infection Disease Control Team/Vaccine Preventable Disease Team		X	Cold chain inspections and staff education
	Chronic Disease Prevention and Tobacco Control Team		X	Community of practice-emails the Nurse Practitioners
Standing Stone Elementary School	Healthy Communities and Injury Prevention Team -Kids Need a Boost		X	Education booth at parent teacher night, resources & booster seats distributed
	Oral Health		X	Dental screening and educational lessons for all of the children (one-on-one direct service, group teaching) in the school
Aboriginal Babies and Beyond Coalition	Reproduction Health Team and Early Years Team	X		Plan and attend events/fair
First Nations Early Literacy Book Bag	Early Years Team	X		Working with Chippewa, Munsee, Oneida to create First Nations Early Literacy book bags
First Nations Breastfeeding Support	Early Years Team	X		Working with Chippewa, Munsee, Oneida to develop a breastfeeding peer support plan
Oneida Childcare	Early Years Team		X	Licensed Childcare Outreach- professional education: child development and Ages and Stages Questionnaire
Chippewa Childcare	Early Years Team		X	Licensed Childcare Outreach- professional education: child development and Ages and Stages Questionnaire
	Healthy Communities and Injury Prevention Team -Kids Need a Boost		X	Staff & parent education
All three communities: Administration level, Fire, Ambulance, Nurses, other staff, members of the communities	Emergency Preparedness		X	2008 developed an e-mail distribution list to First Nations contacts to inform of outbreaks etc. Have completed 2 Fit testing events to Oneida staff and community members. The Emergency Preparedness manager was a part of their emergency exercises for evaluation.

Agency	Team	Partnership	Service	Outcome
Special Events where they would have food ex. Western Fair, Children's Powwow, etc	Food Safety Team		X	Food Safety Inspections
Delaware Public School	Healthy Communities and Injury Prevention Team -Kids Need a Boost		X	Information provided to school, staff & parents through school newsletter, posters & rack cards to all grade one students
Fanshawe Collage- First Nations Centre	Sexual Health Promotion Team		X	Education session to students
John Paul II	Young Adult Team	X		2014: Advocacy work for schools in Northern Ontario, Planned a student educational workshop/retreat-grade 11 religion class on Aboriginal culture/awareness/rights-Elders presented
Lambeth Public School (FN community feeder school)	Child Health Team	X		Created an orientation/transition to First Nations students from Standing Stone school to Lambeth (pen pals, school tours, etc). The school is now responsible for this program.
Other	Infection Disease Control Team/Vaccine Preventable Disease Team		X	Community member have attended the team's annual workshop. Community members have called into the Communicable Disease Triage line.
	Vaccine Preventable Disease Team	X	X	PHN's send out suspension letters to off-reserve students and follow up with nurses on reserve to ensure children get their immunizations
	Child Health Team	X		Offered information regarding Triple P training for their staff members (Chippewa, Munsee, Oneida, N'Amerind, SOAHAC)
	Chronic Disease Prevention and Tobacco Control Team	X		Ministry of Finance working with Chippewa counsel-looking at tobacco use and how it is sold in local First Nations communities. This is in the very beginning stages and MLHU has had discussions on the periphery.
	The Clinic Team	X	X	Clients attend Sexual Health clinic at MLHU, Public Health Nurse complete follow-up calls to clients. Working with Regional HIV/AIDS Connection and local First Nations

Agency	Team	Partnership	Service	Outcome
				administration to develop a needle exchange program.
	Total	16	51 *49 is the total number of services offered as one service was offered to all of the communities	

4. **Were the program/service: requested by the staff in the local First Nations communities or offered by MLHU staff?**
   Twenty programs and services were requested by the staff at the First Nations agency, 28 programs and services were offered by staff at MLHU, and one service was client initiated.

5. **Please identify who are your contacts for the initiative(s), and indicate their title.**
   *a list of contact information is available upon request

6. **If programs/service are offered on the reserve; was permission obtained from band leaders?**
   SOAHC was responsible for obtaining permission for an oral health initiative with band leaders. The Clinic team is in the process of working with the band administration to implement their program.

7. **Does your team have key times that you plan correspondence with the local First Nations communities? If so, when?**
   Of the 14 teams who stated they work with the First Nations communities, 5 stated they have key contact times [on-going (n=3), annually (n=2)]. 11 teams stated they work with the communities on an "as needed" basis.

   *two teams identified two services their team offers, as "on-going" and "as needed basis."

8. **Does your team plan or want to enhance your programs or services to the local First Nations communities?**
   Of all of the teams surveyed, 2 teams are in the process of enhancements (Oral Health and The Clinic team), 3 teams would be interested in enhancing services: if additional resources were available (n=1), if the First Nations communities identified a need (n=1), or if there was internal clarification of the supports we can offer (n=1). Five teams stated they will continue with the work they are already doing, and 7 teams stated they do not plan on enhancing services at this time.

9. **Are there other ways your team would benefit from an internal coordinated First Nations approach to working with this community?**

   A majority (n=17) of the teams felt MLHU would benefit from an internal coordinated approach to working with the First Nations communities. One team explained it would depend on the model used (direct client or policy) if they would be involved or not. Another team stated they could provide advisory as needed and one team stated they would not benefit from this strategy.

   The benefits would be:
   - It will help to see what other teams are doing and able to leverage resources at the table, n=1
   - Cultural sensitivity training is needed, for better services for clients, n=1
   - It will increase meaningful relationships with the communities, n=1
   - We will be able to determine the needs of the community for reproductive health and collaboration with pregnant women, n=1
   - It will help with breaking down internal barriers, n=2

- The more we can increase awareness; we can increase referrals, and support the family/child's needs, n=2
- It is better to have a lead person and one contact instead of having 2-3 different contacts within the agency, n=3
- It will reduce duplication of our own services, and be more effective and efficient, n=3
- It is better for us to work together, so we can provider better services the communities, n=6

10. Are there any special considerations you would like in terms of an agency wide First Nations collaboration?

Special considerations identified:

- Keep an open mind, open communication and collaboration internally, n=1
- Programs that are offered off of reserves don't work- people will not attend. They need to be offered in their community, n=1
- Ask what the community wants, n=1
- We should understand their traditions; our conventional way of working might not be in line with their culture. E.g. sending emails- might not be the best way to make contact with someone, n=1
- If an internal committee created, the members need to be champions; someone who is passionate to make change, sees the visions, and have skills to make change happen, n=1
- Clear terms of reference if a group is created, n=1
- Reps should have to bring back to the teams the information so everyone is kept in the loop, n=1
- Suggestion to have one group (internal/external) together to cut down on time/meetings/staffing, Everyone getting the same message at once, n=3
- MLHU staff need cultural sensitivity training to learn how to work better with this population, n=11

11. Would your team like to have a representative on an internal committee to discuss work being done with the First Nations community to develop an efficient and effective collaborative strategy within MLHU?

In total, 13 teams indicated they would like to be included in an internal committee to develop an efficient and effective coordinated strategy to work with the local First Nations communities. Two teams stated they would like minutes only, and three teams would not be interested since they do not work with this population.

*a list of staff members who are interested is available upon request

12. Comments/additional thoughts or recommendations?

- Create a resource of what MLHU has to offer, so the communities can reach out to us, n=1
- The work that is being done with the communities is an extension of what is already being done, no new programing specifically done for the First Nations, n=1
- Information that is collected for statistics of local First Nations communities is owned by the First Nations communities. There are many rules for collecting or trying to get data from their administration, n=1
- First Nations, Métis, and Inuit funding through the school board provides funding for First Nations children (breakfast club, snacks etc.), n=1
- Federal and provincial funding should not decide what we can and cannot do. If they need our assistance and expertise then we should be able to provide it, while being aware of not duplicating services. Health Canada should be involved as we move forward, n=1
- Be respectful of the indigenous ways, n=1
- Let them [the Board of Health] know where we [MLHU staff] are coming from and why we are focusing on certain topics (SDOH), n=1
- Very happy about the health unit talking about how we can work with this population, n=1

- What is Health Canada doing around Food Safety? Do the communities get food recalls? Offered Food Handling/Safety course? MLHU could be involved if Health Canada is not involved, n=1
- We can work better together, we can do in-services together, n=1
- Concerns for the First Nations members who live in the city and don't want to live or receive support from the First Nations community or be involved with other First Nations agencies for a variety reasons, n=1
- How can we can integrate early years services, n=1
- Ensure that services from the teams are not lost or have to be withdrawn. This will look bad for our reputation if we have to pull out of the communities, breaks their trust in us, n=2
- Need strategies to know how to work better with their population and have positive outcomes (cultural sensitivity training), n=3

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 62-15

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2015 October 15

INFLUENZA: 2014/2015 SEASON REPORT AND 2015/2016 SEASON PLANS

Recommendation

It is recommended that Report No. 62-15 re Influenza: 2014/2015 Season Report and 2015/2016 Season Plans be received for information.

Key Points

- There were 381 laboratory-confirmed cases, 161 hospitalizations, 14 deaths and 40 confirmed facility outbreaks.
- The 2014/2015 flu season was unusually long.
- There was a significant mismatch between circulating influenza strains and strains included in the vaccine, resulting in poor vaccine effectiveness.
- For the 2015-2016 flu season, the Health Unit will offer flu vaccine during its regularly-scheduled immunization clinics.

Overview

During the 2014-2015 influenza season, there were a total of 381 laboratory-confirmed cases of influenza reported to the Health Unit. It should be noted that these numbers likely underestimate the true burden of influenza in the community, as typically many people are infected with influenza but do not have laboratory testing performed and are not reported to the Health Unit. The annual number of influenza cases, outbreaks, deaths and hospitalizations are presented in Table 1. A graph outlining when laboratory-confirmed cases occurred is shown in Appendix A (Figure 1).

Table 1: Annual Influenza Cases, Outbreaks & Hospitalizations in Middlesex-London, 2010-2015

	2010-2011	2011-2012	2012-2013	2013-2014	2014-2015
Laboratory-confirmed Cases	276	106	477	407	**381**
Hospitalizations	161	34	301	206	**161**
Deaths	17	3	26	17	**14**
Outbreaks	28	6	40	19	**40**

For the 2014-2015 season, cases ranged in age from 29 days to 101 years old. Those aged 65 and over accounted for 64% (242/381) of all cases. There were 161 individuals with laboratory-confirmed influenza who were hospitalized; this represents 42% (161/381) of all laboratory-confirmed cases. Those aged 65 years and older accounted for 66% (107/161) of hospitalized cases. There were 14 deaths reported among individuals with laboratory-confirmed influenza. The number of deaths was highest amongst those 65 years of age and older, representing 86% (12/14) of all deaths among reported influenza cases. Laboratory confirmed cases of influenza identified in facilities (i.e., LTCHs and retirement homes) accounted for 31% (118/381) of all cases. A number of cases associated with influenza outbreaks were identified but were not laboratory confirmed and are not included in this analysis.

Influenza Outbreaks

During the 2014-2015 season, 40 influenza outbreaks were declared in facilities; 30 in long-term care settings and ten in retirement homes. Attack rates ranged from 3% to 47%. Duration of influenza outbreaks ranged from 6 to 39 days. Four of the 40 influenza outbreaks had at least one other pathogen identified, such as rhinovirus, respiratory syncytial virus or coronavirus. Of the 40 outbreaks, influenza A was identified in 37 outbreaks, influenza B was identified in one outbreak and two outbreaks had both influenza A and B identified. A graph outlining when outbreaks occurred is shown in Appendix A (Figure 2).

Timing of the Season and Strain Typing

The influenza season typically occurs anytime from October to April. This past season, the first confirmed influenza case was identified on September 29, 2014 and the last case was identified on June 17, 2015. Of the 381 laboratory-confirmed cases in Middlesex-London, 86% were influenza A and 14% were influenza B. Influenza A was the predominant strain at the beginning of the season which was followed by a peak in influenza B activity towards the end of the season. During the 2014-2015 influenza season, viral testing carried out across Canada indicated that there was a poor match between the influenza A H3N2 strain that circulated and the H3N2 strain included in the vaccine. However, testing showed that the influenza B strain included in the vaccine was a good match to the circulating strain of influenza B.

Upcoming 2015-2016 Influenza Season

There are some changes in the provincial and local influenza program this year. The Ministry of Health and Long Term Care (MOHLTC) has included quadravalent influenza vaccines (QIV) for the 6 months through 17 year age group in this year's influenza program. Those over 18 years of age will continue to be offered trivalent influenza vaccine (TIV) which protects against the three strains (two A and one B strains) of influenza viruses. QIV provides protection against the same three strains as TIV and one additional B strain. QIV is recommended for the 6 months through 17 year age group as the burden of illness caused by Influenza B strains is highest in this age group.

Attendance at community influenza clinics has continued to decline and the Health Unit will no longer be holding community influenza clinics. Vaccine is available through health care provider offices, pharmacies which have applied for and received approval from the MOHLTC to provide influenza vaccine to those 5 years of age and older and some workplaces. The number of pharmacies offering influenza vaccine in London and Middlesex County has increased each year since 2012.

Conclusion

The number of confirmed cases during the 2014-2015 influenza season was lower than the previous season; however, the number of cases remained elevated in comparison to previous years. For the 2015-2016 flu season, the Health Unit will offer flu vaccine during its regularly-scheduled immunization clinics. The Health Unit will continue to encourage yearly influenza vaccination to reduce the risk of influenza infection in the population.

This report was prepared by Ms. Marlene Price, Manager Vaccine Preventable Diseases Team, Mr. Tristan Squire-Smith, Manager, Infectious Disease Control (IDC) Team, Ms. Alison Locker, Epidemiologist, Oral Health, Communicable Disease and Sexual Health; and Ms. Eleanor Paget, Public Health Nurse, IDC Team.

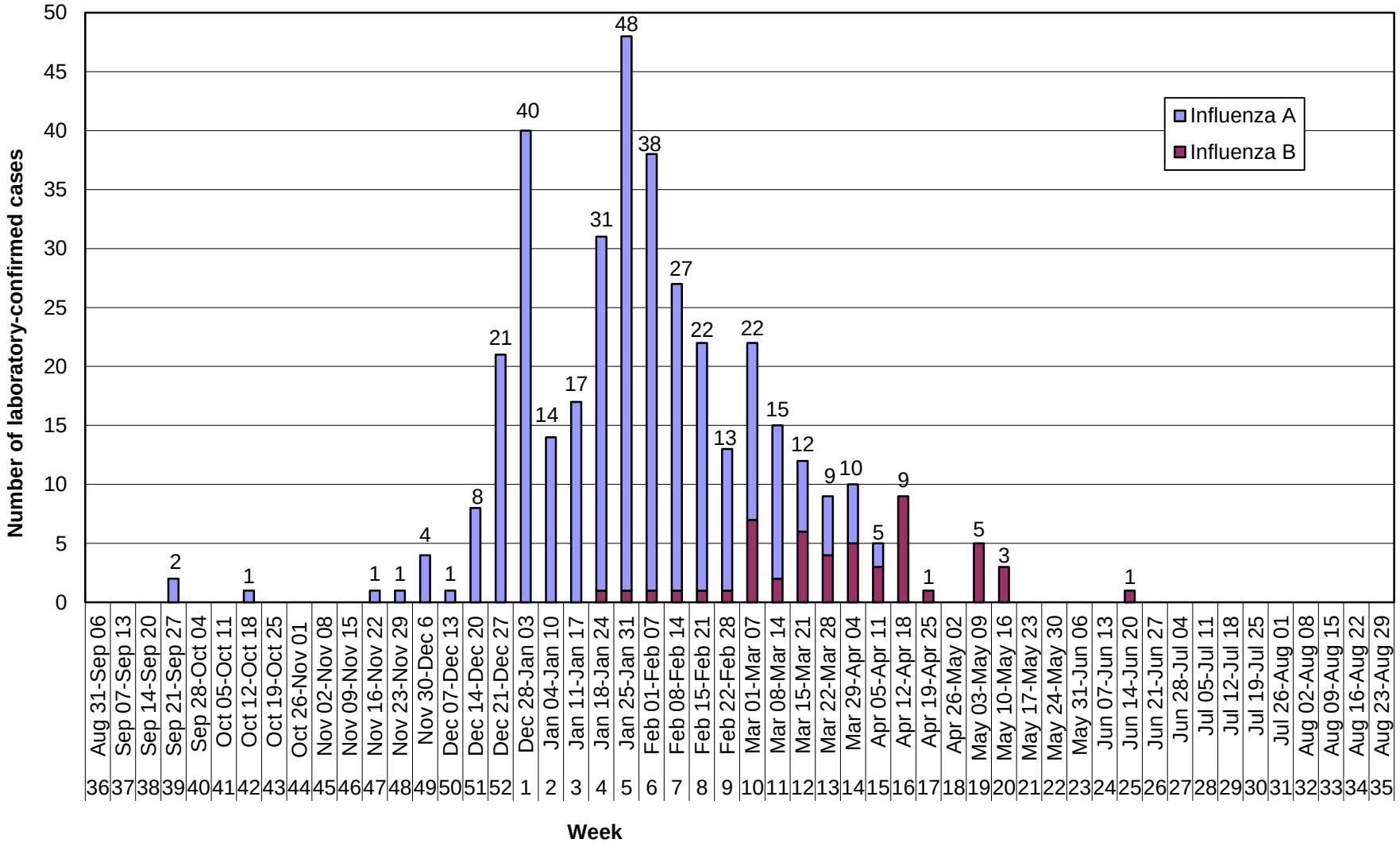
Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health and CEO

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

Appendix A

Figure 1

Laboratory-confirmed influenza cases, by influenza date†
Middlesex-London 2014-2015 influenza season (N=381)

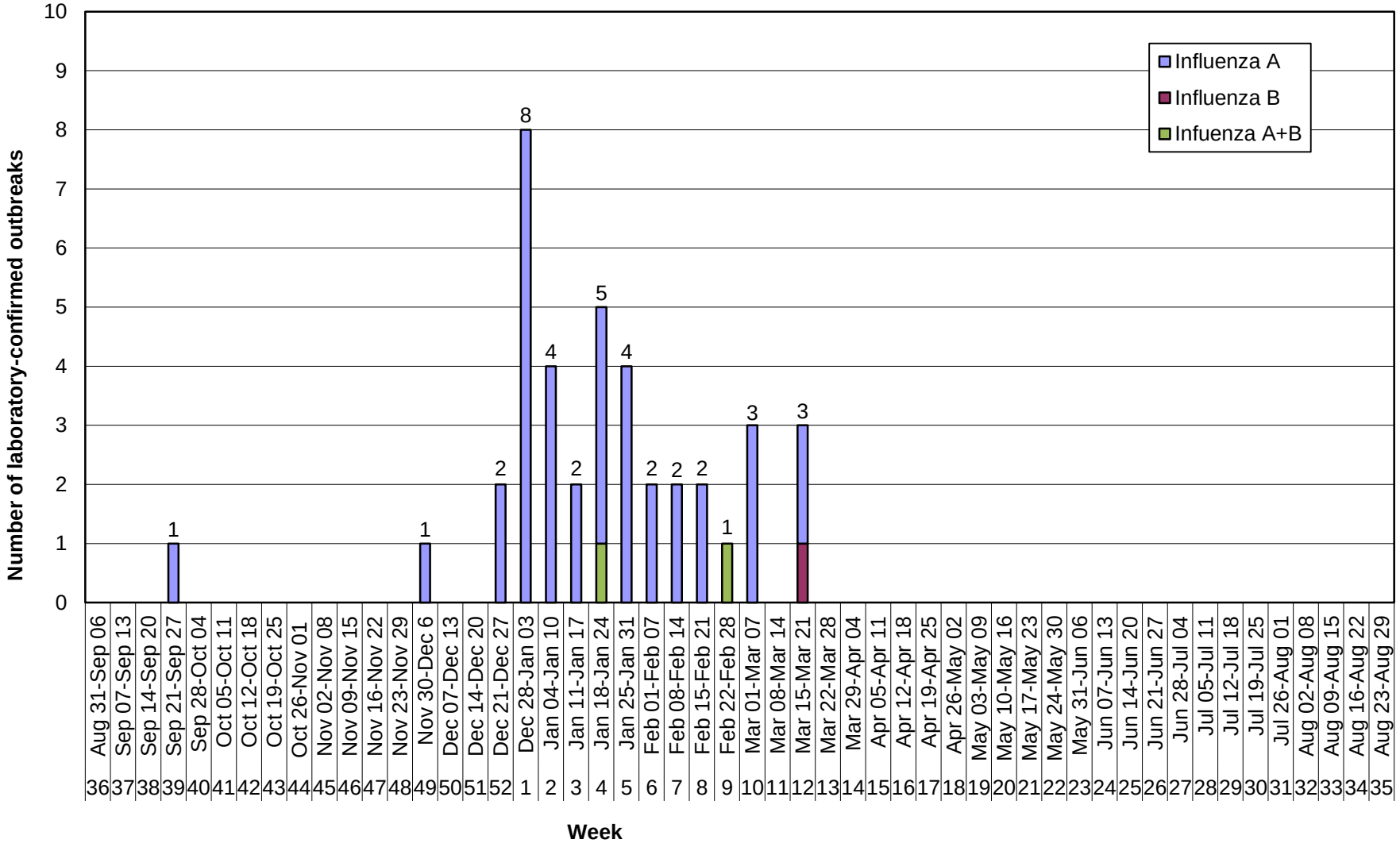


† Influenza date is the earliest of onset date, specimen collection date or reported date.

Appendix A

Figure 2

Laboratory-confirmed influenza outbreaks, by date outbreak declared, Middlesex-London 2014-2015 influenza season (N=40)



MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 63-15

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2015 October 15

MIDDLESEX-LONDON 2014/2015 SCHOOL-BASED DENTAL SCREENING RESULTS

Recommendation

It is recommended that Report No. 63-15 re Middlesex-London 2014/2015 School-based Dental Screening Results be received for information.

Key Points

- During the 2014-2015 school year, the Health Unit screened 16,171 students (83%) in 128 elementary schools through the school-based dental screening program.
- The percentage of students screened in Junior Kindergarten who were caries-free was 78% (decrease of 2% from last year). The percentage of caries-free students in Grade 2 was 59% (same as last year).
- Similar to the previous year, 654 students (4%) were found to have urgent dental needs which made them clinically eligible to receive Children in Need of Treatment (CINOT) funding for their dental care.
- The Health Unit continues to work on strategies to improve oral health outcomes among children in the community, to identify children at risk of poor outcomes, and to increase participation in the school-based dental screening program.

Background

One hundred and twenty-eight (128) elementary schools participated in the school-based dental screening program in the 2014-2015 school year. Students in Junior Kindergarten, Senior Kindergarten, and Grade 2 at elementary schools were screened in accordance with the Oral Health Assessment and Surveillance Protocol of the Ontario Public Health Standards. This screening involves a Registered Dental Hygienist looking in each child's mouth to assess their past history of dental and whether any teeth need urgent attention. The need for and urgency of dental care is recorded and the parents advised of the required follow-up. Based on the screening results of the Grade 2 students at each school, the school is categorized as having "Low", "Medium", or "High" rates of dental problems, as per the Protocol. Increased screening intensity level requires that additional grades be screened.

Results of the 2014-2015 School Year Screening

Participation. Of the 19,535 students who were offered dental screening at the schools that participated in the school-based dental screening program, 16,171 (83%) were screened (Figure 1). For the 2014-2015 school year, the Health Unit did not have parental consent to screen 2.190 (11%) students and 1,211 (6%) students were absent on the day(s) that staff were screening at their schools. The percentage of excluded students is higher than the previous year's percentage, but the percentage of absent students is similar. The numbers of students screened in Junior Kindergarten, Senior Kindergarten, and Grade 2 were 3,702, 4,123, and 4,356.

Screening intensity. Among the 128 elementary schools with Grade 2 in the Health Unit's jurisdiction, 99 were categorized as Low intensity, 15 as Medium intensity, and 14 as High intensity as per the Oral Health Assessment and Surveillance Protocol.

Dental caries. The percentages of Junior Kindergarten, Senior Kindergarten, and Grade 2 students screened who were caries-free, (i.e. have never had cavities or the removal or filling of a tooth because of tooth decay) were 78%, 71%, and 59%, respectively (Figure 3). This demonstrated a decrease in percentage for the Junior Kindergarten students from the previous school year which was 80%; and an increase for the Senior Kindergarten and Grade 2 students which were 70% and 59% respectively. Slightly more than 5% of Grade 2 students screened had two or more teeth with tooth decay (Figure 4).

Urgent dental needs. Six hundred and fifty-four students (4%) of those screened were found to have Urgent dental needs which deemed them clinically eligible to receive Children in Need of Treatment (CINOT) funding for their dental care (Figure 5). Six hundred and thirty students (96%) of those found to have Urgent dental needs were referred to and accepted at local dental offices for treatment. The percentage of students who were referred to and accepted at dental offices is higher than the 92% from the previous school year.

These findings are outlined more fully in the Annual Oral Health Report (Appendix A).

Next Steps

Findings from the 2014-2015 school-based dental screening program as outlined in the "Annual Oral Health Report" (Appendix A) will be shared with local dental and healthcare providers, partner agencies, and the general public. The Health Unit will continue to work on strategies such as the school-based fluoride varnish program to address the percentages of Junior Kindergarten, Senior Kindergarten, and Grade 2 students who are caries-free. The Health Unit is currently working with selected schools to increase awareness about how to identify students experiencing dental discomfort. And finally, the Health Unit continues to work with schools that require active consents to develop strategies to improve participation in the program.

This report was prepared by Dr. Maria van Harten, Dental Consultant and Mr. Chimere Okoronkwo, Manager, Oral Health Team.

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

ANNUAL ORAL HEALTH REPORT

October 2015

Purpose

To provide information about the findings of the Health Unit's school-based screening program from the last school year: September 2014 to June 2015.

Methodology

Publicly funded elementary schools and three private schools participated in the school-based screening program. Students in Junior Kindergarten, Senior Kindergarten, and Grade 2 at publicly funded schools were screened in accordance with the Oral Health Assessment and Surveillance Protocol of the Ontario Public Health Standards.

Based on the screening results of the Grade 2 students at each school, the school was categorized into the following levels of screening intensity: "Low", "Medium", or "High", as per the Protocol. Increased screening intensity level requires that additional grades be screened.

The parents of the students in these grades who decline to have their children screened advise their school administrators who then pass this information on to Health Unit staff. Children whose parents have consented to screening but who are absent on the day of screening may be screened on a subsequent screening day.

Student level data was collected by five Registered Dental Hygienists employed by the Health Unit. The need for and urgency of dental care was recorded and the parents advised of the required follow-up. As well, indicators of previous dental caries were recorded. Data was collected and stored in accordance with the Oral Health Assessment and Surveillance Protocol, the Health Protection and Promotion Act, the Municipal Freedom of Information and Protection of Privacy Act, and the Personal Health Information Protection Act.

The Ministry of Health and Long-Term Care's Oral Health Information Support System was used to generate summary statistics from the student level data. Historical aggregate data was accessed from archived Health Unit spreadsheets. These data were further analysed using Microsoft Excel.

Key Findings

Participation. Of the 19,535 students who were offered dental screening at the schools that participated in the school-based dental screening program, 16,171 or 83% were screened (Figure 1). For the 2014-2015 school year, the Health Unit did not have parental consent to screen 2,190 (11%) students, and 1,211 (6%) were absent on the day(s) that staff were screening at their schools. The percentage of excluded students is higher than the previous year's percentage, but the percentage of absent students is similar.

Screening intensity. Among the 128 elementary schools with Grade 2 in the Health Units jurisdiction, 99 (77%) were categorized as Low intensity, 15 (12%) as Medium intensity, and 14 (11%) as High intensity as per the Oral Health Assessment and Surveillance Protocol which is described in the sidebar (Figure 2).

Dental caries. The percentages of Junior Kindergarten, Senior Kindergarten, and Grade 2 students screened who were caries-free, (i.e. have never had tooth decay or the removal or filling of a tooth because of caries) were 78%, 71%, and 59%, respectively (Figure 3). This demonstrated a decrease in percentage for the Junior Kindergarten students from the previous school year which was 80%; and an increase for the Senior Kindergarten and Grade 2 students which were 70% and 59% respectively. Slightly more than 5% of Grade 2 students screened had two or more teeth with tooth decay (Figure 4).

Urgent dental needs. Six hundred and fifty-four (654) students or 4% of those screened were found to have Urgent dental needs which deem them clinically eligible to receive Children in Need of Treatment (CINOT) funding for their dental care (Figure 5). Six hundred and thirty (630) students or 96% of those found to have Urgent dental needs were referred to and accepted at local dental offices for treatment. The percentage of students found to have Urgent dental needs is similar to the previous school year. The percentage of those students who were referred to and accepted at dental offices is higher than the 92% from the previous school year.

Next Steps

- The Health Unit will continue to work on strategies such as the school-based fluoride varnish program to address the percentages of Junior Kindergarten, Senior Kindergarten, and Grade 2 students who are caries-free.
- The Health Unit is currently working with selected schools to increase awareness about how to identify students experiencing dental discomfort.
- The Health Unit continues to work with schools that require active consents to develop strategies to improve participation in the program.

Results

Figure 1. Percentages of students screened, absent and refused for the 2012-2013, 2013-2014, and 2014-2015 school years

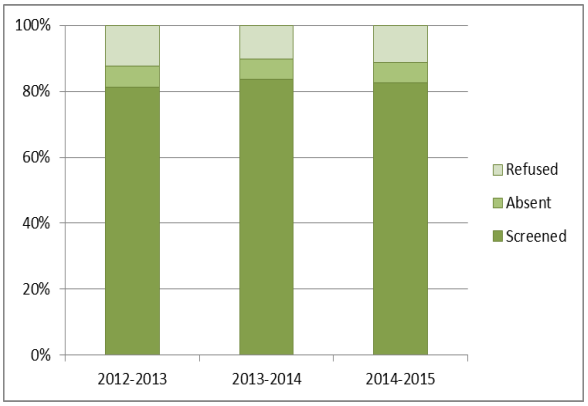


Figure 2. Screening intensity of schools by school year

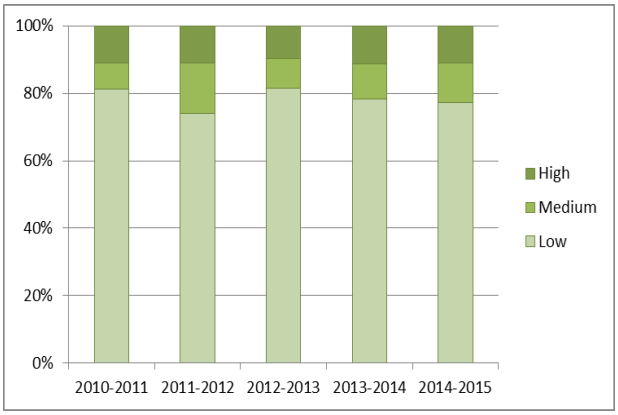


Figure 3. Percentage of students screened who were caries-free by grade for the 2012-2013, 2013-2014, and 2014-2015 school years

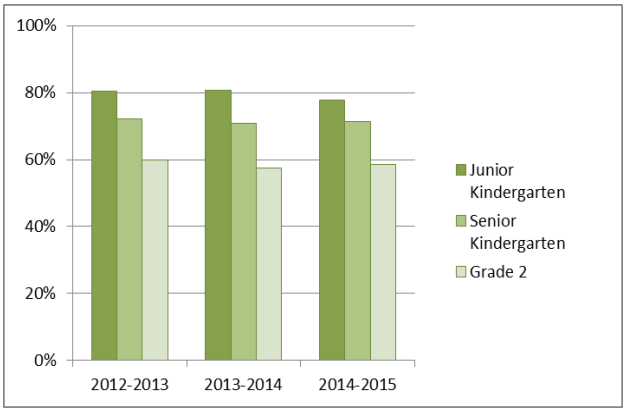


Figure 4. Percentage of Grade 2 students screened with two or more teeth affected by caries (decay, removals, or fillings) by school year

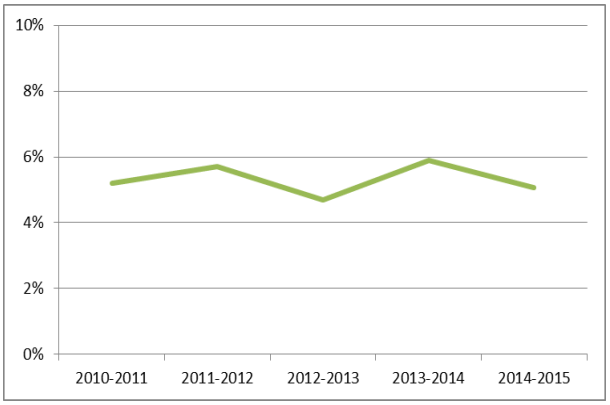
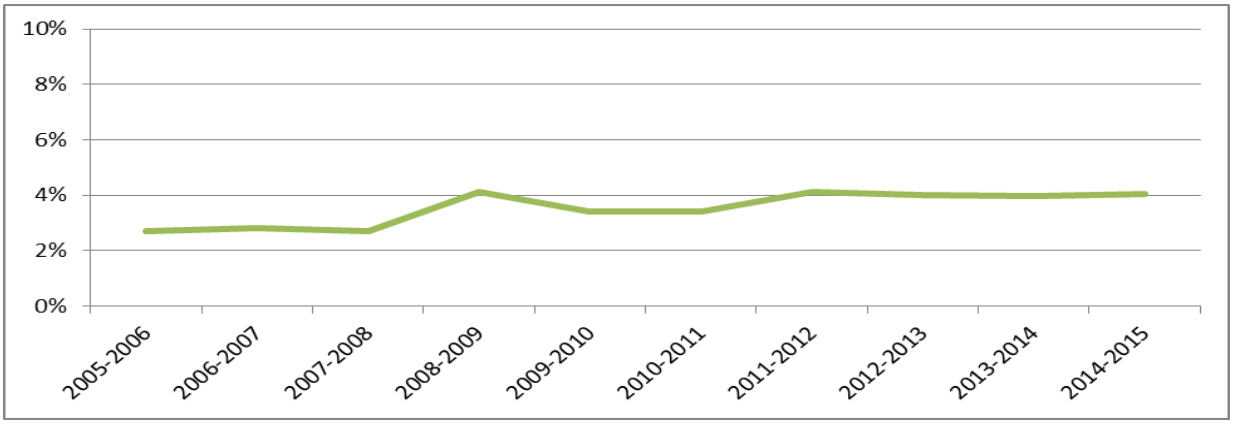


Figure 5. Percentage of students screened with Urgent dental needs by school year



MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 64-15

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2015 October 15

SUMMARY INFORMATION REPORT FOR OCTOBER 2015

Recommendation

It is recommended that Report No. 64-15 re Information Summary Report for October 2015 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. Health units are required by the Ministry of Health and Long-Term Care to be BFI accredited. MLHU is currently preparing for the final stage of External Assessment October 2015.
- Components of the *Electronic Cigarette Act – 2015* (*ECA*) will come into force on January 1, 2016. The Health Unit has received new base funding of $39,500 annually to enforce the provisions of the *Act.* This funding will be used to increase required staff resources.

Background

This report provides a summary of information from Health Unit programs. Additional information is available on request.

Baby-Friendly Initiative Update

The Baby-Friendly Initiative (BFI) is a global, evidence-based strategy that promotes, protects, and supports the initiation and continuation of breastfeeding. The implementation process for BFI includes a comprehensive mix of policy implementation, staff education, review and revision of curricula and resources, practice changes, data collection and community outreach. All Ontario Health Units are required to work towards achieving Baby-Friendly designation, which confirms adherence to all BFI provisions. MLHU is currently preparing for the final step towards becoming designated Baby-Friendly, called the External Assessment. Our External Assessment has been booked for October 28-30, when a team of Assessors from the Breastfeeding Committee for Canada will be speaking with staff and clients, reviewing documents, and observing programs. They will rate MLHU using a standardized assessment tool, and will provide a report to at the end of the visit, outlining whether or not MLHU has been successful in achieving Baby-Friendly status.

Electronic Cigarette Act – 2015 Update

Components of the *Electronic Cigarette Act – 2015* (*ECA*) will come into force on Jan 1st, 2016. The *Act* bans the sale of e-cigarettes and their component parts to anyone under the age of 19 years and bans the use of e-cigarettes in all places where smoking tobacco products is already prohibited under the *Smoke-Free Ontario Act*. Additional components of the *ECA* will come into effect in 2017 including rules around the display, promotion and handling of electronic cigarettes and the prohibition of the sale of electronic cigarettes at certain places. As part of the Program Based Grant process, the Ministry of Health and Long Term Care provided the Health Unit with $39,500 (prorated at $29,625 for 2015 only) of ongoing 100% annual funding to support the added education and enforcement demands of these legislative enhancements. This funding will be used to increase our Tobacco Enforcement Officer and Program Assistant resources on the Tobacco Control Team to conduct and document the additional inspections, education visits and signage delivery, and associated prosecution activity necessary to ensure compliance with the new *Act*. In addition to the base funding, the Health Unit received one-time funding (April 1, 2015 to March 31, 2016) of $39,500 to support the implementation of the Health Unit's *Electronic Cigarette Act* implementation strategy and work plan.

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

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 65-15

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2015 October 15

MEDICAL OFFICER OF HEALTH ACTIVITY REPORT – OCTOBER

Recommendation

It is recommended that Report No. 065-15 re Medical Officer of Health Activity Report – October be received for information.

The following report highlights activities of the Medical Officer of Health (MOH) from the July Medical Officer of Health Activity Report to October 2, 2015.

Throughout the month of September, the MOH attended events and meetings regarding the Mayor's Advisory Panel on Poverty. The MOH will co-chair this Panel with Deputy Mayor Cassidy. The panel will develop recommendations for action on reducing poverty in London.

The MOH attended the 3M Harvest Lunch on September 17 at Bud Gardens. This event marked the United Way of London and Middlesex 2015 campaign launch. They announced that the goal this year will be $9.1 million

On September 17, the MOH and the Middlesex-London Health Unit welcomed Dr. Paul Kershaw to London to present on the challenges of Canadians in their 20s, 30s and 40s. This particular group of citizens faces many challenges such as lower earnings, higher costs, less time and a deteriorating environment. Dr. Kershaw talked about why it's time for a Better Generational Deal, one that works for young and old alike.

On September 18th, the MOH welcomed Deputy Minister Deb Matthews to the Health Unit. She was in London to announce Ontario's Local Poverty Reduction Fund initiatives. The Health Unit is one of eight organizations in Southwestern Ontario to receive funds that will assist in preventing or reducing poverty for children and families. Middlesex-London Health Unit will receive $351,000 to develop a training centre to educate Ontario public health nurses on how to provide the most vulnerable young mothers and their babies with highly specialized supports during pregnancy and early years to help both parents and children achieve their potential.

The Medical Officer of Health and CEO also attended the following teleconferences and events:

September 3	Initial meeting with Daniel Brown, Loran Scholar studying Kinesiology and Rehabilitation Therapy at Western
September 4	Telephone meeting in regards to nutrition with Geoffrey Vogt, YMCA and Danielle Battram, Brecia University College
	Met with MPP Peggy Sattler to discuss Public Health
September 8	Hosted a meeting of the Community Health Collaborative (CHC) Champions at the Health Unit
September 9	Attended the United Way Cabinet Meeting
	Met with Dr. George Zahariadis
September 11	Met with MPP Jeff Yurek to discuss Public Health

September 14	Met with Dr. Gord Schacter to discuss Health Unit Primary Care Support
September 15	Attended a Youth Opportunities Unlimited (YOU) Governance meeting
	Met with Matthew Meyer (LHSC) and Michael Clarke (UWO) in regards to Western Health Systems Research Centre
September 16	participated in a teleconference call with the TOPHC Program Committee
	Participated in a teleconference call of the SW LHIN Health System Leadership Council
September 17	Met in Toronto with the Health Human Development Table
September 24	Attended the YOU Board Meeting
September 25	With Gayane Hovhannisyan, gave a presentation at the University for a Masters of Public Health session
	Met with Paul Hubert, City Councillor
	Attended the OW/ODSP Advocates meeting at the Civic Gardens
September 29	Attended the Orange Door Project event at YOU to celebrate the contribution of $40,000 from The Home Depot Canada Foundation
September 30	Delivered opening remarks at the IDC 2015 Workshop ant Goodwill Industries
	Attended

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

This report addresses Ontario Public Health Organizational Standard 2.9 Reporting relationship of the medical officer of health to the board of health