Public Health Report Card
2013

Accountability
Excellence
Integrity
Wellness
Health
Balanced
Community
Priority Populations
Engagement
Innovation
Service
Professionalism
Healthy Lifestyles
Equity
Compassion
Valued
Standards
Communication
Longer Lives
Transparency
Partnership
Environmental Stewardship
Lived Well
Respect

Northwestern Health Unit
www.nwhu.on.ca

Table of Contents

Message from the Medical Officer of Health 4

Message from the Chair of the Board of Health 6

Message from the Chief Executive Officer 8

Food Safety 10

Infectious Diseases Prevention and Control 11

Sexual Health and Harm Reduction Programs 12

Safe Water – Pools and Spas 14

Safe Water – Small Drinking Water Systems 15

Vaccine-Preventable Diseases – Vaccine Wastage 16

Vaccine-Preventable Diseases – School-Based Immunizations 17

Family Health and Speech, Hearing and Vision 18

Chronic Disease Prevention 20

Injury Prevention - Safer Rides for Kids 21

Chronic Disease Prevention – Tobacco Use Prevention 22

Chronic Disease Prevention – Tobacco Vendor Compliance and Youth Access Legislation 23

Dental Health 24

A New Strategic Plan and a New Office 26

Message from the Medical Officer of Health

IN 2012, THE NORTHWESTERN HEALTH UNIT DEVELOPED OUR NEXT STRATEGIC PLAN. THIS TOOK US ON A JOURNEY OF REFLECTING ON ACCOMPLISHMENTS AND CURRENT CHALLENGES. WE THEN LOOKED FORWARD TO WHAT WE WANT TO ACHIEVE AS AN AGENCY OVER THE NEXT FEW YEARS.

The Board of Health led our strategic planning process. From the beginning, the Board of Health was committed to hearing from health unit staff. This was done through a series of focus groups in several communities, so that the staff in all 14 of our offices had a chance to provide direct input into the next strategic plan. The Board also decided to continue to use the balanced scorecard as our organizing framework for the plan.

Our process resulted in the 2013-16 Strategic Plan. The Plan has nine goals and 16 related measurable objectives. While the plan recognizes the important work that all health unit programs do, and will continue to do as we move forward, it focuses on changes we want to see take place in the health of our communities and our agency.

One of the things highlighted during our strategic planning process was the importance of preventing chronic disease. Illnesses like heart disease, cancer, diabetes, and respiratory diseases seriously affect the health of people in northwestern Ontario. Rates of chronic disease are growing, meaning they will have a larger impact on our health in the future unless we do something about them now. They also contribute significantly to current and future health care costs. For this reason, our next strategic plan provides a focus for all health unit staff and programs: a call to action to increase behaviours that prevent chronic disease, specifically healthy eating and physical activity.

One of the challenges with addressing chronic disease is that there are no easy solutions. As a society, we have not yet found the answers. Traditional approaches that focus on individual behavior change have not succeeded. What we do know is that success in the future will mean doing things differently. This will include working in partnership with others, and doing more work to improve the environment to make individual behavior change easier.

The health unit has already started moving in this direction. An early example of new ideas, new integration and new partnerships has been the use of our mobile dental office in 2012 to provide dental care and health promotion to First Nations communities that had little or no access to dental care. This is a cross-jurisdictional program including direction from First Nations in collaboration with Health Canada, Ontario's public health sector and the Northwestern Health Unit.

As we move forward with our new strategic plan, we will continue to explore new ways of doing things and new partners to work with, both internally and externally. We know that not all of our new ideas will work and that measuring success is sometimes hard. It is often most difficult for chronic disease prevention. There are no quick fixes and success will take time.

I am confident our skilled and dedicated staff are up to the challenge. I want to thank all of our staff for their efforts and input in the 2013-16 Strategic Plan, as well as our Board of Health who provide strong support for all that we do in working to improve the quality and length of life in our communities.

James Arthurs,
MD, MMM, MOH

Life Expectancy

Life expectancy in years, at birth and at age 65, by sex, three-year average, 2007/09	NWHU	Ontario
Life expectancy at birth, All: 2007/09	77.4	81.5
Life expectancy at birth, Males: 2007/09	75.8	79.2
Life expectancy at birth, Females: 2007/09	79.1	83.6
Life expectancy at age 65, All: 2007/09	18.9	20.3
Life expectancy at age 65, Males: 2007/09	17.7	18.7
Life expectancy at age 65, Females: 2007/09	20.1	21.7

Source: Statistics Canada. 2013. Health Profile. Statistics Canada Catalogue No. 82-228-XWE. Ottawa. Released January 29, 2013. http://www12.statcan.gc.ca/health-sante/82-228/index.cfm?Lang=E

Leading Causes of Death

Leading causes of death, Rates per 100,000, three-year average, 2005/2007	NWHU	Ontario
All causes	699.0	521.8
All cancers	195.5	159.1
Colorectal cancer	15.4	17.0
Lung cancer	53.9	40.3
Breast cancer	10.3	12.0
Prostrate cancer	9.2	8.0
All circulatory diseases	182.7	155.6
Ischematic heart disease	96.3	86.9
Cerebrovascular diseases	38.7	30.7
All other circulatory diseases	47.7	38.0
All respiratory diseases	50.7	41.3
Unintentional injuries	51.2	23.4
Suicides and self-inflicted injuries	26.6	7.7

Source: Statistics Canada. 2013. Health Profile. Statistics Canada Catalogue No. 82-228-XWE. Ottawa. Released January 29, 2013. http://www12.statcan.gc.ca/health-sante/82-228/index.cfm?Lang=E

Well-being

Perceived overall health and mental health, population 12 years and older, 2009/2010	NWHU	Ontario
Percent who reported their overall health as very good or excellent, All	56.1	61.0
Percent who reported their overall health as very good or excellent, Male	53.9	61.4
Percent who reported their overall health as very good or excellent, Female	58.2	60.6
Percent who reported their mental health as very good or excellent, All	69.2	74.3
Percent who reported their mental health as very good or excellent, Male	70.2	75.3
Percent who reported their mental health as very good or excellent, Female	68.2	73.3

Source: Statistics Canada. 2013. Health Profile. Statistics Canada Catalogue No. 82-228-XWE. Ottawa. Released January 29, 2013. http://www12.statcan.gc.ca/health-sante/82-228/index.cfm?Lang=E

Message from the Chair of the Board of Health

ON BEHALF OF THE BOARD OF HEALTH, I AM PLEASED TO PROVIDE YOU WITH A REPORT ON THE EFFORTS OF THE NORTHWESTERN HEALTH UNIT (NWHU) IN 2012 TO IMPROVE THE QUALITY AND LENGTH OF LIFE OF THOSE WHO LIVE HERE IN NORTHWESTERN ONTARIO.

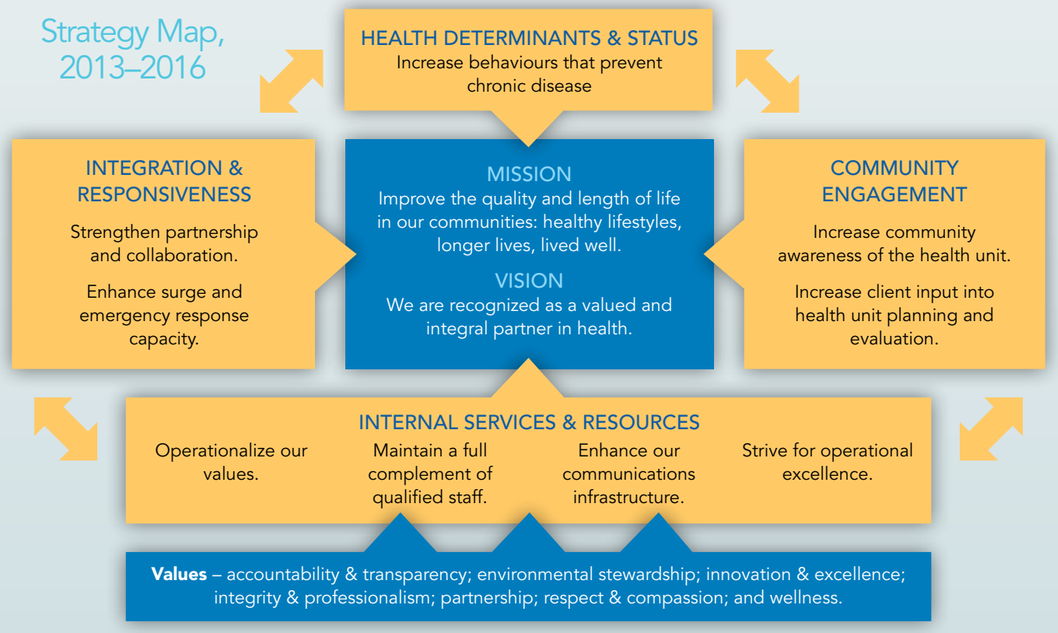
This public health report card gives you a glimpse of the wide range of services provided by the health unit. It also shows how we are measuring our progress in meeting the needs of our communities and the expectations of our two major funders: local municipalities and the Ministry of Health and Long-Term Care (MOHLTC).

The Board of Health leads the health unit. The Board is 11 dedicated people from across northwestern Ontario who each contributes their wide-ranging experience and expertise to the work of the Board.

Each person is appointed by one or more of our local municipalities or by the MOHLTC. The job of the Board of Health is to ensure the effective and efficient delivery of public health programs and services to the people of northwestern Ontario. They do this by providing direction and governance to health unit through the strategic plan and regular oversight of agency activities.

In 2012, the Board of Health developed and approved a new strategic plan for the Northwestern Health Unit. The 2013-16 Strategic Plan outlines goals and objectives to be achieved by health unit staff in support of our vision and mission statements. Like this report, the strategic plan does not capture everything that the health unit does. It only includes those areas where we want to focus our energy on change and improvement.

Strategy Map, 2013–2016



You can see from the Strategy Map (previous page) that there are several goal areas to be addressed, including a new common area of focus for all health unit staff – increasing behaviours that prevent chronic disease. A full version of the strategic plan is available on the health unit website at www.nwhu.on.ca.

The Board of Health contributed to the success of the Northwestern Health Unit in several other ways in 2012. It continued its long history of building strong and supportive relationships with our partners at the Association of Local Public Health Agencies (alPHa), Public Health Ontario (PHO) and the Ministry of Health and Long-Term Care.

Board of Health member Russ Fortier served as a Board member for alPHa. Board members and staff from the health unit participated in several meetings with alPHa, PHO and the MOHLTC, sharing our northern expertise and viewpoint. These strong relationships help build a stronger provincial public health system. I have no doubt they also contributed to our success in securing one-time grant funding from the MOHLTC for several projects in 2012.

As Chair of the Board of Health, I want to say thank you to each of our Board members for their contributions during this past year. We also need to say goodbye to two members who left the Board in 2012: Mel Fisher (Dryden and Machin) and Margaret Harland (Red Lake and Ear Falls). Margaret and Mel both served on the Board of Health for many years. Their insight and work at the board table made us a more effective governance body. We also welcomed a new member to the Board of Health at the end of 2012, Shayne MacKinnon. We look forward to working with our new member from Dryden and Machin in 2013.

Finally, thank you to the staff of the Northwestern Health Unit. As a Board of Health, we are proud of our staff and we know that their dedication and hard work helps us to improve the quality and length of life for the people of northwestern Ontario.

John Albanese,
Chair, Board of Health

2012 Board of Health members

John Albanese (Chair) (Public Appointee)

Julie Roy (Vice-Chair) (Public Appointee)

Coucillor Jim Belluz, La Vallee (Alberton, Chapple, Dawson, Emo, La Vallee, Lake of the Woods, Morley & Rainy River)

Mayor Dennis Brown, Atikokan (Atikokan)

Mayor Dave Canfield, Kenora (Kenora)

Councillor Mel Fisher, Dryden (Dryden & Machin) Jan - Nov 2012

Councillor Shayne MacKinnon, Dryden (Dryden & Machin) Dec 2012 - present

Photo Not Available

Russ Fortier (Public Appointee)

Margaret Harland (Red Lake & Ear Falls)

Councillor Paul Ryan, Fort Frances (Fort Frances)

Councillor Doug Squires, Sioux Lookout (Ignace, Pickle Lake & Sioux Lookout)

Mayor Bill Thompson, Sioux Narrows-Nestor Falls (Kenora & Sioux Narrows-Nestor Falls)

Message from the Chief Executive Officer

THE DEVELOPMENT OF THE 2013-2016 STRATEGIC PLAN WAS THE MOST SIGNIFICANT EVENT OF 2012 AND IT WILL BE THE GUIDING DOCUMENT FOR THE ORGANIZATION GOING FORWARD. Changes are required to the way we do work and how we measure what we do. Unlike previous strategic plans, staff and program managers were fully engaged in its development. Their participation in the process will expedite the adoption of the changes needed to see and measure our success in achieving results.

The second major event of 2012 was the development of the Kenora City View office. This was the largest office development undertaking in my 19 years with the health unit. Due to an excellent logistics plan and a team of dedicated staff, the move created relatively few minor service disruptions. As a result, we now have a centrally-located, accessible office with a modern meeting / training room able to accommodate up to nearly 100 people.

The City View office was not the only building project in 2012. Last summer, we moved our Sioux Narrows-Nestor Falls office to the former tourist information centre in Sioux Narrows. Our new office is far more visible and now provides meeting space for local community groups.

In addition, this year we installed a new internet telephone system (Voice Over IP) in all of our offices. This has nearly eliminated long distance charges and has opened up an array of options for communicating and sharing service delivery across our decentralized offices. One example is the ability to have a dedicated flu line number ring in seven different offices to ensure a live answer.

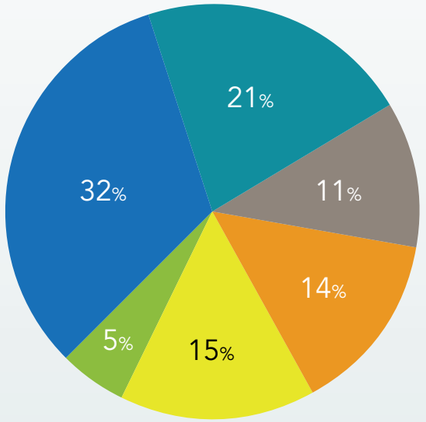
A job analysis of the non-union, non-management staff was also undertaken this year. Our administrative support services have undergone rapid change over the past number of years. This has included new initiatives, such as our CQI program and communications strategy, and changes in technology. The latter include SharePoint, HRWare software, Internet telephone, Helpdesk and – soon – a new website. Other projects included increasing requirements for occupational health and safety, including a Work Well Audit, and the implementation of the new Ontario Public Health Organizational Standards.

In our strive for operational excellence, we continually look to streamline and integrate services. In an era with limited funding and increasing need, difficult decisions have been made to lower administrative costs by finding efficiencies wherever we could. As a result, the health unit ended 2012 in a small surplus financial position. This has allowed us to rebate back to the municipalities just over $128,000.

We will continue to work together to provide effective and efficient corporate services that support program delivery as we implement the 2013-2016 Strategic Plan. Thank you to the staff and Board of Health members who have contributed to our achievements, and who remain the key to our success as we move forward.

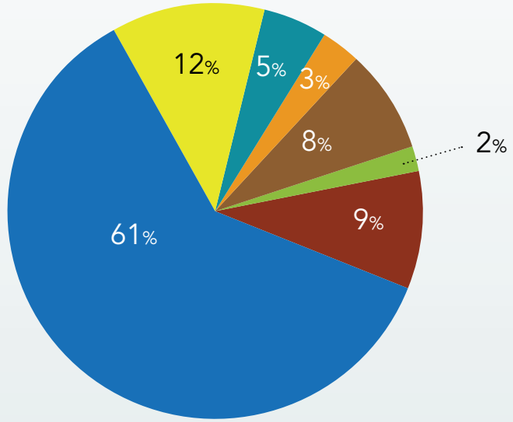
Mark Perrault,
Chief Executive Officer

Sources of funding



- Ministry of Health and Long-Term Care
- MOHLTC Health Promotion Division
- MOHLTC Unorganized Territories Grant
- Ministry of Children and Youth Services
- Municipal Levies
- Other Revenue & User Fees*

Expenses



- Mandatory Cost-Shared Programs
- Unorganized Territories
- Healthy Babies, Healthy Children
- Healthy Smiles Ontario*
- Speech, Hearing & Vision Programs*
- Smoke Free Ontario Programs*
- Other Programs*

Sources of Funding 2012	Total	%
Ministry of Health and Long-Term Care	$ 5,015,390	32%
MOHLTC Health Promotion Division	$ 3,313,310	21%
MOHLTC Unorganized Territories Grant	$ 1,756,327	11%
Ministry of Children and Youth Services	$ 2,182,328	14%
Municipal Levies	$ 2,333,850	15%
Other Revenue & User Fees*	$ 838,485	5%
Total Revenues	**$ 15,439,690**	

**Consolidated revenues and expenses are net of allocated administration fees*

Expenses 2012	Total	%
Mandatory Cost-Shared and Other Related Programs	$ 9,215,436	61%
Unorganized Territories	$ 1,756,327	12%
Healthy Babies, Healthy Children	$ 808,805	5%
Healthy Smiles Ontario*	$ 435,474	3%
Speech, Hearing & Vision Programs*	$ 1,165,345	8%
Smoke Free Ontario Programs*	$ 279,814	2%
Other Programs*	$ 1,403,975	9%
Total Expenses	**$ 15,065,176**	

To access a copy of the full audited financial statement please visit our website at www.nwhu.on.ca

Food Safety

PUBLIC HEALTH INSPECTORS CHECK HIGH-RISK FOOD PREMISES ONCE EVERY FOUR MONTHS WHILE IN OPERATION. THIS IS PART OF OUR WORK TO PREVENT OR REDUCE THE BURDEN OF FOOD-BORNE ILLNESS.

High-risk food premises are those that:
- Prepare hazardous foods such as meat, poultry, fish, or dairy products (essentially, any food capable of supporting the growth of bacteria);
- Serve a high-risk population based on age or medical condition (such as the elderly or children); and/or,
- Handle foods with many preparation steps and foods frequently implicated as causing food poisoning.

Examples of these high-risk premises include nursing homes, hospitals and day cares. In 2012, there were about 600 food premises in the Northwestern Health Unit area. This total includes 38 year-round and six seasonal high-risk food premises.

There are challenges to inspecting all high-risk food premises once every four months:
- The high-risk food premises that are seasonal camps and restaurants are only open and available for inspection for a limited time, most often in the summer when public health inspectors are also busy with other seasonal services (like beach and pool inspections, and small drinking water system inspections).
- The large geographic area covered by the health unit and dispersed nature of our population mean health unit staff must travel large distances to provide service. This may include flying to remote areas where there is no year-round road access.

Despite these challenges, in 2012, 100% of the high-risk food premises were inspected once every four months while in operation. This exceeds the ministry target of 85%.

The 2012 results reflect work in:
- Improved data quality;
- Enhanced time management practices by public health inspectors; and,
- Prioritization of food premises inspections in the overall work of the enforcement team.

Through continued use of efficient business practices, the health unit will again achieve the 2013 ministry target of inspecting 100% of high-risk food premises once every four months while in operation.

Performance Indicator	2011 results	2012 target	2012 results	2013 target
Percentage of high-risk food premises inspected once every four months while in operation	45.0%	>= 85%	100%	100%

Infectious Diseases Prevention and Control

PUBLIC HEALTH NURSES RESPOND TO REPORTS OF CONFIRMED INVASIVE GROUP A STREPTOCOCCAL DISEASE (IGAS) CASES THE SAME BUSINESS DAY.
This ensures those with invasive group A streptococcal disease receive treatment quickly. Rapid treatment helps reduce secondary transmission to close contacts and involved health care providers.

The health unit receives a report from the Ontario Public Health Lab of all positive invasive group A streptococcal disease tests for people living in our catchment area. Follow-up begins the same business day and includes:
- Working with the person to prevent the spread of infection to others in their home, or when they receive medical care;
- Identifying individuals who may have had significant contact with the person, and referring them for appropriate treatment or education; and,
- Evaluating contributing factors to the risk (for example, how did the bacteria get into the person's blood) and determining what can be done to prevent the same thing happening to others.

One of the challenges to quick follow-up in northwestern Ontario is the fact that those diagnosed with invasive group A streptococcal disease are often transferred out of the area for treatment. Once they have left the local area, it can be difficult to locate them and begin the investigation.

Where notification is received after regular business hours, the staff person on-call begins follow-up immediately. The local public health nurse then completes this process on the next business day.

In 2012, the health unit began follow-up of all 25 cases (100%) of reported cases of group A streptococcal disease within 24 hours of notification. The 2013 target for follow-up within 24 hours of notification of a confirmed case of invasive group A streptococcal disease is 100%.

To maintain this level of compliance, the health unit has improved its data collection to pinpoint the start of follow-up work by on-call staff. We will also continue to maintain and strengthen our connections with health care providers in Thunder Bay and Winnipeg. This will result in better follow-up with patients transferred out of our catchment area.

Performance Indicator	2011 results	2012 target	2012 results	2013 target
Percentage of confirmed invasive group A streptococcal disease (iGAS) cases where initiation of follow-up occurred on the same day as receipt of lab confirmation of a positive case	N/A	100%	100%	100%

Sexual Health and Harm Reduction Programs

PUBLIC HEALTH NURSES RESPOND TO REPORTS OF GONORRHEA CASES WITHIN TWO BUSINESS DAYS. THIS ENSURES INDIVIDUALS WITH GONORRHEA AND THEIR SEXUAL CONTACTS RECEIVE PROMPT FOLLOW UP, REDUCING THE BURDEN, TRANSMISSION AND INCIDENCE RATES OF GONORRHEA IN THE COMMUNITY.

The health unit receives a report from testing laboratories of all positive gonorrhea tests for people living in our catchment area. When this happens, a local public health nurse makes sure the person who tested positive receives counseling and education, and checks that the person gets the medical treatment they need. The public health nurse also works with the client to make sure all of their sexual contacts are tested and treated as necessary.

In 2012, the health unit was able to respond to all but one (98.6%) of these reports within two business days.

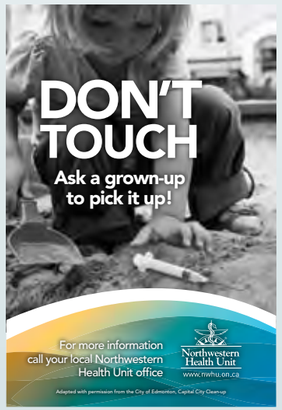
Our near-perfect compliance with the ministry indicator stems from our internal business practices and the strong working relationships we have with our community partners, including local and First Nations health care providers. The 2013 target of responding to 100% of gonorrhea case reports within two business days will be met as we continue to improve business practices and data quality.

To support the goal of reducing the impact of sexually transmitted infections, the health unit also provides prevention education and materials, such as free condoms. In 2012, staff built on the 2011 ***Positive? Me?*** campaign to educate youth aged 15 to 24 years about the importance of being tested for sexually-transmitted infections (STIs). This included social marketing, a media release, promotional items, and website information. During the campaign, health unit Facebook ads received 884 clicks.

Our harm reduction program provides services to reduce the spread of infections among and beyond people using drugs.

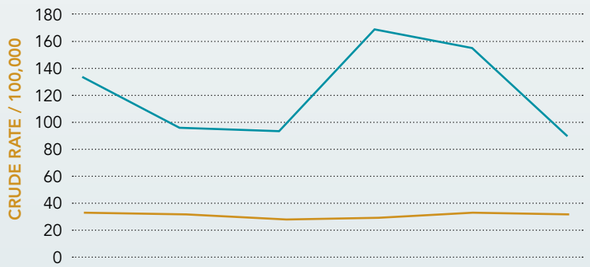
We provide a needle exchange program and educate all clients about the safe disposal of used syringes. The health unit works with community partners to put sharps containers in places such as public washrooms. These containers help prevent needles from being discarded in the community.

The health unit also provides information, support and equipment to anyone who finds used needles in the community. Safe disposal kits are available to anyone who finds needles or the public can call the health unit to retrieve the discarded needles. In 2012, the harm reduction program also developed and distributed posters as part of Earth Day. These posters provided messages for the public about safe handling and disposal of needles, and advised parents and adults about the danger needles might pose to child safety.



Performance Indicator	2011 results	2012 target	2012 results	2013 target
Percentage of confirmed gonorrhea cases where initiation of follow-up occurred within two business days	95.5%	100%	98.6%	100%

GONORRHEA RATES / 100,000
NWHU AND ONTARIO 2007-2012



	2007	2008	2009	2010	2011	2012
NWHU	136.6	97.1	98.4	160.7	153.8	87.9
ONTARIO	31.0	29.9	27.1	30.0	31.4	30.2

Source: Integrated Public Health Information System (iPHIS), extracted June 22, 2012; 2012 data extracted February 21, 2013

Services provided in 2012 through five sexual health clinics – Kenora, Red Lake, Sioux Lookout, Dryden, and Fort Frances – and nine harm reduction sites:

- Public health nurses provided 26 presentations in schools to promote healthy sexuality and to support school curriculum.
- 93,740 condoms were given out through:
  - Community partners (11,866 condoms)
  - Public high schools (6,039 condoms)
  - Sexual health clinics (6,2821 condoms)
  - Needle exchange programs (13,014 condoms).
- 2,036 clients attended 5,403 appointments at our sexual health clinics.
- Hormonal contraception was dispensed 1,265 times.
- 1,622 tests were completed:
  - Chlamydia and Gonorrhea tests (1,025)
  - Pap tests (378)
  - HIV tests (219).
- The harm reduction program:
  - Gave out 201,768 needles;
  - Responded to 22 calls regarding discarded needles;
  - Collected 720 needles from the community; and,
  - Provided 29 safe disposal kits to community partners and the public.

Safe Water – Pools and Spas

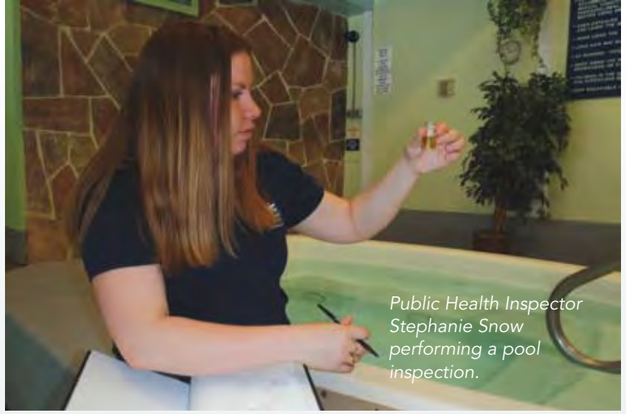
PUBLIC HEALTH INSPECTORS CHECK POOLS AND SPAS ONCE EVERY THREE MONTHS AS PART OF OUR WORK TO REDUCE THE BURDEN OF WATER-BORNE ILLNESS AND INJURY RELATED TO RECREATIONAL WATER USE.

The health unit inspects regulated public pools and spas:

- Prior to opening or reopening after construction, alteration, or closure of more than four weeks;
- At least two times per year, and no less than once every three months while operating; and,
- As necessary to address non-compliance observed during previous inspection(s), to investigate complaints and/or reports of illness or injury and/or to monitor the safety of the facilities.

At this time, the ministry is monitoring performance only for Class A pools. Class A pools and spas include:

- Pools to which the general public is admitted;
- Pools operated in conjunction with (or as a part of) the program of a Young Men's Christian Association or similar institution, or an educational, instructional, physical fitness, or athletic institution supported in whole or in part by public funds or public subscription; or,
- Pools operated on the premises of a recreational camp, for use by campers and their visitors and camp personnel.



Public Health Inspector Stephanie Snow performing a pool inspection.

There are five year-round Class A pools in northwestern Ontario, requiring 20 inspections per year. There are no seasonal Class A pools. In 2012, the health unit completed 100% of the required Class A pools inspections.

The 2012 results reflect work in:

- Improved data quality with previous errors corrected and consistent record-keeping;
- Enhanced time management practices by public health inspectors; and,
- Making pool inspections one of the priorities for enforcement team work.

The 2013 target of inspecting 100% of Class A pools and spas every three months while in operation will be met through continued use of efficient business practices.

Performance Indicator	2011 results	2012 target	2012 results	2013 target
Percentage of Class A pools inspected once every three months and at least twice a year while in operation	0%	>= 75%	100%	100%

Safe Water – Small Drinking Water Systems

PUBLIC HEALTH INSPECTORS CHECK HIGH-RISK SMALL DRINKING WATER SYSTEMS (SDWS) AT LEAST EVERY TWO YEARS AS PART OF OUR WORK TO REDUCE THE BURDEN OF WATER-BORNE ILLNESS CARRIED BY DRINKING WATER.

Small drinking water systems include seasonal residential systems and non-residential systems serving facilities such as churches, tourist camps, motels/hotels, food service establishments, community halls, arenas, trailer parks, and campgrounds.

Systems are classed as low-, medium- or high-risk based on an assessment by a public health inspector. The inspector looks at:

- Source water (well, lake)
- Sample history (laboratory-confirmed bacteriological water results)
- Treatment/distribution (UV, chlorination)
- Operations (complexity of system, training)
- Users (access to drinking water).

All known SDWS were assessed by the end of 2012 and 917 met the provincial definition of a SDWS, with 65 of these classed as high-risk.

Many high-risk systems can improve safety by satisfying basic requirements, like better sampling history and improved treatment. As part of the inspection process, public health inspectors provide support and education to help system operators reduce risk.

To meet ministry requirements, the health unit has:

- Maintained good working relationships with water system operators across the region as we assessed the small drinking water systems. These good relationships contribute to efficient inspections and will continue as we move into the monitoring phase of the SDWS program in 2013.
- Planned that new public health inspectors will be trained as soon as possible after joining the health unit so that all members of the team are qualified to re-inspect small drinking water systems.
- Used geographic information systems (GIS) to map the small drinking water systems in the health unit catchment area allowing us to use limited staff resources efficiently across our large geographical area.
- Scheduled future re-inspections on an alternating cycle. Our target is to inspect 50% of all high-risk systems each year along with the medium- and low-risk systems once every four years.

Half of the high-risk small drinking water systems will be due for re-inspection in 2013. We will maintain our current inspection rate of 100% for high-risk SDWS due for re-inspection in order to meet the ministry target for 2013.

Performance Indicator	2011 results	2012 target	2012 results	2013 target
Percentage of high-risk Small Drinking Water Systems (SDWS) inspections completed for those that are due for re-inspection	N/A	100%	100%	100%

Vaccine-Preventable Diseases – Vaccine Wastage

THE HEALTH UNIT MONITORS HUMAN PAPILLOMA VIRUS (HPV) AND INFLUENZA VACCINE WASTAGE RATES AS A MEASURE OF THE EFFECTIVENESS OF VACCINE STORAGE, HANDLING AND MANAGEMENT PRACTICES.

The health unit acts as the central depot for all publicly-funded vaccines in our catchment area. We receive vaccine supplies from the ministry and use some of that vaccine to provide public health immunization programs, such as flu clinics, school-based immunizations, and routine immunizations for infants, children and adults, including high-risk programs. We also provide vaccine to local health care providers so they can immunize their patients directly.

Vaccine may be considered wasted for three reasons:

- It is stored outside the required temperature range and can no longer be safely used. These "cold chain breaks" can occur when vaccine is being transported, or when refrigerators used for longer-term storage become too warm or too cold.
- It is packaged in multi-dose vials and is not used in a single event (like a flu clinic) – the unused portion in each vial cannot be saved and used later.
- It cannot be used before its expiry date. For example, if the health unit receives 100 doses each year of a particular vaccine and only uses 90 doses, the unused vaccine would normally be sent back to the Ontario Government Pharmacy to be re-distributed to another health unit. However, due to high travel costs, the ministry does not take back vaccine supplies from northern health units. The ministry has decided that it is cheaper to dispose of that unused vaccine. This non-returnable vaccine is no longer included in the calculation of wasted vaccine.

The general ministry target for vaccine wastage rates is "less than five percent." For those health units whose vaccine wastage rates are already less than five percent, the ministry has set a target to maintain or improve the current values.

The Northwestern Health Unit has excellent vaccine management practices:

- To reduce cold chain incidents, we have invested in backup generators for all of our vaccine fridges and for temporary storage systems used to transport vaccine.
- Staff have been provided with education on transportation of vaccine supplies.
- We have implemented a consistent practice of refrigerator and generator maintenance.
- We have refined our inventory management to make best use of multi-dose vials in community settings.

These practices have enabled the health unit to improve our vaccine wastage rates. We surpassed the 2012 ministry targets with a 0.1% HPV wastage rate. The influenza vaccine wastage rate appears to have increased from 0.01% in 2011 to 0.7% in 2012, but this is because the ministry redefined how vaccine wastage rates were measured in 2012. These changes were made, in part, to recognize the geographic issues faced by the Northwestern Health Unit and our distance to the provincial vaccine depot. The 2012 and 2013 figures will provide a more meaningful comparison because the definitions for vaccine wastage rates will remain the same year to year.

In 2013, we plan to maintain or improve our storage and handling practices by focusing on factors within our control. We will also continue collaborating with the ministry to define vaccine wastage accurately in the health unit. We aim to create a balance between the most efficient waste-minimizing practices and use of an inventory system that is suitable for use, given our distance from the provincial depot.

Performance Indicator	2011 results	2012 target	2012 results	2013 target
Percentage of vaccine wasted by vaccine type that is stored/administered by the public health unit (HPV)	0.97%	Maintain or improve current rates	0.1%	Maintain or improve current rates

Performance Indicator	2011 results	2012 target	2012 results	2013 target
Percentage of vaccine wasted by vaccine type that is stored/administered by the public health unit (influenza)	0.1%	Maintain or improve current rates	0.7%*	Maintain or improve current rates

**Note – the ministry changed the way that wastage rates were calculated in 2012.*

Vaccine-Preventable Diseases – School-Based Immunizations

PUBLIC HEALTH NURSES PROVIDE IMMUNIZATIONS TO STUDENTS IN SCHOOL AS PART OF OUR WORK TO REDUCE OR ELIMINATE THE BURDEN OF VACCINE-PREVENTABLE DISEASES.

These school-based immunization programs include vaccination against:

- Hepatitis B for all students in grade seven;
- Meningococcal disease for all grade seven students; and,
- Human papillomavirus (HPV) for grade eight female students.

All of these immunizations are free, are provided at school and are recommended (but not mandatory).

In 2012, 72% of school-aged children received complete immunizations for meningococcal disease. Since this vaccine is given as a single dose, accurate tracking of completed meningococcal disease immunizations is achievable with the current database used by the health unit.

The hepatitis B and HPV vaccines are given in multiple doses several months apart. Limitations of the current database make it difficult to collect accurate and consistent student data over the course of the full immunization schedule. As a result, health unit data collected during the 2012 reporting period could not be used to accurately establish the percentage of school-aged children who have completed immunizations for hepatitis B and HPV. We will continue working with the ministry to establish a system that allows for accurate reporting of hepatitis B and HPV immunizations for school-aged children.

There are opportunities for the health unit to increase our immunization coverage rates. For example, health unit staff interact with many families while providing mandatory childhood immunizations. Time during these meetings could be used to promote vaccines as an effective public health practice and to discuss concerns. The health unit is well positioned to assist any provincial public awareness campaigns necessary to increase support and demand for immunization against hepatitis B, meningococcal disease and human papillomavirus.

Looking to 2013, a ministry target for the 2012/13 school year has been set at 90% for meningococcal disease. We will be able to maintain current coverage rates into 2012/13, but may be unable to meet future targets unless the provincial policy landscape changes to provide additional support to these immunization programs.

Performance Indicator	2011 results	2012 target	2012 results	2013 target
Percentage of school-aged children who have completed immunizations for hepatitis B	71.0% (2010/11)	Maintain or improve current rates	N/A	N/A

Performance Indicator	2011 results	2012 target	2012 results	2013 target
Percentage of school-aged children who have completed immunizations for meningococcal disease	76% (2010/11)	Maintain or improve current rates	81.5% (2011/12)	90%

Performance Indicator	2011 results	2012 target	2012 results	2013 target
Percentage of school-aged children (females only) who have completed immunizations for human papillomavirus (HPV)	52% (2010/11)	Maintain or improve current rates	N/A	90%

Family Health and Speech, Hearing and Vision

THE NORTHWESTERN HEALTH UNIT PROVIDES A WIDE RANGE OF SERVICES TO SUPPORT INFANT AND CHILD HEALTH AND DEVELOPMENT. As part of our work in this area, the health unit is an active partner in the Kenora District Best Start Network and the Rainy River District Best Start Network. These partnerships allow us to identify new and creative ways to provide services and support families. These options would not be possible working alone.

Best Start is a comprehensive, evidence-based early learning and care strategy designed to help give Ontario's children the best possible start in life and support lifelong health and well-being. Local Best Start Networks include agencies, service providers and stakeholders. They reflect the unique composition of each community and a broad range of community perspectives. The Best Start Networks are working to bring community services together in a comprehensive, flexible, and integrated way as recommended in the documents "With our Best Future in Mind" (2009) and "Building our Best Future – An Update" (2011).

In 2012, the health unit's Healthy Babies, Healthy Children and Preschool Speech and Language programs were key partners in planning and implementing two major activities of the Best Start Networks.

In June 2012, the Best Start Network hosted a block party in Fort Frances. Twenty community partners, along with the North Words Preschool Speech and Language Program and the Healthy Babies, Healthy Children program, provided activities that promoted the importance of play. Over 700 participants attended the event. Through the activities, parents and caregivers saw the variety of skills children develop when playing, including language, literacy, numeracy, fine motor skills, rhythm, and gross motor movements. The event also brought a broader awareness of the services available in the district and demonstrated that the service providers are working together to support children and families in our community.

In November 2012, the Best Start Network hosted an early learning symposium featuring Dr. Stuart Shanker, Research Professor of Philosophy and Psychology at York University and Director of the Milton and Ethel Harris Research Initiative at York University. Our work at the Best Start Network had shown that service providers wanted more information about supporting the development of self-regulation in children. Self-regulation is the ability to gain control of bodily functions, manage powerful emotions, and maintain focus and attention. The early learning symposium was a chance to learn from Dr. Shanker and each other about this issue.

Over 350 participants – including parents and service providers – had the chance to hear Dr. Shanker speak about the nature of self-regulation, the experiences that promote the development of self-regulation and the factors that can impede its development. We also learned more about what parents and service providers can do to enhance the self-regulation of children. Staff from the health unit's Preschool Speech and Language and Healthy Babies, Healthy Children programs played a key role in organizing the event. The information we learned will improve the services we provide to families.

The Northwestern Health Unit, as a key partner in the Best Start Networks, is committed to developing an integrated system that will provide seamless access to services and better outcomes for children and families.

Public Health Nurse Kathy Bryck enjoys a visit with mom and baby during a well-baby visit.

In 2012,
- 799 families with a live birth were referred to the Healthy Babies, Healthy Children program
- 100% of families with a live birth received postpartum contact from the health unit
- 91% of referred families were contacted within 48 hours of hospital discharge
- 1,207 family visits were conducted in the Districts of Kenora and Rainy River - 55% of those were by a parenting partner, and 45% were by public health nurses.

From April 2011 to March 2012....
- 515 children received speech and language services through North Words
- The average age of children referred to North Words was 37 months
- 687 infants received an infant hearing screen.

Chronic Disease Prevention

REMEMBER WHEN OUR STREETS WERE FULL OF KIDS PLAYING AND RIDING THEIR BIKES? THE FAMILY DINNER TABLE WAS WHERE WE SHARED OUR LIVES? THOSE DAYS ARE LONG GONE. Children and youth are spending more time in front of screens. Families are spending more time eating out or on the run. Busy lifestyles make it hard for us to plan and prepare home-cooked meals or find time to be physically active.

We've all heard it. Eat right and get active to stay healthy. We know that healthy eating and physical activity are two cornerstones to preventing chronic disease. Traditional approaches to preventing chronic disease have focused on encouraging individuals to make behavior changes. These approaches have failed.

Individual choices are influenced by the environment in which they are made. A city or town built for cars makes it hard for people to walk. Busy lifestyles and grocery stores full of pre-cooked food work against home-cooked, enjoyable family meals.

The environment must support healthy choices. To succeed in preventing chronic disease, the health unit and the community need to change the environment so that it supports individual healthy choices. This is the core of healthy public policy work – developing, implementing and monitoring organizational and community policies that create environments that support healthy individual behaviours.

The health unit models healthy public policy and works with community partners to support healthy public policy. Together, we can be more effective at trying to influence the policies of organizations and communities.

In 2012, the health unit put in place a healthy meetings and events policy. This policy supports healthy eating and physical activity by providing guidelines and suggestions for health unit meetings and events. It has also provided an opportunity for NWHU staff to promote and raise awareness in our communities about the need for similar guidelines in other places.

The health unit has also worked on the following healthy public policy areas in 2012 in the Kenora and Rainy River Districts:

- Supporting existing school policies (daily physical activity, joint use agreements with facilities to reduce rental costs, Policy / Program memorandum (P/PM)150 – School Food and Beverage Policy)
- Workplace policies (healthy meetings and events policy, regular stretch breaks, modified work stations)
- Access to recreation policies (free universal programs, fee subsidy/fee assistance, equipment exchange programs with clubs)
- Supporting development of healthy eating policies for daycares and recreation centres
- Supporting development of municipal land use policies to support active transportation and community garden space.

As we move forward, we will continue to work with our partners to create communities that support healthy eating, physical activity and other healthy behaviours that prevent chronic disease.

Safer Rides for Northwestern Ontario Kids

MOTOR VEHICLE COLLISIONS ARE THE LEADING CAUSE OF INJURY-RELATED DEATH FOR CANADIAN CHILDREN. THESE TYPES OF CRASHES CAN CAUSE MANY SERIOUS INJURIES, SUCH AS DAMAGE TO THE SPINE, HEAD, AND INTERNAL ORGANS. In the event of a motor vehicle collision, the chance of injury can be greatly reduced by protecting children with the appropriate car seat or booster seat for their age, height and weight. Proper installation of car and booster seats is vital.

All children should travel in car seats, booster seats, and seatbelts as intended. Research shows the risk of death or serious injury can be reduced by 75% when children are buckled into correctly installed car seats that are appropriate for their size, development and age. (Source: Parachute Canada, 2013. http://www.parachutecanada.org/policy/item/child-passenger-safety. Accessed July 3, 2013)

Trained Northwestern Health Unit staff provide car seat installation services to the public free of charge on an ongoing basis. In many communities, individuals who have taken the training course from the health unit also offer installations. A proper installation is an opportunity to build community capacity: parents and caregivers can receive the information and tools needed to be able to install the seat themselves.

To ensure universal access to this valuable service, we aim to have a Northwestern Health Unit staff person in each office trained as a Child Restraint System Technician by 2014.

In 2012, the Northwestern Health Unit took many measures to ensure our region's children were buckled in safely:

- Northwestern Health Unit staff inspected and/or installed 73 car seats across the region. Ninety-three percent (93%) of the car seats that we saw were either not installed or installed incorrectly.
- The Northwestern Health Unit helped to organize two Child Restraint System technician training courses, one each in Kenora and Dryden. The two-and-a-half-day course is offered through the Child Passenger Safety Association of Canada, and consists of demonstrations, classroom lessons and activities, and a written and practical examination.
- One Northwestern Health Unit staff also became a trainer of the Child Restraint System technician course. This increased our own capacity to train individuals across the region to be certified as technicians.

Chronic Disease Prevention – Tobacco Use Prevention

HEALTH UNIT SERVICES TO PREVENT SMOKING BY YOUTH FOCUS ON THREE AREAS:

- Youth engagement and development;
- Advocacy for healthy public policy; and,
- Developing and maintaining strong partnerships to support widespread tobacco prevention services.

A youth engagement coordinator works with youth volunteers, community partners and other health unit staff to support tobacco prevention.

We measure success in youth tobacco prevention by the percentage of youth aged 12 to 18 years who have never smoked a whole cigarette. This population health indicator is an indirect measure of the impact of health unit work because it is influenced by larger societal conditions (such as a culture that promotes tobacco use by youth) and the work done by our many partners in preventing tobacco use.

Population-level results for 2011 are not yet available because the indicator is calculated using data from the Canadian Community Health Survey (CCHS). This causes a data lag, which is why the health unit does not have a 2012 target or results. The ministry will monitor results through 2012, and has set a 2013 target (72.1% of youth aged 12 to 18 report that they have never smoked a whole cigarette).

Success in preventing tobacco use by youth depends on the efforts of many stakeholders in our communities, using a full range of intervention strategies. The health unit will contribute to this work by continuing to engage youth in tobacco prevention efforts. We will also build on the strong partnerships already in place with many community stakeholders to ensure a collaborative, evidence-based system of youth engagement and tobacco use prevention.

In 2012…

- 15 youth development activities were held, including Chalk Attacks, Twitter Bomb events and youth presentations to peers and community.
- 27 youth were provided training in public policy, social media, smoke-free movies, and tobacco industry de-normalization.
- Fifteen call-to-action events were staged, including 11 Flavour…Gone! advocacy events supported by local NWHU staff in Ontario, Edmonton and Winnipeg.

Performance Indicator	2011 results	2012 target	2012 results	2013 target
Percentage of youth (ages 12-18) who have never smoked a whole cigarette	N/A	N/A	N/A	>=72.1%

Chronic Disease Prevention – Tobacco Vendor Compliance and Youth Access Legislation

HEALTH UNIT YOUTH TEST-SHOPPERS WORK WITH TOBACCO ENFORCEMENT OFFICERS TO INSPECT EVERY OFF-RESERVE TOBACCO VENDOR (EXCEPT THOSE IN BARS AND RESTAURANTS) AT LEAST TWICE EACH YEAR. THIS IS PART OF OUR WORK TO REDUCE YOUTH ACCESS TO TOBACCO PRODUCTS.

Tobacco vendor behaviour plays a big role in youth access to tobacco products. Tracking vendor compliance allows the health unit to assess the effectiveness of our education and enforcement.

Youth test shoppers who are too young to buy tobacco products legally are recruited and trained each year. Training is given by the health unit tobacco enforcement officers and the youth engagement coordinator. As part of the inspection, the youth test shoppers attempt to purchase tobacco products. Compliance is defined as an inspection that results in a "no sale." Vendors found to be non-compliant are given warnings and are re-inspected within the year. All vendors receive resources including signage, age calculators and educational materials to support compliance with the law.

There were 127 tobacco vendors in the Northwestern Health Unit catchment area in 2012, including 18 seasonal vendors. All tobacco vendors receive at least one inspection each year from a NWHU tobacco enforcement officer to confirm compliance with display and promotion legislation. To confirm compliance with youth access legislation, most vendors also receive two more inspections each year with an under-aged test shopper. This compliance rate is measured. Some tobacco vendors are not inspected as often because they are bars or because of their remote location.

In 2012, the ministry target of 90% was exceeded, as 97% percent of vendors were compliant with youth access legislation at the time of their last inspection. We expect to meet or exceed the 2013 ministry target of 93% vendor compliance with youth access legislation.

Performance Indicator	2011 results	2012 target	2012 results	2013 target
Percentage of tobacco vendors in compliance with youth access legislation at the time of last inspection	93%	>= 90%	97%	>=93%

Dental Health

ORAL HEALTH AND GENERAL HEALTH ARE CLOSELY LINKED. YOU MAY HAVE HEARD THE EXPRESSION "THE MOUTH IS THE WINDOW TO THE BODY." This is true. For example, poor oral health not only causes pain and infection, but is also closely linked to illnesses such as diabetes and lung disease. If your mouth is sore and infected, it is hard to eat or speak, and your nutrition can be affected. Oral health therefore affects your mind, body and spirit.

Dental decay is the number one chronic disease affecting children today and it is almost 100% preventable. (Source: Centers for Disease Control and Prevention. Hygiene-related Diseases: Dental Caries (Tooth Decay. http://www.cdc.gov/healthywater/hygiene/disease/dental_caries.html. Accessed July 4, 2013.) Poor oral health can influence children's growth and ability to thrive. It can affect sleep and cause missed days at school. In fact, children with poor oral health are three times more likely to miss school than children with healthy mouths. (Source: Jackson et al. (2011). Impact of poor oral health on children's school attendance and performance. American Journal of Public Health, 101 (10), 1900-6.)

Good oral health habits – such as making healthy food choices, brushing teeth twice daily with fluoridated toothpaste, drinking fluoridated water, regular flossing, and visits to a dental care provider – can all help prevent decay and maintain a healthy smile for a lifetime.

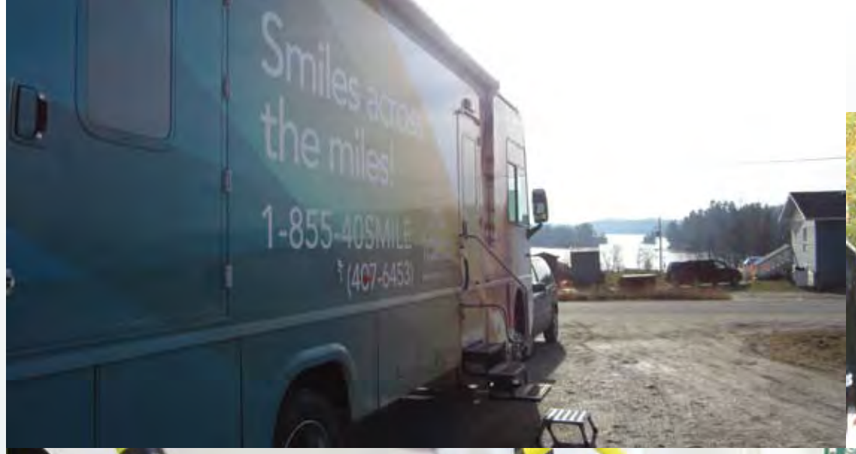
At the Northwestern Health Unit, we continually strive to improve the oral health of children, youth and eligible adults in our communities. Our health unit carefully integrates several dental program areas such as: Children in Need of Treatment (CINOT), Expanded CINOT, Healthy Smiles Ontario (HSO), HSO Mobile Dental Office (MDO), Northern Dental Pilot, Ontario Works Dental Program, preventive clinics, oral hygiene instruction, tooth brushing, public water fluoridation, pit and fissure sealants, and fluoride varnish applications. We also strive to integrate with other health unit programs, including nutrition, speech and language, tobacco cessation, and the Healthy Babies, Healthy Children programs.

In 2012, we provided the following services:

- 7,279 elementary students received a dental screening
- 1,110 high school students received a dental screening
- 5,413 children received topical fluorides
- 622 children received pit and fissure sealants
- 271 children received scaling
- 118 days of service were held between the community clinics and MDO
- 415 clients were seen at the community clinics and MDO.

A review of our Dental Indices Survey (DIS) data from 2008 to 2012 showed that there has been a decrease in decay rates in 4-year-old children by 7% and in 5-year-old children by 5% in our catchment area. This is different from many areas of the province and country where decay rates in young children have been increasing in recent years.

Preventing disease and promoting health are the cornerstones of public health and are great ways to move a wellness agenda forward. We continue to take steps to remove barriers to accessing dental care to allow children, youth and eligible adults to achieve and maintain optimal oral health. It is our goal to make a lasting impact in the dental and overall health of the citizens in northwestern Ontario.



A new strategic plan and a new office

THE BOARD OF HEALTH APPROVED THE 2013-2016 STRATEGIC PLAN FOR THE NORTHWESTERN HEALTH UNIT IN THE FALL OF 2012.

The strategic plan highlights four areas of work for the health unit. These include:

- Efforts to increase levels of physical activity and healthy eating;
- More community input into program planning and evaluation;
- Working in partnership; and
- Strengthening agency services (like IT, HR, Finance) that support program delivery.

In December 2012 the health unit used the grand opening of our new offices in Kenora in the City View Centre at 210 First Street North to tell the community about our strategic plan.

The health unit moved into its new building in Kenora in the fall of 2012. Our new space is centrally located and more accessible than our old office on Wolsley Street. We were able to work with the new building owners who have done a great job in meeting our needs so we can deliver excellent public health services to the community.

For the time being, the health unit will continue to provide clinical services in Kenora out of our Market Square office. Eventually, these services will move to the new City View Centre.

About 100 people showed up to see our new space and to hear about our strategic plan.

Improve the quality and length of life in our communities: **healthy lifestyles**, longer lives, lived well.

We are **recognized** as a valued and integral **partner in health.**

Public Health staff deliver information and programs from each of our offices.

Atikokan	597-6871
Dryden	223-3301
Ear Falls	222-3098
Emo	482-2211
Fort Frances	274-9827
Ignace	934-2236
Kenora	468-3147
Kenora - Market Square	468-3436
Machin	227-2088
Pickle Lake	928-2234
Rainy River	852-3268
Red Lake	727-2626
Sioux Lookout	737-2292
Sioux Narrows	226-9626

Northwestern Health Unit

www.nwhu.on.ca