A G E N D A

MIDDLESEX-LONDON BOARD OF HEALTH

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

THURSDAY, 7:00 p.m.
2011 May 19

MISSION - MIDDLESEX-LONDON BOARD OF HEALTH

The mission of the Middlesex-London Health Unit is to promote wellness, prevent disease and injury, and protect the public's health through the delivery of public health programs, services and research.

MEMBERS OF THE BOARD OF HEALTH

Ms. Patricia Coderre (Chair)	Ms. Viola Poletes Montgomery (Vice-Chair)
Ms. Denise Brown	Ms. Nancy Poole
Mr. Al Edmondson	Mr. Don Shipway
Dr. Francine Lortie-Monette	Mr. Mark Studenny
Ms. Doreen McLinchey	Mr. Joe Swan
Mr. Marcel Meyer	Dr. Graham Pollett (Secretary-Treasurer)

DISCLOSURE OF CONFLICTS OF INTEREST

APPROVAL OF AGENDA

APPROVAL OF MINUTES

SCHEDULE OF APPOINTMENTS

ACTION REQUIRED

1) Report No. 047-11 re Social Determinants of Health Public Health Nursing Positions

2) Report No. 048-11 re Strengthening Early Years Programs: Healthy Babies Healthy Children Program Improvements

FOR INFORMATION

3) Report No. 049-11 re Medical Officer of Health Activity Report – May

4) Report No. 050-11 re Performance Management Framework for Public Health: Accountability Agreements and Performance Indicators

5) Report No. 051-11 re Board of Health Performance Assessment: March Survey

6) Report No. 052-11 2011 re Budget – First Quarter Review

7) Report No. 053-11 re 2012 City of London Budget Target

8) Report No. 054-11 re Healthy Communities Partnership Middlesex-London

9) Report No. 055-11 re Creating Healthy Places Forum

10) Report No. 056-11 re March is Nutrition Month – Family Health Services Activities

11) Report No. 057-11 re Child and Youth Network: Literacy Workgroup

12) Report No. 058-11 re Influenza Immunization Program 2010-2011

13) Report No. 059-11 re Provincial Bed Bug Initiatives – Update

14) Report No. 060-11 re Liquor License Act – Follow Up

CONFIDENTIAL

The Board of Health will move In Camera for the purpose of considering a matter concerning labour relations or employee negotiations.

OTHER BUSINESS

Board of Health Strategic Planning Session - Thursday, May 26, 2011 4:30 - 7:30 p.m.

Next Board of Health Meeting – Thursday, June 16, 2011 7:00 p.m.

CORRESPONDENCE RECEIVED

a) Dated 2011 April 6 (received 2011 April 29) A copy of correspondence from Ms. Amanda Rayburn, Chair, Board of Health, Wellington-Dufferin-Guelph Health Unit, to the Honourable Deb Matthews, Minister Health and Long-Term Care (MOHLTC), expressing concern about the limited eligibility period for girls to receive publicly funded vaccine for the prevention of HPV infection.

b) Dated 2011 April 6 (received 2011 April 29) A copy of correspondence from Ms. Amanda Rayburn, Chair, Board of Health, Wellington-Dufferin-Guelph Health Unit, to the Honourable Deb Matthews, Minister Health and Long-Term Care (MOHLTC), expressing concern about the lack of a publicly funded HPV vaccination program for males.

c) Dated 2011 April 12 (received 2011 April 18) Correspondence from Warden Joanne Vanderheyden, County of Middlesex, advising that "County Council examined a number of important issues associated with the request (to install a generator at 50 King/399 Ridout properties) and at the end of the discussion determined that they could not support the installation of the generator."

d) Dated 2011 April 13 (received 2011 April 13) Correspondence from Mr. Lou Lamoriello, President/CEO/General Manager, New Jersey Devils, in response to the open letter sent to the National Hockey League Board of Governors concerning violence in hockey.

e) Dated 2011 April 19 (received 2011 May 2) Correspondence from Ms. C. Saunders, City Clerk, City of London, advising that at the request of the Middlesex-London Health Unit, the following actions will be taken with respect to violence in hockey:

1. *That the attached communication date February 25, 2011 from Dr. G. Pollett, Secretary-Treasurer, Middlesex-London Health Unit, Dr. P. Jaffe, Professor, Faculty of Education, University of Western Ontario and Mr. R. Hughes, National Coordinator, Centre for Addiction and Mental Health, Centre for Prevention and Science BE SUPPORTED; and,*

2. *That the Commissioner and Board of Governors of the National Hockey League BE ADVISED that the City of London supports the reduction of violence in hockey, as outlined in the above-noted communication.*

f) Dated 2011 April 27 (received 2011 April 29) Copy of correspondence from Dr. Hazel Lynn, Medical Officer of Health for the Grey Bruce Health Unit, to Mr. Gary Bettman and the NHL Board of Governors, stating that the Grey Bruce Board of Health passed the following motion in response to Board Report No. 027-11 from the London-Middlesex Health Unit:

THAT, the Grey Bruce Board of Health endorse the open letter to the National Hockey League (NHL) Commissioner, Gary Bettman, and Board of Directors, regarding violence in hockey.

g) Dated 2011 April 27 (received 2011 May 5) Correspondence from Mr. Randy Brown, Secretary, Board of Health of the Perth District Health Unit advising that the Board of Health of the Perth District Health supported the following resolution:

1. *That the Board of Health endorse the open letter to National Hockey League Commissioner, Gary Bettman, and the Board of Directors attached as Appendix A to Report No. 027-11 re Violence in Hockey; and further*

2. *That Report No. 027-11 re Violence in Hockey be forwarded to Ontario Boards of Health, the Association of Local Public Health Agencies (alPHa) Board of Directors, the Ontario Public Health Association (OPHA) Board of Directors, and the City of London Council requesting endorsement of the open letter to the NHL Commissioner and Board of Directors.*

h) Dated 2011 April 28 (received 2011 May 5) Correspondence from Mr. Jack Butt, Chair of the Board, Leeds, Grenville and Lanark District Health Unit, to The Honourable Lauren Broten, Minister of Children and Youth Services, asking the Minister to consider increased funding for the Preschool Speech and Language Program "to ensure that our children are given the foundation for success in early learning."

i) Dated 2011 May 5 (received 2011 May 9) A copy of correspondence from Dr. Penny Sutcliffe, Medical Officer of Health and Chief Executive Officer, Sudbury and District Health Unit, to Mayors and Reeves within the Sudbury and District Health Unit Catchment Area, advising that the Sudbury and District Board of Health carried the following resolution re Sustainable Mobility:

WHEREAS major diseases affecting the quality and length of life of Canadians are linked to physical inactivity; and

WHEREAS in June 2007, the Sudbury & District Board of Health motion #36-07 identified the need to enhance public health programming in order to address supportive environments for physical activity; and

WHEREAS the Ontario Public Health Standards (2008) require that boards of health work with municipalities to support healthy public policies, including policies that enhance the built environment for physical activity; and

WHEREAS in 2009, the Canadian Medical Association issued their Active Transportation policy statement identifying essential roles for communities and governments; and
WHEREAS local communities are taking seriously their role in creating supportive environments for sustainable mobility, with for example, the January 2010 endorsement of the Espanola Active Community Charter by the Council of the Town of Espanola and the June 2010 City of Greater Sudbury Policy Committee support for the Sustainable Mobility Plan for the City of Greater Sudbury; and

WHEREAS in 2011, the Partners for Community Wellness (Healthy Communities Fund Partnership) identified that access to recreation and sustainable mobility initiatives are key to achieving their wellness goal;

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health recognize that coordinated efforts with municipal governments, public health and other sectors is required in order to develop a comprehensive, community-based approach to address sustainable mobility; and

FURTHERMORE THAT the Sudbury & District Board of Health encourage all municipalities within the Sudbury and Manitoulin districts to develop long-term plans for sustainable mobility; and

FURTHER THAT copies of this motion be forwarded to all Ontario boards of health, provincial government partners and local members of provincial parliament, the Ontario Public Health Association (OPHA), the Association of Local Public Health Agencies (alPHa) and Federation of Northern Ontario Municipalities (FONOM).

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

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 047-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 May 19

Social Determinants of Health Public Health Nursing Positions

Recommendation

It is recommended that the Board of Health endorse the allocation of the two new 100% Ministry of Health and Long-Term Care funded nursing positions for those services described in Report No. 047-11 re Social Determinants of Health Public Health Nursing Positions.

Background

In March 2011, the Health Unit received notice from the Ministry of Health and Long-Term Care (MOHLTC) that $170,040 would be provided to each health unit in Ontario to support two, new, full-time Public Health Nurse (PHN) positions. The new positions are intended to "address the program needs of priority populations impacted most negatively by the determinants of health."

At the April 14, 2011, Board of Health meeting, the Board members were advised of the two new positions in Report No. 035-11 re Two New Full Time Equivalent Public Health Nursing Positions (Appendix A). At that time, Board members accepted the MOHLTC offer and the accompanying conditions. Staff members agreed to present proposals at the May Board of Health meeting for the integration of the new positions into the current staff complement.

Position Proposals

A Senior Management Sub-committee which consists of Mr. Wally Adams, Acting Director, Environmental Health and Chronic Disease Prevention Services; Ms. Diane Bewick, Director, Family Health Services; and Dr. Bryna Warshawsky Associate Medical Officer of Health and Director, Oral Health, Communicable Disease and Sexual Health Services; examined options for the most valuable application of the two new resources and made a recommendation to the Senior Management Team. It was agreed that one of the two positions would be placed within Family Health Services (FHS) and the other position within Oral Health, Communicable Disease and Sexual Health Services (OHCDSHS). The new positions will also work closely with staff members in Environmental Health and Chronic Disease (EHCD) Prevention Services. The following describes how these two new positions will be deployed.

Family Health Services Position

The new PHN within FHS will focus on vulnerable children and families consistent with the priorities established by the Child and Youth Network (CYN) of London and the Middlesex Children's Services Network. Both of these groups have identified children and families as key populations who are significantly impacted by their environment. In the City of London, three key social determinants of health (poverty/literacy/food security) have been identified as priorities and plans have been developed to address these challenges. The new PHN will take a lead role in the ongoing development and implementation of these plans for vulnerable families and children in the community. The PHN will also assist in coordinating Health Unit services to vulnerable families, as well as, act as a designated liaison with the CYN.

Two priority populations which will receive additional focus will be the First Nations population and immigrants and refugees who are new to Canada. In addition, the new PHN will allow the Health Unit to expand services to shelters where vulnerable families and youth are found (e.g., Centre of Hope, My Sister's Place, and Youth Opportunities Unlimited). Nursing services will include health assessment, counseling and linking to community support and other Health Unit programs and services. Staff members also intend to explore the option of the Health Unit Nurse Practitioner accompanying PHNs at designated times to provide primary health care services.

Oral Health, Communicable Disease and Sexual Health Position

The new PHN position in OHCDSHS will focus on enhancing access to programs and services by members of vulnerable populations. The types of programs and services initially considered will be those routinely provided by the service area including family planning, diagnosis and treatment of sexually

transmitted infections, immunizations, tuberculosis control and oral health. Many of these services can be provided in settings that are easily accessible to vulnerable populations or alternatively, clients can be assisted in accessing services provided at the Health Unit offices. As experience is gained, consideration will be given to enhancing services as indicated by evaluation of the new position.

Vulnerable populations to be targeted may include, but are not limited to, those residing in shelters and detention centres; individuals with high risk behaviours (including use of illicit drugs); immigrants and refugees who are new to Canada; First Nations communities and the Amish community.

This new PHN position will work closely with the new position in FHS, other areas of the Health Unit and with community partners to ensure that vulnerable populations have access to coordinated Health Unit and community programs and services.

Summary

The addition of the two PHN positions, which will focus specifically on social determinants of health, is a positive step forward in assisting vulnerable populations in our community. These two positions will work collaboratively within the Health Unit and community to enhance the programs and services already provided to vulnerable populations and to further the effort to address the social determinants of health.

This report was prepared by Mr. Wally Adams, Acting Director, Environmental Health and Chronic Disease Prevention Services; Ms. Diane Bewick, Director, Family Health Services; and Dr. Bryna Warshawsky, Associate Medical Officer of Health and Director, Oral Health, Communicable Disease and Sexual Health Services.

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

This report addresses the following requirement(s) of the Ontario Public Health Standards: Foundational Standard, Family Health Stands and Infectious Diseases Standards.

MIDDLESEX-LONDON HEALTH UNIT Appendix A

REPORT NO. 035-011

TO: Chair and Members of the Board of Health

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

DATE: 2011 April 14

TWO NEW FULL TIME EQUIVALENT PUBLIC HEALTH NURSING POSITIONS

Recommendation

It is recommended that the Board of Health accept the Ministry of Health and Long-Term Care conditions as defined in Appendix B of Board of Health Report No. 035-11 to receive up to $170,040 to support two new full time equivalent Public Health Nursing positions.

Background

On Tuesday, March 15, 2011, electronic versions of letters to Ms. Patricia Coderre, Board of Health Chair and the Medical Officer of Health were received from the Ministry of Health and Long-Term Care (MOHLTC) announcing funding has been approved for this Health Unit to receive up to $170,040 to support two new full time equivalent (FTE) Public Health Nursing (PHN) positions (Appendices A and B). This is ongoing funding which is 100% funded by the MOHLTC.

The new positions are "to address the program and service needs of priority populations, including priority populations impacted most negatively by the determinants of health in the health unit area". Examples provided include Aboriginal/First Nation populations, Francophone populations, low income families, or vulnerable populations affected by bed bug infestations. The new positions are intended to support Ontario's Poverty Reduction Strategy as well as the MOHLTC Mental Health and Addiction Strategy and nursing recruitment/retention commitment.

Funding Requirements

There are a number of requirements related to the funding for the new positions, the first of which is the acceptance by the Board of Health of the MOHLTC terms and conditions defined in Appendix B. An Initial Project Report outlining the intended key achievements and activities related to the new positions must be forwarded to the Ministry no later than April 30, 2011. Subsequent Project Reports are required as per the schedule identified in Appendix B. The third requirement is provision of proof of employment for each new full time equivalent PHN. Only upon receipt of the latter documentation will funding be flowed by the MOHLTC.

Proposed Focus of Each New Position

Clarifying information regarding the criteria applicable to the new positions was not received until April 1, 2011(Appendix C). A Senior Management Team Working Group comprised of Mr. Wally Adams, Acting Director, Environmental Health and Chronic Disease Prevention Services; Ms. Diane Bewick, Director, Family Health Services; Ms. Louise Tyler, Director, Human Resources and Labour Relations; and

Dr. Bryna Warshawsky, Associate Medical Officer of Health and Director, Oral Health, Communicable Disease and Sexual Health Services has been struck to develop a proposed focus for each of the new positions. These proposals will be presented at the May Board of Health meeting. To initiate the funding approval process, it is recommended that the Board of Health acknowledge acceptance of the MOHLTC conditions.

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

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 048-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 May 19

Strengthening Early Years Programs: Healthy Babies Healthy Children Program Improvements

Recommendation

It is recommended that the Board of Health approve the conversion of a full time Family Home Visitor position to a permanent Social Worker position as indicated in Report No. 048-11.

Background

The Healthy Babies Healthy Children (HBHC) program is designed to support new parents and to promote optimal healthy child development for families with young children 0 to 6 years old. Public Health Nurses (PHNs) and Family Home Visitors (FHVs) work together with families to improve child health and development, increase parenting confidence and knowledge, enhance parenting support and increase integration of programs and services that support young families. As a program funded by the Ministry of Children and Youth Services (MCYS), HBHC provides universal screening and assessment as well as more intensive home visiting support for families with children who are at risk of not reaching their full potential.

As part of a larger review of early years services, the MCYS has been moving forward with significant improvements to the HBHC program. Research has been conducted to investigate different home visiting service models for HBHC families over the past two years. The Health Unit participated in this project which examined the impact of incorporating a Social Worker into the team of professionals working with high risk families. The Board of Health has been informed of this research through Report No. 011-09 re Healthy Babies Healthy Children Research Project with a Social Worker, Report No. 085-09 re Integration of a Social Worker Position into the Healthy Babies Healthy Children Program, Report No. 043-10 re Integration of a Social Worker Position into the Healthy Babies Healthy Children Program and Report No. 029-11 re Healthy Babies Healthy Children Research Project with a Social Worker.

Changes to Healthy Babies Healthy Children Program

In March 2011, a memorandum from Assistant Deputy Minister, Mr. Darryl Sturtevant, (Appendix A) was distributed to Medical Officers of Health and Program Directors outlining changes to the HBHC program. Effective January 2012, the following changes will be in place:

- A strengthened screening process will more quickly and effectively identify and support vulnerable families so those who need help the most can access services and supports more quickly;
- The HBHC program will no longer be required to provide a universal phone call or postpartum visit;
- Home visiting will be strengthened through the introduction of province-wide best practices and guidelines and front line staff training funded by the province;
- Public health units will have the option of including a Social Worker on the HBHC home visiting team.
- A comprehensive information package for every new parent will be given to all families before leaving the hospital. It will include a description of local programs and services along with important contact information.

Implications for the Health Unit

The MCYS changes will have a significant impact on low risk postpartum families. After discharge from hospital, families with a new born will no longer receive a phone call and visit from a PHN unless they are identified as being ‘at risk’. This will shift the balance of HBHC work from low risk to high risk families and PHNs will play a more integral role in working with high risk families.

It is also anticipated that at risk pregnant women will be better identified and will receive improved assessment and intervention from PHNs with specialized training in areas such as maternal mental health.

Also of significance to the program is the potential to integrate the role of the Social Worker on the team. As part of the research, the Health Unit has benefitted from the addition of a Social Worker as a member of the blended home visiting teams since 2009. She provided counseling and intervention for approximately 100 families with complex issues in the areas of settlement, employment, education, housing and income. The Social Worker also provided consultation to PHNs on families who did not require in depth social work

services. The province-wide research indicates a multidisciplinary team, that includes a Social Worker, strengthens home visiting services by ensuring that appropriate expertise is used to support families experiencing socioeconomic risks factors. This service has been crucial to achieving positive outcomes and has freed up PHNs and FHVs to focus on health, parenting and psychosocial issues.

Proposed Changes to the HBHC Staffing Model

Based on the MYCS changes, the positive and focused impact of the Social Worker and the increased demands for assessment and intervention for 'at risk' families, alterations to the staffing composition are necessary. It is proposed the new staffing composition for HBHC should include the addition of a permanent Social Worker. This would be accomplished by not filling the vacancy left by a retiring FHV. Although there are 12.5 FHV positions, there has been a vacancy since December 2010. Caseload monitoring indicates that FHVs are able to provide service without a significant wait for HBHC clients. In order to remain within budget, the Social Worker position may need to be less than a full time equivalent.

Although Health Unit staff members believe that universal access to public health services for low risk families remains an important initiative, the MCYS through the HBHC program will no longer provide this service. Family Health Services must determine how it will best support families during the postpartum period within the cost-shared funding model.

Conclusion

Over the next six (6) months, Health Unit staff members will be making significant changes to the delivery of the HBHC program. To be successful in providing services to the increased number of 'at risk' families, the program is required to make changes to the staffing complement.

This report was prepared by Ms. Diane Bewick, Director, Family Health Services; Ms. Nancy Summers, Manager, HBHC West Team; Ms. Suzanne Vandervoort, Manager, HBHC Central Team and Ms. Bonnie Wooten, Manager, HBHC East Team.

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

This report addresses the following requirement(s) of the Ontario Public Health Standards: Family Health Services, Reproductive Health Requirement 7 and Child Health Requirement 9.

Ministry of Children and Youth Services

Assistant Deputy Minister

Strategic Policy and Planning Division

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Ministère des Services à l'enfance et à la jeunesse

Sous-ministre adjoint

Division des politiques et de la planification stratégiques

14e étage
56, rue Wellesley Ouest
Toronto ON M5S 2S3

Ontario

March 22, 2011

MEMORANDUM TO: Medical Officers of Health
Healthy Babies Healthy Children Program Directors

FROM: Darryl Sturtevant
Assistant Deputy Minister

RE: **Strengthening Early Years Programs:**
Healthy Babies Healthy Children Program Improvements

I am writing to outline improvements to the Healthy Babies Healthy Children (HBHC) Program which will be fully implemented as of January 2012. The changes are designed to more quickly and effectively identify and support vulnerable children and families so those who need help the most can access services more quickly.

The HBHC program improvements are part of the government's overall commitment to improve services for children and their families through its Best Start initiative. In addition, they are aligned with the work already underway with Dr. Charles Pascal around the development of a policy framework for Best Start Child and Family Centres.

Many of the HBHC enhancements were discussed at the HBHC Director's meeting held on January 20-21, 2011 in Toronto. At the meeting, we received positive feedback from many of your staff on the program's new direction and the commitment to further strengthen the program.

In summary, the HBHC initiatives discussed at the meeting include:

- A new, more detailed and evidence-based HBHC screening tool that will replace the currently-used Larson and Parkyn. The new screen will provide greater focus on risk identification and will enable your staff to identify and therefore support vulnerable families more quickly. We are very appreciative that some of your public health units are participating in the validation process for the screen;
- A streamlined HBHC screening process that will eliminate the need for the current multiple screens administered to families prior to receiving home visiting from HBHC. The existing post-partum phone call and home visit will no longer be a requirement of HBHC;
- An information package for new parents that will be provided before mother and baby leave the hospital. The package will include child development information, a description of programs available to support children and families and important contact numbers for further assistance. The content for the package will be developed with support from public health units and follow best practices for the sharing of information with parents;

.../cont'd

- Strengthened home visiting through training and the introduction of province-wide best practice guidelines; and
- The option for public health units to include a social worker on the HBHC home visiting team.

Aligned with the HBHC changes, work has begun on a new Junior Kindergarten screen that will complement the current suite of infant and early childhood screenings and support effective transition to school. We know that many health units are already involved in screening children prior to school registration so we will keep you informed and involved as this initiative proceeds.

The changes in HBHC practice and delivery will be supported with ongoing communication and education opportunities. Work-groups with public health unit membership will be established to ensure that an informed, collaborative process is in place to support all parts of the HBHC program enhancements. In partnership with the Ministry of Health and Long-Term Care, we will update the Ontario Public Health Standards (OPHS) HBHC Protocol to reflect the program improvements and develop new guidance documents to support protocol requirements.

The HBHC enhancements are part of our work to strengthen programs in support of the integrative vision of Best Start and the goal of improving outcomes for children and their families. Public health units are critical partners in achieving these goals.

Thank you for your continued support as we move forward in the implementation of this important work.

Darryl Sturdevant
Assistant Deputy Minister
Ministry of Children and Youth Services

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 049-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 May 19

Medical Officer of Health Activity Report – May 2011

Recommendation
It is recommended that Report No. 049-11 re Medical Officer of Health Activity Report – May be received for information.

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

Work continued on the development of a new strategic plan for the Health Unit. As per the process outlined at the April 14, 2011, Board of Health meeting by Ms. Maria Sanchez-Keane, Principal Consultant, Centre for Organizational Effectiveness, a meeting was held with staff and management to discuss the findings of the Discovery Report. The latter document has been previously sent electronically to Board of Health members. A summary highlighting the key points from this meeting was the focus of a subsequent All-Management meeting held May 11, 2011. A verbal update on the status of the strategic planning process will be provided at the May 19th Board meeting.

Planning activities were undertaken for implementation of the Records Management Program. This includes the application of the new Records Classification System, as well as the Record Retention Schedule, both of which were previously approved by the Board of Health. Mr. Ross Graham, Manager, Records Management and Accreditation, began this new position May 2. The date for the official launch of the new Records Management Program has been set for May 31, 2011.

The City of London has initiated its 2012 Budget Process by beginning discussions on budget targets for internal City Departments and external Boards and Commissions who receive City funding. Board members were apprised of this situation through previous electronic correspondence. This situation is highlighted in Board Report 053-11. Further information will be provided at the May 19th Board of Health meeting.

A very successful workshop on Robert's Rules of Order was conducted by Mr. Doug McCarthy, Fanshawe College. This was attended by Board Chair, Ms. Patricia Coderre; Vice Chair, Ms. Viola Poletes-Montgomery; and Board members, Mr. Mark Studenny and Ms. Doreen McLinchey.

Other meetings involving the Medical Officer of Health since the last Board of Health meeting included: opening remarks at the Health and the Built Environment Conference; a meeting with representatives of the Canadian Latin American Association – London; attendance at the celebration of Dr. Neil Farrell's life; a meeting with Attorney General, Chris Bentley; attendance at a Coaching Boys to Men Working Group meeting; attendance at a Violence in The Media Conference planning meeting; attendance at a Regional HIV/AIDS Connection (RHAC) Board meeting; participation in the Community Medicine Seminar for 3rd year UWO medical students; a meeting with Mr. Bill Tucker, Executive Director, Thames Valley District School Board; attendance at the CEO/CAO Business meeting; and attendance at the Canadian Medical Hall of Fame dinner.

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

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 050-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 May 19

Performance Management Framework for Public Health: Accountability Agreements and Performance Indicators

Recommendation

It is recommended that Report No. 050-11 re Performance Management Framework for Public Health: Accountability Agreements and Performance Indicators be received for information.

On Monday May 9, 2011, staff from the Ministry of Health and Long-Term Care conducted a webinar on the development of the Public Health Accountability Agreement template. As part of receiving Provincial funding, each Board of Health will soon be required to sign an Accountability Agreement. The initial Accountability Agreement will set out obligations of Boards of Health and the Ministry of Health and Long-Term Care and the Ministry of Health Promotion and Sport for a three year period i.e., January 1, 2011, to December 31, 2013.

The Accountability Agreement will specify performance expectations for Boards of Health including a set of performance indicators. The first year, 2011, will be a transition year during which baselines for each Board of Health for the performance indicators will be determined. Using the baselines, targets will then be negotiated to reflect a level of improvement for each indicator to be achieved in the subsequent years of the Agreement.

Attached as Appendices A and B are the information package regarding the webinar as well as the PowerPoint slides for the session. Staff will prepare the survey document included in the information package.

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

Performance Management Framework for Public Health: Accountability Agreements and Performance Indicators

Presented by:

Ministry of Health and Long-Term Care

Ministry of Health Promotion and Sport

Ontario

Purpose

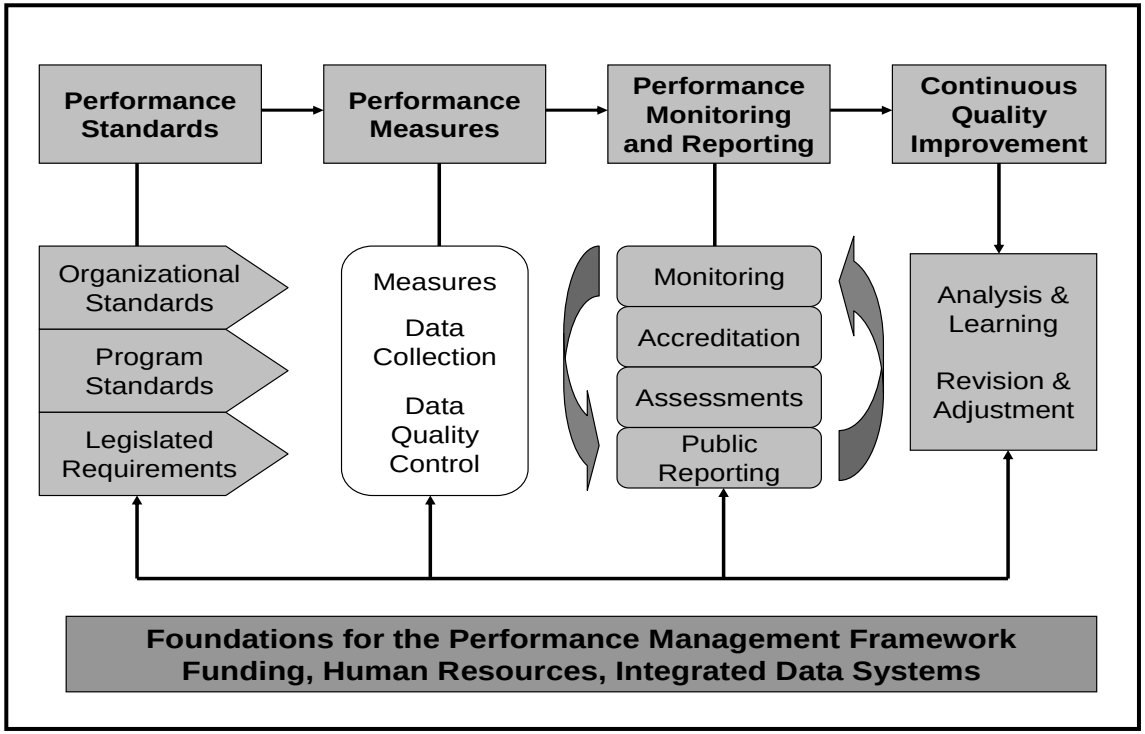
- To outline the context and rationale for the introduction of the new Accountability Agreement process for public health.
- To provide a brief overview of the Accountability Agreements for 2011-13.
- To provide a brief overview of the use of indicators within Accountability Agreements.
- To orient boards of health to the Accountability Agreement E-Survey Consultation process.

Performance Management

- Performance management principles and techniques are widely accepted as management best practice. A key principle is the use of measurement and monitoring strategies to provide evidence for decision making and continuous quality improvement.
- Performance management involves establishing goals, monitoring progress, and making adjustments to achieve desired outcomes.
- The Performance Management Framework for public health in Ontario is being developed using these established principles, methodologies and tools.

Public Health Renewal

- In 2004, the government made a commitment to rebuild public health in Ontario and has made significant progress to date.
- The Final Report of the Capacity Review Committee (2006) outlined a vision of a Performance Management Framework.
- In consultation with the public health sector, work is underway to build the Performance Management Framework.



Objectives of the PM Framework

- The objective of the Performance Management framework is to enable the provincial government and the public health sector:
  - To assess and demonstrate the extent to which the public health system achieves success efficiently and effectively;
  - To ensure that the public health system meets standards and expectations;
  - To promote continuous quality improvement in the public health system; and
  - To demonstrate the contribution of public health to the overall health of Ontarians.

Progress to Date

- The province has made significant progress in the development and implementation of components of the performance management framework. Achievements include:
  - developing new standards for public health, which strengthen public health sector accountability;
  - publishing the Initial Public Report on public health in Ontario, which provides a snapshot of the current state of the public health system;
  - releasing new organizational standards to form baseline expectations of boards of health; and
  - drafting a template for accountability agreements, including a proposed set of performance indicators, for consultation and signing of the agreements in 2011.

Overview of the Draft Accountability Agreement Template

Ontario

Health Protection and Promotion Act Framework for Accountability Agreements

ACCOUNTABILITY AGREEMENTS (s. 81.2 of HPPA)

- The Minister may enter into an accountability agreement with the board of health of any health unit. (s. 81.2).
- Agreement may set out:
  - Requirements for the accountability of boards of health; and
  - Management of the health unit.
- "Minister" here means the Minister of Health and Long-Term Care.
- This agreement may provide for services to be provided by the board which are in addition to those set out in legislation or the regulations (or the OPHS).
- Added to the HPPA in 2007.

Health Protection and Promotion Act Framework for Accountability Agreements

MINISTER MAY MAKE GRANTS (s. 76 of HPPA)

- Minister may make grants for the purposes of the HPPA on such conditions she considers appropriate.
- "Minister" means both Minister of Health and Long-Term Care, and Minister of Health Promotion and Sport (as it relates to the OPHS programs assigned to MHPS by Order-in-Council).
- Currently, most costs of boards of health and medical officers of health funded at 75% provincial, 25% municipal (certain programs funded at 100%).
- Section 72 provides for payment by obligated municipalities. Notices provided to obligated municipalities under section 72(5). Obligated municipalities required to pay the notice. Applies to the 25% of funding which is currently funded by municipalities (not to the provincial share of funding).

Health Protection and Promotion Act Framework for Accountability Agreements

MINISTER MAY PUBLISH GUIDELINES (s. 7 of HPPA)

- Minister may publish guidelines and every board of health must comply with them.
- Current published guidelines are the Ontario Public Health Standards (OPHS). They replaced the 1997 MHPSG.
- Guidelines are transmitted to boards of health and must be available for public inspection at the Ministry.
- Guidelines may adopt by reference any codes, formulas or protocols or procedures, and may require compliance with them. (new in 2007)
- Rolling incorporation of codes, formula or protocols or procedures is permitted. (i.e. reference to a document deemed to be a reference to it as amended from time to time.)
- For rolling incorporation to be effective, the Minister must publish notice of the amendment and transmit the notice to each board of health.

Role of MHPS – OIC Responsibilities

- MHPS Order in Council provides for the following mandatory health programs and services guidelines under the Health Protection and Promotion Act (HPPA) to be provided by MHPS:
    - Chronic Disease Prevention;
    - Prevention of Injury and Substance Misuse;
    - Child Health; and
    - Reproductive Health.
- MHPS may also exercise: “any other provision” of the HPPA “in so far as it relates to the administration or enforcement of section 7 respecting those programs or services…”

Notes:

- The Minister of Health and Long-Term Care publishes Guidelines (section 7 of HPPA).
- No authority for Minister of MHPS to create new mandatory programs.
- OIC for MOHLTC and MHPS just amended to update the name of MHPS (used to be MHP).

Transfer Payment Directive (2008)

1. Principles

- Value for money.
- Recipients are responsible to deliver provincially funded services and are accountable to ministries for the funds they receive and the results achieved.
- Good governance and accountability practices for TP recipients is encouraged.

2. Expectations

- Transfer payments must meet a number of expectations, including:
    - Define the objectives, functions, eligibility criteria and obligations for recipients;
    - Be provided only to legal entities; and
    - Be provided in amounts not exceeding the requirements for the program's objectives.

Transfer Payment Directive (2008)

3. Requirements

- An agreement must be in place before transfer payments are made.
- Agreements must set out:
  - Expectations, terms and conditions of funding to support good governance, value for money and transparency in the administration of transfer payment funds;
  - Documents the rights, responsibilities and obligations of the ministr(ies) and the TP recipient;
  - Include specific, measurable results for the money received, reporting requirements, and any corrective action if results are not achieved; and,
  - Subject to applicable law, allowing independent verification of reported programs and financial information by independent auditors and the Auditor General of Ontario.

What this means for accountability agreements:

- Transfer Payment (TP) template agreement incorporates requirements of the Directive (updated to 2010).
- Grant Terms and Conditions predates the Transfer Payment Directive. It has been updated to incorporate many of the elements required by the TP Directive.
- TP template agreement has been used as a framework for accountability agreements. It also includes elements of the Grant Terms and Conditions.

Accountability Agreements: Development

- The Public Health Accountability Agreement (AA) is built on performance management principles accepted as management best practice.
- The AA uses measurement and monitoring strategies to provide evidence for decision making and continuous quality improvement.
- Sets out obligations of the boards of health AND the Ministry of Health and Long-Term Care (MOHLTC) and the Ministry of Health Promotion and Sport for a 3-year period (January 1, 2011 – December 31, 2013).
    - Finances and performance expectations outlined in the schedules will be amended annually, as required.
- The requirement to comply with the Organizational Standards is included in the AA template.

Accountability Agreements: Development

- New performance management improvement requirements are included in the AA template:
  - Performance indicators and targets; and,
  - Continuous quality improvement (CQI) tools.

- The AA template development:
  - Led by Public Health Division (MOHLTC) and MHPS;
  - Informed by Joint Ministries/Boards of Health Committee (JMB).
    - Performance measurement provisions (Schedule D) was informed by Performance Management Working Group (PMWG) and Indicator Technical Advisory Committee (InTAC).

- Much of the content of the AAs has been used by the ministries and boards of health in the past, and will be familiar to boards of health.

- Signing of the Accountability Agreements is planned for spring/summer 2011.

Accountability Agreement Template: Current *Draft Content*

	Title	Source
Article 1	**Interpretation and Definitions**	**PBG & TP**
Article 2	**Representations, Warranties, and Covenants** • *Includes obligations of Boards of Health (BOH).* • *References Ontario Public Health Standards (OPHS) and Organizational Standards.*	**TP**
Article 3	**Term of the Agreement** • *January 1, 2011 to December 31, 2013.*	**New**
Article 4	**Grant**	**PBG & TP**
Article 5	**Performance Improvement** • *Principles of a proactive and responsive approach to performance improvement, including measurement of performance.* • *Requires the use of Continuous Quality Improvement (CQI) tools (e.g. Performance Variant Reports and action plans).*	**New**
Article 6	**Acquisition of Goods and Services, and Disposal of Assets**	**TP**
Article 7	**Conflict of Interest**	**TP**

Accountability Agreement Template: Current *Draft Content, Continued*

	Title	Source
Article 8	**Reporting, Accounting and Review**	**PBG & TP**
Article 9	**Freedom of Information and Protection of Privacy**	**PBG & TP**
Article 10	**Indemnity**	**PBG & TP**
Article 11	**Insurance**	**PBG & TP**
Article 12	**Termination on Notice**	**PBG & TP**
Article 13	**Termination where no Appropriation**	**PBG & TP**
Article 14	**Event of Default, Corrective Action and Termination for Default**	**TP**
Article 15	**The Grant at the End of a Funding Year**	**PBG & TP**
Article 16	**Notice**	**TP**
Article 17	**Consent by Province**	**TP**

Accountability Agreement Template: Current *Draft Content, Continued*

	Title	Source
Article 18	**Severability of Provisions**	**PBG & TP**
Article 19	**Waiver**	**PBG & TP**
Article 20	**Independent Parties**	**TP**
Article 21	**Assignment of Agreement or The Grant**	**PBG & TP**
Article 22	**Governing Law**	**TP**
Article 23	**Further Assurances**	**TP**
Article 24	**Survival**	**PBG & TP**
Article 25	**Schedules**	**TP**
Article 26	**Counterparts**	**TP**
Article 27	**Joint and Several Liability**	**TP**
Article 28	**Entire Agreement**	**TP**

Accountability Agreement Template: Current *Draft Content, Continued*

	Title	Source
Schedule A	**Program-Based Grants** • *Statement of approved funding by program.* • *Updated annually.*	**PBG**
Schedule B	**Related Program Policies and Guidelines** • *Includes financial management policies and guidelines from PBG guide.* • *Includes CINOT Expansion Program.* • *Will require yearly review and revision by program areas.*	**PBG & New**
Schedule C	**Reporting Requirements** • *Includes calendarized chart of reporting requirements (financial & performance).*	**PBG & New**
Schedule D	**Board of Health/Health Unit Performance** • *Requires BOHs to submit data to Ministries.* • *Requires performance measurement against identified indicators and targets.*	**New**

Use of Indicators within a Performance Management System

Ontario

From Mandatory Program Indicator Questionnaire (MPIQ) to Capacity Review Committee (CRC) Vision

Requirements → **MPIQ**

1997 Mandatory Health Programs and Services Guidelines

CRC Vision (2006)

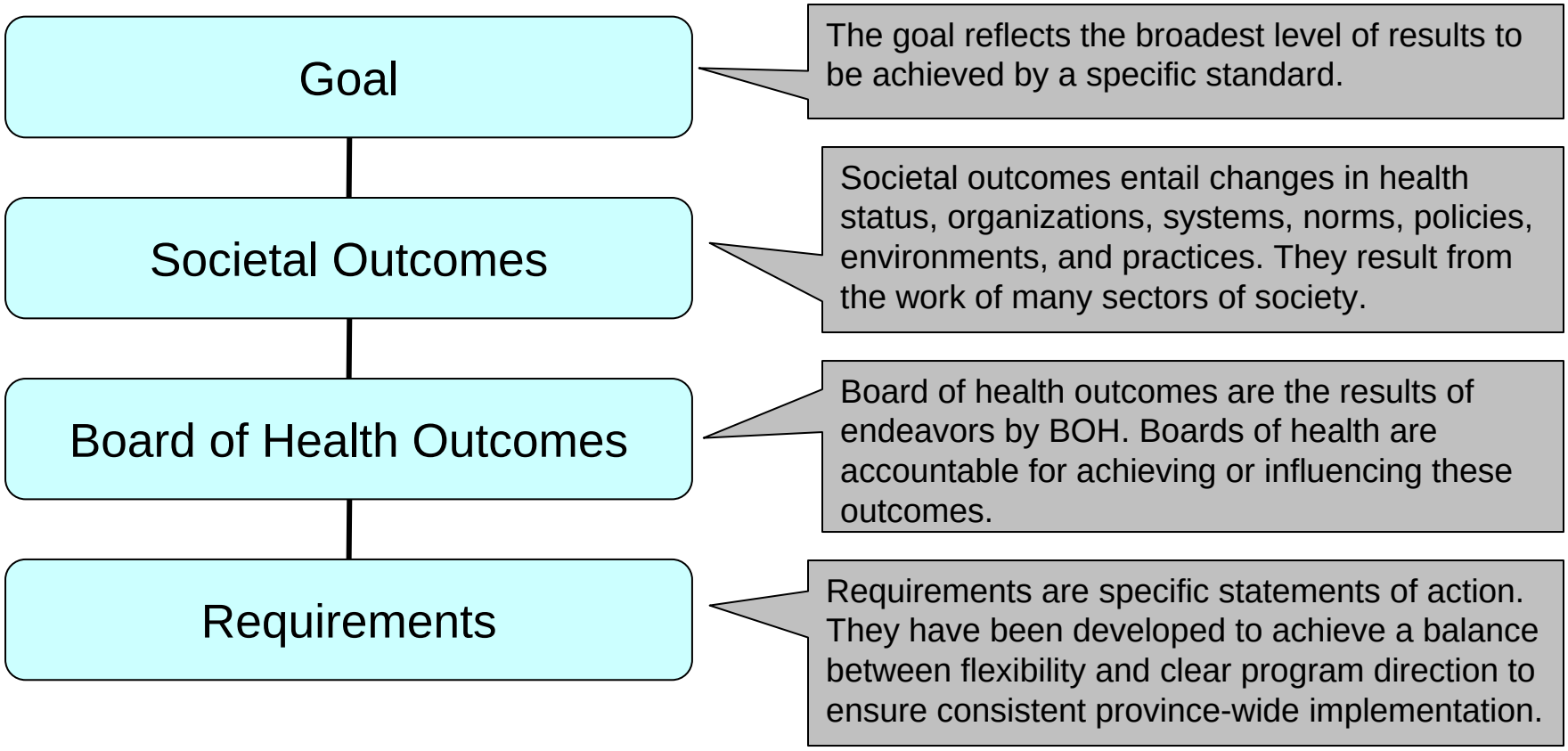
- Standards
- Board of Health Outcomes
- Grants
- Legislated Requirements

- Indicators
- Risk Assessment
- Data Collection

- Public Reporting
- Accountability Agreements
- Accreditation
- Continuous Quality Improvement Tools
- Assessments

Use of Performance Management within the Ontario Public Health Standards

- The OPHS is built on a logic model framework that links activities to immediate and longer term or higher order outcomes.
- The OPHS is explicit that boards of health are accountable for achieving BOH level outcomes.



Accountability Agreements – Performance Indicators

- An initial set of potential accountability agreement performance indicators has been developed in consultation with the InTAC, and received input from the PMWG. Final suite of indicators will be recommended by the JMB Committee.
- All of the indicators have been assessed by the ministries as being feasible for use within the AA process.
  - Some challenges remain, such as requiring new data submissions from health units, but these can be addressed.
- Most performance indicators will be common across all boards of health and will reflect provincial priorities for performance improvement.
- Indicators for health promotion and prevention programs (MHPS) as well as health protection programs (MOHLTC) are both represented.

Accountability Agreements – Performance Indicators

- In the first year, baselines will be established for each indicator, for each board of health. Table A of Schedule D will read “establish baseline” for 2011.
  - Schedule “D” will indicate that indicator is under development.
- Years 2 and 3: targets for performance improvement will be established in consultation with each board of health, relative to its baseline level of achievement.
  - No provincial level targets.
- Results are representative of OPHS and focus on board of health outcomes (i.e., results are primarily within control or significant influence of public health units).
- Outcomes are sensitive to change over time (quarterly/ annually).
- Data for indicators are accessible and available quarterly to yearly.
- Indicators will be in place for at least 3 years (2011 – 2014).

What is an Indicator?

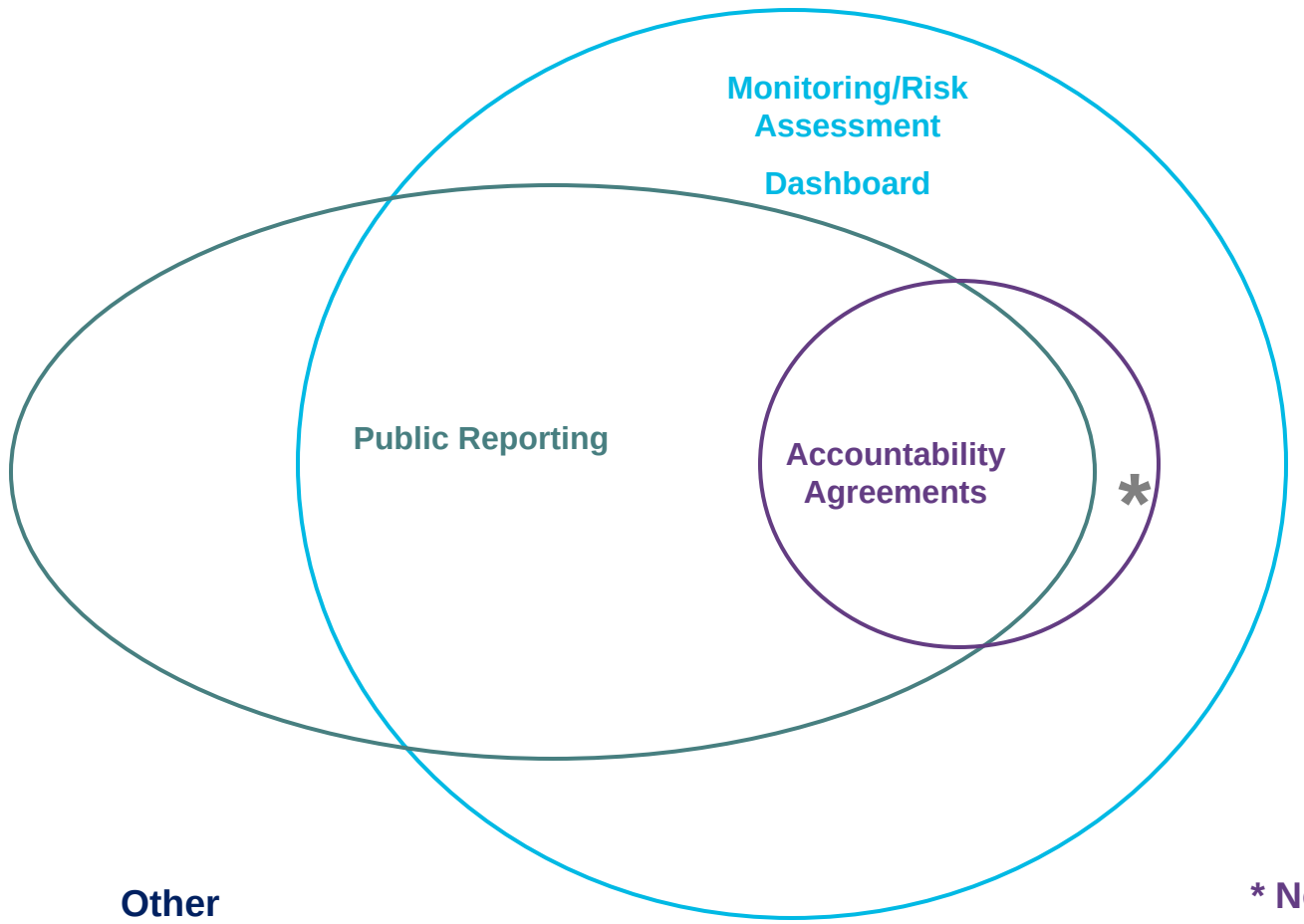
- Indicators are **succinct** measures that aim to **describe** as much about a **system** as possible in as few points as possible.
- Indicators help us **understand** a system, **compare** it and **improve** it.

From: Association of Public Health Observatories (UK) & National Health Service Institute for Innovation and Improvement (UK), 2008

Use of Indicators

- **Current and continuing usage:**
  - To support local program management and manage service delivery; determined at the board of health level.
  - To inform surveillance activities and policy development; requirements support program managers within government.
- **Proposed uses within performance management system:**
  - Public reporting
  - Accountability agreements
  - Monitoring/Risk assessment
- **The same indicators may be used for multiple purposes.**

How Indicators Fit Together



Different Indicators for Different Uses

Purpose	**Examples of Indicators** (for Infectious Disease Program)
Public Reporting • To demonstrate movement on public health priorities at the provincial and health unit levels	# of respiratory infection outbreaks in long-term care homes
Performance Improvement (through AAs) • To demonstrate clear movement on government priorities	% of infectious disease cases lost to follow up
Monitoring Risks • To proactively protect the health of the public by being alert for Boards of Health or individual programs at risk as early as possible.	# of influenza outbreaks (too low could be a sign of poor surveillance) OR % of reportable disease cases closed with disposition of "complete" within specific time period
• Other Government Indicators: To monitor program specific issues.	
• Other Public Health Unit Indicators: To monitor program administration.	

Using Targets

- Targets will be used to identify and communicate the government's expectations about the level of performance required by boards of health for each AA indicator, and will be negotiated as part of the AA process.

- In the first year, data will be collected for each indicator in order to establish baselines.

- Schedule D will outline board of health performance expectations including common indicators for all boards. Board-specific targets/performance corridors will begin post-implementation phase (i.e., 2012 and beyond).

Accountability Agreements Timeline

<table>
<tr><th>January – June

2011</th><th>June – September

2011</th><th>October – December

2011</th><th>January – December

2012 - 2013</th></tr>
<tr><td rowspan="2">AA Template & Indicators Drafted

Consultation with BOHs & PHUs</td><td>Finalize AA Template & Performance Indicators</td><td>Initiate Baseline Data Collection</td><td rowspan="2">Monitoring and Measurement Begins</td></tr>
<tr><td>Identify Board-specific indicators as needed.

Boards of Health sign AAs</td><td>Negotiate targets on all performance indicators for Years 2 & 3.</td></tr>
</table>

- The technical documentation setting out the derivation of each indicator will be completed once the AA indicators have been finalized.

Proposed Performance Indicators for Inclusion in 2011-2013 Accountability Agreements

Ontario

Environmental Health Program Standards

Food Safety

1. % of high risk food premises inspected once every 4 months while in operation

Safe Water

2. Proportion of pools and public spas by class inspected while in operation
3. % of completed SDWS inspections, of those that are high risk, that are due for inspection

Infectious Diseases Program Standards

Sexual Health

4. Time between health unit notification of an STI and initiation of follow up

Infectious Disease Prevention and Control

5. Time between health unit notification of an i-GAS case and initiation of follow up
6. % of invasive Group A streptococcus (i-GAS) cases lost to follow-up
7. % of known high risk personal service settings inspected annually

Vaccine Preventable Disease

8. % of vaccine wasted by vaccine type (HPV, influenza, pneumococcal, and DPT) that are stored/ administered by the PHU.
9. % completion of reports related to vaccine wastage by vaccine type (HPV, influenza, pneumococcal, and DPT) that are stored/ administered by other healthcare practitioners.
10. % of school-aged children who have completed immunizations for Hepatitis B, HPV and meningococcus

Chronic Diseases and Injuries Program Standards

Chronic Disease Prevention

11. % of youth (ages 12 - 19) who have never smoked a whole cigarette
12. % tobacco vendor compliance with legislation by infraction type
13. Status of local policy development related to physical activity and healthy eating (Qualitative Indicator)

Prevention of Injury and Substance Misuse

14. Fall-related emergency department visits by age group (infants; toddlers; school-aged children; adults; seniors)
15. % of population that exceeds Low-Risk Drinking Guidelines

Family Health Program Standards

Child Health & Reproductive Health

16. Baby Friendly Initiative Status: re-designated BFI; designated BFI; advanced work towards BFI; intermediate work towards BFI; preliminary work towards BFI; or, no plans for BFI.

Consultation Overview: e-Survey

Ontario

Background on E-Survey

- Starting on May 9th, each board of health will have the opportunity to provide consolidated feedback on the draft Agreement template, including the proposed list of indicators, via an online survey tool.

- The feedback will be synthesized and presented to JMB to help inform their final recommendations to the ministries on the Agreement template and the set of performance indicators.

- Individual board of health responses will be treated as confidential and only aggregate results will be shared with JMB.

How do you participate?

- Each board of health will have the opportunity to submit one collated response on behalf of their board and are encouraged to use a collaborative process to complete the survey.
- The survey will be predominantly quantitative in nature, with room for a few open-ended questions.
- Boards can complete a section at a time and then return to the e-survey at a later time. Boards of health are encouraged to complete all sections of the e-survey. Click ‘Done’ at the end to ensure that all your responses are saved as you exit the survey.
- The survey introduction contains information on how to contact ministry staff who will be available to deal with any technical concerns from respondents.

e-Survey Access

- Boards of Health will receive a letter of instruction on how to participate in the survey.
- Each board of health will be provided with a unique password via email from the consultant to access the survey website (these will be sent to MOH/CEOs).
- The survey will be accessible as of May 9th (9 a.m. EST) , and will be closing on Wednesday May 25th (5:30 p.m. EST) .
- The survey will be accessible through Survey Monkey at: http://www.surveymonkey.com/s/E-Survey_Accountability_Agreement
- Survey website will include:
  - Instructions for completion of e-Survey
  - e-Survey
  - Link to the draft Accountability Agreement template and proposed performance indicators document

What we are asking of you:

1. Review the Draft Accountability Agreement template and information on the proposed set of performance indicators prior to completing the survey.

2. While reading, think about whether the template meets your expectations or if you would need additional information to clarify your understanding.

3. Consider whether you anticipate any implementation challenges, and what tools could help support your board of health to overcome them.

For follow-up information:

- If you have technical questions about accessing the survey please contact Nicole Consitt, Public Health Practice Analyst, Public Health Practice Branch at 416.327.7627 or by e-mail at: nicole.consitt@ontario.ca

- If you have questions about the consultation process, the Accountability Agreement template, or Ministry of Health and Long-term Care performance indicators, please contact Michele Weidinger, Performance Management Lead, Public Health Practice Branch at 416.314.1728 or by e-mail at: michele.weidinger@ontario.ca

- If you have questions about Ministry of Health Promotion and Sport performance indicators, please contact Anne-Joyelle Occhicone, Program Standards Advisor, Standards, Programs, and Community Development Branch at 416.327.1728 or by e-mail at: anne-joyelle.occhicone@ontario.ca

Thank you!

Questions?

Ontario

Appendices

Important Links

Capacity Review Committee Final Report

http://www.health.gov.on.ca/english/public/pub/ministry_reports/capacity_review06/capacity_review06.html

Ontario Public Health Standards

http://www.health.gov.on.ca/english/providers/program/pubhealth/oph_standards/ophs/index.html

Initial Report on Public Health

http://www.health.gov.on.ca/english/public/pub/pubhealth/init_report/

Ontario Public Health Organizational Standards

http://www.health.gov.on.ca/en/pro/programs/publichealth/orgstandards/default.aspx

Advisory Committees

- The ministries have convened a number of advisory committees to provide expert advice in the development of the performance management framework and its components. These include:
  - The Performance Management Working Group (PMWG): responsible for providing strategic direction to the government on the performance management framework and its components (see Appendix 1 for membership list)
  - The Joint Ministries-Boards of Health Committee (JMB): responsible for proposing the language of the accountability agreement template and advising on indicators for inclusion within the accountability agreements (see Appendix 2 for membership list)
  - The Indicator Technical Advisory Committee (InTAC): responsible for the independent analysis and development of indicators as put forth by the Ministries (see Appendix 3 for membership list)
  - The Public Health Policy Indicators Advisory Group: responsible for providing technical expertise and advice on a qualitative, policy-related indicator that is being developed by the Ministry of Health Promotion and Sport (see Appendix 4 for membership list)

Performance Management Working Group (PMWG) Membership

Co-Chairs

Dr. Rosana Pellizzari,	Medical Officer of Health, Peterborough County-City Health Unit
Michèle Harding,	Director (A), Public Health Practice Branch, MOHLTC

Members from Health Units and Other Organizations

Karen Beckermann,	Manager, Planning and Performance, Toronto Public Health
Dr. Vera Etches,	Associate Medical Officer of Health, Ottawa Public Health
Dr. Charles Gardner,	Medical Officer of Health & Chief Executive Officer, Simcoe-Muskoka District Health Unit
Mary Johnson,	Board of Health member, Eastern Ontario Health Unit
Dr. Jeff Kwong,	Scientist, Institute for Clinical Evaluative Sciences
Dr. Robert Kyle,	Medical Officer of Health, Durham Regional Health Unit
Dr. George Pasut,	Vice President, Ontario Agency for Health Protection and Promotion
Suzanne Ross	Director, Public Health, Eastern Ontario Health Unit
Dr. Robert Schwartz,	Deputy Director and Director of Evaluation & Monitoring, University of Toronto
Shelley Stalker,	Manager, Epidemiology and Research, York Region Community and Health Services
Cynthia St. John,	Chief Executive Officer, Elgin St. Thomas Health Unit
Dr. Jo Ann Tober,	Chief Executive Officer, Brant County Health Unit
Dr. Erica Weir,	Associate Medical Officer of Health, York Region Community and Health Services
Shelley Westhaver,	Director, Clinical Services Division, Sudbury & District Health Unit
Carol Woods,	Program Director, Research, Evaluation, Epidemiology, and Sexual Health, Algoma Public Health

Members from the Ontario Government

Laura Belfie,	Manager, Standards, Programs and Community Development (MHPS)
Thomas Custers,	Manager, Strategic Policy & Planning Branch, MHPS
Domenic Della Ventura,	Team Lead, Performance and Accountability, LHIN Liaison Branch, MOHLTC
Sahba Eftekhary,	Senior Specialist, Strategic Alignment Branch, MOHLTC
Karen Johnson,	Epidemiologist, Public Health Protection and Promotion Branch, MOHLTC
Naomi Kasman,	Senior Health Analyst, Health Analytics Branch, MOHLTC
Roselle Martino,	Director, Chief Medical Officer of Health Office, MOHLTC
Laura Pisko-Bezruchko,	Director, Standards, Programs and Community Development, MHPS
Siamak Tenzif,	Senior Advisor, Health Systems Strategy Division, MOHLTC
Representative,	Early Years Programs Unit, MCYS

Joint Ministries/Boards of Health Committee (JMB) Membership

Joint-Chairs

Jean Lam,	Assistant Deputy Minister, Sport, Public Health and Community Programs Division, (MHPS)
Mary Johnson,	Chair, alPHa Board of Health Section, Eastern Ontario Health Unit
Sylvia Shedden,	Assistant Deputy Minister (A), Public Health Division (MOHLTC)

Members from Health Units and Other Organizations

Maria Harding,	Representative, alPHa Board of Health Section, Thunder Bay District Health Unit
Dr. Allen Heimann,	Representative, alPHa Council of Medical Officers of Health, Windsor-Essex County Health Unit
Patricia Hewitt,	Representative, alPHa Association of Public Health Business Administrators, Manager Public Health Programs, Halton Region Health Unit
Dale Jackson,	Chair, alPHa Association of Public Health Business Administrators, Hastings and Price Edward Counties Health Unit
Dr. Robert Kyle,	Medical Office of Health, Durham Regional Health Unit
Dr. Paul Roumeliotis,	Chair, alPHa Council of Medical Officer's of Health, Eastern Ontario Health Unit
Dr. Penny Sutcliffe,	Representative, alPHa Council of Medical Officers of Health, Sudbury & District Health Unit
Jane Speakman,	Representative, Public Health Lawyers' Association, City of Toronto
Valerie Sterling,	Representative, alPHa Board of Health Section, Toronto Public Health
Cynthia St. John,	CEO, Elgin St. Thomas Health Unit
Jo Ann Tober,	CEO, Brant County Health Unit

Members from the Ontario Government

Laura Belfie,	Manager, Standards, Programs and Community Development (MHPS)
Pier Falotico,	Director, Financial Management Branch (MOHLTC)
Michèle Harding,	Director (A), Public Health Practice Branch (MOHLTC)
Roselle Martino	Director, Chief Medical Officer of Health Office (MOHLTC)
Joe Nazareth,	Manager, Financial Management Branch (MOHLTC)
Laura Pisko-Bezruchko	Director, Standards, Programs and Community Development (MHPS)
Alex Rishea,	Senior Policy Analyst, Early Years Programs Unit (MCYS)
Liam Scott,	Counsel, Legal Services Branch (MOHLTC)

Indicator Technical Advisory Committee (InTAC) Membership

Co-Chairs

Paul Fleiszer,	Manager, Metrics and Planning, Toronto Public Health
Joanne Thanos,	Epidemiologist, Public Health Practice Branch, MOHLTC

Members from Health Units and Other Organizations

Sherri Deamond,	Epidemiologist, Durham Region Health Department
Foyez Haque,	Epidemiologist, Porcupine Health Unit
Joanna Oliver,	Epidemiologist, Halton Region Health Department
Suzanne Sinclair,	Epidemiologist, KFL&A Public Health
Julie Stratton,	Manager, Region of Peel Health Department
Brenda Guarda,	(A) Chair, Core Indicators Working Group (APHEO), Team Lead, Simcoe-Muskoka District Health Unit
Colleen Van Berkel,	Public Health Research Education & Development, Director, City of Hamilton Public Health
Shelley Stalker,	APHEO representative Manager, Epidemiology, York Region Health Department
Dr. Jeff Kwong,	Institute for Clinical and Evaluative Sciences
Gilliam Lim,	Ontario Agency for Health Protection and Promotion

Members from the Ontario Government

Dr. Elizabeth Rael,	Senior Epidemiologist, Strategic Policy Branch, MHPS
Naomi Kasman,	Senior Health Analyst, Health Analytics Branch, MOHLTC
Michael Whelan,	Senior Epidemiologist, Public Health Protection and Prevention Branch, MOHLTC

Public Health Policy Indicators Advisory Committee Membership

Chair

Anne-Joyelle Occhicone	Program and Standards Advisor, Ministry of Health Promotion and Sport

Members from Health Units

Anne Birks	Manager, Toronto Public Health
Darlene Mecredy	Director, Kingston, Frontenac, Lennox and Addington Public Health
Ena DePeuter	Manager, Thunder Bay District Health Unit
Joanne Beyers	Community Nutrition Specialist, Sudbury and District Health Unit
Katherine Pigott	Manager, Region of Waterloo Public Health
Mary Lou Albanese	Manager, Middlesex-London Health Unit
Tami McCallum	Manager, Niagara Region Public Health
Victoria Morley	Manager, York Region Health Services Department

Members from the Ontario Government

Laura Belfie	Manager, Standards, Programs, and Community Development Branch, MHPS

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 051-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 May 19

Board of Health Performance Assessment: March Survey

Recommendation

It is recommended that Report No. 051-11 re Board of Health Performance Assessment: March Survey be received for information.

Background

At the request of the Board of Health, a process and survey tool was developed and approved in November 2010 to help self-assess the performance of the Board of Health. In February 2011, the Ontario Public Health Organizational Standards were released specifying that "The Board of Health shall have a self-evaluation process of its governance practices and outcomes that is implemented at least every other year and results in recommendations for improvements in Board effectiveness and engagement."

A working group of the Board of Health determined that the survey tool (Appendix A) be administered three times a year (March, June and November) and the process be reviewed after one year of implementation. The results of the March survey are presented in this Report.

March Board Assessment Findings

The March self-assessment survey was completed online or on paper in late March by 8 of 11 Board of Health members. The results have been analyzed and summarized by a Program Evaluator and are presented in Appendix B. Appendix C presents the attendance record of Board members for information referred to in the summary of survey findings.

Cautionary Notes

The summary of survey findings is not intended to be the result of an independent and rigourous assessment of Board functioning. Rather, it is intended to generate discussion amongst Board members, so they can better identify areas deemed as strengths and those requiring improvement.

In addition, it may be somewhat premature for Board members to provide a valid assessment of the scale items on the survey (i.e., 1. How well has the Board done its job? and 2. How well has the Board conducted itself?) as the Board's membership has changed significantly since the new year, and not all members have been able to attend the first three meetings of 2011.

If Board performance issues are to be discussed in a public forum, members may be somewhat less likely to identify problem areas. One mechanism the Board may wish to consider is addressing this report when sitting as Committee of the Whole.

Board members also need to consider how representative the collective findings are of the whole Board of Health given that not all members completed the survey.

This report was prepared by Ms. Evelyn Crosse, Epidemiologist, and Ms. Michelle Sangster Bouck, Program Evaluator, Family Health Services.

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

This report addresses Board of Health direction given to Board Working Group #3 and Requirement 4.3 Board of Health Self-evaluation, Ontario Public Health Organizational Standards.

MIDDLESEX-LONDON HEALTH UNIT

Board of Health Performance Assessment Tool

This survey is expected to take approximately 10-15 minutes.

Please complete by Friday March 25, 2011.

As part of the Board's commitment to good governance and continuous quality improvement, all Board members are invited to complete the Board of Health Performance Assessment Tool. The tool is intended to 1) focus on the Board as a whole, 2) identify areas of strength, and 3) areas that could be enhanced.

Please note however, that your participation is voluntary and you may choose not to participate or not to respond to all questions.

"*Performance of Individual Board Members*" should not be submitted. It is provided to support self-reflection on your role as a Board member.

The results will be summarized and shared with the Board. All responses will be handled in confidence and individual responses will not be identifiable from the summary.

Once the summary has been shared with the Board, the questionnaires will be destroyed.

Please return your questionnaire in a sealed envelope to Sherri Sanders, Executive Assistant to the Board of Health. If you have any questions about the survey, please contact Sherri Sanders, 519-663-5317, Ext. 3011 or at sherri.sanders@mlhu.on.ca

Thank you

The electronic copy has the same content, yet will look different to accommodate the formatting required for the on-line survey.

A. How Well Has the Board Done Its Job?

Please Note: the scale is from 1= "Strongly Disagree" to 7 = "Strongly Agree"

Please indicate the extent to which you agree with the following statements?

The Board:

	Strongly Disagree 1	2	3	Neither Disagree Or Agree 4	5	6	Strongly Agree 7	Don't Know
1. Has a common understanding of the Board's mandate, scope and authority.	❑	❑	❑	❑	❑	❑	❑	❑
2. Keeps abreast of relevant trends, events and emerging issues.	❑	❑	❑	❑	❑	❑	❑	❑
3. Understands the Health Unit's mission.	❑	❑	❑	❑	❑	❑	❑	❑
4. Has a working knowledge of Board bylaws.	❑	❑	❑	❑	❑	❑	❑	❑
5. Ensures that the Health Unit has a long-term strategic plan.	❑	❑	❑	❑	❑	❑	❑	❑
6. Ensures that the Health Unit is responsive to needs of local communities.	❑	❑	❑	❑	❑	❑	❑	❑
7. Ensures processes are in place to identify, assess and manage any risks to the Health Unit	❑	❑	❑	❑	❑	❑	❑	❑
8. Focuses on long-term results and substantial policy issues rather than operational detail.	❑	❑	❑	❑	❑	❑	❑	❑
9. Is able to interpret, analyze and assess financial information, reports and proposals.	❑	❑	❑	❑	❑	❑	❑	❑

Please Note: the scale is from 1= "Strongly Disagree" to 7 = "Strongly Agree"

	Strongly Disagree 1	2	3	Neither Disagree Or Agree 4	5	6	Strongly Agree 7	Don't Know
10. Has adequate information to monitor organizational performance. e.g. financial management; delivery of Ontario Public Health Standards ; work force issues, etc.	❑	❑	❑	❑	❑	❑	❑	❑
11. Ensures that decisions are based on accurate, timely and the best available information.	❑	❑	❑	❑	❑	❑	❑	❑
12. Has a process for handing urgent matters between meetings.	❑	❑	❑	❑	❑	❑	❑	❑
13. Is knowledgeable of the programs and services offered by the Health Unit.	❑	❑	❑	❑	❑	❑	❑	❑
14. Regularly assesses the performance of the MOH/CEO in a systematic way.	❑	❑	❑	❑	❑	❑	❑	❑

15. Additional observations, comments or suggestions about how well the Board has done its job:

B. How Well Has the Board Conducted Itself?

Please Note: the scale is from 1= "Strongly Disagree" to 7 = "Strongly Agree"

Please indicate the extent to which you agree with the following statements?

	Strongly Disagree 1	2	3	Neither Agree or Disagree 4	5	6	Strongly Agree 7	Don't Know
1. Board members are aware of what is expected of them.	❑	❑	❑	❑	❑	❑	❑	❑
2. The roles and responsibilities of the board are clearly defined and separate from those of staff.	❑	❑	❑	❑	❑	❑	❑	❑
3. <u>Complete ONLY If a New Board member</u> New Board members receive an effective orientation to their responsibilities as a Board member.	❑	❑	❑	❑	❑	❑	❑	❑
4. The Board is satisfied with the ongoing education it receives in order to fulfill its responsibilities.	❑	❑	❑	❑	❑	❑	❑	❑
5. Board information packages provide the right information and are received in a timely manner.	❑	❑	❑	❑	❑	❑	❑	❑
6. Board meeting agendas are well planned so that all necessary board business is addressed.	❑	❑	❑	❑	❑	❑	❑	❑
7. Agendas are appropriate e.g. topics are relevant to the mission and goals of the Health Unit; items are clearly identified as for information, discussion or decision.	❑	❑	❑	❑	❑	❑	❑	❑
8. Board members come prepared to participate in the discussion and decision–making.	❑	❑	❑	❑	❑	❑	❑	❑

Please Note: the scale is from 1= "Strongly Disagree" to 7 = "Strongly Agree"

	Strongly Disagree 1	2	3	Neither Disagree Or Agree 4	5	6	Strongly Agree 7	Don't Know
9. The Board uses its meeting time effectively and efficiently i.e. discussion is focused, clear, concise and on topic.	❑	❑	❑	❑	❑	❑	❑	❑
10. All board members participate in important board discussions.	❑	❑	❑	❑	❑	❑	❑	❑
11. Board members do a good job of encouraging and dealing with different points of view.	❑	❑	❑	❑	❑	❑	❑	❑
12. Board members respect the rules of confidentiality	❑	❑	❑	❑	❑	❑	❑	❑
13. Decisions are supported once made.	❑	❑	❑	❑	❑	❑	❑	❑
14. Board decisions and processes are available to staff and community partners.	❑	❑	❑	❑	❑	❑	❑	❑
15. The Board Chair runs the meetings effectively.	❑	❑	❑	❑	❑	❑	❑	❑

16. Additional observations, comments or suggestions about how well the Board has conducted itself:

C. Open-Ended Questions

1. **What I like most about our meetings:**

2. **What I like least about our meetings:**

3. **Please indicate what training opportunities you would like as a board member.**

4. **What is the most important thing the Board could do to improve its performance as a Board?**

5. **Do you have additional comments that will help the Board increase its effectiveness?**

Thank you!

MIDDLESEX-LONDON HEALTH UNIT

Performance of Individual Board Members
(Not to be Submitted)

Are you satisfied with your performance as a board member in the following areas?

Please Note: the scale is from 1= "Strongly Disagree" to 7 = "Strongly Agree"

	Strongly Disagree 1	2	3	Neither Disagree or Agree 4	5	6	Strongly Agree 7	Don't Know
1. I am aware of what is expected of me as a board member.	❑	❑	❑	❑	❑	❑	❑	❑
2. I have a good record of meeting attendance.	❑	❑	❑	❑	❑	❑	❑	❑
3. I read the minutes, reports and other materials in advance of the board meetings.	❑	❑	❑	❑	❑	❑	❑	❑
4. I frequently encourage other board members to express their opinions at board meetings.	❑	❑	❑	❑	❑	❑	❑	❑
5. I am encouraged to express my opinions at board meetings.	❑	❑	❑	❑	❑	❑	❑	❑
6. I feel comfortable to ask questions if I do not understand something.	❑	❑	❑	❑	❑	❑	❑	❑
7. I am a good listener at board meetings.	❑	❑	❑	❑	❑	❑	❑	❑
8. I follow through on things I have said I would do.	❑	❑	❑	❑	❑	❑	❑	❑
9. I maintain the confidentiality of all board decisions.	❑	❑	❑	❑	❑	❑	❑	❑
10. When I have a different opinion than the majority, I raise it.	❑	❑	❑	❑	❑	❑	❑	❑

Please Note: the scale is from 1= "Strongly Disagree" to 7 = "Strongly Agree"

	Strongly Disagree 1	2	3	Neither Disagree or Agree 4	5	6	Strongly Agree 7	Don't Know
11. I support board decisions once they are made even if I do not agree with them.	❑	❑	❑	❑	❑	❑	❑	❑
12. I stay informed about issues relevant to the Health Unit mission and bring information to the attention of the board.	❑	❑	❑	❑	❑	❑	❑	❑
13. I understand my legal responsibilities.	❑	❑	❑	❑	❑	❑	❑	❑

14. Additional observations, comments or suggestions about my own performance as a Board Member:

THIS QUESTIONNAIRE IS FOR INDIVIDUAL USE ONLY AND IS NOT TO BE SUBMITTED.

Middlesex-London Board of Health Performance Assessment: Summary of Findings, March 2011

How Well Has the Board Done Its Job?

- Overall, respondents perceived that the Board of Health has done their job well. On a scale 7-point scale, where 7 is strongly agree, 86% of responses were either a 6 or 7. There were no statements to which any respondents disagreed.

- The strongest agreement ratings were given to the statements "The Board ensures that the Health Unit is responsive to needs of local communities" and "The Board ensures that decisions are based on accurate, timely and the best available information."

- The statement with the weakest agreement rating was; "The Board has a working knowledge of Board bylaws."

How Well Has the Board Conducted Itself?

- Respondents perceived that the Board of Health has conducted itself well. On a scale 7-point scale, where 7 is strongly agree, 88% of responses were either a 6 or 7. There were no statements to which any respondents disagreed.

- The strongest agreement ratings were given to the following statements: "The roles and responsibilities of the board are clearly defined and separate from those of staff," "Board information packages provide the right information and are received in a timely manner," and "Board decisions and processes are available to staff and community partners."

- The statements with the weakest agreement rating were; "Board members are aware of what is expected of them," and "All Board members participate in important board discussions."

Summary of Written Comments

- Overall, respondents liked that the Board Meetings were well run and covered diverse topics and current health issues. Respondents also liked the information provided to Board Members by health unit staff through written reports and the availability of staff to answer questions at Board Meetings. It was also suggested that staff presentations adhere to assigned timelines.

- A key issue highlighted in the written comments was concern about attendance at Board Meetings by new Board Members. It was also mentioned that attendance ultimately impacts the ability to assess Board performance (see Appendix C).

- Specific requests for training opportunities for Board Members around (1) Ministry level policies and legislation changes; (2) legal and liability issues, and 3) two requests for “Robert’s Rules of Order” workshop.

- Other comments about training opportunities for Board Members reflected openness to participation; a request for online learning for those unable to attend ALPHA meetings outside of Middlesex-London, and encouragement for Board Members to seek out available opportunities.

- Other comments in response to a final open-ended question about “The most important thing the Board could do to improve its performance” focused on the importance of:
    - strategic decision-making and embracing the strategic planning sessions,
    - evaluating and prioritizing what we do,
    - planning programs and initiatives based on evidence.

MIDDLESEX-LONDON BOARD OF HEALTH MEETING **Appendix C**
Attendance Record January – March, 2011

Member	Jan	Feb	Mar
Brown, Ms. Denise	P	X	X
Coderre, Ms. Patricia	P	P	T
Edmondson, Mr. Al	P	P	P
Lortie-Monette, Dr. Francine	P	P	P
McLinchey, Ms. Doreen	P	P	P
Meyer, Mr. Marcel	P	P	X
Poletes Montgomery, Ms. Viola	P	P	P
Poole, Ms. Nancy	P	P	P
Shipway, Mr. Don	P	P	P
Studenny, Mr. Mark	P	P	X
Swan, Mr. Joe	X	P	X
P Indicates Present T Indicates Participated by Teleconference X Indicates Absent			

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 052-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 May 19

2011 Budget – First Quarter Review

Recommendation

It is recommended that Report No. 052–11 re 2011 Budget – First Quarter Review be received for information.

1st Quarter Review

The attached Budget Summary (Appendix A) shows actual and budgeted expenditures net of offset revenues for the three-month period January 1st to March 31st, 2011. For the programs with a March 31st year-end, this report shows the actual (unaudited) and budgeted expenditures net of offset revenues for the year ended March 31, 2011.

Cost-Shared Programs

For the first quarter of the year, Cost-Shared programs are reporting a favourable variance of $872,648. This is owing to unallocated resources awaiting the provincial grant approval and the remainder is primarily timing differences (or the fact that the budget is spread equally over twelve months, while actual expenditures are not). Timing difference should not generate any surplus.

While it's still early in the operating year, it appears that the Cost-Shared Programs are on course to completing the year in a break-even position.

Other Programs

For the December 31st programs, the first quarter shows a favourable variance of $345,185. This is owing to timing difference in wages and benefits and other operating expenses. The Healthy Smiles Ontario program will likely generate a surplus as this is a new program and will not be able to reach all of the target population in its first year.

For the March 31st programs, there currently is a surplus of $57,969. These programs have not been through their annual audit. Over the summer, the year end process will be completed and an audit performed with financial statements being presented to the Board of Health in the Fall.

Summary

It is projected the Health Unit will complete the operating year on a break-even position. This position is fairly fluid due to the uncertainty of provincial funding for the cost-shared programs as well as the 100% provincially funded programs. March 31st year end programs will likely generate modest program surpluses; however, this cannot be confirmed until after the year-end audit process has been completed.

Mr. John Millson, Director, Finance and Operations will be in attendance at the May 19th Board meeting to address any questions regarding this report.

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

This report addresses - Policy No. 4-20 Expenditure Reports as outlined in the MLHU Administration Policy Manual.

Middlesex-London Health Unit
BUDGET SUMMARY
As at March 31, 2011

	2011 YTD ACTUAL	2011 YTD BUDGET	VARIANCE (OVER) / UNDER	% VARIANCE	2011 ANNUAL BUDGET
COST-SHARED PROGRAMS					
Oral Health, Communicable Disease & Sexual Health Services					
Office of the Associate Medical Officer of Health	$ 80,353	$ 79,270	$ (1,083)	-1.4%	$ 317,078
Vaccine Preventable Diseases	240,261	249,831	9,570	3.8%	999,325
The Clinic	264,292	273,193	8,901	3.3%	1,092,773
Sexual Health Promotion	77,100	82,626	5,526	6.7%	330,502
Infectious Disease Control	126,177	136,217	10,040	7.4%	544,867
Dental Prevention	163,057	199,434	36,377	18.2%	797,735
Children In Need of Treatment (CINOT)	107,143	118,420	11,277	9.5%	473,680
Total Oral Health, Comm. Disease & Sexual Health Services	***$ 1,058,383***	***$ 1,138,991***	***$ 80,608***	***7.1%***	***$ 4,555,960***
Environmental Health & Chronic Disease & Injury Prevention					
Office of the Director	$ 79,240	$ 93,869	$ 14,629	15.6%	$ 375,474
Environmental Health	424,848	557,095	132,247	23.7%	2,228,380
Chronic Disease and Injury Prevention	291,170	360,399	69,229	19.2%	1,441,596
Vector Borne Disease Program	45,356	153,989	108,633	70.5%	615,956
Total Environmental Health & Chronic Disease & Injury Prev	***$ 840,614***	***$ 1,165,352***	***$ 324,738***	***27.9%***	***$ 4,661,406***
Family Health Services					
Office of the Director	$ 75,490	$ 119,836	$ 44,346	37.0%	$ 479,344
Program Evaluation		$ 58,686	$ 58,686	100.0%	$ 234,744
Young Families Team	271,321	318,167	46,846	14.7%	1,272,669
Family Health Promotion Team	213,540	281,890	68,350	24.2%	1,127,560
Infant & Family Development Team	144,729	175,985	31,256	17.8%	703,938
Young Adult Team	163,790	229,704	65,914	28.7%	918,814
Child Health Team	255,693	333,321	77,628	23.3%	1,333,283
Infant Line Program	9,464	17,001	7,537	44.3%	68,004
Let's Grow Program	6,601	10,826	4,225	39.0%	43,303
Total Family Health Services	***$ 1,140,628***	***$ 1,545,416***	***$ 404,788***	***26.2%***	***$ 6,181,659***

	2011 YTD ACTUAL	2011 YTD BUDGET	VARIANCE (OVER) / UNDER	% VARIANCE	2011 ANNUAL BUDGET
Office of the Medical Officer of Health					
Office of the Medical Officer of Health	$ 100,880	$ 88,835	$ (12,045)	-13.6%	$ 355,339
Communications	48,416	58,343	9,927	17.0%	233,373
Special Projects	61,706	33,616	(28,090)	-83.6%	134,463
Travel Clinic	15,757	17,409	1,652	9.5%	69,635
Emergency Planning	5,501	7,205	1,704	23.6%	28,820
Total Office of the Medical Officer of Health	***$ 232,260***	***$ 205,408***	***$ (26,852)***	***-13.1%***	***821,630***
Finance & Operations	***118,665***	***147,465***	***28,800***	***19.5%***	***589,859***
Human Resources & Labour Relations	***144,609***	***156,592***	***11,983***	***7.7%***	***626,368***
Information Technology Services	***228,750***	***226,245***	***(2,505)***	***-1.1%***	***904,978***
General Expenses & Revenues (Benefits and Operations)	***1,023,490***	***1,074,578***	***51,088***	***4.8%***	***4,298,312***
TOTAL COST-SHARED PROGRAMS	**$ 4,787,399**	**$ 5,660,047**	**$ 872,648**	**15.4%**	**$ 22,640,172**

	2011 YTD ACTUAL	2011 YTD BUDGET	VARIANCE (OVER) / UNDER	% VARIANCE	2011 ANNUAL BUDGET
OTHER PROGRAMS					
December 31 Year-End Programs:					
Infectious Disease Control (MOHLTC)	$ 263,152	$ 283,185	$ 20,033	7.1%	$ 1,132,740
Small Drinking Water Systems (MOHLTC)	18,120	26,775	8,655	32.3%	107,100
Infection Control & Prevention Nurse (MOHLTC)	19,584	20,600	1,016	4.9%	82,400
Smoke Free Ontario (MHP)	198,085	254,376	56,291	22.1%	1,017,502
Dental Treatment (User Fees)	9,023	-	(9,023)	-	-
Healthy Babies/Healthy Children (MCYS)	485,767	620,828	135,061	21.8%	2,483,313
Healthy Smiles Ontario (MHLTC)	84,605	217,757	133,152	61.1%	871,028
Total December 31 Year End Programs	***$ 1,078,336***	***$ 1,423,521***	***$ 345,185***	***24.2%***	***$ 5,694,083***
March 31 Year-End Programs (1):					
Smart Start for Babies (Federal)	$ 144,173	$ 152,430	$ 8,257	5.4%	$ 152,430
Tyke Talk - Preschool Speech & Language (MCYS)	1,462,445	1,474,315	11,870	0.8%	1,474,315
Blind-Low Vision Program (MCYS)	158,593	158,702	109	0.1%	158,702
Infant Hearing Screening Program (MCYS)	811,228	848,961	37,733	4.4%	848,961
Total March 31 Year End Programs	***$ 2,576,439***	***$ 2,634,408***	***$ 57,969***	***2.2%***	***$ 2,634,408***
TOTAL OTHER PROGRAMS	**$ 3,654,775**	**$ 4,057,929**	**$ 403,154**	**9.9%**	**$ 8,328,491**
TOTAL MIDDLESEX-LONDON HEALTH UNIT	**$ 8,442,174**	**$ 9,717,976**	**$ 1,275,802**	**13.1%**	**$ 30,968,663**

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 053-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 May 19

2012 City of London Budget Target

Recommendation

It is recommended that Report No. 053 -11 re 2012 City of London Budget Target be received for information.

Background

The City of London has initiated its 2012 budget process by establishing budget targets for City departments and external Boards and Commissions who receive City funding. The target for the Middlesex-London Health Unit (MLHU) would result in an expedited transition to a 75%/25% cost-sharing arrangement. This report explains the history behind the current funding arrangement and highlights the potential impact of the proposed 2012 budget target.

Public Health Funding History

Prior to 1998, public health units were funded on a 75% provincial/25% municipal basis. In 1998, public health funding was downloaded 100% to municipalities. This was changed in 1999 when the province assumed 50% of public health funding.

In May 2004, the provincial government announced increased funding to public health units as a result of deficiencies found in the public health system through reviews undertaken of the provincial response to the 2003 SARS Crisis. In a December 9, 2004, letter to Boards of Health, the then Chief Medical Officer of Health, the late Dr. Sheila Basrur stated, "New provincial funding is intended to enhance the total funding available for public health in order to improve local public health capacity." The Province committed to strengthen the public health system by increasing its level of funding to 75% from 50% over a three-year period. The sequencing for this change was to be as follows:

- January 1, 2005 – 55% province, 45% municipalities
- January 1, 2006 – 65% province, 35% municipalities
- January 1, 2007 – 75% province, 25% municipalities.

As per Dr. Basrur's correspondence, the intention of this funding transition to 75%/25% was to increase funding to public health units, not simply to rearrange the cost-sharing of the current level of funding. By having municipalities hold to their 2004 funding contributions to public health units, the province would achieve increased funding to public health by not just increasing its percentage of the funding, but also by increasing the actual amount of dollars. Both City of London and Middlesex County Councils agreed to the proposed 2005 Board of Health budget plan to maintain their contribution at the 2004 funding level.

This was especially important for this Health Unit, in that prior to 2004, the MLHU ranked 34th out of 37 health units on a per capita funding basis. In addition, a provincial survey of health units regarding compliance with the Mandatory Health Program and Services Guidelines demonstrated this Health Unit was in significant noncompliance with many of the key indicators.

Cap of Provincial Grant

The Province announced during the 2006 budget process that it was capping its grant to Boards of Health to a 5% annual increase. This resulted in an altered cost-sharing formula from that originally scheduled for 2006, i.e., 62%/38% rather than 65%/35%. However, both the City of London and Middlesex County Councils agreed to continue the Board of Health budget plan which called for maintaining each municipal funder's budget contribution to remain at the 2004 level on an ongoing basis. This would enable the 75%/25% cost-sharing arrangement to be achieved over a longer period of time (10 years) rather than the originally scheduled 3 year period. In 2009, the province made an additional change to its level of funding, capping its annual grant increase to 3% where it has remained.

The success of the 2005 Board of Health budget plan can be seen in Appendix A which demonstrates the increase in funding ($7.9 million) realized by MLHU since 2004 resulting from annual provincial funding

increases, with no increase in funding from either municipality over the same period. The current cost-sharing ratio is 67%/33%.

City of London – 2012 Budget Target

City of London staff is presently engaging City Council in a 2012 budget target process. On May 10th, City staff presented to City Council (sitting as Committee of the Whole) the proposed 2012 budget targets for Civic Departments and Boards & Commissions. The proposal would achieve an overall residential property tax increase of 1.5%. As part of attaining this target, it was recommended that the City reduce its contribution to the MLHU in an amount which would result in a 75%/25% cost-sharing arrangement in 2012. The outcome of the Committee of the Whole meeting related to MLHU funding is the new target calls for a $500k reduction in 2012 with a phase-in to a 75%/25% cost-shared arrangement by 2014.

The potential budget impact of this revised target for 2012 would be an 8.07% City of London and Middlesex County budget reduction and an overall budget decrease of $137,047, as depicted in Table I below.

Table I – 2012 City of London Proposed Budget Target Impact

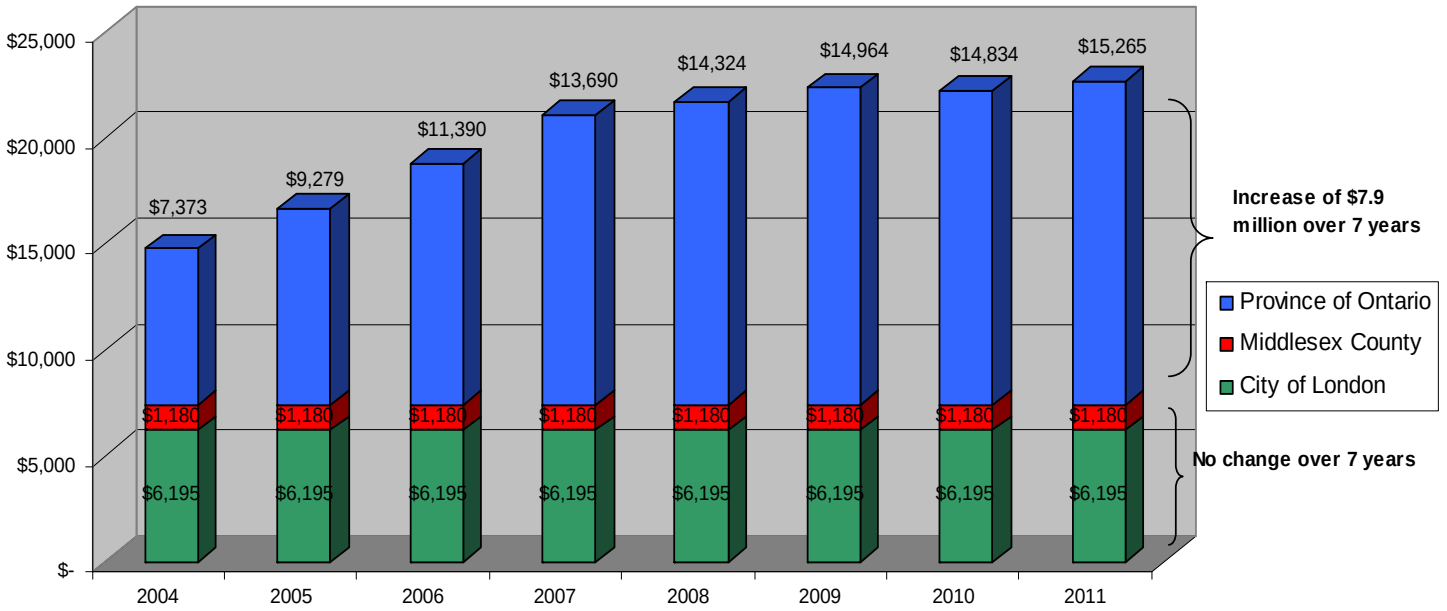
	Total	Province	City	County
2011 Cost-Shared Programs	$ 22,640,172	$ 15, 265,102	$ 6,195,059	$ 1,180,011
2012 Cost-Shared Target	22,503,125	15,723,055	5,695,059	1,085,011
Increase/(Decrease)	**(137,047)**	**457,953**	**(500,000)**	**(95,000)**

Mr. John Millson, Director, Finance and Operations, will be in attendance at the May 19th Board of Health meeting to answer any questions.

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

This report addresses Policy No. 4-10, (Budget Preparation and Approval) as outlined in the MLHU Administration Policy Manual.

2004 - 2011 Cost-Shared Program Funding ($000's)



MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 054-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCP, Medical Officer of Health
DATE: 2011 May 19

Healthy Communities Partnership Middlesex-London

Recommendation
It is recommended that the Board of Health Report No. 054-11 re Healthy Communities Partnership Middlesex-London be received for information.

Background
The Ontario Ministry of Health Promotion and Sport (MHPS) initiated the Healthy Communities Fund in 2009. The Healthy Communities Fund (HCF) provides funding to community partnerships to plan and deliver integrated programs that improve the health of Ontarians. The HCF plays a key role in helping the MHPS achieve its vision of "Healthy Communities Working Together and Ontarians Leading Healthy and Active Lives." The HCF has three main streams:

1. Grant Project Stream – A one-window approach to funding local, regional and provincial organizations to deliver health promotion initiatives that address two or more of the MHPS priority areas – physical activity, injury prevention, healthy eating, mental health promotion, reducing tobacco use and exposure and preventing alcohol and substance misuse.
2. Resource Stream – Provides training and support to build capacity for those working to advance health promotion in Ontario, including local partnerships and organizations that apply for funding through the HCF Grants Project Stream.
3. Partnership Stream – Promotes coordination planning and action among community groups to create policies that make it easier for Ontarians to be healthy. The Partnership Stream will link planning with community action by ensuring alignment between the communities' priority areas of focus and programs funded under the Grant Stream.

All Ontario Public Health Units were asked to take the lead for the Partnership Stream to move policies forward at the local level.

Healthy Communities Partnership – Middlesex-London
The Middlesex-London community has a rich history of working in partnerships. Numerous City of London and Middlesex County departments and associated committees, non-government and not for profit organizations are in existence whose mandates address a variety of community health and well-being issues. Capitalizing on these interconnections, several community engagement activities took place between September 2010 and March 2011 to form the Healthy Communities Partnership (HCP) - Middlesex-London. A critical component of the community engagement activities was the formation of the HCP-Middlesex-London Core Group which took responsibility for finalizing recommended actions for the community and developing the operational plans for submission to the MHPS. Ms. Mary Lou Albanese, Manager, Healthy Communities and Injury Prevention Team, is the Chair of this Group. Also involved in this initiative are Public Health Nurses Ms. Bernie McCall and Ms. Jan Tomlinson.

Deliverables
Between September 2010 and March 2011 there were a number of deliverables expected by the MHPS from the HCP-Middlesex-London. They consisted of:

1. Multiple stakeholder consultations addressing the six priority areas - physical activity, sport and recreation; healthy eating; tobacco use and exposure; injury prevention; alcohol and substance misuse; and mental health promotion - to identify two action recommendations (either program/service/education/policy) for each of the six priority areas,
2. A two-page summary containing a brief community profile, a description of the stakeholder consultation process, and the two recommended actions for each priority area,
3. A comprehensive community profile focused on the six priority areas (Appendix A), and
4. Operational plans and budget request from June 2011 to March 2012.

Policy Priorities
Following 21 meetings with key stakeholders, including the Francophone community, between August 2010 and January 2011, all of the partners came together on February 28, 2011, for a full day stakeholder

meeting. Participants took part in a small group priority setting exercise where the top two policy actions for the Middlesex-London community were selected:

1. Mental health promotion and substance misuse – develop policies that ensure access to mental health promotion resources and services, including those related to alcohol and substance misuse, and
2. Physical activity, sport and recreation – development and endorsement of a Physical Activity Charter based on the Global Call for Action at the 3rd International Congress on Physical Activity and Public Health (ICPAPH).

An operational plan was developed and submitted for each of the two selected policy priorities. Currently, HCP Middlesex-London is in the process of finalizing the governance structure consisting of the Core Group to continue to oversee the entire project with a working group for each of the priority areas. Moving policy forward in a community takes time and requires stakeholder/decision-maker support. The next year will entail securing support and further developing policies for implementation that will continue creating a healthy Middlesex-London.

The report was written by Ms. Mary Lou Albanese, Program Manager, Healthy Communities and Injury Prevention Team.

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

This report addresses the following requirement(s) of the Ontario Public Health Standards: Child Health, Chronic Disease Prevention, Environmental Health and Injury Prevention.

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 055-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 May 19

Creating Healthy Places Forum

Recommendation
It is recommended that the Board of Health Report No. 055-11 re Creating Healthy Places Forum be received for information.

Background
On April 21, 2011, the Health Unit as part of the Middlesex-London Healthy Communities Partnership, together with the Planning Departments from City of London and Middlesex County, organized and presented the Creating Healthy Places Forum. The partnership began in January 2011 with a meeting of the three (3) organizations that are interested in planning and building communities that enhance the health and wellbeing of residents of Middlesex-London.

Public health has long recognized the impact of the environment on health. Dating back to the 1800's, the Canadian Public Health Association described that sanitary reformers advocated for hygienic management and treatment of waste and sewage within the environment. With modernization and industrialization came major public health milestones with environmental links such as rabies vaccines, chlorination to disinfect drinking water, pasteurization of milk, creation of the *Food and Drug Act*, and universal precautions for communicable diseases. The decades following brought regulations for seat belt use, automobile emission control and smoking, all of which recognized connections between the environment and health.

Built Environment
Health Canada defines the built environment as the arrangement of activities or land uses within community settings, and the nature of the physical connections between the places where we live, work, and play – including homes, schools, workplaces, parks/recreation areas, business areas and roads. The built environment encompasses all buildings, spaces and products that are created or modified by people. It impacts indoor and outdoor physical environments e.g. climate conditions and indoor/outdoor air quality as well as social environments e.g. civic participation, community capacity and investments, and subsequently health and quality of life. Recent research has made the link between the built environment and its impact on quality of life, including health.

There has been a growing interest in land use planning processes among public health professionals in response to health and social science research that demonstrates the substantial impact that the built environment can have on human health and wellbeing. Health is not solely an outcome of individual health behaviours or decisions and but it is heavily influenced by factors beyond the control of the individual person.

The Ontario Public Health Standards (2008) are based on the recognition that the health of individuals and communities is significantly influenced by complex interactions between social and economic factors, the physical environment, and individual behaviours and conditions, known as the social determinants of health. Together they play a key role in determining the health status of the population as a whole. Addressing the determinants of health and reducing health inequities are fundamental to the work of public health in Ontario.

Creating Healthy Places Forum
The Forum on April 21st began with an opening address by the Medical Officer of Health followed by three internationally known keynote speakers:

- Dr. Larry Frank is the Bombardier Chairholder in Sustainable Transportation at the University of British Columbia and a Senior Non-resident Fellow of the Brookings Institution. He specializes in the interaction among land use, travel behaviour, air quality, and health.
- Mr. Ken Greenberg is an architect and urban designer, living in Toronto. For over three decades he has played a pivotal role on public and private assignments in urban settings throughout North America and Europe, focusing on the rejuvenation of downtowns, waterfronts, neighbourhoods and university campuses from the scale of the city region to that of the city block.

- Dr. Jason Gilliland is Director of the Urban Development Program, Associate Professor of Geography, and Associate Professor of Health Sciences at the University of Western Ontario. He is also a scientist with both the Children's Health Research Institute and the Lawson Health Research Institute based in London. He is a regular consultant for municipal and provincial departments of planning, transportation, housing, children's services, food & agriculture, and public health.

The day was a success with 155 registrations. There were representatives from numerous sectors – City of London , County of Middlesex , Consulting Engineers, Developers, Landscapers, Builders (local and regional), Planners (local and regional), Elementary School Board staff, Municipal Community/Social Service groups, Fanshawe College, University of Western Ontario, and public health staff (local and regional). Many positive comments were shared by the participants who demonstrated an eagerness to Create Healthy Places in their communities. To be successful, it is imperative that communication continues with other stakeholders with a vested interested in planning and building communities that enhance the health and well being of the residents.

Future Plans
The process is underway to identify how to move this public health priority further in the community. Future meetings are planned with the City and County Planning Departments to discuss the continuation of the partnership. On May 31st, a city planner will be providing a Planning 101 workshop for some of the staff and managers in the Environmental Health Chronic Disease Prevention Service area. There are also plans for future discussions with Dr. Gilliland to develop a partnership with the University of Western of Ontario.

The report was written by Ms. Mary Lou Albanese, Manager, Healthy Communities and Injury Prevention Team.

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

This report addresses the following requirement(s) of the Ontario Public Health Standards: Child Health, Chronic Disease Prevention, Environmental Health and Injury Prevention.

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 056-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 May 19

March is Nutrition Month – Family Health Services Activities

Recommendation
It is recommended that Report No. 056-11 re March is Nutrition Month – Family Health Services Activities be received for information.

Background
Dietitians of Canada develops an annual Nutrition Month campaign every March to highlight the professional role of registered dietitians and to promote nutrition messages to consumers. Nutrition Month presents a great opportunity to raise awareness of the valuable contribution healthy eating makes to the overall health of Canadians. Throughout the year, staff members of Family Health Services (FHS) promote healthy eating by providing practical, current, evidence-based information through a variety of channels. As well, practical tools are provided to help support individuals and care providers to make healthier food choices. This year, FHS took advantage of an ongoing "Physician Outreach" strategy employed by the Young Families Team to link ongoing health promotion work in nutrition with Nutrition Month activities. A package of healthy eating information and resources for ages 0 to 6 years was mailed to 300 physicians. The package included information about the World Health Organization (WHO) Growth Charts for Canada, a nutrition risk screening tool called NutriSTEP ®, and new campaign material called Trust Me Trust My Tummy. Physicians also received a letter encouraging them to call Health Connection if they wanted to receive multiple copies of the resources included in the package. In addition, the package of nutrition information was mailed to 110 childcare centres. These resources and their purposes are described below.

WHO Growth charts
Dietitians of Canada, the Canadian Paediatric Society, the College of Family Physicians of Canada, and Community Health Nurses of Canada recommend the adoption of the WHO growth charts in Canada, replacing the American Centers for Disease Control and Prevention growth charts. Staff members in FHS started using these very important tools in mid-2010. The WHO growth charts, which are considered the gold standard for assessing the growth of all children, illustrate how all healthy children should grow, are based on the growth of a breastfed population, and can be used for multi-ethnic populations in Canada. Earlier in 2010, FHS developed practice guidelines and provided training to public health nurses (PHNs) to implement these tools in their practice. The intent was to inform physicians that the Health Unit had made a practice change and to share the growth charts with them.

NutriSTEP ® Nutrition Risk Screening Tool for Preschoolers 3 to 5 year olds
FHS is implementing the provincial NutriSTEP® program. NutriSTEP® is a validated, self-administered questionnaire for parents and caregivers of 3-5 year old children related to food intake and physical activity. It is available in eight languages and can be completed in five minutes. Health care providers can offer the NutriSTEP® questionnaire to parents of preschoolers to complete and help them obtain a score. The score indicates whether the child is at low, moderate or high risk for nutrition concerns. When preschoolers are identified as high risk, health care providers can discuss the results and give parents information about follow-up with a registered dietitian for nutrition consultation and are encouraged to discuss the child's growth and development with their family physician, paediatrician or nurse practitioner. Accompanying resources and a website were developed and provided.

Trust Me Trust My Tummy Resources
The purpose of this campaign is to create awareness among parents and caregivers that children are born with the ability to know when they are hungry and when they are full. Resources emphasize that the parents' role in feeding their children is to decide what foods to offer, when to offer meals and snacks and where their child will eat. Parents are encouraged to let their children decide how much to eat, which foods to eat at meals and snacks and not engage in battles over food. This approach is recommended for all children starting at birth and regardless of weight, height or activity level. Resource material including displays, posters, fact sheets and magnets were adapted from Huron County Public Health in December 2010. Physicians were asked to display the poster in their office and call Health Connection if they wanted more fact sheets and magnets. To date, 18 physicians have called Health Connection to request healthy eating information. Staff members have distributed the "Trust Me Trust My Tummy"

material through Well Baby and Breastfeeding Clinics throughout the City and County in March. Displays were set up in ten locations for at least the duration of the clinic and up to two weeks at some sites. PHNs also distributed two easy-to-prepare, low cost recipes in the clinics throughout March. In addition, a community based event was conducted. The public health dietitian and a dietetic intern offered a food demonstration at the Northbrae Hub in March. Two healthy recipes were prepared and parents and children had the opportunity to taste the recipes and ask questions.

Conclusion

Nutrition Month provided an opportunity to highlight ongoing healthy eating promotion activities performed by staff such as resource development, awareness raising and skill building for health care providers including physicians. PHNs from the Young Families Team and the registered dietitian from the Family Health Promotion Team continue to collaborate to promote the unique role that healthy eating contributes to the overall health of young growing families.

This report was prepared by Ms. Ginette Blake, Public Health Dietitian, Family Health Promotion Team; Mr. Jim Madden, Manager, Family Health Promotion Team; and Ms. Ruby Brewer, Manager, Young Families Team.

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

This report addresses the following requirement(s) of the Ontario Public Health Standards: Child Health requirements: 4, 5, 7, 8 and 11.

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 057-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 May 19

Child and Youth Network: Literacy Workgroup

Recommendation
It is recommended that Report No. 057-11 re Child and Youth Network (CYN) Literacy Workgroup be received for information.

Background
The City of London Child and Youth Network (CYN) Literacy Implementation Team has continued to carry out its plan to improve literacy outcomes through a collaborative, integrative approach among home, school and community. The development and distribution of the Baby's Book Bag (BBB) is an important part of this plan. The purpose of the BBB is to highlight the importance of early literacy and provide information and resources to all expectant families and those with infants up to age 12 months. The package includes age-appropriate board books, a CD of rhymes and songs, literacy tips and community resource information are included. (See Appendix A). The BBB is a result of the collaborative partnership between the CYN Emergent Literacy Workgroup, Kiwanis Club Forest City-London and the Health Unit.

Baby's Book Bag Distribution
The Health Unit supports the work of the Literacy Implementation Team through its continued involvement in BBB distribution through prenatal classes, Smart Start for Babies, and most recently by Public Health Nurses (PHNs) and Family Home Visitors (FHVs) to vulnerable families, many of whom are newcomers to Canada. As part of the Healthy Babies Healthy Children program, approximately 60 PHNs and FHVs have received training about resources and key literacy messages. In 2010, the BBB was distributed to approximately 1,700 parents and expectant parents. A preliminary review of the evaluations completed indicates that this strategy has been well received by parents.

To support the County of Middlesex in its efforts to promote emergent literacy to prenatal clients and young families, the Health Unit provided funding to purchase BBB resources. A community committee was established in Middlesex County to develop a plan to integrate literacy messaging/information into interactions with young families who live in the County.

Learning about Literacy Training Bag
To spread the message about literacy and to further enhance the distribution of the BBB throughout the community, Health Unit staff members, in collaboration with the Emergent Literacy Workgroup, participated in the development of a Learning About Literacy Training Bag. This resource expands upon the original BBB by including additional materials to support community professionals who work with families of infants from birth to 18 months.

In March 2011, a train-the-trainer workshop, Learning about Literacy, was held for community professionals in both London and Middlesex, who have contact with families with children under 18 months. The goals of this workshop were to increase knowledge about emergent literacy and encourage professionals to integrate literacy messages into their practice/programming. This event attracted over 40 community professionals. Evaluations from this event were very positive. Each participant received the Learning about Literacy Training Bag. Participants also signed up to distribute the BBB to families in London with which they work. To date, over 10 organizations have ordered approximately 300 bags for distribution to families.

To further spread the literacy message, Health Unit staff members have showcased the CYN literacy display and accompanying materials at events such as prenatal fairs and toddler events, successfully accessing thousands of more London families.

Website
Another key activity of the CYN Literacy Plan was the development of a website. On April 28, 2011, Family Literacy Day, the **thisISliteracy.ca** website was launched. This locally developed site provides information and interactive activities and links for community professionals, families and children from birth to 18 years. It includes blogs for parents and resources for children and teens, such as teen reviews of different video games, CDs and books.

Future Plans
The next phase of the emergent literacy strategy will be to continue to expand on training opportunities and BBB distribution. Future training sessions may be offered later in the Fall for additional community partners. For 2011, the cost sharing partnership will continue between the CYN network and the local London Kiwanis Club for both financial and volunteer support. The emergent literacy workgroup will begin to explore the idea of physician engagement in the community and build on existing activities through the Health Unit Early Identification strategy.

This report was prepared by Ms. Debbie Shugar, Manager, tykeTALK, Infant Hearing Program and Blind-Low Vision Program and Ms. Jennifer Limburg, PHN, Family Health Promotion Team.

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

This report addresses the following requirement(s) of the Ontario Public Health Standards: To promote the health of children and youth.

REPORT NO. 100-09

TO: Chair and Members of the Board of Health

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

DATE: 2009 June 18

CHILD AND YOUTH NETWORK: LITERACY WORKGROUP

Recommendation

It is recommended that Report No. 100–09 re Child and Youth Network: Literacy Workgroup be received for information.

Background

As outlined by Ms. Diane Bewick in Report No. 102-08 (September, 2008), The City of London Child and Youth Network (CYN) developed a long term plan to 2015 to address four priority areas: Anti-Poverty, Literacy, Healthy Eating/Healthy Physical Activity and Family Centred Service System in order to ensure that children and youth are safe, have supportive relationships and reach their potential in school and in life. In 2008, almost one out of every four children and youth in London is being left behind – because of poverty, problems in school, health problems and social stresses.

Literacy is the ability to identify, understand, interpret, create, communicate and compute, using printed and written materials in varying contexts. It is the ability to express thoughts, feelings and ideas. Literacy involves a continuum of learning, enabling individuals to achieve their goals, to develop their knowledge and potential, and to participate fully in their community and in wider society. In London:

- 27.3% of children are not ready to learn when they enter Grade 1
- 19 of 26 neighborhoods have at least 20% of children not ready to learn
- 1 in 3 children ages 8 to 14 is not meeting the literacy and numeracy standards established by the Province
- 1 in 5 adults is functioning at the lowest level of literacy, often unable to read basic signs and medicine instructions.

These statistics demonstrate that children who struggle with basic literacy become youth and finally adults who struggle with literacy. The London statistics are in line with the provincial average for literacy rates. Yet being average represents a significant loss of social and economic potential for both the individual and the community. Improving literacy plays a fundamental role in enabling individuals and families to increase their well-being.

The Literacy sub-group, of which two Health Unit staff are active participants, has established an outcome goal identified in a specific workplan (Appendix A):

By 2011, London will have implemented an integrated approach to improving literacy through a collaborative effort between home, school and community.

The overarching goal is to become a provincial leader in child, youth and family literacy by 2015. To move this agenda forward the sub-group developed a four -part strategy: promote literacy to the whole community, take a neighbourhood approach to literacy, promote literacy from birth, and improve family literacy. The strategies each have a three-year action plan.

Priority Action Areas

The neighbourhood literacy strategy will establish criteria for selecting a neighbourhood, begin a selection process based on the criteria, develop and recommend model components, recommend an accountability mechanism, recommend a demonstration neighbourhood to CYN and key decision makers, confirm a neighbourhood and put a neighbourhood plan in place. As of May 2009, the CYN approved the recommendation that the Huron Heights planning district be chosen as the demonstration neighbourhood.

The emergent literacy strategy will examine and identify best practices, develop and recommend model components, partner with MLHU prenatal classes to include emergent literacy information, develop literacy bags for pre-natal and early post-natal distribution, develop a literacy display for community events, play a literacy DVD in doctor's offices/walk-in clinics, establish baseline measures and develop a train the trainer model. Information and a video presentation on emergent literacy have been added to the MLHU prenatal curriculum as of the fall 2008. The CYN network has entered into a partnership with the Forest City Kiwanis Club to develop and distribute literacy bags. Kiwanians have donated $25,000 to help purchase bags and board books. The bags, which will also include select community resources and handouts about literacy will be distributed at MLHU prenatal classes beginning in the fall. Kiwanis members will be trained to give a short presentation to families when delivering the bags. The literacy display is presently being developed and will be available for prenatal fairs beginning in the fall.

The family literacy strategy will examine and identify best practices, develop and recommend model components, establish baseline measures, develop a train the trainer model and build on the community map to form the basis for a family literacy resource website. A summary of best practices was received by a consultant with Literacy Links South Central and is being reviewed to determine key elements of successful family literacy programs. A Family Literacy website for practitioners and families is in the early stages of investigation.

This report was prepared by Ms. Debbie Shugar, Manager/System Facilitator, tykeTALK the Infant Hearing Program-SW Region and the Blind Low Vision Early Intervention Program and Ms. Jennifer Limburg, Public Health Nurse, Family Health Promotion Team.

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

This report addresses the following requirement(s) of the Ontario Public Health Standards:
To promote the health of children and youth.

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 058-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 May 19

Influenza Immunization Program 2010-2011

Recommendation

It is recommended that Report No. 058-11 re **Influenza Immunization Program 2010-2011** be received for information.

Ontario Universal Influenza Immunization Program

The objectives of the Universal Influenza Immunization Program in Ontario are to provide individual protection against influenza, decrease the spread of the virus, reduce the impact on the health care system and reduce the economic impact related to influenza.

For the 2010-2011 influenza season, the World Health Organization (WHO) and the National Advisory Committee on Immunization (NACI) recommended that the seasonal influenza vaccine provide protection against the following three strains: A/H1N1/California (pandemic H1N1 strain), A/H3N2/Perth (new strain) and B/Brisbane (same as previous year). The 2010-2011 seasonal influenza vaccine was a good match to the circulating strains of influenza in the community.

Distribution of Vaccine

Distribution of influenza vaccine to health care providers, provision of community influenza immunization clinics and promotion of the influenza vaccine are the main components of the influenza immunization program in Middlesex-London. This year, the Health Unit distributed 99,190 doses of flu vaccine to health care providers: 10,050 doses to hospitals; 8,360 doses to long term care homes; and 7,530 doses to nursing agencies that provide workplace influenza vaccination clinics. Unused vaccine will be returned over the next few months which will allow for an estimate of the amount of influenza vaccine that was administered in these community settings. However, less vaccine was distributed to health care providers this year compared to previous years. As well, the staff immunization rates averaged 35% for hospital staff and 52.5% for staff who work in long term care facilities, which continues a downward trend seen in the last few years.

Influenza Vaccine Clinics

Each year, the Health Unit offers community influenza clinics in several locations across the City and County. A total of 13,479 doses of seasonal influenza doses were administered at 24 community influenza clinics during October, November and December 2010, including 137 doses administered at a drive-through clinic for those not able to manage attendance at a community clinic. Clinics were also held at shelters in the City and County to provide immunization to the residents and their families who otherwise would not likely attend a community clinic. Two hundred and fifteen (250) influenza immunizations were given at these clinics. Influenza vaccine was also administered at regularly-scheduled clinics at the 50 King Street and Strathroy offices. Separate Health Unit-based clinics at the 50 King Street office were set up in early January 2011, in response to an increased demand for influenza vaccine related to an increase in influenza activity in the community, reports of hospital bed shortages and reports of deaths related to influenza. The total number of doses of influenza vaccine administered through the Health Unit program for the 2010-2011 season was 16,759 doses, compared to 18,948 doses for the 2008-2009 season, 21,209 doses for the 2007-2008 season and 23,802 doses for the 2006-2007 season. The data for the 2009-2010 season is not provided because it was the pandemic year and so not comparable with the usual influenza season. Other health units in the province are also reporting a decreased uptake of the influenza vaccine for this influenza season.

Promotion

The Ministry of Health and Long Term Care develops and implements a provincial advertising campaign each year to promote influenza immunization. The Health Unit began its promotion in early October with a media release and a letter to parents sent home through the schools in the City and County. The community influenza clinic schedule was advertised in the local newspapers beginning in October until the clinics finished in December.

An Influenza Information section was created for the front page of the Health Unit's website so that visitors to the website could easily access information about influenza including information about the vaccine, the community clinic schedule and the vaccine consent form. There was also a section for health care professionals.

The media was included in the distribution of weekly influenza surveillance reports which included the weekly number of influenza cases, hospitalizations and deaths in the London area as well as the total numbers for the influenza season. Information from these reports resulted in interviews to discuss the local situation generating newspaper articles and other media stories

There were a total of 12 influenza-related media interviews. Influenza immunization was stressed as the primary means of preventing influenza during these interviews.

Planning for the 2011-2012 Influenza Season

Planning is underway for next year's influenza season. Many of the community clinic locations are booked. The criteria for site selection include ability to handle a large clinic set up, accessibility of the location, parking availability etc. Clinics are located at various sites across Middlesex-London so that residents can attend a clinic without having to travel far. City sites are almost always close to a bus route. The drive-through clinic will be held in mid-October and clinics for vulnerable populations are being planned as well.

This year's low vaccine uptake and the amount and severity of influenza illness will form the basis of messaging for next year's influenza season. Posters promoting the vaccine and directing the public to the web site for clinic locations and dates will be developed and placed in areas such as community arenas, areas with community bulletin boards, public libraries etc. Facebook is being explored as possible means to provide education for the public and to direct people to community clinics.

This report was prepared by Ms. Marlene Price, Manager, Vaccine Preventable Diseases Team.

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

This report addresses the following requirement(s) of the Ontario Public Health Standards: Vaccine Preventable Diseases

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 059-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 May 19

Provincial Bed Bug Initiatives - Update

Recommendation
It is recommended that Report No. 059-11 re Provincial Bed Bug Initiatives – Update be received for information.

Background
At the January 20, 2011, Board of Health meeting, Board members received Report No. 012-11 re Provincial Bed Bug Initiatives. In that report, the Board was advised that the Ministry of Health and Long-Term Care (MOHLTC) had announced funding was available to health units on a one time basis to implement local bed bug control and awareness initiatives. The Board was also advised that staff members on the Environmental Health Team (EHT) were awaiting the details of the funding approval criteria and the application process.

Funding Application and Approval
The EHT received the details of the funding approval criteria and the application process in late January and submitted an application to the MOHLTC in February, 2011. Funding was available to carry out bed bug initiatives in two separate funding streams: Stream #1 – education and outreach; Stream #2 - supports and interventions to assist vulnerable populations. In addition to carrying out activities under the two funding streams, health units receiving funding will be expected to collect data on the degree of infestations and the populations and settings most impacted by bed bug infestations in their health units. They must then report that data back to the MOHLTC in a manner to be prescribed at a later date. Further details of the Public Health Unit Bed Bug Support Fund are contained in Appendix A.

EHT staff members completed the funding application requesting funding in the amount of $205,450.00 - $40,000 to support activities in Stream #1 and $165,450 to support activities in Stream #2. As described in Appendix A, the MOHLTC disbursed available funds to health units based on a number of considerations. The Health Unit received notification on April 26, 2011, that it had been awarded funding in the amount of $180,103.00, approximately 88% of the original request (See Appendix B). This funding amount will enable staff to implement the proposed activities at almost the originally intended scale.

Implementation
Staff members have begun to carry out the activities described in the funding proposal. These activities include beginning the process to recruit a temporary Health Promoter and contacting community partners to schedule a meeting for the purposes of developing a Middlesex-London Bed Bug Working Group. Staff will report back to the Board on the progress of the Bed Bug initiative at a future Board meeting.

This report was written by Mr. Wally Adams, Acting Director, Environmental Health and Chronic Disease Prevention Services.

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

This report addresses the following requirement(s) of the Ontario Public Health Standards:
Section 2) a) ii) of the *Identification, Investigation and Management of Health Hazards Protocol* requiring the Board of Health to liaise and maintain partnerships with the community and relevant local, provincial and federal agencies with an interest in and mandate for prevention of health hazards in the environment through committees, meetings and/or regular communications for the purpose of sharing expertise and information.

Ontario

Public Health Unit Bed Bug Support Fund

Q&As

1. **What will the funding for bed bugs support?**

   One-time funding (at 100%) for the period up to March 31, 2012 is being provided to 33 health units across Ontario. This investment is part of the government commitment to support bed bug related activities in Ontario's public health units (PHUs). Funded activities are to be related to one or both of the following:

   (i) Education and outreach to the public and stakeholders to enhance awareness in the identification, prevention and control of bed bug infestations; and/or,
   (ii) Supports to vulnerable populations impacted most negatively by bed bug infestations.

2. **Why is the government providing this funding to health units now?**

   As in other places around the world, bed bug infestations are on the rise in Ontario. While bed bugs are not known to spread diseases to humans, they can cause significant stress and anxiety to individuals suffering with infestations, and can have an impact on peoples' mental health and well-being.

   The Government of Ontario is committed to maintaining the health and well-being of Ontarians. Up to $5M has been announced for PHUs across Ontario to address the issue of rising bed bug infestations.

   This funding commitment also responds to recommendations made at the Toronto Bed Bug Summit hosted by MPP Mike Cole in September 2010.

3. **What else is the government doing to address the issue of bed bugs in Ontario?**

   The provincial government has developed a communications and education strategy to help Ontarians fight bed bugs. The website – www.bedbugsinfo.ca and www.infopunaisedeslits.ca – is intended to help the public and stakeholders do three key things effectively: Prevent, Identify and Act.

   The website is a one-stop-shop for accurate information and simple, easy-to-use tips to combat infestations. It also houses resources including a video, document templates, posters, fact sheets and other tools for stakeholders, including PHUs, to use in various settings to bring the prevent/identify/act message to the public.

   An *Integrated Pest Management Program for Controlling Bed Bugs* is also available on the website. This program covers the fundamental components of an integrated pest management (IPM) program that includes planning, education, identification, inspection, record keeping, preparation, treatments and evaluation. It is applicable to all stakeholders who live in or manage residential and/or commercial dwellings; to the pest management industry and other industry; and to government and community agencies that work with vulnerable populations.

This document stresses bed bug prevention through education of clients, residents, facilities managers, and landlords and provides an educational resource for professionals and service providers who as part of their job visit or come into contact with persons who have a bed bug infestation.

4. **Are all health units receiving funding?**

   No. All PHUs were invited to submit an application for funding. Only those PHUs that submitted an application to the ministry are eligible to receive funding. However all health units that did apply have been approved for varying levels of funding.

5. **How was the funding amount per health unit determined?**

   The ministry reviewed all applications received based on common criteria. In addition, follow-up was done with individual PHUs where further clarification was required. The intent was that most, if not all, PHUs that applied could qualify for funding within the available range identified in the application package assuming that they met the assessment criteria and that they adequately addressed any follow-up questions.

6. **Why did our health unit not receive the total amount of funding requested?**

   The total amount of funds requested from the health units exceeded the total funding available. As a result many health units did not receive the full amount requested. In order to ensure the total funding recommended remained within the funds available, applications were reviewed based on common criteria, with the intent that each PHU that applied would receive funding within the available range identified. As a last step, funding was further reduced proportionally for all health units to bring the total recommended funding to the available amount.

7. **Why did our health unit not receive the maximum amount of funding specified in the funding application?**

   An estimated range of funding was calculated based on the proportion of the provincial population served by each health unit and was specified in the funding application as a guide for health units. Because the total amount of funds requested from the health units exceeded the total funding available, in many cases, health units did not receive the full amount requested or did not receive the maximum amount of funding specified in the funding application.

8. **What is the sustainability of the one-time funding after March 31, 2012?**

   This is one-time provincial funding at 100% to be spent by March 31, 2012.

9. **Our health unit would like to hire additional staff to support activities related to bed bug infestations. Can we expect annual funding to support these new FTEs?**

   No. This is one-time, 100% provincial funding.

10. **How will Health Units sustain activities initiated through this one-time funding?**

Health Units are encouraged to consider opportunities for leveraging existing capacity and resources and for collaboration with other PHUs and local partners to promote the sustainability of activities initiated through this one-time funding.

11. Is the funding subject to any conditions?

Yes. This one-time funding is subject to the following conditions:

- Funding must align with the activities and services detailed in the health unit's application for funding.
- Funding is intended to support activities in one or both of the following streams:
  a) Education and outreach to the public and stakeholders to enhance awareness and knowledge in the identification, prevention and control of bed bug infestations, and/or
  b) Supports to vulnerable populations (e.g. individuals with physical, mental health or addiction issues; people living in poverty; the under-housed or homeless, or frail elderly) impacted most negatively by bed bug infestations.
- Costs must be fully incurred by March 31, 2012.
- Funding is subject to the 2010 Program-Based Grants Terms and Conditions.
- Health units will be expected to collect data on the degree of infestations, and the populations and settings most impacted by bed bug infestations in their area.

12. What are the reporting requirements associated with this funding?

Health units that received funding under this initiative are subject to reporting requirements, which include financial reports (e.g. quarterly and settlement reports) and a report back on key achievements and the direct impact of funded activities. Reporting of this information to the province will allow for assessment of the scope of the bed bug issue in the province and the effectiveness of implemented activities.

13. What should be included in the initial/final report?

The project report is to include:

- A description of activities implemented and delivered under the one-time funding including the streams under which activities were identified (e.g. education and outreach, and/or supports to vulnerable populations)
- Description of successes of the delivered activities under both streams, if applicable
- Impact of activities on decreasing bed bug infestations in the public health unit area

The surveillance and evaluation report is to include:

- Data/evidence on the current level of bed bug infestations in the health unit area including any detail on particular settings and populations impacted by infestations
- Data/evidence on any increase or decrease in bed bug infestations in your health unit area
- Effectiveness of interventions to address the level of bed bug infestations and for those particular settings and populations impacted by infestations

14. What are the deadlines for the initial/final report?

For the project report:

For the period April 1, 2011* to March 31, 2012

Name of Report	For the Period Of	Due Date
Initial Project Report for 2011	April 1, 2011 to June 30, 2011	July 31, 2011
Final Project Report for 2011	July 1, 2011 to March 31, 2012	April 30, 2012

For the surveillance and evaluation report:

For the period April 1, 2011* to March 31, 2012

Name of Report	For the Period Of	Due Date
Initial Surveillance and Evaluation Report for 2011	April 1, 2011 to September 30, 2011	October 31, 2011
Final Surveillance and Evaluation Report for 2011	October 1, 2011 to March 31, 2012	April 30, 2012

* Health Units are not required to report retroactive to April 1, 2011. The initial reports should be understood to cover the period starting as soon as funding is communicated to PHUs.

The Ministry will provide report templates for each of the required reports.

If you have any further questions, please contact Jacky Sweetnam, Manager (A), Practice and Standards Unit, Public Health Practice Branch, Ministry of Health and Long-Term Care at jacky.sweetnam@ontario.ca or at (416) 314-1042.

Ministry of Health and Long-Term Care

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Ontario

HLTC2976FL-2011-74

APR 2 6 2011

Ms. Patricia Coderre
Chair
Middlesex-London Board of Health
50 King Street
London ON N6A 5L7

Dear Ms. Coderre:

I am pleased to confirm that the Ministry has approved one-time funding of up to $180,103 (at 100%) for the Middlesex-London Health Unit to be spent by March 31, 2012 under the recently announced Bed Bug Support Fund. This investment is part of the government's commitment to fund bed bug related activities.

In a subsequent letter, Ms. Sylvia Shedden, Acting Assistant Deputy Minister, Public Health Division, Ministry of Health and Long-Term Care will be writing to Dr. Graham Pollett, Medical Officer of Health, Middlesex-London Health Unit, to provide the accountability and administrative details regarding this funding.

I would like to take this opportunity to thank you for your continued commitment and dedication to protecting and promoting the health of Ontarians.

Sincerely,

Deb Matthews

Deb Matthews
Minister

c: Hon. Steve Peters, MPP, Elgin-Middlesex-London
Maria Van Bommel, MPP, Lambton-Kent-Middlesex
Hon. Christopher Bentley, MPP, London West
Khalil Ramal, MPP, London-Fanshawe
Dr. Graham Pollett, Medical Officer of Health, Middlesex-London Health Unit

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 060-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 May 19

Ontario's Liquor Licence Act Proposed Changes – Follow Up

Recommendation
It is recommended that Report No. 060-11 re Ontario's Liquor Licence Act Proposed Changes – Follow Up be received for information.

At the April 14, 2011, Board of Health meeting, Board members reviewed Report No. 041-11 re Changes to Ontario's Alcohol Regulatory System – Liquor Licence Act (attached as Appendix B) and passed the following resolutions:

1. *That the Board of Health endorse the resolutions related to alcohol attached as Appendices A and B to Report No. 041-11; and further*
2. *That these resolutions be forwarded to the Association of Local Public Health Agencies (alPHa) for consideration at the 2011 alPHa Annual Meeting.*

Subsequent to the Board meeting, correspondence was received from The Honourable Chris Bentley, Ontario Attorney General, in response to Board of Health correspondence on this issue (Appendix A). In addition, Attorney General Bentley invited the Medical Officer of Health and Ms. Mary Lou Albanese, Manager, Healthy Communities and Injury Prevention Team, to a meeting which occurred on April 29, 2011. During this 45 minute session, there was open dialogue regarding the proposed Liquor Licence Act amendments with both parties clarifying their views. The outcome of this exchange, however, did not result in either side altering its position.

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

This report addresses the following requirement(s) of the Ontario Public Health Standards: Prevention of Injury and Substance Misuse and Chronic Diseases and Injuries Appendix A

Attorney General
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Toronto ON M7A 2S9
Tel: 416-326-4000
Fax: 416-326-4016

Procureur général
Édifice McMurtry-Scott
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Téléc.: 416-326-4016

Our Reference #: M11-02110

Dr. Graham Pollett
Medical Officer of Health & Chief Executive Officer
Middlesex-London Health Unit
50 King Street
London, ON
N6A 5L7

Dear Dr. Pollett:

Thank you for your letter regarding the proposed modernization of Ontario's Alcohol Regulation System.

The McGuinty government is taking steps to update Ontario's liquor laws to better serve Ontarians. The proposed changes are intended to boost the hospitality and tourism industries, respond to business needs and provide a better consumer experience at Ontario festivals and special events.

We have been consulting with stakeholders on the three broad areas of licensing, enforcement and special occasion permits. This is not about increasing access. It's about bringing Ontario into the 21st century by identifying longstanding and unnecessary restrictions and allowing our hospitality industry, bars, restaurants, festivals and other events to operate competitively in this modern economy.

In conducting these consultations, the government is also examining the way we enforce our liquor laws by considering new monetary penalties as an enforcement option for Ontario's alcohol regulator. While enhanced flexibility around the sale and service of alcohol is being proposed, the high standards we expect for the socially responsible sale, service, and consumption of alcohol will not be compromised.

My Parliamentary Assistant, David Zimmer, along with ministry officials, have led focused consultations with provincial associations and groups, including police services, municipalities and the tourism sector. Proposed regulatory changes have now been posted on the Regulatory Registry following this initial consultation period and are available for comment. You may access the Regulatory Registry at the following website: www.ontariocanada.com/registry.

Thank you again for your comments on the proposed modernization of Ontario's Alcohol Regulation System.

Sincerely,

Hon. Chris Bentley
Attorney General

TO: Chair and Members of the Board of Health

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

DATE: 2011 April 14

PROPOSED ALCOHOL RELATED RESOLUTIONS FOR THE 2011 ASSOCIATION OF LOCAL PUBLIC HEALTH AGENCIES ANNUAL MEETING

Recommendations

It is recommended:

1. ***That the Board of Health endorse the resolutions related to alcohol attached as Appendices A and B to Report No. 041-11; and further***

2. ***That these resolutions be forwarded to the Association of Local Public Health Agencies (alPHa) for consideration at the 2011 alPHa Annual Meeting.***

Background

The research community (Appendix C) has consistently found that increased availability and access to alcohol is associated with increases in consumption and alcohol-related harms. Furthermore, researchers have agreed that regulating the physical availability of alcohol, including restrictions on sales, is one of the top alcohol policy practices in reducing harm (World Health Organization, 2009 and Barbor et al., 2010).

Today, alcohol continues to be a prominent concern as it contributes to both economic and health impacts in our community. In 2002, the annual costs in Canada for health care, directly related to alcohol consumption was $3.3 billion, and the total direct and indirect costs was $14.6 billion (Rehm et al., 2009). Alcohol is associated with increased levels of health and social costs in Ontario and is causally related to over 65 medical conditions including injury (impaired driving, drowning, falls, fires, suicide, homicide, sexual assault and other violence) and chronic disease (liver disease, cancers, high blood pressure, mental health problems, and stroke) (Barbor et al., 2010; Rehm et al., 2009; Roerecke et al., 2007). Locally, alcohol consumption rates are higher than the provincial average and pose a significant risk to our community:

- The 2009 Ontario Student Drug Use and Health Survey indicates that general alcohol use in the last year, binge drinking, and hazardous drinking, among students Grades 9-12 was higher in the South West Local Health Integration Network (LHIN) area (82.3%, 46.5%, and 35% respectively) than the provincial average (69.4%, 32.9% , and 27.5% respectively).

- Adult alcohol use in the South West LHIN area (2007) was also higher than the province in general alcohol use in the last year (84% vs. 81%), exceeding drinking guidelines (26% vs. 23%), hazardous drinking (18% vs. 16%), and weekly binge drinking (13% vs. 11%).

Currently access to alcohol in Ontario is readily available with 7-day a week sales and at a wide variety of buying venues. As of 2009/2010 there were 611 Liquor Control Board of Ontario (LCBO) stores, 436 The Beer Store (TBS) locations, and 216 agency stores (independent local retailers authorized to sell LCBO and TBS products in smaller towns across Ontario) with a total of 188 million store transactions. In addition to these stores, as of 2008/2009 there were 16,663 Liquor Licensed Establishments (bars and restaurants) and a further 56,143 Special Occasion Permits Issued in Ontario (LCBO, TBS, and Alcohol & Gaming Commission of Ontario [AGCO] Annual Reports).

Although alcohol revenue from taxes is often touted as a financial benefit to the province, it is important to understand the countering health and economic costs associated with alcohol use. In 2002-2003, alcohol cost the province $456 million more in direct health care and law enforcement costs than the net revenue and sales tax brought in from LCBO as indicated by Gerald Thomas, senior research and policy analyst at the Canadian Centre on Substance Abuse (CCSA) in September 2010. Above and beyond these direct costs there are also billions of dollars spent in indirect costs related to alcohol including lost productivity, absenteeism, victim assistance, and addiction/preventative services.

Boards of Health play a key role in a comprehensive approach (prevention, harm reduction, treatment, criminal justice, and advocating for healthy public policy) to reduce risk of injuries and chronic disease related to alcohol. This Board of Health has proven its commitment to responsible action concerning healthy alcohol policy and supportive environments through the endorsement of the March 2008, alcohol related resolutions sent to the 2008 alPHa Annual Meeting (Report No. 026–08) (Appendix D).

Current Issue

Ontario Attorney General, The Honourable Chris Bentley, announced in February 2011 that the Ontario government would be exploring changes to the alcohol regulatory system, the Liquor Licence Act (LLA) of Ontario, in the areas of licensing and enforcement (Appendix E). Of greatest concern, are those proposed modifications that increase access/availability to alcohol. This includes the amendments "giving the public more freedom to circulate in festival areas including the retail area with drinks;" "extending the hours that alcohol can be served at special events;" and "allowing all-inclusive vacation packages to be sold in Ontario."

Prior to any changes being legislated to the current LLA it is imperative that a formal review and impact analysis of the health and economic effects of alcohol in Ontario is completed. Ontario, unlike British Columbia, Nova Scotia, Saskatchewan, Quebec and Alberta which is in progress, does not have a provincial alcohol strategy although identified as a required best practice in the prevention of alcohol related injuries, deaths and diseases.

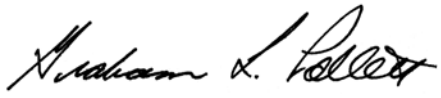
To that end, two resolutions have been drafted for submission to the Association of Local Public Health Agencies 2011 Annual Meeting. The resolutions call for:

1. A formal review and impact analysis of the health and economic effects of alcohol in Ontario and thereafter the development of a provincial Alcohol Strategy (Appendix A); and
2. Maintaining the Liquor Licence Act (LLA) of Ontario in its current form until the review and development of a provincial alcohol strategy have been completed (Appendix B).

Conclusion

Alcohol is a public health issue. Alcohol policies play a vital role in the health and safety of communities. While such policies can reduce harm and health risks when effectively researched and implemented, they can likewise increase harm and health risks when weakened by unsounded changes. The resolution put forward would provide a complete picture of the health and economic impact of alcohol in Ontario and thus provide information to strengthen regulatory legislation and to develop a comprehensive provincial alcohol strategy to reduce alcohol related harm, death and diseases.

This report was written by Mary Lou Albanese, Manager Healthy Communities and Injury Prevention and Melissa Rennison, PHN, Healthy Communities and Injury Prevention.



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

This report addresses the following requirement(s) of the Ontario Public Health Standards:
Prevention of Injury and Substance Misuse and Chronic Diseases and Injuries Appendix A

TITLE Conduct a formal review and impact analysis of the health and economic effects of alcohol in Ontario and thereafter develop a provincial Alcohol Strategy

SPONSOR Middlesex-London Board of Health

WHEREAS There is a well-established association between easy access to alcohol and overall rates of consumption and damage from alcohol; and (Barbor et al., 2010)

WHEREAS Ontario has a significant portion of the population drinking alcohol (81.5%), exceeding the low risk drinking guidelines (23.4%), consuming 5 or more drinks on a single occasion weekly (11.2%), and reporting hazardous or harmful drinking (15.6%); and (CAMH Monitor)

WHEREAS Ontario youth (grades 9-12) have concerning levels of alcohol consumption with 69.4% having drank in the past year, 32.9% binge drinking (5 or more drinks), and 27.5% of students reporting drinking at a hazardous level; and (OSDUHS Report)

WHEREAS Each year alcohol puts this province in a $456 million deficit due to direct costs related to healthcare and enforcement; and (G. Thomas, CCSA)

WHEREAS Billions of dollars are spent each year in Canada on indirect costs associated with alcohol use (illness, disability, and death) including lost productivity in the workplace and home; and (The Costs of Sub Abuse in CAN, 2002)

WHEREAS Nearly half of all deaths attributable to alcohol are from injuries including unintentional injuries (drowning, burns, poisoning and falls) and intentional injuries (deliberate acts of violence against oneself or others); and (WHO – Alcohol and Injury in EDs, 2007)

WHEREAS Regulating the physical availability of alcohol is one of the top alcohol policy practices in reducing harm; and (Barbor et al., 2010)

WHEREAS The World Health Organization (WHO, 2011) has indicated that alcohol is the world's third largest risk factor for disease burden and that the harmful use of alcohol results in approximately 2.5 million deaths each year. Alcohol is associated with increased levels of health and social costs in Ontario and is causally related to over 65 medical conditions; and

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) petition the Ontario government to conduct a formal review and impact analysis of the health and economic effects of alcohol in Ontario and develop a provincial Alcohol Strategy.

TITLE Maintain the Current Liquor Licence Act (LLA) of Ontario

SPONSOR Middlesex-London Board of Health

WHEREAS Removing designated alcohol areas at events jeopardizes the ability of servers/bar tenders to monitor the number of drinks one person has consumed and as a result, increases the possibility of over-service, over-consumption and alcohol-related harms; and (Barbor et al., 2010)

WHEREAS Removing designated alcohol areas at events increases the risks that underage youth would be able to sneak into the event either with their own alcohol or may have access to alcohol purchased by someone of legal drinking age; and (Barbor et al., 2010)

WHEREAS Alcohol consumption affects a person's judgment, coordination and reflexes and thus allowing for tiered seating is likely to increase the amount of injuries at events; and (Barbor et al., 2010)

WHEREAS There is strong and consistent evidence from a number of countries that changes to hours or days of sale have significant impacts on the volume of alcohol consumed and on the rates of alcohol-related problems; and (Barbor et al., 2010; Vingilis et al., 2007; Vingilis et al., 2005; Stockwell & Chikritzhs, 2009)

WHEREAS Research shows that the provision of alcohol at reduced or no cost increases overall alcohol consumption; and (Barbor et al., 2010; Giesbrecht et al., 2008; Mann et al., 2005)

WHEREAS Allowing the public with alcohol into areas of a restaurant, such as the kitchen, raises concerns regarding food safety and sanitation; and

WHEREAS Allowing tourist operators to offer fixed price packages that include liquor makes it difficult for servers/bar tenders to monitor the number of drinks one person has consumed and as a result, increases the risk of over-service, over-consumption and alcohol-related harms. Under the Liquor Licence Act, it is illegal to serve customers to intoxication. In an "all-you-can-drink" environment, this law is severely compromised; and (Barbor et al., 2010; Thombs et al., 2009)

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) petition the Ontario government to maintain the Liquor Licence Act (LLA) of Ontario as it is currently written until a formal review and impact analysis of the health and economic effects of alcohol in Ontario is completed.