

# AGENDA

## MIDDLESEX-LONDON BOARD OF HEALTH

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

THURSDAY, 7:00 p.m.  
2011 October 20

### MISSION - MIDDLESEX-LONDON BOARD OF HEALTH

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

### MEMBERS OF THE BOARD OF HEALTH

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

### **DISCLOSURE OF CONFLICTS OF INTEREST**

### **APPROVAL OF AGENDA**

### **APPROVAL OF MINUTES**

### **SCHEDULE OF APPOINTMENTS**

7:10 – 7:20 p.m. Mr. Ross Graham, Manager, Special Projects re Item # 4

7:20 – 7:30 p.m. Ms. Barb Sussex, Staff Immunization Nurse, re Item # 6

7:30 – 8:00 p.m. Mr. John Millson, Director, Finance and Operations, re Item # 3

### **ACTION REQUIRED**

- 1) Report No. 090-11 re Request for Proposal 11-03: Graphic Design Services
- 2) Report No. 091-11 re Tender 11-01: Janitorial Services
- 3) Report No. 092-11 re 2012 Proposed Budget – Cost-Shared Programs
- 4) Report No. 093-11 re Achieving the Ontario Public Health Standards Organizational Standards

## **FOR INFORMATION**

- 5) Report No. 094-11 re Medical Officer of Health Activity Report – October
- 6) Report No. 095-11 re 2011 Staff Immunization Program Update
- 7) Report No. 096-11 re 2011 – 2012 Influenza Vaccination Program Plans
- 8) Report No. 097-11 re Ontario Council on Community Health Accreditation Site Visit
- 9) Report No. 098-11 re Engaging Youth in School Communities
- 10) Report No. 099-11 re Media Summary Report – January to June 2011

## **CONFIDENTIAL**

11) The Board of Health will move in camera for the purpose of considering a matter concerning labour relations or employee negotiations.

## **OTHER BUSINESS**

Next scheduled Board of Health Meeting – Thursday, November 17, 2011 7:00 p.m.

## **CORRESPONDENCE RECEIVED**

- a) Dated 2011 September 1 (received 2011 September 8) Correspondence from The Honourable Margaret Best, Minister, Health Promotion and Sport, to Dr. Graham Pollett, Secretary Treasurer, responding to a letter from Dr. Pollett, forwarded from The Honourable Steve Peters re limiting youth exposure to images of tobacco/smoking in films.
- b) Dated 2011 September 15 (received 2011 September 20) Correspondence from Ms. Laura Pisko-Bezruchko, Director, Standards, Programs & Community Development Branch, Ministry of Health Promotion & Sport, to Dr. Graham Pollett, Medical Officer of Health, confirming that the Government of Ontario will provide one-time funding of up to \$961,888 for Tobacco Control Coordination from January 1, 2011, to December 31, 2011.
- c) Dated 2011 September 16 (received 2011 September 21) Correspondence from Mr. Bill Rayburn, Chief Administrative Officer, County of Middlesex, to Dr. Graham Pollett, Medical Officer of Health, re generator request at 50 King Street, London.
- d) Dated 2011 September 20 (received 2011 September 27) Correspondence from Ms. Maria Harding, Chair, Board of Health, Thunder Bay District Health Unit, to Dr. Graham Pollett, Medical Officer of Health, expressing thanks for his assistance in supervising the former Thunder Bay Acting Medical Officer of Health, Dr. Henry Kurban.
- e) Dated 2011 October 3 (received 2011 October 5) A copy of correspondence to The Honourable Margaret Best, Minister, Health Promotion and Sport, from Mr. Daryl Vaillancourt, Chairperson, North Bay Parry Sound District Health Unit, advising that the Board of Health passed the following resolution:

***Be It Resolved, That the Board of Health for the North Bay Parry Sound District Health Unit recommends that all municipalities within the North Bay Parry Sound District Health Unit service area develop and adopt a by-law banning smoking***

- 1) in all municipally-owned or operated outdoor recreation areas (e.g. parks, beaches, playgrounds, sports fields including spectator areas, etc.);
- 2) at entrances and exits of all municipally owned or operated buildings or for the entire property;
- 3) on, and within a 9 metre buffer zone of, all patios where food or drinks are sold, and

**Furthermore Be It Resolved,** That the by-law include a provision for business owners to apply to be included in the smoking prohibition for either a 9 metre set-back or for the entire property, and

**Furthermore Be It Resolved,** That the by-law allow special events and festivals to be designated as smoke-free, and

**Furthermore Be It Resolved,** That a copy of this resolution be forwarded to member municipalities within the North Bay Parry Sound District Health Unit service area, the Minister of Health Promotion and Sport, Public Health Ontario (Health Promotion, Chronic Disease and Injury Prevention), Smoke-Free Ontario, the Minister of Health and Long-Term Care, Ontario Boards of Health, Ontario Medical Officers of Health, and the Association of Local Public Health Agencies.

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

**MIDDLESEX-LONDON HEALTH UNIT  
REPORT NO. 090-11**

TO: Chair and Members of the Board of Health  
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health  
DATE: 2011 October 20

**Request for Proposal 11- 03: Graphic Design Services**

**Recommendation**

It is recommended that the Board of Health enter into non-exclusive service agreements with the following four (4) graphic design firms for the three year period November 1, 2011, to October 31, 2014:

- 1) ***Kreative Advertising***
- 2) ***Si Design***
- 3) ***Keyframe Communications***
- 4) ***Imantis Advertising***

**Background**

The Health Unit currently engages the services of four (4) design and marketing firms on a project-by-project basis for the design and production of displays, posters, brochures, and other promotional and campaign materials. The Health Unit entered into agreements with four (4) firms to enable more companies the opportunity to work with MLHU, to recognize the strengths of the different firms, and to allow for choice of design. All firms must comply with the Health Unit's Graphic Standards.

The four (4) firms entered into three year non-exclusive service agreements with the Health Unit in late-October 2008. The companies delivered approximately \$129,000 of work in 2009 and \$83,000 worth of work in 2010. The companies have delivered approximately \$40,500 worth of work from January to September, 2011.

**2011 Request for Proposal (RFP)**

With the current contracts set to expire this fall, the Health Unit issued a Request for Proposal (RFP) for Graphic Design Services on June 25, 2011. Notice of the procurement opportunity was provided to eight (8) known service providers and advertised in the London Free Press and on the health unit's website. The RFP closed on August 4, 2011, and seventeen (17) submissions were received.

An Evaluation Committee consisting of members from the Environmental Health and Chronic Disease Prevention Services Team; Family Health Services; Oral Health, Communicable Disease and Sexual Health Services; Communications and Finance & Operations reviewed the submissions. The submissions were evaluated based on predetermined evaluation criteria which included personnel, experience, qualifications, methodology, cost, range of services, response times and value added benefits.

From the seventeen (17) firms who expressed interest, seven (7) were selected to participate in a presentation and to submit samples of previous work. Presentations were made to the Evaluation Committee on September 20, 2011, and the Committee met on September 26, to develop a final recommendation to be presented to the Board of Health.

**Conclusion**

As a result of the RFP process, the Evaluation Committee was unanimous in its recommendation to award the contracts to four (4) firms. The Evaluation Committee recommends awarding three (3) year non-exclusive service contracts to Kreative Advertising, Si Design, Keyframe Communications, and Imantis Advertising.

This report was prepared by Ms. Melody Couvillon, Manager of Procurement & Operations, and Mr. Dan Flaherty, Manager, Communications, on behalf of the Evaluation Committee.

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

**MIDDLESEX-LONDON HEALTH UNIT  
REPORT NO. 091-11**

TO: Chair and Members of the Board of Health  
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health  
DATE: 2011 October 20

**Tender 11-01: Janitorial Services**

**Recommendation**

It is recommended that contracts for Janitorial Services for a three (3) year period be awarded as follows:

- i) Metropolitan Maintenance – for leased premises located at 50 King Street and 399 Ridout Street, London Ontario for a total amount of \$448,090.20, and further;
- ii) Double M & M – for leased premises located at the Kenwick Mall, 51 Front Street, Strathroy, Ontario for a total amount of \$41,425.80.

**Background**

The Health Unit currently engages the services of two (2) janitorial contractors to provide janitorial services at the following leased premises: 50 King Street in London (which includes leased meeting room space within the County Building at 399 Ridout Street) and 51 Front Street (Kenwick Mall in Strathroy). Janitorial services for the leased space at 201 Queens Avenue, London, is managed through Farhi Holdings Corporation.

**2011 Request for Tender**

On July 18, 2011, the Health Unit issued a Request for Tender for Janitorial Services. Notice of the procurement opportunity was provided directly to eight (8) known service providers and advertised in the London Free Press and on the Health Unit's website. A site visit was conducted at each of the sites July 28, 2011, to enable bidders to address local conditions, facility structure, and any foreseen difficulties they may encounter during the duration of the contract. The site visit was attended by six (6) potential bidders.

The tender was publically opened on August 17, 2011, and four (4) submissions were received. Attached as Appendix A is a summary of the bids received.

During the evaluation of the tender by Ms. Melody Couvillon, Manager of Procurement and Operations, it was apparent that the low bid received, from Double M & M for the 50 King Street premises, had considerably under estimated the number of man hours required to complete the work as outlined in the specifications. A meeting was conducted with Double M & M, and it was agreed that they would withdraw their bid for the 50 King Street premise. The recommendations for award are based on the lowest bidder who meets all terms, conditions and specifications as outlined in the tender.

**Conclusion**

As a result of the tender process undertaken, it is recommended that the janitorial contracts be awarded for a three (3) year period to Metropolitan Maintenance for 50 King Street and 399 Ridout Street leased premises in the amount of \$448,090.20, and to Double M & M for leased office space at 51 Front Street, Kenwick Mall, Strathroy in the amount of \$41,425.80.

This report was prepared by Ms. Melody Couvillon, Manager of Procurement & Operations. Ms. Couvillon will be attendance at the October 20<sup>th</sup> Board meeting to address any questions regarding this report.

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

**APPENDIX A**

**Summary of Tender results for Janitorial Services**  
**Wednesday, August 17, 2011**

	<b>Bid #1</b>	<b>Bid #2</b>	<b>Bid #3</b>	<b>Bid #4</b>
	Double M & M 786 Little Hill Street London, N5Z 1M9	Omni Facility Services Canada Ltd. 931 Leathorne Street, Unit E London, N5Z 3M7	Metropolitan Maintenance 163 Stronach Crescent London, N5V 3G5	Bee-Clean Building Mtce. 315 Consortium Court London, N6E 2S8
	<b>Amount</b>	<b>Amount</b>	<b>Amount</b>	<b>Amount</b>
<b>Part A:<sup>1</sup></b>				
<b>50 King Street</b>				
Year 1	\$125,796.12	\$133,287.74	\$133,972.80	\$165,019.68
Year 2	132,074.40	135,953.50	137,322.12	168,320.04
Year 3	138,664.56	138,672.84	140,752.80	171,686.40
<b>Sub Total</b>	<b>\$396,535.08</b>	<b>\$407,914.08</b>	<b>\$412,047.72</b>	<b>\$505,026.12</b>
<b>399 Ridout Street</b>				
Year 1	\$10,807.32	\$14,632.60	\$11,729.40	\$12,804.12
Year 2	11,336.16	14,886.60	12,000.60	13,060.20
Year 3	11,892.12	15,184.44	12,312.48	13,321.44
<b>Sub Total</b>	<b>\$34,035.60</b>	<b>\$44,703.64</b>	<b>\$36,042.48</b>	<b>\$39,185.76</b>
<b>Total Part A</b>	<b>Withdrawn</b>	<b>\$452,617.72</b>	<b>\$448,090.20</b>	<b>\$544,211.88</b>
<b>Part B:</b>				
<b>51 Front Street</b>				
Year 1	\$13,383.72	No Bid	\$19,512.84	\$15,442.08
Year 2	\$13,804.08		\$20,001.00	\$15,750.96
Year 3	\$14,238.00		\$20,502.72	\$16,065.96
<b>Total Part B</b>	<b>\$41,425.80</b>	<b>No Bid</b>	<b>\$60,016.56</b>	<b>\$47,259.00</b>

**Notes:**

- 1) Part A combines contracted services for the leased premises of 50 King Street and 399 Ridout Street locations due to the proximity of the buildings, as well as the need for shared resources of the staff to complete the work at both sites.

**MIDDLESEX-LONDON HEALTH UNIT  
REPORT NO. 092-11**

TO: Chair and Members of the Board of Health  
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health  
DATE: 2011 October 20

**2012 Proposed Budget – Cost-Shared Programs**

**Recommendations**

It is recommended:

- 1) That the Board of Health approve the 2011 base budget adjustments as described in Report No. 092-11; and further
- 2) That the Board of Health approve the 2012 proposed budget for the Mandatory & Related Programs budget (Cost-Shared Programs) at the net amount of \$23,084,266 representing an increase of \$444,094, as described in Scenario #1 of Report No. 092 -11.

**Background**

Each year the Board of Health reviews and approves the Health Unit's Cost-Shared Programs budget. This budget accounts for approximately 75% of the total Board of Health net expenditures. The remaining 25% of net expenditures are made up of 100% programs. The Mandatory & Related Programs budget is cost-shared between the Ministry of Health & Long-Term Care (MOHLTC), Ministry of Health Promotion and Sport (MHPS), The City of London, and The County of Middlesex.

Consistent with past practice, the City of London is the first of the three funding agencies to require a 2012 budget submission. Table 1 below, summarizes the relevant steps in the City's budget process and the anticipated completion dates.

**Table 1 – 2012 City of London Budget Timetable**

	<b>Due Date</b>
Financial Planning & Policy Technical Review	October 27 <sup>th</sup> , 2011
Tabling of the City of London Budget to the Strategic Priorities and Policy Committee	December 5 <sup>th</sup> , 2011
Public Engagement – Shopping Malls	January 14 <sup>th</sup> , 2012
Public Participation	January 17 <sup>th</sup> , 2012
Strategic Priorities and Policy Committee Review	February 2 <sup>nd</sup> , 2012
Council Approval	February 21 <sup>st</sup> , 2012

**Factors Influencing the 2012 Proposed Budget**

There are a number of factors influencing the development of the 2012 Board of Health budget for its cost-shared programs. They are:

- A. 2011 Base Budget Adjustments
- B. The City of London's Budget Direction for 2012-2014
- C. New Provincial Accountability Framework

Each will be reviewed.

**A. 2011 Base Budget Adjustments**

In 2010 and 2011 there have been a number of budget allocations (base adjustments) that need to be reviewed as part of the Board's consideration of the 2012 proposed operating budget. These items can be categorized as follows:

- i) 2010 Organizational Realignment
- ii) 2011 Additional Provincial Revenues
- iii) Provincial Wage Restraint
- iv) 2011 Strategic Plan Initiatives

i) 2010 Organizational Realignment

Organizational realignment occurred in 2010 as a result of the discontinuation of the Public Health Research, Education and Development (PHRED) program and an external review of the Information Services area. The Board approved the establishment of three Director positions: Director, Human Resources and Labour Relations; Director, Finance and Operations; and Director, Information Technology. The latter position was recommended by the external review of IT Services and represented a new position. The Director, Human Resources and Labour Relations, and Director, Finance and Operations, were promotions for the then Managers of those respective areas.

The closing of the PHRED program resulted in the disbandment of the Research, Education, and Evaluation and Development Services (REED) area. This led to the realignment of a number of positions such as the Librarian, Epidemiologist and Program Evaluator. This Board of Health approved realignment was the subject of Confidential Board of Health Report 096-10. It has become apparent since the realignment that a number of these positions require administrative support. The Directors Committee has identified 3.5 FTE administrative support positions to address this need, with the necessary funding (\$203,000) to come from the 2011 additional provincial revenues referenced below.

ii) 2011 Additional Provincial Revenues

In March 2011, the Board of Health approved a revised estimate for 2011 provincial revenues. The original 2011 budget was developed on the assumption that the provincial cost-shared program grant would be increased by 1.5%. Early in March, revised information from the province indicated health units could expect a 3% increase in grant revenues. This increase was realized and consequently has provided an additional \$215,580 for 2011. Board Members will recall that this amount was earmarked for the upgrades to the HVAC system at the 50 King Street office, but for 2012 this amount remains in the base budget and can therefore be reallocated. This is the funding source for the 3.5 FTE administrative support positions addressed above.

iii) Provincial Wage Restraint

As a result of the Restraint Act coming into force March 24, 2010, non union/management position salaries were frozen for a period of two years. The provincial government also issued a policy which requires public sector employers such as the Health Unit to negotiate 0% compensation increases over the two year term of the Act with unions who did not have signed collective agreements prior to March 24, 2010. Both Health Unit unions' (ONA and CUPE) collective agreements expired March 31, 2010. Under the provincial policy, the province will not reimburse Health Units for its share of any compensation increases awarded contrary to this policy. In effect, the Act has frozen salaries and benefits for a two year period. However, the base budget for 2010 was set prior to the Restraint Act, and included an amount for anticipated staff salary increases. A portion of these funds have been reallocated to address the implementation of the recently approved Board of Health Strategic Directions. The application of these reallocated funds is described below.

iv) 2011 Strategic Plan Initiatives

The Board of Health approved a strategic planning Ten Year Vision and Three Year Strategic Directions document at the June 16, 2011, Board of Health meeting. Two positions have been identified to support the implementation of the Board direction: 1.0 FTE Communication Coordinator position and 1.0 FTE Records Management and Continuous Quality Improvement position. The funding for these positions, which totals \$180,618, is from the unallocated 2010 base budget dollars referenced in iii) Provincial Wage Restraint above.

Table 2 below summarizes these budget reallocations.

**Table 2 – 2011 Base Budget Changes**

	<b>Net Increase / (Decrease)</b>
Realignment – Administrative Support:	\$ 203,303
Strategic Initiatives:	180,618
• Communications Coordinator – (Social Media) \$79,202	
• Continuous Quality Improvement / Records Management \$101,416	
2011 Additional Provincial Grant (1.5%)	(215,580)
2010 Base Budget Reallocation	(168,341)
<b>Total additional budget requirements</b>	<b>\$ 0</b>

**B. The City of London’s Budget Direction for 2012-2014**

At the May 2011, Board of Health meeting, Report No. 053-11 (attached as Appendix A) regarding the 2012 City of London Budget Target was received for information. The report provided a history of public health funding, the Board of Health’s business plan for strengthening public health resources without a resultant increase in funding from local municipalities (which was subsequently endorsed by both City Council and County Council), and a preliminary overview of the potential impact of the City of London 2012 -2014 budget direction for this Health Unit.

The City of London’s overall 2012 budget target would result in a residential property tax increase of 1.5%. Included in this target is a reduction in City funding to the Health Unit of \$1.5 million over a three year period (i.e. 2012 – 2014 inclusive). This would be done by reducing the City’s funding by \$500,000 (or 8.07%) in each of the next three years. Board members will recall that the municipal portion of the cost-shared budget is split between the City and the County on a proportionate population basis. Consequently, if the City reduces its funding by the proposed amount, it is anticipated that this will result in a reduction of \$95,000 from Middlesex County in each of the next three years. The impact of this approach would diminish many of the gains the Board has made since the implementation of its Business Plan in 2005. The full impact is described later in this report.

**C. New Provincial Accountability Framework**

At the last Board of Health meeting, the Board of Health authorized the signing of the Ministry of Health and Long-Term Care (MOHLTC) and Ministry of Health Promotion and Sport (MHPS) Public Health Accountability Agreement (PHAA). This agreement sets out the obligations of the Board of Health and the two provincial ministries for a three year period ending December 31, 2013. Board of Health compliance with the requirements of the PHAA is a necessary condition for receiving provincial funding. Among other items, the PHAA identifies key performance indicators, the obligation to deliver programs and services that meet the Ontario Public Health Standards (OPHS), and provides specific governance covenants or commitments that the Board must meet. The 2012 proposed budget must be reviewed with the PHAA Board of Health obligations in mind.

**2012 Proposed Cost-Shared Budget Scenarios**

The Directors Committee met several times over the past two months to prepare budget estimates for the 2012 operating year. These discussions led to the development of the following two scenarios for Board members’ consideration.

**A. Scenario #1 (Recommended)**

This scenario for the 2012 budget is based upon the following assumptions:

- 1) The Board of Health maintains its 2005 Business Plan which calls for a 0% municipal budget increase for 2012
- 2) A 3% provincial grant increase for 2012
- 3) Adoption by the Board of Health of the base budget reallocations described above and highlighted in Table 2 above.

Under this scenario, it can be seen from Table 3 below, that these assumptions would yield an additional \$444,094 in provincial grant funding or a 2.02% increase over the 2011 net budget for cost-shared programs. Table 4 below provides the 2012 net budget by funding body.

**Table 3– 2012 Gross Cost-Shared Budget – By Program**

	2011 Board of Health Approved Budget	2012 Budget	Increase / (Decrease)
Mandatory Programs (68:32)	\$ 22,024,216	\$ 22,468,310	\$ 444,094
Vector Borne Disease (75:25)	615,956	615,956	0
<b>Total Cost-Shared</b>	<b>\$ 22,640,172</b>	<b>\$ 23,084,266</b>	<b>\$ 444,094</b>

**Table 4 – 2012 Cost-Shared Budget – By Funding Body**

	Total	Province	City	County
Mandatory Programs	\$ 22,468,310	\$ 15,247,229	\$ 6,065,708	\$ 1,155,373
Vector Borne Disease	615,956	461,967	129,351	24,638
<b>2012 Total Cost-Shared</b>	<b>\$ 23,084,266</b>	<b>\$ 15,709,196</b>	<b>\$ 6,195,059</b>	<b>\$ 1,180,011</b>
<b>2011 Total Cost-Shared</b>	<b>\$ 22,209,013</b>	<b>\$ 15,265,102</b>	<b>\$ 6,195,059</b>	<b>\$ 1,180,011</b>
<b>Increase/(Decrease)</b>	<b>\$ 444,094</b>	<b>\$ 444,094</b>	<b>\$ 0</b>	<b>\$ 0</b>

Table 5 below provides an overview of budget changes for cost-shared programs across the entire organization. It can be seen the 2012 anticipated salary and benefit adjustments can be accommodated with a 0% municipal, 3% provincial grant increase (\$444,094).

**Table 5 – 2012 Budget Requirements**

Description	Increase/(Decrease)
<b>2012 Requested Budget Changes</b>	
- OMERS pension rate increase	\$ 154,000
- Anticipated salary and benefit adjustments	330,094
- Procurement efficiencies	(40,000)
<b>2012 Provincial Funding Requirement</b>	<b>\$ 444,094</b>

**B. Scenario #2 (Municipal Reduction as per the City of London Direction)**

This scenario for the 2012 proposed budget is based upon the following assumptions:

- 1) The Board of Health complies with the City Council's 2012 budget direction resulting in a \$500,000 City funding reduction and an anticipated \$95,000 Middlesex County funding reduction for each of the next three years;
- 2) A 3% provincial grant increase for each year for the next three years (i.e. 2012, 2013, 2014);
- 3) Adoption by the Board of Health of the base budget reallocations described above and highlighted in Table 2.

Under this scenario, the Board needs to consider the full impact of the three year municipal reduction of approximately \$1.8 million dollars. Taking into consideration anticipated wage and benefit increases over this three year period, it is estimated that the total reduction required would be approximately \$2.2 million. This would require the Board of Health to significantly cut programs and services as there is no other way to achieve a reduction of this magnitude. In addressing this scenario, Directors have determined that approximately 25 FTE positions would need to be eliminated over a three (3) year period. The program and services cuts would result in non-compliance on the part of the Board of Health in meeting its Provincial Health Accountability Agreement obligations.

## Conclusion

In 2005, the Board of Health adopted a Business Plan for strengthening local public health resources. This Business Plan was in response to provincial and federal government reviews of the limitations of the public health response to the SARS situation in 2004.

The Business Plan called for the City of London and County of Middlesex to hold to their 2004 public health funding levels. Funding enhancements would be realized through annual increases to the provincial cost-shared program grant. The Business Plan which was endorsed by City of London and Middlesex County Councils has been highly successful as demonstrated in Appendix B. It can be seen that a \$8.4 million increase in base budget funding has been realized since 2005, with no change in the level of municipal funding over that same period.

Historically, public health units in Ontario have been funded on a 75% provincial, 25% municipal basis. For this Health Unit, the municipal share has been allocated to each funder on a proportionate population basis (i.e. 84% City of London, 16% Middlesex County which would result in the 25% municipal share being split on a 21% City / 4% County basis). Adoption of the 2005 Board of Health Business Plan by City and County Councils resulted in an altered funding arrangement. This was done with the understanding that over time, as the provincial grant increases occurred, the funding arrangement would return to 75% / 25%. Appendix C highlights the progress made to date toward that end. It can be seen that the 2012 proposed budget under Scenario #1 would result in a 68% / 32% cost-shared arrangement and that it is anticipated that by 2023 the cost-shared arrangement will be 75% / 25%.

For 2012, the City of London has indicated it intends to expedite the return to a 75% / 25% cost-shared arrangement such that it is in place by 2014. This would be achieved through a \$500,000 reduction in City funding for each of the next 3 years. Assuming a concomitant reduction in Middlesex County funding, the overall impact is an estimated \$2.2 million reduction. This would result in substantial losses to the staff complement (25 FTE) and cuts to programs and services.

Given the success to date of the Board of Health 2005 Business Plan with its 0 % increases to municipal funding until a 75% / 25% funding arrangement is restored; and given that the Board of Health will not be able to meet its obligations under the Public Health Accountability Agreement if the City of London's 2012-2014 budget directions are implemented, it is strongly recommended that the Board of Health maintain the 2005 Business Plan and approve a 2012 cost-shared budget in the net amount of \$23,084,266 representing an increase of \$444,094 (Scenario #1 of this report).

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

**This report addresses** Policy #4-010 BUDGET PREPARATION AND APPROVAL as outlined in the MLHU Administration Policy Manual.

TO: Chair and Members of the Board of Health

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

DATE: 2011 May 19

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## **2012 CITY OF LONDON BUDGET TARGET**

### ***Recommendation***

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

### **Background**

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

### **Public Health Funding History**

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

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

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

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

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

## Cap of Provincial Grant

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

The success of the 2005 Board of Health budget plan can be seen in Appendix A which demonstrates the increase in funding (\$7.9 million) realized by MLHU since 2004 resulting from annual provincial funding increases, with no increase in funding from either municipality over the same period. The current cost-sharing ratio is 67%/33%.

## City of London – 2012 Budget Target

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

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

**Table I – 2012 City of London Proposed Budget Target Impact**

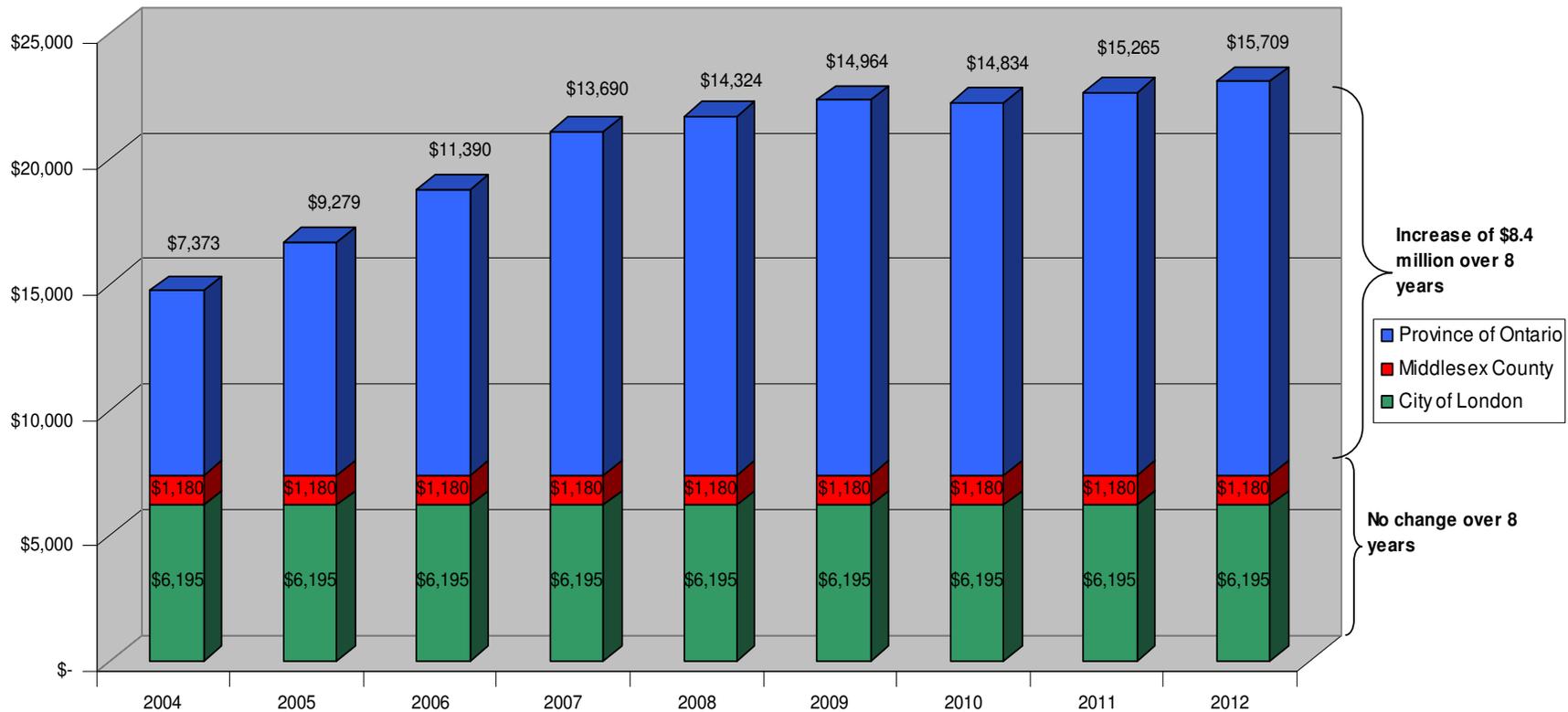
	<b>Total</b>	<b>Province</b>	<b>City</b>	<b>County</b>
2011 Cost-Shared Programs	\$ 22,640,172	\$ 15,265,102	\$ 6,195,059	\$ 1,180,011
2012 Cost-Shared Target	22,503,125	15,723,055	5,695,059	1,085,011
<b>Increase/(Decrease)</b>	<b>(137,047)</b>	<b>457,953</b>	<b>(500,000)</b>	<b>(95,000)</b>

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

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

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

# 2004 - 2012 Cost-Shared Program Funding (\$000's)



**Comparison of Proportionate Share of Funding by Funding Body**

	<b>Province</b>	<b>City</b>	<b>County</b>
2004	50.00%	42.00%	8.00%
2005	55.00%	37.80%	7.20%
2006	62.00%	31.90%	6.10%
2007	66.00%	28.60%	5.40%
2008	66.30%	28.31%	5.39%
2009	67.18%	27.57%	5.25%
2010	66.56%	28.09%	5.35%
2011	67.21%	27.54%	5.25%
2012	68.05%	26.84%	5.11%
.....	.....	.....	.....
2023	75.00%	21.00%	4.00%

**MIDDLESEX-LONDON HEALTH UNIT  
REPORT NO. 093-11**

TO: Chair and Members of the Board of Health  
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health  
DATE: 2011 October 20

**Achieving the Ontario Public Health Organizational Standards**

**Recommendation**

It is recommended that the Board of Health members complete the Ministry of Health and Long-Term Care online training module for the Public Health Organizational Standards and Ontario Public Health Standards.

**Background**

The terms and conditions of the Public Health Accountability Agreement state that Boards of Health must maintain written procedure to ensure compliance with the Ontario Public Health Organizational Standards (OS) (Appendix A). Since the Accountability Agreement applies retroactively, the Health Unit could be held accountable for OS compliance as of January 1, 2011, and be asked to produce proof of compliance upon request (see OS article 2.4).

**Summary of the Organizational Standards**

The OS are an addendum to the Ontario Public Health Standards (OPHS), and contain 44 requirements for Boards of Health. The requirements are divided into six categories:

1. Board Structure (8 requirements) - Summarizes the required composition of Boards of Health under the Health Protection and Promotion Act (HPPA).
2. Board Operations (10 requirements) - Summarizes mandatory Board functions under the HPPA with an additional requirement: Board of Health Policies (item 2.10), which outlines mandatory bylaws and policies (e.g., use of subcommittees, procurement of external advisors, etc.).
3. Leadership (2 requirements) - Describes the Board's responsibility to provide "governance direction to the administration" regarding (a) delivery of the OPHS; (b) organizational effectiveness through evaluation of the organization and strategic planning; (c) stakeholder relations and partnership building; (d) research and evaluations, including ethical review; (e) compliance with all applicable legislation and regulations; (f) workforce issues, including recruitment of the Medical Officer of Health; (g) financial management, including procurement; and (h) risk management. This standard describes requirements of a strategic plan and requires each Board to maintain a 3-5 year strategic plan.
4. Trusteeship (3 requirements) – Describes the accountability of Boards to the public, as well as required orientation, continuing education, and self-evaluation activities for Board of Health members.
5. Community Engagement & Responsiveness (5 requirements) – Describes the relationship of the Board to the public. This includes the requirement for health unit administration to develop and implement community engagement, stakeholder engagement and client service strategies. Each has specific components, for example:
  - a. Recruitment and engagement of community partners and the public to participate in the development of the strategic and operational plans for the board of health, and in the evaluation of programs and services (from 5.1, community engagement)
  - b. Collaborative relationships with key health sector partners, including but not limited to the chief executive officer(s) of the local health integration network(s), hospital administrators, long-term care facility administrators, community health centre administrators and community care access centre administrators, to identify mechanisms for collaboration and coordination in planning and service delivery (from 5.2, stakeholder engagement)
  - c. Set times for responsiveness to enquiries (from 5.5, client service).

6. Management Operations (16 requirements) – Describes the responsibilities of Health Unit administration. As the largest standard, the requirements are designed to assist health units plan, manage risk and continually improve quality. The following are required:

- |  |                                    |
|--|------------------------------------|
| 6.1 Operational plan   | 6.9 Capital funding plan           |
| 6.2 Risk management  | 6.10 Service level agreements      |
| 6.3 Medical officer of health provides direction to staff      | 6.11 Communications strategy       |
| 6.4 Eligibility for appointment as a medical officer of health | 6.12 Information management        |
| 6.5 Educational requirements for public health professionals   | 6.13 Research ethics               |
| 6.6 Financial records  | 6.14 Human resources strategy      |
| 6.7 Financial policies and procedures                          | 6.15 Staff development             |
| 6.8 Procurement  | 6.16 Professional practice support |

### **Achieving the Organizational Standards**

The addition of the OS to the compliance framework for Boards of Health will likely replace Accreditation. In effect, OS compliance makes Accreditation mandatory, as was recommended by the Capacity Review Committee in 2006. Similarly to preparing for Accreditation, achieving the OS will be a critical quality assurance process for the Health Unit as staff members work to improve the organization's effectiveness and efficiency, and in turn improve population health in Middlesex-London. While all staff and Board of Health members will be involved in achieving the OS, ongoing monitoring of compliance is the responsibility of the Special Project portfolio.

Given the importance of compliance with the OS to each Board of Health's fulfillment of its legislated duties and responsibilities, it is recommended that all Board of Health members participate in online training to become more familiar with the Organizational Standards. Link to Board of Health E-Learning Module:

[www.publichealthontario.ca/portal/server.pt?open=512&objID=2508&PageID=0&cached=true&mode=2&userID=8438](http://www.publichealthontario.ca/portal/server.pt?open=512&objID=2508&PageID=0&cached=true&mode=2&userID=8438)

This report was prepared by Mr. Ross Graham, Manager, Special Projects.

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

**This report addresses** the Ontario Public Health Organizational Standards (OS) at the Middlesex-London Health Unit.

# Ontario Public Health Organizational Standards

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



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# Part I: Introduction

## Purpose

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The Ontario Public Health Organizational Standards (Organizational Standards) establish the management and governance requirements for all boards of health and public health units. Similar to the Ontario Public Health Standards (OPHS) 2008 (or as current),<sup>1</sup> which outline the expectations for providing public health programs and services, the Organizational Standards outline the expectations for the effective governance of boards of health and effective management of public health units. Organizational Standards help promote organizational excellence, establish the foundation for effective and efficient program and service delivery and contribute to a public health sector with a greater focus on performance, accountability and sustainability.

## Scope and Accountability

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This document specifies requirements that all boards of health are required to implement throughout their organizations. This document contains both new requirements for boards of health as well as requirements related to governance and management from existing sources. The existing obligations within the *Health Protection and Promotion Act* (HPPA)<sup>2</sup> and its Regulations have been included here so as to provide a single compiled set of governance and management requirements that boards of health are obligated to meet as a board of health.

Outside of these obligations, boards of health have other duties and responsibilities, which relate to their role as employers, holders of personal and personal health information, corporate entities, service providers and so on. The legal obligations of boards of health in these areas are set out in other provincial and federal legislation and regulation. Boards of health may also be subject to local municipal by-laws. This document does not contain an exhaustive list of the legal obligations of boards of health, as these additional obligations are beyond the scope of this document. Boards of health need to be aware of and to meet these additional obligations.

Boards of health are accountable for implementing the requirements established in this document throughout their organizations. The scope of the Organizational Standards includes activities that will assist boards of health in developing strong governance and management practices, which in turn are a support to the planning and delivery of public health programs and services.

The Organizational Standards are complementary to the OPHS and support the Principles outlined in the OPHS that guide boards of health in assessment, planning, delivery, management, and evaluation of public health programs and services. While there may be variations in the internal lines of authority in different boards of health, the expectation is that all boards of health will implement and meet each of the Organizational Standards requirements. Because the Organizational Standards are complementary to the OPHS, there are no program specific requirements, nor have the sections of HPPA which relate to program delivery been repeated here.

The Organizational Standards apply to all boards of health, regardless of the type of board governance model. Any exceptions as required by the HPPA have been noted.

Currently, there are five types of board governance models operating in Ontario's public health sector as follows:

- **Autonomous:** Separate from any municipal organization but with multi-municipal representation, including citizen representatives appointed by municipalities; potential for provincial appointees.
  - **Autonomous/Integrated (a subset of Autonomous):**  
Only one municipality appoints representatives including citizen representatives; potential for provincial appointees; operates within municipal administrative structure.
- **Regional:** Boards are Councils of Regional Government (federations of local municipalities); no citizen representatives; no provincial appointees.
- **Single-Tier:** Boards are Councils of Single-Tier Municipalities (areas with only one level of municipal government); no citizen representatives; no provincial appointees.
  - **Semi-Autonomous (a subset of Single-Tier):**  
Single-Tier Council appoints members to a separate “board of health” including citizen representatives; Council approves budget and staffing; no provincial appointees.

Although the language of the requirements may appear to apply primarily to autonomous boards, this is not the intention. Regardless of the governance model, the board of health as the governing body is legally accountable to the government of Ontario, and is the body that has the authority to enter into agreements with ministries.

The strategies that boards of health use to implement the necessary practices to meet the requirements will vary from board to board, in part due to differences in management structures. While in some boards of health, there is a Chief Executive Officer\* (CEO) as well as a Medical Officer of Health (MOH), in others, the MOH plays both roles. Another variation is seen in regional boards, where the MOH relates to a Chief Administrative Officer (CAO) to coordinate services provided by the region, such as HR, procurement, and finances. In these requirements, the CEO and CAO roles have not explicitly been acknowledged but this does not preclude the delegation of administrative and management responsibilities to the CEO or CAO, as appropriate for each organization.

Note that for clarity, the requirements refer to these senior management positions as “the administration.” All of the requirements in Section 6: Management Operations reference the board of health as the governing body delegating management tasks to the administration, which is meant to clarify that the board itself is not expected to be involved in undertaking these tasks, but should be ensuring these activities take place through the management team.

In order to respect the board of health as the body that is accountable to the ministries while also respecting the delegation of authority for the day-to-day management and administrative tasks to the MOH (and CEO or

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\* Within the body of the document, the term executive officer is meant to include all related titles such as CEO, CAO and COO (Chief Operating Officer).

other executive officers, where applicable), the requirements have been written to make these distinctions explicit. Where the board of health as the governing body is expected to fulfill a requirement directly, the requirement states: “The board of health shall...” In cases where the expectation is that the board would delegate the responsibilities to the management team, the language of the requirement shifts to “The board of health shall ensure that the administration...”.

## Background

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As stated in the OPHS, boards of health have the responsibility for the delivery of local public health programs and services. The effective delivery of required public health programs and services can be supported by a strong organizational structure which includes effective and efficient governance and management practices. The Organizational Standards are one component of a comprehensive public health performance management system currently being developed for the province of Ontario. By addressing structural aspects such as human resources management, administrative policies, board of health functioning, and financial management, it is intended that the Organizational Standards will help establish consistent organizational processes in all boards of health across the province that will in turn facilitate desired program outcomes.

Although there is limited research and evidence available related to the development of organizational standards within the public health sector, the development of the Organizational Standards was based on a consolidation of the relevant themes and ideas from available peer-reviewed and grey literature, resources and organizations.

## How Can the Organizational Standards Help Public Health Units?

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Research indicates that improvements in processes and structures used to make important decisions will lead to improved results.<sup>3</sup> As such, an essential component of performance management, from which targets and goals can be developed, is the establishment of performance standards.<sup>4</sup> As part of a comprehensive public health performance management system, the Organizational Standards can help boards of health achieve their objectives and improve operations by clearly communicating expectations of boards of health and public health units.<sup>5</sup>

The Organizational Standards can help boards of health make managerial decisions to improve the quality and effectiveness of programs and services, prioritize and allocate resources, inform managers about needed changes in operations to improve efficiency, and identify required changes in policy or program directions to meet goals and objectives.<sup>4,6</sup> The Organizational Standards can be used as a tool for planning and operational assessment by helping boards of health stay on course toward improving outcomes, identifying gaps in training, leadership, and resources, and encouraging collaboration to reach goals.<sup>5,7</sup>

The Principles that guide boards of health outlined in the OPHS include Capacity and Partnership and Collaboration.<sup>1</sup> The Principle of Capacity includes the areas of organizational structures and processes; workforce planning, development, and maintenance; information and knowledge systems; and financial resources. The Principle of Partnership and Collaboration refers to fostering partnerships and collaborating

with community partners, and creating supportive environments for health through community and citizen engagement.<sup>1</sup> The Organizational Standards will assist boards of health to operate according to the Principles outlined in the OPHS that are relevant to governance and management.

## Framework of the Organizational Standards

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The Ontario Public Health Organizational Standards document outlines the requirements for boards of health and the management practices of each public health unit.

The Organizational Standards requirements are grouped into the following categories:

- Board Structure
- Board Operations
- Leadership
- Trusteeship
- Community Engagement and Responsiveness
- Management Operations

Within each category, there are varying numbers of requirements. These are either new requirements, which are based on best practice advice from the literature on governance and administration or have been transferred from the HPPA and its regulations. These have been consolidated within this document to assist boards of health to have a complete understanding of the requirements they are obligated to meet in the areas of governance, management and administration. Each requirement identifies whether it is a new requirement or originates from the HPPA or its regulations.

To ensure consistency, the obligations under the HPPA or its regulations are written exactly as they appear in the original source documents, along with the specific section numbers for ease of referencing back to the original source.

## Organizational Standards Categories

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Following is a description of the concepts that are addressed in the requirements within each category. The first five categories lay out the requirements that apply directly to boards of health governing bodies. The final category, Management Operations, relates to the responsibilities that will be carried out by the administration of each health unit, under the senior executives who report to the governing body.

### 1. Board Structure

Boards of health operate through a formal structure that supports governance through a set of expectations regarding membership, size, terms of office, reporting relationships, and other structural features.

### 2. Board Operations

In order to ensure good governance, board of health members must be aware of current and emerging best practices regarding board operations, which include the establishment of by-laws, as well as policies and

practices related to the conduct of meetings. Board of health members must also have an understanding of their duties and responsibilities as individuals and as a group, and must have an understanding of evaluation to improve their effectiveness as a board.

### 3. Leadership

Leadership functions at the board of health level require that the board of health assess and take action to improve its governance processes to accomplish its objectives of strategic direction setting, promotion of appropriate ethics and values within the organization, effective organizational performance management and accountability, and effective coordination of board of health activities at all levels of the organization.

While the board of health has responsibility for strategic direction setting, the management team has a related responsibility in operational planning to support the board of health's strategic priorities and objectives. A strong strategic plan will recognize internal and external forces for and against change, incorporate strategies to overcome resistance to change and address gaps, and include a commitment to action steps to adapt to changes.

### 4. Trusteeship

In carrying out their functions, board of health members must fulfill fiduciary duties of care, loyalty, and good faith. While the board of health as the governing body typically delegates the day-to-day management of the public health unit to the MOH, CEO and other senior management, board members retain responsibility for oversight and monitoring of the organization's operations and performance.

Carrying out fiduciary duties requires that board members exercise duty of care, which is the duty to exercise appropriate diligence and make decisions that are informed, and the duty of loyalty, which is the duty to put the interests of the organization before those of the individual.

As part of their duty of loyalty, board members also need to act in good faith, which involves acting with honesty of purpose and in accordance with evolving corporate governance best practices.

### 5. Community Engagement and Responsiveness

Public health units are expected to undertake their operational duties in a way that demonstrates an understanding of the local community's context, openness to the community and its needs, and innovation to address emerging needs or gaps in services.

Because public health is rooted in community-based practice; partnerships with all types of organizations are a necessary part of the operational practice of a public health unit. The effectiveness of these partnerships will depend on the work involved in engaging local communities, collaborating with community partners, monitoring and evaluating these partnerships, and public health unit involvement in networking and local planning within the community.

This section contains requirements which refer to both community partners and stakeholders. To be clear, community partners include the agencies, organizations and groups which the board of health works directly with, or partners with or consults with in the design or delivery of programs and services. In the OPHS, the list of community partners includes the voluntary sector, non-governmental organizations, local associations, community groups, networks, coalitions, academia, government bodies, the private sector

and others. Stakeholders is a broader category which includes all of the types of community partners noted above as well as clients, the general public, the media and staff. Anyone with an interest in public health could be considered a stakeholder.

## 6. Management Operations

A strong organization will have administrative practices that support transparency and accountability, and demonstrate organizational effectiveness and due diligence in exercising day-to-day responsibilities.

Strong organizations will also have an operational planning process that describes how the strategic directions, priorities and objectives of the organization will be achieved in concrete terms within a specified timeframe. The resulting operational plan may include several separate documents, such as an HR strategy, an IT strategy, financial projections, program planning framework, and an evaluation framework. Together, this information provides an overall picture of how the public health unit will use available resources to meet objectives.

The requirements within the Management Operations category relate to the administrative functions in terms of:

- Financial management;
- Information management;
- Communication strategies;
- Human resources planning and management; and
- Program management.

# Part II: The Ontario Public Health Organizational Requirements

## 1. Board Structure

### Goal/Objective

To ensure that the structure of the board of health facilitates effective governance and respects the required partnership with municipalities as well as the need for local flexibility in board structure.

### Requirements

#### 1.1 Definition of a board of health

*There shall be a board of health for each public health unit. (HPPA, s.48) A board of health is composed of the members appointed to the board under this Act and the regulations. (HPPA, s.49 (1)) The term of office of a municipal member of a board of health continues during the pleasure of the council that appointed the municipal member but, unless ended sooner, ends with the ending of the term of office of the council. (HPPA, s.49(7))* (Does not apply to all municipalities – see HPPA s.49(9) and (10) for exceptions)

#### 1.2 Number of members on a board of health

*There shall be not fewer than three and not more than thirteen municipal members of each board of health. (HPPA, s.49(2))* (Does not apply to all municipalities – see HPPA s.49(9) and (10) for exceptions)

#### 1.3 Right to make provincial appointments

*The Lieutenant Governor in Council may appoint one or more persons as members of a board of health, but the number of members so appointed shall be less than the number of municipal members of the board of health. (HPPA, s.49(3))* (Does not apply to all municipalities – see HPPA s.49(9) and (10) for exceptions)

*A member of a board of health appointed by the Lieutenant Governor in Council may be appointed for a term of one, two or three years. (HPPA, s.51(1))*

#### 1.4 Board of health may provide public health services on reserve

*A board of health for a public health unit and the council of the band on a reserve within the public health unit may enter into an agreement in writing under which (a) the board agrees to provide health programs and services to the members of the band; and (b) the council of the band agrees to accept the responsibilities of the council of a municipality within the public health unit. An appointment under this section may be for one, two or three years. (HPPA, s.50 (1) and (4))*

*The council of the band that has entered into the agreement has the right to appoint a member of the band to be one of the members of the board of health for the public health unit.*

*The councils of the bands of two or more bands that have entered into agreements under HPPA, s.50(1) have the right to jointly appoint a person to be one of the members of the board of health for the public health unit instead of each appointing a member under HPPA, s.50(2). (HPPA, s. 50(2) and (3))*

**1.5 Employees may not be board of health members**

*No person whose services are employed by a board of health is qualified to be a member of the board of health. (HPPA, s.51(3))*

**1.6 Corporations without share capital**

*Every board of health is a corporation without share capital (i.e., Corporations Act and Corporations Information Act do not apply). (HPPA, s.52(1) and (2)) (Does not apply to all municipalities – see HPPA s.55 for exceptions)*

**1.7 Election of the board of health chair**

*At the first meeting of a board of health in each year, the members of the board shall elect one of the members to be chair and one to be vice-chair of the board for the year. (HPPA, s.57(2)) (Does not apply to all municipalities – see HPPA s.55 for exceptions)*

**1.8 Municipal membership**

*The number of municipal members per municipality for specific boards of health is set out. (HPPA, Reg.559)*

## 2. Board Operations

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### Goal/Objective

To enable boards of health to operate in a manner that promotes an effective board, effective communication and transparency.

### Requirements

#### 2.1 Remuneration of board of health members

*A board of health shall pay remuneration to each member of the board of health on a daily basis and all members shall be paid at the same rate. A board of health shall pay the reasonable and actual expenses of each member of the board of health. The rate of the remuneration paid by a board of health to a member of the board of health shall not exceed the highest rate of remuneration of a member of a standing committee of a municipality within the public health unit served by the board of health, but where no remuneration is paid to members of such standing committees the rate shall not exceed the rate fixed by the Minister and the Minister has power to fix the rate. (HPPA, s.49(4), (5), and (6)) (Does not apply to all municipalities – see HPPA s.49(9) and (10) for exceptions)*

*HPPA, s.49(4) and (5) do not authorize payment of remuneration or expenses to a member of a board of health, other than the chair, who is a member of the council of a municipality and is paid annual remuneration or expenses, as the case requires, by the municipality. (HPPA, s.49(11))*

#### 2.2 Informing municipalities of financial obligations

*A board of health shall give annually to each obligated municipality in the public health unit served by the board of health a written notice that complies with the following requirements:*

- *The notice shall specify the amount that the board of health estimates will be required to defray the expenses referred to in HPPA, s.72(1) for the year specified in the notice.*
- *If the obligated municipalities in the public health unit have entered into an agreement under HPPA, s.72(3) respecting the proportion of the expenses referred to in HPPA, s.72(1) to be paid by each of them, the notice shall specify the amount for which the obligated municipality is responsible in accordance with the agreement.*
- *If the obligated municipalities in the public health unit have not entered into an agreement under HPPA, s.72(3) respecting the proportion of the expenses referred to in HPPA, s.72(1) to be paid by each of them, the notice shall specify the amount for which the obligated municipality is responsible in accordance with the regulations.*
- *The notice shall specify the times at which the board of health requires payments to be made by the obligated municipality and the amount of each payment required to be made. (HPPA, s.72(5))*

**2.3 Quorum**

*A majority of the members of a board of health constitutes a quorum of the board. (exceptions apply) (HPPA, s.54)*

**2.4 Content of by-laws**

*A board of health shall pass by-laws respecting, (a) the management of its property; (b) banking and finance; (c) the calling of and proceedings at meetings; and (d) the appointment of an auditor.*

*A board of health may pass by-laws respecting, (a) the appointment, duties and removal of officers (other than the medical officer of health or an associate medical officer of health) and employees, and the remuneration, pensions and other benefits of officers and employees; and (b) any other matter necessary or advisable for the management of the affairs of the board of health. (HPPA, s.56(1) and (2))*

**2.5 Minutes, by-laws and policies and procedures**

*A board of health shall keep or cause to be kept minutes of its proceedings and the text of the by-laws and resolutions passed by it. (HPPA, s.58)*

**2.6 Appointment of a full-time medical officer of health**

*Every board of health (a) shall appoint a full-time medical officer of health; and (b) may appoint one or more associate medical officers of health, of the board of health. If the position of medical officer of health of a board of health becomes vacant, the board of health and the Minister, acting in concert, shall work expeditiously towards filling the position with a full-time medical officer of health. (HPPA, s.62(1) and (2))*

**2.7 Appointment of an acting medical officer of health**

*Where (a) the office of medical officer of health of a board of health is vacant or the medical officer of health is absent or unable to act; and (b) there is no associate medical officer of health of the board or the associate medical officer of health of the board is also absent or unable to act, the board of health shall appoint forthwith a physician as acting medical officer of health. (HPPA, s.69(1))*

**2.8 Dismissal of a medical officer of health**

*A decision by a board of health to dismiss a medical officer of health or an associate medical officer of health from office is not effective unless, (a) the decision is carried by the vote of two-thirds of the members of the board; and (b) the Minister consents in writing to the dismissal. A board of health shall not vote on the dismissal of a medical officer of health unless the board has given to the medical officer of health (a) reasonable written notice of the time, place and purpose of the meeting at which the dismissal is to be considered; (b) a written statement of the reason for the proposal to dismiss the medical officer of health; and (c) an opportunity to attend and to make representations to the board at the meeting. (HPPA, s.66(1) and (2))*

## 2.9 Reporting relationship of the medical officer of health to the board of health

*The medical officer of health of a board of health reports directly to the board of health on issues relating to public health concerns and to public health programs and services under this or any other Act. The medical officer of health of a board of health is responsible to the board for the management of the public health programs and services under this or any other Act. (HPPA, s.67(1) and (3))*

*The medical officer of health of a board of health is entitled to notice of and to attend each meeting of the board and every committee of the board, but the board may require the medical officer of health to withdraw from any part of a meeting at which the board or a committee of the board intends to consider a matter related to the remuneration or the performance of the duties of the medical officer of health. (HPPA, s.70)*

## 2.10 Board of health policies

The board of health shall develop and implement policies or by-laws as applicable regarding the functioning of the governing body, including:

- Use of sub-committees, which includes a process for establishing sub-committees and the requirement for the development of Terms of Reference (if sub-committees are used);
- Frequency of meetings;
- Rules of order for meeting procedures, including recognizing delegations to meetings and conditions for special meetings of the board;
- Preparation of meeting agenda and materials;
- Preparation of minutes and other record-keeping;
- Selection of officers (i.e., executive committee members)
- Selection of board members based on skills, knowledge, competencies and representativeness of the community, where boards of health are able to recommend the recruitment of members to the appointing body;
- Remuneration and allowable expenses for board members;
- Procurement of external advisors to the board, such as lawyers and auditors (if applicable);
- Conflict of interest;
- Confidentiality;
- MOH and executive officers (where applicable) selection process, remuneration, and performance review; and
- Delegation of the MOH duties during short absences such as during a vacation.

In addition, the board of health shall ensure that board of health by-laws, and policies and procedures are reviewed and revised as necessary, and at least every two years.

## 3. Leadership

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### Goal/Objective

To ensure the board of health members develop a shared vision for the organization, use a proactive, problem solving approach to establishing the organization's strategic directions, and take responsibility for governing the organization to achieve their desired vision.

### Requirements

#### 3.1 Board of health stewardship responsibilities

The board of health shall provide governance direction to the administration and ensure that the board remains informed about the activities of the organization on the following:

- The delivery of the OPHS and its Protocols;
- Organizational effectiveness through evaluation of the organization and strategic planning;
- Stakeholder relations and partnership building;
- Research and evaluations, including ethical review;
- Compliance with all applicable legislation and regulations;
- Workforce issues, including recruitment of the MOH and any other senior executives (i.e., CEO where applicable);
- Financial management, including procurement policies and practices; and
- Risk management.

#### 3.2 Strategic plan

The board of health shall have a strategic plan and shall ensure that it:

- Expresses the philosophy/mission, a values statement, and the goals and objectives of the board of health;
- Describes how equity issues will be addressed in the delivery and outcomes of programs and services;
- Describes how the outcomes of the Foundational Standard in the 2008 OPHS (or as current), will be achieved;
- Establishes policy direction regarding a performance management and quality improvement system;
- Considers organizational capacity;
- Establishes strategic priorities for the organization that address local contexts and integrate local community priorities;
- Covers a 3 to 5 year timeframe;
- Includes the advice and input of staff, and community partners; and
- Is reviewed at least every other year and revised as appropriate.

## 4. Trusteeship

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### Goal/Objective

To ensure that board of health members have an understanding of their fiduciary roles and responsibilities, that their operations are based on the principles of transparency and accountability, and that board of health decisions reflect the best interests of the public's health.

### Requirements

#### 4.1 Transparency and accountability

The board of health shall operate in a transparent and accountable manner by ensuring that staff and community partners have access to information about board decisions and processes in a timely manner.

The board of health shall develop and implement policies and practices regarding:

- Criteria for holding closed board or committee meetings;
- Public access to key organizational documents including the strategic plan, by-laws, policies and procedures, and minutes of board meetings.

#### 4.2 Board of health member orientation and training

The board of health shall ensure that board of health members are aware of their roles and responsibilities and emerging public health issues and trends by ensuring the development and annual implementation of a comprehensive orientation plan for new board members and a continuing education program for continuing board members.

Orientation and continuing education activities shall occur on an on-going basis and shall include information on the following topics:

- The structure, vision, mission goals and objectives of the public health unit;
- Overview of the strategic plan, the planning process, its relationship to the operational plan, and performance monitoring;
- Community demographics overview, including information on social and cultural diversity;
- Program and service overview, including organizational emergency preparedness planning;
- Provincial government structure and the funding streams of the three ministries;
- The duties and responsibilities of board members, including requirement to attend board meetings, advanced review of meeting materials, understanding of board of health policies and procedures, and understanding of public health issues;
- Board members' fiduciary responsibilities in terms of trusteeship, due diligence, avoiding conflict of interest, maintaining confidentiality, strategic oversight, ethical and compliance oversight, stakeholder engagement, MOH (and executive officers, where applicable) compensation, risk management oversight and succession planning; and
- Opportunities for board members to participate in conferences or seminars that are sponsored or hosted by other organizations.

### **4.3 Board of health self-evaluation**

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. This may be supplemented by evaluation by key partners and/or stakeholders.

The self-evaluation process shall include consideration of whether:

- Decision-making is based on access to appropriate information with sufficient time for deliberations;
- Compliance with all federal and provincial regulatory requirements is achieved;
- Any material notice of wrongdoing or irregularities is responded to in a timely manner;
- Reporting systems provide the board with information that is timely and complete;
- Members remain abreast of major developments in governance and public health best practices, including emerging practices among peers; and
- The board as a governing body is achieving its strategic outcomes.

## 5. Community Engagement and Responsiveness

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### Goal/Objective

To ensure that the board of health is responsive to the needs of the local communities and shows respect for the diversity of perspectives of its communities in the way it directs the administration of the health unit in planning, operating, evaluating and adapting its programs and services.

### Requirements

#### 5.1 Community engagement

The board of health shall ensure that the administration develops and implements a community engagement strategy which includes:

- The provision of information to the public on the board of health's mission, roles, processes, programs and activities to improve the health of its communities;
- The dissemination of results of population health assessments to its communities;
- Providing all information noted above in formats that are accessible to everyone in local communities, and are available through a variety of methods, including a website; and
- The recruitment and engagement of community partners and the public to participate in the development of the strategic and operational plans for the board of health, and in the evaluation of programs and services.

#### 5.2 Stakeholder engagement

The board of health shall ensure that the administration develops and implements a stakeholder engagement strategy which includes:

- Establishing and participating in collaborative partnerships and coalitions which address public health issues with non-health sector partners such as community planning organizations, boards of education, social housing authorities, labour organizations, children and youth services and local chambers of commerce;
- Collaborative relationships with key health sector partners, including but not limited to the chief executive officer(s) of the local health integration network(s) (LHINs), hospital administrators, long-term care facility administrators, community health centre administrators and community care access centre administrators, to identify mechanisms for collaboration and coordination in planning and service delivery;
- Establishing relationships with schools of public health and/or other related academic programs to promote the development of qualified workers for public health; and
- Monitoring and evaluating these partnerships to determine their effectiveness and identify and address gaps.

#### 5.3 Contribute to policy development

The board of health shall contribute to the development and/or modification of healthy public policy, as described in the Ontario Public Health Standards, 2008 (or as current), by facilitating community involvement and engaging in activities that inform the policy development process.

#### **5.4 Public reporting**

The board of health shall produce an annual financial and performance report to the general public, with a description of the mission, roles, processes, programs and operation of the public health unit and performance indicators, to ensure transparency and accountability.

#### **5.5 Client service standards**

The board of health shall ensure the administration develops and implements a set of client service standards which will articulate the organization's commitment to provide services that are accessible and timely for clients, community partners and the general public. Client service standards shall include:

- Set times for responsiveness to enquiries;
- Accessibility of programs and services in terms of locations, hours of service, and language; and
- Provision of public information in a manner that is timely and accessible, in multiple formats.

## 6. Management Operations

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### Goal/Objective

To ensure that the administration of the board of health uses a proactive, problem solving approach to establishing its operational directions, demonstrates its organizational priorities and objectives through its actions on program delivery, and functions in an efficient and effective manner.

Note that the requirements in this section require that the board delegate tasks to the senior staff of the health unit, described here as “the administration.” This is further defined in the introduction, within the Management Structures section.

### Requirements

#### 6.1 Operational plan

The board of health shall ensure that the administration establishes an operational plan for the organization which:

- Describes the composition, responsibilities and function of the public health unit;
- Documents the internal processes for managing day-to-day operations of programs and services to achieve the required board of health outcomes as per OPHS;
- Demonstrates that the operational activities of the public health unit are aligned with the board of health’s goals, objectives and priorities, as described in the strategic plan;
- Includes objectives, activities, timeframes, responsibilities, intended results, monitoring processes, an organizational chart and internal reporting requirements;
- Contains planned activities based on an assessment of its communities’ needs;
- Demonstrates efforts to minimize barriers to access; and
- Describes the monitoring of key performance indicators to support continuous quality improvement and evidence-informed public health practice.

The development of the operational plan shall involve staff at all levels of the organization and include input from community partners and shall be reviewed and updated at least annually, or more often as required by local circumstances, with the date of the most recent revisions noted.

Achievement of the operational plan shall be monitored and reported in status reports on a quarterly basis to board members and staff.

#### 6.2 Risk management

The board of health shall ensure that the administration monitors and responds to emerging issues and potential threats to the organization, from both internal and external sources, in a timely and effective manner. Risk management is expected to include but is not limited to: financial risks, HR succession and surge capacity planning, operational risks, and legal issues.

#### 6.3 Medical officer of health provides direction to staff

*The employees of and the persons whose services are engaged by a board of health are subject to the direction of and are responsible to the medical officer of health of the board if their duties relate to the delivery of public health programs or services under this or any other Act. (HPPA, s.67(2))*

**6.4 Eligibility for appointment as a medical officer of health**

*No person is eligible for appointment as a medical officer of health or an associate medical officer of health unless (a) he or she is a physician; (b) he or she possesses the qualifications and requirements prescribed by the regulations for the position; and (c) the Minister approves the proposed appointment. (HPPA, s.64)*

**6.5 Educational requirements for public health professionals**

*The educational and experiential qualifications of boards of health staff are specified for the positions of business administrator, public health dentist, dental hygienist, public health inspector, public health nurse, and public health nutritionist. (HPPA, Reg.566)<sup>8</sup>*

**6.6 Financial records**

*The board of health shall keep or cause to be kept (a) books, records and accounts of its financial affairs; (b) the invoices, receipts and other documents in its possession that relate to the financial affairs of the board.*

*The board of health shall cause to be prepared statements of its financial affairs in each year including but not limited to (a) an annual statement of income and expenses; (b) an annual statement of assets and liabilities; and (c) an annual estimate of expenses for the next year. (HPPA, s.59(1) and (2))*

**6.7 Financial policies and procedures**

The board of health shall ensure that the administration implements appropriate financial management and oversight which ensures that the following are in place:

- A plan for the management of physical and financial resources;
- A process for internal financial controls, which is based on generally accepted accounting principles;
- A process to ensure that areas of variance are addressed and corrected;
- A procedure to ensure that the procurement policy is followed across all programs/services areas;
- A process to ensure the regular evaluation of the quality of service provided by contracted services, in accordance with contract standards;
- A process to inform the board of health regarding resource allocation plans and decisions, both financial and workforce related, that are required to address shifts in need and capacity; and
- A budget forecast for the current fiscal year that does not project a deficit.

**6.8 Procurement**

The board of health shall comply with Section 270(2) of the *Municipal Act, 2001*,<sup>9</sup> which requires that the board of health ensures that the administration adopts policies with respect to its procurement of goods and services.

Such policies shall include:

- The types of procurement processes that shall be used;
- The goals to be achieved by using each type of procurement process;
- The circumstances under which each type of procurement process shall be used;
- The circumstances under which a tendering process is not required;

- The circumstances under which in-house bids will be encouraged as part of the tendering process;
- How the integrity of each procurement process will be maintained;
- How the interests of the board, the public and persons participating in the procurement process will be protected; and,
- How and when the procurement processes will be reviewed to evaluate their effectiveness.

The board of health is expected to implement procurement policies and practices that align with those of the relevant municipality as appropriate.

### **6.9 Capital funding plan**

*A board of health may acquire and hold real property for the purpose of carrying out the functions of the board and may sell, exchange, lease, mortgage or otherwise charge or dispose of real property owned by it. HPPA, s.52(3) does not apply unless the board of health has first obtained the consent of the councils of the majority of the municipalities within the public health unit served by the board of health. (HPPA, s.52(3) and (4))*

The board of health that owns its own building(s) shall maintain a capital funding plan, which includes policies and procedures to ensure that funding for capital projects is appropriately managed and reported.

### **6.10 Service level agreements**

Where a board of health functions as part of a municipal or regional government and is required to contribute financially to the corporate provision of services (e.g., IT, HR, financial management services), the board of health shall ensure that the administration negotiates a service level agreement with its local government which includes a description of the scope, volume and timeliness of services to be provided for a specific cost.

### **6.11 Communications strategy**

The board of health shall ensure that the administration develops an overall communication strategy that is complementary to the program specific communication strategies required in the OPHS and its Protocols, and addresses both external and internal audiences. The communication strategy shall include:

- Guidelines for sharing information with community partners and staff;
- A plan to ensure consistency in messaging at all levels, to all audiences;
- Dissemination plans to disseminate relevant research findings for each approved research project proposal;
- Guidelines for use of relationships with media channels (e.g., print, radio, television, web) to share health information with general public and targeted populations or audiences;
- Plan for use of multiple modalities to ensure accessibility;
- Strategies for educating community partners and the public about key public health issues; and
- An internal communication strategy, including the posting of minutes of senior management team meetings, which informs staff of significant management decisions.

### 6.12 Information management

The board of health shall ensure that the Medical Officer of Health, as the designated health information custodian under the Personal Health Information Protection Act, maintains information systems that support the organization's mission and workforce by providing infrastructure for data collection/analysis, program management, administration and communications.

The board of health shall ensure that the Medical Officer of Health establishes, maintains and implements policies and procedures related to data collection and records management, which ensure:

- Compliance with all applicable legislation, regulations and policies, including the HPPA, *Municipal Freedom of Information and Protection of Privacy Act (MFIPPA)*,<sup>10</sup> and *Personal Health Information Protection Act (PHIPA)*<sup>11</sup> to the management of all personal information and personal health information in board of health records;
- Data quality in the creation and collection of data;
- Confidentiality in how records are used and accessed;
- Use of current and appropriate security features, including strong encryption of personal health information during transfers and when stored on mobile devices;
- A records maintenance process that includes remediation of errors;
- Appropriate records retention process that varies by type of record;
- Secure disposal of records; and
- That the purposes and appropriate uses of data being created are communicated to and respected by staff and management who collect, enter, store, analyze, use and/or destroy the data.

This requirement applies to all information that the board of health has in its control, including personal information and personal health information.

### 6.13 Research ethics

The board of health shall ensure that the administration establishes, maintains and implements policies and procedures related to research ethics that reflect accepted standards of practice.

### 6.14 Human resources strategy

The board of health shall ensure that the administration establishes a human resources strategy, based on a workforce assessment which considers the competencies, composition and size of the workforce, as well as community composition, and includes initiatives for the recruitment, retention, professional development and leadership development of the public health unit workforce.

The board of health shall ensure that the administration establishes and implements written human resource policies and procedures which are made available to staff, students, and volunteers. All policies and procedures shall be regularly reviewed and revised, and include the date of the last review/revision. Written policies and procedures shall be maintained concerning:

- Orientation of public health unit staff;
- The availability of job standards and position descriptions for staff;
- A process to ensure that staff meet qualifications for their positions, job classifications and licensure (as required);

- Contents of a personnel file and provisions for access; complete personnel files shall be maintained for each staff member, with appropriate policies and practices regarding the confidentiality of personnel information;
- Occupational health and safety policies;
- Recruitment and retention strategies, including workplace health practices;
- A code of conduct;
- Compensation policy;
- Reporting relationships;
- Discipline and labour relation policies;
- Staff performance evaluation processes; and
- Succession planning.

### **6.15 Staff development**

The board of health shall ensure that the administration develops a workforce development plan which identifies the training needs of staff, including discipline specific and management training, and encourages opportunities for the development of core competencies and partnerships with academic institutions.

The board of health shall ensure that the administration provides formal and informal opportunities for leadership development, such as educational programs, membership in professional associations, coaching and mentoring, for staff at all organizational levels and with consideration to equity and fairness.

The board of health shall ensure that the administration fosters an interest in public health practice for future health professionals by supporting student placements.

### **6.16 Professional practice support**

The board of health shall support a culture of excellence in professional practice for all regulated and unregulated health professions that ensures inter-professional collaboration and learning, and that staff are able to comply with professional regulatory body requirements where applicable. A range of models could be used, including the designation of professional practice leads.

Effective January 2013, boards of health are required to designate a Chief Nursing Officer (CNO) to be responsible for nursing quality assurance and nursing practice leadership.\*

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\* Further work will be undertaken during 2011 with the Registered Nurses Association of Ontario (RNAO) and the Association of Nursing Directors and Supervisors in Official Health Agencies in Ontario (ANDSOOHA) to define the role and requirements of the CNO position within a public health context. Implementation expectations and the associated resource implications will be identified and addressed as part of the development of the model.

## Part III: References

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- <sup>7</sup> Bakes-Martin R, Corso LC, Landrum LB, Fisher VS, Halverson PK. Developing national performance standards for local public health systems. *J Public Health Manag Pract*. 2005;11(5): 418-421.
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- <sup>11</sup> *Personal Health Information Protection Act*, S.O. 2004, c. 3, Sch. A. Available from: [http://www.e-laws.gov.on.ca/html/statutes/english/elaws\\_statutes\\_04p03\\_e.htm](http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_04p03_e.htm).

**MIDDLESEX-LONDON HEALTH UNIT  
REPORT NO. 094-11**

TO: Chair and Members of the Board of Health  
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health  
DATE: 2011 October 20

**Medical Officer of Health Activity Report – October**

**Recommendation**

It is recommended that Report No. 094-11 re Medical Officer of Health Activity Report – October be received for information.

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

Work continued on the drafting of the 2012 proposed budget. This included several meetings of the Senior Management Team (Directors Committee) and is the subject of Board of Health Report 092-11, this agenda. In addition, the Senior Management Team began development of objectives for the Board of Health approved 3 Year Strategic Plan Directions.

Collective Bargaining continued with a conciliation meeting involving the Ontario Nurses Association (ONA). While an agreement was not reached, both sides did agree to continue meeting. Further information regarding this situation will be provided at the October 20, 2011, Board of Health meeting.

The Ontario Council on Community Health Accreditation conducted its first annual follow-up compliance visit. There were numerous activities undertaken to prepare for this review which were coordinated by Mr. Ross Graham, Manager, Special Projects. Further details are provided in Board of Health Report 097-11, this agenda.

An information session entitled “What’s New in Public Health” was conducted for Health Care Providers. The agenda for this initiative is attached (Appendix A). The Medical Officer of Health emceed the event with staff presentations being made by Public Health Nurses, Ms. Melissa Rennison and Ms. Bernadette Garrity; Health Unit Dental Consultant, Dr. Maria vanHarten; and Dr. Bryna Warshawsky, Associate Medical Officer of Health and Director, Oral Health, Communicable Disease and Sexual Health Services.

Other meetings involving the Medical Officer of Health since the last Board meeting included: Attendance at the Ontario Public Health Association Annual meeting and conference; a meeting with Regional HIV/AIDS Connection (RHAC) senior staff concerning Needle Exchange program funding; attendance at a RHAC Board of Directors meeting. The Medical Officer of Health has been appointed Chair of the Healthline.ca Board of Directors. The Medical Officer of Health took a weeks holidays since the last Board of Health meeting.

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

**MIDDLESEX-LONDON HEALTH UNIT  
REPORT NO. 095-11**

TO: Chair and Members of the Board of Health  
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health  
DATE: 2011 October 20

**2011 Staff Immunization Program Update**

**Recommendation**

It is recommended Report No. 095 -11 re 2011 Staff Immunization Program Update be received for information.

**Background**

The Health Unit's Staff Immunization Program was transferred from the Communicable Disease and Sexual Health Service Area to the Occupational Health and Safety Program in June 2010. Since the program transfer, a number of changes have been implemented and further administrative enhancements are planned, with a view to better monitor, track and encourage increased staff participation in the program.

In September 2009, the Staff Immunization and TB Skin Testing Policy was updated to include Seasonal Influenza vaccine. Over 90% of staff had Pandemic H1N1 vaccine in 2009-2010. However, seasonal flu vaccine was poorly received that year. During 2010-2011, just over 60% of all (approximately 356 full, part-time, casual and contract) staff received seasonal influenza vaccine.

**Program Improvements and Enhanced Promotion Strategies**

Following the transfer of the Staff Immunization Program, a preliminary review of the program was conducted to determine areas of strength and opportunities for improvements. As a result of this review a number of actions were taken:

- The Staff Immunization Nurse provided presentations to the Directors and Joint Occupational Health and Safety Committees regarding the most current information about the influenza virus and how it spreads, along with key aspects of the Staff Immunization Policy as it relates to the responsibilities of the Employer and the Committee under the Occupational Health and Safety Act.
- The Staff Immunization Nurse attended 14 Team/Service Area meetings to discuss the policy requirements, encourage greater participation and respond to any staff concerns regarding the program
- As Adacel/Boostrix is 'Highly Recommended' for all staff working with pregnant women and children under the age of one year, staff working with this population were identified and encouraged to update their immunization to meet this requirement.
- A number of limitations to the confidential staff immunization (SIM) database were identified. While this database has served as an effective tool for electronically documenting the immunization status of all staff members, programming to allow for dynamic and comprehensive statistical reporting was not in place. The SIM database has been redesigned to fill this gap and allow for tracking the number of staff receiving various recommended vaccines and tests. The update also allows us to more accurately create reports outlining staff response to vaccines.

**Seasonal Influenza**

All staff members are required to receive the seasonal influenza vaccine annually. Staff uptake of this vaccine is moderate compared to long-term care facilities (57% in 2010-2011) and hospitals (36% in 2010-2011). These statistics were reported under Board Report No. 082-11 at the September 11, 2011, meeting. Given that all Health Unit staff members have contact with the general public either personally or professionally and that many of those same staff members work with vulnerable individuals in the community, it is important for them to be protected each year with the seasonal influenza vaccine. Obviously, the ideal would be to have full staff participation.

To that end, a promotional strategy has been enacted for the 2011-2012 influenza season. This strategy includes staff education sessions, promotional posters and the scheduling of five (5) staff immunization clinics, offered at each Health Unit office. These clinics are intended to increase the opportunities for staff to avail themselves of the vaccine. Staff members who receive the vaccine will be given a green silicone bracelet with the slogan 'You're in good hands --- I got my flu shot'. The slogan was the creation of Eleanor Paget, Public Health Nurse, with the Infectious Disease Program.

### **Summary**

With the introduction of these new strategies to promote the vaccine, it hoped that the number of staff protecting themselves from seasonal influenza will increase. Other plans are currently underway for the continued improvement of this program that includes a review of the policy and the development of a strategy to better target new employees.

The staff immunization program is striving to meet the needs of the employees of the Health Unit. Education about the importance of vaccines and the opportunity for staff to easily access the vaccines and tests to protect themselves and the people they serve are being provided.

Ms. Barb Sussex, Staff Immunization Nurse, and Ms. Vanessa Bell, Manager, Privacy and Occupational Health & Safety, will be in attendance at the October 20<sup>th</sup> Board meeting to address any questions regarding this report.

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

**This report addresses** Policy 8-060: Immunization and TB Skin Testing Recommendations for Staff and CERV Team Members, as outlined in the MLHU Administration Policy Manual.

**MIDDLESEX-LONDON HEALTH UNIT  
REPORT NO. 096-11**

TO: Chair and Members of the Board of Health  
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health  
DATE: 2011 October 20

**2011-2012 Influenza Vaccination Program Plans**

***Recommendation***

*It is recommended that Report No. 096-11 re **2011-2012 Influenza Vaccination Program Plans** be received for information.*

**Background**

At the September 2011 Board of Health meeting, the Board reviewed Report No. 082-11 entitled, 2010-11 Influenza Season in Middlesex-London, which outlined the severity of the last influenza season. During the 2010-2011 season, 161 hospitalizations and 17 deaths occurred among Middlesex-London residents with laboratory-confirmed influenza. Routine influenza vaccination is the most important strategy to prevent influenza illness and its complications which include pneumonia, worsening of underlying medical conditions, hospitalization and death. Since the introduction of the Universal Influenza Immunization Program in 2000, all people six (6) months and over who live or work in Ontario have been eligible for free influenza vaccine. This report will describe the Health Unit's plans for the 2011-2012 influenza vaccination season and the changes in the vaccination program for this year.

**Publicly Funded Influenza Vaccines**

Three influenza vaccines are being publicly funded through the Ontario Universal Influenza Immunization Program. Two (2) of the vaccines (Vaxigrip and Agriflu) can be used for anyone 6 months of age and older. These products will be used at Health Unit clinics and will be distributed by the Health Unit to physicians, nurse practitioners, hospitals, nursing agencies providing workplace clinics and to nursing homes and retirement homes for their staff members and for some residents in retirement homes.

A limited supply of a third vaccine, Flud, will be available for those 65 years of age and older. Flud contains a helper substance, called an adjuvant, which may induce a better immune response in those 65 year of age and older who generally do not respond as well to influenza vaccine as younger individuals. This vaccine will be provided by the Health Unit for individuals 65 years of age and older who live in nursing homes and some residents of retirement homes.

**Health Unit Clinics**

The Health Unit is again offering influenza immunization clinics in several locations in Middlesex County and in the City of London. A total of 15 community clinics are being provided as well as a drive-through influenza clinic at the Health Unit for physically challenged individuals, those with immune system disorders, and people for whom large crowds would be difficult. A list of the 2011-2012 clinics can be found in Appendix A. In collaboration with staff members from Family Health Services, additional clinics will be provided at certain high risk locations such as shelters and subsidized-housing complexes. The Seasonal Influenza Vaccine Information Sheet – 2011-2012 being used at the clinics is provided in Appendix B.

**Promotion of the Influenza Vaccine and Vaccination Clinics**

A poster promoting the influenza vaccine and directing the public to the Health Unit's web site for clinic locations and dates has been developed and is being placed in areas such as community arenas, areas with community bulletin boards and public libraries (Appendix C). Information, including the list of community clinics, is being sent to parents through the schools to encourage influenza vaccination for all family members. A yellow box entitled, Influenza Info, has been created on the front page of the Health Unit web site for health care professionals and the general public to obtain information about influenza, the vaccine and community clinics.. The community influenza clinic schedule will be advertised in City and County newspapers beginning in mid-October.

## Changes in this Year's Program

There are two changes in this year's program. Previously, children 6 to 35 months of age received a half dose (0.25 ml) of influenza vaccine. The National Advisory Committee on Immunization (NACI) is now recommending that children 6 to 35 months receive 0.5 ml per dose of influenza vaccine. The rationale for this change is the demonstration of a modest improvement in immunity with the 0.5 ml dose, without any increase in adverse effects. Now all age groups will receive the same dose of the vaccine (0.5 ml) which will make delivery of vaccinations at community clinics simpler. Children between 6 months and less than 9 years of age who have never received the seasonal influenza vaccine before, still require two doses of the vaccine (each of 0.5 ml) this season; the doses are administered at least one month apart.

In previous years, NACI recommended that persons who were allergic to eggs should not routinely receive influenza vaccines since these vaccines are manufactured using eggs. However, a growing number of studies have demonstrated that most egg-allergic persons can safely receive inactivated influenza vaccine. NACI has therefore revised its recommendations to advise that those with mild allergic reactions to eggs (eg. gastrointestinal symptoms or localized hives after eating eggs) can be vaccinated with inactivated influenza vaccine using routine practices, along with an extended period of observation following vaccination (30 minutes instead of the usual 15 minutes). Those with more severe egg allergy (eg. widespread hives, or breathing or circulatory problems after eating eggs) can also be vaccinated using a graded process where the egg allergic person receives 10% of the dose, waits 30 minutes and, if they tolerate this small dose, they then receive the remaining 90% of the dose. Only those individuals reporting a mild egg allergy will be immunized at the Health Unit's influenza clinics. Individuals with a more severe egg allergy will be advised to see their health care provider to discuss vaccination options.

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

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

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

# INFLUENZA VACCINATION CLINICS

*The influenza vaccine is free and available to anyone 6 months of age and older.  
If possible, please bring your Health Card or Driver's License*

<b>WESTERN FAIR GROUNDS "Special Events Building"</b> 316 Rectory Street, London	<b>Tuesday October 25, 2011</b> 4:00 p.m.- 8:00 p.m.
<b>SOUTH LONDON COMMUNITY CENTRE</b> 1119 Jalna Blvd., London	<b>Thursday October 27, 2011</b> 4:00 p.m.- 8:00 p.m.
<b>CHERRYHILL PUBLIC LIBRARY (located in Cherryhill Village Mall)</b> 301 Oxford Street, W London	<b>Monday October 31, 2011</b> 9:00 a.m.-1:00 p.m.
<b>KENWICK MALL</b> 51 Front Street East, Strathroy	<b>Tuesday November 1, 2011</b> 4:00 p.m.- 8:00 p.m.
<b>LORD ELGIN PUBLIC SCHOOL</b> 1100 Victoria Drive, London	<b>Thursday November 3, 2011</b> 3:30 p.m.- 7:00 p.m.
<b>LUCAN COMMUNITY MEMORIAL CENTRE</b> 263 Main Street, Lucan	<b>Friday November 4, 2011</b> 4:00 p.m.- 8:00 p.m.
<b>GLENCOE AGRICULTURAL HALL</b> 268 Currie Road, Glencoe	<b>Friday November 4, 2011</b> 4:00 p.m.- 8:00 p.m.
<b>GREEK CANADIAN CLUB</b> 965 Sarnia Road, London	<b>Thursday November 10, 2011</b> 4:00 p.m.- 8:00 p.m.
<b>CLARKE ROAD SECONDARY SCHOOL</b> 300 Clarke Road, London	<b>Saturday November 12, 2011</b> 10:00 a.m.- 3:00 p.m.
<b>LAMBETH COMMUNITY CENTRE</b> 7112 Beattie Street West, London	<b>Thursday November 17, 2011</b> 4:00 p.m.- 8:00 p.m.
<b>STRATHROY DISTRICT COLLEGIATE INSTITUTE</b> 361 Second Street, Strathroy	<b>Friday November 18, 2011</b> 4:00 p.m.- 8:00 p.m.
<b>CARLING HEIGHTS OPTIMIST COMMUNITY CENTRE</b> 650 Elizabeth Street, London	<b>Thursday November 24, 2011</b> 4:00 p.m.- 8:00 p.m.
<b>AILSA CRAIG COMMUNITY CENTRE</b> 155 Annie Ada Shipley Street, Ailsa Craig	<b>Friday November 25, 2011</b> 4:00 p.m.- 8:00 p.m.
<b>NORTH DORCHESTER OPTIMIST YOUTH CENTRE</b> 1563 Richmond Street, Dorchester	<b>Thursday December 1, 2011</b> 4:00 p.m.- 8:00 p.m.
<b>SOUTH LONDON COMMUNITY CENTRE</b> 1119 Jalna Blvd., London	<b>Saturday December 3, 2011</b> 10:00 a.m.- 3:00 p.m.

<b>MIDDLESEX-LONDON HEALTH UNIT</b> 50 King Street, London  <i>Drive-Thru Flu Clinic: For people who are physically challenged including mobility issues, those with immune system disorders, and people for whom large crowds would be difficult.</i>  <b>BY APPOINTMENT ONLY – CALL 519-663-5317 EXT. 2330</b>	<b>Saturday October 29, 2011</b> 10:00 a.m.–3:00 p.m.
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For more information about the influenza vaccine or vaccination clinics, call 519-663-5317 ext. 2330 or visit [www.healthunit.com](http://www.healthunit.com) and click on the yellow "Influenza Info" button.



\* Note: Sites are wheelchair accessible

## SEASONAL INFLUENZA VACCINE INFORMATION SHEET – 2011-2012

**Be sure to read this whole sheet carefully before receiving the influenza vaccine.**

### What is influenza?

Influenza (commonly known as “the flu”) is a respiratory infection that is caused by a virus. People with influenza quickly become ill with a cough, fever, sore throat, headache, muscle aches and tiredness. People of any age can get influenza. Most people are sick for 2 to 7 days, although the cough may last for weeks. Influenza can lead to complications such as pneumonia, hospitalization, and even death. The elderly, young children and those with long-term health issues, such as heart and lung problems, diabetes and cancer, are more likely to develop these complications. Influenza spreads easily from infected people to others through coughing and sneezing. It can also be picked-up by touching unwashed hands and from surfaces and objects such as toys.

### How well does seasonal influenza vaccine protect against influenza?

This year’s seasonal influenza vaccine provides protection against three strains of influenza, one of which is the pandemic H1N1 strain.

Protection from the influenza vaccine develops about two weeks after the shot. In most years, the vaccine works well to prevent illness from influenza in healthy children and adults. In elderly people, the vaccine helps prevent pneumonia, hospitalization and deaths from influenza. The vaccine may not work as well in people who have problems with their immune system or who are taking medication that affects their immune system, however it is still very important for these people to be vaccinated.

### Who should get the seasonal influenza vaccine and when?

Anyone six months of age and over should consider getting vaccinated to protect themselves and their families from influenza and to avoid losing time from work and school due to influenza illness. The influenza vaccine is particularly important for people at risk of getting seriously ill from influenza and people in close contact with them. **The vaccine is considered safe for women at all stages of pregnancy, and for breastfeeding mothers.**

### What are the risks from seasonal influenza vaccine?

The seasonal influenza vaccine is very safe and serious side effects are very rare. Because the influenza vaccine does not contain live virus, you cannot get flu from the vaccine. Most people who get the vaccine have either no side-effects or only mild side effects such as soreness, redness or swelling where the shot was given. Some people may get a fever, muscle aches or headache that start shortly after getting the flu shot, and last about 1 to 2 days.

- Life-threatening allergic reactions are very rare.
- An illness called Guillain-Barré Syndrome (GBS), which causes muscle paralysis, occurred after the influenza vaccine in 1976 and may occur very uncommonly after the influenza vaccine in some other influenza seasons.
- During the 2000-2001 influenza season, an “Oculo-Respiratory Syndrome” (ORS) was reported after the influenza vaccine. This syndrome began within 24 hours after vaccination and was generally mild; symptoms included red eyes, cough, wheezing, and/or swelling of the face. Some of these symptoms may be noted after the influenza vaccine.

.... See over

## How often should I get a seasonal flu shot?

The seasonal influenza vaccine is given each year. This year's vaccine contains the same strains as last year. It is important to receive the vaccine this year, even if you received it last year, in order to obtain high levels of protection that will last throughout the upcoming flu season. Children between 6 months of age and younger than 9 years of age who have **never received the seasonal** influenza vaccine before require two doses of the influenza vaccine at least 4 weeks apart. The two doses of vaccine help the child's body develop stronger protection against influenza. Everyone else only receives one seasonal influenza vaccine each year.

## Who should not get the seasonal influenza vaccine?

- Anyone who has had a serious allergic to a previous influenza vaccine.
- Tell the nurse if you have had an allergic reaction to any of the following so that you can receive the influenza vaccine that is right for you:
  - **thimerosal** - a form of mercury found in other vaccines and contact lens solution (*found in Vaxigrip and Fluviral*);
  - **neomycin** - an antibiotic (*found in Vaxigrip, Agriflu and Fluad*);
  - **kanamycin** - an antibiotic (*found in Agriflu and Fluad*).
- Infants younger than 6 months of age.
- People who are seriously ill with an infection that started recently should wait until they recover before receiving the seasonal influenza vaccine.
- People who have had severe Oculo-Respiratory Syndrome (ORS) after a past influenza vaccine that required them to be in the hospital.
- People with a history of Guillain-Barré Syndrome (GBS) that developed within 8 weeks of a past influenza vaccine.

## Before receiving the influenza vaccine, tell the nurse if you:

- Are allergic to:
  - Egg or egg products;
  - A past vaccine;
  - Thimerosal or the antibiotics neomycin or kanamycin.
- Have a bleeding disorder or are taking medication that could affect blood clotting.

## Some general information about the vaccination:

- Wearing a short sleeve shirt makes it easier for you to get your vaccine.
- You will be asked to wait in the clinic area for at least 15 minutes after the needle is given.
- Older children, adolescents and adults can consent to their own vaccinations if they are able to understand the benefits and risks of receiving and not receiving the vaccine.
- There is no cost for the influenza vaccination.

**If you have any questions about influenza or the influenza vaccine, please discuss them with the nurse before receiving your vaccine.**

**The Middlesex-London Health can be reached at 519-663-5317 ext. 2330.** (*Revised September 27, 2011*)

**MIDDLESEX-LONDON HEALTH UNIT  
REPORT NO. 097-11**

TO: Chair and Members of the Board of Health  
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health  
DATE: 2011 October 20

**Ontario Council on Community Health Accreditation Site Visit**

**Recommendation**

It is recommended that Report No. 097-11 re Ontario Council on Community Health Accreditation Site Visit be received for information.

**Background**

Board members will recall that the Health Unit underwent an accreditation review by the Ontario Council on Community Health Accreditation (OCCHA) in September 2010. The outcome of this process was the awarding of an Unconditional Accreditation designation for three years, representing the highest award issued by OCCHA. In contrast to previous accreditation surveys, OCCHA modified the accreditation process to include an annual follow up site visit and questionnaire component. This report highlights the submitted questionnaire and describes the activities undertaken during the site visit.

**Questionnaire Submission**

The Health Unit completed and submitted the questionnaire to OCCHA on September 9, 2011 (Appendix A). The questionnaire featured examples of projects completed in the past 12-24 months that demonstrated ongoing compliance with the OCCHA Standards. The questionnaire section headings and submitted examples of compliance since the 2010 survey are highlighted below.

<b>Section Heading from Annual Questionnaire</b>	<b>Submitted Compliance Examples</b>
1. Collaboration	a) Healthy Community Picture Report b) Infection Control Network Workshop
2. Research & Knowledge Exchange	a) Food Handler Training Assessment b) Early ID - 18 Months Well-Baby Visits
3. Planning & Implementation	a) Bed Bugs Program b) The Clinic's Client Survey
4. Health Promotion	a) e) Cook It Up! b) HPV Vaccination Campaign c) Hepatitis C Conference d) Helmets on Kids Partnership e) Prenatal Health Service Providers Network f) Smoke-Free Movies Campaign
5. Monitoring & Evaluation	a) Volunteer Vision Screening b) Be a Breast Friend c) Community Visits Evaluations
6. Health Hazards & Risk Management	a) T-Block Inspection b) Emergency Response Report
7. External Communications	a) DineSafe

Board members are encouraged to review the submitted questionnaire (Appendix A) as the examples provided by staff are an impressive representation of the Health Unit's high degree of community partner collaboration and program innovation.

**Site Visit**

OCCHA surveyors conducted their annual visit to the Health Unit on September 30, 2011, to a) review progress on the 2010 follow-up items, and b) appraise MLHU evidence of ongoing achievement of the standards. Upon arrival, the surveyors were greeted by members of the Health Unit leadership team and Accreditation Committee. The evidence-review process was paperless. The results of the visit were discussed during an informal debriefing, and the official results will be sent to the Health Unit in the first week of December 2011.

This report was prepared by Mr. Ross Graham, Manager, Special Projects.

Graham L. Pollett, MD, FRCPC  
T 416-321-1100 ext. 3000

## OCCHA Annual Questionnaire

*This questionnaire is intended to facilitate the annual accreditation review of the public health unit. The public health unit will be asked to provide updated information/evidence on-site where applicable.*

NAME OF HEALTH UNIT: **Middlesex-London Health Unit (MLHU)**

1	<b>Date of current Strategic Plan (e.g., 2010-2013)</b>	2011-2021	
	Did the health unit monitor/review the strategic plan during the past 12 months? ( <b>Standard 1A</b> )	Yes	No
		<b>X</b>	
	If yes, please identify monitoring activities and dates:		
	<p>In May 2010, MLHU hired Ms. Maria Sanchez-Keane of the Centre for Organizational Effectiveness, London, ON to assist with the development of a 10 year vision and 3 year strategic directions. The development process included:</p> <ul style="list-style-type: none"> <li>• Surveying external community partners, peer health units and clients; as well as</li> <li>• Numerous interviews, focus groups and planning sessions with MLHU staff, management and Board of Health (BOH) members.</li> </ul> <p>The BOH approved the vision and strategic directions on June 16<sup>th</sup>, 2011 and MLHU is now focused on operationalizing these directions (e.g., development of indicators and goals, assigning roles and responsibilities) in order to achieve this vision.</p>		
	<b>Monitoring Activity (please provide evidence on-site in support of activities noted, e.g., minutes)</b>	<b>Date</b>	
	<b>2010</b>		
	MSK attends BOH meeting - Report No. 121-10	October 21	
	Staff Kick-Off Meeting	October 21	
	Key Stakeholder - Wisdom Circle	November	
	MLHU Staff Focus Groups	November 11,17, 22, 23	
	Volunteer Survey	December	
	DC Meeting – Item 3.2 Strategic Planning Client Survey Update	December 1	
	DC Focus Group	December 15	
	<b>2011</b>		
	MOH and MSK meeting	January 4	
	DC – Wisdom Circle	January 10	
	BOH - Wisdom Circle	January 11	
	Launch of client survey	January 10	
	Launch of South western Ontario MOH survey	January 17	
	SPC meeting	January 26	
	SPC meeting	March 9	
	SPC meeting	March 18	
	MOH and MSK meeting	March 22	
	MSK attends BOH meeting - Report No. 039-11	April 14	
	DC meeting – Item 3.6 Strategic Planning Update	April 27	
	All Staff meeting	April 29	

	NUM full day strategic directions session		May 11
	DC meeting – <b>Item 3.7</b> Strategic Planning Update		May 25
	DC meeting – <b>Item 3.3</b> Strategic Planning Update		June 1
	BOH approves Strategic Plan - <b>Report No. 063-11</b>		June 16
	NUM morning indicator session		June 23
	DC indicator review session		June 23
	DC and MSK finalizing indicators discussion		August 27
	DC afternoon discussion – operationalizing strategic plan		September 7
	<b>Definitions</b>		
	NUM = Non-Union Management; DC = Directors Committee; GP = Dr. Graham Pollett; MSK = Maria Sanchez-Keane; MOH = Medical Officers of Health; SPC = Strategic Planning Committee (membership = DC and BOH representation); Wisdom Circle = Session to gather feedback from the most relevant community partners		
2	Has the governing body held regular meetings over the past 12 months?  Please attach a list of Board meetings and attendance for the past 12 months. <b>(Standard 2E)</b>	<b>Yes</b>	<b>No</b>
		<b>X</b>	
3	Has orientation been provided to any new Board members during the past 12 months? <b>(Standard 2G)</b>  If yes, please provide evidence on-site of any orientation on-site, e.g., minutes, attendance roster, etc.	<b>Yes</b>	<b>No</b>
		<b>X</b>	<b>N/A</b>
4	Provide an update of continuing education activities offered to and/or attended by Board of Health members in the past 12 months: <b>(Standard 2H)</b>  <b>See attached</b>		
5	Please provide the dates of senior management meetings held in the past 12 months (i.e., mm/dd) <b>(Standard 3B)</b>  <b>2010 Directors Committee</b> <ul style="list-style-type: none"> <li>• October 6, 20, 27 (chair Jim Reffle)</li> <li>• November 3, 17, 24 (chair Graham Pollett)</li> <li>• December 1, 15, 22 (chair Graham Pollett)</li> </ul> <b>2011 Directors Committee</b> <ul style="list-style-type: none"> <li>• January 5, 19, 26 (chair Diane Bewick)</li> <li>• February 2, 16, 23 (chair John Millson)</li> <li>• March 23 (chair Graham Pollett)</li> <li>• April 20, 27 (chair Graham Pollett)</li> <li>• May 4, 18, 25 (chair Rich Shantz)</li> <li>• June 1, 15, 22 (chair Louise Tyler)</li> <li>• September 7, 21, 28 (chair Bryna Warshawsky - planned)</li> </ul>		
6	Are there any <b>new</b> planning/coordinating committees to ensure program planning, coordination, implementation, monitoring and evaluation? <b>(Standard 3C)</b>  If yes, please attach terms of reference. <i>(Note: Minutes for the past 12 months will be reviewed on-site).</i>	<b>Yes</b>	<b>No</b>
		<b>X</b>	

7	Have there been any changes to the organizational structure of the health unit during the past 12 months? (Includes both agency and program level changes). <b>(Standards 4A and 4B)</b>	<b>Yes</b>	<b>No</b>
	If yes, please attach all applicable (i.e., revised) organizational charts.	X	
8	Has the Board of Health received/approved the audited financial statements in the past 12 months? <b>(Standard 5D)</b>		
	If yes, please provide a copy of the audited financial statements and minutes of Board approval on-site. <b>If no, please explain:</b>	X	
9	Have monthly workplace inspections been conducted at all office locations for the past 12 months? (Please note: a review of inspection reports will be conducted on-site.) <b>(Standard 5F)</b>		
	Have WHMIS needs been assessed in the past 12 months? <b>(Standard 5F)</b>	X	
<b>If yes, please explain the process for assessing WHMIS needs (e.g., on-line survey, etc.):</b>			
WHMIS Inventories for each Service Area have undergone significant restructuring and updating to ensure that controlled products no longer in use at MLHU are removed and new products introduced into the work environment are included on the list.			
On March 29, 2011, a meeting was held with the key contacts for WHMIS within each Service Area. The revised draft Inventories were reviewed and agreement was reached that these will serve as the basis for the annual assessment and/or retraining of staff as necessary. Given the significant changes to the Inventories this year, Service Areas where these products are used will conduct a 2011 staff (re)training session. This session is scheduled to occur on September 15, 2011.			
<b>Please provide evidence (e.g., on-line attendance/tracking sheet).</b>			
<b>If no, please explain:</b>			
Please note the date of your last fire drill: <b>(Standard 5F)</b>		2010 = September 24 <sup>th</sup>	
Please provide evidence (e.g., minutes of Health and Safety Committee, etc.)		2011 = September X (planned)	
10	Has the health unit renewed its insurance for the physical, financial and human resources of the agency? <b>(Standard 5G)</b>	<b>Yes</b>	<b>No</b>
	If yes, please provide most recent insurance rider.	X	
11	Has the Board of Health approved the most current agency budget? <b>(Standard 5I)</b>		
	If yes, please note date of approval and provide minutes:  The 2011 cost-shared budget was approved on January 20, 2011 (Report No. 002-11). Minutes	X	

	provided on site.		
	If no, please explain:		
12	Have regular financial statements been provided to appropriate staff during the past 12 months? <b>(Standard 5I) No evidence required annually.</b>	Yes	No
		X	
13	Has annual certification of applicable staff been conducted in the past 12 months? (Note: validation of annual certification for all relevant staff will be reviewed on-site). <b>(Standard 7B)</b>	X	
	Does this include all relevant professional staff providing services on a contractual basis (i.e., clinic physicians, clinic dentists)? (Note: The agency shall provide on-site evidence that this has been completed) <b>(Standard 7E)</b>	X	
14	Has orientation to both the health unit and specific program area been provided to all new staff in the past 24 months? <b>(Standard 8A)</b>	X	
	If an agency staff orientation was conducted, please provide date:		
	MLHU continues to offer quarterly comprehensive agency orientation for new staff. The Agency Orientation provides an overview of all programs and services at MLHU and the organizational structure.		
	<ul style="list-style-type: none"> <li>• September 14, 2009 – Corporate Services</li> <li>• October 7, 2009 – Agency Orientation</li> <li>• March 24, 2010 – Corporate Services</li> <li>• March 29, 2010 – Agency Orientation</li> <li>• June 14, 2010 – Corporate Services</li> <li>• June 22, 2010 – Agency Orientation</li> <li>• October 18, 2010 – Corporate Services</li> <li>• February 22, 2011 – Agency Orientation – Combined</li> <li>• May 31, 2011 – Agency Orientation – Combined</li> <li>• October 4, 2011 – Agency Orientation – Combined</li> </ul>		
15	Have performance evaluations been conducted for all staff in the past 12 months in a manner consistent with agency policy? <b>(Standard 9B)</b> Note: No additional evidence is required unless this was noted as an area of concern or follow-up during the Year 1/Reaccreditation survey.		X
	If no, please explain:		
	As per policy 5-060, “comprehensive performance appraisals will be conducted at a minimum of every 2 years for all full and part-time employees.” Currently, all these employees have up date performance appraisals with the exception of staff who have been on extended leaves in the last two calendar years, or staff who have been hired or transferred into different positions. Also, there has been a change in the form and process for performance appraisals for public health nurses, and nurses who have entered the first stage of the new process are being reported as having had a performance appraisal. Otherwise, it would appear that the performance appraisal was overdue, as the new process is a two-year process.		

16	<p>Please provide one example from the past 24 months where programs/services shared best available evidence with community partners, priority populations and target groups to increase community capacity in the areas of health promotion and disease prevention. <b>(Standard 10B)</b>  <b>Note:</b> Applicable programs are: CDP, PISM and SHSTI. The example provided cannot be from the same program as the example provided in the previous year s(i.e., Year 1 or Year 2). (The agency is required to provide on-site evidence in support of the example noted.)</p> <p>The Healthy Community Partnership (HCP) is among agencies, organizations and individuals in Middlesex-London (ML) interested in improving the community through development and implementation of policy. HCP was preceded by a needs-assessment, where MLHU gathered local, provincial and national data related to six priority areas. Data were then segregated by priority and vulnerable populations to enhance understanding of the community landscape. This analysis was summarized in a Healthy Communities Picture Report in order to inform community partners and stakeholders about the current health status in ML. Prior to publication, the data were shared and discussed at various stakeholder meetings, focus groups and community consultations. A policy scan of ML was also conducted to identify existing policies related to the six priority areas.</p> <p>The report was mailed to community partners, published electronically and an email out was send with the report's location. After review and discussion of the report and evidence, HCP identified physical activity and mental health promotion as the top priorities for ML in 2011/12.</p>
17	<p>Please provide one example from the past 24 months where programs/services collaborated with community partners, priority populations and target groups to develop, plan and implement programs/services and policies related to health promotion, health protection and disease prevention. <b>(Standard 10C)</b>  <b>Note:</b> Applicable programs are: IDPC, TB and SHSTI. The example provided cannot be from the same program as the example provided in the previous year s(i.e., Year 1 or Year 2). (The agency is required to provide on-site evidence in support of the example noted.)</p> <p>Each fall, the MLHU Infectious Disease Control Team (IDC) offers an infection prevention and control workshop for staff, infection control professionals and administrators of hospitals, long-term care homes and retirement homes in Middlesex-London (i.e., target groups). Workshop topics are selected based on feedback from the previous year, as well as quarterly meetings with stakeholders. The 2010 workshop was held on September 30th and included discussions on:</p> <ul style="list-style-type: none"> <li>• Vaccines for Seniors</li> <li>• 46 Days of Outbreak: A Lifetime of Lessons Learned</li> <li>• Antibiotics – To Use or Not to Use</li> <li>• C. difficile in Long Term Care Settings.</li> </ul> <p>The workshop was conducted in partnership with the Southwestern Ontario Infection Control Network (i.e., community partner). The Network shared the workshop cost, and provided training on evidence-informed infection prevention and control (i.e., fostering implementation of disease prevention programs/services). Over 70 registrants from a variety of care settings participated including nursing homes, hospitals, retirement homes and the health unit, and feedback was very positive.</p>
18	<p>Please provide updated list of research (inventory of research) conducted in the past 12 months. <b>(Standard 11B)</b> <b>(Note: This can be provided on-site or included in the questionnaire)</b></p>

	<p style="text-align: center;">Inventory will be provided on-site.</p>
	<p>Please provide at least one (1) example <u>and</u> evidence where a program decision was made, by either the health unit and/or community partner as a result of research/evaluation activities.</p> <p>In early 2011, MLHU surveyed 856 non-institutional premises to determine food-handler training needs. This was necessary given new City and County by-laws requiring a certified food handler (CFH) be present at all times in establishments where food is being prepared. The survey also gathered information about:</p> <ul style="list-style-type: none"> <li>• Barriers to participation in certification including literacy and timing/location of training</li> <li>• How food handler training would be accessed (i.e. online, corporate trainer, health unit, health unit's training partner)</li> </ul> <p>The results indicated that 2047 food-handlers required training. Planning is currently underway to redeploy teaching resources from MLHU and its training partner to meet these anticipated increases in the demand. Identified barriers will be addressed by offering courses on weekends and in rural areas. A course in Cantonese is also being considered (this was the most frequently identified language barrier). The CFH curriculum will also be reviewed and revised with specific consideration of adult education principles.</p>
	<p>Please provide at one (1) example <u>and</u> evidence of fostering or engaging in knowledge exchange with a community partner.</p> <p>In November 2009, MLHU was selected to promote the new Physician fee code for the 18 Month Enhanced Well Baby Visit (introduced to promote early identification of developmental concerns for children at 18 months). MLHU then founded:</p> <ol style="list-style-type: none"> <li>1. Middlesex-London Community Early Years Partnership (MLCEYP) - 16 agencies that provide services to families with children aged 0-4 years</li> <li>2. Early Identification Physician Champion Group - promotes the Well Baby Visit in the community and discusses upcoming servicing opportunities</li> </ol> <p>Knowledge exchange with physicians, young families and community partners occurred via family practice visits, distribution of binders outlining MLHU programs and services, educational presentations, displays, early-years information fairs, in-person and tele-consultations with Public Health Nurses, and the development of the "As We Grow Together" journal. MLCEYP is now providing "train the trainer" opportunities. Agency partners will also be able to promote the Well Baby Visit. MLHU staff continue to play a leadership role in this area.</p>
19	<p>Please provide two (2) examples of evidence informed decision making from the past 24 months (Please indicate program and provide a brief description. Evidence will be required on-site in support of the examples provided): <b>(Standard 12F)</b></p> <p>1) In January 2011, MLHU was granted \$180,000 to conduct bed bug surveillance, as well as an education campaign to prevent and mitigate bed bug infestations (BBI). 40% was allocated to assist vulnerable populations to deal with BBI (often worst affected and not financially equipped).</p> <p>As part of the bed bug program/funding, MOHLTC created evidence-informed brochures, websites and fact sheets. These materials informed MLHU's approach to BBI surveillance and are used in the education campaign. MLHU has also formed the Community Bed Bug Working Group (made up of community stakeholders) to better serve all members of the community with this issue.</p> <p>2) 363 clients completed a survey to identify ways to improve services at the MLHU Family</p>

Planning/Birth Control Clinic and the Sexually Transmitted Infections (STI) Clinic. Findings from the client survey were used to inform program planning of two clinical sexual health services. Specifically, clients were surveyed on wait-times, quality and their experience. The survey was self-administered in order to gather perspectives from a large number sample, and to provide anonymity.

Survey results led to a pilot where an extra nurse (RN) and physician (MD) were added to the Wednesday STI Clinic. During the pilot, staff overtime and number of clients who left without treatment were tracked. After 3-months, there was no overtime accumulated and the clinic was often completed earlier. The number of clients who left without treatment also decreased from 3 per clinic to 0.2 per clinic. After this evaluation, resources in the clinic were reallocated to allow for an extra RN every Wednesday evening. MDs were pleased with the client flow and continue to add a MD when planning their schedule.

20	Are there current operational plans for all program areas? ( <i>Standard 12G</i> )	Yes	No
			X

If no, please explain:

Although the majority of MLHU programs/teams have current operational plans (see the attached list), some do not. Most programs/teams without operational plans have been waiting to use the revised operational planning tool (i.e., these areas continue to use their 2010 operational plans).  
Exceptions:

IT has undergone significant restructuring since the fall of 2010 based upon recommendations of an external review conducted in the spring of 2010. This review called for significant expansion of IT's scope as well as personnel changes including:

- the hiring of an I.T. Director in the fall of 2010
- restructuring of existing staff roles and responsibilities
- the recruitment and filling of two vacant positions
- the hiring of a full-time Business Analyst in the summer of 2011
- temporary Helpdesk outsourcing and evaluation thereof

As the majority of the external review's restructuring recommendations have now been implemented, IT will develop Operational Plans moving forward using the revised operational template and planning process in the winter of 2011.

The Special Projects Portfolio (SP) hired a new Manager in May 2011 which brought together the roles of Accreditation Coordinator and Records Manager. The previous Records Manager did not have an operational plan. To remedy this, the SP portfolio developed an implementation plan for Records & Information Management Program (RIMP) which was approved by the Directors Committee on May 25th, 2011 (item 3.3). This plan extends to December 2011. SP will develop a full operational plan using the revised operational planning tool, and will include the additional elements of SP portfolio (e.g., policy and procedure review, corporate documentation, etc.).

21	<p>Please provide two (2) examples from the past 24 months where programs/services provided opportunities for education and skills development to community partners and priority populations.<b>(Standard 13A)</b></p> <p><b>Note:</b> Applicable programs are: CDP, PISM, SHSTI, VPD, FS and SW. The examples provided cannot be from the same programs as the example provided in the previous year s(i.e., Year 1 or Year 2). (The agency is required to provide on-site evidence in support of the examples noted.)</p> <p>1) Cook It Up! (CIU) was a cooking pilot program for at-risk youth that ran from May 2009 to November 2010. CIU included at-risk youth (aged 13-18) and resulted in the development of a manual (completed October 2010) for other organizations interested in implementing a similar project. Youth participants were selected from various local community agencies offering programs and services to this age group.</p> <p>The CIU program provided education, awareness, and skill building opportunities related to: nutrition; food safety, preparation and selection; cooking; and agriculture fieldtrips to local farms and markets. CIU modules included recipes featuring Ontario-grown foods and were facilitated by local chefs and farmers. Activities within each module were targeted to the participants' needs and interests.</p> <p>2) The Human Papillomavirus (HPV) Vaccine Campaign was designed to increase the public's awareness of HPV and the Gardasil Vaccination. The priority populations were female grade-eight students, their parents/guardians, and teachers of grade-eight students. The campaign was held in September 2010 and included the distribution of information packages; drop-in information sessions; targeted advertisements on Facebook for teens and their parents linked to video and print content on the Health Unit's website.</p> <p>MLHU staff developed and distributed HPV packages to all female grade-eight students in Middlesex-London. Information packages were also distributed to male grade-eight students to increase their awareness and support of HPV vaccine. Information sessions gave parents/guardians of grade-eight students the opportunity to learn more about HPV and vaccination. Attendees were encouraged to develop their knowledge of immunization and ability to make evidence-based decisions for themselves (i.e., skill development). MLHU also met with Superintendents from both the Catholic and public school boards to encourage their support of the HPV immunization program.</p>
22	<p>Please provide two (2) examples from the past 24 months where programs/services worked with community agencies, partners and organizations to identify and develop strategies to create and enhance supportive environments.<b>(Standard 13B)</b></p> <p><b>Note:</b> Applicable programs are: CDP, RH, CH, PISM and SHSTI. The example provided cannot be from the same programs as the examples provided in the previous years (i.e., Year 1 or Year 2). (The agency is required to provide on-site evidence in support of the examples noted.)</p> <p>1) MLHU and its community partners held a Hepatitis C Conference (HCC) on May 17th, 2011. The HCC planning group included individuals from other health units, the Regional HIV/AIDS Committee, the Canadian Liver Foundation, a local community health centre and teaching hospital.</p> <p>The target audience was individuals who work with clients with HC. The goal was to give attendees</p>

an overview of HC and discuss epidemiology, treatment and research of HC in order to foster an improved and supportive environment for clients with HC. The attendees also reviewed barriers/challenges to working with HC clients, and strategies to improve practice and better coordinate services. 117 people attended HCC, including students, hospital and community clinicians, as well as a few individuals with HC. Evaluations were very positive and indicated a need for more events discussing HC. HCC increased knowledge and built relationships among providers. It also established connections with workers from the justice system, and local mental health service providers.

2) As a member of the Helmets on Kids Partnership (HKP), MLHU collaborates with community partners to develop strategies that create a supportive environment related to bike safety and injury prevention.

HKP is led by local members of the Ontario Trial Lawyers Association and the Brain Injury Association. HKP includes school board, hospital, health unit and police representation, and strives to put a helmet on every child in London, ON. Approx. 1,400 helmets were distributed in 2010. HKP meets throughout the year to plan the annual launch event. This event includes a school assembly, guest speakers, a helmet safety video, helmet fitting demonstration and bicycle rodeo. HKP raises awareness regarding the importance of wearing a helmet, as well as provides helmets to children who otherwise would not have them.

23 Please provide two (2) examples from the past 24 months where the agency developed strategies to promote, support and/or implement healthy public policy within the community. **(Standard 13C)**  
**Note: Applicable programs are: CDP, RH, CH, PISM, VPD and HHPM. The examples provided cannot be from the same programs as the examples provided in the previous years (i.e., Year 1 or Year 2).** (The agency is required to provide on-site evidence in support of the examples noted.)

1) The Community Prenatal Health Service Providers Network was created in summer of 2010. The goal of this network is to strengthen and enhance prenatal health services in Middlesex-London. The network aims to meet needs of this population via:

- Collaboration/coordination with a network of prenatal health service providers
- Knowledge exchange and development of a community of practice to increase consistent, evidence-based practice via establishment of policy at prenatal health service providers
- Advocacy to influence local policy by increasing the profile of prenatal issues

The Network connects local professionals to engage them towards the following key objectives:

1. Develop an inventory of credible service providers for collaboration/referral
2. Provide evidence in order for clients to make informed decisions
3. Support, protect and promote normal childbirth (using the Centering Pregnancy philosophy)
4. Provide recommendations to the regional Child & Youth Network on how prenatal care function can be provided in London, ON

2) MLHU has been a member of the Ontario Coalition for Smoke-Free Movies since its inception in February, 2010. Two MLHU staff are part of the coalition and work to educate Middlesex-London residents about the importance of smoke-free movies and to implement five healthy public policy changes:

1. Rate new movies depicting tobacco use to have an adult rating

	<p>2. Require strong anti-smoking ads prior to movies depicting tobacco use in all distribution channels</p> <p>3. Certify no payoffs for displaying tobacco</p> <p>4. Stop identifying tobacco brands</p> <p>5. Require films with tobacco imagery assigned a youth rating to be ineligible for government film subsidies</p> <p>Two additional MLHU staff also work at a regional level with nine member Health Units (Windsor-Essex, Chatham-Kent, Sarnia-Lambton, MLHU, Elgin-St. Thomas, Oxford, Huron, Perth and Grey-Bruce) and at the provincial level to coordinate efforts to implement the desired policy changes. Activities in Middlesex-London to support these changes include a youth postcard writing campaign, youth poster competition, elementary school trivia challenges, a lesson plan for grade 8 students, events at movie theatres, press releases, advertisements and distribution of microwave popcorn displaying a link to the provincial website. A milestone was achieved on June 24th, 2011 when a meeting was held with Ontario Film Review Board. During this meeting, coalition members and youth advocates further petitioned for these policy changes.</p>		
24	<p>Have programs/services monitored activities and documented and disseminated outcomes (i.e., have operational plans been reviewed) in the past 12 months? Evidence (at least 3 examples from across programs) will be required on-site (<b>Standard 15C</b>)</p>	Yes	No
	<p>1) The Volunteer Vision Screening Program examined kindergarten children for vision impairments (which can impact developmental, learning and health outcomes). In 2010, an evaluation began to determine the efficacy of this program. The evaluation results indicated that screening at this stage was too late because the program only identified vision issues in 4% of children, when in fact 17% had significant vision impairment for the 09/10 school year. These results led MLHU management to recommend that the program be discontinued and replaced with a new program that:</p> <ul style="list-style-type: none"> <li>• Raises awareness emphasizing on eye examinations prior to school entry</li> <li>• Provides education to parents, childcare providers, school staff and physicians on the link between vision and learning</li> <li>• Increases environmental support for vision loss</li> <li>• Advocates for policy requiring eye examinations prior to school entry</li> </ul> <p>By replacing the school vision screening program with a comprehensive approach to pre-school eye health, there is an anticipated result of increased proportion of children that achieve school readiness and optimize their developmental, learning and health outcomes. A report was presented to the BOH in February 2011 requesting approval of this recommendation. Principals of elementary schools in Middlesex-London were notified of the evaluation results, the program's discontinuation and replacement. Program volunteers were recognized for their effort at the 2011 volunteer recognition dinner.</p> <p>2) MLHU participated in the "Be a Breast Friend" (BBF) campaign, which used hair stylists to communicate the importance of early detection of breast cancer and breast health. Following the completion of BBF, MLHU evaluated whether a) the campaign increased the number of mammography screenings, and b) hairstylists were an effective medium for communicating the importance of early detection of breast cancer. The results of the limited evaluation indicated a positive response to the project. However, partially due to the small sample size, the BBF campaign was not considered the most effective methods of promoting breast health and mammography</p>	X	

	<p>screenings.</p> <p>The results were summarized in a report, and sent to the members of the Southwestern Cancer Prevention &amp; Early Detection Network (SWCPEDN). This network is made up of area cancer prevention practitioners, and reports to the Provincial Cancer Prevention and Screening Council at Cancer Care Ontario.</p> <p>3) Public health nurses (PHN's) at MLHU traditionally have offered universal home visits to all postpartum families. Resource constraints necessitated a critical review of the delivery of postpartum home visiting services in 2009-2010. In April 2009, a committee reviewed the impact of workload and resources within the Healthy Babies Healthy Children program. Committee members identified a number of problem areas including a high volume of referrals received, and managing workload regarding low-risk referrals.</p> <p>One of the resolutions was to explore a new model of care for low-risk postpartum families in the community. Community visits were suggested as an alternative to home visits for healthy low-risk postpartum families. Factors affecting decision-making regarding a new model of care included community needs, research evidence, resource availability, peer health unit models, as well as MLHU HBHC program monitoring and evaluation data.</p>
	<p>Provide one (1) example from the past 24 months where an operational plan has been reviewed and/or revised due to changing priorities, financial and/or program developments. Evidence will be required on-site.</p> <p>Public health nurses (PHN's) at MLHU traditionally have offered universal home visits to all postpartum families. Resource constraints necessitated a critical review of the delivery of postpartum home visiting services in 2009-2010. In April 2009, a committee reviewed the impact of workload and resources within the Healthy Babies Healthy Children program. Committee members identified a number of problem areas including a high volume of referrals received, and managing workload regarding low-risk referrals.</p> <p>One of the resolutions was to explore a new model of care for low-risk postpartum families in the community. Community visits were suggested as an alternative to home visits for healthy low-risk postpartum families. Factors affecting decision-making regarding a new model of care included community needs, research evidence, resource availability, peer health unit models, as well as MLHU HBHC program monitoring and evaluation data.</p>
25	<p>Provide one (1) example of an assessment and response of a reported incident in the past 12 months (Please indicate program and provide a brief description. Evidence will be required on-site in support of the example provided.) <b>(Standard 16B)</b></p> <p>On December 2<sup>nd</sup> 2010, a complaint of asbestos exposure was made to the City of London after an attempt to replace old, damaged ceiling tiles in a building known as the "T-Block." The building was immediately closed by the City and MLHU was called to perform an assessment. MLHU assessed the asbestos exposure period between November 23 and December 3, 2010. Samples of air and the ceiling tiles (bulk) were sent to be tested. The test results indicated that the exposure to asbestos during and after maintenance was low and that the public health risks of patrons/users are considered minimal or low and the building was reopened on January 10, 2011. On January 13, 2011, a MLHU representative conducted an on-site inspection after the building was cleaned. The</p>

	<p>on-site inspection led MLHU to recommend a more thorough maintenance and monitoring schedule, based on the age of the building and the presence of asbestos in the building.</p> <p>These results were summarized in a report and presented to the City. The City notified the Ministry of Labour of the recommendations, who as a precaution decided to close the facility for further maintenance. The report was also published on the City's website.</p>		
26	<p>Has the Health Unit reviewed and/or tested the emergency response plan and continuity plan (s) in the past 12-15 months? Please provide evidence on-site (e.g., minutes, testing results or summary, etc.). <b>(Standard 16C)</b></p>	<p><b>Yes</b></p> <p><b>No</b></p>	<p><b>Yes</b></p> <p><b>No</b></p>
	<p><b>If no, please note exceptions and/or explain:</b></p>		
27	<p>Please provide one (1) example from the past 12 -24 months where information was provided to community partners, priority populations or the public to increase awareness and/or promote awareness of public health and community resources, programs and services. [Please note program, communication strategy/channel, target group (e.g., community partner, priority population) and the purpose (i.e., enhance knowledge, increase awareness or promote availability).] Evidence will be required on-site. <b>(Standard 18A)</b></p> <p>DineSafe's mission is to implement a food safety inspection disclosure system to increase compliances with legislation, improve food safety, reduce the risk of food-borne illnesses, increase the transparency of inspections, improve the public's accessibility to information, and to increase public confidence in the food inspection process and food industry. DineSafe was implemented on October 1, 2010. MLHU created:</p> <ul style="list-style-type: none"> <li>• The DineSafe website</li> <li>• FAQ brochures for the public</li> <li>• An Operators Manual</li> <li>• The "It's Easy to be Green" checklist</li> <li>• Newspaper, radio, transit, and billboard advertisements</li> <li>• Three press releases</li> <li>• Red, yellow, green and rainbow inspection report signs to be placed at every food establishment in Middlesex-London</li> </ul> <p>Prior to implementation, MLHU held two public information sessions in September 2011. MLHU sent the Operators Manual and the Checklist to all food establishments to help them prepare for implementation. Food inspectors hand out a green, red or yellow inspection report to each food establishment. These reports allow the public to view the latest food inspection prior to dining. Patrons are also able to view restaurants inspections on the DineSafe website.</p>		
28	<p>Has the health unit <u>released</u> the most current annual report, including financial statements? <b>(Standard 18C)</b></p>	<p><b>Yes</b></p> <p><b>No</b></p>	<p><b>Yes</b></p> <p><b>No</b></p>
	<p>If yes, please note date of release (Evidence required on-site):</p> <p><b>June 16, 2011</b></p>		

If no, please explain:						
29	Have there been any major changes ( <i>other than those already identified in this questionnaire</i> ) in how your agency does business in the past year (i.e., structural, organizational, etc.)?	<table border="1"> <thead> <tr> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr> <td>X</td> <td></td> </tr> </tbody> </table>	Yes	No	X	
Yes	No					
X						
<p>If yes, please describe: (Note: No additional evidence will be required on-site in support of this description.)</p> <ul style="list-style-type: none"> <li>Dental Consultant – Amalgamation of the Dental and Communicable Disease/Sexual Health Service Areas included the conclusion of a Director, Dental Services position. The administrative functions of that role are now shared by the Manager, Oral Health and the Director, Oral Health, Communicable Disease &amp; Sexual Health. Public health dental functions are now performed by a Dental Consultant. The Dental Consultant is a public health dentist, and the position is shared with the Huron County, Elgin-St. Thomas, Perth District and Lambton Health Units.</li> <li>Specialized Environmental Health Teams – In February 2011, the Food Safety &amp; Vector Borne Disease, Safe Water &amp; Rabies, and Health Hazard Prevention &amp; Management teams began using a specialized program delivery model. Instead of having public health inspectors (PHIs) perform a generalist role, most PHIs became members of only specialized team (i.e., each environmental health team now has a team of specialized PHIs).</li> <li>Separate Chronic Disease and Injury Prevention Teams – Also in early 2011, the Environmental Health &amp; Chronic Disease Prevention Service Area separated the chronic disease and injury prevention functions. Chronic disease work was localized to the Chronic Disease &amp; Tobacco Control team. Injury prevention was localized to the Health Communities &amp; Injury Prevention team.</li> <li>Food Safety Inspections via Hedgehog – Planning begin in fall 2010 for the Infectious Disease Control team to use Hedgehog software for all food safety inspections. This has required new equipment and ongoing staff training, as well as technical support in partnership with the Environmental Health &amp; Chronic Disease Prevention Service Area.</li> <li>Expanded Nurse Practitioner Role – The 1.5 FTE Nurse Practitioners (NP) at MLHU provide episodic acute care. In the past year, Family Health Services teams have begun regularly referring clients to the NP. This includes referrals from family home visitors, who visit postpartum families, as well as public health nurses/promoters who work in elementary and high schools.</li> <li>Involvement in Child &amp; Youth Network – MLHU participation in the City of London’s Child &amp; Youth Network (CYN) has increased over the past year. In contrast to 2009/10 practices, Family Health Services staff members now often apply for project funding through the CYN, and have adopted many of the tools created by the CYN (e.g., ACE and Integration Assessment Tool).</li> <li>Records &amp; Information Management – Following over a year of planning, and the approval of the Classification System/Retention Schedule (January 2010 Board Meeting - Report No. 004-11), MLHU began implementing the Records &amp; Information Management Program (RIMP). RIMP includes sorting and mandatory retention periods for all shared electronic information</li> </ul>						

and paper (currently excluding e-mail and each staff's private drive). All individuals at MLHU have participated in RIMP and the first major RIMP audit will occur in fall 2011.

Completed questionnaires should be submitted to the Ontario Council on Community Health Accreditation at: 3370 South Service Road, Burlington, Ontario, L7N 3M6. Questionnaires should be submitted not less than 2 weeks before the annual review date. Questionnaires can also be faxed directly to the OCCHA office at 905-639-6534. An electronic copy of this questionnaire can also be downloaded from the OCCHA website returned electronically to [meighanfinlay@occha.org](mailto:meighanfinlay@occha.org). Should you have any questions or concerns related to this questionnaire, please contact Meighan Finlay, Executive Director at 905-639-6367. We thank you for your cooperation in facilitating the annual accreditation review of your public health unit.

OCCHA Annual Agency Questionnaire – January 2011

### List of APPENDICIES

AQ #	Item	Appendix
2	List of board meetings and attendance for the past 12 months	A
4	Continuing Education activities for MLHU Board of Health Members Sept 2010-Sept 2011	B
6	Terms of Reference for any new planning/coordinating committees	C
7	Organizational charts with any changes to the organizational structure of the health unit during the past 12 months	D
20	List of programs with and without current operational plans	E

**MIDDLESEX-LONDON HEALTH UNIT  
REPORT NO. 098-11**

TO: Chair and Members of the Board of Health  
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health  
DATE: 2011 October 20

**Engaging Youth In School Communities**

**Recommendation**

It is recommended that Report No. 098-11 re Engaging Youth in School Communities be received for information.

**Background**

In 2009, the Health Unit and the London Youth Council partnered to undertake the Youth Create Healthy Communities initiative and received a Healthy Communities Fund grant from the Ministry of Health Promotion and Sport. The Youth Create Healthy Communities Team was created to empower youth to take a leadership role in motivating peers to make a difference about health and social issues in the school and broader community. The Team is made up of a staff member from the Health Unit's Young Adult Team, one young adult facilitator who is paid a stipend from the grant money and the remaining members are volunteer youth from area secondary schools.

**Supporting Literature**

Youth engagement actively involves youth in addressing issues that affect them personally and/or that they believe are important. Youth engagement is widely recognized by many policymakers and institutions as a key strategy to improving the lives of children and youth. In addition, youth engagement puts the healthy schools model into practice. By involving youth in the design, implementation and evaluation of programs and healthy school services, activities can be offered that are more accessible and responsive to the young people's needs and priorities. Youth engagement has many health promotion benefits such as:

- Meeting new people and creating relationships with adults and youth;
- Learning new organizational skills;
- Building citizenship skills;
- Increasing self-confidence;
- Increasing knowledge about health and social issues,
- Building advocacy skills,
- Creating leaders for the future.

**Youth Empowerment Conference**

The Youth Create Healthy Communities Team identified the need for a peer-led conference that would provide members from various secondary school communities with youth engagement skills. As a result, local youth designed, planned and hosted the "Youth Empowerment Conference: Engaging Youth to Build Healthy School Communities" on Thursday, September 28, 2011, at the Health Unit (see Appendix A for details). Over 100 students and educators from 13 secondary schools participated in this motivating, youth-led conference. Participants listened to important messages about wise decision making from youth leaders, Matt Evans, Executive Director of the Ontario Students against Impaired Driving, and Randy Komi, former Laurier Healthy Schools Committee member. Participants also took part in an open dialogue session which had them identify key health issues and how they would address them in their school community. Finally, participants completed action plans (Appendix B) that outlined key strategies for addressing health in their school. A follow up evaluation will be sent to school contacts in May 2012 to report on the outcomes of the action plans.

**Summary**

Engaging youth to work together to address common health and community concerns is a promising strategy for improving the health of youth in Middlesex-London. The recruitment of youth to become involved in the Youth Create Healthy Communities initiative has provided invaluable opportunities for local youth to grow, develop and demonstrate many skills and talents. The Young Adult Team will continue to facilitate youth to action through the support of the Youth Create Healthy Communities Team.

This report was prepared by Ms. Jacqueline Lindfield, Public Health Nurse, and Ms. Christine Preece, Manager, Young Adult Team, Family Health Services.

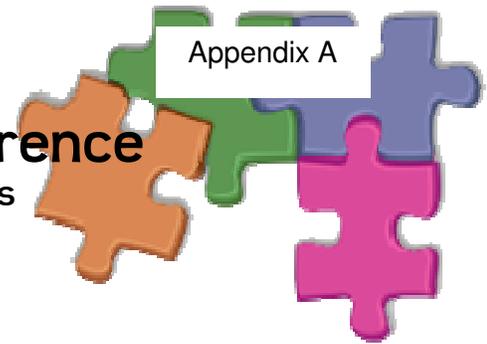
Graham L. Pollett, MD, FRCPC  
Medical Officer of Health

**This report addresses** the following requirement(s) of the Ontario Public Health Standards: Chronic Disease Prevention Standard 7, Sexual Health, STIs, and Blood-borne Infections 4,5,6 and Child Health Standard 4, 5 6 and 8.

Middlesex-London Health Unit presents...

# Youth Empowerment Conference

Engaging youth to build Healthy Schools



Middlesex-London Health Unit County Building  
Wednesday, September 28<sup>th</sup>, 2011  
9:00am-1:45pm

Please join us in a fun day of team-building, youth engagement and creativity. This **FREE** conference is open to 3-5 students and a staff member from London and Middlesex County secondary schools as enrolment allows. The conference is for both male and female students.

Please register with your school name, the teacher advisor name and number of students attending by September 14<sup>th</sup> by email to [Jacqueline.Lindfield@mlhu.on.ca](mailto:Jacqueline.Lindfield@mlhu.on.ca)

## Key Note Speakers:

### **Matt Evans**

Matt is an accomplished Canadian actor who is dedicated to helping teens. He has worked with Youth programs for over 17 years and is the Executive Director of Ontario Students Against Impaired Driving (OSAID).

### **Randy Komi**

Randy is a second year student at the University of Western Ontario. He graduated from Laurier secondary school in 2009 where he was an active Healthy School Committee member. In his free time he performs stand-up comedy and is passionate about school involvement.

## Youth-led Open Spaces Session:

The afternoon session will be a student-led open spaces dialogue focusing on the following concepts: School Safety; Eating Well and Getting Active; Personal Wellbeing; the Environment; and Social Justice. This is an opportunity for students to collaborate on ideas related to school health and take on leadership roles.

**A free healthy lunch will be provided to all participants.**

Each attending school will receive a resource package for enhancing school health and engaging students.



**ML** BUREAU DE SANTÉ DE  
MIDDLESEX-LONDON  
HEALTH UNIT  
[www.healthunit.com](http://www.healthunit.com)

This event is funded in part y the Ministry of Health Promotion and Sport  
Healthy Communities Fund

# Youth Empowerment Conference

Engaging youth to build Healthy Schools



## AGENDA

<b>9:00</b>	<b>Arrival</b>
<b>9:20</b>	<b>Welcoming remarks from Christine Preece</b>
<b>9:25</b>	<b>Label your Table</b>
<b>9:45</b>	<b>Key Note Speaker: Matt Evans</b>
<b>10:30</b>	<b>Tin Foil Challenge</b>
<b>10:45</b>	<b>Lunch</b>
<b>11:45</b>	<b>Guest Speaker: Randy Komi</b>
<b>12:00</b>	<b>Open Spaces Youth-Led Discussions</b>
<b>1:00</b>	<b>Recap of day</b>
<b>1:15-1:45</b>	<b>Groove Fitness</b>



**ML** BUREAU DE SANTÉ DE  
MIDDLESEX-LONDON  
HEALTH UNIT  
[www.healthunit.com](http://www.healthunit.com)

This event is funded in part by the Ministry Of Health Promotion  
Healthy Communities Fund

Youth Empowerment Funding  
Application  
Engaging youth to build Healthy Schools

\_\_\_\_\_ (School Name) is applying to the Middlesex-London Health Unit, Young Adult Team, for funding which will be used to make our school a healthier place.

The school health issue that we would like to work on is:

\_\_\_\_\_

Please list the changes you hope to accomplish as a result of working on this school health issue.

\_\_\_\_\_

The number of students attending our school is approximately \_\_\_\_\_

The number of students and staff that are expected to be involved in this initiative is approximately \_\_\_\_\_

The student leads for the project at the school are: \_\_\_\_\_

\_\_\_\_\_

The staff Advisor(s) for this initiative is: \_\_\_\_\_

**Project Description:** Using the chart below please tell us about the activities that will be planned to tackle the issue you identified above. Identify different activities to address the issue under the categories listed below: education; school environment, social supports and community partners.

Activities:	
<b>Education</b> <i>Think of ways to inform students and staff about the issue. How can you ensure the information is credible?</i>	<b>School Environment</b> <i>What is it about the school environment that could be changed to support this issue?</i>
<b>Social Support</b> <i>Who at school can help with your ideas? Is there someone a student could talk to about this issue?</i>	<b>Community Partners</b> <i>Who in the community can help with this issue? Can the school get involved with something already happening in the community?</i>

\*\*\*If you need assistance with this activity please connect with the Public Health Nurse assigned to

\_\_\_\_\_  
Principals Signature

**Report Back Form Youth Empowerment Conference**  
Engaging youth to build Healthy Schools

The school health issue that our school worked on was: \_\_\_\_\_  
\_\_\_\_\_

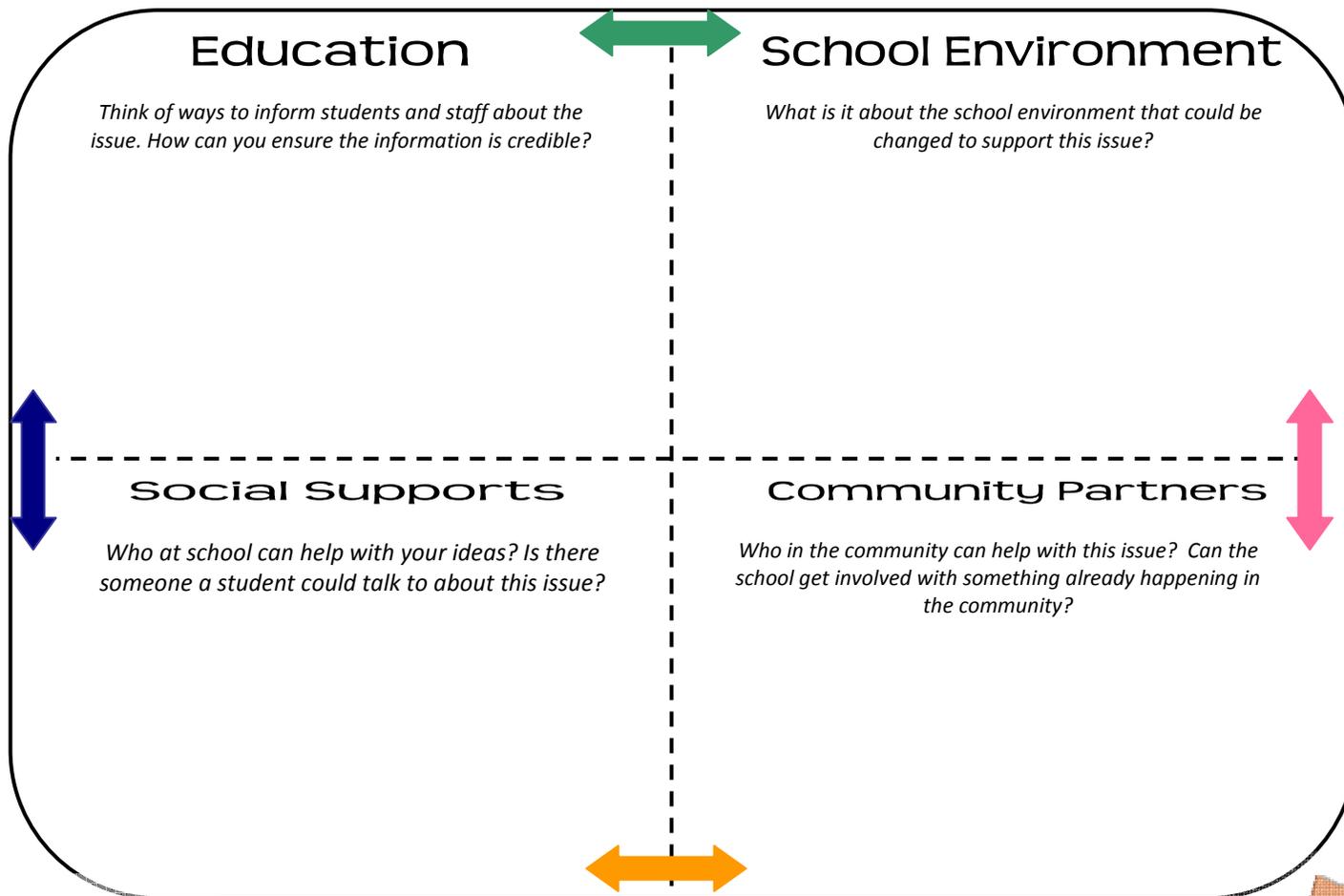
As a result of working on this school health issue the following positive change has occurred in our school environment (list the changes that have happened): \_\_\_\_\_  
\_\_\_\_\_

The approximate number of students and staff reached by our activities was \_\_\_\_\_

The student leads for the project at the school were: \_\_\_\_\_  
\_\_\_\_\_

The staff Advisor(s) for this project was: \_\_\_\_\_.

**Activity Description:** Using the chart below please tell us about the activities that took place at your school to tackle the school health issue identified above. Briefly tell us about the different activities that were done to address the issue under the categories listed below: education; school environment, social supports and community partners. Please list the date the activities took place on.



\_\_\_\_\_  
Principal's Signature

**MIDDLESEX-LONDON HEALTH UNIT  
REPORT NO. 099-11**

TO: Chair and Members of the Board of Health  
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health  
DATE: 2011 October 20

**Media Summary Report - January To June 2011**

**Recommendation**

It is recommended that Report No. 099-11 re Media Summary Report - January to June 2011 be received for information

During the first half of 2011 there were 647 media reports noting the involvement and activities of the Health Unit in the community. This is an increase (9%) over the 594 media reports for the first half of 2010 and also over the first half of 2009 (5.5%), when there were 613 media stories about the Health Unit.

The increased coverage in the first half of this year can be traced to several major stories that received a lot of attention from reporters and news editors across the region. The top story of 2011 so far has been the impact of Influenza on the community in the winter and spring. A stubborn flu strain, combined with low vaccination rates led to increased illnesses, absenteeism, hospitalizations and deaths. The Health Unit issued weekly Community Influenza Updates and created a Flu Info icon on the main website which increased awareness and interest in the story as well. Media outlets also provided significant coverage of food safety issues in the first half of the year, including the DineSafe program and the lead-up to its introduction in Middlesex County on July 1<sup>st</sup>. As well, there was a high number of stories about extreme weather alerts and tobacco control, including awareness about the impact of smoking in movies.

Radio reports were the main source of information about the Health Unit, citing the MLHU 377 times; followed by print media with 141 stories, 127 television news stories, and 2 Internet-based news outlets.

The first half of 2011 saw the introduction of three new media outlets. Two new Torstar newspapers: the daily Metro London and weekly London Community News, both of which are free, were launched in the spring; while Blackburn Radio introduced its new radio station, CKLO (Free-FM), in May.

In all, 43.9% of stories were initiated by the media themselves, while, 27.4% of stories came after news releases were issued; program promotion accounted for just over 22%, while 6.4% of media coverage came as a result of Board of Health reports. As a result, there were on average just over 3.5 media stories about the Health Unit per day in the first half of 2011. For a detailed overview, please refer to the attached Media Summary Report (Appendix A).

This report was prepared by Mr. Dan Flaherty, Manager, Communications.

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

**This report addresses** Policy #9-40 Media Relations, as outlined in the MLHU Administration Policy Manual.

<b>1. MEDIA COVERAGE*</b>				<b>TOTAL: 647</b>
<b>RADIO</b>	<b>TV</b>	<b>PRINT</b>	<b>INTERNET</b>	
377	127	141	2	

\* These figures reflect the number of times that each item was aired.

<b>2. Origin Codes</b>			
Media Release (MR)	68	Media Initiated (EXT)	109
Board Reports (BR)	16	MLHU Initiated (INT)	55

<b>3. NEWS/CURRENT AFFAIRS COVERAGE</b>			
Date	Code	Outlet	Topic
04-Jan	EXT	London Free Press	Lice Squad (company that travels to homes to remove head lice)
04-Jan	EXT	London Free Press	visitor restrictions at LHSC cancer unit due to flu
05-Jan	EXT	The London Free Press	Norwalk - signs & symptoms: what is it? How it works?
05-Jan	MR	Middlesex Banner	not too late to get flu shot
05-Jan	EXT	AM980	Seasonal illnesses prompt reminder about how to reduce spread of viruses
05-Jan	MR	NewsTalk 1290 CJBK	not too late to get flu shot
05-Jan	MR	AM980	not too late to get flu shot
06-Jan	EXT	X-FM Fanshawe	Radio documentary on losing weight as a New Year's resolution
07-Jan	MR	X-FM Fanshawe	Preventing seasonal illnesses
08-Jan	INT	London Free Press	client survey ad
10-Jan	EXT	AM980	\$5 million in provincial funding for bed bugs programming
10-Jan	EXT	CBC Radio One - London	\$5 million in provincial funding for bed bugs programming
10-Jan	EXT	X-FM Fanshawe	\$5 million in provincial funding for bed bugs programming
11-Jan	EXT	UWO Gazette	\$5 million in provincial funding for bed bugs programming
11-Jan	EXT	London Free Press	health violations at Ming's Restaurant
11-Jan	MR	AM980	Community Flu Report
11-Jan	MR	NewsTalk 1290 CJBK	Community Flu Report
11-Jan	MR	A-News	Community Flu Report
12-Jan	INT	Dorchester Signpost	client survey ad
12-Jan	INT	Middlesex Banner	client survey ad
13-Jan	EXT	L'action	healthy eating for adults
13-Jan	INT	The Londoner	client survey ad
13-Jan	INT	Parkhill Gazette	client survey ad
14-Jan	EXT	Today's Parent magazine	Healthy Babies Healthy Children

14-Jan	EXT	XFM	study reports that fewer women getting gardasil shot
14-Jan	EXT	NewsTalk 1290 CJBK	Bed Bugs - Provincial Funding announcement
15-Jan	EXT	London Free Press	Child & Youth Network promoting literacy
17-Jan	EXT	London Free Press	Government of Ontario Air Quality report - what does it mean for London
18-Jan	EXT	UWO Gazette	Government of Ontario Air Quality report - what does it mean for London
18-Jan	EXT	X-FM Fanshawe	Caffeine consumption - effects of drinking a lot of caffeine
18-Jan	MR	X-FM Fanshawe	Launch of new Move for Two DVD
18-Jan	MR	Rogers TV London Daytime	Launch of new Move for Two DVD
19-Jan	EXT	Middlesex Banner	DineSafe program coming to Middlesex Centre
19-Jan	INT	London Free Press	increase in flu activity in community, no beds available in hospitals
19-Jan	INT	London Free Press	Streaming of January Board of Health meeting
19-Jan	MR	London Free Press	Move for Two DVD launch at Prenatal Fair
19-Jan	EXT	NewsTalk 1290 CJBK	Influenza Update - how are things going?
19-Jan	EXT	CHCH TV	Bed crunch at hospitals / influenza
19-Jan	MR	A-News	Launch of new Move for Two DVD
20-Jan	EXT	Transcript & Free Press	Ontarians urged to get flu shots
20-Jan	INT	London Free Press	Increase in flu activity, # of flu shots down, surgeries cancelled
20-Jan	BR	X-FM Fanshawe	Dr. Jean Clinton's presentation to Board of Health
20-Jan	BR	X-FM Fanshawe	Influenza update Board of Health report
21-Jan	MR	AM980	Cold Weather Alert Issued for Middlesex-London (Jan.21/11)
21-Jan	MR	CJBK	Cold Weather Alert Issued for Middlesex-London (Jan.21/11)
21-Jan	MR	ATV	Cold Weather Alert Issued for Middlesex-London (Jan.21/11)
22-Jan	EXT	London Free Press	Housing budget affected by bed bugs
22-Jan	MR	London Free Press	Cold Weather Alert Issued for Middlesex-London (Jan.21/11)
24-Jan	EXT	The Dorchester Signpost	Glitterbug machine in Dorchester - importance of hand washing
26-Jan	MR	Dorchester Signpost	Seasonal illnesses prompt reminder about how to reduce spread of viruses
26-Jan	INT	XFM	Influenza surveillance report (Jan.20/11)
27-Jan	INT	Exeter Times Advocate	DineSafe program coming to Middlesex County
27-Jan	INT	Transcript & Free Press	DineSafe program coming to Middlesex County
27-Jan	INT	Strathroy Age Dispatch	Influenza surveillance report (Jan.20/11)
27-Jan	MR	NewsTalk 1290 CJBK	Community Flu Report
28-Jan	EXT	London Free Press	decline in HPV vaccinations to gr. 8 girls
28-Jan	INT	London Free Press	Influenza surveillance report (Jan.20/11)
28-Jan	EXT	AM980	JLC announces MMA event coming to London - MLHU reax
31-Jan	EXT	London Free Press	Food Safety - owner of Ming's; previous issues in Sault-Ste-Marie
01-Feb	MR	London Free Press	Promotion of Driven to Quit Challenge in Victoria Park
01-Feb	EXT	CBC Radio One - London	MMA Event coming to London
02-Feb	EXT	UWO Gazette	MMA Event coming to London
02-Feb	EXT	Dorchester Signpost	DineSafe program coming to Thames Centre
02-Feb	INT	Middlesex Banner	Do you want to quit smoking? (Stop Study)
02-Feb	INT	Middlesex Banner	Driven to Quit

02-Feb	INT	Dorchester Signpost	Driven to Quit
02-Feb	MR	Middlesex Banner	Cold Weather Alert Issued for Middlesex-London (Feb.1/11)
02-Feb	EXT	NewsTalk 1290 CJBK	MMA Event coming to London
03-Feb	INT	Dorchester Signpost	Do you want to quit smoking? (Stop Study)
03-Feb	INT	Transcript & Free Press	Do you want to quit smoking? (Stop Study)
03-Feb	INT	Transcript & Free Press	Driven to Quit
03-Feb	INT	Strathroy Age Dispatch	Driven to Quit
03-Feb	INT	Strathroy Age Dispatch	Do you want to quit smoking? (Stop Study)
07-Feb	EXT	UWO Gazette	Birth Control
07-Feb	EXT	X-FM Fanshawe	Healthy Sexual Relationships / STIs
07-Feb	EXT	X-FM Fanshawe	Update on flu season
08-Feb	MR	X-FM Fanshawe	Community Flu Report
08-Feb	MR	AM980	Community Flu Report
08-Feb	MR	NewsTalk 1290 CJBK	Community Flu Report
08-Feb	MR	CBC Radio One - London	Community Flu Report
08-Feb	MR	X-FM Fanshawe	Cold Weather Alert
08-Feb	MR	AM980	Cold Weather Alert
08-Feb	MR	A-News	Community Flu Report
09-Feb	INT	London Free Press	Influenza surveillance report (Feb.3/11)
10-Feb	EXT	London Free Press	Fluoride debate
10-Feb	EXT	Strathroy Age Dispatch	DineSafe program coming to Strathroy-Caradoc
10-Feb	INT	Strathroy Age Dispatch	Influenza surveillance report (Feb.3/11)
10-Feb	EXT	CHRW Radio	Radio show on Sex trade workers
11-Feb	EXT	London Free Press	Fluoride debate
14-Feb	BR	London Free Press	Board of Health report re: fluoridation of London drinking water
14-Feb	EXT	X-FM Fanshawe	MMA Event coming to London
14-Feb	MR	AM980	Cold Weather Alert
14-Feb	MR	A News	Number of cold weather days this year compared to 2010
15-Feb	MR	London Free Press	Cold Weather Alert Issues for Middlesex-London (Feb.14/11)
15-Feb	MR	AM980	Community Flu Report
15-Feb	MR	CBC Radio One - London	Community Flu Report
15-Feb	EXT	A-News	Local cases of bed bugs
16-Feb	EXT	Middlesex Banner	Closing of Gain Centre - MLHU will remain in mall location
16-Feb	EXT	Middlesex Banner	Battle against mosquitoes in Parkhill
16-Feb	INT	London Free Press	Influenza surveillance report (Feb.10/11)
17-Feb	BR	AM980	Fluoride Board Report
17-Feb	EXT	NewsTalk 1290 CJBK	Fluoride in drinking water
17-Feb	BR	A-News	Fluoride Board Report
17-Feb	MR	Rogers TV London Daytime	STOP on the Road
18-Feb	BR	London Free Press	Board of Health supports fluoridation of London drinking water
18-Feb	BR	X-FM Fanshawe	Board of Health supports fluoridation of London drinking water
19-Feb	EXT	London Free Press	Fluoride debate
19-Feb	INT	London Free Press	Do you want to quit smoking? (Stop Study)

21-Feb	BR	CHRW Radio	Fluoride
22-Feb	EXT	X-FM Fanshawe	New flu vaccine for seniors - Fluad
22-Feb	MR	Rogers TV London - Daytime	Nic-O-Time Challenge for Teens
24-Feb	MR	Strathroy Age Dispatch	Nic-O-Time Challenge for Teens
24-Feb	INT	Rogers TV London - Daytime	Mother Reach Trillium grant
26-Feb	EXT	London Free Press	Peter Jaffe letter to Gary Bettman on fighting in hockey
02-Mar	INT	Middlesex Banner	Influenza surveillance report (Feb.22/11)
03-Mar	EXT	London Free Press	Presentation by Paul Connett re: fluoride in drinking water
03-Mar	EXT	The Londoner	Fighting doesn't belong in hockey
03-Mar	EXT	<a href="http://www.ourlondon.ca">www.ourlondon.ca</a>	Fluoride in drinking water
04-Mar	EXT	London Free Press	Fluoride debate
04-Mar	EXT	London Free Press	Fluoride debate - why now?
05-Mar	EXT	London Free Press	Fluoride debate
09-Mar	EXT	London Free Press	London high school food safety violations
09-Mar	EXT	A-News	London high school food safety violations
10-Mar	EXT	Western News	Fanshawe, UWO food safety violations
10-Mar	EXT	London Free Press	Fanshawe, UWO food safety violations
10-Mar	INT	NewsTalk 1290 CJBK	Fluoride in drinking water issue
11-Mar	EXT	NewsTalk 1290 CJBK	Fanshawe, UWO food safety violations
14-Mar	EXT	Your Health & Fitness Magazine	Breast cancer screening
15-Mar	EXT	UWO Gazette	Food safety violations at UWO eateries
15-Mar	EXT	X-FM Fanshawe	Dangers of human biting
15-Mar	MR	X-FM Fanshawe	Parenting Teens videos
15-Mar	MR	X-FM Fanshawe	Parenting Teens videos
15-Mar	MR	A-News	Parenting Teens videos
16-Mar	EXT	Middlesex Banner	Update at County Council meeting
16-Mar	INT	London Free Press	Internet streaming of March Board of Health meeting
16-Mar	INT	Middlesex Banner	Request for a bylaw to implement DineSafe program in North Middlesex
16-Mar	MR	Middlesex Banner	Teen parenting video modules
16-Mar	MR	Middlesex Banner	Presentation of plaque to Vance Blackmore
16-Mar	BR	X-FM Fanshawe	Fluoride in drinking water issue - report to Board of Health
17-Mar	EXT	London Free Press	Possible increase in provincial funding to health units
17-Mar	BR	NewsTalk 1290 CJBK	Letter to NHL Board of Governors re: violence in hockey
23-Mar	EXT	Middlesex Banner	Budget update at County Council meeting
23-Mar	EXT	Middlesex Banner	CERV presentation a County Council meeting
26-Mar	MR	AM980	Latest Cold Weather Alert from MLHU
29-Mar	EXT	UWO-Fanshawe Journalism program	Nutritious Food Basket
29-Mar	EXT	UWO J-School	Nutritional concerns/issues around prepared frozen foods
Mar	EXT	Today's Parent magazine	How to relieve Braxton-Hicks contractions
Apr	EXT	Your Health & Fitness Magazine	Understanding head lice
Apr	EXT	Your Health & Fitness Magazine	Middlesex-London set to get in motion
01-Apr	INT	Magazine Latino	Mosquito larviciding continues in Middlesex-London (Spanish)

01-Apr	EXT	NewsTalk 1290 CJBK	Influenza Surveillance Report (Mar. 31/11)
01-Apr	EXT	X-FM Fanshawe	Oral Health Month
04-Apr	INT	London Free Press	Mosquito larviciding continues in Middlesex-London
06-Apr	EXT	Middlesex Banner	Mosquito larviciding continues in Middlesex-London
06-Apr	EXT	Dorchester Signpost	Mosquito larviciding continues in Middlesex-London
06-Apr	EXT	Middlesex Banner	Mosquito control begins in Parkhill
06-Apr	EXT	XFM	Influenza Surveillance Report (Mar. 31/11)
07-Apr	EXT	The Londoner	Mosquito larviciding continues in Middlesex-London
07-Apr	EXT	Transcript & Free Press	Mosquito larviciding continues in Middlesex-London
07-Apr	EXT	Strathroy Age Dispatch	Mosquito larviciding continues in Middlesex-London
08-Apr	EXT	London Free Press	Flu season deadliest in years (Influenza Surveillance Report Mar. 31/11)
08-Apr	EXT	Sun Media (Calgary Sun)	Camper Beware - things to consider before sending your child to camp
13-Apr	INT	London Free Press	Streaming of April Board of Health meeting
13-Apr	EXT	A-News	Spring medicine clean-up
14-Apr	BR	AM980	Call for action against smoking in movies (Board of Health report)
14-Apr	BR	X-FM Fanshawe	Call for action against smoking in movies (Board of Health report)
15-Apr	BR	London Free Press	Call for action against smoking in movies (Board of Health report)
18-Apr	BR	London Free Press	Proposed Alcohol Related Resolutions for the 2011 alPHa annual mtg
19-Apr	EXT	London Free Press	Memory stick containing records from speech/hearing clinic @ UWO missing
19-Apr	EXT	Toronto Star	Speaking out against violence in hockey
19-Apr	BR	SRC Windsor - French CBC	Call for action against smoking in movies (Board of Health report)
20-Apr	INT	Middlesex Banner	Influenza Surveillance Report (Apr.14/11)
21-Apr	INT	London Free Press	Influenza Surveillance Report (Apr.14/11)
26-Apr	EXT	Rogers TV London "Inside London"	National Immunization Week
29-Apr	INT	Magazine Latino	Mosquito larviciding continues in Middlesex-London
29-Apr	EXT	NewsTalk 1290 CJBK	Bed bugs issue in London
04-May	EXT	Strathroy Age Dispatch	Snow emergency reviewed
04-May	INT	Middlesex Banner	BeCause they thought home was the safest place...
04-May	INT	Dorchester Signpost	BeCause they thought home was the safest place...
05-May	EXT	Scene Magazine	Emergency Preparedness Week 2011
05-May	INT	London Free Press	Influenza Surveillance Report (Apr.28/11)
05-May	INT	Strathroy Age Dispatch	BeCause they thought home was the safest place...
05-May	INT	Transcript & Free Press	BeCause they thought home was the safest place...
16-May	EXT	My-FM Strathroy	Pool safety as we head towards summer
17-May	EXT	CBC Radio Ontario Today	Binge Drinking - why isn't the message getting through?
18-May	INT	Magazine Latino	Mosquito larviciding continues in Middlesex-London
18-May	INT	London Free Press	Streaming of May Board of Health meeting
20-May	EXT	London Free Press	Mixed martial arts event at JLC
25-May	MR	AM980	Vector-Borne Disease surveillance program

25-May	MR	X-FM Fanshawe	Vector-Borne Disease surveillance program
25-May	MR	NewsTalk 1290 CJBK	Vector-Borne Disease surveillance program
25-May	MR	CHRW - University of Western Ontario	Vector-Borne Disease surveillance program
25-May	MR	A-News	Vector-Borne Disease surveillance program
26-May	MR	Metro	Launch of 2011 VBD Surveillance Program
27-May	EXT	London Free Press	Vector-Borne Disease surveillance program
30-May	MR	Metro	Smoke-Free Movies news release
30-May	MR	AM980	Heat Alert Issued for Middlesex-London (May 30/11)
30-May	MR	My-FM Strathroy	Smoke-Free Movies news release
30-May	MR	NewsTalk 1290 CJBK	Smoke-Free Movies news release
30-May	MR	X-FM Fanshawe	Smoke-Free Movies news release
30-May	MR	NewsTalk 1290 CJBK	Heat Alert Issued for Middlesex-London (May 30/11)
31-May	EXT	London Free Press	Concerns in schools around heat alerts
31-May	MR	London Free Press	Heat Alert Issued for Middlesex-London (May 30/11)
31-May	MR	X-FM Fanshawe	Heat Alert Issued for Middlesex-London (May 30/11)
31-May	MR	My-FM Strathroy	Heat Alert Issued for Middlesex-London (May 30/11)
31-May	MR	NewsTalk 1290 CJBK	Heat Alert Issued for Middlesex-London (May 30/11)
31-May	MR	Rogers TV London "Inside London"	Smoke-Free Movies news release
01-Jun	INT	Magazine Latino	Mosquito larviciding continues in Middlesex-London
01-Jun	MR	Middlesex Banner	HU calls for changes to film ratings system to address tobacco use
01-Jun	MR	Metro	Heat Alert Issued for Middlesex-London (May 30/11)
01-Jun	EXT	X-FM Fanshawe	Sun Safety
02-Jun	MR	Transcript & Free Press	Launch of 2011 VBD Surveillance Program
07-Jun	MR	London Free Press	Health Unit issues Heat Alert
07-Jun	EXT	CBC Radio London - News	Anti-pornography conference
07-Jun	MR	AM980	Health Unit issues Heat Alert
07-Jun	MR	NewsTalk 1290 CJBK	Health Unit issues Heat Alert
08-Jun	MR	AM980	Extreme Heat Alerts
08-Jun	EXT	A-News	Non-smoking apartment building - what does Health Unit think?
08-Jun	MR	ourlondon.ca	Smoke-Free Movies news release
10-Jun	EXT	Metro	Sun safety
10-Jun	EXT	Metro	MLHU monitoring for cases of E.coli
10-Jun	EXT	LE Rempart	Riques de l'exposition au soleil
13-Jun	INT	Coffee News	Community Early Years Fair
15-Jun	INT	Dorchester Signpost	DineSafe in Middlesex County
15-Jun	INT	London Free Press	Streaming of June Board of Health meeting
16-Jun	INT	Strathroy Age Dispatch	DineSafe in Middlesex County
16-Jun	EXT	A-News	Pool Inspections - how are they done, what are the results?
20-Jun	EXT	AM980	Pool Safety - how to stay safe
22-Jun	EXT	Middlesex Banner	Vector-Borne Disease surveillance program
22-Jun	EXT	London Free Press	London councillor attendance at Board of Health meetings
22-Jun	INT	Middlesex Banner	DineSafe in Middlesex County

22-Jun	INT	Dorchester Signpost	DineSafe in Middlesex County
22-Jun	EXT	A-News	Pool Inspections - how does the inspection process work - what are inspections like??
23-Jun	EXT	Metro	Swimming safety
23-Jun	INT	The Londoner	Kids Corner - Smoking in Movies is Not Okay!
24-Jun	EXT	UWO School of Journalism	Listeriosis - in-person interview
24-Jun	EXT	A-News	Pool Inspections - spas and hot tubs
25-Jun	INT	London Free Press	RFP -Graphic Design Services
25-Jun	INT	London Free Press	DineSafe in Middlesex County
29-Jun	BR	London Free Press	Screening of high-risk moms in London hospitals
29-Jun	INT	Dorchester Signpost	DineSafe in Middlesex County
29-Jun	MR	Dorchester Signpost	DineSafe in Middlesex County
30-Jun	EXT	Interrobang - Fanshawe College	Sexual health - safe and fun sex
30-Jun	INT	The Londoner	Kids Corner - Smoking in Movies is Not Okay!
30-Jun	MR	AM980	DineSafe in Middlesex County
30-Jun	MR	NewsTalk 1290 CJBK	DineSafe in Middlesex County
30-Jun	EXT	Rogers TV - Strathroy - "Inside Strathroy"	Importance of Immunizations
30-Jun	EXT	Rogers TV - Strathroy - "Inside Strathroy"	Vector-Borne Disease surveillance program

\* The Communications Department issues Public Service Announcements (PSA's) to all local radio, tv & newspaper outlets on a regular basis. However, because it is very difficult to track if or when PSA's are aired we have not included this information.