Northwestern Health Unit
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BOARD OF HEALTH FOR THE NORTHWESTERN HEALTH UNIT

MEETING MINUTES

Regular Board of Health Meeting
Friday, August 10, 2012
Dryden Holiday Inn Express Meeting Room

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MEMBERS PRESENT: John Albanese, Chair
Jim Belluz, Dennis Brown, Dave Canfield, Mel Fisher, Russ Fortier, Paul Ryan, Doug Squires, Bill Thompson

PARTICIPATING:
Dr. Jim Arthurs, Medical Officer of Health (MOH)
Mark Perrault, CEO
Jennifer McKibbon, Manager, Enforcement
Donna Stanley, Manager, Infectious Disease
Alex Berry, CQI Coordinator
Shannon Robinson, Health Promotion Coordinator

REGRETS: Margaret Harland, Julie Roy

1. CALL TO ORDER

Chair John Albanese called the meeting to order at 8:30 a.m.

2. APPROVAL OF AGENDA

Motion / Resolution: 69-2012	
THAT the Agenda for the Board of Health meeting dated August 10, 2012, be approved.	D. Squires D. Brown

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3. DECLARATIONS OF PECUNIARY INTEREST & GENERAL NATURE THEREOF

None was declared.

4. MINUTES OF BOARD OF HEALTH MEETING, June 28, 2012

Motion / Resolution: 70-2012	
THAT the Minutes of the Board of Health meeting held June 28, 2012, be approved as written.	P. Ryan R. Fortier
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5. SENIOR MANAGEMENT REPORTS

Medical Officer of Health Report - *Dr. Jim Arthurs, Medical Officer of Health (MOH)*

It doesn't matter what your favorite sport is – or even if you don't care for sports, the opening ceremony for the 2012 Olympic Games likely caught your eye. The reviews call it typical (British) history: who are we; where did we come from; and where are we going? - with some dry British wit, pride, some past heroes, the monarchy, and continued success.

There are a lot of buzz words floating around: hard work, dedication, young standouts, returning veteran competitors; and all with a focus on excellence and winning. But it really isn't all about winning. It is about doing the best that you can, and about teamwork. I watched the women's cycling road race this morning and saw some teamwork among competitors ensure that those three breakaway sprinters were going to stand on the podium together. Without their competitive teamwork they could have faded to someone else taking their place. This occurred in the presence of pouring rain and the challenge of the slippery road surface. If this does not inspire our youth and seniors to "get up and move", then I do not know what will.

Let's take a look at some of our own buzz words – though we call them our mission, vision and values. Our measurements of success are not as simple as a time clock, points, or who crosses the finish line first. They have been developing over time to be better understandable. What does living a long life well, mean to us? Retrospectively measuring the length of life is easy; however, measuring the quality of life is complex and measuring the quality of adjusted life years saved (QALYS) is even more complex. What does it mean to live healthy lifestyles for the vulnerable populations that didn't get a good start in life?

Our Values:

- Partnerships
- Wellness
- Respect
- Compassion
- Environmental stewardship
- Innovation and excellence
- Integrity and professionalism
- Accountability and transparency

How do we operationalize them as a corporation or personally by living them?

Bob Dylan's "The Times They Are A-Changin" and his other songs of the 60's chronicled the social issues of the times. He once said, *"A hero is someone who understands the responsibility that comes with his freedom."*

<u>Ministry of Health and Long-Term Care Strategic Planning</u>

Mark Perrault and I had the opportunity to attend the Ministry's public health sector meeting on Monday, July 23 to provide input on their strategic planning. Virtually all of their proposed values match our own. The age of accountability, measurement, quality improvement, efficiency, effectiveness, and outcomes has surely arrived. Whether "austerity" is a pertinent word for our situation in Ontario with its $15 billion deficit, it is

certain that fiscal responsibility must be one of our measurements of quality improvement. Chief Medical Officer of Health Dr. Arlene King suggested that there are certainly programs that we need to improve their implementation. In her words, "what should we continue and improve; what should we start doing that we are not doing; and what perhaps should we stop doing"? There were suggestions made regarding definitions of values and goals, and the improvements necessary:

1. Healthy environments
2. Burden of chronic disease
3. Maternal, infant, and child/youth health
4. Infectious disease prevention and control
5. Emergency preparedness and response
6. Public health capacity and infrastructure

Perhaps the most controversial issue dealt with the sixth goal, regarding what is the most efficient and effective organizational structure for provincial and local public health. It was suggested that this should be the first and most important goal. Another question concerned the issue of what programs we should perhaps stop doing. If they are mandatory programs, does that mean that the Ontario Public Health Standards will need to be reviewed and possibly revised?

Mark Perrault and I will share the collective input when it becomes available. We both feel that our organizational structure fits well with the quality improvements and measurements that are necessary, and that our proposed strategic plan may well be "ahead of the curve".

Infectious Disease Program

Submitted by Donna Stanley, Manager. Infectious Disease

This report references the following Balanced Scorecard domains, as referenced in the Northwestern Health Unit Strategic Plan:

Health Determinants and Status
Community Engagement
Integration and Responsiveness

Strategic Objectives:

- Improved data for a more comprehensive risk assessment related to infectious diseases
- Engaging the public in understanding their risk and the impact of preventive measures
- Support the work of our community health care partners within their role in public health

<u>Vaccine Preventable Diseases Program</u>

For school based immunization programs, Hepatitis B, Meningococcal, Gardasil, we have maintained records on who we have immunized, as well as adding to IRIS database information received from community healthcare partners.

Enhancement:

We are actively seeking data from First Nations and other community health care partners so that we can optimize the quality of our vaccine coverage information.

We are maintaining records on response to request for consent to immunize, categorizing our non-immunized as: medical exemptions, exemptions for reasons of conscience, refusal. We are documenting the measures we are taking to ensure we provide opportunity for all families to make informed choices, i.e., contacting families to ensure they understand the risks and benefits and have equal opportunities to consent to and receive the vaccines.

Influenza Immunization:

The annual influenza vaccine program has traditionally focused on number of vaccines delivered.

Enhancement:

Review of evidence shows that 'herd immunity' is strongly affected by the proportion of school-aged children immunized against the 'flu because this group spreads the disease very efficiently to others in their lives, and also generally has an excellent immune response. Well individuals of all ages and walks of life will have little to no contact with primary care, likely only contact with emergency room if care is required.

We will be targeting access issues directly during the 2012 influenza season: focusing upon those who do not have regular contact with primary care; who experience difficulty accessing services due to transportation issues, work and school hours, disability, homelessness or domestic challenges (e.g., utilizing a women's shelter).

Routine Immunization:

Community health care providers are an important access point for routine immunizations for infants and pre-school children; the Northwestern Health Unit is unique in the degree of provision of vaccine to these groups, as most Ontario health units do not provide this service.

It is ideal that those primary health care providers who are immunizing infants and young children continue to do so. When families visit their primary care provider, a more comprehensive scope of care can be offered at a time when development is rapid and early detection of problems is vital.

The Vaccine Preventable Disease (VPD) program team continues to immunize all ages, but it is ideal that we focus most strongly on adults, travelers, the influenza campaign and school-based programming – access points to immunization for those who are not in frequent contact with primary care providers.

The publicly funded vaccine schedule has changed extensively over the past decade. We must maintain a high calibre of knowledge and understanding, and also have mechanisms to support our health care partners so that they can continue their role confidently and efficiently in a comprehensive immunization program.

Our public health nurses and program assistants are available on an ongoing basis to primary care nurses and physicians to interpret immunization needs and the use of vaccine. These working relationships are strong and well-used. With the introduction of difficult scheduling changes, we have set up one-on-one appointments and multiple, brief teleconferences to help our partners learn the changes. These were attended by a small number, but attended repeatedly by some who found it helpful to have repetition.

During 2012 we launched an online interactive education tool including a video of actual practice, to support our community partners in making the choice to immunize on time, and to provide complete protection for all clients. Evaluation of this tool continues.

Enhancements:

In fall 2012 we will be tracking our communications with health care providers more closely to find patterns and opportunities for education:

- provide quick access tools, respecting the fast pace of a primary health care setting; tools that provide fast, relevant facts in a usable way
- one-to-one training and updates offered regularly
- potential for rapid-access phone support throughout the region to enable primary care providers to avoid missed opportunities to immunize based on inability to access information quickly
- planning for and providing an Immunization Symposium in Fort Frances in fall 2013, focusing on primary health care providers, tailoring the content to identified needs tracked throughout the year leading up to it

<u>Vector Borne Diseases</u>

We have historically accepted and submitted ticks found on humans for speciation and disease testing.

Enhancement:

- In 2012 we advertised and offered collection kits with information about tick species and Lyme Disease risk and instructions on how to remove a tick. We promoted passive surveillance, building capacity for risk assessment.
- In the fall of 2012 we plan to perform active surveillance for deer ticks, having attended training for this in May. The Ministry of Health and Long Term Care is interested in the data we collect and, depending on fall 2012 results, will potentially come to our area in spring 2013 to conduct further surveillance.

- The surveillance work will enable us to educate primary care providers in effective Lyme Disease case identification by providing risk assessment information: if we have a consistent local population of Lyme Disease-infected vectors (ticks), versus if we do not – this information is vital as part of an assessment to rule in or out a diagnosis of Lyme Disease.

Enforcement Program

Submitted by Jennifer McKibbon, Manager. Enforcement

This report references the following Balanced Scorecard domains, as referenced in the Northwestern Health Unit Strategic Plan:

Internal Resources and Services

Strategic Objective:

Our objective is to provide accurate and timely reports regarding enforcement field work, and to organize workload.

Work towards this objective has been ongoing for the tenure of the current Manager. It remains a work-in-progress, but great strides have been made in 2012.

Accurate and Timely Reports:

Systems for tracking field inspections, premises inventory and accountability agreement measures had to be developed and/or properly utilized to move towards this objective.

There are three electronic tracking systems used by enforcement officers to record inspection data. Two are on-line data collection systems designed and maintained by the Ministry of Health and Long-Term Care (the 'Ministry'); and one is an inspection tracking program purchased by the Health Unit and also used by the majority of other public health units in Ontario.

Inspections are entered into a field tablet (basically a heavy-duty laptop) that is brought back to the office and plugged into the server. The collected field data is uploaded to the appropriate tracking systems.

The inspection tracking systems used by the enforcement team are:
- Tobacco Inspection System (TIS - Ministry) – used by tobacco enforcement officers for tobacco vendors and workplace inspections.
- Risk Categorization (RCat - Ministry) – used by public health inspectors for risk assessments of small drinking water systems.
- Hedgehog (HH – Northwestern Health Unit) – used by public health inspectors for inspections in the safe water, food safety, infections control and rabies programs.

The enforcement team is responsible for five Ministry accountability agreement measures, and four of them (high risk food, class A pools, tobacco vendors and Small Drinking Water Systems) are measured by one of these databases. The Ministry databases will provide the measure of whether we meet the targets for the latter two performance indicators. The first two targets are tracked and measured on our own HH system. Either way, we need to be confident that the data is correct and fair.

Databases for all three tracking systems are premise-based. The report function and usefulness of a database is entirely dependent on how accurate the data is, i.e. *garbage in = garbage out*. Thus the first (lengthy and laborious) step was to clean up the databases by eliminating duplicates, removing premises that did not 'belong', closing premises that no longer operated, and checking the accuracy of those that remained. It also became evident that there were missing premises – ones that should have been listed but were not, and for which there was no record of past inspections. Currently TIS lists 137 tobacco vendors and 3000+ businesses; RCat lists over 900 drinking water systems; and HH tracks over 875 premises. There is some overlap (e.g., a small drinking water system can also be a food premise; the TIS business directory would include all of the other premises); but each database is now much closer to a complete, up-to-date and accurate listing of the premises that we have responsibility to inspect.

Database administrators (one program assistant and one field staff) were assigned for each database. Their responsibility was to review data clean-up work as it progressed and to troubleshoot glitches with assistance from the provincial helpdesk for TIS and RCat and our own helpdesk for HH. These administrators have accomplished significant self-learning and have become a much-needed resource for the rest of the team (including the Manager) when working in these databases.

We brought in a HH trainer for in-depth staff training of both our team and IT staff, which significantly increased our understanding of the HH system and how to get the most out of it. One outcome was the capacity to create our own e-inspection form within HH so that paper inspection forms could be eliminated along with the duplication of work they created.

Individual workplans, based upon the updated and cleaned premises lists, were developed for each officer so that every premise for which we are responsible has an officer assigned to it. Officers can exchange premises where appropriate; but the premises do not get lost or forgotten or missed – an issue with the ongoing staff changes within the enforcement team.

Measuring Progress / Success:
All three tracking systems have reports that can be consulted for information about the data in the system. The reports that are available to us from the Ministry systems are somewhat limited; but we are able to utilize them to determine our compliance with the accountability agreements and to provide comparisons with our internal work plans and 'Excel' tracking documents.

The most dramatic improvement can be seen in the Hedgehog data, where all the data belongs to us and we have complete access to the whole database. We are able to provide accurate completion rate reports for various inspection types and ensure that we meet Ministry deadlines for the quarterly or three-times-a-year inspections required in the accountability agreements.

Next Steps:
The three databases are now "accurate enough" given the resources available to commit to this ongoing task. The landscape is always changing – premises open and close all the time, so we are never in a position to say that our databases are 100% correct or complete. But we are much more confident that we know what has to be done and can measure our success in getting it done.

Health Promotion Coordinator Report
(Foundations Team)

Submitted by Shannon Robinson, Health Promotion Coordinator

In June I had the opportunity to attend the annual Canadian Public Health Association conference in Edmonton, Alberta. The Conference theme was related to Creating and Sustaining Healthy Environments. Healthy physical and social environments are important health promotion strategies discussed in the Ottawa Charter. Since 1986 the Charter has been a key resource for health promotion and public health, and is embedded in our Northwestern Health Unit program planning forms.

At the Conference there were strong links between the content presented and the direction that our current strategic planning process is leading us. Two examples are: the importance of the built environment, and the ecological determinants of health.

Built environments are key factors in determining health. We know that our health depends on the choices that we make – how active we are, what we eat, whether we smoke or drink heavily, use illegal drugs or misuse prescription drugs. What we sometimes forget (and what is so important to remember) is that our choices are all made in the context of the environments we live in. Furthermore, that these environments are affected by local, provincial and national policies and decisions.

There is promising evidence from New York, as presented by Karen Lee from New York City Department of Health and Mental Hygiene. New York is seeing success in stopping the trend of rising obesity – and has documented a small drop in rate of childhood obesity. Success is partly attributed to the efforts over the past 10 years to alter the built environment. For example:

- Improving the food environment through programs like: green carts – which provide new vendor permits only to those sellers offering fresh fruits and veggies; meal and vending standards for all city schools, agencies, and hospitals; health bucks for purchasing veggies and fruits; and the public posting of menu calorie counts by restaurants.

- Making public spaces more amenable to physical activity or active transportation – creating active design guidelines for developers; implementing an urban cycling program to increase the number of bike lane miles across the city; and integrating physical activity into school policy.

For more information on the New York approach, see:
www.nyc.gov/html/om/pdf/2012/otf_report.pdf

The ecological determinants of health cannot be ignored. Trevor Hancock, founder of the Healthy Cities movement, shared a presentation on how declining ecosystem health is the primary threat to health in the 21st century. Factors like climate change, ozone depletion, decreasing biodiversity, deforestation, and wetland loss affect health.

During his presentation he talked about the damage that using resources in an unsustainable way can do to the planet and to humans. An underlying premise was that the planet will survive, but that a lot of humans and other species are going be harmed and that the suffering is not going to be equitably distributed. This unequal distribution of harm is

something that should resonate deeply with us, as public health practitioners concerned with the health and well-being of the most vulnerable populations and the social determinants of health.

He identifies five roles for public health. Perhaps the most relevant to us at this time is to "be part of the solution". It is time to operationalize our value of environmental stewardship, with concrete ideas and actions making their way into our plans over the next four years.

The Conference solidifies the importance of ongoing learning opportunities for staff development: knowledge exchange, sharing innovative ideas, networking and relationship building, and getting re-energized for public health practice. Access the conference documents at:
http://resources.cpha.ca/CPHA/Conf/Code/PresentationsAll.php?y=2012&l=E

Chief Executive Officer Report

Submitted by Mark Perrault, Chief Executive Officer

Kenora Office Move

Today, Thursday, July 26, 2012, is the last day that I will work out of our office at 21 Wolsley Street, which has been my place of work for the past 19 years and has been the Northwestern Health Unit's administrative headquarters for the past 25 years. Like the childhood home that you grow up in, you have regrets when it finally leaves the family because of the great life moments that happened there.

For me, 21 Wolsley Street will hold special memories of staff that I have worked with over the years, who mentored me, guided me, and shared many laughs with me. As we leave, we do owe many thanks to the staff and management of the Lake of the Woods District Hospital who have been great landlords and, more importantly, valued colleagues and friends.

Moving a 10,000 square foot office that hosts your central filing system, resource centre, vaccine depot and your IT infrastructure is a monumental undertaking; especially since work must go on. Yet as I write this, things are remarkably calm and organized. The credit goes to our incredible move team who seem to have thought of everything and who have consistently kept staff apprised over the past months. The members of the move team, led by Melanie Buffet-Gauthier, Senior Human Resource Officer, are: Valdine McEwan, Val Grafham, Marilyn Herbacz, Stephanie Sirman, Lori Lunny, Pam Baxter, Paige Baxter, Lee Pitt, Neil Bird, Matt Weare, Dorothy Strain, Shannon Robinson, Cindy Crandall, and Gillian Lunny. They will be working non-stop over the next week in order to have our new office up and running on August 7. I just cannot put the right words together to thank them enough.

Ministry of Health and Long-Term Care Strategic Planning

On Monday, July 23, Dr. Arthurs and I attended a public health strategic planning session in Toronto at the invitation of the Chief Medical Officer of Health. It was attended by most public health units' medical officers of health and chief executive officers. This was timely, as we are in the final stages of our strategic planning cycle. From everything I heard on Monday, we are in alignment with the emerging provincial strategy.

Funding Update

The Ministry of Health and Long-Term Care's announcement of a 2% increase over 2011 funding for our 2012 cost shared budget and unorganized territories funding grant was not unexpected. Although we requested a 3% increase, we cannot be disappointed in light of the province's fiscal situation. We were unsuccessful in obtaining one-time funding for our office renovations and website project, but fortunately we did set aside funds in our capital reserves for the office projects.

There have been additional unanticipated costs for the new Kenora office due to changes in the initial scope (six additional offices, cabinetry, change room, upgraded flooring, generator and electrical work); however, we will be able to absorb these costs within our existing budget from unfilled position vacancies and by being conservative in our other budget lines. By the end of the year, I expect that we will not have to utilize all of the funds set aside in our capital reserves for the office projects.

Finance Report

Submitted by Lois Bailey, Chief Financial Officer

Total revenues for the five months ending May 31, 2012, are $6,263,737 (including a carry-over of funding from 2011) and total expenditures $6,314,989 resulting in an excess of expenditures over revenues (or a deficit) of $51,252. The cost shared programs not including Healthy Babies, Healthy Children are reporting a deficit of $49,590; whereas the 100% funded and other programs are running a shortfall of $1,665.

The Ministry of Health and Long-Term Care released the 2012 budget on July 17, 2012, and announced that health units received an increase of up to 2% for mandatory and related programs, or less, depending on their budget submission. The Northwestern Health Unit requested a budget increase of 3% for both mandatory programs and for the unorganized territories grant. The one percent difference amounts to a shortfall of $74,370 that can be offset by the postponement in hiring the communications advisor. The Ministry applied a 2% increase to some funded positions and programs including the Infection Prevention and Control Nurse position and the Public Health Nurses Initiative positions. As expected, many programs received the same funding as in 2011. A small increase to the needle exchange program will help offset the growing demand for supplies. In 2011, the Small Drinking Water System (SDWS) program received both base funding of $172,550 and one-time funding of $146.200. Health units were advised that the program would be cost-shared in 2012 and the one-time funding would be eliminated. Based on the actual number of SDWSs in our catchment area, our health unit received an increase of $42,350 to the base resulting in total funding from the Ministry of $214,900.

The Ministry approved the request to continue funding vaccine distribution out of Meno-Ya-Win Health Centre ($75,000) and also approved the purchase of two new vaccine fridges for $14,000. Funding for phase II of Panorama in the amount of $54,238 for the year was also provided. At this time the Ministry did not approve any capital requests for leasehold improvements, but have been known to approve projects later in the year pending available funds. Hopefully funding will be approved at a later date for City View, Sioux Narrows and the new website. Although the 2012 budget contained a provision for leasehold improvements for a new office in Ignace, that project has been delayed.

The 2012 program budgets and financial statements have been adjusted to reflect the announcement and a worksheet is included to show the changes from the Board of Health 2012 approved budget to agree to the budget column presented in the enclosed financial statements. Funding has been accrued to record amounts due from the Ministry between January and May. The Ministry advised that funding increases will be flowed upon receipt of the Accountability Agreement.

Submitted by Dr. James Arthurs, Medical Officer of Health, and Mark Perrault, Chief Executive Officer

5.1 Medical Officer of Health (MOH) Report – *Provided by Dr. Arthurs*

Dr. Arthurs reported that he is providing vacation coverage for Dr. David Williams, MOH, Thunder Bay District Health Unit during August 15-27, 2012.

Dr. Arthurs introduced Donna Stanley, Manager, Infectious Disease; Jennifer McKibbon, Manager, Enforcement; and Shannon Robinson, Health Promotion Coordinator, who were in attendance to address questions arising from their reports submitted to the Senior Management Report.

Discussion, Questions

Health Promotion Coordinator Report, Page 7: Shannon Robinson commented that experience and evidence gleaned from New York City's initiatives to address the rise in childhood obesity can be translated to northwestern Ontario. Considerations include creating 'built environments' conducive to physical activity and developing public policy such as limiting the size of soft drinks sold in a community.

Air Quality Report: A report of the Health Unit's recent survey of indoor air quality of municipal arenas was distributed. Jennifer McKibbon reported that this is the first year that the testing has been conducted on an extensive basis, with equipment borrowed from Public Health Ontario. All communities within the catchment area that maintain arenas were contacted for the opportunity for testing. Seven communities were able to provide access within the testing period. Each municipality tested will receive a report for their facility. It was noted that councils have the option or means to obtain testing via alternate processes. Some facilities have their own monitoring equipment.

Influenza Immunizations: Donna Stanley informed that the Health Unit immunized 17% of the catchment population during the 2011-2012 influenza immunization season. This is a relatively high immunization rate for Ontario health units. The majority of immunizations are given by other community health care providers, who are not required to report numbers of immunizations administered. It is impossible to measure success of the immunization campaign by numbers of immunizations provided, because the total number of vaccinations provided cannot be determined. Total number of immunizations provided by the Health Unit during the 2011-2012 season increased by a small amount over the previous season; however, it is impossible to determine if this reflects an overall increase to total vaccinations.

Preparations for the 2012-13 influenza immunization season including identified target populations and information campaigns to publicize the Health Unit's immunization clinic schedules were described.

Motion / Resolution: 71-2012	
THAT the Report of the Medical Officer of Health be accepted as presented.	J. Belluz P. Ryan

5.2 Chief Executive Officer Report

Additional Verbal Report– *Provided by Mark Perrault, CEO*

Kenora Office Move:
Staff have moved from Wolsley office and the new City View office was operational on August 7, 2012. Appreciation was extended to move personnel and to staff for their efforts. The Ministry of Health and Long-Term Care did not approve the Health Unit's request for one-time funding for the move costs; however, they may review the request at a later date. The Board of Health allocated Reserve funds for the costs. The funds have not yet been reported as funding.

New Web site: The project is underway. Some costs may be deferred to the 2013 budget.

Finance Report: The Ministry of Health and Long-Term Care announced a 2% funding increase over 2011 for 2012. The report page for cost shared programs has been adjusted accordingly for revenue. To May 31 reporting date, increased Ministry funding for 2012 was not flowed.

The Ministry provided an additional $40,000 (full funding) for the Small Drinking Water Systems (SDWS) program for air charter expenses for inspections for remote facilities. Appreciation was extended to Jennifer McKibbon, Manager, Enforcement, for her work to inform Ministry officials of the unique costs in this area associated with inspections of remote facilities legislated by SDWS program regulations.

Motion / Resolution: 72-2012	
THAT the Report of the Chief Executive Officer be accepted as presented.	R. Fortier D. Brown

Meeting Break: 10:30 a.m.
The recess included a short walk guided by Dryden office staff Lindsay Desaulniers, Health Promoter, and Lenore Plett, Program Assistant. .
John Albanese called the meeting to order at 11:00 a.m.

6. STRATEGIC PLANNING 2012

Alex Berry, CQI Coordinator, outlined the timeline and process for completion of the draft 2013-2016 strategic plan. The final document will be submitted for approval to the Board of Health's October meeting. The plan will be distributed to community and government agencies/bodies. Feedback from community and individuals (clients) will be actively pursued.

Appreciation was extended to Alex Berry and Russ Fortier, Board of Health representative to the Strategic Planning Working Group, for their work to facilitate the strategic planning process.

7. NORTHWESTERN HEALTH UNIT POLICIES

7.1 New Policy

Mark Perrault introduced new Policy, Healthy Meetings and Events. The Health Unit intends to promote the policy with community partners and other interested bodies.

Motion / Resolution: 73-2012	
THAT new Northwestern Health Unit Policy: Healthy Meetings and Events be approved, effective immediately.	B. Thompson D. Squires

8. IN CAMERA SESSION

At 11:40 a.m. Board of Health members moved to an in camera session.
Russ Fortier, Dr. Arthurs, Mark Perrault, and Alex Berry left the meeting.

Motion / Resolution: 74-2012	
THAT the Board of Health moves to an in camera session to discuss: *personal matters concerning an identifiable individual, including municipal or Board employees.*	R. Fortier D. Brown

At 11:50 a.m. Board of Health members moved out of the in camera session to resume regular business.
Russ Fortier, Dr. Arthurs, Mark Perrault, and Alex Berry rejoined the meeting.

Motion / Resolution: 75-2012	
THAT the Board of Health moves out of the in camera session to resume regular business.	J. Belluz M. Fisher

9. NON AGENDA ITEMS

(*Accepted following completion of Agenda #8)*
Northern Evacuations: Dr. Arthurs and Donna Stanley, Manager, Infectious Disease (and Emergency Planning) participate in regular regional teleconferences with provincial Emergency Management officials regarding evacuations for northern communities threatened by fires.

Association of Local Public Health Agencies (alPHa) Board of Directors: Russ Fortier, North West Region representative, outlined the alPHa Board of Directors 2012-2013 meeting schedule. Discussion took place regarding a Health Unit presentation to alPHa's fall conference. Management will follow up with Mr. Fortier.

10. NEXT MEETING DATES

September Board of Health meetings
Annual Education Session (*Closed to the public)*
Wednesday-Thursday, September 12-13 Location: Sioux Lookout

Regular Monthly Meeting:
Date: Friday, September 14 Time: 8:30 a.m.
Location: Forest Inn, Sioux Lookout

Executive Committee meeting
Date: Friday, August 24 Time: 11:00 a.m.
Location: Kenora City View Board Room

11. ADJOURNMENT

Dave Canfield adjourned the meeting at 12:00 p.m.

BOARD OF HEALTH FOR THE NORTHWESTERN HEALTH UNIT:

CONFIRMED AS WRITTEN

THIS ..... DAY OF 2012

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CHAIR, BOARD OF HEALTH

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RECORDING SECRETARY