

A G E N D A
MIDDLESEX-LONDON BOARD OF HEALTH

Thursday, September 15, 2011 at 7:00 p.m.
399 Ridout Street North
Side Entrance, (Recessed Door)
Board of Health Boardroom

DISCLOSURE OF CONFLICTS OF INTEREST

APPROVAL OF AGENDA

APPROVAL OF MINUTES

SCHEDULE OF APPOINTMENTS

7:10 – 7:30 p.m. Mr. David Arnold, Senior Manager, KPMG LLP, and Mr. John Millson, Director, Finance and Operations re Item #1.

7:30 – 7:40 p.m. Ms. Brenda Marchuk, Community Nursing Specialist re Item #6.

7:40 – 7:50 p.m. Dr. Bryna Warshawsky, Associate Medical Officer of Health and Director, Oral Health, Communicable Disease and Sexual Health Services re Item #4.

ACTION REQUIRED

- 1) Report No. 079-11 re 2010 Auditor's Reports and Financial Statements
- 2) Report No. 080-11 re 2011 Ministry Funding & Terms and Conditions
- 3) Report No. 081-11 re Smoke-Free Outdoor Public Spaces Position Statement
- 4) Report No. 082-11 re 2010-11 Influenza Season in Middlesex-London

FOR INFORMATION

- 5) Report No. 083-11 re Medical Officer of Health Activity Report – September
- 6) Report No. 084-11 re Health Unit Action on Poverty: Environmental Scan 2011 Report
- 7) Report No. 085-11 re Parkhill Mosquito Control Program
- 8) Report No. 086-11 re Validation of Healthy Babies Healthy Children Screen: Participation in a Provincial Initiative
- 9) Report No. 087-11 re 2011 Budget – Second Quarter Review
- 10) Report No. 088-11 re Board of Health Performance Assessment: June Survey

CONFIDENTIAL

11) The Board of Health will move in camera for the purpose of considering personal matters about an identifiable individual, including Board employees

OTHER BUSINESS

Next scheduled Board of Health Meeting – Thursday, October 20, 2011 7:00 p.m.

CORRESPONDENCE RECEIVED

- a) Dated 2011 May 24 (received 2011 July 11) A copy of correspondence from Dr. Penny Sutcliffe, Medical Officer of Health and Chief Executive Officer, Sudbury and District Health Unit, to The Honourable Chris Bentley, Ontario Attorney General, advising that the Sudbury and District Board of Health passed the following resolutions:

WHEREAS on February 23, 2011, the Ministry of the Attorney General proposed changes to the Liquor Licence Act (LLA) including the removal of restricted areas for alcohol beverages at community festivals /events and the extension of alcohol serving hours at special events from 1 a.m. to 2 a.m.; and

WHEREAS in Sudbury, 84% of adults and 60% of teens (12 to 18 years of age) indicated they had consumed alcohol, which is significantly higher than for Ontario adults (79%) and teens (45%) and among current drinkers 12 years of age and over, 20% reported hazardous or harmful drinking in Sudbury, compared to the Ontario rate of 15%. (CCHS, 2007/08); and

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

WHEREAS alcohol is causally related to over 65 medical conditions. 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; and

WHEREAS research strongly indicates that when alcohol is made readily available, consumption and associated problems increased; conversely when restrictions are on availability are in place, associated problems with alcohol use decrease. Thus the regulation of the physical availability of alcohol is one of the top alcohol policy practices in reducing harm (Barbor et al., 2010); and

WHEREAS the proposed changes to the LLA present the potential for substantial negative public health impacts on the health of our individuals and our communities; and

WHEREAS Boards of Health are mandated to work with municipalities and community partners to develop healthy policies and programs that address alcohol use;

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health petition the provincial Ministry of the Attorney General to consider the negative impact to existing healthy public policy in Ontario and to not proceed with the proposed changes to Ontario's Liquor Licence Act; and

FURTHERMORE 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), and the Association of Local Public Health Agencies (aLPHa)

- b) Dated 2011 June 6 (received 2011 July 5) Correspondence from The Honourable Deb Matthews, Minister of Health and Long-Term Care, to Dr. Graham Pollett, Medical Officer of Health, thanking Dr. Pollett and Health Unit staff for their dedication and professionalism in delivering the Public Health Research, Education and Development (PHRED) program now that the wind-down of the PHRED program is complete.
- c) Dated 2011 June 22 (received 2011 July 11) A copy of correspondence from Dr. Penny Sutcliffe, Medical Officer of Health and Chief Executive Officer, Sudbury and District Health Unit, to Ms. Kim Sloss, Clerk-Administrator, Township of Sables-Spanish Rivers, advising that the Sudbury and District Board of Health passed the following resolutions:

WHEREAS major diseases affecting the quality and length of life of Canadians are linked to physical inactivity; 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 policies to increase road and off-road safety; and

WHEREAS the Sudbury & District Board of Health recognizes that coordinated efforts with municipal governments, public health and other sectors is required in order to develop a comprehensive, community based approach to address safe and sustainable mobility; and

WHEREAS the development of safe cycling paths can reduce crash and injury rates; and

WHEREAS the Council of the Township of Sables-Spanish Rivers passed a resolution (motion number 2011 - 27) petitioning the Minister of Transportation and the Minister of Northern Development and Mines as well as the Share the Road Cycling Coalition to work with municipalities and First Nations to establish a safe cycling trail from Sault Ste. Marie to Sudbury, tying into other cycling trails that are being developed;

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health, as a health partner of the Township of Sables-Spanish Rivers, support the development of safe cycling paths between Sudbury and Sault Ste. Marie; and

FURTHER THAT copies of this motion be forwarded to all Ontario Boards of Health, provincial government partners and local members of provincial parliament, North Shore Tribal Council, Share the Road Cycling Coalition, the Ontario Public Health Association (OPHA), the Association of Local Public Health Agencies (aLPHa) and Federation of Northern Ontario Municipalities (FONOM).

- d) Dated 2011 June 24 (received 2011 July 4) A copy of correspondence from The Honourable Steve Peters, MPP for Elgin-Middlesex-London to the Honourable Deb Matthews, Minister of Health and Long-Term Care;

The Honourable Margaret Best, Minister of Health Promotion; and The Honourable John Gerretsen, Minister of Consumer Services attaching a letter from Dr. Graham Pollett, Secretary-Treasurer of the Middlesex London Board of Health, requesting that the Ontario government do what it can to reduce the impact of smoking in movies on youth.

- e) Dated 2011 July 28 (Received 2011 August 4) Correspondence from The Honourable John Gerretsen, Minister of Consumer Services, responding to a letter from Dr. Pollett, forwarded from The Honourable Steve Peters re limiting youth exposure to images of tobacco/smoking in films.
- f) Dated 2011 August 10 (received 2011 August 10) A copy of correspondence from Dr. Paul Roumeliotis, President, Association of Local Public Health Agencies (alPHa), to The Honourable Kathleen Wynne, Minister of Transportation, expressing alPHa's support for the recommendations contained in the Ontario Medical Association's new Policy Paper, Enhancing Cycling Safety in Ontario.
- h) Dated 2011 August 22 (received 2011 August 21) Correspondence from Dr. Arlene King, Chief Medical Officer of Health, thanking Dr. Pollett and Health Unit staff for their support and quick action during the summer's response to forest fires in Northwestern Ontario.
- i) Dated 2011 August 23 (received 27 August 2011) Correspondence from The Honourable Deb Matthews, Minister of Health and Long-Term Care, to Ms. Pat Coderre, Chair, Middlesex London Board of Health, advising that the MOHLTC will provide new base funding to support the implementation of the Chief Nursing Officer (CNO) initiative.
- j) Dated 2011 August 23 (received 2011 September 6) A copy of correspondence from Dr. Hazel Lynn, Medical Officer of Health, Grey Bruce Health Unit, to The Honourable Dalton McGuinty, Premier of Ontario, and The Honourable Margaret R. Best, Minister of Health Promotion and Sport, advising that that Board of Health passed resolution 2011-78:

WHEREAS tobacco use is known to have direct and indirect harm on the health of the smoker as well as those who are exposed to second-hand smoke, and

WHEREAS there is no safe level of exposure to second-hand smoke and implementing policies that establish smoke-free environments is the most effective way to reduce this exposure, and

WHEREAS the levels of second-hand smoke have been found to be just as high outdoors as indoors, and

WHEREAS 4 in 5 Grey Bruce residents are non-smokers and should be protected from second-hand smoke in the public places they choose to visit, and

WHEREAS outdoor sport and recreation areas are intended to promote health and wellbeing for all Grey and Bruce County residents, and

THAT the Grey Bruce Health Unit encourage all Lower Tier Municipalities in Grey and Bruce counties to support a County wide by-law banning smoking in the aforementioned areas, and

BE IT FURTHER RESOLVED THAT the Grey Bruce Health Unit will support both Counties and the Municipalities to build public awareness of the by-law, and

FURTHER THAT the Grey Bruce Health Unit will share the enforcement of the by-law with the County, if so desired by either County, and

FURTHER THAT a copy of this resolution be forwarded to Bruce County Council; Grey County Council; Councils, CAOs and Recreation Departments of the Municipalities of Arran-Elderslie, Brockton, Kincardine, Northern Bruce Peninsula, South Bruce, Meaford, Grey Highlands, West Grey, Townships of Huron Kinloss, Georgian Bluffs, Chatsworth, Southgate, Towns of Saugeen Shores, South Bruce Peninsula, Blue Mountains, Hanover and City of Owen Sound, Chief of Chippewas of Nawash First Nation, Chief of Saugeen First Nation, Grey and Bruce County MP's and MPP's, Ontario Minister of Health Promotion and Sport and the Premier of Ontario

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

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 079-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 September 15

2010 Auditor's Reports and Financial Statements

Recommendation

It is recommended that the Board of Health accept the audited 2010 & 2011 Financial Statements as appended to Report No. 079-11 for the following programs:

- i) Middlesex-London Health Unit, December 31st (2010) Consolidated Programs
- ii) Middlesex-London Health Unit, March 31st (2011) Consolidated Programs

Attached as Appendix A are draft Consolidated Financial Statements for Health Unit programs with an operating year from January 1, 2010, to December 31, 2010, and for the programs with an operating year from April 1st, 2010, to March 31st, 2011.

The Health Unit auditors, KPMG LLP, did not require any items to be noted on an Auditor's Management Recommendation Letter for these programs.

Mr. John Millson, Director, Finance and Operations, and Mr. David Arnold, Senior Manager, KPMG LLP, will be in attendance at the September 15th Board meeting to address any questions regarding this report.

A common practice in presenting an Audit Report is for the Auditors to meet in private with a Board of Directors excluding the Chief Executive Officer, Chief Financial Officer and all other staff. While this option has not been exercised in the recent past, Board members should be aware of its existence should they so wish to avail themselves.

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

This report addresses By-law #2 Banking & Finance, part 7 (d) re annual audit

**MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 080-11**

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 September 15

2011 Ministry Funding & Terms and Conditions

Recommendation

It is recommended that the Board of Health accept the terms and conditions of the provincial government Public Health Accountability Agreement attached as Appendix A to Report No. 080-11.

2011 Provincial Government Funding Approval

The provincial government approved its share of the Health Unit 2011 operating budget on August 2, 2011. Attached as Appendix A are the funding letters and Schedule A of the provincial Accountability Agreement received from the Ministry of Health and Long-Term Care (MOHLTC) and the Ministry of Health Promotion and Sport (MHPS) which sets out the funding allocations by program. The base funding for Mandatory Programs, Infection Prevention and Control Nurse (100% funded), and the Infectious Disease Control Program (100% funded) increased by 3%. This is the first increase since the Infectious Disease Control (formerly SARS) program began in 2004. Included in this Program are 10.5 full-time equivalent positions.

Also new in 2011, the Health Unit received 100% funding for: the Needle Exchange program, Bed Bug initiative, and two new Public Health Nurse positions to address service needs for those most affected by the social determinants of health (e.g., poverty, lack of education, unemployment).

Accountability Agreement (Terms and Conditions of Funding)

Also new for 2011 as part of receiving ministry funding, each Board of Health is required to enter into an Accountability Agreement with the Province. The Accountability Agreement (attached as Appendix B) sets out the obligations of the Middlesex London Board of Health, MOHLTC and MHPS for a three year period ending December 31, 2013.

Being the first year of such an agreement, the Board of Health and Ministries have until December 2011 (or by such later date as mutually agreed upon by the Parties) to establish appropriate baseline performance indicators as outlined in Schedule D of the Agreement. Once completed, all parties are then to agree on performance targets for years 2 and 3 of the Agreement.

As of the writing of this report, no further details have been received regarding the process for Boards of Health to negotiate the baseline performance indicators and targets for 2012 and 2013.

Board members reviewed an initial draft of the Accountability Agreement at the May 19, 2011, Board of Health meeting (Report No. 050-11). As a result of feedback received from the field, minor revisions were made primarily to the performance indicators. The Accountability Agreement was addressed by Ministry staff at the June Association of Local Public Health Agencies (alPHa) meeting.

As funding from the provincial government is subject to each Board of Health signing the Accountability Agreement, it is recommended that the Board of Health agree to the defined terms and conditions. In so doing, it is understood that the 2011, 2012, and 2013 performance indicators are yet to be negotiated and will be the subject of a future Board report once this process is completed.

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

**Ministry of Health
and Long-Term Care**

Office of the Minister

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80 Grosvenor Street
Toronto ON M7A 2C4
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**Ministry of
Health Promotion and Sport**

Office of the Minister

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HLTC2976FL-2011-194

AUG 02 2011

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

Dear Ms. Coderre:

We are pleased to advise you that the government will provide the Middlesex-London Board of Health up to \$17,938,894 in annual base funding to support the provision of mandatory and related public health programs and services in your community. The annual base amount includes 3% growth funding, or less if requested, for mandatory programs, funding for the Children In Need Of Treatment (CINOT) Expansion Program, and funding previously approved for new Full-Time Equivalent public health nursing positions.

In addition to the annual base funding, we are pleased to provide up to \$744,503 in one-time funding for the 2011 funding year to support projects related to the delivery of mandatory and related public health programs and services. The one-time amount includes funding previously approved to support local initiatives aimed at preventing and controlling bed bug infestations.

The Executive Director (A) of the Public Health Division, Ministry of Health and Long-Term Care, and Assistant Deputy Minister of Sport, Public Health and Community Programs, Ministry of Health Promotion and Sport, will be writing to Dr. Graham Pollett, Medical Officer of Health, Middlesex-London Health Unit, shortly concerning the terms and conditions governing this funding.

Thank you for your dedication and commitment to Ontario's public health system.

Sincerely,

Handwritten signature of Deb Matthews in black ink.

Deb Matthews
Minister of Health and Long-Term Care

Handwritten signature of Margaret Best in black ink, with a long horizontal line extending to the right.

Margarett Best
Minister of Health Promotion and Sport

Ms. Patricia Coderre

- c: Hon. Steve Peters, MPP, Elgin-Middlesex-London
- Maria Van Bommel, MPP, Lambton-Kent-Middlesex
- MPP Constituency Office, London North Centre
- Hon. Christopher Bentley, MPP, London West
- Khalil Ramal, MPP, London-Fanshawe
- Dr. Graham Pollett, Medical Officer of Health, Middlesex-London Health Unit
- Valerie Sterling, President, Association of Local Public Health Agencies
- Liz Haugh, President, Ontario Public Health Association
- Peter Hume, President, Association of Municipalities of Ontario

Ministry of Health
and Long-Term Care

Executive Director's Office

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11th Floor, Hepburn Block
Toronto ON M7A 1R3

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Ministry of
Health Promotion and Sport

Office of the
Assistant Deputy Minister
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Ministère de la Santé
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AUG 02 2011

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

Dear Dr. Pollett:

**Re: Ministry of Health and Long-Term Care and Ministry of Health Promotion and Sport
Agreement with the Board of Health for the Middlesex-London Health Unit**

This letter is further to the recent letter from the Honourable Deb Matthews, Minister of Health and Long-Term Care, and the Honourable Margaret Best, Minister of Health Promotion and Sport, in which they informed you that the government will provide the Middlesex-London Health Unit up to \$17,938,894 in annual base funding to support the provision of mandatory and related public health programs and services in your community, and up to \$744,503 in one-time funding for the 2011 funding year to support projects related to the delivery of mandatory and related public health programs and services.

We are, therefore, pleased to provide you with 2 copies of the Public Health Accountability Agreement (the "Agreement"), which includes the terms and conditions governing this funding.

The annual base amount includes 3% growth funding, or less if requested, for mandatory programs, funding previously approved for new Full-Time Equivalent public health nursing positions, and funding for other related public health programs such as Children In Need Of Treatment (CINOT) Expansion, Healthy Smiles Ontario, Infectious Diseases Control, Infection Prevention and Control Nurses, and Vector-Borne Diseases. The one-time amount includes funding previously approved to support local initiatives aimed at preventing and controlling bed bug infestations.

As you are aware, Ontario has felt the effects of the global recession and is running a deficit in order to create jobs and protect public services. While the contributions of those who deliver public services are valued and appreciated, the public also expects those who are paid by tax dollars to do their part to help sustain public services.

Dr. Graham Pollett

The government has passed the *Public Sector Compensation Restraint to Protect Public Services Act, 2010* (the "Act"), which freezes compensation plans for all non-bargaining employees in the broader public sector, including the Ontario Public Service, for two years. For employees who bargain collectively, the government will respect all current collective agreements. When these agreements expire and new contracts are negotiated, the government will work with transfer payment partners and bargaining agents to seek agreements of at least two years' duration that do not include net compensation increases. The fiscal plan provides no funding for compensation increases for future collective agreements.

Funding provided by the province to transfer payment partners and agencies is for the purpose of providing and protecting public services and is not to be diverted to fund increases in employee compensation.

The provision of funding does not relieve your organization from responsibility for complying with the Act and does not permit it to give increases that are not authorized by the Act.

Please review the Agreement carefully and sign both copies enclosed and return both copies to:

Brent Feeney
Lead, Funding and Accountability
Public Health Standards, Practice and Accountability Branch
Public Health Division, Ministry of Health and Long-Term Care
393 University Avenue, Suite 2100
Toronto ON M7A 2S1

When all the parties have signed the Agreement, we will return one copy to you and will begin to flow the funds reflected in Schedule A of the Agreement.

If you have any questions, please contact Mr. Feeney at 416-212-6397 or by email at brent.feeney@ontario.ca.

Yours truly,



Roselle Martino
Executive Director (A)
Public Health Division, MOHLTC



Steve Harlow
Assistant Deputy Minister
Sport, Public Health and
Community Programs, MHPS

Attachment

- c: Dr. Arlene King, Chief Medical Officer of Health, Public Health Division
- Pier Falotico, Director, Financial Management Branch, MOHLTC
- Michael Parzei, Director, Fiscal, Oversight & Performance Branch, MOHLTC
- John Millson, Manager, Finance & Operations, Middlesex-London Health Unit
- Liz Haugh, President, Ontario Public Health Association
- Peter Hume, President, Association of Municipalities of Ontario
- Valerie Sterling, President, Association of Local Public Health Agencies

SCHEDULE A

PROGRAM-BASED GRANTS

Middlesex-London Board of Health

Base Funding		2011 Approved Allocation
Mandatory Programs (75%)		\$14,803,135
Children In Need Of Treatment (CINOT) Expansion Program (75%)		\$57,468
Enhanced Food Safety – Haines Initiative (100%) (1)		\$60,000
Enhanced Safe Water Initiative (100%) (1)		\$26,720
Healthy Smiles Ontario Program (100%)		\$871,027
Infection Prevention and Control Nurses Initiative (100%)	# of FTEs 1.00	\$84,872
Infectious Diseases Control Initiative (100%)	# of FTEs 10.50	\$1,166,722
Needle Exchange Program Initiative (100%) (1)		\$176,243
Public Health Awareness Initiatives: Infection Prevention and Control Week (100%)		\$8,000
Public Health Nurses Initiative (100%) (2)	# of FTEs 2.00	\$170,040
Small Drinking Water Systems Program (100%)		\$52,700
Unorganized Territories (100%)		-
Vector-Borne Diseases Program (75%)		\$461,967
Sub-Total		\$17,938,894

One-Time Funding	2011 Approved Allocation
Bed Bugs (100%) (3)	\$180,103
Healthy Smiles Ontario – Capital (100%) (4)	\$510,000
Small Drinking Water Systems (100%)	\$54,400
Sub-Total	\$744,503

Total	\$18,683,397
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- (1) Base Funding is pro-rated for the 9 month period of April 1, 2011 to December 31, 2011.
- (2) To receive funding for the Public Health Nurses Initiative, boards of health are required to provide proof of offer of employment, which should not include any personal or identifiable information related to the nurse recruit.
- (3) One-time funding is approved for the 12 month period of April 1, 2011 to March 31, 2012.
- (4) One-time funding is approved for the 9 month period of April 1, 2011 to December 31, 2011.

THIS Public Health ACCOUNTABILITY AGREEMENT effective as of the first day of January, 2011

B E T W E E N :

**HER MAJESTY THE QUEEN IN RIGHT OF
ONTARIO**
as represented by the **Minister of Health and
Long-Term Care and the Minister of Health
Promotion and Sport**

(the "Province")

- and -

Middlesex-London Board of Health

(the "Board of Health")

Background:

The Province provides grants to boards of health under the *Health Protection and Promotion Act (Act)* pursuant to section 76 of that Act.

By receiving the grant provided to boards of health under section 76 of the *Act*, each board of health is expected to deliver programs and services that meet the Ontario Public Health Standards and other requirements of the *Act*.

It is acknowledged that boards of health may provide additional programs and services in response to local needs as indicated in the Ontario Public Health Standards published under section 7 of the *Act* and in section 9 of the *Act*. Provincial funding, however, is intended to support those programs that all boards of health are required to provide under the *Act* (and other programs only if specifically authorized by the Ontario Government) and is not intended to cover the potential total scope of public health programming.

Under section 81.2 of the *Act*, the Minister of Health and Long-Term Care may enter into an agreement with the board of health of any health unit for the purpose of setting out requirements for the accountability of the board of health and the management of the health unit.

Consideration:

In consideration of the mutual covenants and agreements contained herein and for other good and valuable consideration, the receipt and sufficiency of which are expressly acknowledged, the Parties agree as follows:

**ARTICLE 1
INTERPRETATION AND DEFINITIONS**

- 1.1 **Interpretation.** For the purposes of interpretation:
- (a) words in the singular include the plural and vice-versa;
 - (b) words in one gender include all genders;
 - (c) the background and the headings do not form part of the Agreement; they are for reference only and shall not affect the interpretation of the Agreement;
 - (d) any reference to dollars or currency shall be to Canadian dollars and currency; and
 - (e) "include", "includes" and "including" shall not denote an exhaustive list.

- 1.2 **Definitions.** In this Agreement, the following terms shall have the following meanings:

"Act" means the *Health Protection and Promotion Act*.

"Admissible Expenditures" are those considered by the Ministries to be reasonable and necessary for boards of health to achieve and/or maintain compliance with the Ontario Public Health Standards, the Organizational Standards, this Agreement, and other requirements of the Act and, as such, are eligible for reimbursement by the Ministries. These expenditures must be authorized in accordance with the policies of the Board of Health, consistent with government policies, and related to the implementation of Organizational Standards and the delivery of mandatory and related programs.

"Agreement" means this agreement entered into between the Province and the Board of Health and includes all of the schedules to the agreement listed in section 25.1.

"Effective Date" means the date set out at the top of the Agreement.

"Event of Default" has the meaning ascribed to it in section 14.1.

"Funding Year" means:

- (a) in the case of the first Funding Year, the period commencing on the Effective Date and ending on the following December 31st; and
- (b) in the case of Funding Years subsequent to the first Funding Year, the period commencing on January 1 following the end of the previous Funding Year and ending on the following December 31st.

"Grant" means the grant provided to the Board of Health by the Province pursuant to section 76 of the Act and this Accountability Agreement.

“Indemnified Parties” means her Majesty the Queen in right of Ontario, her ministers, agents, appointees and employees.

“Ministers” means Her Majesty the Queen in Right of Ontario as represented by the Minister of Health and Long-Term Care and the Minister of Health Promotion and Sport, and **“Ministries”** shall refer to both ministries. Where necessary in the Schedules to this Agreement to differentiate Programs under the responsibility of each Ministry, MOHLTC is used to describe the Ministry of Health and Long-Term Care, and MHPS is used to describe the Ministry of Health Promotion and Sport.

“Negative Performance Variant” means any of: a) the inability to achieve a result within the range of results for a Performance Indicator as set out in Schedule D; b) any matter that could significantly affect the Board of Health’s ability to achieve a Performance Target as set out in Schedule D; c) non-compliance with any other aspect of the Act, the regulations, the Ontario Public Health Standards, or the Organizational Standards; d) non-compliance with the budget approval and financial reporting processes; or e) any other matter that could significantly affect the Board of Health’s ability to perform its obligations under this Agreement.

“Non-Admissible Expenditures” are those considered by the Ministries to be unrelated to the provision of mandatory and related programs, the Organizational Standards, the requirements of this Agreement, and other requirements of the Act. Examples of expenditures that are not admissible include: sick time and vacation accruals, donations to individuals or organizations, capital fund reserves, and depreciation on capital assets/amortization.

“Notice” means any communication given or required to be given under Agreement, as described in Article 16.

“Notice Period” means the period of time within which the Board of Health is required to remedy an Event of Default, and includes any such period or periods of time by which the Province considers it reasonable to extend that time.

“Ontario Public Health Standards” means the Ontario Public Health Standards published by the Minister of Health and Long-Term Care pursuant to section 7 of the Act.

“Organizational Standards” means the Ontario Public Health Organizational Standards as released by the Ministries on February 18, 2011 or as updated and as provided to the Board of Health.

“Parties” means the Province and the Board of Health.

“Party” means either the Province or the Board of Health.

“Performance Corridor” means the calculated range of results respecting a Performance Target for a Performance Indicator based on the technical variance of the data and other contextual factors.

“Performance Indicator” means a measure of board of health performance for which a Performance Target is set, and to which the Board of Health will be held accountable for achieving results under the terms of this Agreement.

“Performance Target” means a planned result for a Performance Indicator against which actual results can be compared (as further specified in Table A of Schedule D.)

“Positive Performance Variant” means a successful achievement beyond the range of results for a Performance Indicator as set out in Schedule D.

“Program(s)” means:

- a) **Mandatory Program(s):** the health programs and services boards of health must provide to their local communities in accordance with section 5 of the Act and the Ontario Public Health Standards.
- b) **Related Program(s):** the programs described in Schedule “B”.

“Reports” means the reports described in Schedule “C”.

“Tangible Capital Asset” is a physical asset (e.g., building and land, information technology and telecommunications equipment, vehicles, furniture and other equipment) that has a useful life of more than one year and is used on a continuing basis for the delivery of mandatory and related programs.

“Wind-Down Amount” means the amount the Province sets if the Agreement is terminated under sections 12.3(c) or 13.2(c).

ARTICLE 2 REPRESENTATIONS, WARRANTIES AND COVENANTS

2.1 **General.** The Board of Health represents, warrants and covenants that:

- (a) it is, and shall continue to be for the term of the Agreement, a validly existing legal entity with full power to fulfill its obligations under the Agreement;
- (b) unless otherwise provided for in this Agreement, any information the Board of Health provided to the Province in support of its requests for a Grant (including information relating to any eligibility requirements) was true and complete at the time the Board of Health provided it and shall continue to be true and complete for the term of this Agreement, unless otherwise reported in writing by the Board of Health to the Province.

2.2 **Execution of Agreement.** The Board of Health represents and warrants that:

- (a) it has the full power and authority to enter into the Agreement;

- (b) it will fulfill the obligations set out in the Schedules to this Agreement in accordance with their terms;
- (c) it will deliver Programs and services that meet the Ontario Public Health Standards published under section 7 of the Act, and will comply with the Organizational Standards;
- (d) it has taken all necessary actions to authorize the execution of the Agreement including, where required, passing a board resolution or municipal by-law authorizing the Board of Health to enter into the Agreement with the Province.

2.3 **Governance.** The Board of Health represents, warrants and covenants that it has, and shall maintain, in writing, for the period during which the Agreement is in effect:

- (a) procedures to ensure compliance with the Organizational Standards;
- (b) a code of conduct and ethical responsibilities for all persons at all levels of the Board of Health's organization;
- (c) procedures to ensure the ongoing effective functioning of the Board of Health;
- (d) decision-making mechanisms;
- (e) procedures to provide for the prudent and effective management of the Grant;
- (f) procedures to enable the successful completion of the obligations set out in the Schedules to this Agreement;
- (g) procedures to enable the timely identification of risks to the Board of Health's ability to perform its obligations under this Agreement and strategies to address the identified risks;
- (h) procedures to enable the preparation and delivery of all Reports required pursuant to Article 8; and,
- (i) procedures to deal with such other matters as the Board of Health considers necessary to ensure that the Board of Health carries out its obligations under the Agreement.

2.4 **Supporting Documentation.** Upon request, the Board of Health shall provide the Province with proof of the matters referred to in this Article 2.

**ARTICLE 3
TERM OF THE AGREEMENT**

- 3.1 **Term.** The term of the Agreement shall commence on the Effective Date and shall, subject to section 3.2, expire on **December 31st, 2013** unless terminated earlier pursuant to Article 12, Article 13 or Article 14.
- 3.2 **Agreement to Continue.** The Parties shall negotiate a new, successor agreement to this Agreement to be effective January 1, 2014. Despite section 3.1, this Agreement shall continue according to its terms until such time as a new agreement is agreed to between the Parties, unless terminated earlier pursuant to Article 12, Article 13, or Article 14.
- 3.3 **Application of Schedules during Term.** A schedule, or parts of a schedule, may apply for only part of the Term of this Agreement. Where a schedule, or part of a schedule, applies for only part of the Term of this Agreement, it shall be so indicated in the schedule.
- 3.4 **Amendments to Schedules during Term.** The Parties agree that amendments to the Schedules may be made, on the written consent of both parties, during the Term of this Agreement. Without limiting the generality of the foregoing, the Schedules may be amended to reflect:
- (a) Updated allocations in Schedule A;
 - (b) New policies and guidelines in Schedule B;
 - (c) New reporting requirements in Schedule C; and
 - (d) Updated Performance indicators, baselines, and targets in Schedule D.
- 3.5 **Annual Review of Schedules.** The Parties agree to review the schedules to this Agreement on an annual basis, at the end of each Funding Year, to determine if amendments are appropriate.
- 3.6 **Additional Schedules during Term.** The Parties agree that additional Schedules may be added to this Agreement on the written consent of both parties during the Term of this Agreement.

**ARTICLE 4
GRANT**

- 4.1 **Grant Provided.** The Province shall:
- (a) provide the Board of Health a Grant for the purpose of carrying out the obligations set out in the Act, the regulations under the Act, the Ontario Public Health Standards, the Organizational Standards, and this Agreement including the Schedules to this Agreement;

- (b) deposit the Grant into an account designated by the Board of Health provided that the account resides at a Canadian financial institution.

4.2 Limitation on Payment of the Grant. Despite section 4.1, the Province:

- (a) is not obligated to provide any Grant to the Board of Health until the Board of Health provides a valid certificate of insurance or other proof as provided for in section 11.2;
- (b) is not obligated to provide instalments of the Grant until it is satisfied with the progress of the obligations set out in this Agreement and the Schedules;
- (c) may adjust the amount of the Grant it provides to the Board of Health in any Funding Year based upon the Province's assessment of the information provided by the Board of Health pursuant to section 8.1;
- (d) if, pursuant to the provisions of the *Financial Administration Act* (Ontario), the Province does not receive the necessary appropriation from the Ontario Legislature for payment under the Agreement, the Province shall not be obligated to make any such payment, and, as a consequence, the Province may:
 - (i) reduce the amount of the Grant; or
 - (ii) terminate the Agreement pursuant to section 13.1 and cease providing Grant funding for a period or periods specified by the Province; and
- (e) may withhold 1% of the bi-weekly Grant payments from the Board of Health which are specified in Schedule A if the Board of Health's complete settlement reports (consisting of Audited Financial Statements, Auditor's Questionnaire with Auditor's Report, and a Certificate of Settlement) are not submitted by the deadline of June 30th of any Funding Year, or such other deadline as the Province specifies in writing, until such time as all the settlement reports are provided.

4.3 Use of Grant Funding. The Board of Health shall:

- (a) use the Grant only for the purposes of the Act and to provide or to ensure the provision of the health programs and services in accordance with sections 4, 5, 6, and 7 of the Act and for the purposes of carrying out the obligations in the Schedules.
- (b) use the Grant only for the provision of the Programs described in this Agreement and the schedules.
- (c) carry out the obligations in the Schedules:
 - (i) in accordance with the terms and conditions of the Agreement; and

- (ii) in compliance with all federal and provincial laws and regulations, all municipal by-laws, and any other orders, rules and by-laws related to any aspect of the Programs.
- (d) Spend the Grant only on Admissible Expenditures.
- 4.4 **User Fees.** As the Province provides Grants for the delivery of public health programs and services, the Board of Health agrees that the Province is eligible to receive its current cost-share percentage of the net revenue from any user fees charged by the Board of Health.
- 4.5 **No Changes.** The Board of Health shall not make any changes to Schedules, the timelines and/or the use of the Grant without the prior written consent of the Province.
- 4.6 **Interest Bearing Account.** If the Province provides the Grant to the Board of Health prior to the Board of Health's immediate need for the Grant, the Board of Health shall place the Grant in an interest bearing account in the name of the Board of Health at a Canadian financial institution.
- 4.7 **Interest.** If the Board of Health earns any interest on the Grant, it must be reported. If interest income is not reported in the manner specified by the Province, 1% of the Board of Health's cash flow may be withheld through future payments.
- 4.8 **No Interest Payable by Province.** The Board of Health agrees that the Province shall not pay interest on any amount to which the Board of Health may otherwise be entitled under this Agreement.
- 4.9 **Rebates, Credits and the Grant.** The Board of Health shall not use the Grant for any costs, including taxes, for which it has received, will receive, or is eligible to receive, a rebate, credit or refund.

ARTICLE 5 PERFORMANCE IMPROVEMENT

- 5.1 **Performance Improvement.** The Parties agree to adopt a proactive and responsive approach to performance improvement ("Performance Improvement Process"), based on the following principles:
 - (a) a commitment to continuous quality improvement;
 - (b) a culture of information sharing and understanding; and
 - (c) a focus on risk-management.

- 5.2 **Performance Obligations.** The Board of Health shall use best efforts to achieve agreed upon Performance Targets within the established Performance Corridors for the Performance Indicators specified in Schedule "D".
- 5.3 **Elements of Performance Improvement Process.** The Board of Health's Performance Improvement Process shall include, but is not limited to:
- (a) Measuring the Board of Health's performance according to Performance Indicators set out in Schedule D; and
 - (b) The use of continuous quality improvement tools including, but not limited to those specified in sections 5.4, 5.5, and 5.6.
- 5.4 **Negative Performance Variant Reports.** If a Negative Performance Variant is identified by either the Province or Board of Health, the Board of Health shall immediately submit in writing a Negative Performance Variant Report to the Province which shall include:
- (a) a description of the Negative Performance Variant;
 - (b) the cause of the Negative Performance Variant;
 - (c) an assessment of the impact of the Negative Performance Variant on achieving the obligations set out in this Agreement; and
 - (d) a description of how the Board of Health plans to resolve the Negative Performance Variant and the timeline within which the Board of Health expects to resolve it.
- 5.5 **Positive Performance Variant Reports.** If a Positive Performance Variant is identified by either the Province or Board of Health, the Board of Health may be asked to submit in writing a Positive Performance Variant Report to the Province which shall include:
- (a) a description of the Positive Performance Variant and contributing success factor(s);
 - (b) an assessment of the lessons learned; and
 - (c) a description of how the Board of Health plans to maintain or enhance success.
- 5.6 **Action Plan.** The Province may request in writing, either before or after a Negative Performance Variant Report(s) specified in section 5.4, that the Board of Health submit an Action Plan to address the Negative Performance Variant. The Action Plan shall describe:
- (a) the remedial actions undertaken (or planned to be undertaken) by the Board of Health;
 - (b) the time frame when the remedial action are expected to be completed;

- 5.7 **Approval of Action Plan.** The Action Plan must be approved by both the Province and the Board of Health prior to its implementation. Any revisions to the Action Plan also require the approval of both the Province and the Board of Health.
- 5.8 **Province Right to Request Information.** The Province may request additional data or information, or may request meetings with the Board of Health to support performance improvement as specified in this Article.

ARTICLE 6 ACQUISITION OF GOODS AND SERVICES, AND DISPOSAL OF ASSETS

- 6.1 **Acquisition.** If the Board of Health acquires supplies, equipment or services with the Grant, it shall do so through a process that promotes the best value for money. All procurement of goods and services should be consistent with the Organizational Standards, good procurement practices, and applicable government directives.
- 6.2 **Asset Management.** The Board of Health shall maintain an inventory of all Tangible Capital Assets developed or acquired with a value exceeding \$5,000 or a value determined locally that is appropriate under the circumstances.
- 6.3 **Disposal.** The Board of Health shall not, without the Province's prior written consent, sell, lease or otherwise dispose of any asset purchased with the Grant or for which the Grant was provided, the cost of which exceeded \$100,000 at the time of purchase.

ARTICLE 7 CONFLICT OF INTEREST

- 7.1 **No Conflict of Interest with use of the Grant.** The Board of Health shall carry out the obligations set out in this Agreement and use the Grant without an actual, potential or perceived conflict of interest. Note: nothing in this agreement applies to any other local or municipal conflict of interest not dealing with the use of the Grant.
- 7.2 **Conflict of Interest Includes.** For the purposes of this Article, a conflict of interest includes any circumstances where:
- (a) the Board of Health; or
 - (b) any person who has the capacity to influence the Board of Health's decisions,

has outside commitments, relationships or financial interests that could, or could be seen to, interfere with the Board of Health's objective, unbiased and impartial

judgment relating to its obligations under this Agreement and the use of the Grant.

- 7.3 **Disclosure to Province.** The Board of Health shall:
- (a) disclose to the Province, without delay, any situation that a reasonable person would interpret as either an actual, potential or perceived conflict of interest; and
 - (b) comply with any terms and conditions that the Province may prescribe as a result of the disclosure. Note that the Province may determine that no further action is required if it determines that the conflict has been adequately addressed in accordance with the Board of Health conflict of interest policies.

ARTICLE 8 REPORTING, ACCOUNTING AND REVIEW

- 8.1 **Preparation and Submission.** The Board of Health shall:
- (a) submit to the Province at the address provided in section 16.1 or at any other address specified by the Province, all Reports in accordance with the timelines and content requirements set out in Schedule "C".
 - (b) submit to the Province at the address provided in section 16.1, or at any other address specified by the Province, any other reports requested by the Province in accordance with the timelines and content requirements specified by the Province;
 - (c) ensure that all Reports and other reports are completed to the satisfaction of the Province; and
 - (d) ensure that all Reports and other reports are signed on behalf of the Board of Health by an authorized signing officer.
- 8.2 **Record Maintenance.** The Board of Health shall keep and maintain:
- (a) all financial records (including invoices) relating to the Grant in a manner consistent with generally accepted accounting principles for a period of not less than seven (7) years; and
 - (b) all non-financial documents and records relating to the Grant or otherwise in connection with Article 5 (Performance Improvement) and the Schedules in accordance with applicable law and Board of Health policies.
- 8.3 **Inspection.** The Province, its authorized representatives or an independent auditor identified by the Province may, at its own expense, upon twenty-four hours' Notice to the Board of Health and during normal business hours, enter

upon the Board of Health's premises to review the Board of Health's expenditure of the Grant and/or assess compliance with Article 5 (Performance Improvement), for these purposes, the Province, its authorized representatives or an independent auditor identified by the Province may:

- (a) inspect and copy the records and documents referred to in section 8.2; and
 - (b) conduct an audit or investigation of the Board of Health in respect of the expenditure of the Grant, or compliance with Article 5 (Performance Improvement).
- 8.4 **Assessment.** The Province may carry out an assessment of the Board of Health under section 82 of the Act if the legal requirements for an assessment under that section have been met. An assessment may be conducted under the terms of that section irrespective of whether or not an inspection is conducted under section 8.3 of this Agreement.
- 8.5 **Disclosure.** To assist in respect of the rights set out in section 8.3, the Board of Health shall disclose any information requested by the Province, its authorized representatives or an independent auditor identified by the Province, and shall do so in a form requested by the Province, its authorized representatives or an independent auditor identified by the Province, as the case may be, subject to applicable law.
- 8.6 **No Control of Records.** No provision of the Agreement shall be construed so as to give the Province any control whatsoever over the Board of Health's records.
- 8.7 **Auditor General.** For greater certainty, the Province's rights under this Article are in addition to any rights provided to the Auditor General pursuant to section 9.1 of the *Auditor General Act* (Ontario) and under the *Audit Statute Law Amendment Act*

ARTICLE 9 FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY

- 9.1 **FIPPA.** The Board of Health acknowledges that the Province is bound by the *Freedom of Information and Protection of Privacy Act* (Ontario) (FIPPA) and that any information provided to the Province in connection with the Agreement may be subject to disclosure in accordance with FIPPA.
- 9.2 **MFIPPA.** The Province acknowledges that the Board of Health is bound by the *Municipal Freedom of Information and Protection of Privacy Act* (Ontario) (MFIPPA) and that any information provided to the Board of Health in connection with the Agreement may be subject to disclosure in accordance with MFIPPA.
- 9.3 **Confidentiality of records.** The Board of Health shall ensure that all personal information or personal health information in its custody or under its control is

managed in accordance with the provisions of the Act and its regulations, the *Municipal Freedom of Information and Protection of Privacy Act* and its regulations, the *Personal Health Information Protection Act* and any other applicable legislation.

ARTICLE 10 INDEMNITY

- 10.1 **Indemnification.** The Board of Health hereby agrees to indemnify and hold harmless the Indemnified Parties from and against any and all liability, loss, costs, damages and expenses (including legal, expert and consultant fees), causes of action, actions, claims, demands, lawsuits or other proceedings, by whomever made, sustained, incurred, brought or prosecuted, in any way arising out of or in connection with the Programs or otherwise in connection with the Agreement, unless solely caused by the negligence or wilful misconduct of the Province.

ARTICLE 11 INSURANCE

- 11.1 **Board of Health's Insurance.** The Board of Health represents and warrants that it has, and shall maintain for the term of the Agreement, at its own cost and expense, with insurers having a secure A.M. Best rating of B+ or greater, or the equivalent, all the necessary and appropriate insurance that a prudent person carrying out programs and services similar to the programs and services covered by this Agreement would maintain, including commercial general liability insurance on an occurrence basis for third party bodily injury, personal injury and property damage, to an inclusive limit of not less than two million dollars (\$2,000,000) per occurrence. The policy shall include the following:
- (a) the Indemnified Parties as additional insureds with respect to liability arising in the course of performance of the Board of Health's obligations under, or otherwise in connection with, the Agreement;
 - (b) a cross-liability clause;
 - (c) contractual liability coverage; and
 - (d) a 30 day written notice of cancellation, termination or material change.
- 11.2 **Proof of Insurance.** The Board of Health shall provide the Province with proof of insurance in the form of a valid certificate of insurance that confirms the insurance coverage as required in section 11.1. The Board of Health shall provide a copy of the certificate of insurance to the Province prior to the receipt of Grant funding under this Agreement.

**ARTICLE 12
TERMINATION ON NOTICE**

- 12.1 **Termination on Notice.** The Province may terminate the Agreement at any time upon giving at least 120 days Notice to the Board of Health.
- 12.2 **Termination of Specific Program.** Despite section 12.1, the Province may terminate any Program that is funded by a Grant under this Agreement with 120 days Notice. If a Program funded by a Grant under this Agreement terminates for any reason, the parties agree to amend the Agreement and Schedules to incorporate any necessary changes to the Agreement.
- 12.3 **Consequences of Termination on Notice by the Province.** If the Province terminates the Agreement pursuant to section 12.1, the Province may:
- (a) cancel all further instalments of the Grant;
 - (b) demand the repayment of any Grant remaining in the possession or under the control of the Board of Health; and/or
 - (c) assist the Board of Health to wind down the Program, project, or other initiative purchased with the Grant, set the Wind-Down Amount; and
 - (i) permit the Board of Health to offset the Wind-Down Amount against any Grant amount remaining in the possession or under the control of the Board of Health; and/or
 - (ii) subject to section 4.7, provide the Grant to the Board of Health to cover the Wind-Down Amount.

**ARTICLE 13
TERMINATION WHERE NO APPROPRIATION**

- 13.1 **Termination Where No Appropriation.** If, as provided for in section 4.2(d), the Province does not receive the necessary appropriation from the Ontario Legislature for any payment the Province is to make under the Agreement, the Province may terminate the Agreement immediately by giving Notice to the Board of Health.
- 13.2 **Consequences of Termination Where No Appropriation.** If the Province terminates the Agreement pursuant to section 13.1, the Province may:
- (a) cancel all further instalments of the Grant;
 - (b) demand the repayment of any Grant funds remaining in the possession or under the control of the Board of Health; and/or

- (c) to assist the Board of Health to wind down a Program, project or other initiative purchased with the Grant, set the Wind-Down Amount, and permit the Board of Health to offset such Wind-Down Amount against the amount owing pursuant to section 13.2(b).
- 13.3 **No Additional Grant Funding.** For purposes of clarity, if the Wind-Down Amount exceeds the Grant remaining in the possession or under the control of the Board of Health, the Province shall not be required to provide additional Grant funding to the Board of Health.

ARTICLE 14
EVENT OF DEFAULT, CORRECTIVE ACTION AND TERMINATION FOR DEFAULT

- 14.1 **Events of Default.** Each of the following events may constitute at the sole option of the Province an Event of Default:
- (a) the Board of Health breaches any representation, warranty, covenant or other material term of the Agreement, including failing to do any of the following in accordance with the terms and conditions of the Agreement:
 - (i) carry out its obligations in the Schedules;
 - (ii) use or spend the Grant; and/or
 - (iii) provide, in accordance with section 8.1, Reports or such other reports as may have been requested pursuant to section 8.1(b);
 - (b) the Board of Health's operations, or its organizational structure, changes so that it no longer meets one or more of the applicable eligibility requirements of the Program under which the Province provides the Grant; and,
 - (c) the Board of Health ceases to operate, is merged or otherwise dissolved.
- 14.2 **Consequences of Events of Default and Corrective Action.** If an Event of Default occurs, the Province may, at any time, take one or more of the following actions:
- (a) initiate any action the Province considers necessary in order to facilitate the successful continuation or completion of the Board of Health's obligations under this Agreement;
 - (b) provide the Board of Health with an opportunity to remedy the Event of Default;
 - (c) suspend the payment of the Grant for such period as the Province determines appropriate;
 - (d) reduce the amount of the Grant;

- (e) cancel all further installments of the Grant;
- (f) demand the repayment of any amounts of the Grant remaining in the possession or under the control of the Board of Health that is not already promised by legal agreement that the Board of Health has with another person;
- (g) demand the repayment of an amount equal to any Grant the Board of Health used for purposes not agreed upon by the Province;
- (h) demand the repayment of an amount equal to any Grant the Province provided to the Board of Health; and/or
- (i) terminate the Agreement at any time, including immediately, upon giving Notice to the Board of Health.

14.3 **Opportunity to Remedy.** If, in accordance with section 14.2(b), the Province provides the Board of Health an opportunity to remedy the Event of Default, it shall provide Notice to the Board of Health of:

- (a) the particulars of the Event of Default; and
- (b) the Notice Period.

14.4 **Board of Health not Remediating.** If the Province has provided the Board of Health with an opportunity to remedy the Event of Default pursuant to section 14.2(b), and:

- (a) the Board of Health does not remedy the Event of Default within the Notice Period;
- (b) it becomes apparent to the Province that the Board of Health cannot completely remedy the Event of Default within the Notice Period; or
- (c) the Board of Health is not proceeding to remedy the Event of Default in a way that is satisfactory to the Province,

the Province may extend the Notice Period, or initiate any one or more of the actions provided for in sections 14.2 (a), (c), (d), (e), (f), (g), (h) and (i).

14.5 **When Termination Effective.** Termination under this Article shall take effect as set out in the Notice.

14.6 **Ministry's Rights under the Act maintained.** Nothing in this Agreement shall limit the Province's or the Chief Medical Officer of Health's rights under section 82 of the Act to conduct an assessment of the Board of Health if the conditions under that section are met.

**ARTICLE 15
RETURN OF THE GRANT**

- 15.1 **Return of The Grant.** If the Province requests in writing the repayment of the whole or any part of the Grant; due, for example, to an Event of Default; the amount requested shall be deemed to be a debt due and owing to the Province and the Board of Health shall pay the amount immediately.
- 15.2 **Method of Return.** The Province may recover the Grant requested in section 15.1 through a cash-flow adjustment. If a cash-flow adjustment is not possible, the Board of Health shall repay the amount payable by cheque payable to the Minister of Finance and mailed to the Province at the address set out in the Province's request for repayment.
- 15.3 **Interest on the Grant Payable.** The Province reserves the right to demand interest on any amount owing by the Board of Health at the then current rate charged by the Province on accounts receivable. Interest shall accrue 30 days after Notice has been provided under section 15.1 for repayment of the Grant.
- 15.4 **Unused Grant.** The Board of Health agrees that it shall report to the Province in writing any part of the Grant that has not been used or accounted for by the Board of Health, either 30 days prior to the end of the Funding Year, in the quarterly reports, or in a report provided as soon thereafter as possible, and when the amount of the unused Grant is known.
- 15.5 **Carry Over of Grant Not Permitted.** The Board of Health is not permitted to carry over the Grant from one calendar year to the next, unless pre-authorized in writing by the Province.
- 15.6 **Return of Unused Grant.** Without limiting any rights of the Province under Article 13, or sections 15.1 or 15.2, if the Board of Health has not spent all of the Grant allocated for the Funding Year as provided for in the Schedules, the Province may:
- (a) demand the return of the unspent Grant; or
 - (b) adjust the amount of any further instalments of the Grant accordingly.

**ARTICLE 16
NOTICE**

- 16.1 **Notice in Writing and Addressed.** Notice shall be in writing and shall be delivered by e-mail, postage-prepaid mail, personal delivery or facsimile, and shall be addressed to the Province and the Board of Health respectively as set out below or as either Party later designates to the other by Notice:

To the Province:

Ministry of Health and Long-Term Care and
Ministry of Health Promotion and Sport

393 University Ave., Suite 2100
Toronto ON M7A 2S1

Attention:

Sylvia Shedden
Director, Public Health Standards, Practice
and Accountability Branch

Fax: 416-314-7078
E-mail: sylvia.shedden@ontario.ca

To the Board of Health:

Middlesex-London Board of Health

50 King Street
London ON N6A 5L7

Attention:

Dr. Graham Pollett
Medical Officer of Health

Fax: 519-663-9413
E-mail: graham.pollett@mlhu.on.ca

- 16.2 **Notice Given.** Notice shall be deemed to have been received:
- (a) in the case of postage-prepaid mail, seven days after a Party mails the Notice; or
 - (b) in the case of e-mail, personal delivery or facsimile, at the time the other Party receives the Notice.
- 16.3 **Postal Disruption.** Despite section 16.2(a), in the event of a postal disruption:
- (a) Notice by postage-prepaid mail shall not be deemed to be received; and
 - (b) the Party giving Notice shall provide Notice by personal delivery, by facsimile, or by e-mail.

**ARTICLE 17
CONSENT BY PROVINCE**

- 17.1 **Consent.** The Province may impose any terms and conditions on any consent the Province may grant pursuant to the Agreement.

**ARTICLE 18
SEVERABILITY OF PROVISIONS**

- 18.1 **Invalidity or Unenforceability of Any Provision.** The invalidity or unenforceability of any provision of the Agreement shall not affect the validity or enforceability of any other provision of the Agreement. Any invalid or unenforceable provision shall be deemed to be severed.

**ARTICLE 19
WAIVER**

- 19.1 **Waivers in Writing.** If a Party fails to comply with any term of the Agreement, that Party may only rely on a waiver of the other Party if the other Party has provided a written waiver in accordance with the Notice provisions in Article 16. Any waiver must refer to a specific failure to comply and shall not have the effect of waiving any subsequent failures to comply.

**ARTICLE 20
INDEPENDENT PARTIES**

- 20.1 **Parties Independent.** The Board of Health acknowledges that it is not an agent, joint venturer, partner or employee of the Province, and the Board of Health shall not take any actions that could establish or imply such a relationship.

**ARTICLE 21
ASSIGNMENT OF AGREEMENT OR THE GRANT**

- 21.1 **No Assignment.** The Board of Health shall not assign any part of the Agreement or the Grant without the prior written consent of the Province.
- 21.2 **Agreement to Extend.** All rights and obligations contained in the Agreement shall extend to and be binding on the Parties' respective heirs, executors, administrators, successors and permitted assigns.

**ARTICLE 22
GOVERNING LAW**

- 22.1 **Governing Law.** The Agreement and the rights, obligations and relations of the Parties shall be governed by and construed in accordance with the laws of the Province of Ontario and the applicable federal laws of Canada. Any actions or proceedings arising in connection with the Agreement shall be conducted in Ontario.
- 22.2 **Conflicts - Ontario.** In the event of a conflict between this Agreement and the Ontario Public Health Standards, the Organizational Standards or the Act or its regulations, the Ontario Public Health Standards, Organizational Standards or the Act or its regulations prevail.
- 22.3 **Conflicts – Municipal.** In the event of a conflict between any requirement of this Agreement and any municipal or local requirement at law to which the Board of Health is subject, the Board of Health shall comply with the stricter requirement.

**ARTICLE 23
FURTHER ASSURANCES**

- 23.1 **Agreement into Effect.** The Parties shall do or cause to be done all acts or things necessary to implement and carry into effect the terms and conditions of the Agreement to its full extent.

**ARTICLE 24
SURVIVAL**

- 24.1 **Survival.** The provisions in Article 1, Article 4, Article 5, 8.1 (to the extent that the Board of Health has not provided the Reports or other reports to the satisfaction of the Province), 8.2, 8.3, 8.4, 8.5, 8.6, 8.7, Articles 9, 10 and 11, sections 13.2, 14.2, 14.3, 14.4, Articles 15, 18, 19, 21, 26, 27, 28, and all applicable Definitions, cross-referenced provisions and schedules shall continue in full force and effect for a period of seven years from the date of expiry or termination of the Agreement.

**ARTICLE 25
SCHEDULES**

- 25.1 **Schedules.** The Agreement includes the following schedules:
- (a) Schedule "A" – Program-Based Grants;
 - (b) Schedule "B" – Related Program Policies and Guidelines;
 - (c) Schedule "C" – Reporting Requirements.
 - (d) Schedule "D" – Board of Health Performance
- 25.2 **Purpose of Schedules.** The purpose of the schedules under the Agreement is to:
- (a) Specify the Grant to be allocated from the Province to the Board of Health to deliver Programs and services that meet the Ontario Public Health Standards, and other requirements of the Act, and the Organizational Standards;
 - (b) Provide the Board of Health with further information on expectations related to the Grant;
 - (c) Improve and strengthen the Province's ability to effectively analyze the Board of Health's expenditures and ensure accountability for the use of the Grant; and,

- (d) Contribute to a public health sector with a greater focus on performance improvement, accountability and sustainability.

ARTICLE 26 COUNTERPARTS

- 26.1 **Counterparts.** The Agreement may be executed in any number of counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

ARTICLE 27 JOINT AND SEVERAL LIABILITY

- 27.1 **Joint and Several Liability.** Where the Board of Health is comprised of more than one entity, all such entities shall be jointly and severally liable to the Province for the fulfillment of the obligations of the Board of Health under the Agreement.

**ARTICLE 28
ENTIRE AGREEMENT**

- 28.1 **Entire Agreement.** The Agreement constitutes the entire agreement between the Parties with respect to the subject matter contained in the Agreement and supersedes all prior oral or written representations and agreements.
- 28.2 **Modification of Agreement.** The Agreement may only be amended by a written agreement duly executed by the Parties.

The Parties have executed the Agreement on the dates set out below.

HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO
as represented by the Minister of **Health and Long-Term Care**

Name: _____ Date _____
Title:

HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO
as represented by the Minister of **Health Promotion and Sport**

Name _____ Date _____
Title:

Middlesex-London Board of Health

I/We have authority to bind the Board of Health.

Name: _____ Date _____
Position:

Name: _____ Date _____
Position:

SCHEDULE A

PROGRAM-BASED GRANTS

Middlesex-London Board of Health

Base Funding		2011 Approved Allocation
Mandatory Programs (75%)		\$14,803,135
Children In Need Of Treatment (CINOT) Expansion Program (75%)		\$57,468
Enhanced Food Safety – Haines Initiative (100%) (1)		\$60,000
Enhanced Safe Water Initiative (100%) (1)		\$26,720
Healthy Smiles Ontario Program (100%)		\$871,027
Infection Prevention and Control Nurses Initiative (100%)	# of FTEs 1.00	\$84,872
Infectious Diseases Control Initiative (100%)	# of FTEs 10.50	\$1,166,722
Needle Exchange Program Initiative (100%) (1)		\$176,243
Public Health Awareness Initiatives: Infection Prevention and Control Week (100%)		\$8,000
Public Health Nurses Initiative (100%) (2)	# of FTEs 2.00	\$170,040
Small Drinking Water Systems Program (100%)		\$52,700
Unorganized Territories (100%)		-
Vector-Borne Diseases Program (75%)		\$461,967
Sub-Total		\$17,938,894

One-Time Funding	2011 Approved Allocation
Bed Bugs (100%) (3)	\$180,103
Healthy Smiles Ontario – Capital (100%) (4)	\$510,000
Small Drinking Water Systems (100%)	\$54,400
Sub-Total	\$744,503

Total	\$18,683,397
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- (1) Base Funding is pro-rated for the 9 month period of April 1, 2011 to December 31, 2011.
- (2) To receive funding for the Public Health Nurses Initiative, boards of health are required to provide proof of offer of employment, which should not include any personal or identifiable information related to the nurse recruit.
- (3) One-time funding is approved for the 12 month period of April 1, 2011 to March 31, 2012.
- (4) One-time funding is approved for the 9 month period of April 1, 2011 to December 31, 2011.

SCHEDULE B

RELATED PROGRAM POLICIES AND GUIDELINES

BASE FUNDING:

B1. CINOT Expansion Program (MHPS)

The CINOT Expansion Program provides coverage for basic dental care for children 14 through 17 years in addition to general anaesthetic coverage for children 5 through 13 years. Boards of health must be in compliance with the Ontario Public Health Standards and the CINOT Protocol.

Boards of health must use the Oral Health Information Support System (OHISS) application to process all CINOT Expansion claims. Financial report data should align with expenditures as recorded in OHISS and reflected in Age Profile and Procedure Code Profile Reports for the period January 1st through December 31st.

Boards of health will not be permitted to transfer any projected CINOT Expansion Program surplus to their CINOT 0-13 year old budget.

B2. Enhanced Food Safety – Haines Initiative (MOHLTC)

The Enhanced Food Safety – Haines Initiative was established to augment a board of health's capacity to deliver the Food Safety Program as a result of the Provincial Government's response to Justice Haines' recommendations in his report "Farm to Fork: A Strategy for Meat Safety in Ontario".

Base funding for this initiative must be used for the sole purpose of implementing the Food Safety Program Standard. Eligible expenses include such activities as: hiring staff, delivering additional food-handler training courses, providing public education materials, and program evaluation. Funded projects/activities must be over and above the level of activities underway or planned based on existing mandatory programs base funding.

B3. Enhanced Safe Water Initiative (MOHLTC)

Base funding for this initiative must be used for the sole purpose of increasing the Board of Health's capacity to meet the requirements of the Safe Water Program Standard. Funded projects/activities must be over and above the level of activities underway or planned based on existing mandatory programs base funding.

B4. Healthy Smiles Ontario Program (MOHLTC)

Base funding for the Healthy Smiles Ontario (HSO) Program may only be used for costs associated with the HSO Program in accordance with the following conditions:

1. Base funds may only be used for ongoing day-to-day expenses associated with delivering services under the HSO Program in accordance with the HSO Capital and Operational Funding Policy Guideline, unless otherwise approved by the MOHLTC.

2. Boards of Health must use the Oral Health Information Support System (OHISS) to administer the HSO Program.
3. Boards of health must enter into Service Level Agreements with any organization they partner with for purposes of delivering the HSO Program. The Service Level Agreement must set out clear performance expectations and ensure accountability for public funds. For greater certainty, this condition also applies where a board of health may be providing funding for capital improvements to partnering organizations.
4. Any significant changes to the MOHLTC-approved HSO business model, including changes to plans, partnerships, or processes, or otherwise as outlined in the board of health's MOHLTC-approved business case and supporting documents must be approved by the MOHLTC before being implemented.
5. Any contract or subcontract entered into by the board of health for the purposes of implementing the HSO Program must be conducted according to relevant municipal procurement guidelines.

B5. Infection Prevention and Control Nurses Initiative (MOHLTC)

The Infection Prevention and Control Nurses Initiative was established to support one additional FTE Infection Prevention and Control Nurse for every board of health in the province.

Base funding for the initiative must be used for the creation of additional hours of nursing service (FTE) and for nursing salaries/benefits and cannot be used to support operating or education costs. The applicant must have a nursing designation (Registered Nurse, Registered Practical Nurse, or Registered Nurse in the Extended Class), and must have or is committed to obtaining a Certification in Infection Control within three (3) years of beginning of employment.

The majority of the Infection Prevention and Control Nurses time must be spent on infection prevention and control activities. Boards of health are required to maintain this position as part of baseline nursing staffing levels.

B6. Infectious Diseases Control Initiative (180 FTEs) (MOHLTC)

Boards of health are required to remain within both the funding levels and the number of FTE positions approved by the Ministry.

Base funding for this initiative must be used solely for the purpose of hiring and supporting staff (e.g. recruitment, salaries/benefits, accommodations, program management, supplies and equipment, other directly related costs) to monitor and control infectious diseases, and enhance a board of health's ability to handle and coordinate increased activities related to outbreak management.

Staff funded through the Infectious Diseases Control Initiative is required to be available for redeployment, when requested by the Ministry, to assist other boards of health with managing outbreaks and to increase the system's surge capacity.

B7. Needle Exchange Program Initiative (MOHLTC)

Base funding for this initiative must be used for the purchase of needles and syringes, and their associated disposal costs, for the Boards of Health's Needle Exchange Program.

B8. Public Health Awareness Initiatives (MOHLTC)

Infection Prevention and Control Week

Infection Prevention and Control Week occurs annually during the third week of October.

Base funding for this initiative must be used for development, purchasing, and distribution of materials, and/or educational sessions to promote educational awareness during Infection Prevention and Control Week.

Expected outcomes include: increased public awareness of infection prevention and control principles; increased knowledge of infection prevention and control practices for service providers; and improved health of Ontarians. Appropriate use of funds include, but are not limited to: conducting public education sessions; honorarium for a speaker; creation and development of teaching aids and promotional items (e.g. fact sheets, pamphlets, etc.); distributing educational resources; media releases/articles, and poster displays to raise awareness in different settings.

Funds are not to be used for staff salaries and benefits, staff education (e.g. attendance at a conference) and for payment of staff professional fees/dues.

B9. Public Health Nurses Initiative (MOHLTC)

The Public Health Nurses Initiative was established to support two new FTE public health nursing positions for each board of health as part of the 9,000 Nurses Commitment.

Public health nurses with specific knowledge and expertise will provide enhanced supports to address the program and service needs of priority populations impacted most negatively by the social determinants of health in the Board of Health area.

Boards of health are required to adhere to the following: base funding for this program must be used for the creation of additional hours of nursing service (FTEs); boards of health must commit to maintaining baseline nurse staffing levels and creating two new public health nursing FTEs above this baseline; base funding is for public health nursing salaries and benefits only and cannot be used to support operating or education costs; and, boards of health must commit to maintenance of, and gains towards, the 70% full-employment target for nurses. The applicant must be a registered nurse and must have or be committed to obtaining the qualifications of a public health nurse as specified under the Act.

To receive base funding for these positions, boards of health are required to sign back agreeing to the terms and conditions of the funding and provide proof of offer of employment including starting salary level and benefits for each FTE (per the March 10, 2011 administrative letter).

B10. Small Drinking Water Systems Program (MOHLTC)

Base funding for this program must be used for eligible start-up costs, including: salaries, wages and benefits to support the public health inspector resources to conduct initial and ongoing site-specific risk assessments of all small drinking waters systems; ongoing office accommodation costs; transportation and communication costs; and supplies and equipment.

Please note that the ongoing Small Drinking Water Systems Program funding allocation (cost-shared on a 75% provincial / 25% municipal basis) will be determined once the initial risk assessments have been completed by December 31, 2011.

B11. Unorganized Territories (MOHLTC)

Base funding must be used for the delivery of mandatory programs in Unorganized Territories (areas without municipal organization).

B12. Vector-Borne Diseases Program (MOHLTC)

The Vector-Borne Diseases Program focuses on all reportable and communicable vector-borne diseases and outbreaks of vector-borne diseases, which include, but are not limited to, West Nile virus and Lyme Disease.

ONE-TIME FUNDING:

B13. Bed Bugs Initiative (MOHLTC)

One-time funding for the Bed Bugs Initiative was established to support local efforts aimed at preventing and controlling bed bug infestations.

One-time funding for this initiative must align with the activities and services detailed in the board of health's application for funding. One-time 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. The board of health is also expected to collect data on the degree of infestations, and the populations and settings most impacted by bed bug infestations in their area. Reporting of this data to the province will allow for assessment of the scope of the bed bug issue in the province and the effectiveness of implemented interventions.

Ineligible activities/items as part of this one-time funding include: translation costs for communication resources and materials; costs associated with the creation of communication resources and materials already available for use and customization by health units at www.bedbugsinfo.ca; office supplies and IT equipment such as laptops; any funding identified only as "miscellaneous" or as "other items"; and costs associated with the replacement, depreciation or repair of bed bug related equipment (e.g. monitoring equipment such as the Night Watch).

For further details regarding conditions of this one-time funding, please refer to the

funding letter dated April 28, 2011 which outlines the accountability and administrative details for the bed bugs initiative.

B14. Healthy Smiles Ontario - Capital (MOHLTC)

One-time capital funds may only be used for the purchase of program dental equipment, necessary leasehold improvements and/or mobile dental clinics for development or expansion of community dental infrastructure. Funds may only be used in accordance with the HSO Capital and Operational Funding Policy Guideline, unless otherwise approved by the MOHLTC. Any changes to the MOHLTC-approved business case must be approved by the MOHLTC before being implemented.

Boards of health must enter into Service Level Agreements with any organization they partner with for purposes of delivering the HSO program. The Service Level Agreement must set out clear performance expectations and ensure accountability for public funds. For greater certainty, this condition also applies where a board of health may be providing funding for capital improvements to partnering organizations.

Any contract or subcontract entered into by the board of health for the purposes of implementing the HSO Program must be conducted according to relevant municipal procurement guidelines.

B15. Small Drinking Water Systems Program (MOHLTC)

One-time funding for this program must be used for eligible start-up costs, including: salaries, wages and benefits to support the public health inspector resources to conduct initial and ongoing site-specific risk assessments of all small drinking waters systems; ongoing office accommodation costs; transportation and communication costs; and supplies and equipment.

OTHER:

B16. Vaccine Programs (MOHLTC)

Funding on a per dose basis will be provided to boards of health for the administration of the following vaccines:

Influenza

The MOHLTC will continue to pay \$5.00/dose for the administration of the influenza vaccine. In order to claim the Universal Influenza Immunization Program administration fee, boards of health are required to submit, as part of quarterly reports, the number of doses administered. Reimbursement by the MOHLTC will be made on a quarterly basis based on the information.

Meningococcal

The MOHLTC will continue to pay \$8.50/dose for the administration of the meningococcal vaccine. In order to claim the meningococcal vaccine administration fee, boards of health are required to submit, as part of quarterly

reports, the number of doses administered. Reimbursement by the MOHLTC will be made on a quarterly basis based on the information.

Human Papilloma Virus (HPV)

The MOHLTC will continue to pay \$8.50/dose for the administration of the HPV vaccine. In order to claim the HPV vaccine administration fee, boards of health are required to submit, as part of quarterly reports, the number of doses administered. Reimbursement by the MOHLTC will be made on a quarterly basis based on the information.

SCHEDULE C

REPORTING REQUIREMENTS

The Board of Health is required to provide the following reports/information in accordance with the direction provided in writing by the Province:

ONGOING REPORTING REQUIREMENTS			
Due Date	Description of Item	From	To
January 31	4 th Quarter Financial Report (to December 31)	BOH	MOHLTC
January 31	Project Report for Public Health Nurses Initiative ¹	BOH	MOHLTC
February 28	CINOT Expansion Budget Request	BOH	MHPS
April 01	Program-Based Grants Budget Request	BOH	MOHLTC
April 01	Valid Certificate of Insurance	BOH	MOHTLC
April 01	Implementation Plan for the Enhanced Food Safety – Haines Initiative	BOH	MOHLTC
April 01	Implementation Plan for the Enhanced Safe Water Initiative	BOH	MOHLTC
April 30	1 st Quarter Financial Report (to March 31)	BOH	MOHLTC
June 30 (or earlier if possible)	Annual Settlement Report (consisting of Audited Financial Statements, Auditor's Questionnaire with Auditor's Report, and a Certificate of Settlement) ^{2,3}	BOH	MOHLTC
July 31	2 nd Quarter Financial Report (to June 30)	BOH	MOHLTC
October 31	3 rd Quarter Financial Report (to September 30)	BOH	MOHLTC
As Requested	Needle Exchange Program Activity Reports	BOH	MOHLTC
As Requested	Infection Prevention and Control Week Report Back	BOH	MOHLTC

ONGOING REPORTING REQUIREMENTS			
Due Date	Description of Item	From	To
As Requested	Baby Friendly Initiative Designation Status Report	BOH	MHPS

ONE-TIME REPORTING REQUIREMENTS			
Due Date	Description of Item	From	To
July 31, 2011	Bed Bugs – Initial Project Report for 2011	BOH	MOHLTC
October 31, 2011	Bed Bugs – Initial Surveillance and Evaluation Report for 2011	BOH	MOHLTC
April 30, 2012	Bed Bugs - Final Surveillance and Evaluation Report for 2011	BOH	MOHLTC
April 30, 2012	Beg Bugs – Final Project Report for 2011	BOH	MOHLTC
As Requested	One-Time Funding Project Report Backs	BOH	MOHLTC & MHPS

Notes:

- 1 – Specific reporting requirements are outlined in the March 10, 2011 administrative letter.
- 2 – Annual Settlement Reports: As of 2008, the Ministries limited the re-evaluation of settlements to one year after the settlement results have been provided to the Board of Health.
- 3 – The Audited Financial Statements must separately identify funding provided by MOHLTC and MHPS and include a separate account of the revenues and expenditures of mandatory programs, as a whole, and each related program. This may be presented in separate schedules by program category or by separate disclosure in the notes to the Audited Financial Statements.

SCHEDULE D
BOARD OF HEALTH PERFORMANCE

PART A. PURPOSE OF SCHEDULE

To set out Performance Indicators to improve board of health performance and support the achievement of improved health outcomes in Ontario.

PART B. PERFORMANCE OBLIGATIONS

Definitions

1. In this Schedule, the following terms have the following meanings:

“**BOH Baseline**” means the result at a given time for a performance indicator that provides a starting point for establishing targets for future board of health performance and measuring changes in such performance.

“**Developmental Indicator**” means a measure of performance or an area of common interest for creating a measure of performance that requires development due to factors such as the need for new data collection, methodological refinement, testing, consultation, or analysis of reliability, feasibility or data quality before being considered to be added as a Performance Indicator.

FUNDING YEAR 2011 - OBLIGATIONS

1. The Province will:
- (a) Provide to the Board of Health technical documentation on the Performance Indicators set out in Table A including methodology, inclusions and exclusions for the Performance Indicators and their corresponding Performance Corridors; and,
 - (b) Provide the Board of Health with the values for the Performance Indicators set out in Table A.
2. **Both Parties** will,
- (a) By December 2011 (or by such later date as mutually agreed to by the Parties), establish appropriate BOH Baselines for all Performance Indicators;
 - (b) Once BOH Baselines are established, develop Performance Targets for 2012 and 2013 for the Performance Indicators outlined in Table A;

- (c) Collaborate on the development of Developmental Indicators for areas of mutual interest including, but not limited to:
 - (i) physical activity;
 - (ii) healthy eating and nutrition;
 - (iii) child and reproductive health;
 - (iv) comprehensive tobacco control; and
 - (v) equity.

FUNDING YEARS 2012-13 - OBLIGATIONS

- 1. The Province will:
 - (a) Provide the Board of Health with values for the Performance Indicators set out in Table A.
- 2. **Both Parties** will,
 - (a) Establish appropriate BOH Baselines for Performance Indicators where required;
 - (b) Once remaining BOH Baselines are established, develop Performance Targets for 2012 and 2013 for the Performance Indicators outlined in Table A;
 - (c) By December 31, 2012 (or by such later date as mutually agreed to by the Parties), refresh Performance Targets for 2013 for the Performance Indicators outlined in Table A; and
 - (d) Collaborate on the development of Developmental Indicators for areas of mutual interest including, but not limited to:
 - (i) physical activity;
 - (ii) healthy eating and nutrition;
 - (iii) child and reproductive health;
 - (iv) comprehensive tobacco control; and
 - (v) equity.

Table A: Performance Indicators Based on Program Standards³				
INDICATOR	Baseline	Performance Target¹		
		2011²	2012	2013
% of high risk food premises inspected once every 4 months while in operation	TBD	Establish Baseline		
Proportion of pools and public spas by class inspected while in operation	TBD	Establish Baseline		
% of completed SDWS inspections, of those that are high risk, that are due for re-inspection	TBD	Establish Baseline		
Time between health unit notification of Gonorrhoea and initiation of follow up	TBD	Establish Baseline		
Time between health unit notification of an i-GAS case and initiation of follow up	TBD	Establish Baseline		
% of known high risk personal services settings inspected annually	TBD	Establish Baseline		
% of vaccine wasted by vaccine type (HPV, influenza, pneumococcal, and DPT) that are stored/ administered by the PHU	TBD	Establish Baseline		
% completion of reports related to vaccine wastage by vaccine type (HPV, influenza, pneumococcal, and DPT)	TBD	Establish Baseline		

Table A: Performance Indicators Based on Program Standards ³				
INDICATOR	BOH Baseline	Performance Target ¹		
		2011 ²	2012	2013
% of school-aged children who have completed immunizations for Hepatitis B, HPV and meningococcus	TBD	Establish Baseline		
% of youth (ages 12 - 19) who have never smoked a whole cigarette	TBD	Establish Baseline		
% tobacco vendor compliance with legislation by infraction type	TBD	Establish Baseline		
Fall-related emergency department visits by age group (age groups TBD)	TBD	Establish Baseline		
% of population that exceeds Low-Risk Drinking Guidelines	TBD	Establish Baseline		
Baby Friendly Initiative Status	TBD	Establish Baseline		

Notes:

- 1) Performance Corridors for each Performance Target are identified below the Performance Target in brackets.
- 2) BOH Baselines will be established for each Performance Indicator during Funding Year 2011, where possible. Reporting on Performance Targets will begin in Funding Year 2012.
- 3) Reporting on Organizational Standards and other items will begin in Funding Year 2012.

**MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 081-11**

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCP, Medical Officer of Health
DATE: 2011 September 15

Smoke-Free Outdoor Public Spaces Position Statement

Recommendation

It is recommended:

1. That the Board of Health endorse the Smoke-Free Outdoor Public Spaces Position Statement attached as Appendix A to Report No. 081-11; and further
2. That the Board of Health direct staff to prepare a report summarizing existing municipal bylaw amendment options for establishing smoke-free outdoor public spaces.

Background

Smoking and other forms of tobacco use remain the leading cause of preventable death and disease in Ontario. Although significant achievements have been made in tobacco control, there is a need for more work to be done in the area of outdoor public spaces. While the Smoke-Free Ontario Act (SFOA) prohibits smoking in enclosed workplaces and public places, the issue of exposure to outdoor secondhand smoke is an ongoing challenge for municipalities across Ontario. A provision of the SFOA permits municipalities to pass smoking by laws which exceed the requirements of the Act and where such by laws are in place, "the provision that is more restrictive of smoking prevails." The Public Health Ontario Agency's Evidence to Guide Action Report, prepared by leading tobacco researchers, calls for policy changes to eliminate exposure to outdoor tobacco smoke and to limit youth's exposure to tobacco use as the next phase of tobacco control across Ontario.

Historically, exposure to second-hand smoke was assumed only to be harmful indoors during the act of smoking. However, recent research indicates that outdoor levels of tobacco smoke within one to two meters of a lit cigarette can be just as high, and just as harmful as indoor tobacco smoke. When there is no wind, cigarette smoke will rise and then fall, and will saturate the local area with second-hand smoke. When there is a breeze, cigarette smoke will spread in various directions, and will expose non-smokers down-wind. The accumulation of dangerous carcinogens in relatively confined areas, including entrance-ways and patios, is particularly concerning.

Children and youth face greater risks from exposure to tobacco smoke, both in terms of health effects and the behavioural influence of social exposure to tobacco use. Research indicates the more youth witness tobacco use, especially by friends, family members, role models or community leaders, the more likely they are to start using tobacco products.

Smoke-free outdoor public spaces support cessation efforts by reducing the amount of exposure to tobacco use. Constant exposure to tobacco use in outdoor public spaces only compromises those efforts and prevents smokers from achieving smoke-free status.

Public Support for Strengthened Smoking Bans

Currently there are over 40 municipalities in Ontario with by laws in effect which limit smoking in outdoor public places, to varying degrees, including the Municipality of Chatham-Kent; the Town of Collingwood and the cities of Barrie, Hamilton, Kingston, Toronto and Woodstock. The success of these municipal by-laws helps to pave the way for other communities to follow suit.

Rapid Risk Factor Surveillance System (RRFSS) data collected in Middlesex-London between May and December 2009, indicate that there is strong public support for municipal bylaws that prohibit smoking in outdoor public spaces (see Figure 1). In addition, the Health Unit's Tobacco Control Program receives a significant number of complaints and inquiries from concerned citizens about smoking in outdoor spaces, including doorways to public places and workplaces, supporting the RRFSS data.

Figure 1. Support for local by-laws for smoke-free public places.
Adults (18+) in Middlesex-London May – Dec 2009.

Figure 1

The highest level of support was observed for

doorways to public places (89.9% ± 2.1%), doorways to workplaces (88.9% ± 2.2%), and playgrounds (86.5% ± 2.4%). Support for smoke-free sport fields was found among 81.0% (± 2.7%) of adults, and among three-quarters for smoke-free beaches and patios (74.3% ± 3.1% and 73.4% ± 3.1%, respectively).

Source: RRFSS May – Dec 2009.

* It is important to note that only 5.3% (± 1.6%) of the respondents did not support any suggested by-laws.

Conclusion

Tobacco-free environments provide the greatest level of protection from second-hand smoke, help to prevent young people from starting to use tobacco products and assist smokers to quit smoking.

Public Health Ontario recommends that tobacco use be eliminated in selected outdoor public spaces such as doorways to public and commercial buildings, transit shelters, parks and playgrounds, outdoor sports facilities, beaches, patios, sidewalks and public events such as parades or outdoor entertainment venues. A telephone survey of Middlesex-London residents indicates strong support for bylaws in line with these recommendations. Endorsement of the position statement, along with the preparation of a report outlining bylaw options available for the City of London and the County of Middlesex will better position the Health Unit to support and/or advocate for the amendment of current bylaws or the implementation of new smoke-free outdoor public spaces bylaws for Middlesex-London.

This report was prepared by Ms. Amy Yateman, Health Promoter, and Ms. Linda Stobo, Manager, Chronic Disease Prevention and Tobacco Control Team.

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

This report addresses the following requirement(s) of the Ontario Public Health Standards: Comprehensive Tobacco Control; **1, 6, 7, 11**

Smoke-Free Outdoor Public Spaces Position Statement

Position Statement:

All outdoor public spaces should be smoke-free in that:

1. Smoke-free outdoor public spaces provide further protection from second-hand smoke. There is no safe level of second-hand smoke, and it is just as dangerous when exposure occurs outdoors as it is indoors.
2. Smoke-free outdoor public spaces reduce youth exposure to tobacco use. Community environments play an important role in influencing young people's behaviours, as the more youth witness tobacco use, the more likely they are to start using tobacco products, i.e., children learn by example.
3. Smoke-free outdoor public spaces create a more supportive environment for those attempting to quit. Constant exposure to tobacco use in outdoor settings complicates the efforts of those smokers trying to become smoke-free.

Introduction

Smoking and exposure to tobacco smoke have been clearly established as the cause of a large number of diseases and health conditions. Despite legislation to restrict smoking in indoor public places, Ontarians continue to be exposed to tobacco smoke outdoors. Yearly, more than a thousand Canadian non-smokers die from exposure to environmental tobacco smoke. Thousands more are diagnosed with illnesses related to tobacco use. By restricting tobacco use in outdoor public places, fewer people will be exposed and the prevalence of death and disease from exposure will decrease.

Rationale

1. Health Effects

Scientific evidence indicates that there is no safe level of second-hand smoke. Second-hand smoke is particularly dangerous to children as they are still growing and developing. Research evidence indicates a failure to ban smoking in outdoor venues such as parks, playgrounds, and open outdoor spaces can expose non-smokers to levels of second-hand smoke as high as or higher than exposure in indoor spaces where smoking is restricted. Long-term second-hand smoke exposure increases the risk of heart disease, stroke and cancer. It has been found that air quality in an outdoor environment, such as a patio, playground or park, is significantly affected when cigarettes are smoked and that outdoor tobacco smoke can be comparable to indoor concentrations when someone is standing near a smoker.

2. Role Modeling and the Impact on Children and Youth

Children and young adults are likely to copy the behaviours they see. Youth smokers smoke most where they often see adults smoking (i.e., parks, sports fields, etc.). Modeling smoking as a normal behaviour can be reduced through policies that restrict smoking in the presence of children and youth. Allowing smoking in outdoor public places promotes and normalizes tobacco use. Stronger restrictions on smoking in outdoor public places can have a protective effect on smoking uptake among youth and young adults.

3. Environmental Impact

The litter created by discarded cigarette butts and packages has associated environmental costs. While not only making parks, playing fields and playground space less attractive, the residue in cigarette butts contains toxic chemicals. Cigarette filters create a lingering litter and toxic waste management challenge, as they are not bio-degradable. Also, discarded cigarette butts in public outdoor spaces can pose a threat to children and pets.

4. Community Support

Data collected in the 2009 Rapid Risk Factor Surveillance System (RRFSS) survey show that support level among Middlesex-London residents is high for smoke-free outdoor public spaces. The highest support was observed for doorways to public places (89.9%), doorways to workplaces (88.9%) and playgrounds (86.5%). Support for smoke-free sports fields (81%), beaches (74.3%) and patios (73.4%) were also high. Support was higher among non-smokers and no difference was found between City of London and Middlesex County respondents. Only 5.3% of the respondents did not support any of the by-law options.

5. Bylaws in Other Jurisdictions

Many municipalities in Ontario have enacted smoke-free outdoor public spaces by-laws. Toronto, Barrie, Hamilton, Woodstock, Collingwood, Chatham-Kent, Ingersoll and St. Thomas have all implemented by laws. The majority of the municipalities prohibit smoking within a 9-15 metre radius of playground equipment. Barrie has implemented a comprehensive smoke-free park by law that prohibits smoking in all outdoor public spaces, with no distance rule.

References

Evidence Guide to Action Report

Smoke-Free Ontario Scientific Advisory Committee

RRFSS May – Dec 2009

Middlesex-London Health Unit

Middlesex-London Community Picture

Healthy Communities Partnership

Smoke-Free Parks

Physicians for a Smoke-free Canada

LEARN: Adolescents' Smoking Behaviour and Role Modeling

Program Training and Consultation Centre

LEARN: What is the Scientific Rationale for Environmental Tobacco Smoke (ETS) and Outdoor Air Regulation, and the Evidence-Based Supports for Policy Development?

Program Training and Consultation Centre

Health Concerns: About Tobacco Control

Health Canada

Smoke-Free Ontario Strategy

Ministry of Health Promotion & Sport

September 2011

**MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 082-11**

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 September 15

2010-11 Influenza Season in Middlesex-London

Recommendation

It is recommended that Report No. 082-11 re 2010-11 Influenza Season in Middlesex-London be forwarded to Middlesex London hospitals, long-term care facilities and family physicians.

There was significant influenza activity during the 2010-11 influenza season in Middlesex-London. Compared to the 2009-10 pandemic influenza season, fewer laboratory-confirmed cases were identified; however, more deaths were reported and there were more outbreaks in institutions. As well, long-term care home and hospital staff influenza immunization rates were lower than in previous seasons (with the exception of the 2009-10 pandemic season when seasonal influenza vaccinations rates were very low).

General Overview

During the 2010-11 influenza season, 276 laboratory-confirmed cases of influenza were reported to the Health Unit (240 cases of influenza A and 36 cases of influenza B) (see Appendix A -Figure 1). The majority of these were community cases (206 total; 171 influenza A and 35 influenza B) while 70 cases were associated with institutional outbreaks (69 influenza A and 1 influenza B). By comparison, 391 laboratory-confirmed cases of influenza were reported in the 2009-10 pandemic influenza season.

One hundred and sixty-one individuals with laboratory-confirmed influenza were hospitalized during the 2010-2011 influenza season (58% of the total laboratory-confirmed cases). The greatest number of hospitalized cases were among those aged 65 years and older; 94 of 151 (62%) people with laboratory-confirmed influenza in this age group were hospitalized (see Appendix A Figure 2). Seventeen deaths were reported in Middlesex-London in individuals with laboratory-confirmed influenza; 11 were seniors (aged 65 years and over), 3 were between the ages of 18 and 64 and 3 were under the age of 18 years. By comparison, 92 hospitalizations and 8 deaths were reported in individuals with laboratory-confirmed influenza during the 2009-10 pandemic influenza season.

Institutional Outbreaks

Twenty-eight influenza A outbreaks were declared in Middlesex-London health care institutions during the 2010-11 influenza season. This is significantly higher than the two outbreaks identified in the previous season. The increased number of outbreaks in 2010-11 may have been related to greater susceptibility to this season's circulating strains in those over the age of 65 years. Additionally, influenza vaccination rates among hospital and some long term care staff were lower than in most previous years, which means that patients and residents were at increased risk for influenza exposure from unvaccinated staff members.

Of the 28 influenza A outbreaks in Middlesex-London this season, 24 were declared in long term care homes, 2 were in retirement homes and 2 were in acute care hospitals. The first influenza outbreak of the season was identified on September 21, 2010 (which is quite early and well before the influenza vaccine was available) and the last one was identified on February 26, 2011 (see Appendix A Figure 3). The outbreaks lasted an average of 14.5 days and affected between 3 to 44% of residents or patients on the outbreak-affected unit or in the outbreak-affected facility.

Influenza Immunization

When there is a good match between the vaccine strain and circulating strains, the influenza vaccine is 70-90% effective in preventing influenza in healthy children and adults. In those over 65 years of age, influenza immunization has been shown to be 35%-45% effective in preventing influenza infection. While influenza immunization is not as effective at preventing infection in the elderly compared to healthy children and younger adults, it has been shown to significantly decrease the incidence of pneumonia, hospital admissions and deaths in this population (National Advisory Committee on Immunization Influenza Statement 2010-11).

Of the 240 laboratory-confirmed cases for which immunization information was available, only 48.8% had received the influenza vaccine this year. Of the 104 people under 65 years of age who were diagnosed with laboratory-confirmed influenza, 86 (83%) were not immunized. This figure was lower among those 65 years of age and older where only 37 of 136 (27%) were unimmunized (see Appendix A Figure 4).

Based on Ministry of Health and Long Term Care's requirements, influenza vaccination rates were collected for long term care and retirement home residents and staff as well as for acute care hospital staff. By November 15, 2010, 91% of residents in long term care homes and retirement homes were vaccinated against influenza (range - 52.5% to 100%).

By November 15, 2010, almost 57% of staff in long term care homes and retirement homes were vaccinated against influenza with a range of 20% to 100% for individual facilities. The overall average is similar to that for the province (58.2%). The vaccination rates both provincially and locally were lower than most previous seasons with the exception of the 2009-10 pandemic season when rates of seasonal influenza vaccination were very low (see Appendix A Figure 5).

On average, only 36% of staff members working at hospitals were vaccinated against influenza by November 2010 with a range of 31% to 59% for individual facilities. This is lower than the provincial rate of 42% for acute care hospitals. As with long term care and retirement home staff, the seasonal influenza vaccination rates among hospital staff both provincially and locally were lower than most previous seasons, with the exception of the 2009-10 pandemic influenza season (see Appendix A Figure 5).

Summary

Middlesex-London had a very active influenza season in 2010-11. The number of facility outbreaks and the number of deaths associated with influenza were higher compared to those of the previous season. In addition, the uptake of the influenza vaccine was lower in staff of acute care hospitals and some long term care and retirement homes compared to most previous years. The poor uptake of the influenza vaccine among health care providers is not unique to Middlesex London and provincial and local strategies need to be considered to address this problem. One possible strategy is the public disclosure of the staff influenza immunization rate by facility for long term care homes and hospitals.

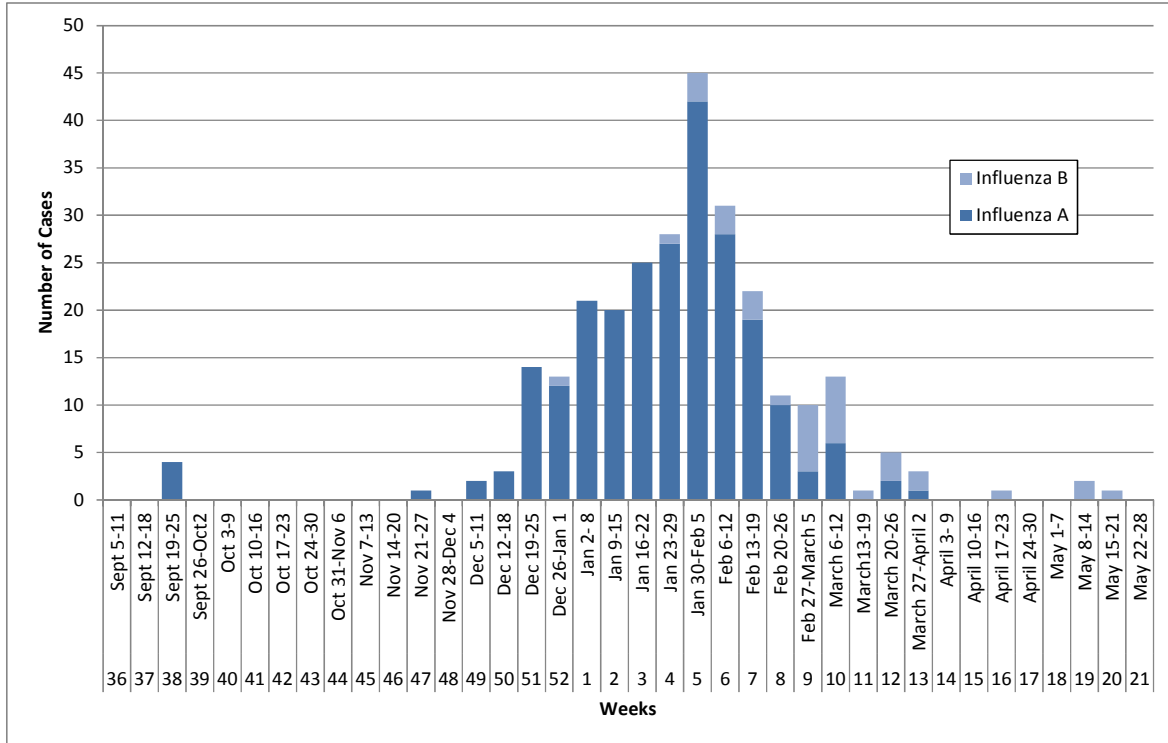
This report was prepared by Ms. Eleanor Paget, Public Health Nurse; Ms. Cathie Walker, Manager, Infectious Disease Control Team; and Ms. Carolyn Coppens, Acting Epidemiologist, Oral Health, Communicable Disease and Sexual Health Services.

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

This report addresses the following requirement(s) of the Ontario Public Health Standards:
The board of health shall interpret and use surveillance data to communicate on risks to relevant audiences in accordance with the Infectious Diseases Protocol and the Population Health Assessment and Surveillance Protocol.

Appendix A

Figure 1 –Laboratory-Confirmed Cases of Influenza in Middlesex-London by Week of Onset*, 2010-2011 Influenza Season



*Note: If date of onset was not available, the date the specimen was collected was used instead.

Figure 2 –Hospitalized vs. Non-Hospitalized Cases with Laboratory-Confirmed Influenza in Middlesex-London, by Age group, 2010-2011 Influenza Season

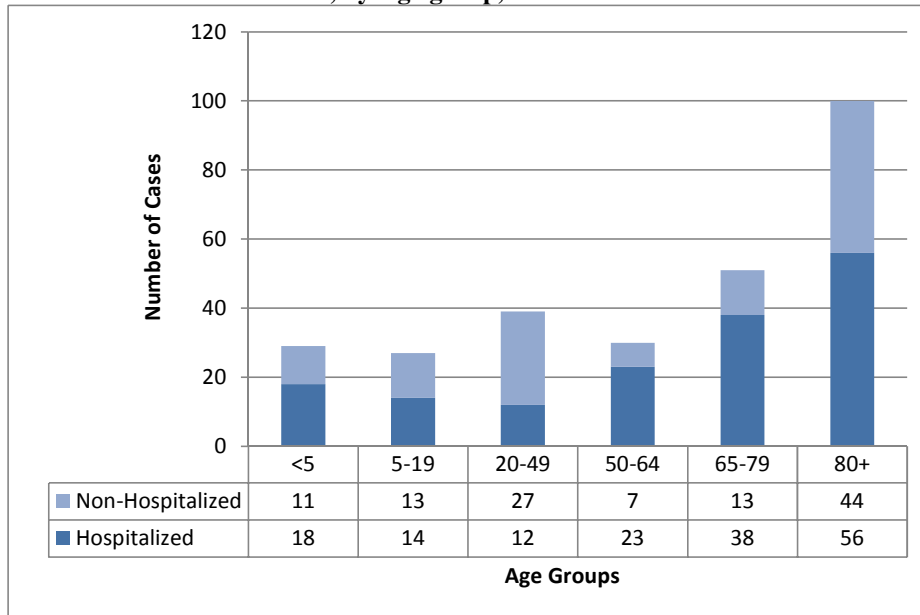


Figure 3 –Number of Influenza Outbreaks Declared in Institutional Settings, Middlesex-London, 2010-2011 Influenza Season

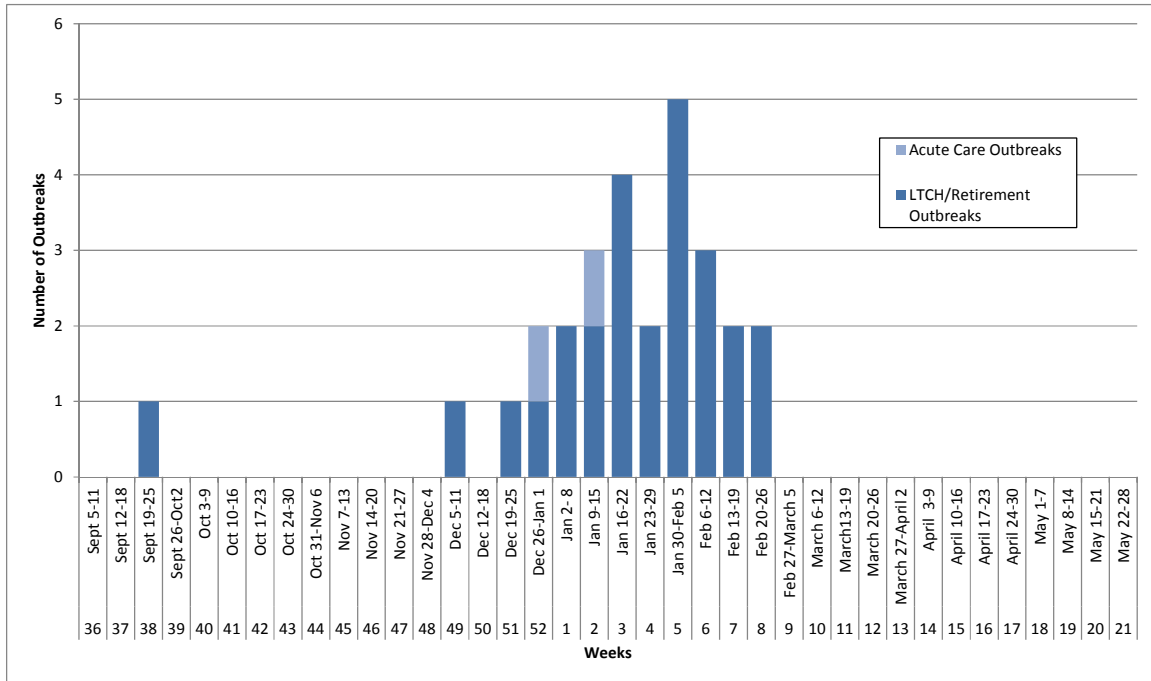
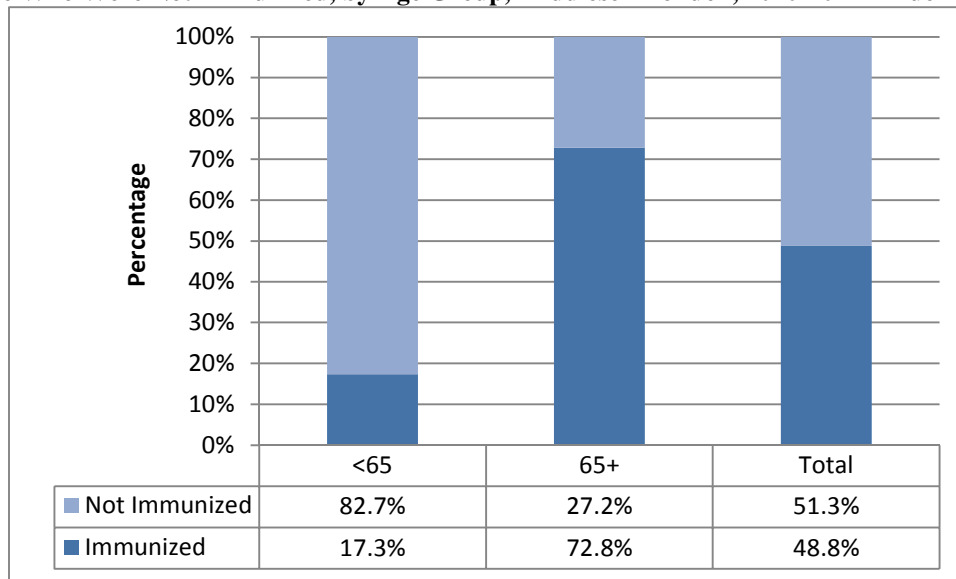
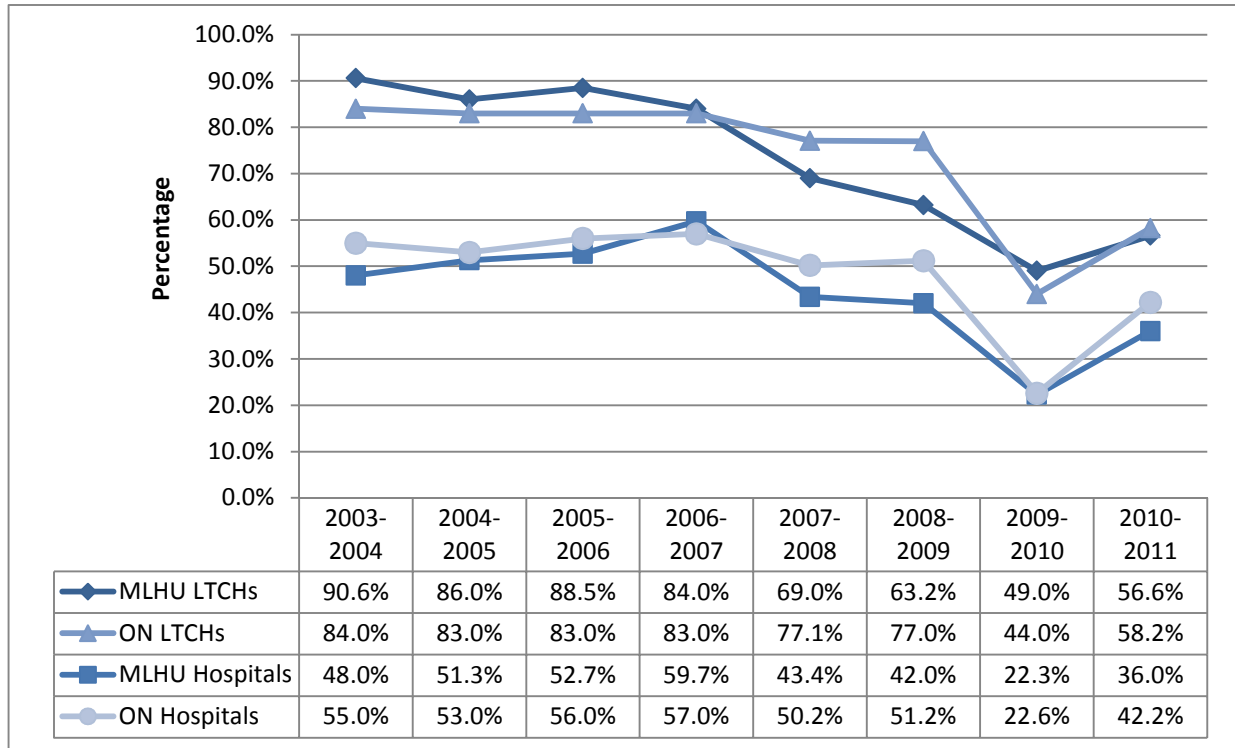


Figure 4 –Proportion of Laboratory Confirmed Cases of Influenza who were Immunized Compared to Those Who Were Not Immunized, by Age Group, Middlesex-London, 2010-2011 Influenza Season



Note: Results are based on the 240 cases with available immunization information

Figure 5 –Average Staff Immunization Coverage Rates for Hospitals and Long Term Care Homes in Middlesex-London and Ontario, 2003-2011*



*Note: Data collected as of November of each year with the exception of the 2009-2010 season when data was collected in January.

**MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 083-11**

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 September 15

Medical Officer of Health Activity Report – September

Recommendation

It is recommended that Report No. 083-11 re Medical Officer of Health Activity Report – September be received for information.

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

With the Board of Health approving the 10 Year Vision and 3 Year Outcome Strategic Plan document at the June 16, 2011, Board of Health meeting, staff continued the process of developing outcomes and indicators. A meeting of all non union staff was held as were 3 meetings of the Senior Leadership Team for this purpose. These meetings were facilitated by Ms. Marie Sánchez-Keane. Work will continue over the coming weeks with the intent of presenting an update to the Board of Health at the October Board meeting.

The unusually high mosquito population situation in Parkhill resulted in much activity by the Medical Officer of Health and Vector Borne Disease staff. Resident concerns and frustrations resulted in a petition being presented to North Middlesex Municipal Council. The Medical Officer of Health worked closely with Ms. Linda Creaghe, Chief Administrative Officer, North Middlesex Municipality, and Mr. Tom Prout, Executive Director, Ausable Bayfield Conservation Authority, to develop and oversee the implementation of an action plan to address this situation. This included the holding of a public meeting at the Parkhill Community Centre attended by approximately 400 residents. The mosquito situation is the subject of Report 085-11 this agenda.

Health Unit staff were involved in preparations to receive First Nations evacuees from Northern Ontario due to multiple forest fires. The City of London and Towns of Lucan and Dorchester were prepared to receive evacuees. Fortunately conditions improved and the evacuation centres were not required, however, preparing the sites for readiness required a great deal of work by all those involved. To coordinate the Health Unit's involvement, the Medical Officer of Health called an Incident Management Team together. Staff members were also involved on each Municipality's Planning Committees, and there were many teleconference meetings.

On June 21, 2011, the Medical Officer of Health made a presentation to London City Council sitting as Committee of the Whole on the mandate of the Health Unit. He took this opportunity to highlight the funding sources for the agency including the breakdown by funder. Health Protection and Promotion Act municipal funding obligations were also reviewed. Preparations for the 2012 budget are well underway and the proposed 2012 Health Unit budget will be presented at the October Board of Health Meeting.

A retirement reception was held for Mr. Jim Reffle, former Director, Environmental Health and Chronic Disease Prevention Services (EHCDP), on June 29, 2011. The Medical Officer of Health spoke on behalf of the Board and staff. Over the summer months recruitment was initiated to fill the Director vacancy created by Mr. Reffle's retirement. On Tuesday September 6, 2011, it was announced that Mr. Wally Adams was the successful candidate. Prior to his appointment, Mr. Adams was the Manager of Rabies & Safe Water Programs Team, and recently the Acting Director of EHCDP Services. He has over 25 years of experience in the field of environmental public health. Mr. Adams is a graduate of the British Columbia Institute of Technology (Diploma of Environmental Health) and the University of Western Ontario (Bachelor of Laws).

Other meetings involving the Medical Officer of Health since the last Board meeting included: attendance at a meeting of the Healthline.ca board of Directors; participation in the Community Medicine Seminars for 3rd Year UWO Medical students; attendance at a Ministry of Health and Long-Term Care – Ontario Medical Association Medical Officer of Health Technical Working Group meeting; a meeting with Middlesex County Chief Administrative Officer, Mr. Bill Rayburn; attendance at the Regional HIV/AIDS

Connection (RHAC) Annual General Meeting and participation in the Middlesex County Warden's Charity golf event. The Medical Officer of Health also took 3 weeks vacation.

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

**MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 084-11**

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 September 15

Health Unit Action on Poverty: Environmental Scan 2011 Report

Recommendation

It is recommended that Report No. 084-11 re Health Unit Action on Poverty: Environmental Scan 2011 Report be received for information.

Background

The Health Unit has a long history of providing programs and services to meet the needs of those living in the community in poverty. Explicit expectations for action on factors impacting health, such as poverty, are embedded within the Ontario Public Health Standards (OPHS). These Standards direct public health to identify priority populations (those at risk of socially produced health inequities) in order to: 1. modify universal programs to meet the needs of priority populations or develop specific strategies and 2. provide population health information, including determinants of health and health inequities to the public, community partners and health care providers.

In early 2011, in preparation for organizational strategic planning, the Directors Committee commissioned a report that would assist in the development of an implementation plan for public health strategies to address poverty. Ms. Brenda Marchuk, Community Health Nursing Specialist, was seconded to undertake this initiative (Appendix A). Information was gathered in four areas through a focused review of the literature, a summary of current Health Unit programs and services addressing poverty, an overview of some of the anti-poverty strategies currently underway within the community, and a summary of how other health units in the province are addressing the issue. The Action on Poverty: Environmental Scan 2011 Report (Appendix B) summarizes the findings which are highlighted below.

Findings in the Literature

Numerous recent reports addressing the social determinants of health, including reports specific to public health in Canada, were reviewed. Common themes in the literature regarding public health's role in addressing determinants of health such as poverty emphasize the importance of collaboration with other sectors, providing leadership and support to other stakeholders in policy advocacy, strengthening staff knowledge, improving organizational leadership, and strengthening the assessment and reporting of the existence and impact of health inequities in the community.

Currently, the Health Unit delivers seven programs identified in Ontario's Poverty Strategy. These include the Healthy Babies Healthy Children (HBHC) Program, Free vaccination/immunization programs, Children in Need of Dental Treatment (CINOT) Program, Healthy Smiles Ontario Program, Pre-school Speech/Language Programs, Infant Hearing Programs, and the Blind-Low Vision Program. The majority of Health Unit poverty strategies fall under the Family Health Program Standard and the Chronic Diseases and Injuries Program Standard of the OPHS. Multiple examples of engagement in community and intersectoral collaborations, as well as programs that were modified to meet the unique capacities and needs of individuals living in poverty, were identified. The review revealed several examples of school-based programs (e.g., snack/meal programs and sexual outreach clinic), and food security initiatives (e.g., community gardens and healthy eating in youth group home settings). Similarly, Health Unit staff members participate on a number of local committees that address programs and services for individuals living in poverty (e.g., Hunger Relief Action Coalition and Intercommunity Health Centre). Few examples of participation in advocacy efforts to reduce poverty (e.g. formal Board statements or direct advocacy as an organization) could be found. Only a few examples of strategies were identified that engage the priority population in problem identification, intervention planning and evaluation.

The City of London has multiple examples of activities to address poverty. These include the Mayor's Anti-Poverty Action Group, the London Community Housing Strategy, London Community Plan on Homelessness, Life*Spin, and London and Middlesex Local Immigration Partnership, to name a few. In addition, the Ending Poverty Implementation Team of the Child & Youth Network has specific strategies to increase awareness and engagement of the community's understanding, reduce the impact of, and

break the cycle of poverty. Middlesex County has an initiative called Middlesex Supports that provides financial assistance to programs that help prevent and reduce the depth of child poverty.

The Ontario Public Health Agency (OPHA) conducted a survey on this subject of health units across the province in the summer of 2010. Actions on the social determinants of health were evident in the work of the majority of responding organizations. Health units listed numerous activities related to the Ontario Poverty Reduction Strategy, examples of modified interventions, the fostering of supportive social networks, and the coordination of client care and referral. The top areas for improvement at the local level were identified as policy advocacy and staff development. Sudbury & District Health Unit and Waterloo Region Public Health are considered leaders in the area of social inequities and public health practice.

Recommendations

In order for the Health Unit to advance efforts in addressing poverty, this important determinant of health will need to become a significant part of the long-term strategic plan. Staff education that focuses on policy advocacy and how to engage populations experiencing poverty at all levels of program development will be important. This will enable enhanced commitment to multisectoral strategies to address poverty and provide a direct link to the health sector. Finally, a more purposeful reporting of the relationship between health and social inequities in all health status reporting, along with intentional dissemination of this knowledge, will enhance the community's understanding of the issue.

Next Steps

At the June 16, 2011, Board of Health meeting, Board members approved the Strategic Plan document entitled, 'Ten Year Vision and Three Year Strategic Directions' (Report No. 063-11). Included in the Three Year Strategic Directions is a strategic direction "Reducing Health Inequities." The Senior Management Team members are currently developing three year outcomes and indicators. An important part of this process will be to address poverty.

This report was prepared by Ms. Diane Bewick, Director, Family Health Services and Senior Nurse Leader, and Ms. Brenda Marchuk, Community Health Nursing Specialist, Family 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: Requirements 3, 4, 5.



**Terms of Reference
Addressing Poverty Initiative
January 21, 2011**

Purpose:

To develop an implementation plan for public health strategies to address poverty.

Objectives:

- 1) To review the literature on effective measures to address poverty.
- 2) To review and document current programs/activities involving staff to address poverty.
- 3) To prepare a report summarizing the findings in 1) and 2), together with recommendations for future direction.
- 4) To review and document key current community initiatives intended to address poverty.
- 5) To assess how other selected Health Units are addressing this issue in their communities.
- 6) To make comment on how poverty (SDOH) is (are) included into Public Health Program Standards.

Timeline:

3 months

Accountability:

Project coordinator reports to Directors Committee

**MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 085-11**

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 September 15

Parkhill Mosquito Control Program

Recommendation

It is recommended that Report No. 085-11 re Parkhill Mosquito Control Program be received for information.

Background

Historically, the town of Parkhill has had a problem with mosquitoes and has had an annual mosquito control program for many years. This program is carried out by a private firm. In addition, as part of the Vector-Borne Disease (VBD) program, Health Unit staff members conduct surveillance activities in the Parkhill area looking for evidence of mosquitoes capable of spreading West Nile Virus (WNV) or vector mosquitoes as they are called. Staff members apply larvicide to areas where vector mosquito larvae are found thereby complementing the Municipality's mosquito control program.

This year, following heavy snowmelt and increased spring rainfall, bodies of water located in Parkhill flooded, creating many peripheral pools of standing water in wooded areas located throughout the town. This resulted in a higher than usual mosquito population such that residents of Parkhill began to experience a serious nuisance mosquito problem in early June that continued into August.

At the June 16th Board of Health meeting, Board members, Ms. Doreen McLinchey, a North Middlesex Council Member and Parkhill resident, and Mr. Don Shipway, Mayor, North Middlesex, brought the situation to the Medical Officer of Health's (MOH) attention. In particular, they sought his support for the North Middlesex Municipal Council application to the Ausable Bayfield Conservation Authority (ABCA) to drain a large area of standing water on municipal land to the north of Parkhill. This location was identified as a major mosquito breeding site.

On June 17, 2011, Mr. David White, Manager, VBD program; and VBD staff, Mr. Hugo Ortiz and Mr. Jeremy Hogeveen, together with a North Middlesex Municipal employee visited the standing water site to undertake an assessment. From the specimens taken, vector mosquito larvae were identified.

In light of this finding and the potential WNV public health issue, a letter of support for the draining of the site was immediately (June 18, 2011) sent by the MOH to North Middlesex Municipality Chief Administrative Officer (CAO), Ms. Linda Creaghe. The initial ABCA response requested additional information from the Municipality. This led to the scheduling of a meeting by the CAO and the MOH with ABCA General Manager, Mr. Tom Prout, to discuss the situation.

This meeting was held on July 14, 2011, at the ABCA main office in Exeter. Land ownership and jurisdictional responsibilities were discussed and clarified as was a coordinated approach to address Parkhill residents' concerns. It was agreed to hold a public meeting to update Parkhill residents on current mosquito control activities and planned actions.

Public Meeting and Subsequent Action

The public meeting was held at the Parkhill Community Centre on July 19th beginning at 6:00 p.m. Approximately 400 engaged residents filled the Centre and actively participated during the question and answer portion of the meeting. Presentations were made by North Middlesex, ABCA and MLHU staff. The meeting was chaired by Mayor Shipway.

Clear direction was given by resident attendees that they did not wish to proceed with implementation of an adulticide (spraying of malathion) mosquito control program. Adulticiding is the only option for reducing adult mosquito populations. Whereas the larvicide agents are environmentally friendly products, the adulticide agent is not. Residents strongly supported actions which would reduce mosquito breeding sites including draining of swampy areas and clean up of the section of the creek which runs through the Town as well as the creek bed down stream of the reservoir dam.

A subsequent meeting of the Working Group (North Middlesex CAO, ABCA General Manager and MOH) together with involved staff from all three agencies, was held July 26th and an action plan agreed upon. This is summarized in the joint press release attached as Appendix A. Health Unit staff involvement focused on enhanced mosquito surveillance (an additional mosquito trap was implemented), treatment of non-roadside catch basins (of which 21 were brought to staff's attention following the public meeting) and providing assistance in establishing a mosquito control web page on the North Middlesex Municipal website to enable Parkhill residents to access accurate, up to date information including a question and answer section. As well a Twitter account was established. Health Unit staff also continued to treat standing water sites with identified vector-borne larvae.

On August 31st the Working Group met to review progress to date. Adult mosquito counts had dropped significantly as evidenced by the trap results. Discussion centered on strategies for implementation which would reduce the mosquito population on a long term basis. These included select cutting of trees in swampy areas to allow better penetration of sunlight and removal of barriers (such as log jams) to water flow down stream of the dam. Funding issues for these initiatives are to be followed up by North Middlesex and ABCA staff. The next meeting of the Working Group is planned for the last week of September.

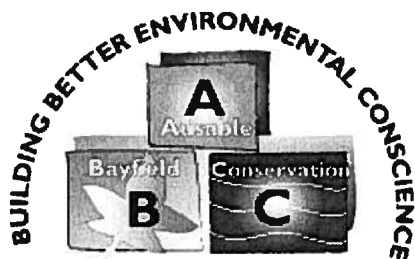
Summary

The mosquito population in Parkhill this past spring and summer was among the highest experienced in many years. This resulted in a serious nuisance problem for residents who were unable to partake of regular outdoor activities. The situation gained national attention (Appendix B). Health Unit staff worked closely with North Middlesex Municipal and Ausable Bayfield Conservation Authority staff to implement control measures to address the immediate problem. Plans are underway to develop a long-term approach for effective mosquito control.

This report was prepared by Mr. David White, Manager, Environmental Health; Mr. Jeremy Hogeveen, Vector-Borne Disease Coordinator; and Ms. Elizabeth Milne, Vector-Borne Disease Field Technician.

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

This report addresses the following requirements of the Ontario Public Health Standards: Section 7(c)(i) of the *Infectious Diseases Protocol* requiring the Board of Health to develop an integrated vector-borne management plan which shall be comprised of vector surveillance. Section 8 of the *Health Hazard Prevention and Management Standard* requiring the Board of Health to develop a local vector-borne management strategy based on surveillance data and emerging trends in accordance with the Infectious Diseases Protocol, 2009.



Ausable Bayfield Conservation Authority

www.abca.on.ca

Media Releases

Joint response to mosquitoes in Parkhill

Posted: July 28, 2011

Joint response to Parkhill mosquito problem underway

A coordinated response to the on-going mosquito issue in Parkhill is underway. Residents of the town have been enduring high numbers of the biting insects this year, and more than 400 people attended a public meeting about the situation on July 19. As a result, senior staff from the Municipality of North Middlesex, Ausable Bayfield Conservation Authority (ABCA), and the Middlesex-London Health Unit (MLHU) met again on Tuesday, July 26. This second gathering of the three agencies aimed to highlight actions taken since the recent public meeting and to determine further strategies to reduce mosquito populations and potential breeding sites in the Parkhill area.



"Staff members from the three organizations have started the work necessary to control mosquitoes, and we need to continue that work," said Tom Prout, General Manager and Secretary Treasurer of the ABCA. "We will continue to work with the people in the community to help make it possible once again for residents to enjoy all areas of Parkhill, both inside and outside."

For updates on the joint mosquito control effort visit: <http://www.healthunit.com/sectionList-nm.aspx?sectionid=1153>

Actions undertaken so far include the application of mosquito larvicide to 11 additional catch basins with more locations pending. Some potential mosquito habitat has been removed, as well, and water flow is being improved in ditches, creeks and drains based on information provided by the public. Great Lakes Lawn Care has also started applying garlic to a parcel of land at the Great Canadian Hideaway campground near Parkhill to evaluate its effectiveness.

Also underway is an in-depth investigation of a 25-hectare (62-acre) management area, downstream of the Parkhill Dam, that is a combination of conservation authority, municipal, and private land. Follow-up action is expected to increase flow where water is stagnant, improve drainage, and reduce standing water and low-lying areas where mosquitoes can breed.

Further action is scheduled for August, including removal of obstructions in Cameron-Gillies Drain to improve flow and reduce stagnation. Activities to reduce potential mosquito habitat will also take place at locations upstream of the dam, adjacent to sewage ponds, at catch basins on private property, at the landfill site, and along the old railway tracks. The municipality has created opportunities for residents to take part in the clean-up effort along the former railway tracks. The tentative date for that volunteer clean-up effort is Saturday, August 13. Rain date is Saturday,

7.4

August 20. Visit www.northmiddlesex.on.ca or phone **519-294-6244** for details. A sign-up list is available at Town Hall.

Senior staff from the three organizations will meet again August 31 to monitor progress, and schedule another public meeting to provide a progress report. The local organizations have also agreed to develop a public webpage where citizens can access regular updates about the joint mosquito control response and obtain answers to questions asked by the public. A link to that site will be posted at www.northmiddlesex.on.ca by the end of next week.

See attached backgrounder for additional information.

Backgrounder

Residents of Parkhill have reported high numbers of mosquitoes in some past years but the increase in mosquitoes this year, following a wet spring, has prompted widespread public concern and national media interest. The mosquito abatement and larviciding program that has been used in the past does not appear to have been as effective this year.

A public meeting held on Tuesday, July 19 drew more than 400 Parkhill-area residents. Comments expressed by residents underlined the extent of the mosquito problem in Parkhill and the need for short-term and long-term action, providing local agencies with helpful information about areas of standing water and habitat where mosquitoes could breed.

The Municipality of North Middlesex, the Ausable Bayfield Conservation Authority (ABCA), and the Middlesex-London Health Unit (MLHU) are working cooperatively, with the public, to reduce mosquito habitat and standing water in areas identified by the public at that community meeting. Senior staff of the local organizations have met twice in July to coordinate the response.

A 25-hectare (62-acre) management area downstream of Parkhill Dam, that is a mix of conservation authority, municipal, and privately owned land, remains an area of focus. The response by the three local organizations will also reduce potential mosquito habitat at other locations, including areas upstream of the dam, adjacent to sewage ponds, in catch basins adjacent to houses, in the landfill site, along the former railway line, and by reducing obstructions in the Cameron-Gillies Drain.

Actions to reduce mosquito habitat and standing water, and to increase flow to reduce stagnant water, include:

The Municipality of North Middlesex receiving permission from the Ontario Ministry of Agriculture, Food and Rural Affairs to remove blockings in the Cameron-Gillies Drain between Victoria Street and Mill Craig Street. This work will take place the first week of August.

The municipality is creating volunteer opportunities for residents to take part in a clean-up effort along the former railway tracks. The tentative date for the volunteer clean-up along the rail line has been set as Saturday, August 13 with rain date as Saturday, August 20. Individuals or groups wishing to assist with this effort are invited to provide their name and contact information to the municipality. Visit northmiddlesex.on.ca or contact the municipality at **519-294-6244** for details. A sign-up list is also available at the Town Hall.

MLHU staff members have been fielding calls from the public about mosquito breeding habitats in town and catch basins on their properties for testing and control. The Health Unit has conducted site visits, answered questions, and treated 11 additional catch basins with larvicide. The treatment of other locations is pending. Contact information for reporting these areas is **519-245-3230** or **519-663-5317** or e-mail health@mlhu.on.ca

The MLHU is adding a second adult mosquito monitoring station in Parkhill.

ABCA has removed some potential mosquito habitat and is undertaking in-depth investigation of a 25-hectare (62-acre) management area downstream of Parkhill Dam. Follow-up action from the review is expected to improve flow and drainage, and reduce standing water and stagnation. Some obstructions have already been identified.

The organizations have also agreed to develop a public web page where citizens can access regular updates about the joint mosquito response and obtain answers to questions asked by the public. A link to that site will be posted at www.northmiddlesex.on.ca by August 5.

A Twitter account will be established by August 5 to provide the public with updates and links to information about the joint mosquito response in Parkhill.

The Municipality of North Middlesex is accepting the names of individuals who would be interested in assisting the municipality with the control of the mosquito problem in Parkhill. One of the ways being considered is the formation of a special committee of council which would involve citizens who would meet to strategize and develop an approach for the long-term control of the mosquito population. Recommendations would then be forwarded to council for consideration.

ABCA will conduct an elevation survey to assess low-lying areas where water could pool and that may be re-graded or otherwise enhanced for better drainage and less standing water.

ABCA will work to find funding support for a long-term strategy to implement on-the-ground actions to reduce mosquito habitat and standing water in Parkhill.

North Middlesex and ABCA staff will walk the Parkhill Creek downstream of Parkhill Dam and identify, for the purposes of removal, obstructions in the creek, between McInnis Road and Parkhill Dam.

Municipal staff will ask for council approval to selectively harvest trees on municipal land in the area of focus in order to increase evaporation and reduce mosquito habitat.

Old tires are being removed from the landfill site on a weekly basis to reduce mosquito habitat.

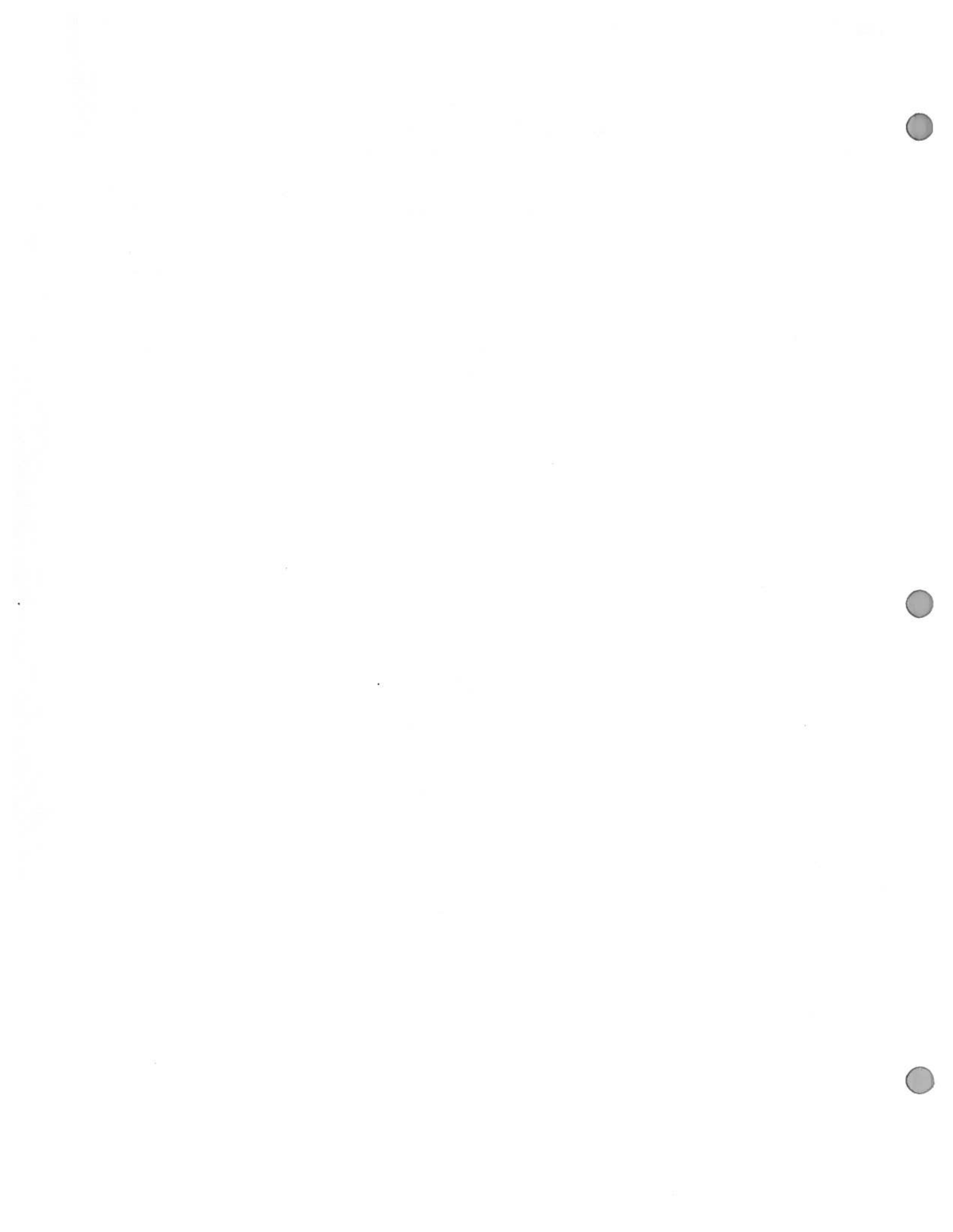
The organizations have also agreed to provide regular updates, on actions taken, to public and media.

Senior staff from the three agencies will meet again on August 31.

A public meeting will be scheduled to report on progress of the joint mosquito control effort.

While mosquito numbers declined recently at a monitoring station downstream of Parkhill Dam, overall mosquito populations in the Parkhill area remain high.

[Previous Page](#)



MACLEANS CA



Categories: Environment

Mosquitoes are eating us alive

They're causing uncommon havoc this summer. Parkhill, Ont. is the epicentre of itch.

by Cigdem Iltan on Friday, July 22, 2011 9:00am - 1 Comment



Photographs by Cole Garside

There is a buzz in the air in Parkhill, Ont. It's a picturesque town of about 1,700—that is, if you don't count the mosquitoes. Nestled partway between Lake Huron and London in North Middlesex County, the town's residents have spent the summer living through what reads like the plot to a B movie. In the time it takes to swat through clouds of mosquitoes on the path between the front door and the car door, it's not uncommon for people to get 10 or 12 bites, North Middlesex Mayor Don Shipway says. "Kids can't even go outside," he told *Maclean's*. "People are frustrated; it is going to be a health hazard if we don't get it under control."

The mosquitoes have always been bad in Parkhill, but this year is different. The numbers are staggering: less than 30 km away in Strathroy, a mosquito trap attracted 800 of the insects in four weeks. In the same time period in Parkhill, the same type of trap caught 51,000. "I've been involved in mosquito control for 10 years and it's the worst I've ever seen it," says Middlesex-London Health Unit vector-borne disease coordinator Jeremy Hogeveen.

Parkhill isn't the only community with residents spending their summer covering themselves in DEET. Mosquito populations in parts of the Prairies have exploded this summer after heavy spring rainfall and flooding. The

Edmonton Eskimos moved their practice inside last week after general manager Eric Tillman likened the roofless Commonwealth Stadium to the jungle. And in Regina, councillors voted to add \$200,000 to the fight against the bugs this summer, bringing the city's total mosquito suppression budget to \$500,000. The latest count puts the number of mosquitoes in Saskatchewan's capital at more than double the historical average.

But in Parkhill, the mosquito problem is literally sucking the life out of the community. The town's splash pad has been empty all season. Evening barbecues are out of the question. So far this summer, Parkhill resident Jenny Jutzi has taken her 11-year-old and 14-year-old sons out of town to the lake, on picnics, hiking and to visit their grandmother. "Anywhere else but Parkhill," she says. "It's just horrible here. I'm from Manitoba originally, so I know what mosquitoes are all about, living along Lake Winnipeg. But this is bad."

Long-time resident Carrie Muma says her brother put his family's Parkhill home up for sale last week after their 14-month-old son had a bad reaction to mosquito bites. "They want to leave town to get away from this problem," says Muma, who has collected 23 pages of signatures on a petition to convince the local conservation authority to take action on the issue. "This cannot be affecting our livelihood like this." Still, there isn't an impending mass exodus as some media reports have indicated, Muma says. Instead, most townspeople are ready to face the mosquito scourge head on. "This issue has gone on for years. The rest of us are hoping to get to the bottom of it," she says.

The mosquitoes have always been bad in Parkhill, but snow runoff and heavy spring rain this year created an ideal breeding ground. And many have blamed the roughly 62 acres of stagnant, wet areas downstream of the town dam as the primary source of the problem. The local conservation authority, health unit and municipality have been in talks with residents about the situation, with short-term solutions such as spraying to kill adult mosquitoes, and long-term solutions such as draining still water on the table for discussion.

But do the mosquitoes in Parkhill pose an actual health threat to the community? What has many residents worried is that among the species of mosquitoes found in the town exist the kind capable of transmitting West Nile virus and other mosquito-borne diseases, says Middlesex-London's medical officer of health Dr. Graham Pollett. So far, there's no evidence of West Nile in the community, but a viable risk exists. "We have a potential public health issue," Pollett says. There hasn't been any positive West Nile activity in Parkhill since 2005, according to the health unit's Hogeveen. It's cold comfort for Parkhill townspeople. "You can take that on the plus side," Hogeveen says, "but you're still getting eaten alive."

Tags: [DEET](#), [Edmonton Eskimos](#), [mosquitoes](#), [Parkhill](#)

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**MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 086-11**

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 September 15

Validation of Healthy Babies Healthy Children Screen: Participation in a Provincial Initiative

Recommendation

It is recommended that Report No. 086-11 re Validation of Healthy Babies Healthy Children Screen: Participation in a Provincial Initiative be received for information.

Background

The new Healthy Babies Healthy Children Screening Tool (HBHC Screen) was developed in response to a need for a more focused and enhanced tool to better screen families into the HBHC program. The HBHC Screen will identify the following:

- At risk families who may benefit from HBHC services during the prenatal postnatal and early child development periods
- Risks earlier in the screening process that may have been initially identified
- Risk factors that can be more effectively managed through involvement with HBHC home visiting program.

Validation of the HBHC Screen was initiated at the provincial level by the Ministry of Children and Youth Services (MCYS). All the questions on the new HBHC Screen will be validated to assess for risk factors that can be effectively managed through involvement with the HBHC home visiting program. A number of processes have been undertaken by the MCYS to develop the new Screen including: literature review, consultation with the Ministry of Health Promotion and Sport, consultation with other provinces, and consultation with experts from the field. Ten health units, including MLHU, have been participating in the validation process.

Activities of the Validation Process

Over the past 6 months, the following activities have been undertaken by the Health Unit:

- Inter-rater reliability by Health Unit staff
- Education sessions (8) for hospital staff at London Health Sciences Centre (LHSC) and Strathroy Middlesex General Hospital (SMGH)
- Participation from the Pre-admission Clinics (prenatal) and Mother Child Units (postpartum) at LHSC and SMGH to collect the present screens and the new HBHC screen from July to Sept of this year.
- Random selection and completion of 55 In-Depth Assessments (IDA) for families screened as low risk .
- Input provided into the content of the new HBHC Screen by participating in an on-line survey.

As of September 2011, all aspects of the validation process have been completed except the screens from the hospitals which will continue until the end of the month. This aspect of the validation exercise has been a positive experience as it has enabled Health Unit staff to work more closely with the hospital staff to share common experiences, better understand each other's services and clarify the purpose and expectations involved with screening clients. Staff will continue to monitor success with the completion of the screens in the hospital setting.

Next Steps

The plan as set out by MCYS is to complete the analysis of the data collected from the validation process during the fall months and aim for implementation of the new HBHC Screen in January 2012. As previously shared with the Board of Health in Report No. 048-11 (attached as Appendix A), the MCYS has announced significant changes to the HBHC program in January 2012. The Health Unit will no longer be required to provide low risk postpartum women a universal phone call 48 hours after discharge from hospital or to provide a postpartum home visit. The focus of the HBHC program will be only on 'at risk' families and so it is important that this improved HBHC Screen be more effective in identifying these families. Over the fall months, the HBHC program will prepare for changes to the program by establishing a staffing model to fit the work with 'at risk' families, enhance follow-up with prenatal clients and implementation of the HBHC Screen.

Summary

As a result of Health Unit staff participation in the validation process, the Health Unit is in a good position for implementation of the new HBHC Screen. Health Unit staff members are aware of the content of the tool and the challenges of implementing a new screen with hospitals and primary care practitioners. Staff members also have an awareness of the need to manage workload as a result of a more effective screening, especially in the prenatal period. It has also provided the opportunity to nurture relationships with the hospitals as partners in caring for pregnant and young families.

This report was prepared by Ms. Nancy Summers, Manager, Family Health Services.

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.

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 FHV's 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 FHV's 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

<p>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.</p>
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**MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 087-11**

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 September 15

2011 Budget – Second Quarter Review

Recommendation

It is recommended that Report No. 087-11 re 2011 Budget – Second Quarter Review be received for information.

2nd Quarter Review

The attached Budget Summary (Appendix A) shows actual and budgeted expenditures net of offset revenues for the six-month period January 1st to June 30th, 2011. For the programs with a March 31st year-end, this report shows the actual and budgeted expenditures net of offset revenues for the three-month period April 1st to June 30th, 2011.

Cost-Shared Programs

On August 2, 2011, the provincial government approved funding allocations for 2011 which marks the final step of Health Unit budget approval process. The net budget for cost-shared programs for 2011 is \$22,640,172.

For the first half of the year, Cost-Shared Programs are reporting a favourable variance of \$1,063,729. The majority of this variance is explained by timing differences in salary payments and other payments, staff vacancies, seasonal programming, and natural turnover. Analysis of operating accounts to June 30th and projections to the year-end does not suggest that there will be a significant surplus. Therefore, at this time, a break even position is anticipated by year end.

100% Funded Programs/Initiatives

There are two groups of 100% provincially funded programs: those with a calendar operating year ending December 31st (e.g., Smoke Free Ontario, Healthy Smiles Ontario, Healthy Babies Healthy Children); and those with a fiscal year ending March 31st (e.g., Tyke Talk, Blind-Low Vision Program).

For the December 31st programs, the second quarter shows a favourable variance of \$831,368. The majority of this variance is explained in timing differences in other operating expenditures (non salary related). For example, in the Smoke Free Ontario and the Healthy Babies Healthy Children Programs many of the one-time funded projects are in development so that the project funds will be expended later in the operating year.

The Healthy Smiles Ontario program will generate a significant surplus as the number of clients anticipated to access the program has not yet materialized in 2011. The Ministry of Health and Long-Term Care (MOHLTC) is allowing public health units to submit business cases to redirect funding for projects to heighten awareness and promote utilization of this new oral health program. The Health Unit did submit business case proposals in the areas of: social media campaign, print media campaign, public transit campaign, mail inserts, health care provider events, promotional information and oral hygiene take away kits, and translation/interpreter services.

For the March 31st programs, there currently is a favourable variance of \$128,562. At this time, it is not expected that these programs will generate significant favourable variances by year end.

Mr. John Millson, Director, Finance and Operations will be in attendance at the September 15th 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.

	2011 YTD ACTUAL	2011 YTD BUDGET	VARIANCE (OVER) / UNDER	% VARIANCE	2011 ANNUAL BUDGET
<i>Office of the Medical Officer of Health</i>					
Office of the Medical Officer of Health	\$ 227,310	\$ 185,050	\$ (42,260)	-22.8%	\$ 370,099
Communications	114,414	117,529	3,115	2.7%	235,058
Special Projects	75,305	74,922	(383)	-0.5%	149,843
Travel Clinic	33,973	35,442	1,469	4.1%	70,883
Emergency Planning	13,733	15,651	1,918	12.3%	31,302
Records / CQI Management	53,248	3,468	(49,780)	-1435.4%	6,936
<i>Total Office of the Medical Officer of Health</i>	\$ 517,983	\$ 432,062	\$ (85,921)	-19.9%	864,121
<i>Finance & Operations</i>	273,275	297,180	23,905	8.0%	594,360
<i>Human Resources & Labour Relations</i>	327,619	325,220	(2,399)	-0.7%	650,439
<i>Information Technology Services</i>	404,526	465,652	61,126	13.1%	931,304
<i>General Expenses & Revenues (Benefits and Operations)</i>	1,681,038	2,045,304	364,266	17.8%	4,090,608
TOTAL COST-SHARED PROGRAMS	\$ 10,256,361	\$ 11,320,090	\$ 1,063,729	9.4%	\$ 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)	\$ 526,304	\$ 583,361	\$ 57,057	9.8%	\$ 1,166,722
Small Drinking Water Systems (MOHLTC)	39,576	53,550	13,974	26.1%	107,100
Infection Control & Prevention Nurse (MOHLTC)	39,584	42,436	2,852	6.7%	84,872
Smoke Free Ontario (MHP)	378,447	539,474	161,027	29.8%	1,078,948
Dental Treatment (User Fees)	(6,459)	-	6,459	-	-
Healthy Babies/Healthy Children (MCYS)	1,065,710	1,388,178	322,468	23.2%	2,776,356
Healthy Smiles Ontario (MHLTC)	167,983	435,514	267,531	61.4%	871,028
Total December 31 Year End Programs	\$ 2,211,145	\$ 3,042,513	\$ 831,368	27.3%	\$ 6,085,026
March 31 Year-End Programs (1):					
Smart Start for Babies (Federal)	\$ 25,271	\$ 38,108	\$ 12,837	33.7%	\$ 152,430
Tyke Talk - Preschool Speech & Language (MCYS)	348,642	379,237	30,595	8.1%	1,516,946
Blind-Low Vision Program (MCYS)	29,136	39,676	10,540	26.6%	158,702
Infant Hearing Screening Program (MCYS)	140,150	214,740	74,590	34.7%	858,961
Total March 31 Year End Programs	\$ 543,199	\$ 671,761	\$ 128,562	19.1%	\$ 2,687,039
TOTAL OTHER PROGRAMS	\$ 2,754,344	\$ 3,714,274	\$ 959,930	25.8%	\$ 8,772,065
TOTAL MIDDLESEX-LONDON HEALTH UNIT	\$ 13,010,705	\$ 15,034,364	\$ 2,023,659	13.5%	\$ 31,412,237

**MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 088-11**

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 September 15

Board of Health Performance Assessment: June Survey

Recommendation

It is recommended that Report No. 088-11 re Board of Health Performance Assessment: June Survey be received for information.

At the request of the Board of Health, a process and survey tool were developed and approved in November 2010 to help self-assess the performance of the Board of Health. In February 2011, the Ontario Public Health 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 per year (March, June, November), and the process be reviewed after one year of implementation. Results of the March survey were reported at the May meeting in Report No. 051-11. The results of the June survey are presented as Appendix B of this report.

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

This report addresses Board of Health direction given to Board Working Group # 3 and the draft Ontario Public Health Organizational Standards

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

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

	Strongly Disagree			Neither Disagree Or Agree			Strongly Agree	Don't Know
	1	2	3	4	5	6	7	
10. Has adequate information to monitor organizational performance. e.g. financial management; delivery of Ontario Public Health Standards ; work force issues, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Ensures that decisions are based on accurate, timely and the best available information.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Has a process for handing urgent matters between meetings.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Is knowledgeable of the programs and services offered by the Health Unit.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Regularly assesses the performance of the MOH/CEO in a systematic way.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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	Neither Agree or Disagree					Strongly Agree	Don't Know
	1	2	3	4	5	6	7	
1. Board members are aware of what is expected of them.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The roles and responsibilities of the board are clearly defined and separate from those of staff.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. <u>Complete ONLY If a New Board member</u> New Board members receive an effective orientation to their responsibilities as a Board member.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. The Board is satisfied with the ongoing education it receives in order to fulfill its responsibilities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Board information packages provide the right information and are received in a timely manner.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Board meeting agendas are well planned so that all necessary board business is addressed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Board members come prepared to participate in the discussion and decision-making.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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

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

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

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

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

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

How Well Has the Board Done Its Job?

- On a 7-point scale, where 7 is 'strongly agree', 65% of responses were either a 6 or 7.
- Additionally 15% of the statements had a response of 1 or 2, where 1 is 'strongly disagree'
- The strongest agreement rating was given to the statement "Ensures that the Health Unit has a long-term strategic plan" followed by and "Has a process for handling urgent matters between meetings" and then "Ensures that decisions are based on accurate, timely and the best available information."

How Well Has the Board Conducted Itself?

- On a 7-point scale, where 7 is 'strongly agree', 72% of responses were either a 6 or 7.
- 22% of the responses were a 1 or 2, where 1 is 'strongly disagree'.
- The strongest agreement ratings were given to the following statements: "Board meeting agendas are well planned so that all necessary board business is addressed." and "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."
- The statements with the weakest agreement rating were; "The roles and responsibilities of the board are clearly defined and separate from those of staff." and "Board members come prepared to participate in the discussion and decision-making."

Summary of Written Comments

- Overall, respondents liked that the Board meetings had engaging conversation on a variety of topics. Additionally it was felt that there was respectful debate over issues despite the diversity of views.
- While some comments indicate that most Board Members have taken sufficient action to make themselves aware of all the topic areas and to fully participate in Board discussions there are other comments that indicate some Board Members have not done this. There was also concern about attendance at Board meetings by Board Members.

- It was also noted that staff presentations and meeting length should be kept within the time allotted.
- Specific requests for training opportunities for Board Members around Ministry level policies and legislation changes including accountability agreements.

The Most Important Thing the Board Could Do to Improve Its Performance

- A final open-ended question asked respondents about the most important thing the Board could do to improve its performance. Comments indicated:
 - The need for individual members and Board as whole to ensure they represent all areas of Middlesex London in their decisions
 - Members should become more knowledgeable about the business and functions of the Board including annual review of responsibilities and accountabilities