AGENDA
MIDDLESEX-LONDON BOARD OF HEALTH

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

Thursday, 7:00 p.m.
2014 September 18

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

Mr. David Bolton
Ms. Denise Brown
Mr. Al Edmondson
Ms. Patricia Fulton
Mr. Marcel Meyer (Chair)
Mr. Stephen Orser (Vice Chair)
Mr. Ian Peer
Ms. Viola Poletes Montgomery
Ms. Nancy Poole
Mr. Mark Studenny
Ms. Sandy White

SECRETARY-TREASURER

Dr. Christopher Mackie

DISCLOSURE OF CONFLICTS OF INTEREST

APPROVAL OF AGENDA

APPROVAL OF MINUTES

BUSINESS ARISING FROM THE MINUTES

DELEGATIONS

7:05 – 7:15 p.m.	Ms. Trish Fulton, Chair, Finance and Facilities Committee re Item #1 - Finance and Facilities Committee Meeting September 4, 2014
7:15 – 7:25 p.m.	Mr. Mark Studenny, Chair, Governance Committee re Item #2 – Governance Committee Meeting September 18, 2014
7:25 – 7:40 p.m.	Ms. Kim Leacy, Registered Dietitian re Items #3 - 2014 Nutritious Food Basket Survey Results and #4 - Provincial Poverty Project

Item #	Report Name and Number	Link to Additional Information	Delegation	Recommendation	Information	Brief Overview
Committee Reports						
1	Finance and Facilities Committee Meeting September 4, 2014 (Report 052-14)	Appendix A September 4th Agenda	x	x		To receive information and consider recommendations from the September 4th FFC meeting
2	Governance Committee Meeting September 18, 2014 (verbal report)	September 18th Agenda	x	x		To receive information and consider recommendations from the September 18th GC meeting
Delegation and Recommendation Reports						
3	2014 Nutritious Food Basket Survey Results and Implications for Government Public Policy (Report 053-14)	Appendix A	x	x		To report NFB results for Middlesex-London and recommend the Board advocate for an increase in social assistance rates
4	Provincial Poverty Project (Report 054-14)		x	x		To provide an update on the provincial and local poverty simulation project and recommend that Board members encourage municipal candidates to complete the municipal candidate survey related to poverty planned for release on September 15th
Information Reports						
6	2013 Year End Performance on Accountability Indicators (Report 056-14)	Appendix A			x	To report about the Health Unit's strong performance on the 2013 Year-End Accountability Agreement performance indicators
5	Progress on the Shared Services Review Recommendations (Report 055-14)	Appendix A			x	To update the Board about progress on management's plan to address the recommendations of the PricewaterhouseCoopers report
7	Summary Information Report (Report 057-14)	Appendix A Appendix B Appendix C			x	To provide a summary of various Health Unit programs in the Environmental Health & Chronic Disease Prevention Services area
8	Medical Officer of Health Activity Report – July Report (Report 058-14)				x	To provide an update on the activities of the MOH for August and September

CONFIDENTIAL

OTHER BUSINESS

- Next Finance and Facilities Committee Meeting: Thursday, October 2, 2014 @ 9:00 a.m.
- Next Governance Committee Meeting: TBD
- Next Board of Health Meeting: Thursday, October 16, 2014 @ 7:00 p.m.
  (Board of Health Members are invited to get the seasonal Flu Shot at the Immunization Clinic at 50 King St. prior to the Board Meeting. Please let Sherri know if you plan to get the Flu Shot on Oct. 16th.

CORRESPONDENCE

a) Date: 2014 June 17 (Received 2014 June 17)
Topic: Thank you for donation to The Hardy Geddes Foundation
From: Ms. Nancy Poole, Board of Health Member
To: Mr. Marcel Meyer, Chair, Board of Health

b) Date: 2014 July 30 (Received 2014 August 1)
Topic: Motion passed by London City Council re: Civic administration collaborating with MLHU on initiatives related to prescription and non-prescription drug use impacts in the City of London
From: Ms. Cathy Saunders, City Clerk, City of London
To: Dr. Christopher Mackie, MOH and CEO, MLHU

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

ADJOURNMENT

PUBLIC SESSION – MINUTES

MIDDLESEX-LONDON BOARD OF HEALTH

2014 July 17

MEMBERS PRESENT: Mr. David Bolton
Mr. Al Edmondson
Ms. Trish Fulton
Mr. Marcel Meyer (Chair)
Mr. Ian Peer
Ms. Viola Poletes Montgomery (via telephone)
Mr. Stephen Orser (Vice-Chair)
Ms. Nancy Poole
Mr. Mark Studenny
Ms. Sandy White

ABSENT: Ms. Denise Brown

OTHERS PRESENT: Dr. Christopher Mackie, Medical Officer of Health & CEO (Secretary-Treasurer)
Ms. Sherri Sanders, Executive Assistant to the Board of Health (Recorder)
Mr. Wally Adams, Director, Environmental Health and Chronic Disease Prevention Services
Ms. Diane Bewick, Director, Family Health Services & Chief Nursing Officer
Ms. Laura Di Cesare, Director, Human Resources and Corporate Strategy
Mr. Dan Flaherty, Manager, Communications
Mr. John Millson, Director, Finance and Operations
Mr. Alex Tyml, Online Communications Co-ordinator

MEDIA PRESENT: none

Mr. Marcel Meyer, Chair of the Board of Health, called the meeting to order at 7:00 p.m.

DISCLOSURES OF CONFLICT(S) OF INTEREST

Chair Meyer inquired if there were any disclosures of conflict of interest to be declared. None were declared.

APPROVAL OF AGENDA

It was moved by Ms. Poletes Montgomery, seconded by Mr. Edmondson *that the **AGENDA** for the July 17, 2014 Board of Health meeting be approved.*

Carried

APPROVAL OF MINUTES

It was moved by Mr. Bolton, seconded by Mr. Peer *that the public session **MINUTES** of the June 19, 2014 Board of Health meeting be approved.*

Carried

BUSINESS ARISING FROM THE MINUTES - none

DELEGATION AND RECOMMENDATION REPORTS

1. Finance and Facilities Committee: July 3 Meeting (Report 044-14)

Ms. Fulton requested the permission of the Finance and Facilities Committee members to strike the second motion from Report 044-14 that reads as follows: Approve the Gifts and Honorariums policy as amended. The FFC committee members agreed to strike the motion.

Therefore, it was moved by Mr. Bolton, seconded by Mr. Meyer *that the motion "to approve the Gifts and Honorariums policy as amended" be removed from Report No. 044-14 re Finance and Facilities Committee: July 3 Meeting to enable the Finance and Facilities Committee time to further discuss Policy 4-055.*

Carried

It was moved by Ms. Poletes Montgomery, seconded by Mr. Edmondson *that the Board of Health:*

1) Approve the Out of Town Travel Expenses, Tangible Capital Assets, Use of Personal Vehicle, Grant Applications and Agreements, and Corporate Sponsorship policies as appended to Report No. 029-14FFC, and further

2) Approve the Donation Acceptance policy after staff investigation and further review by the Finance and Facilities Committee is complete.

Carried

2. **South Western Ontario Public Health Mutual Assistance Agreement (Report 045-14)**

It was moved by Mr. Peer, seconded by Mr. Orser *that the Board of Health endorse the Mutual Assistance Agreement for South Western Ontario Public Health Units attached as Appendix A to Report No. 045-14.*

Carried

3. **Medical Officer of Health Activity Report – July Report (Report 046-14)**

It was moved by Ms. White, seconded by Mr. Studenny *that Report No. 046-14 re Medical Officer of Health Activity Report – July be received for information.*

Carried

IN CAMERA

At 7:15 p.m., it was moved by Mr. Peer, seconded by Ms. White *that the Board of Health move in camera to discuss the following:*

1) Matters concerning labour relations or employee negotiations, and
2) Personal matters about an identifiable individual, and
3) Matters concerning litigation or potential litigation.

Carried

At 8:45 p.m., it was moved by Mr. Bolton, seconded by Ms. White *that the Board of Health return to public forum and report that matters were discussed concerning the following:*

1) Matters concerning labour relations or employee negotiations, and
2) Personal matters about an identifiable individual, and
3) *Matters concerning litigation or potential litigation.*

Carried

Appointment of an Associate Medical Officer of Health (Report 047-14)

It was moved by Ms. White, seconded by Mr. Orser *that it be reported in a public forum that the Board of Health passed the following motions:*

1) *To approve the recommendation of the Medical Officer of Health and the Chair of the Board of Health to appoint Dr. Gayane Hovhannisyan to the position of Associate Medical Officer of Health (AMOH) for Middlesex-London Health Unit pending approval by the Minister of Health and Long-Term Care; and further*

2) *To submit all necessary documentation to the Minister of Health and Long-Term Care and the Chief Medical Officer of Health for the approval of the appointment; and further*

3) *To offer Dr. Hovhannisyan the base salary rate of $194,820 and support an application from Dr. Hovhannisyan for additional compensation to the Minister of Health and Long-Term Care as per the guidelines set out in the 2014/2015 Medical Officer of Health / Associate Medical Officer of Health Compensation Initiative; and further*

4) *To support the separation of the AMOH role from the role of Director of Oral Health, Communicable Disease and Sexual Health Services, and the initiation of the recruitment process for the permanent fulltime Director.*

Carried

2013 Surplus (Report 051-14)

It was moved by Mr. Edmondson, seconded by Ms. Poole *that it be reported in a public forum that the Board of Health passed the following:*

1) *To approve providing the remaining 2013 operating surplus to the municipal funders, in the amount of $551,902, at the same rate as they fund the municipal component of the Health Unit's budget ($463,602, or 84% to the City of London, and $88,300, or 16% to the County of Middlesex); and further*

2) *To approve subsequently requesting the use of some of the surplus to fund costs related to the current negotiations; and further*

3) *To approve using all or a portion of the $200,000 set aside in the 2014 budget process for mitigating inflationary pressures related to staffing costs to fund costs related to the current negotiations.*

Carried

Memorandum of Settlement with CUPE Local 101 (Report 048-14)

It was moved by Mr. Peer, seconded by Mr. Studenny *that it be reported in a public forum that the Board of Health passed the following:*

1) *To approve the Memorandum of Settlement with CUPE Local 101, (Appendix A) to Report No. 048-14; and further*

2) *To authorize the immediate payment of the signing bonus.*

Carried

CORRESPONDENCE - none

OTHER BUSINESS

Next Finance and Facilities Committee Meeting: Thursday, September 4, 2014 @ 9:00 a.m.
Next Governance Committee Meeting: Thursday, September 18, 2014 @ 5:00 p.m.
Next Board of Health Meeting: Thursday, September 18, 2014 @ 7:00 p.m

It was moved by Ms. White, seconded by Mr. Orser *that the scheduled August Board of Health meeting be cancelled.*

Carried

ADJOURNMENT

At 8:50 p.m., it was moved by Mr. Studenny, seconded by Mr. Orser *that the meeting be adjourned.*

Carried

_____ _____

MARCEL MEYER
Chair

CHRISTOPHER MACKIE
Secretary-Treasurer

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 052-14

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2014 September 18

FINANCE AND FACILITIES COMMITTEE: SEPTEMBER 4, 2014 MEETING

The Finance and Facilities Committee (FFC) met at 9:00 a.m. on September 4, 2014 (Agenda). The draft public minutes are attached as Appendix A. The following items were discussed at the meeting and recommendations made:

Reports	Summary of Discussion	Recommendations for Board of Health's Consideration
Financial Policies Review (029-14FFC)	From Business Arising from Minutes	It was moved by Mr. Meyer, seconded by Mr. Peer *that staff members prepare a report for the October Finance and Facilities Committee meeting that deals with Policy 4-055 Gifts and Honorariums.* Carried
Q2Finance Policies Review (**030-14FFC**)	Mr. Millson anticipates a break even situation at end of year; however, negotiations and the unknown provincial funding level (anticipating no more than 2%) could impact the final outcome. Dr. Mackie highlighted Table 1 which identifies year end projects that may need to be deferred in 2014 or require the use of previously created reserve funds if there is a reduction in provincial funding.	It was moved by Mr. Bolton, seconded by Mr. Peer *that the Finance and Facilities Committee receive Report No. 030-14FFC re Second Quarter Financial Update for information.* Carried
Janitorial Services – Contract Award (**031-14FFC**)	Mr. Millson and Dr. Mackie explained the tender process and reported that both companies in the motions are companies that have not previously be contracted by the Health Unit.	It was moved by Mr. Meyer, seconded by Mr. Bolton *that the Finance and Facilities Committee make recommendation to the Board of Health to award the following two year contracts for janitorial services:* *i) GDI Integrated Facility Services – for leased premises located at 50 King Street and 399 Ridout Street, London Ontario for a total amount of $241,238.00, and further;* *ii) Bee Clean Building Maintenance – for leased premises located at the Kenwick Mall, 51 Front Street, Strathroy, Ontario for a total amount of $25,832.56.* Carried
Committee Tools / Checklists (**032-14FFC**)	Chair Fulton discussed the information that Mr. Ian Jeffries, Audit Partner, KPMG, provided about financial governance. Chair Fulton suggested that the information	It was moved by Mr. Bolton, seconded by Mr. Meyer *that the Finance and Facilities Committee receive Report No. 032-14FFC re Committee Tools /Checklist for information.* Carried

	be incorporated into a Work Plan for the Committee. Mr. Millson explained that a new Schedule E to the Accountability Agreement will be added that Boards must meet. This will also need to be incorporated into the Work Plan.	
Program Budget Marginal Analysis (PBMA) Criteria/Weights (**033-14FFC**)	Dr. Mackie explained that approximately 175 staff participated in sessions to discuss Health Unit values and direction. He explained that the changes in weight presented in Report 033-14FFC were a result of the staff input. The Committee asked Dr. Mackie to express its gratitude to staff for their work on the weightings and values information.	It was moved by Mr. Peer, seconded by Mr. Bolton *that the Finance and Facilities Committee endorse the revised weightings of the PBMA Criteria as proposed in this report.* Carried
Middlesex-London Health Unit – March 31st Draft Financial Statements (**034-14FFC**)	Dr. Mackie explained that the April 1st to March 31st programs are earmarked for specific projects; therefore, any surpluses must be returned to their respective Ministry.	It was moved by Mr. Bolton, seconded by Mr. Peer *that the Finance & Facilities Committee recommend that the Board of Health approve the audited Consolidated Financial Statements for the Middlesex-London Health Unit, March 31st, 2014 as appended to Report No. 034-14FFC.* Carried
MOHLTC Reconciliation Report (**035-14FFC**)		It was moved by Mr. Meyer, seconded by Mr. Bolton *that the Finance & Facilities Committee make recommendation to the Board of Health to approve the 2013 Ministry of Health & Long-Term Care Reconciliation Report as appended to Report No. 035-14FFC.* Carried
Committee Work Plan (Verbal)	Chair Fulton explained that the Committee requires a Work Plan that would contain a checklist of monthly projects that the committee is required to review.	Chair Fulton will review the minutes of the FFC and create a draft of the monthly reports that committee reviewed between August 2013 and September 2014.
STI Clinic Review – Sole Source Procurement (**036-14FFC**)		It was moved by Mr. Bolton, seconded by Mr. Peer that the Finance and Facilities Committee receive Report No. 036-14FFC re STI Clinic Review – Sole Source Procurement for information.

The Finance and Facilities Committee moved in camera to discuss an issue concerning an identifiable individual.

Next Meeting

The next meeting of the Finance and Facilities Committee is scheduled for Thursday, October 1, 2014 @ 9:00 a.m.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

PUBLIC MINUTES
Finance and Facilities Committee
50 King Street, Room 3A
MIDDLESEX-LONDON BOARD OF HEALTH
2014 September 4 9:00 a.m.

COMMITTEE MEMBERS PRESENT: Mr. David Bolton
Ms. Trish Fulton (Chair)
Mr. Marcel Meyer
Mr. Ian Peer

REGRETS: Mr. Stephen Orser

OTHERS PRESENT: Dr. Christopher Mackie, Medical Officer of Health and CEO
Mr. John Millson, Director, Finance and Operations
Ms. Sherri Sanders, Executive Assistant to the Board of Health (Recorder)
Ms. Laura Di Cesare, Director, Human Resources and Labour Relations

At 9:00 a.m., Ms. Trish Fulton, Committee Chair, welcomed everyone to the July Finance and Facilities Committee (FFC) meeting.

DISCLOSURES OF CONFLICT(S) OF INTEREST

Chair Fulton inquired if there were any disclosures of conflict of interest to be declared. None were declared.

APPROVAL OF AGENDA

It was moved by Mr. Bolton, seconded by Mr. Peer *that the Agenda for the July 3, 2014 FFC meeting be approved. Confidential item in public domain and will inquire to consider in camera.*

Carried

APPROVAL OF MINUTES

It was moved by Mr. Bolton, seconded by Mr. Peer *that the **Public Minutes** from the July 3, 2014 Finance and Facilities Meeting be approved.*

Carried

BUSINESS ARISING FROM MINUTES

It was moved by Mr. Meyer, seconded by Mr. Peer *that staff prepare a report for the October Finance and Facilities Committee meeting that deals with Policy 4-055 Gifts and Honorariums.*

Carried

NEW BUSINESS

Q2Finance Policies Review (Report 030-14FFC)

Mr. John Millson, Director, Finance & Operations assisted Committee members with their understanding of this report. He anticipates a break even situation at end of year; however, negotiations and the unknown provincial funding level (anticipating no more than 2% increase) could impact the final position at year end. Dr. Mackie highlighted Table 1 which identifies priority projects that are not yet funded. Management will work to identify funds from current operating dollars to cover these expenses, but they may need to be deferred to 2015 or require seeking funds from other sources.

It was moved by Mr. Bolton, seconded by Mr. Peer *that the Finance and Facilities Committee receive Report No. 030-14FFC re Second Quarter Financial Update for information*.

Carried

Janitorial Services – Contract Award (**Report 031-14FFC**)

Mr. Millson and Dr. Mackie explained the tender process and reported that both companies in the motions below are companies that have not previously be contracted by the Health Unit.

It was moved by Mr. Meyer, seconded by Mr. Bolton *that the Finance and Facilities Committee make recommendation to the Board of Health to award the following two year contracts for janitorial services:*

i) GDI Integrated Facility Services – for leased premises located at 50 King Street and 399 Ridout Street, London Ontario for a total amount of $241,238.00, and further;

ii) Bee Clean Building Maintenance – for leased premises located at the Kenwick Mall, 51 Front Street, Strathroy, Ontario for a total amount of $25,832.56.

Carried

Committee Tools / Checklists (**Report 032-14FFC**)

Chair Fulton discussed the information that Mr. Ian Jeffries, Audit Partner, KPMG, provided about financial governance.

Mr. Millson explained that a new Schedule E to the Accountability Agreement will be added that Boards must meet.

It was moved by Mr. Bolton, seconded by Mr. Meyer *that the Finance and Facilities Committee receive Report No. 032-14FFC re Committee Tools /Checklist for information*.

Carried

Program Budget Marginal Analysis (PBMA) Criteria/Weights (**Report 033-14FFC**)

Dr. Mackie explained that approximately 150 to 175 staff participated in sessions to discuss Health Unit values and direction. He explained that the changes in weight presented in Report 033-14FFC were a result of input from staff and frontline management.

Dr. Mackie reminded Committee members that the Proposed Values Tree (Appendix B to this report) was reviewed (as a tree diagram) at the July 18, 2014 Board education session.

It was moved by Mr. Peer, seconded by Mr. Bolton *that the Finance and Facilities Committee endorse the revised weightings of the PBMA Criteria as proposed in this report.*

Carried

The Committee asked Dr. Mackie to express its gratitude to staff for their work on the weightings and values information.

Middlesex-London Health Unit – March 31st Draft Financial Statements (**Report 034-14FFC**)

The purpose of the financial statements is for the Health Unit to settle the funds provided for the Health Unit programs with a March 31st year end. Dr. Mackie explained that the April 1st to March 31st programs are earmarked for specific projects, and surpluses must be returned to the respective Ministry.

It was moved by Mr. Bolton, seconded by Mr. Peer *that the Finance & Facilities Committee recommend that the Board of Health approve the audited Consolidated Financial Statements for the Middlesex-London Health Unit, March 31st, 2014 as appended to Report No. 034-14FFC.*

Carried

MOHLTC Reconciliation Report (Report 035-14FFC)

It was moved by Mr. Meyer, seconded by Mr. Bolton *that the Finance & Facilities Committee make recommendation to the Board of Health to approve the 2013 Ministry of Health & Long-Term Care Reconciliation Report as appended to Report No. 035-14FFC.*

Carried

Committee Work Plan - Verbal

Chair Fulton explained that the Committee requires a Work Plan that would contain a checklist of monthly projects that the committee is required to review. Chair Fulton will review the minutes of the FFC and create a draft of the monthly reports that committee reviewed between August 2013 and September 2014.

IN CAMERA

At 10:10 a.m. it was moved by Mr. Peer, seconded by Mr. Meyer *that the Finance and Facilities Committee move in camera to discuss an issue concerning an identifiable individual.*

Carried

At 10:30 a.m., it was moved by Mr. Meyer, seconded by Mr. Bolton *that the Finance and Facilities Committee return to a public forum and report that a discussion was held about an issue concerning an identifiable individual.*

Carried

STI Clinic Review – Sole Source Procurement (Report 036-14FFC)

It was moved by Mr. Bolton, seconded by Mr. Peer *that the Finance and Facilities Committee receive Report No. 036-14FFC re STI Clinic Review – Sole Source Procurement for information.*

Carried

Mr. Peer agreed to present the Finance and Facilities Committee Report at the Board of Health meeting on September 18, 2014, in Chair Fulton's absence

ADJOURNMENT

At 10:40 a.m., it was moved by Mr.Bolton, seconded by Mr. Meyer *that the meeting be adjourned.*

Carried

_____
TRISH FULTON
Chair

_____
CHRISTOPHER MACKIE
Secretary-Treasurer

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 053-14

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health and CEO

DATE: 2014 September 18

2014 NUTRITIOUS FOOD BASKET SURVEY RESULTS AND IMPLICATIONS FOR GOVERNMENT PUBLIC POLICY

Recommendations

It is recommended that the Board of Health:

1. ***Send a letter to the Premier of Ontario, the Right Honourable Kathleen Wynne, commending her for taking the initiative to update the provincial poverty plan and requesting that the province increase social assistance rates to reflect the rising cost of nutritious food and safe housing.***

2. ***Forward Report No. 053-14 re 2014 Nutritious Food Basket Survey Results and Implications for Government Public Policy to the City of London, Middlesex County, and appropriate community agencies***.

Key Points

- The Nutritious Food Basket survey is conducted annually by all public health units in Ontario to measure the cost of basic, healthy eating.
- The annual survey results repeatedly demonstrate that social assistance rates are not adequate for our most vulnerable Middlesex-London residents to afford basic needs.
- Social determinants of health such as food access, income, housing and employment explain part of the wide health inequities existing within and across societies; these determinants are strongly influenced by public policy decisions.

Background

Annually during the month of May, all Ontario public health units conduct the Nutritious Food Basket (NFB) survey in accordance with the requirements under the Ontario Public Health Standards. The survey provides a measure of the cost of basic healthy eating taking into consideration current nutrition recommendations and average food purchasing patterns of Canadians. The NFB results can be used to: estimate the basic cost for an individual or household to eat healthy; compare the basic cost of healthy eating with income and other basic living expenses; plan programs that promote access to nutritious, safe and culturally acceptable foods; and inform policy decisions.

A Public Health Dietitian on the Chronic Disease Prevention and Tobacco Control Team is responsible for the data collection and analysis of the Nutritious Food Basket survey to provide a measure of the cost of food available to residents in Middlesex-London. In 2014, 12 grocery stores in Middlesex-London were surveyed, including areas of variable economic status.

Survey Results

In May 2014, the estimated local monthly cost to feed a family of four was $804.64. This is an $18.14 or 2.3% increase from the estimated cost in May 2013.

Table 1 highlights some real life situations for Middlesex-London residents utilizing 2014 income rates, rental costs and food costs. The NFB annual survey repeatedly demonstrates that people with low

incomes cannot afford to eat healthy, after meeting other essential needs for basic living. Appendix A, "***The Cost of Healthy Eating 2014***", provides an overview of the affordability of food costs in relation to basic needs and profiles opportunities for community action.

Table 1 – Monthly Income and Cost of Living Scenarios for 2014

	Single Man on Ontario Works (OW)	Single Man on ODSP	Single Woman over 70 (Old Age Security / Guaranteed Income Security)	Family of 4 Ontario Works	Family of 4 Minimum Wage Earner	Family of 4 Median Income (after tax)
Monthly Income (Including Benefits and Credits)	$709	$1179	$1513	$2158	$2748	$6954
Estimated Monthly Rent	$585	$757	$757	$1146	$1146	$1146
Food (Nutritious Food Basket)	$225.51	$225.51	$163.72	$804.64	$804.64	$804.64
WHAT'S LEFT?*	**-$101.51**	**$196.49**	**$592.28**	**$207.36**	**$797.36**	**$5003.36**

* People still need funds for utilities, phone, transportation, cleaning supplies, personal care items, clothing, gifts, entertainment, internet, school supplies, medical and dental costs and other costs.

Notes: Rental estimates are from *Canadian Mortgage and Housing Corporation Rental Market Statistics, Spring 2014*. Utility costs may or may not be included in the rental estimates. Utility costs vary considerably based on age and condition of housing, type of heating, range of appliances, air conditioning or cooling and household size.

Opportunities for Action

A poverty awareness project, being led by local and provincial partners, will build awareness and support for healthy public policy among local decision makers to help reduce poverty and food insecurity. More information about this project is detailed in Report No. 054-14.

Social determinants of health such as food access, income, housing and employment help explain the wide health inequities existing within and across societies; these determinants are strongly influenced by government public policy decisions. Poor nutrition can lead to increased risk for chronic and infectious diseases, increased risk of low birth weight pregnancies, and negative impacts on the growth and development of children. In 2012, 69.5% of Ontario households receiving social assistance were food insecure. Social assistance rates are not adequate for our most vulnerable Middlesex-London residents to afford basic needs. It is recommended that the Board of Health advocate to the Ontario Government to increase social assistance rates to a level that reflects the rising cost of nutritious food and safe housing.

This report was prepared by Ms. Kim Leacy, Registered Dietitian, Ms. Claire Paller, Program Evaluator, and reviewed by Ms. Linda Stobo, Manager, Chronic Disease Prevention & Tobacco Control Team.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health and CEO

This report addresses the following requirements of the Ontario Public Health Standards (2014): Foundational Standard 3, 4, 5, 8, 9, 10; Chronic Disease Prevention 2, 7, 11, 12

the Cost of Healthy Eating 2014

Each year, Middlesex-London Health Unit tracks the cost of food from local grocery stores using the Nutritious Food Basket survey.

Food Affordability

When money is tight, people cut food budgets to pay for other expenses.

They buy cheaper, less nutritious foods or skip meals.

Poor diets increase risk of infectious & chronic diseases (e.g. diabetes, heart disease and cancer).

Children in low income households are more likely to get sick and struggle in school.

Income is one of the best predictors of health.

What is left after monthly rent & food costs?

	Single person	Family of 4
Income (from Ontario Works)	$709	$2158
Rent	$585	$1146
Food	$226	$805
REMAINING	-$102	$207

In 2013, ~11,085 London households received Ontario Works each month, including 6,700 children under the age of 18.

AND

People still need to pay for: heat and hydro, transportation, child care, phone/internet, clothing, medical costs, school supplies, personal care items, household cleaners, etc.

THEREFORE

Our most vulnerable residents do not have adequate funds to meet their basic needs.

All Middlesex-London residents should have access to a nutritious, adequate & culturally acceptable diet.

Last year, **43,344** visits were made to the London Food Bank, **36%** of these were children.

What can you do to help?

Engage with municipal candidates

- ✓ Read what candidates think about poverty reduction at: www.healthunit.com/hungry-for-action
- ✓ Ask candidates about their views on affordable housing, transit and child care
- ✓ Vote in the municipal election on October 27th

Learn more about hunger & poverty

- ✓ Could you afford your basic needs on social assistance? Try dothemath.thestop.org
- ✓ Did you make a low income wage last the month? playspent.org
- ✓ Visit www.vibrantcommunities.ca to learn about cities reducing poverty

Support the local economy

- ✓ Buy local products from local farmers and merchants
- ✓ Download the Get Fresh … Eat Local map for Middlesex-London market locations (www.healthunit.com/eating-local)

Volunteer

- ✓ Donate time, food or money to support the London Food Bank
- ✓ Apply to be a Bridges out of Poverty|Circles ally, child minder, meal provider or coalition member. For more info e-mail: sclarke@goodwillindustries.ca
- ✓ Share gardening skills or donate growing space to local groups

For more information visit: www.healthunit.com/cost-of-healthy-eating

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT
www.healthunit.com

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 054-14

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health and CEO

DATE: 2014 September 18

PROVINCIAL POVERTY PROJECT

Recommendations

It is recommended that the Board of Health:

1. ***Encourage all candidates in the municipal election to complete the municipal candidate survey; and,***
2. ***Participate in the local poverty simulation event in November and encourage City and County councilors to participate.***

Key Points

- Poverty negatively impacts health and the ability to create a healthy, vibrant community.
- A collaborative local and provincial project is underway with the goal of building awareness and support among local decision makers for healthy public policy to help reduce poverty and food insecurity in municipalities across Ontario.
- A municipal candidate survey was distributed to London and Middlesex County municipal election candidates including questions about the candidate's views on municipal governments' role in poverty reduction, affordable housing and affordable transportation.
- Survey results will be posted on the Health Unit website starting September 29th.
- Municipal, provincial and federal government representatives are encouraged to participate in the next phase of the project, the local poverty simulation event planned for November.

Background

Poverty negatively impacts health and the ability to create a healthy, vibrant community. It is a real concern when any Middlesex-London resident can't afford basic needs, including nutritious and sufficient food. Income is one of the best predictors of health; however, many Middlesex-London residents perceive upstream social determinants of health, like income and education, as having less impact on health compared to downstream factors, like access to health care and lifestyle choices, which indicates the need for greater public awareness. These social determinants of health are influenced heavily by public policy decisions that are made by municipal, provincial and federal governments.

This project is being led by the Ontario Society of Nutrition Professionals in Public Health and supported by local planning teams. It is a collaborative initiative with the goal of building awareness and support among local decision makers for healthy public policy to help reduce poverty and food insecurity in municipalities across Ontario. Currently, 15 regions are participating in the project, including Algoma, Chatham-Kent, Elgin St. Thomas, Grey Bruce, Huron, Kenora-Rainy River, Middlesex-London, Niagara, Peel, Perth, Peterborough, Sudbury, Timiskaming, and Windsor-Essex. The Ontario Public Health Standards mandate Boards of Health to address the social determinants of health with the objective of reducing health inequities. This is one strategy to help meet the requirement.

The current initiatives include a municipal election candidate survey (Sept/Oct 2014) and coordinated, local poverty simulation events (Nov 2014).

Municipal Candidate Survey

Informed by a literature review of available evidence, the municipal candidate survey aims to raise awareness with:

- municipal election candidates about evidence-based strategies that municipalities could employ to address local poverty.
- voters about municipal election candidates' views on poverty reduction strategies for municipalities, including those that impact food access.

A draft survey, with the content informed by evidence and composed primarily of close-ended questions, was prepared and disseminated to the local planning teams of participating communities. The local planning teams then tailored the questions to meet the local community context and need. At the time of preparing this report, the London and Middlesex County surveys were still being finalized; however, questions intend to address candidate views on the municipality's role in poverty reduction, affordable housing and affordable transportation. The survey was distributed to London and Middlesex County candidates September 15th, with a response requested by September 26th. Results will be posted starting September 29th on the Health Unit website.. The candidate survey and literature review was funded in part by a grant from the Heart and Stroke Foundation. The final version of the municipal candidate survey will be provided to the Board of Health on September 18th.

Next Steps

The Association of Local Public Health Agencies (alPHa) has endorsed the project and intends to promote the municipal candidate survey as part of a public health primer sent to all candidates. Locally, the municipal candidate survey results will be promoted primarily through social media (e.g., Facebook, Twitter). The survey results may also be promoted at various All Candidates Events across London and Middlesex County by representatives from the organizations on the local planning team.

The second phase of the project is coordinated, local poverty simulation events occurring across Ontario in November. Local decision makers and influencers, including City and County Councilors, Members of Provincial Parliament and Members of Parliament will be invited to attend a London and Middlesex County poverty simulation event. At the event, participants will be assigned roles in 'families' and will manage the unexpected challenges of a marginalized life and barriers to accessing community resources during a simulated month. The goal of the poverty simulation is to impact programming and policy decisions by affecting local decision makers and influencers' attitudes toward people living in poverty and the barriers they face.

This report was prepared by Ms. Kim Leacy, Registered Dietitian, and reviewed by Ms. Jayne Scarterfield, Public Health Nurse, and Ms. Linda Stobo, Manager, Chronic Disease Prevention and Tobacco Control Team.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards (2014): Foundational Standard 3, 4, 5, 8, 9; Chronic Disease Prevention 7, 11, 12.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 055-14

TO: Chair and Members of the Finance & Facilities Committee

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2014 September 18

PROGRESS ON THE SHARED SERVICES REVIEW RECOMMENDATIONS

Recommendation

It is recommended that Report No. 055-14 re Progress on the Shared Services Review Recommendations be received for information.

Key Points

- Since the completion of the Shared Services Review in 2013, staff have worked to address nearly all of the operational improvement recommendations made by PricewaterhouseCoopers.
- Significant progress has been made on the highest priority "phase 1" recommendations, as well as the "phase 2" recommendations.
- Final report will come to the Board in September 2015.

Background

Board of Health members will recall that PricewaterhouseCoopers (PwC) was hired to conduct an Efficiency and Shared Services Review of MLHU's administration in 2013. At the May 2013 meeting, PwC reported the results of this review (see Report No. 063-13). The Board then passed a resolution enabling staff to begin addressing PwC's recommendations.

At the June 2013 and September 2013 meetings, staff reported the initial implementation plan (see Report No. 089-13) and progress-to-date on the six highest priority "phase 1" recommendations (see Report No. 095-13), respectively. This report provides a progress update on both "phase 1" and the rest of the recommendations ("phase 2").

Progress on the Recommendations

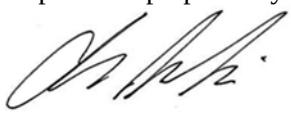
Six of the 27 recommendations were identified as high-priority and addressed in "phase 1" as they offered greatest return on investment. The other recommendations were categorized as "phase 2." See Appendix A for full details of progress on the recommendations. Notable progress includes:

- Finance policies revised
- Implementation of a new intranet platform to facilitate many automated processes
- Development and piloting of fee-for-service public fit-testing service
- New PBMA process implemented
- Budget processes overhauled
- Travel Clinic lease negotiated

Next Steps

Staff will continue to work to address the recommendations of the Shared Services Review. For some items that have been 'completed,' such as the PBMA process, MLHU will focus on further refinement (in the spirit of continuous quality improvement). Staff will continue to update the Board on the progress of the recommendations of the Shared Services Review.

This report was prepared by Mr. Ross Graham, (former) Manager of Strategic Projects.



Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

Appendix A: Progress on Shared Services Review Recommendations

Rec.	No.	PHASE 1 - Activities	Comment
1a	1	Streamline the following paper-based processes: timesheets, attendance management, expense reimbursement, purchase requisitions, new employee/volunteer/student enrollment	**In-progress.** MLHU now using SharePoint Intranet software which facilitates process automation. Mileage submissions are now automated, with other processes in development.
1b	9	Investigate overhead cost-sharing with the Travel Clinic physicians	**Completed** and submitted as part of the 2013 PBMA process.
	10	Investigate revenue-generating opportunities from providing fit-testing to health service providers and students	**Completed**. Public fit-testing service currently offered as a 1-year pilot. Service on track to be profitable within 1-year timeframe. CERV volunteers are assisting and staff hours have been increased to accommodate bookings.
	11	Investigate revenue-generating opportunities for MLHU to charge speaker-fees	**Completed**. No opportunities available at this time.
	14	Integrate and align planning and budgeting activities (incl. clarification of roles, communication of expectations from all parties involved, and discussion of ongoing collaborative support)	**Completed**. Successful PBMA process completed in 2013 for the 2014 budget. Over $1M reallocated toward higher impact services. Planning is underway for 2015.
2c	17	Update expense, travel, mileage, catering, and procurement policies to ensure they are in accordance with best practices and support effective control and monitoring of costs. Communicate key points and/or notable changes to staff and educate Managers regarding enforcement expectations and accountabilities	**Completed**. Policies reviewed by PwC, MLHU Staff and Board of Health, then implemented. Managers and staff now being educated on policy changes. Education to be completed by Q4.
3a	21	Develop clearly-defined, measurable, outcomes–focused internal key performance indicators (KPIs) that provide meaningful direction for desired operational improvement which focus efforts on the efficiency and effectiveness of operations	**In-progress.** All teams required to provide list of PIs as part of 2014 operational planning. Balanced scorecard with organization KPIs being developed as part of strategic planning. Now focusing on developing team-specific KPIs as part of 2015 operational planning process.
Rec.	**No.**	**PHASE 2 - Activities**	**Comment**
1a	3	Investigate software to automate/manage attendance management	**In-progress** as part of activity #1 (in phase 1).
	4	Investigate software to automate/monitor staff learning/development activities (incl. resume tracking, certification)	**In-progress**. Has been developed for MLHU specific training and will be expanded to all staff development activities.
	5	Investigate software to automate/manage critical incidents	**In-progress** as part of activity #1 (in phase 1).
1b	6	Reduce bulk inventory and storage requirements	**Completed -** Offsite storage reduced by 200 ft^2.
	7	Reduce amount of offsite records storage	**In-progress**. Focusing on highest volume records: immunization consent forms.
	8	Revive Facilities Committee to examine space requirements and determine if MLHU can reduce its footprint	**In-progress.** Working with external consultant to examine space requirements.

	12	Investigate revenue-generating opportunities for charging private organizations for Emergency Plan review	**Investigation Complete.** No opportunities at this time.
2a	13	Investigate mechanism to formalize "in-year" reallocation of budget resources	**Completed**. Now part of quarterly variance review.
2b	15	Investigate collaboration when planning campaigns to determine opportunities for partnership and resource-sharing (planning should include Communications to ensure development of integrated campaigns and prevent duplication of effort)	**Investigation Complete.** Processes in place to maximize partnerships and resource sharing.
	16	Investigate increased centralization of purchasing function and requirement of business cases for large expenditures	**In-progress**. Little benefit from future centralization, but possible improvements via greater use of business cases.
2c	18	Update corporate purchasing card policy (restrict use to a defined set of expense types	**Completed** as part of activity #17 (in phase 1).
	19	Develop a succession planning program and provide professional development opportunities for potential successors of critical positions within the organization	**Planned**. Moved from phase 1 to phase 2 given transition of HR Director.
	20	Develop a standard process for first aid training across MLHU	**In-progress**.
3b	22	Investigate mechanism to actively monitor, evaluate, and recognize performance against goals and internal KPIs	**In-progress** as part of activity #21 (in phase 1).
	23	Investigate mechanism to motivate and incent continuous operational improvement	**Ongoing** as part of activity #21 (in phase 1).
4a	24	Investigate expanded use of collective purchasing with external partners	**In-progress**. Membership in the Elgin Middlesex Oxford Purchasing Cooperative (OMOP) providing significant value.
	25	Investigate IT cost avoidance/savings through cost-sharing arrangements via further collaboration with external partners	**Completed.** Now part of standard IT practice.
	26	Investigate opportunities with external partners to share/avoid costs for common, provincial, and/or national campaigns or leverage additional resources	**Investigation Complete.** Processes in place to maximize partnerships and resource sharing.
Rec.	**No.**	**EXCLUDED Activities**	**Comment**
1a	2	Implement procurement module of accounting system	Investigation revealed that efficiency would be derived from automating the purchase requisitions module, but not the procurement module.
4a	27	Investigate adoption of "enhancement of partnerships with external stakeholders" as an organizational priority and require all functions to develop stakeholder maps, a process for determining and evaluating partners, and action plans to establish/sustain partnerships	**In-progress**. Integrate into 2015/16 strategic planning process.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 056-14

TO: Chair and Members of the Board of Health

FROM: Chris Mackie, Medical Officer of Health

DATE: 2014 September 18

2013 YEAR END PERFORMANCE ON ACCOUNTABILITY INDICATORS

Recommendation

It is recommended that Report No. 056-14 re 2013 Public Health Performance Indicators Year-End Results be received for information.

Key Points

- The Health Unit has demonstrated strong performance on the 2013 Year-End Accountability Agreement performance indicators meeting or exceeding the targets on 9 of 10 indicators.
- There are limitations to the performance indicator data and some one-time funding helped the Health Unit reach some performance targets.

Background

Under section 5.2 of the Accountability Agreement between the Middlesex-London Board of Health and the Ministry of Health and Long Term Care (MOHLTC), the Board has agreed to use best efforts to achieve agreed upon Performance Targets for the Indicators specified.

There are currently 17 performance indicators which are reported to the MOHLTC at mid-year and at the end of each year. These indicators reflect the program areas of food safety, water safety, infectious disease control, vaccine preventable disease, tobacco control, injury prevention, substance abuse and child health. For each of these indicators, a 2013 target was negotiated and agreed upon by both the Board and MOHLTC.

2013 Year-End Results

In August 2014, the MOHLTC published the Health Unit's mid-year performance on 10 indicators (Appendix A). Of those 7 not reported, two were deferred pending policy development work, three did not have data released in the reporting time period, and two were not reported as data were collected for monitoring purposes due to the pending implementation of Panorama.

Of the 10 indicators reported, the Health Unit met or exceeded targets on 9 of 10.

Indicator		Middlesex London Health Unit		Comment
		Target	Year-End Performance	
1	% of high risk food premises inspected once every 4 months	100%	99.7%	
2	% of Class A pools inspected	100%	100%	
3	% of high-risk Small Drinking Water Systems (SDWS) inspections completed for those that are due for inspection	100%	100%	

4	% of gonorrhea cases with follow-up within 2 days	>70%	100%	
5	% of iGAS cases with follow-up on same day as receipt of lab confirmation	100%	100%	
7a	% of vaccine wasted by vaccine type that are stored/administered by the public health unit (HPV)	Maintain current rate – 0%	0.0%	
7b	% of vaccine wasted by vaccine type that are stored/administered by the public health unit (Influenza)	Maintain current rate – 1.2%	0.2%	
9c	% of children with completed immunizations for Meningococcus	90.0%	92.4%	2012/2013 schools year (As of June 30, 2013)
11	% of tobacco vendors in compliance with youth access legislation	≥ 90%	99.7%	
14	Baby-Friendly Initiative (BFI) Status	Advanced	Advanced	

Limitation in the Data and One-Time Funding

The indicators presented in this report are an incomplete representation of the work that public health units do to protect and promote the health of Ontario residents but have been chosen to:

- Reflect government priority;
- Core business of public health;
- Measure Board of Health level outcomes as per the OPHS, 2008;
- Be responsive to change by action of the Board of Health;
- Provide opportunity for performance improvement;
- Have available data sources; and
- Are sensitive, timely, feasible, valid, reliable, understandable, and comparable.

The report also notes that health units operate under unique local factors and there is variability across health units such as demographics, geographic size, human resources, etc., that impact each health unit differently and caution is advised when comparing health unit performance.

This report was prepared by Mr. Jordan Banninga, Manager of Strategic Projects.

Christopher Mackie, MD, MHSc
Medical Officer of Health

PUBLIC HEALTH PERFORMANCE INDICATORS 2013 YEAR-END RESULTS

August 2014

Ontario

Table of Contents

Introduction

This report provides an overview and analysis of the 2013 year-end Public Health Accountability Agreement performance indicator results. The purpose of this report is to provide health units with a summary of 2013 year-end performance results from across the province and to provide context for their individual performance.

Implementation of the Ministry of Health and Long-Term Care's (MOHLTC) Performance Management Framework for public health in Ontario has been ongoing since 2006 through a series of projects and initiatives led by the government in an effort to strengthen Ontario's public health system. Accountability Agreements (AAs) between boards of health and the government were introduced in 2011. The AAs provide a framework for setting specific performance expectations, and establish data reporting requirements to support monitoring of these performance expectations. The AAs are an integral component of the Performance Management Framework. This report marks another milestone as we continue to progress forward in a culture of performance management and continuous quality improvement.

This report presents nominal results to health units for the first time since reporting on these indicators began. Sharing nominal results supports continuous quality improvement efforts at the local level through the sharing of best practices among peers. Also included in the report are some of the strategies that health units and MOHLTC have identified as helpful in improving performance and reaching targets.

The indicators presented in this report represent the product of the initial work undertaken by the province, in collaboration with health units, to monitor, measure and report on health unit performance. Over the three-year period since the establishment of performance indicators, significant improvements have been made. Many lessons have been learned about the definitions, interpretation, data management, data reporting and practices related to each indicator. These learnings have resulted in improvements to the *Technical Document: Public Health Accountability Agreement Indicators 2011-13* and have helped to ensure consistency in business practices and data reporting, to increase data accuracy and integrity, and most importantly, to improve program planning, delivery and data management at the local level.

The initial 2011-13 suite of indicators comprised a total of 14 indicators (with 17 unique data sets for reporting). Of the 17 data sets, 10 were reported at 2013 year-end. Of those not reported, two were deferred pending policy development work, three did not have data released in the reporting time period, and two were not reported as data were collected for monitoring purposes due to the pending implementation of Panorama. Refer to Table 1. For detailed data definitions and formulas for each indicator, please refer to the *Technical Document: Public Health Accountability Agreement Indicators 2011-13 (December 19, 2013)*.

This report contains a chapter for each indicator to provide background information such as context, limitations, interpretations and next steps. 2013 performance results per health unit and overall analysis are presented for each indicator.

To assist with ease of reading, names of health units and indicators are abbreviated. Refer to Appendix 1 for a listing of the complete health unit names and Appendix 2 for a listing of the complete indicator names.

Considerations for Interpretation

The following points provide important context for the interpretation of the data in this report.

- The indicators presented are incomplete in that they represent a selection of indicators available at this time, but only begin to describe a subsection of the work that is undertaken by health units to protect and promote the health of Ontarians.
- These specific indicators were chosen through a collaborative process, considering the following criteria:
    - Reflect a government priority;
    - Reflect the core business of public health;
    - Measure at the board of health outcome level as per the *Ontario Public Health Standards, 2008* (where possible);
    - Responsive to change by actions of boards of health;
    - Opportunity for performance improvement;
    - Available data source, or data could be collected directly from all boards of health; and
    - Sensitive; timely; feasible; valid; reliable; understandable; and comparable.
- Many of the indicators have evolved since their inception. Over time, changes have been made to formulas, reporting periods, reporting methods or data sources to address measurement challenges or more accurately reflect the work being measured. For this reason, year over year comparisons of performance may be misleading and are therefore not included.
- There is significant variation between health units in volumes of premises, cases etc., as shown in the health protection indicator chapters. No correlation was found between volumes and performance upon analysis. For example, a performance result of 90% may represent either 90/100 inspections completed or 9/10 inspections completed. Although there is significant variation in volumes across health units for most indicators, the performance results reflect the relative ability of each health unit to complete all required activities within its jurisdiction.
- Each health unit operates under unique local factors and there is variability across health units in terms of demographics, geographic size, human resources, etc. Caution is advised when comparing health unit performance results due to these local attributes, which impact each health unit differently.
- Performance targets were set for all indicators to encourage performance improvement or to maintain the high level of performance already achieved. Targets may vary by health unit depending on the degree of performance improvement the health unit is working to achieve. With the exception of indicator 11 (% of tobacco vendors in compliance with youth access legislation at the time of last inspection), targets have not been included in the report.
- Analysis was conducted to compare overall target achievement across indicators. Because each indicator has a unique history, evolution and interpretation it was felt that such a comparison may be misleading and is therefore not included.

- Together with data collection, negative performance variant reports are used as part of the performance management system to encourage health units to reflect on shortfalls and identify mitigation strategies to increase future performance. Positive performance variant reports are used to identify successes and best practices.

Performance indicators are one piece of the larger Performance Management Framework for public health. The MOHLTC continues to partner with health units, Public Health Ontario, health promotion resource centres and other public health organizations to develop, improve and implement additional components of the framework to build a better public health system in Ontario.

Table 1: 2011-13 Accountability Agreement indicators with 2013 year-end reporting status

#	Indicator	2013 Year-end Reporting Status
1	% of high-risk food premises inspected once every 4 months while in operation	Reported
2	% of Class A pools inspected while in operation	Reported
3	% of high-risk Small Drinking Water Systems (SDWS) inspections completed for those that are due for inspection	Reported
4	% of confirmed gonorrhea cases where initiation of follow-up occurred within 2 business days	Reported
5	% of confirmed Invasive Group A Streptococcal Disease (iGAS) cases where initiation of follow-up occurred on the same day as receipt of lab confirmation of a positive case	Reported
6	% of known high risk personal services settings inspected annually	Not reported; indicator deferred
7a,b	% of vaccine wasted by vaccine type that are stored/administered by the public health unit (HPV, Influenza)	Reported
8	% completion of reports related to vaccine wastage by vaccine type that are stored/administered by other health care providers	Not reported; indicator deferred
9a,b	% of school-aged children who have completed immunizations for Hepatitis B, HPV	Not reported; data collected for monitoring purposes
9c	% of school-aged children who have completed immunizations for Meningococcus	Reported
10	% of youth (ages 12 - 18) who have never smoked a whole cigarette	Data not available until Fall 2014*
11	% of tobacco vendors in compliance with youth access legislation at the time of last inspection	Reported
12	Fall-related emergency visits in older adults aged 65 +	Data not available until Fall 2014*
13	% of population (19+) that exceeds the Low-Risk Drinking Guidelines	Data not available until Fall 2014*
14	Baby-Friendly Initiative (BFI) Status	Reported

* Data not available for the 2013 year-end reporting period and will be available later in 2014.

Health Protection Indicators

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

Context

The *Food Safety Protocol*, *2008* (or as current), of the *Ontario Public Health Standards, 2008* requires that boards of health conduct inspections of all fixed high-risk food premises "not less than once every four months".

This indicator monitors the proportion of fixed high-risk food premises that received a routine inspection at least once in each three month period.

This indicator is considered important because high-risk food premises prepare and handle foods where the risk of food-borne illness is high. Frequent inspections ensure adequate monitoring for possible risks of food-borne illness to the population. This is an important public health activity to reduce the incidence of food-borne illnesses.

The numerator and denominator include premises which are open and high-risk for at least one full three month period during the year.

Limitations

This indicator uses self-reported data from health units. There is no separate data source with which to confirm the results.

Data quality and accuracy are dependent on the quality of the food premises inventory and inspection tracking systems used at health units.

There is currently no standardized risk categorization model and the risk categorization of food premises may vary across health units.

Interpretation

Each high-risk food premises must receive three inspections in a year, each within the appropriate timeframe, to be counted towards the performance result for this indicator. Once a premise misses one required inspection, for example in the first three month period, that premise will never be able to meet the required inspection frequency, and target achievement is affected.

Because of the lack of standardization of risk categorization, the results should not be compared across health units, but should be used to assess change against each health unit's previous performance.

Next Steps

MOHLTC has retained this indicator in the 2014 Public Health Funding and Accountability Agreement. Targets are being established for all health units, and data reporting on performance will take place for 2014 year-end.

2013 Performance Results and Analysis

The 2013 volumes of fixed, high-risk food premises per health unit varied greatly across the province, ranging from a low of 36 premises to a high of 5064 premises, as shown below. MOHLTC explored whether or not there was a correlation between volumes and performance. The R^2 value was extremely low indicating that there is essentially no correlation between volumes and health unit performance.

	Low	Median	Average	High
# of high-risk food premises	36	225	500	5064

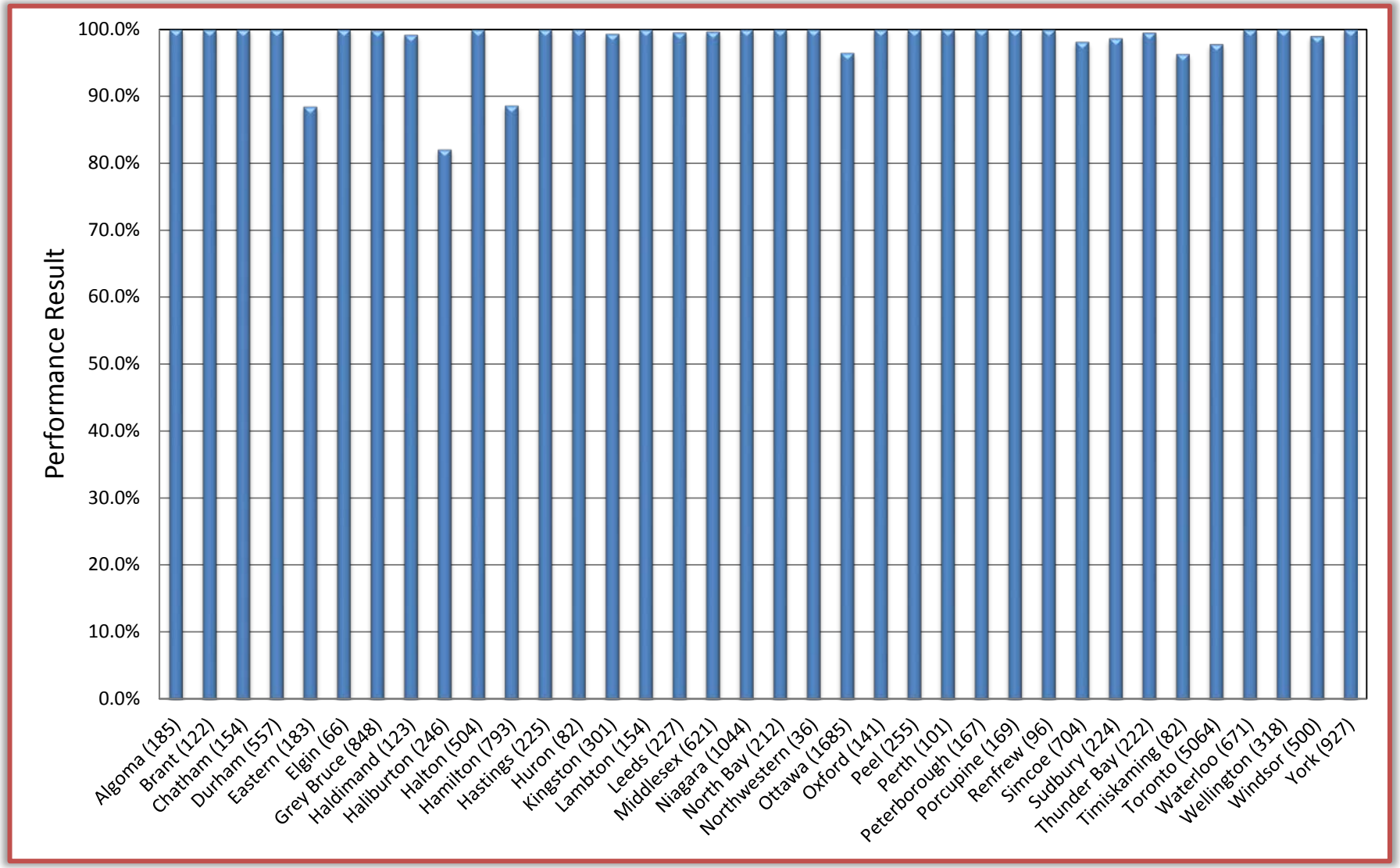
67% of health units (24/36) achieved their 2013 target for inspection of high-risk food premises. Of the 12 health units that did not achieve their targets, 58% (7/12) missed completing all required inspections within the required time periods in one to three food premises.

81% of health units (29/36) improved or maintained their performance over their 2012 results.

Results at a Glance

Achieved 2013 target	24/36 (67%)
Did not achieve target	12/36 (33%)
Missed inspections in 3 or fewer premises (of those who did not achieve target)	7/12 (58%)
Maintained/Improved 2012 performance	29/36 (81%)

Figure 1: Food inspections health unit 2013 performance (n=36)



The number in brackets following the abbreviated health unit name indicates the # of high-risk food premises in that health unit.

Low	Median	Average Health Unit Performance	High
82.1%	100.0%	98.4%	100.0%

Indicator # 2. % of Class A pools inspected while in operation

Context

The *Recreational Water Protocol, 2008* (or as current), of the *Ontario Public Health Standards, 2008* requires that boards of health inspect regulated public pools and public spas at least two times per year and no less than once every three months while in operation.

Regular inspections provide an opportunity to educate owners/operators on up-to-date methods of ensuring recreational water safety. Therefore, monitoring inspection rates is a way of assessing the reach of health units' activities to educate pool and spa operators and inspect for compliance, both of which are believed to lead to reduced public exposure to recreational water safety risks.

This indicator tracks the proportion of year-round Class A pools (including municipal pools) inspected once in every three month quarter, and Class A seasonal pools inspected at least twice a year while in operation, in accordance with O. Reg. 565 and the *Recreational Water Protocol, 2008* (or as current).

The numerator and denominator include year-round pools which are open for at least one full quarter during the year and seasonal pools which were open for any length of time.

Limitations

This indicator uses self-reported data from health units and therefore, there is no separate data source with which to confirm the results.

Data quality and accuracy are dependent on the quality of the pools inventory and inspection tracking systems at the health unit.

Interpretation

Year-round pools must receive four inspections, each within the specified three month period, in a year to be included in the performance result for this indicator. Once a pool misses one required inspection, for example in the first or second quarter of the year, that pool will never be able to meet the required inspection frequency, and target achievement is affected.

Next Steps

MOHLTC has retained this indicator in the 2014 Public Health Funding and Accountability Agreement. Targets are being established for all health units, and data reporting on performance will take place for 2014 year-end.

2013 Performance Results and Analysis

The 2013 volumes of year-round Class A pools per health unit ranged across the province from a low of 4 pools to a high of 198 pools, as shown below. MOHLTC explored whether or not there was a correlation between volumes and performance. The R^2 value was extremely low indicating that there is essentially no correlation between volumes and health unit performance.

	Low	Median	Average	High
# of class A pools	4	13	26	198

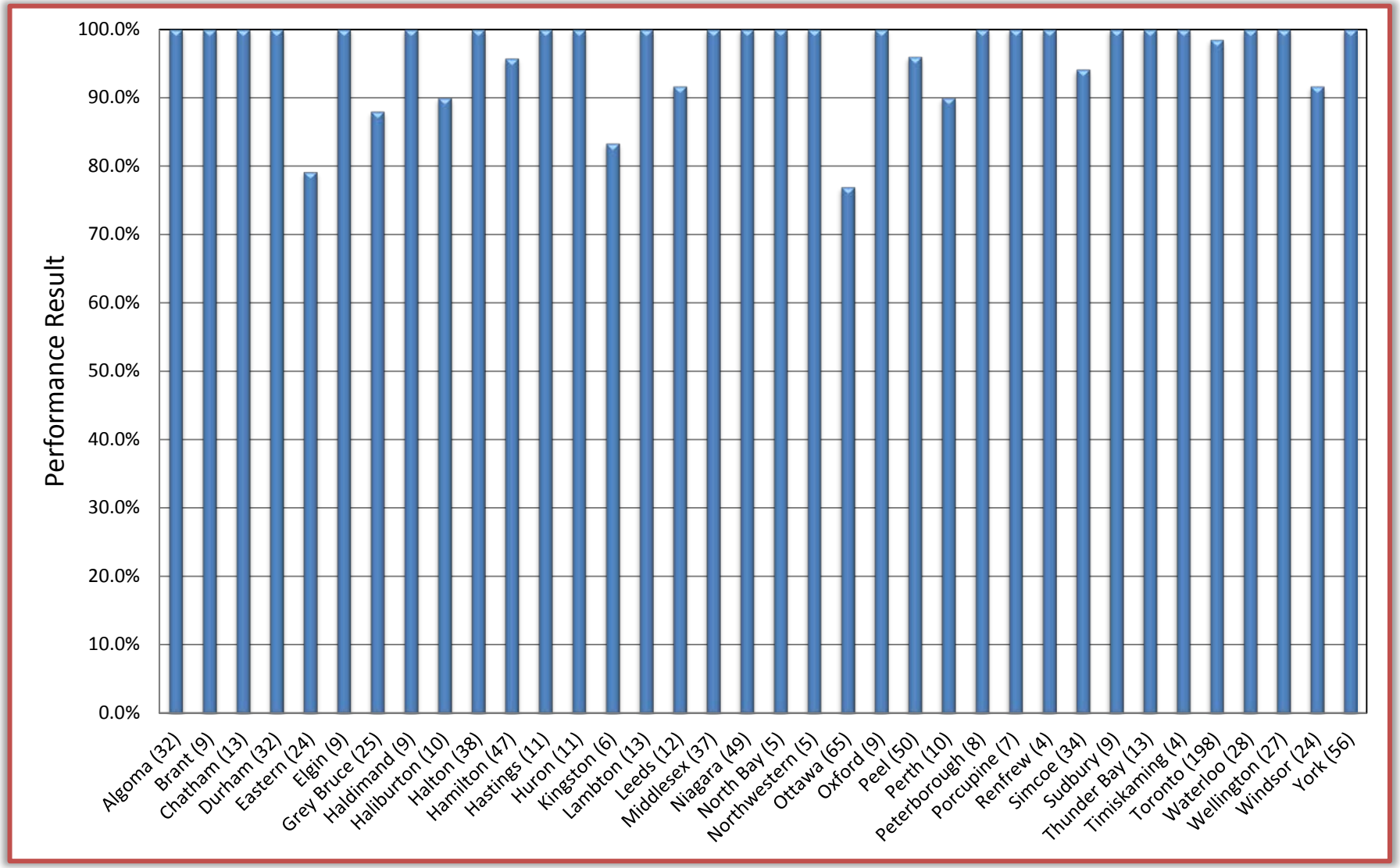
69% of health units (25/36) achieved their 2013 target for inspection of Class A pools. Of the 11 health units that did not achieve their targets, 73% (8/11) missed completing all required inspections within the required time periods for one or two pools.

75% of health units (27/36) improved or maintained their performance over their 2012 results.

Results at a Glance

Achieved 2013 target	25/36 (69%)
Did not achieve target	11/36 (31%)
Missed inspections in 1 or 2 pools (of those who did not achieve target)	8/11 (73%)
Maintained/Improved 2012 performance	27/36 (75%)

Figure 2: Pools inspections health unit 2013 performance (n=36)



The number in brackets following the abbreviated health unit name indicates the # of class A pools in that health unit.

Low	Median	Average Health Unit Performance	High
76.9%	100.0%	96.5%	100.0%

Indicator # 3. % of high-risk Small Drinking Water Systems (SDWS) inspections completed for those that are due for inspection

Context

The *Drinking Water Protocol*, *2008* (or as current), of the *Ontario Public Health Standards, 2008* requires high-risk SDWS to have routine risk inspections not less than once every two years.

SDWS inspections are conducted by public health inspectors to determine the level of operator compliance with the applicable regulation, to assess the safety of the drinking water supply, and to reduce the incidence of water-borne illness.

This indicator tracks the proportion of SDWS with completed inspections of those that have been assessed as high-risk and are due for inspection in the identified year.

Health units had the option to provide data from local health unit data systems for this indicator in 2013 due to challenges with Risk Categorization and Assessment Tool (RCat) that affected the 2013 data. Health units are still required to use RCat to calculate risk categorizations and to record completed assessments.

All health units that had high-risk SDWS that were due for re-inspection had a 100% target for 2013.

Limitations

The date the risk category was finalized in RCat is used to determine whether a system will be included in this indicator. Where there is a significant lag in time between the date of the risk assessment and the date of the information entry into RCat, a system may be captured as assessed in a different time period from its actual inspection date. It is the responsibility of health unit staff to ensure maintenance of records to ensure data accuracy.

There were some IT issues related to the integrity of data migration from local systems to RCat, which affected health units' ability to use RCat records for reporting. This was resolved by allowing health units to confirm the data reported for this indicator using records in local data systems.

Interpretation

A high-risk SDWS is considered to be eligible for inclusion when it has received an inspection at any time in the two years since its previous risk assessment. This allows for the inclusion of all SDWS that are inspected earlier than on a strict two-year inspection cycle within this indicator, as this is a fair reflection of health units' practice of spreading inspections out over the inspection cycle time period.

Health units that do not have any SDWS or do not have any 'active' high-risk SDWS for a given year will not have a result for this indicator.

The indicator measures routine inspections and does not include non-routine inspections (owner/operator requested, complaint or incident generated).

Next Steps

MOHLTC will continue to reinforce to health units the need to ensure RCat records are maintained, as required by the *Drinking Water Protocol*, *2008* (or as current).

This indicator has been maintained as a performance indicator in the 2014 Public Health Funding and Accountability Agreement for those health units where additional performance improvement is possible based on 2013 results. For all other health units, this has become a monitoring indicator in 2014; that is no target will be set, but performance will be assessed.

2013 Performance Results and Analysis

The volumes of high-risk SDWS due for inspection in 2013 per health unit ranged across the province from a low of 1 to a high of 105, as shown below. MOHLTC explored whether or not there was a correlation between volumes and performance. The R^2 value was extremely low indicating that there is essentially no correlation between volumes and health unit performance.

	Low	Median	Average	High
# SDWS	1	9	25	105

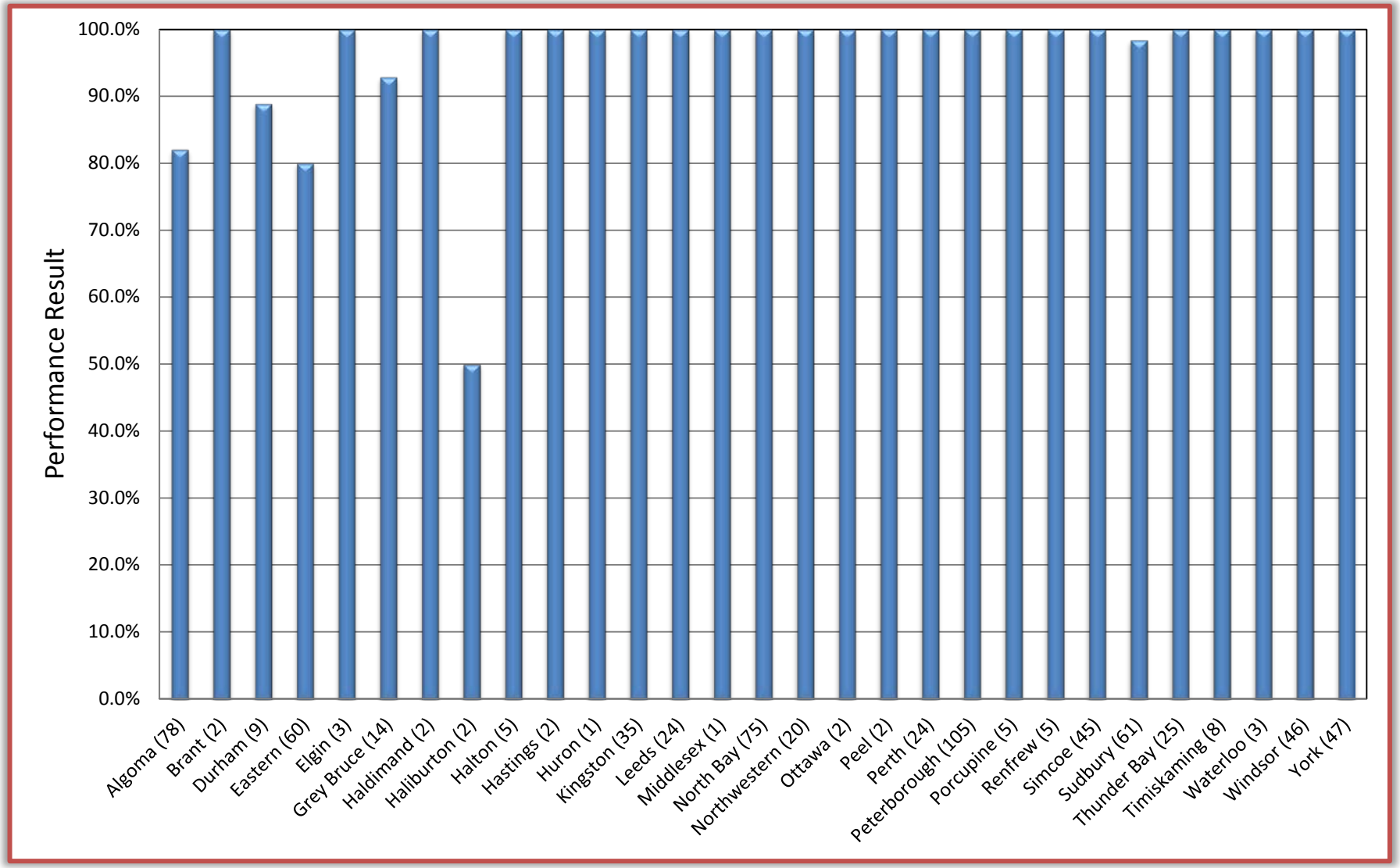
79% of health units (23/29) achieved their 2013 target for this indicator. Of the six health units that did not achieve their target, 67% (4/6) missed one SDWS inspection.

Of the 20 health units that had SDWS due for inspection in both 2012 and 2013, 80% (16/20) improved or maintained their performance over their 2012 results.

Results at a Glance

Achieved 2013 target	23/29 (79%)
Did not achieve target	6/29 (21%)
Missed inspection of 1 SDWS (of those who did not achieve target)	4/6 (67%)
Maintained/Improved 2012 performance	16/20 (80%)

Figure 3: SDWS inspections health unit 2013 performance (n=29)



Number in brackets following the abbreviated health unit name indicates # of high-risk SDWS due for inspection in the health unit in 2013.

Low	Median	Average Health Unit Performance	High
50.0%	100.0%	96.3%	100.0%

Indicator # 4. % of confirmed gonorrhea cases where initiation of follow-up occurred within 2 business days

Context

Appropriate public health case management and timely case management are described in the *Infectious Diseases Prevention and Control* Standard and the *Infectious Diseases Protocol, 2008* (or as current) including the disease-specific chapter for gonorrhea, of the *Ontario Public Health Standards, 2008*.

Timeliness is a critical aspect of effective health unit case management to ensure cases and contacts receive prompt treatment to reduce the secondary spread of infections.

This indicator monitors the timeliness of health unit follow-up of confirmed cases of gonorrhea.

Next Steps

This indicator has been maintained as a performance indicator in the 2014 Public Health Funding and Accountability Agreement for those health units where additional performance improvement is possible based on 2013 results. For all other health units, this has become a monitoring indicator in 2014; that is no target will be set, but performance will be assessed.

2013 Performance Results and Analysis

The 2013 volumes of confirmed gonorrhea cases varied greatly across health units in the province, ranging from a low of 3 confirmed cases to a high of 2189, as shown below. MOHLTC explored whether or not there was a correlation between volumes and performance. There appeared to be a notable negative correlation between performance and confirmed case count. However, as Toronto has roughly the same number of cases as the rest of the health units combined, it was identified as an outlier that was possibly influencing the observed result. The analysis was re-run without Toronto. Once Toronto was removed, the correlation between case count and health unit performance disappeared.

	Low	Median	Average	High
# gonorrhea cases	3	26	124	2189

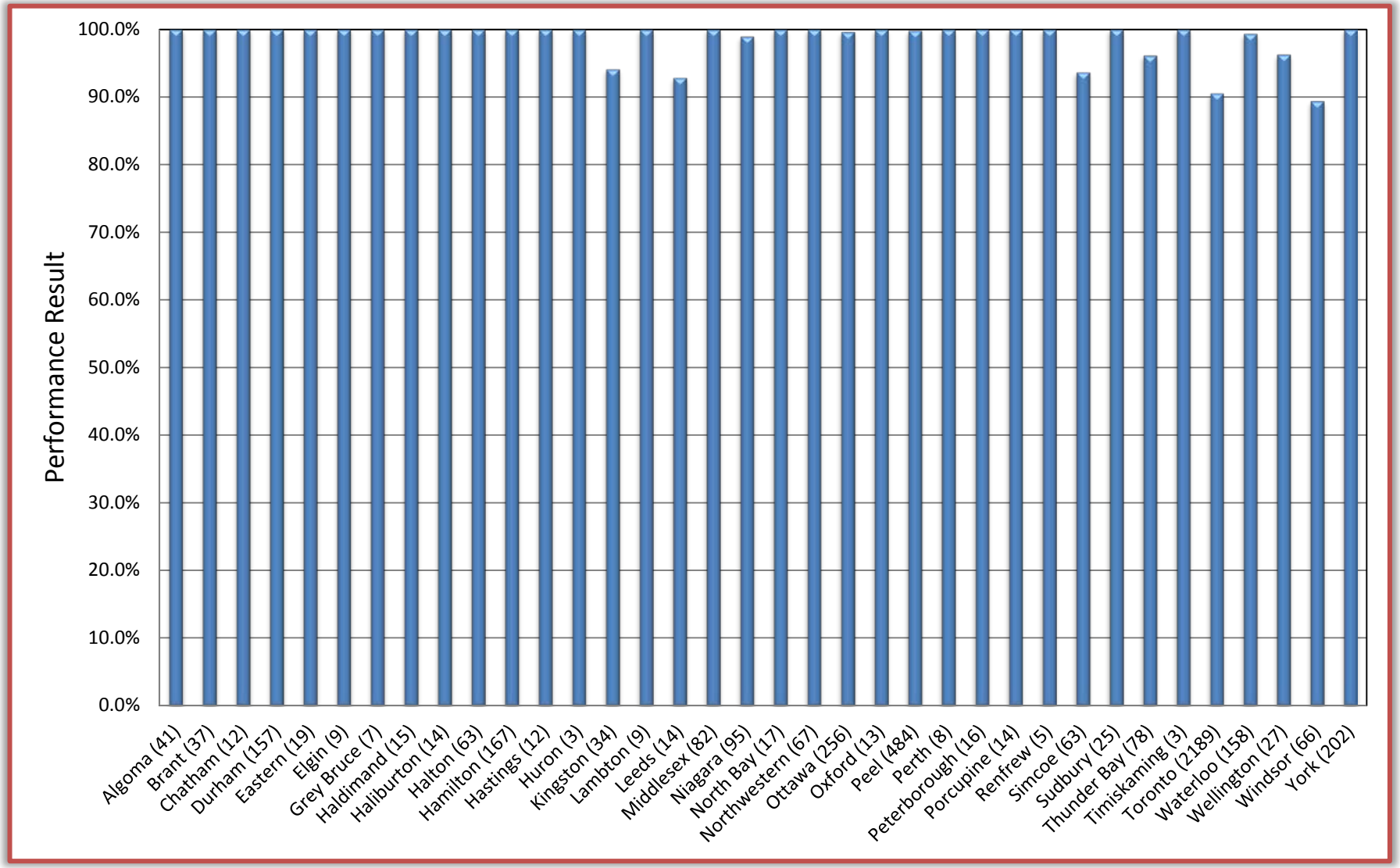
75% of health units (27/36) achieved their 2013 target for cases of gonorrhea followed-up within two business days. Of the nine health units that did not achieve their targets, 56% (5/9) did not follow-up within two business days for one case.

83% of health units (29/35) improved or maintained their performance over their 2012 results. Note, one health unit did not have any confirmed cases of gonorrhea in 2012; therefore, results are based on 35 health units.

Results at a Glance

Achieved 2013 target	27/36 (75%)
Did not achieve target	9/36 (25%)
Missed follow-up within 2 business days on 1 case (of those who did not achieve target)	5/9 (56%)
Maintained/Improved 2012 performance	29/35 (83%)

Figure 4: Gonorrhea follow-up health unit 2013 performance (n=36)



The number in brackets following the abbreviated health unit name indicates the # of confirmed gonorrhea cases in that health unit.

Low	Median	Average Health Unit Performance	High
89.4%	100.0%	98.6%	100.0%

Indicator # 5. % of confirmed Invasive Group A Streptococcal Disease (iGAS) cases where initiation of follow-up occurred on the same day as receipt of lab confirmation of a positive case

Context

Appropriate public health case management is described in the *Infectious Diseases Prevention and Control* Standard and the *Infectious Diseases Protocol, 2008* (or as current), including the disease-specific chapter on iGAS of the *Ontario Public Health Standards, 2008*.

Investigation of confirmed cases should begin as soon as possible after receiving a report.

Monitoring timeliness of health unit response to lab confirmed cases of iGAS is important because iGAS poses a significant burden of disease and timeliness of response is important in efforts to reduce the spread of illness.

In 2013, all health units had a 100% target.

Next Steps

This indicator has been maintained as a performance indicator in the 2014 Public Health Funding and Accountability Agreement for those health units where additional performance improvement is possible. For all other health units, this has become a monitoring indicator in 2014; that is no target will be set, but performance will be assessed.

2013 Performance Results and Analysis

The 2013 volumes of confirmed iGAS cases varied across health units in the province from a low of 0 confirmed cases to a high of 118 cases, as shown below. MOHLTC explored whether or not there was a correlation between volumes and performance. The R^2 value was extremely low indicating that there is essentially no correlation between volumes and health unit performance.

	Low	Median	Average	High
# iGAS cases	0	10	18	118

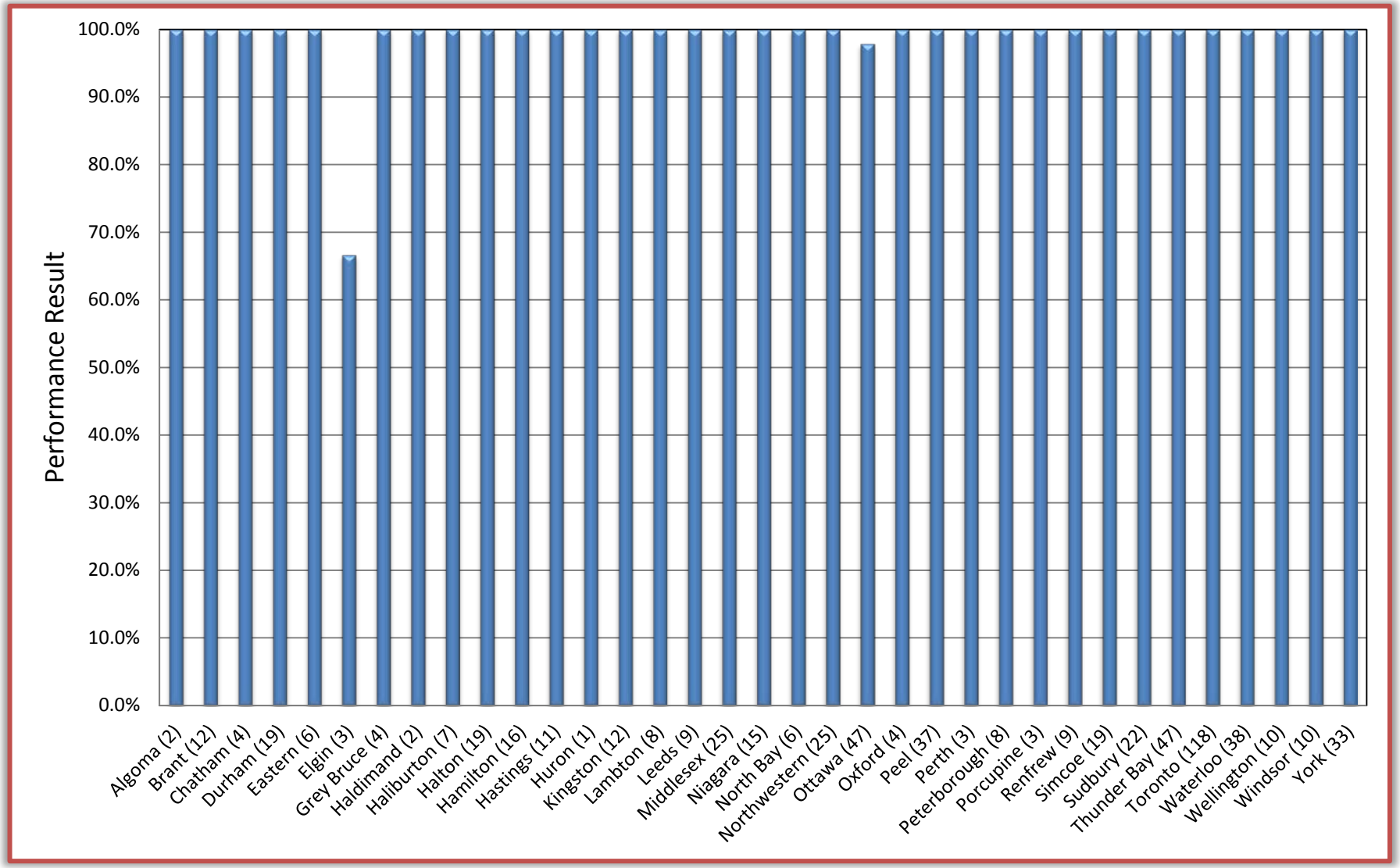
94% of health units (33/35) achieved their 100% target in 2013 (one health unit did not have any iGAS cases in 2013). Of the two health units that did not achieve their target, both did not follow-up on the same day for one case.

94% of health units (32/34) improved or maintained their performance over their 2012 results. Note this denominator is 34 as it is limited to those health units that had iGAS cases in both 2012 and 2013.

Results at a Glance

Achieved 2013 target	33/35 (94%)
Did not achieve target	2/35 (6%)
Missed follow-up on the same day for 1 case (of those who did not achieve target)	2/2 (100%)
Maintained/Improved 2012 performance	32/34 (94%)

Figure 5: iGAS follow-up health unit 2013 performance (n=35)



The number in brackets following the abbreviated health unit name indicates the # of confirmed iGAS cases in that health unit.

Low	Median	Average Health Unit Performance	High
66.7%	100.0%	99.0%	100.0%

Indicator # 7a. % of vaccine wasted by vaccine type that are stored/administered by the public health unit (HPV)

Context

The *Vaccine Storage and Handling Protocol, 2008* (or as current) of the *Ontario Public Health Standards, 2008* requires that vaccine wastage should not exceed five percent for any one product.

It is believed there are opportunities for further efficiencies by implementing efforts to reduce vaccine wastage, and this is a priority for the MOHLTC.

This indicator relates to the effectiveness of local health unit vaccine storage, handling and management practices. This indicator monitors the percentage of HPV vaccine wasted that is stored, transported, or administered by the health units.

The *Ontario Public Health Standards, 2008* states that wastage rates should not exceed 5%. Since vaccine wastage of other health care providers is excluded for the indicators, targets lower than 5% have been negotiated for many health units.

Limitations

Data quality and accuracy are dependent on the inventory management practices at the health unit.

Health units have indicated that calculating HPV vaccine wastage on the calendar year is challenging since ordering and administration is based on the school year.

Interpretation

The data source for this indicator has changed since the baselines were established. To establish the baselines, data were extracted using an existing data source.

In 2012 and 2013, health units were asked to report on a variety of data elements to calculate the indicator.

The formula to calculate HPV vaccine wastage was revised in 2012 and once again in 2013 to improve alignment with the World Health Organization methodology.

In 2013, health units reported on all vaccine doses received, distributed, returned, and administered. All doses not accounted for were considered wasted.

For health units that experienced large amounts of vaccine wastage, this was mostly due to vaccine expiry and cold chain failures.

Next Steps

MOHLTC has retained this indicator in the 2014 Public Health Funding and Accountability Agreement. Calculation for HPV vaccine wastage will be based on the school year. The first measurement period will be the 2014/2015 school year.

2013 Performance Results and Analysis

The 2013 volumes of HPV doses in the care and control of a health unit varied greatly across the province, ranging from a low of 440 doses to a high of 38243 doses, as shown below. MOHLTC explored whether or not there was a correlation between volumes and performance. The R^2 value was extremely low indicating that there is essentially no correlation between volumes and health unit performance.

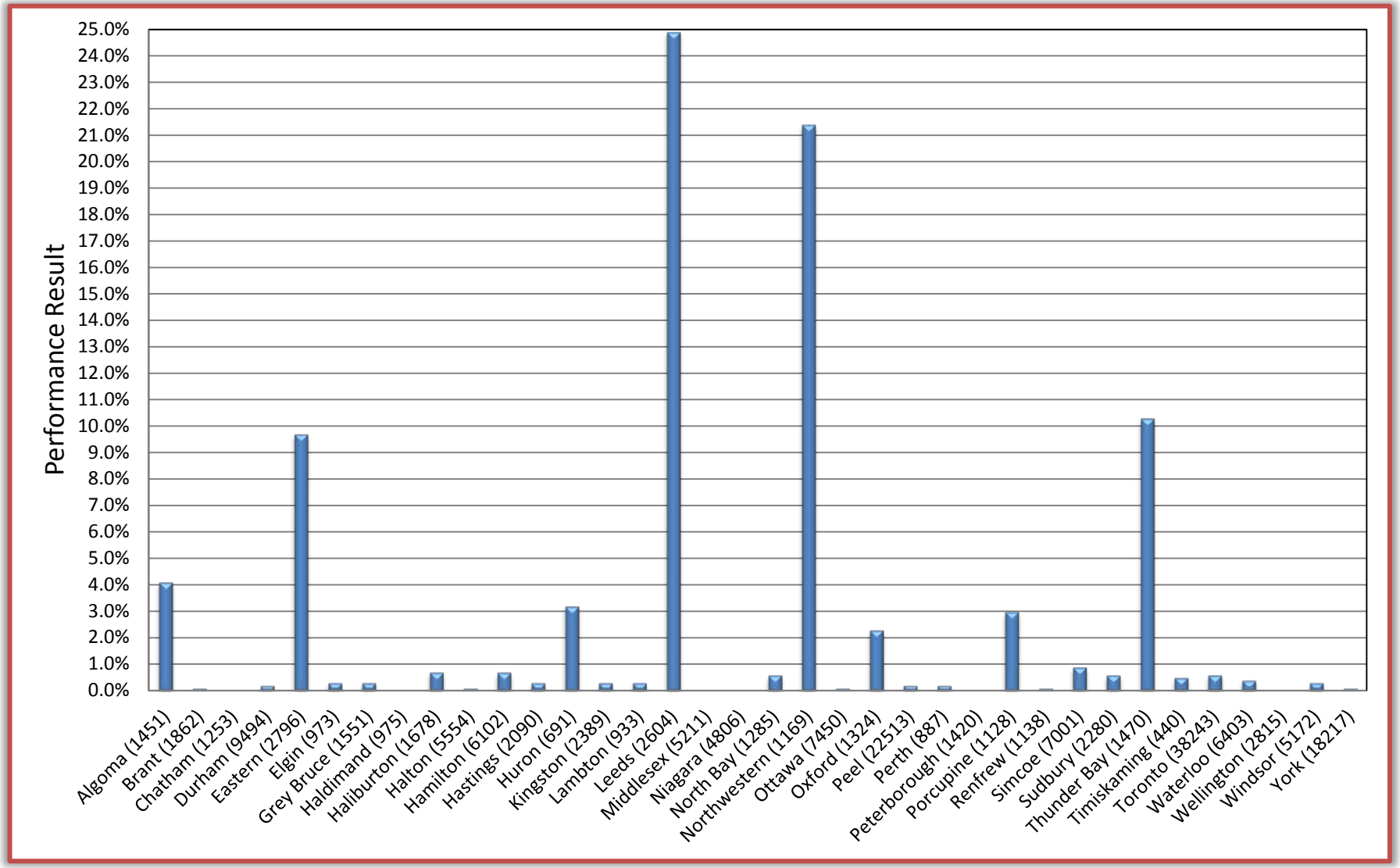
	Low	Median	Average	High
# doses in care of health unit	440	1976	4799	38243

44% of health units (16/36) achieved their 2013 target for HPV vaccine wastage. 78% of health units (28/36) had wastage below 1%; 11% of health units (4/36) had wastage between 1% and 5%; and 11% of health units (4/36) had wastage greater than 5%.

Results at a Glance

Achieved 2013 target	16/36 (44%)
Did not achieve target	20/36 (56%)
Had <1% wastage	28/36 (78%)
Had between 1% and 5% wastage	4/36 (11%)
Had >5% wastage	4/36 (11%)

Figure 6: HPV vaccine wasted 2013 performance (n=36)



The number in brackets following the abbreviated health unit name indicates the # HPV doses in the care of that health unit.

Low	Median	Average Health Unit Performance	High
0.0%	0.3%	2.4%	24.9%

Indicator # 7b. % of vaccine wasted by vaccine type that are stored/administered by the public health unit (Influenza)

Context

The *Vaccine Storage and Handling Protocol*, *2008* (or as current), of the *Ontario Public Health Standards, 2008* requires that vaccine wastage should not exceed five percent for any one product.

It is believed there are opportunities for further efficiencies by implementing efforts to reduce vaccine wastage, and this is a priority for the MOHLTC.

This indicator relates to the effectiveness of local health unit vaccine storage, handling and management practices. This indicator monitors the percentage of influenza vaccine wasted that is stored, transported, or administered by the health units.

The *Ontario Public Health Standards, 2008* states that wastage rates should not exceed 5%. Since vaccine wastage of other health care providers is excluded for the indicators, targets lower than 5% have been negotiated for many health units.

Limitations

Data quality and accuracy are dependent on the inventory management practices at the health unit.

As this indicator is calculated based on the calendar year, the indicator measures the wastage and distribution of a portion of two influenza seasons rather than one complete influenza season.

Interpretation

The data source for this indicator has changed since the baselines were established. To establish the baselines, an existing data source was used as an input to the calculation of the indicator.

In 2012 and 2013 health units were asked to report on a variety of data elements to calculate the indicator.

The formula to calculate influenza vaccine wastage was revised in 2012 and once again in 2013 to improve alignment with the World Health Organization methodology.

In 2013, health units reported on all vaccine doses received, distributed, returned, and administered. All doses not accounted for were considered wasted.

Next Steps

MOHLTC has retained this indicator in the 2014 Public Health Funding and Accountability Agreement. Calculation for influenza vaccine wastage will be based on the flu season. The first measurement period will be the 2014/2015 flu season.

2013 Performance Results and Analysis

The 2013 volumes of influenza doses in the care and control of a health unit varied greatly across the province, ranging from a low of 719 doses to a high of 15759 doses, as shown below. MOHLTC explored whether or not there was a correlation between volumes and performance. The R^2 value was extremely low indicating that there is essentially no correlation between volumes and health unit performance.

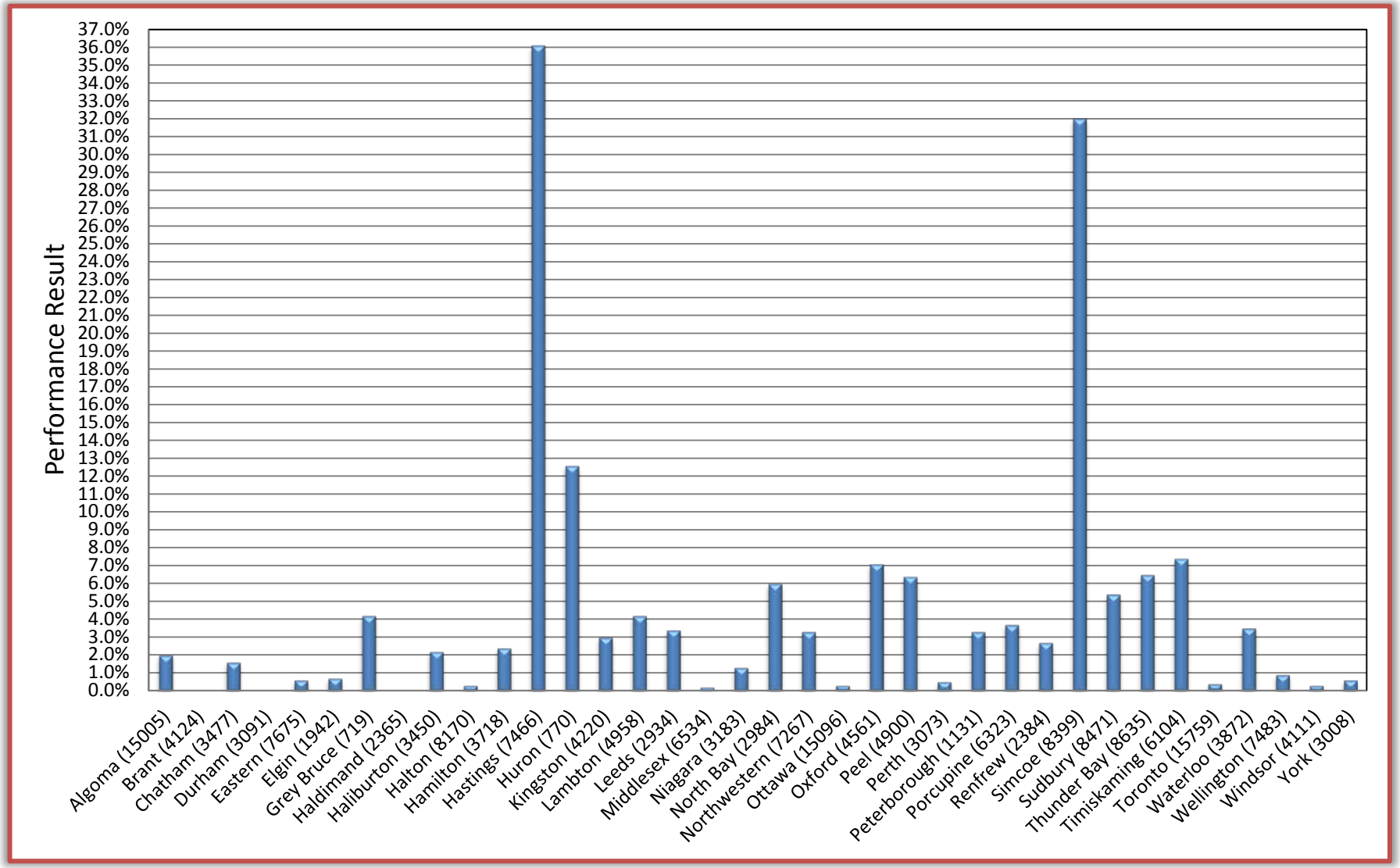
	Low	Median	Average	High
# doses in care of health unit	719	5482	4172	15759

50% of health units (18/36) achieved their 2013 target for influenza vaccine wastage. 36% of health units (13/36) had wastage below 1%; 39% of health units (14/36) had wastage between 1% and 5%; and 25% of health units (9/36) had wastage greater than 5%.

Results at a Glance

Achieved 2013 target	18/36 (50%)
Did not achieve target	18/36 (50%)
Had <1% wastage	13/36 (36%)
Had between 1% and 5% wastage	14/36 (39%)
Had >5% wastage	9/36 (25%)

Figure 7: Influenza vaccine wasted 2013 performance (n=36)



The number in brackets following the abbreviated health unit name indicates the # influenza doses in the care of that health unit.

Low	Median	Average Health Unit Performance	High
0.0%	2.6%	4.6%	36.1%

Indicators # 9a. & 9b. % of school-aged children who have completed immunizations for Hepatitis B, HPV

Context

These indicators monitor the percentage of:

- Grade 7 students who have completed their immunization series with the Hepatitis B vaccine by the end of the school year; and
- Grade 8 female students who have completed their immunization series with the Human Papillomavirus (HPV) vaccine by the end of the school year.

These indicators reflect the effectiveness of local school based immunization programs. Immunization coverage assessment establishes immunization trends over time, facilitates the identification of sub-populations with inadequate coverage, and contributes to the evaluation of immunization promotion initiatives.

Under the *Ontario Public Health Standards, 2008* the board of health is required to promote and provide provincially-funded immunization programs to any eligible person in the health unit. A board of health outcome identified in the *Ontario Public Health Standards, 2008* is that "children have up-to-date immunizations according to the current Publicly Funded Immunization Schedule for Ontario and in accordance with the *Immunization of School Pupils Act* and the *Day Nurseries Act* (where applicable)".

The data for the 2012/2013 school year for indicators 9a (completed immunizations for Hepatitis B) and 9b (completed immunizations for HPV) are currently not being reported but were collected by MOHLTC for monitoring purposes. For the 2011/2012 school year, the results were not reported as they appeared to show higher than expected results. MOHLTC worked with Public Health Ontario to review the data and try to determine if there was an issue with the Immunization Records Information System (IRIS) application. Ultimately, the analysis demonstrated that the IRIS application, including changes in IRIS logic parameters, likely had little impact on the observed provincial vaccine coverage rates. As a precautionary measure, however, MOHLTC continued collection of these data for monitoring purposes for the 2012/2013 school year. With the anticipated implementation of Panorama and ongoing transition efforts, MOHLTC will continue to monitor the results for Hepatitis B and HPV coverage but performance achievement will not be reported at this time.

Next Steps

Performance targets were not established for these indicators in 2014 as health units are in the process of being transitioned to Panorama.

MOHLTC will continue to collect data on completed immunizations for Hepatitis B and HPV for monitoring purposes.

Indicator # 9c. % of school-aged children who have completed immunizations for Meningococcus

Context

Under the *Ontario Public Health Standards, 2008*, the board of health is required to promote and provide provincially-funded immunization programs to any eligible person in the health unit.

A board of health outcome identified in the *Ontario Public Health Standards, 2008* is that "children have up-to-date immunizations according to the current *Publicly Funded Immunization Schedules for Ontario* and in accordance with the *Immunization of School Pupils Act* and the *Day Nurseries Act* (where applicable)".

Immunization coverage assessment establishes immunization trends over time, facilitates the identification of sub-populations with inadequate coverage, and contributes to the evaluation of immunization promotion initiatives.

This indicator monitors the percentage of Grade 7 students who have completed their immunization series with the meningococcal conjugate C (Men-C-C) or quadrivalent meningococcal conjugate (Men-C-ACYW135) vaccine by the end of the school year.

This indicator reflects the effectiveness of local school based immunization programs.

Interpretation

The data source for this indicator is currently the Immunization Records Information System (IRIS).

For the 2011/2012 school year, IRIS coverage reports for the above vaccine were requested as of August 31, 2012.

For the 2012/2013 school year, IRIS coverage reports for the above vaccine were requested as of June 30, 2013 and August 31, 2013.

Results from the June 30, 2013 reports are being reported for performance purposes. Since baselines were established from reports as of June 15, 2010, this is more consistent with how baselines were established.

Next Steps

Performance targets were not established for this indicator in 2014 as health units are in the process of being transitioned to Panorama.

MOHLTC will continue to collect data on completed immunizations for Meningococcus for monitoring purposes.

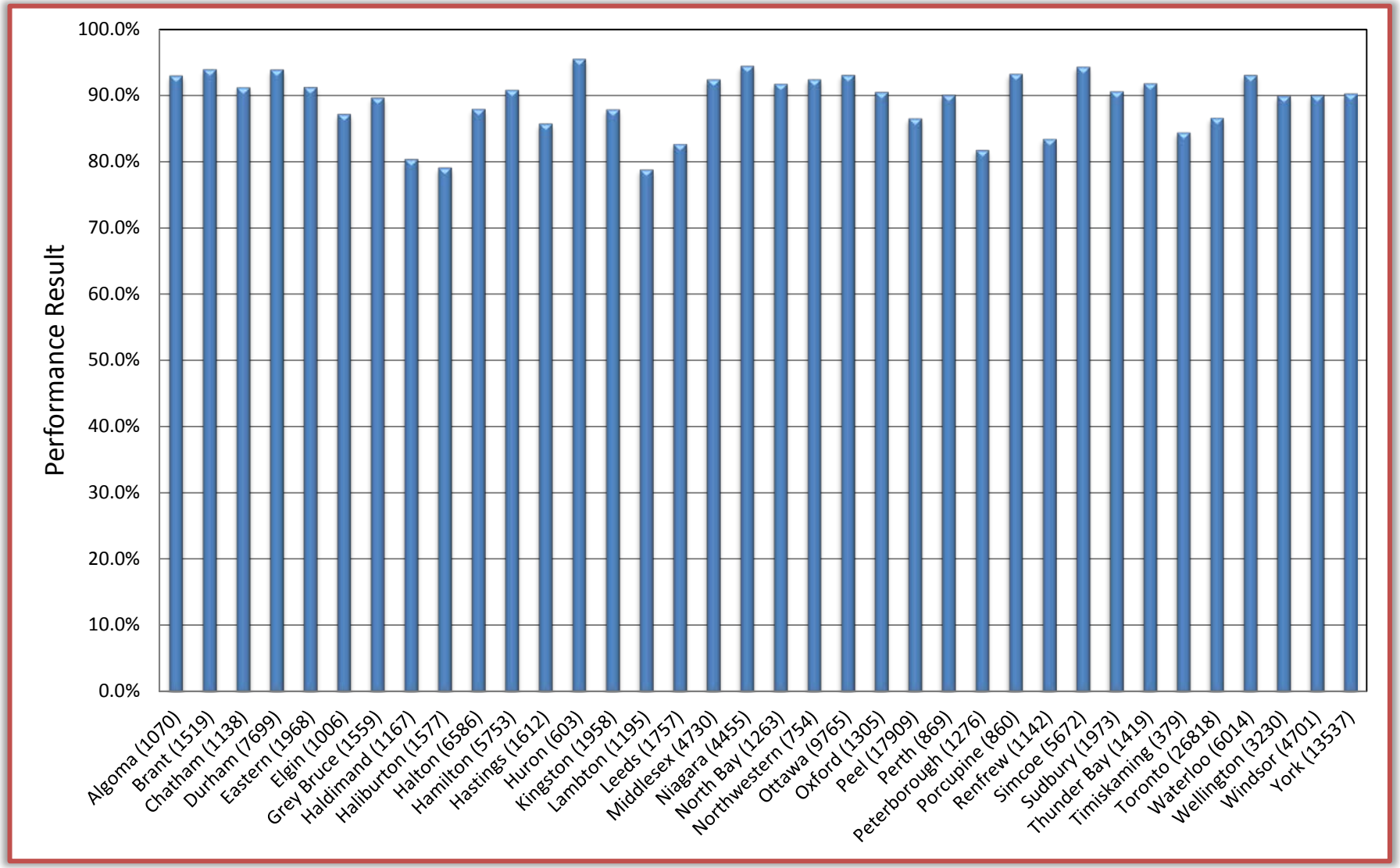
2013 Performance Results and Analysis

The Grade 7 student cohort eligible to receive publicly funded Meningococcus vaccine varied across each health unit in the province, ranging from a low of 379 students to a high of 26818, as shown below. MOHLTC explored whether or not there was a correlation between volumes and performance. The R^2 value was extremely low indicating that there is essentially no correlation between volumes and health unit performance.

	Low	Median	Average	High
# students eligible for immunization	379	1595	4062	26818

Note that an analysis of meningococcus target achievement is not included because the indicator measures outcomes at a population level, and due to the nature of the indicator, a technical variance in the data is to be expected.

Figure 8: Meningococcus coverage 2013 performance (n=36)



The number in brackets following the abbreviated health unit name indicates the # students eligible for immunization in that health unit.

Low	Median	Average Health Unit Performance	High
78.8%	90.4%	89.2%	95.5%

Strategies for Achieving Health Protection Performance Targets

The following information was extracted from positive performance variant reports (PPVRs) that health units voluntarily submitted as part of the 2012 public health performance indicators year-end reporting. These strategies were implemented following 2012 year-end, resulting in performance improvements in 2013. It should be noted that submission of PPVRs to MOHLTC was a voluntary process in the 2011-13 Accountability Agreement, available to health units that wanted to share their successes. Highlights of some strategies used to improve performance at health units are being shared so that they may be adopted or adapted by other health units, where applicable, to support continuous quality improvement efforts.

Examples of strategies implemented by the field to improve performance include:

- Creating a dashboard that is linked to the Hedgehog Inspection Program. The dashboard allowed staff to view scheduled tasks or inspections that were pending or overdue. Additionally, the manager was able to use the dashboard for oversight and ongoing monitoring of inspection activities to ensure accountability. (Niagara)
- Collaborating with a group of health units also using Hedgehog and with Hedgehog programmers and developers to make system improvements. These improvements have led to successful extraction of data from the Hedgehog system. (Simcoe)
- Developing a plan with inspection staff to be able to deal with potential challenges or delays that can arise in the field. This included having a Food Safety Supervisor available for rapid response in order to avoid delays and having a system in place to deploy backup tablets and printers in the event of equipment breakdown. (Simcoe)
- Formalizing ongoing and routine reporting processes to increase the likelihood that targets are achieved. This included holding consistent team meetings for updates, conducting monthly individual Public Health Inspector reviews, and using Microsoft SharePoint to track workflow. (Waterloo; Leeds; and, Northwestern)
- Quantifying process map timeliness to identify inefficiencies and areas for improvement in program area operations. Data were collected by staff members and used to examine the efficiency of the team's response time and the total time for file completion. (Simcoe)
- Improving integration with community partners, including nurse practitioners and liaisons at the hospital and family health teams. This was done to enhance knowledge and support the fax-back system in the community. (Simcoe)
- Implementing an improvement plan to enhance performance. Key features included: reallocating resources to ensure timely data entry, increasing staff awareness of the Public Health Accountability Agreement, engaging staff for input on performance improvement, reviewing charts of cases not followed up within a certain timeframe, and conducting monthly reviews of follow-up times by the case-management team. (Ottawa)

Health Promotion Indicators

Indicator # 11. % of tobacco vendors in compliance with youth access legislation at the time of last inspection

Context

This indicator measures compliance with sections 3(1) and 3(2) of the *Smoke-Free Ontario Act* (SFOA), which prohibit the sale of tobacco products to persons under the age of 19 years.

Tobacco vendor behaviour is an important aspect in monitoring youth access to tobacco products. Therefore, tracking vendor compliance rates will allow boards of health to assess the effectiveness of their education and enforcement efforts.

Under the *Ontario Public Health Standards, 2008,* boards of health are required to implement and enforce the Smoke Free Ontario Act in accordance with provincial protocols, including but not limited to the *Tobacco Compliance Protocol, 2008* (or as current).

Board of health outcomes include:

- Priority populations adopt tobacco free living;
- Tobacco vendors are in compliance with the Smoke Free Ontario Act;
- Youth have reduced access to tobacco products.

Interpretation

The data source for this indicator is the MOHLTC Tobacco Information System (TIS).

TIS vendor compliance rates are established at mid-year (June) and at year-end (December).

Compliance rates for mid-year are reported for information purposes; year-end compliance rates are reported for performance purposes.

Next Steps

MOHLTC will continue with mid-year and year-end reporting for this indicator.

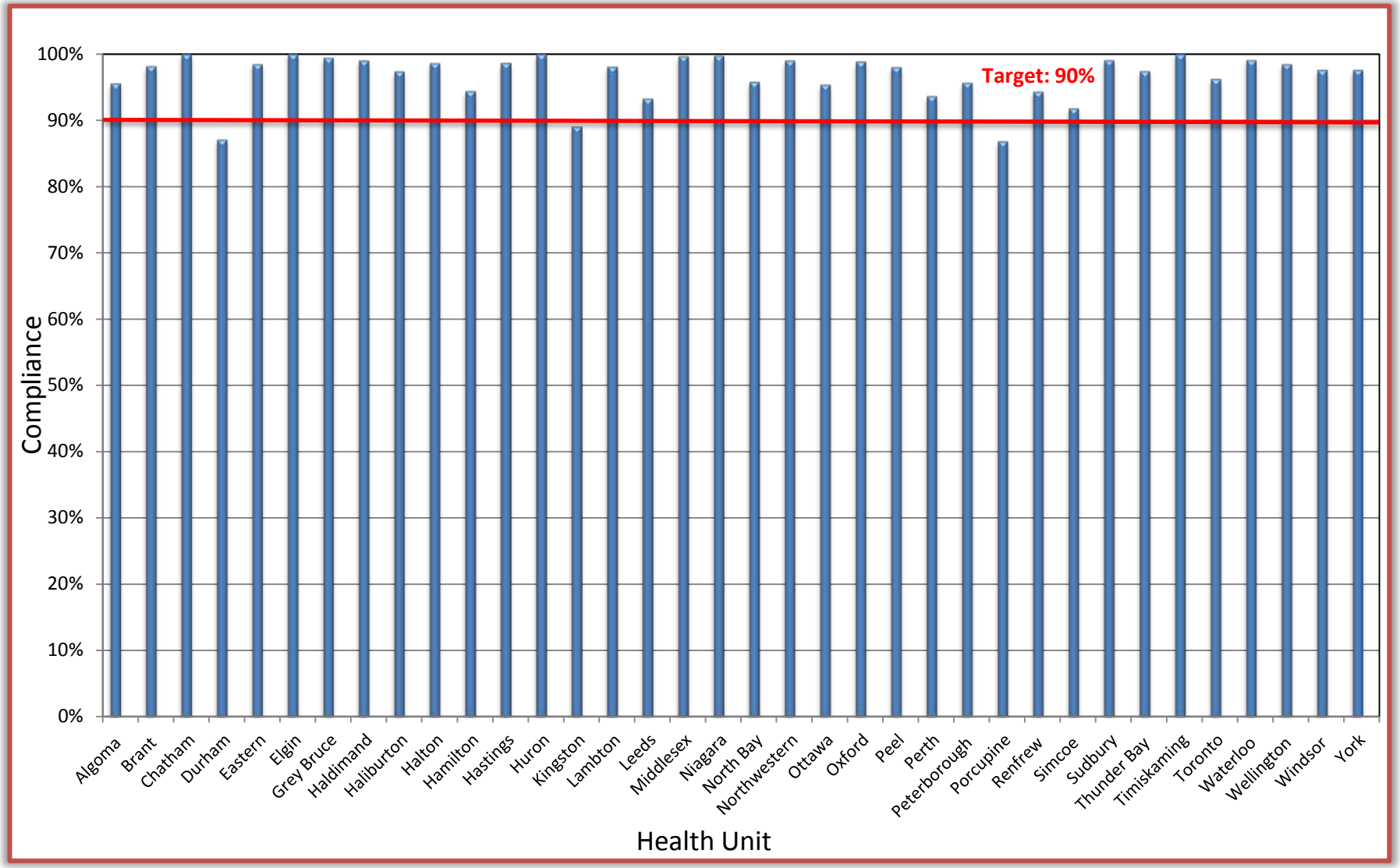
2013 Performance Results and Analysis

91.7% (33/36) health units achieved their 2013 target.

Results at a Glance

Achieved 2013 target	33/36 (92%)
Did not achieve target	3/36 (8%)
Mean performance	96.7%
Median performance	98.1%
Performance range	86.8% - 100.0%
Average performance increase	1.5%

Figure 9: Tobacco Vendor Compliance 2013 performance (n=36)



Indicator # 14. Baby-Friendly Initiative (BFI) Status

Context

The Baby-Friendly Initiative (BFI) is evidenced based and recognized globally and by the World Health Organization as a best practice, designed to improve breastfeeding outcomes for mothers and babies by improving the quality of their care and establishing breastfeeding as the cultural norm.

The BFI Status indicator monitors public health performance related to the implementation of a number of BFI requirements to promote, support and protect breastfeeding. Breastfeeding requirements are identified in the *Reproductive Health and Child Health* Standards of the *Ontario Public Health Standards, 2008*.

This indicator monitors the Baby-Friendly Initiative (BFI) implementation status of all Ontario health units using the Public Health Unit BFI Status Report. BFI status categories are:

- Preliminary work towards BFI (primarily the planning phase);
- Intermediate work towards BFI (implementation of the BFI 10 Steps) ;
- Advanced work towards BFI (verification of BFI 10 Steps implementation by BFI Ontario/Breastfeeding Committee for Canada (BCC));
- BFI designation (includes Re-designation); and
- BFI maintenance/preparation for Re-designation.

Interpretation

Ontario's health units self-report using the BFI Status Report and the Reference Guide definitions. When a health unit is in the Advanced Category, the length of time to complete each requirement depends on the quality of the work completed in the Intermediate Category as well as the recommendations provided by BCC. Thus, some targets may not have been met within the anticipated time frame identified, although steady progress is being maintained.

Next Steps

MOHLTC will continue mid-year and year-end reporting for this indicator.
MOHLTC to clarify reporting requirements for BFI maintenance/planning for BFI re-designation to support continuous quality improvement.
MOHLTC to require all health units to maintain BFI designation through BCCs BFI re-designation process every five years.

2013 Performance Results and Analysis

This indicator shows steady performance improvements since November 2011 baseline collection where seven of 36 health units were BFI designated and 18 of 36 health units were in the Preliminary Category.
At 2013 year-end:

- 11 of 36 health units were BFI designated
- no health units were in the Preliminary Category
- 20/36 health units achieved their 2013 BFI Status target
    - Of the 16 health units that did not achieve their target
        - 7 were in the Advanced Category
        - 9 were in the Intermediate Category

Between January and June 2014, an additional four health units became BFI designated, bringing the total number of health units designated in the province to 15.

Results at a Glance

BFI Designated	**11/36 (31%)**
Achieved 2013 target	20/36 (56%)
Did not achieve target	16/36 (44%)
Maintained or improved performance beyond 2012	36/36 (100%)

Figure 10.1: BFI Status 2013 performance (n=36)

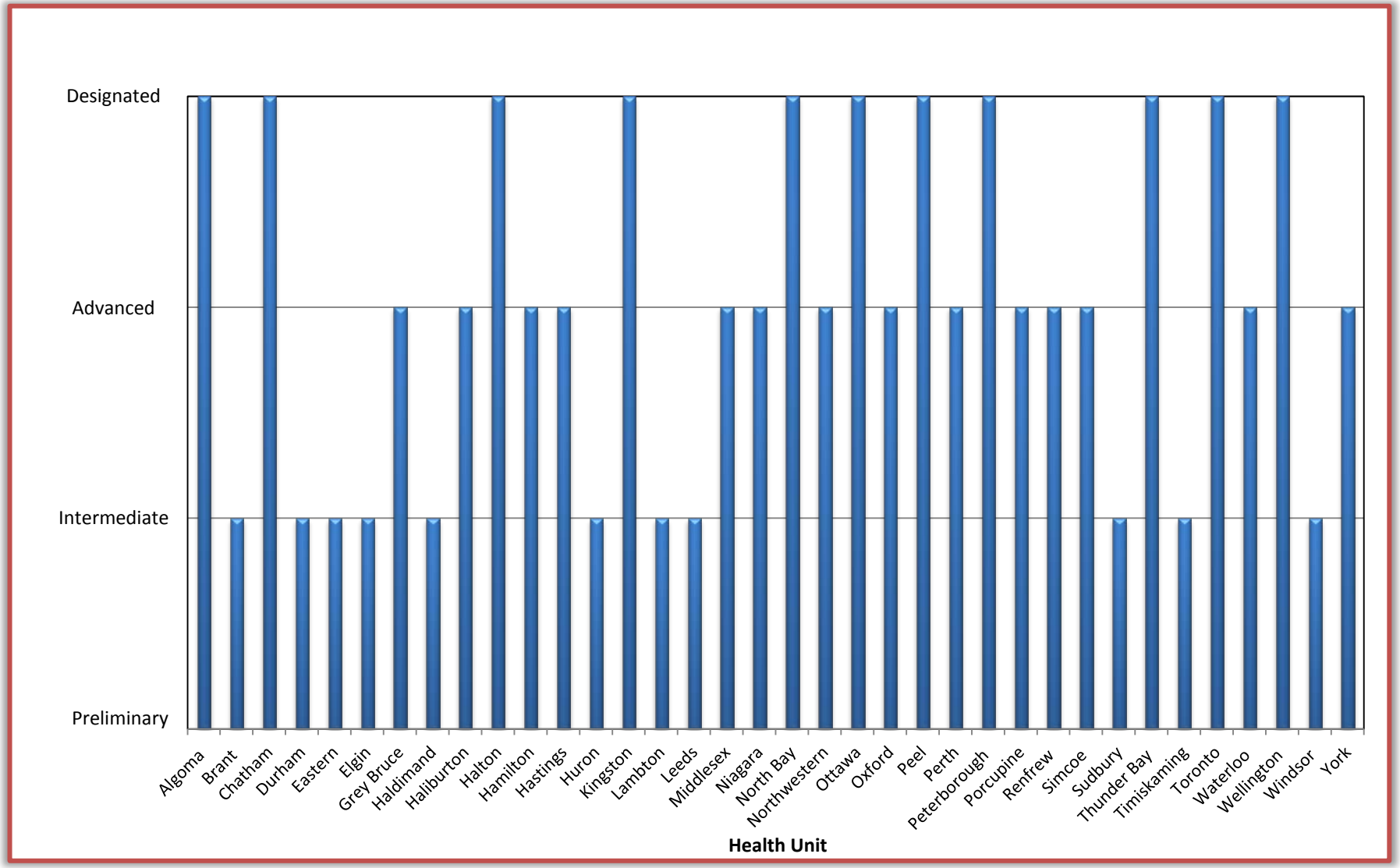
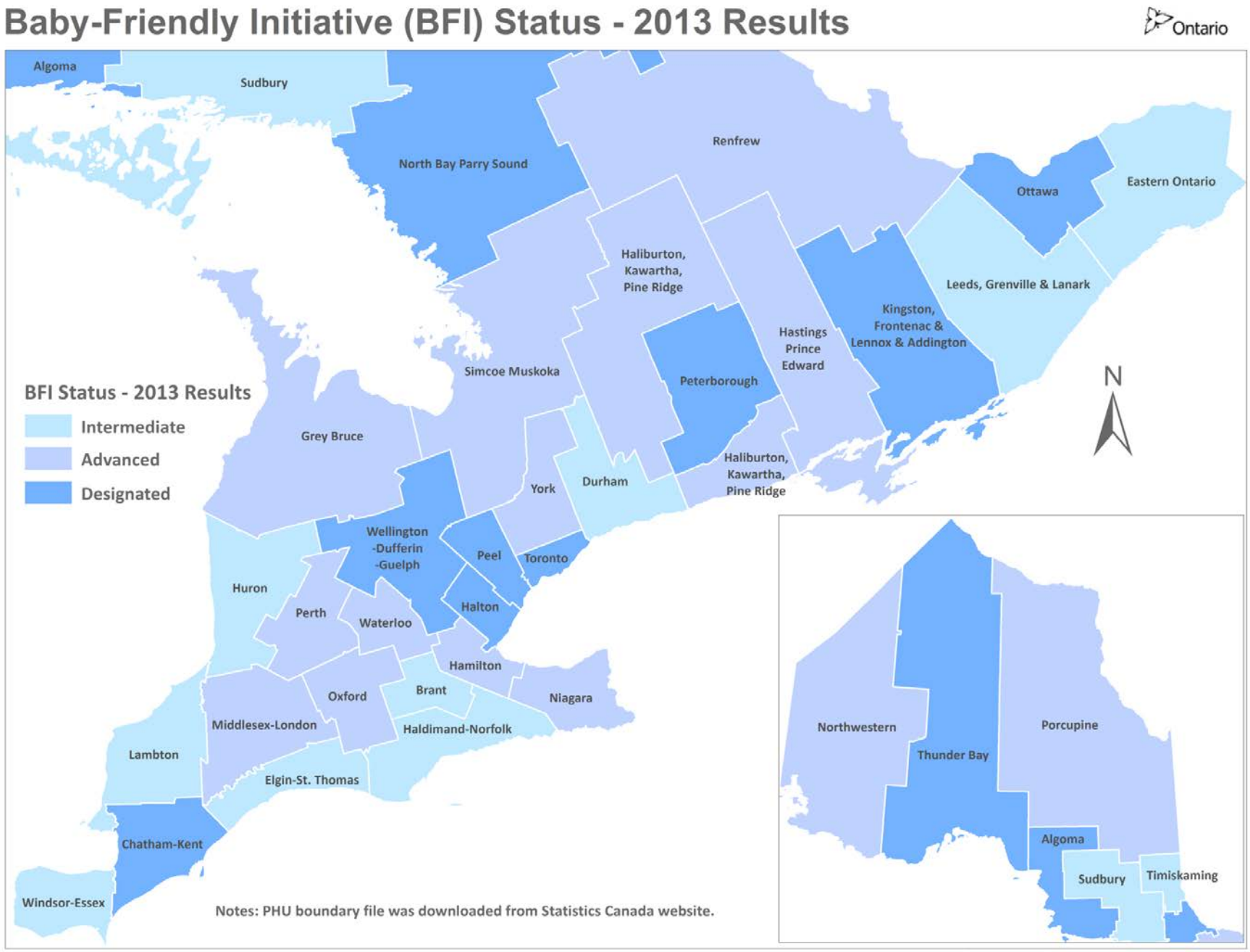


Figure 10.1 shows the 2013 year-end BFI Status performance of all health units.

Figure 10.2: BFI Status 2013 Performance Results Mapped by Health Unit



Prepared by Health Analytics Branch, Health System Information Management and Investment Division, Ministry of Health and Long-Term Care (August 2014)

Strategies for Achieving Health Promotion Performance Targets

The following strategies have been identified based on MOHLTC review, as well as the positive performance variant reports (PPVRs) submitted by health units who achieved or made significant progress with a health promotion indicator in either the 2012 or 2013 reporting periods.

Indicator #11: Tobacco Vendor Compliance:

What is working well:

1. Tobacco Information System (TIS)
    - Ongoing improvements in data collection and management methods (e.g. health unit data entry as per program guidelines, standardized approach to data entry)
    - MOHLTC owned data system vs. other data sources (e.g. CCHS) gives control over data availability; real-time; high quality
    - Health units are inputting data more frequently to ensure data is more reliable and timely
2. Improved linkages between Tobacco Program Guidelines and Public Health Accountability Agreements
    - Reinforces program level requirements for vendor compliance
    - Identifies specific local issues so MOHLTC can work with the health units to address them (e.g. issues related to test shoppers, capacity, program implementation)
3. Health unit reporting twice per year provides opportunity to identify and address issues

Indicator #14: Baby-Friendly Initiative (BFI) Status:

Positive Performance Attributes:

1. Utilization of resource supports:
    - Linked to BFI supporting organizations (e.g. BFI Ontario, Breastfeeding Committee for Canada, BFI designated health units)
    - Leverage benefits as an RNAO Spotlight Organization through implementation of best practices and developing a culture focussed on quality
2. Organizational supports:
    - Senior management leadership support
    - Dedicated BFI coordinator – health unit lead for keeping the BFI designation process on track
    - Local breastfeeding/BFI committee – multidisciplinary collaboration within and beyond health unit supports sustainability and shared ownership
    - BFI champions – facilitate BFI progress; may be senior management or program staff

3. Effective planning and implementation strategies:

    - Utilized workplans to identify key steps and processes for implementation of best practices
    - Planned surveillance and data collection (e.g. regular infant feeding surveys)
    - Addressed local needs
    - Collaborating with and supporting other agencies in their BFI Journey
    - Documented work and progress

4. Continuous Quality Improvement:

    - Health units begin planning for BFI redesignation following BFI designation
    - Policies and processes related to knowledge transfer, education, training, ensure maintenance of BFI designation

5. Sharing of BFI lessons learned:

    - Positive Performance Variant Reports were submitted by the following health units with agreement to share with others: Niagara Region; Oxford County; Porcupine; City of Toronto; Wellington-Dufferin-Guelph; Kingston, Frontenac, Lennox and Addington; City of Ottawa
    - BFI designated health units have provided updates at the MOHLTC Health Promotion Division, Ontario Family Health Management in Public Health Network teleconferences and have invited others to connect with them as needed
    - BFI Ontario provides a teleconference quarterly for all community health agencies (e.g. health units, community health centres, family health teams, etc.) who are interested in, working towards, or BFI designated. Learnings are shared in this community of practice

Summary

The *Public Health Performance Indicators 2013 Year-end Results* report provides health units' performance indicator results based on indicators in the 2011-13 Accountability Agreement, together with lessons learned related to the indicators.

Overall the report shows high levels of achievement for most health units across the indicators. The implementation of performance indicators has provided opportunities for health units to review their existing performance and business practices in order to improve or maintain strong performance in key areas of public health importance.

Several health units voluntarily provided positive performance variant reports to MOHLTC following successful achievement of their target for an indicator. MOHLTC has summarized this information to further enable peer to peer support and knowledge exchange related to best practices. Health units are encouraged to use this report to reach out to others to better support performance across all indicators. Valuable insights were also provided in the negative performance variant reports required by MOHLTC in instances where achievements of targets were not obtained.

While considerable progress has been achieved since baselines were established, there remain opportunities for continued improvement for each health unit. Where health units have achieved high levels of performance, it is expected that processes will remain in place to continue achieving these high levels.

Sharing health unit progress and accomplishments to date supports a culture of performance management. This report represents another step forward in strengthening the public health system in Ontario through continuous quality improvement, transparency and accountability.

Appendices

Appendix 1: Health Unit Names and Abbreviations

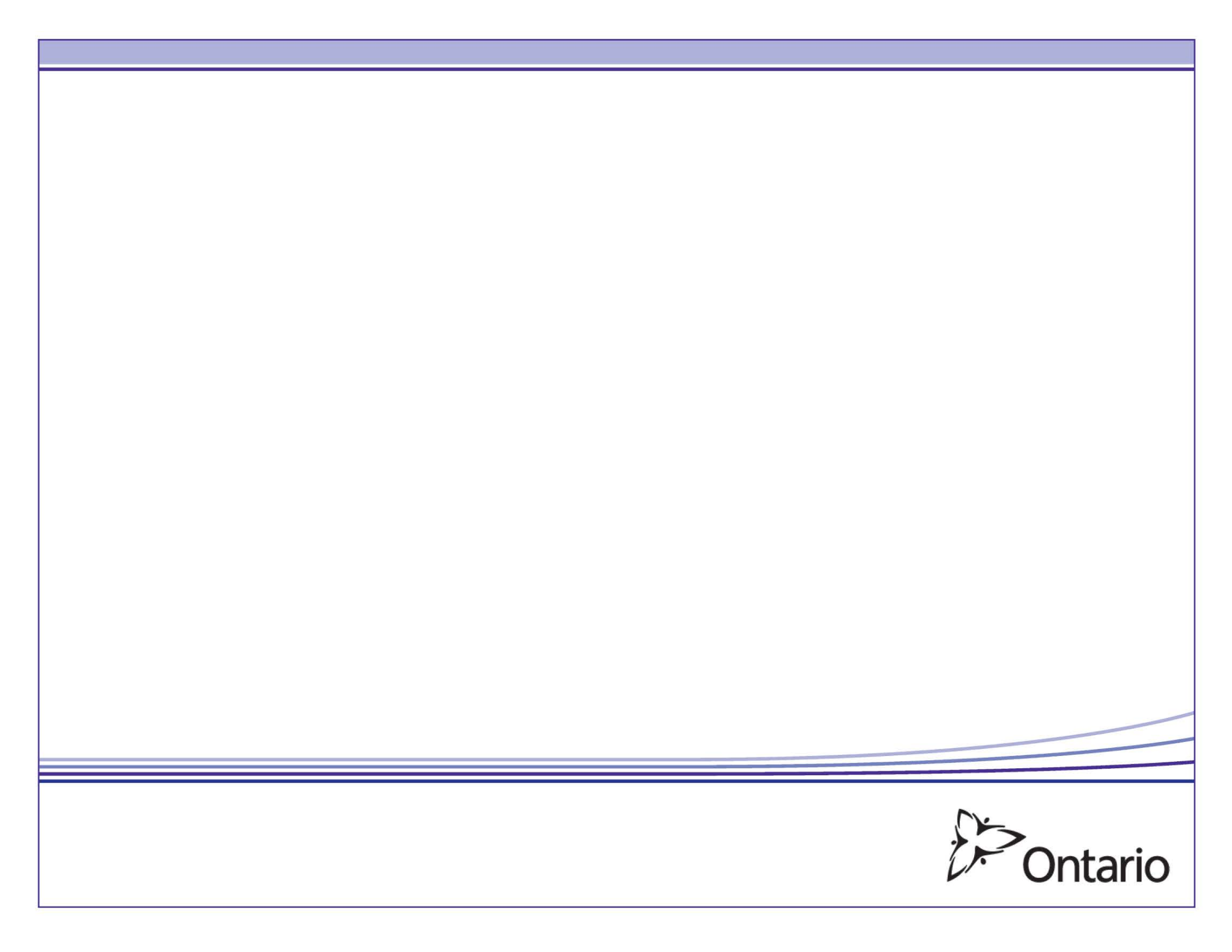
Names of health units have been abbreviated in this document. Refer to the table below for the full legal name of Ontario's 36 boards of health, as per the HPPA, regulation 553.

#	Health Unit Name as per the HPPA	Abbreviated Name
1	The District of Algoma Health Unit	Algoma
2	Brant County Health Unit	Brant
3	Chatham-Kent Health Unit	Chatham
4	Durham Regional Health Unit	Durham
5	The Eastern Ontario Health Unit	Eastern
6	Elgin-St. Thomas Health Unit	Elgin
7	Grey Bruce Health Unit	Grey Bruce
8	Haldimand-Norfolk Health Unit	Haldimand
9	Haliburton, Kawartha, Pine Ridge District Health Unit	Haliburton
10	Halton Regional Health Unit	Halton
11	City of Hamilton Health Unit	Hamilton
12	Hastings and Prince Edward Counties Health Unit	Hastings
13	Huron County Health Unit	Huron
14	Kingston, Frontenac and Lennox and Addington Health Unit	Kingston
15	Lambton Health Unit	Lambton
16	Leeds, Grenville and Lanark District Health Unit	Leeds
17	Middlesex-London Health Unit	Middlesex
18	Niagara Regional Area Health Unit	Niagara
19	North Bay Parry Sound District Health Unit	North Bay
20	Northwestern Health Unit	Northwestern
21	City of Ottawa Health Unit	Ottawa
22	Oxford County Health Unit	Oxford
23	Peel Regional Health Unit	Peel
24	Perth District Health Unit	Perth
25	Peterborough County-City Health Unit	Peterborough
26	Porcupine Health Unit	Porcupine
27	Renfrew County and District Health Unit	Renfrew
28	Simcoe Muskoka District Health Unit	Simcoe
29	Sudbury and District Health Unit	Sudbury
30	Thunder Bay District Health Unit	Thunder Bay
31	Timiskaming Health Unit	Timiskaming
32	City of Toronto Health Unit	Toronto
33	Waterloo Health Unit	Waterloo
34	Wellington-Dufferin-Guelph Health Unit	Wellington
35	Windsor-Essex County Health Unit	Windsor
36	York Regional Health Unit	York

Appendix 2: Indicator Names and Abbreviations

Names of indicators have been abbreviated in this document. Refer to the table below for the full indicator name.

#	Complete Indicator Name	Abbreviated Name
1	% of high-risk food premises inspected once every 4 months while in operation	Food Inspections
2	% of Class A pools inspected while in operation	Pools Inspections
3	% of high-risk Small Drinking Water Systems (SDWS) inspections completed for those that are due for inspection	SDWS Inspections
4	% of confirmed gonorrhea cases where initiation of follow-up occurred within 2 business days	gonorrhea Follow-up
5	% of confirmed Invasive Group A Streptococcal Disease (iGAS) cases where initiation of follow-up occurred on the same day as receipt of lab confirmation of a positive case	iGAS Follow-up
6	% of known high risk personal services settings inspected annually	--
7a,b	% of vaccine wasted by vaccine type that are stored/administered by the public health unit (HPV, Influenza)	HPV Wastage Influenza Wastage
8	% completion of reports related to vaccine wastage by vaccine type that are stored/administered by other health care providers	--
9a, b	% of school-aged children who have completed immunizations for Hepatitis B, HPV	--
9c	% of school-aged children who have completed immunizations for Meningococcus	Meningococcus
10	% of youth (ages 12 - 18) who have never smoked a whole cigarette	--
11	% of tobacco vendors in compliance with youth access legislation at the time of last inspection	Tobacco Vendor Compliance
12	Fall-related emergency visits in older adults aged 65 +	--
13	% of population (19+) that exceeds the Low-Risk Drinking Guidelines	--
14	Baby-Friendly Initiative (BFI) Status	BFI Status


Ontario

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 057-14

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2014 September 18

SUMMARY INFORMATION REPORT FOR SEPTEMBER 2014

Recommendation

It is recommended that Report No. 057-14 re Information Summary Report for September and the attached appendices be received for information.

Key Points

- Harvest Bucks, a farmers' market vegetable and fruit voucher program led by the Health Unit, had a successful second year and was supported by strong community partnerships.
- The in Motion™ Community Challenge is happening October 1 to 31, 2014.

Background

This report provides a summary of information from a number of Health Unit programs. Appendices provide further details, and additional information is available upon request.

Harvest Bucks

In its second year, Harvest Bucks, a farmers' market vegetable and fruit voucher program led by the Health Unit, added additional farmers' markets locations and made Harvest Bucks available for direct purchase by community organizations, as well as through application process for sponsorship. $11,070 Harvest Bucks were distributed by 8 community organizations to 353 London households with $8,350 (75%) redeemed. The Harvest Bucks application process has been revised to help ensure organizations receiving sponsorship effectively support program goals and to help ensure program funds are appropriately managed and allocated. Attached to this report as Appendix A is the Evaluation Summary Report, and attached as Appendix B is the 2013 Harvest Bucks Infographic.

In Motion™ Community Challenge

Obesity and chronic disease rates continue to go up as physical activity rates go down. Evidence indicates that community physical activity challenges can be effective in motivating individuals to become physically active. The 2014 in Motion™ Community Challenge is happening October 1 to 31st and will be bigger and better, building upon the great inaugural campaign of 2013! Links to tips, information, the tracker and the app can be found at www.inmotion4life.ca. Further details can be found in Appendix C.

This report was prepared by Ms. Kim Leacy, Registered Dietitian, Ms. Claire Paller and Ms. Melissa McCann, Program Evaluators and Ms. Linda Stobo & Ms. Mary Lou Albanese, Managers in Environmental Health and Chronic Disease Prevention Services.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

Harvest Bucks

Summary and Evaluation (2013)

Program Background

The Harvest Bucks program is a vegetable and fruit voucher program started in 2012. Each voucher is redeemable for $2 of fresh vegetables and fruit at participating London farmers' markets. Stakeholder feedback was collected from voucher recipients, distributing organizations and participating farmers' markets.

Significant Program Changes

- 5 additional farmers' market locations
- Steering Committee to provide program guidance
- Harvest Bucks available for direct purchase by individuals and organizations
- Open application for organizations to apply for funding (full funding and partial funding)
- Application Review Committee to review funding applications

Highlights

358 **London households received Bucks**

6 **Participating farmers' markets**[1]

$11,070 **Distributed**

- $3,390 funded
- $7,680 direct purchase
- $3,070 increase from 2012

$8,356 **Redeemed**

- 75% redeemed (63% in 2012)
- $2,448 funded programs
- $5,902 direct purchase
- $3,334 increase from 2012

8 **Funded programs (7 full, 1 partial)**[2]

9 **Direct purchase programs**[3]

---

[1] Covent Garden Market (indoor and outdoor), Farmers' and Artisans' Market at the Western Fair, Masonville Farmers' and Artisans' Market, Southdale Farmers' Market, and University Heights Public School Market

[2] Crouch Neighbourhood Resource Centre, London InterCommunity Health Centre (4 programs), South London Neighbourhood Resource Centre, Thames Valley Children's Centre, and University Heights Public School

[3] London InterCommunity Health Centre (2 programs), Middlesex-London Health Unit (5 programs), N'Amerind, and Private Purchase

Child & Youth Network

Bureau de santé de Middlesex-London Health Unit
www.healthunit.com

Farmers' & Artisans' Markets

Covent Garden Market
The Heart of London

Program Objectives

<u>Objective 1</u>: To increase access to and consumption of fresh vegetables and fruit for targeted Londoners.

Voucher Recipients Reported (Response Rate: Funded: 36%, n=55; Direct: 34%, n=69) ….

- 98% (funded) and 84% (direct) ate all or most of the vegetables and fruit they purchased
- 69% (funded) and 84% (direct) ate more vegetables and fruit
- 47% (funded) and 51% (direct) purchased produce they can't usually afford
- 29% (funded) and 34% (direct) tried new vegetables and fruit

Distributing Organizations Reported (Response Rate: Funded: 100%, n=8; Direct: 67%, n=6) ….

- 5 out of 8 (funded) and 4 out of 6 (direct) perception of increased access to and consumption of vegetables and fruit for voucher recipients

"Participants expressed what a help the Harvest Bucks were in their limited food budget. They expressed eating more fruits and vegetables due to having the bucks…"

~ Direct Purchaser

"… Participants were quite vocal about how amazing it felt to consume fresh produce, and how happy they were that they could provide fresh produce to their families. Some participants vocalized that they tried new produce that they had never tried before, like squash."

~ Funded Program Staff

<u>Objective 2</u>: To increase awareness, knowledge and comfort/familiarity with farmers' markets.

Voucher Recipients Reported (Response Rate: Funded: 36%, n=55; Direct: 34%, n=69) ….

- 94% (funded) and 95% (direct) intend to buy vegetables and fruit at a farmers' market in the future
- 25% (funded) and 56% (direct) bought vegetables and/or fruit for the first time at a farmers' market
- 37% (funded) and 39% (direct) became more comfortable going to a farmers' market
- 33% (funded) and 28% (direct) learned that fresh vegetables and fruit were less expensive at a farmers' market than they thought
- 31% (funded) and 26% (direct) felt more connected to their community

Distributing Organizations Reported (Response Rate: Funded: 100%, n = 8; Direct: 67%, n = 6) ….

- 4 out of 8 (funded) and 4 out of 6 (direct) perception of increased market awareness and knowledge
- 5 out of 8 (funded) and 3 out of 6 (direct) perception of increased market comfort level and familiarity

"There was a higher level of comfort and familiarity with the farmer's markets. Friendly relationships were established between the farmers and the participants."

~ Funded Program Staff

"There was a noticeable increase in awareness and knowledge of farmer's markets. Most of them had never been into a farmer's market before."

~ Funded Program Staff

<u>Objective 3</u>: To increase the comprehensiveness of local community programming through a reduction in barriers to participants' access to vegetables and fruit.

Funded and direct programs reported several additional benefits that the Harvest Bucks added to their existing programming, including:

- Provided incentive for clients to participate in the program
- Supported nutrition recommendations promoted in the program by reducing the financial barriers to purchase produce
- Increased program emphasis on seasonal local foods

"One of the greatest benefits was the increase of males that we saw register for our collective kitchen program ... The [Area] is known to have the largest single male population living in poverty. With the lack of male specific services in London, and the issues surrounding men accessing services, the Harvest Bucks program created an incentive for men to begin attending a program. Even after the Harvest Bucks were distributed, the men returned for the sessions afterwards …"

~ Funded Program Staff

"The distribution of Harvest Bucks allowed us to focus on seasonal local foods even more prominently than we normally would. We prepared foods with fresh local produce at every session we provided."

~ Direct Purchaser

"It was nice to be able to say this produce is in season, it is available at the market, and here is inspiration to purchase it. Everybody was thrilled to receive the bucks regardless of their economic situation."

~ Funded Program Staff

Facilitators and Barriers to Harvest Bucks Redemption

<u>Facilitators</u>

(Reported by distributing organizations)

- Program content related to healthy eating including trying new food and food preparation
- Ongoing relationships with voucher recipients and ability to provide reminders to use Bucks
- Voucher recipient and/or organization in close proximity to farmers' markets
- Reduce transportation barriers by offering bus tickets
- Farmers' market orientation (e.g., market tour)
- Voucher recipients' enjoyment and comfort with the farmers' market experience
- Voucher recipients' familiarity in using Bucks previously
- Voucher recipients' food insecurity providing motivation to use Bucks

<u>Barriers</u>

(Reported by voucher recipients and/or distributing organizations)

- Distribution of Harvest Bucks to voucher recipients later in the program or year
- Limited farmers' market hours
- Signage at farmers' market not visible to some participants
- Lack of transportation to farmers' market
- Voucher recipients' difficulty carrying large quantity of produce after purchasing
- Voucher recipients' daily challenges and stress
- Voucher recipients' limited food skills for produce preparation
- Voucher recipients' taste preferences for sugar/fat/salt and limited exposure to produce

Implications for Practice

Key recommendations for change are listed below. Recommendations are based on the evaluation, lead evaluators' consultation and operational program knowledge, and giving consideration to the overall program goals and intended outcomes.

- Have funded Harvest Bucks available earlier in the growing season
- Enhance selection criteria for funded programs including factors such as comprehensive food literacy programming, farmers' market orientation and addressing transportation barriers
- Distribute Harvest Bucks to voucher recipients multiple times to increase impact
- Develop a tracking system to help ensure participants receiving additional Harvest Bucks have used previously distributed Harvest Bucks
- Review the system for identifying participating vendors to minimize voucher recipient confusion
- Develop strategies to enhance the administration of the evaluation to increase response rates
- Explore the inclusion of additional farmers' markets

Acknowledgements

Steering Committee
Brianna Colenutt, Registered Dietitian, London InterCommunity Health Centre
Cheryl McKeever, Executive Director, Glen Cairn Community Centre
Christine Scheer, Farmers' Market Manager, Covent Garden Market
Joshua Archer, HEHPA Project Manager, Child and Youth Network
Kate Ledgley, Ending Poverty Project Manager, Child and Youth Network
Kim Leacy, Registered Dietitian, Middlesex-London Health Unit
Michelle Navackas, Market Manager, Farmers' and Artisans' Market at the Western Fair
Shelly Happy, Community Development Worker, London InterCommunity Health Centre

Application Review Committee
Deborah Peckham, Steering Committee Member, London Homeless Coalition
Josh Chadwick, Community Harvest Coordinator, London Food Bank
Kim Leacy, Registered Dietitian, Middlesex-London Health Unit
Sheila Foster, Manager, Ontario Works London

Program Donors
Thank you to the following donors for their contribution to the Harvest Bucks Program:

- Arthur Ford Public School
- Child and Youth Network
- Kim Leacy
- Paul Swan
- Anita Quenneville
- Covent Garden Market
- Middlesex-London Health Unit
- The Church of St. Jude

100% of funds received are used to purchase Harvest Bucks for funded programs. Tax receipts are provided for donations of $100 or more.

To learn more about Harvest Bucks, email kim.leacy@mlhu.on.ca.

HARVEST BUCKS 2013

Vegetable & fruit farmers' market voucher program started in 2012

89%

of Middlesex-London residents did NOT meet their vegetable & fruit requirement based on Canada's Food Guide[1]

Did you know?

Eating enough vegetables & fruit is important for healthy living, healthy weights & prevention of chronic diseases.

$11,070 *Harvest Bucks distributed*

8 *Funded programs[2]* + **9** *Direct purchase programs[3]*

358 *London households received Bucks*

6 *Participating farmers' markets[4]*

75%

Harvest Bucks redeemed ($8,356)

Direct purchase voucher recipients reported[5] they:

84% *ate all or most of the vegetables & fruit purchased*

84% *ate more vegetables & fruit in general*

95% *intend to buy vegetables & fruit at a farmers' market in the future*

100% of donations received are used to purchase Harvest Bucks for funded programs.

Tax receipts are provided for donations of $100 or more.

To become a program donor or to learn more, please contact: kim.leacy@mlhu.on.ca

Harvest Bucks is a partnership of:

Covent Garden Market
Farmers' & Artisans' Market at the Western Fair
London's Child and Youth Network
Middlesex-London Health Unit

[1] Souce: Canadian Community Health Survey 2011 - Public Use Microdata File.
[2] Programs apply for funding for Harvest Bucks [3] Programs directly purchase Harvest Bucks
[4] Covent Garden Market (indoor and outdoor), Farmers' and Artisans' Market at the Western Fair, Masonville Farmers' and Artisans' Market, Southdale Farmers' Market and University Heights Public School Market
[5] Based on a 34% response rate (n=69)

Middlesex-London Health Unit, August 2014

Appendix C

IN MOTION™ COMMUNITY CHALLENGE

Background

In 2013, the Middlesex-London in Motion™ Community Partnership initiated the in Motion™ Community Challenge pilot. The Challenge encourages residents to be physically active while providing them the opportunity to track their physical activity minutes while being a part of a larger community initiative. The objective is to increase the awareness of the importance of physical activity while getting individuals, young and old, to move just a little bit more.

Physical activity minutes can be tracked on a paper tracker or through an app specifically developed for the Challenge that can be found at www.inmotion4life.ca. In 2013, the community tracked 2 million physical activity minutes.

2014 – 'Up For the Challenge'

The 2014 in Motion™ Community Challenge will be bigger and better than 2013. The Partnership has been working diligently since early spring to strategize and plan the second successful Community Challenge which has been expanded to include Middlesex County. This year's objectives are to surpass the 2 million minutes tracked in 2013 and to increase the number of participants taking part in the Challenge. The Challenge will be promoted using a multifaceted approach which will include the following:

- all 15 libraries in Middlesex (MS) County and 16 libraries in the City of London will have in Motion™ Community Challenge displays, distribute the paper trackers, award prizes in contests, and provide promotional items;
- in-person visit by a Partnership member to each of the 8 recreational managers in MS County to promote the Challenge;
- information being available at all community and recreational centers in the City and County;
- extensive print, billboard, radio, television and internet messaging;
- street flags will be flying on the lamp posts in downtown London on Wellington St., Richmond St., and Queens Ave. for the month of October;
- a social media campaign through twitter and Facebook including the Everyday Champion and other contests; and
- distribution of promotional items, posters and rack cards by community partners and the in Motion™ Community Challenge Street Team.

School Strategy – "The Envelope"

With the assistance of the London Catholic District School Board and Thames Valley District School Board Learning Coordinators, a new school component has been included in 2014. Each elementary school teacher in every school will get an envelope with participating instructions. The decision to participate will be up to the teacher. The strategy involves giving each child a paper tracker to take home to their family to encourage participation with their family outside of school hours. Suggestions for activities will also be provided to each teacher in an in Motion™ Community Challenge physical activity calendar that can be posted in the classroom.

All classes choosing to participate and returning 60% of their trackers will be entered into a draw for a class trip. All schools in the City of London and Middlesex County are encouraged to participate.

Launch

In lieu of an event launch, on October 1st, the in Motion™ Partnership Chair will make live morning appearances on 3 morning shows to announce the start of the month long Challenge. The Partnership decided on a radio launch for 2014 to broaden the reach to a larger audience.

Conclusion

Physical inactivity continues to be a public health concern in our community. The in Motion™ Community Challenge is one strategy in a comprehensive approach aimed at increasing the awareness of our community about the importance of physical activity and to support and encourage individuals to be physically active by participating in a Community Challenge.

The 2014 in Motion™ Community Challenge will be bigger and better, building upon the great inaugural campaign of 2013!

Are you 'Up for the Challenge?'

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 058-14

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2014 September 18

MEDICAL OFFICER OF HEALTH ACTIVITY REPORT – SEPTEMBER

Recommendation

It is recommended that Report No. 058-14 re Medical Officer of Health Activity Report – September be received for information.

The following report highlights activities of the Medical Officer of Health (MOH) from the July Medical Officer of Health Activity Report to September 8, 2014.

Throughout the summer months, the Medical Officer of Health continued to meet with staff on a regular basis as well as take some time for vacation days.

In preparation for the July 18th Board of Health & Senior Leadership Team Planning Day, five Strategic Planning Focus Group sessions were held to allow all Health Unit staff to contribute to the development of the new strategic plan. These sessions were very engaging and allowed staff to discover and discuss the values & "noble cause" that drive MLHU's work. The Planning Day included both a discussion of the principles of generative governance and work to further develop the Health Unit's vision and mission.

Work continues on the PBMA 2015 process. The Senior Leadership Team (SLT) reviewed the weights and criteria and developed the time line for this year's process. In mid-August, Senior Leaders reviewed the draft criteria and weights with Managers for input and feedback. On September 2, Jordan Banninga, Manager, Strategic Projects assisted SLT in finalizing the weights and criteria which will now be presented to the Board for approval.

The MOH presented at the Association of Municipalities of Ontario AMO Conference on August 19th on the topic of "Healthy Communities by Design".

The Medical Officer of Health and CEO also attended the following teleconferences and events:

July 10	Met with TRR Architects to discuss a space needs assessment for the Health Unit
July 14	Met with LHSC staff to discuss Partnering in Transition – Code Red Project
July 15	Travelled to Toronto to attend farewell celebration for Dr. Arlene King
July 16	Met with LHSC staff to discuss drug strategy
July 16	As United Way Cabinet member, met with London Police Services to encourage their participation in United Way fundraising
July 17	Via teleconference, met with Mark Spowart, a reporter, to discuss IV drug use in London
July 17	Attended Board of Health meeting

July 21	In the role of United Way Cabinet member, met with staff at the London Transit Commission to encourage their participation in United Way fundraising
July 28	Met with Mary Lou Albanese, Manager of Environmental Health and Chronic Disease Prevention and Dan Flaherty, Manager of Communications to discuss an InMotion CTV/Bell Media advertising proposal
July 29	Attended a Public Health Ontario Grand Rounds teleconference – The Healthy Babies Healthy Children Process Implementation Evaluation
July 30	Met with Shaun Elliot, CEO at the YMCA to discuss opportunities for collaboration between the Y and MLHU
July 30	Attended a meeting with Dr. Sharon Koivu, LHSC to discuss harm reduction and drug strategy
August 18	Welcomed Dr. Gayane Hovhannisyan, Associate Medical Officer of Health to the Health Unit
August 18	Met with Dan Flaherty, manager Communications and Jason Micallef, Marketing Coordinator to discuss an Agency-Wide Communications Campaign
August 20	Attended a meeting with Glen Pearson and Martha Powell to provide MLHU input in regards to the potential restructuring of the London and Area Food Bank
August 22	Participated in a meeting at the London InterCommunity Health Centre to discuss Partnering in Transformation: Code Red Project. This meeting was attended by several local agencies, including: LHSC, SWLHIN, City of London, UWO
September 2	Co-presented at Grand Rounds, Western Centre for Public and Family Medicine, with Dr. Bryna Warshawsky on Ebola and Drug Use in this region
September 4	Attended September Finance and Facilities Committee meeting
September 5	Met by teleconference with Dr. Arlene King, former Ontario Chief Medical Officer of Health, to discuss the future of public health in Ontario

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

This report addresses Ontario Public Health Organizational Standard 2.9 Reporting relationship of the medical officer of health to the board of health