AGENDA
MIDDLESEX-LONDON BOARD OF HEALTH
Governance Committee

399 Ridout Street, London
Middlesex-London Board of Health Boardroom
Thursday, January 15, 2014 6:00 p.m.

1. **DISCLOSURE OF CONFLICTS OF INTEREST**

2. **APPROVAL OF AGENDA**

3. **APPROVAL OF MINUTES**

   - September 18, 2014 Governance Committee Meeting

4. **BUSINESS ARISING FROM THE MINUTES**

5. **NEW BUSINESS**

   5.1.1. Strategic Planning Update (Report No. 01-15GC)
   5.1.2. Board of Health Orientation (Report No. 02-15GC)
   5.1.3. Medical Officer of Health Performance Appraisal Process (Report No. 03-15GC)

6. **OTHER BUSINESS –** Next meeting

7. **ADJOURNMENT**

MINUTES
MIDDLESEX-LONDON BOARD OF HEALTH
Governance Committee

399 Ridout Street, London
Middlesex-London Board of Health Boardroom
Thursday, September 18, 2014 5:00 p.m.

Committee Members Present:	Mr. Al Edmondson Mr. Marcel Meyer Mr. Mark Studenny (Chair) Ms. Sandy White
Regrets:	Ms. Viola Poletes Montgomery
Others:	Dr. Christopher Mackie, Medical Officer of Health & CEO Ms. Sherri Sanders, Executive Assistant to the Board of Health (Recorder) Ms. Laura Di Cesare, Director Human Resources and Corporate Strategy (via teleconference) Mr. Jordan Banninga, Manager, Strategic Projects

Mr. Mark Studenny, Chair of the Governance Committee, called the Committee to order at 5:00 p.m.

1. DISCLOSURES OF CONFLICT(S) OF INTEREST

Mr. Studenny inquired if there were any disclosures of conflict of interest to be declared. None were declared.

2. APPROVAL OF AGENDA

It was moved by Mr. Edmondson, seconded by Mr. Meyer *that the AGENDA for the September 18, 2014 Governance Committee meeting be approved.*

Carried

3. APPROVAL OF MINUTES

It was moved by Mr. Meyer, seconded by Ms. White *that the Minutes from the May 15, 2014 Governance Committee meeting be approved.*

Carried

4. BUSINESS ARISING FROM THE MINUTES

None

5. NEW BUSINESS

5.1. BOH Orientation and Training (Report 04-14GC)

Ms. Laura Di Cesare, Director of Human Resources and Strategic Planning, assisted Committee members with their understanding of this report. Committee members agreed that introducing an online learning component would be valuable and ensure most current information.

It was suggested that the Health Unit send information to the City and County about expectations of board, roles and responsibilities legislative requirements and required to ensure it is clearly understood who we are, what we

do and what to expect when you come to the board. It was also suggested that orientation information include a contact list of "Who Does What."

It was moved by Mr. Edmondson, seconded by Ms. White *that Report No. 04-14GC be approved as amended (#3) below:*

1) *The Governance Committee receive Report No. 04-14GC re Board of Health Orientation and Training for discussion;*

2) *The previous two day in-person orientation for new Board of Health members be reduced to a one day orientation augmented by other orientation and training elements as outlined in Appendix A.*

3) *Staff will develop a job description including expectations, for Board of Health members to increase awareness about the Board and the Health Unit. The Governance Committee will review the information before the document is sent to municipal decision makers.*

Carried

5.2 Strategic Planning Process Update (Report 05-14GC)

Ms. Di Cesare assisted Committee members with their understanding of this report. She outlined the proposed Values that were suggested by consultation sessions with over 145 Health Unit employees. She also presented the timeline for the process. She also reported that the strategic planning process is on schedule.

After discussion, it was moved by Mr. Meyer, seconded by Ms. White *that the Governance Committee receive Report No. 05-14GC re Strategic Planning Process Update for information*.

Carried

6. OTHER BUSINESS - Next Meeting Thursday, January 15, 2015 @ 6:00 p.m.

7. ADJOURNMENT

At 6:35 p.m., it was moved by Ms. Poletes Montgomery, seconded by Mr. Meyer *that the meeting be adjourned.*

Carried

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MARK STUDENNY
Chair

CHRISTOPHER MACKIE
Secretary-Treasurer

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 01-15GC

TO: Chair and Members of the Governance Committee

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2015 January 15

STRATEGIC PLANNING PROCESS UPDATE

Recommendation

It is recommended that the Governance Committee receive Report No. 01-15GC re: "Strategic Planning Process Update" for information.

Key Points

- We have completed the "Defining the Challenge" phase which consisted of the development of the mission, vision and values tree, the research report and communications plan.
- Focus is now shifting towards "Setting the Course" which entails synthesizing this information into strategic priorities for the next five years and the development of a strategic plan monitoring process such as a balanced scorecard for public health.
- Strategic priorities and the strategic plan monitoring process will link operational planning to strategic organizational goals.

Background

Governance Committee members will recall endorsing the proposed strategic planning process at the May 2014 meeting (Report No. 03-14GC) and the progress report at the September 2014 meeting (Report No. 05-14GC). Since that time, staff have continued to move the strategic planning process forward.

Progress to Date

The strategic planning process has moved through the "Defining the Challenge" phase into "Setting the Course" (Appendix A). Progress to date includes:

Mission, vision and value tree – The mission, vision and values tree was developed following two Board of Health and Senior Leadership Team (SLT) retreats, 5 MLHU staff consultation, subsequent review and validation from the Strategic Plan Advisory Committee (SPAC) and approval from Senior Leadership Team (SLT) and the Board of Health (Appendix B).

Research report – The research report explores evidence-based concepts that describe the components of high performing health unit. Information was drawn from peer-reviewed literature and data about the Middlesex-London community to help the SLT identify strategic priorities and define activities to enhance performance (Appendix C).

Communication Planning – A SPAC sub-group was formed to map out communications tactics for the strategic plan. Key activities during the "Defining the Challenge" and "Setting the Course" phases include: posting information prominently on the HUB (intranet), introducing the mission, vision, values tree at an all-staff town hall and coordinating progress updates through Non-union leadership (NLT) and program area meetings.

Next Steps

A town hall event will be held on January 20, 2015 to unveil the mission, vision and values tree for the strategic plan. Concurrently, the Senior Leadership Team will be holding three priority selection sessions to determine the strategic priorities, integrate priorities with operational planning and to develop a strategic plan monitoring process.

The Strategic Plan Advisory Committee, Non-union Leadership Team, staff and Board members will be engaged throughout the "Setting the Course" phase to refine and validate the Middlesex-London Health Unit strategic plan.

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

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

Appendix A: Strategic Planning Process

Phases		Governance Committee, BOH Role	Senior Leadership, Staff Role	Product
Planning	• Develop strategic planning process	• 1st Retreat to review and develop process, mission & vision statement	• Develop, review & endorse process	Work plan & road map
Defining The Challenge	• Pre-work + mission & vision	• Review & approval process • 2nd Retreat to review and develop mission & vision statement	• 2nd Retreat to review and develop mission & vision statement • Staff launch	Draft mission & vision
	• Validate mission & vision with staff • Develop mission, vision, values tree.	• Review & finalize mission, vision and values tree	• Participate in staff consultations and develop set of organizational values	Consensus on mission and vision, values tree
	• Conduct research		• Develop research report to help identify priorities	Research Report
Setting The Course	• Identified priorities and activities	• Review draft priorities and monitoring process	• Review research findings and develop strategic priorities and monitoring process	Identify strategic priorities and monitoring process
	• Link plan to operations		• Integrate strategic work into operational plans	Strategic priorities addressed in operational plans
	• Write & submit plan for approval	• Review draft strategic plan and monitoring process	• Draft, validate and refine the strategic plan and monitoring process	Draft strategic plan & monitoring process
Plan Launch & Keeping it Relevant	• Write & submit plan for approval	• Approve strategic plan and plan monitoring process	• Submit strategic plan for approval	Approved strategic plan & monitoring process
	• Launch strategic plan • Begin monitoring process	• Launch final plan • Implement monitoring process	• Launch final plan	Launched strategic plan

VISION, MISSION AND VALUES TREE

Vision: People Reaching Their Potential

Mission: To promote and protect the health of our community

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

www.healthunit.com

What makes a high performing health unit?

A research report to inform strategic planning at

Middlesex-London Health Unit

EXECUTIVE SUMMARY

Why a *Research* Report?

An important step in the development of a strategic plan is to understand best practices of performance excellence in the local context of the organization. The research report examines local data and literature that aims to describe:

What makes a high performing health unit?

This data, along with reflection on feedback from the current strategic planning launch event and information gathered from the previous strategic planning process form the foundation of the research report.

Balanced Scorecard for Public Health

The balanced scorecard for public health helps align performance of an organization around its mission, vision and strategic priorities. The framework facilitates monitoring and assessment of strategy implementation as well as assigns accountability for performance at all levels of the organization. Four important areas to consider in strategic priority development are: health determinants and status; community engagement; resources and services; and, integration and responsiveness (Woodward, Manuel & Goel, 2004).

Alignment of Literature and Local Data

In the research report, local data and research literature were examined under the framework of a balanced scorecard for public health. The intention of this exercise was to present the evidence from the literature and the local context in each quadrant of the scorecard to inform selection of strategic priorities.

Findings

Key findings from the research report show that Middlesex-London is well placed within non-modifiable factors such as population size and board structure to be high performing and improve health outcomes. Modifiable factors such as community engagement, leadership, organizational culture, and external partnerships can be changed to drive public health unit performance. The literature specifically identifies administrative evidence-based practices that drive evidence-informed decision making, which improves modifiable factors and ultimately leads to downstream impact on health outcomes. Information summarized in each of the quadrants informs the strategic priorities in the context of the local community values, attitudes and values of staff, and views from important health unit stakeholders.

Next Steps

The research report presents the characteristics of high performing public health units in the framework of the balanced scorecard for public health to help decision makers formulate strategic priorities for MLHU.

INTRODUCTION

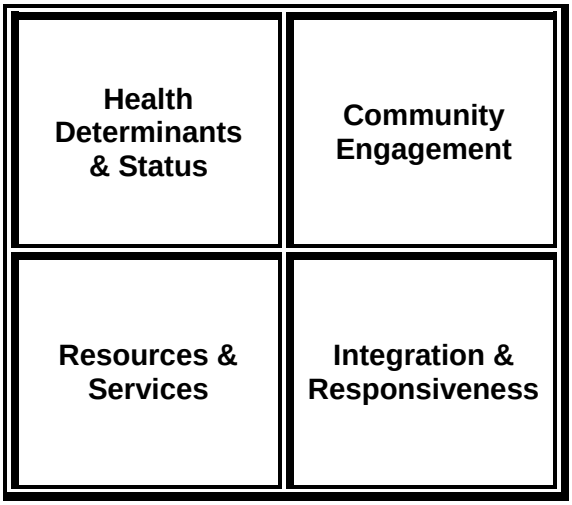
The goal of this research report is to explore evidence-based concepts that describe what makes a high performing health unit. Information drawn from peer-reviewed literature and data about the Middlesex-London community has been compiled to help identify strategic priorities and define activities to enhance performance. The data has been organized by the four quadrants of a Balanced Scorecard for Public Health model proposed by the Institute for Clinical Evaluative Sciences (ICES) (Woodward, Manuel & Goel, 2004).

BALANCED SCORECARD FOR PUBLIC HEALTH

To realize the mission and vision set forth in a strategic planning cycle an organization may use the balanced scorecard to help define strategic priorities and monitor progress through key performance indicators. Originally developed in the 1990's by Kaplan & Norton (1992) for use in private sector, the balanced scorecard prescribes four important perspectives:

1) Customer – How do customers see us?
2) Internal business – What must we excel at?
3) Innovation and learning – Can we continue to improve and create value?
4) Financial – How do we look to shareholders?

Realizing that key performance indicators in the private sector differ from those in the public sectors, a modified Balanced Scorecard for Public Health was proposed by the ICES (Woodward, Manuel & Goel, 2004). There are four modified quadrants that could be used to assess public health performance:



The scorecard was subsequently recommended by the Capacity Review Committee in 2005 for use by public health units in Ontario (Tamblyn et al. 2006). Several PHU's followed this recommendation and have used the balanced scorecard or a similar performance management framework. These include: Elgin-St. Thomas, York, Ottawa, Simcoe-Muskoka, Sudbury & District, Perth District, Peel, Huron, North Bay-Parry Sound and Brant County.

Better suited to the work of public health, this adapted model maintains principles from the Kaplan and Norton model. Understanding our community's needs, ensuring performance excellence, providing an ideal work environment to promote excellence and working with our many partners are public health applications of the four principles outlined by Kaplan and Norton. Evidence about successful strategies in the four areas of balanced scorecard from both the local population data sources and the research literature are outlined below.

LOCAL DATA SOURCES

Key themes from local data were identified that link to the ICES balanced scorecard quadrants and potential areas for strategic priorities. Summaries of each of the local data sources as they relate to the quadrants are presented. The following local data sources were included:

- MLHU staff input from Strategic Plan Launch
- Environics Analytics - Focus Ontario Fall 2013 – (Environics Research Group, 2013)
- 2011 MLHU Discovery Report (Centre for Organizational Effectiveness, 2011)
- A Statistical Portrait of London – Neighborhood Profiles (City of London, 2014)
- Ontario Municipal Benchmarking Initiative – 2012 Performance Report (Ontario Municipal CAO's Benchmarking Initiative, 2013)
- Forum Research – 2012 poll of satisfaction with municipal services (Bozinoff, L., 2012)
- Rapid Risk Factor Surveillance System (RRFSS) data – Familiarity with the Health Unit

LITERATURE REVIEW

In April, 2014 a literature search was conducted with the aim of determining the characteristics and best practices of high performing health units. Details of the search strategy can be found in Appendix A. The results of the literature review are presented by quadrant of the ICES Balanced Scorecard.

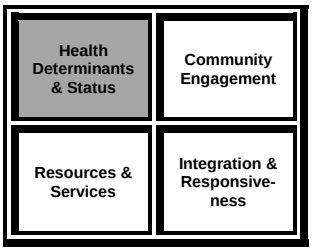
There were a number of ways that individual research papers defined high performance outcomes for public health agencies. Some used improved health status, which is the ultimate end goal of public health work. Others used shorter term outcomes such as compliance with established standards or evidence based decision making (EBDM) behaviours. No matter the type of outcome used, all provide some value to this discussion. Kanarek at al. (2006) and Ingram et al (2012) found that performance measures in local public health agencies were associated with health outcomes. Short term outcomes, such as enhancement of evidence-informed practice, will impact the performance of local public health agencies. This will, in turn, impact long term health outcomes of the community.

More specifically, variations in performance were associated with health outcomes of the community served. Brownson et al (2012) connected administrative evidence-based practices with organizational performance. Evidence-based decision making or evidence-informed decision making, as it is termed in Ontario, is essential to effective public health practice.

CONNECTING THE DOTS

The next four sections provide local context and a research evidence base, framed within the ICES balanced scorecard quadrants, to help identify strategic priorities, define activities and develop recommendations for monitoring sustained progress.

QUADRANT 1 – HEALTH DETERMINANTS & STATUS



The primary purpose of this quadrant is to identify the need for public health services (Woodward, Manuel & Goel, 2004). The Health Determinants and Status quadrant typically contains measures that make up health status reports, such as rates of disease, morbidity and mortality, and measures of health behaviours and social determinants of health. It is often possible to compare indicators from this quadrant to standard populations such as peer groups or provincial averages. Measures of health determinants and status can be used to assess the relative need for public health services in a health unit and are useful for estimating the potential contribution of public health services on population health outcomes. In isolation this quadrant does not adequately reflect health unit performance since health outcomes are influenced by a number of factors, such as poverty, literacy levels and employment rates, that lie beyond the direct scope of influence and responsibility of local public health units and their boards.

What the literature says:

The strongest predictor of public health agency performance, according to a systematic review conducted by Hyde and Shortell in 2012, was size of population served. Brownson (2012) also found this to a very important predictor or performance. Specifically, Mays et al (2006) found that the larger the jurisdiction size, up to a maximum of 500,000 people, was found to be a positive predictor performance.

The socioeconomic status of a community is a strong predictor of health status in a community (Hajat, 2009; Harris, 2014; Hyde, 2012). Addressing the social determinants of health in a community may be one of the most successful methods of elevating health status in the community, although this is not considered to be a short term modifiable characteristic.

What the local data says:

The 2013 estimate of population size of Middlesex-London was about 468,000, an ideal population size for the best performance of health unit (Ontario Ministry of Health and Longterm Care, 2013) according to the research cited above.

Given the breadth of the mandate of public health it is not possible to prioritize health status topics. Comparison of one topic to another to identify the top priority is an apples to oranges comparison. Rather than highlight key health status issues, the use of health status information

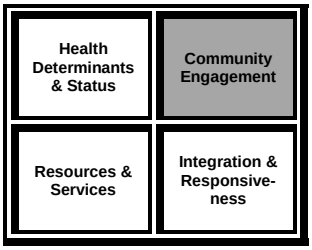
should be considered for decision making in all topic areas of the mandate. Specifically it can be used to determine the needs of the populations served and the impacts of the interventions implemented. It can also be used to estimate baseline measures of outcomes and monitor progress. Local health status and outcomes data on a variety of topics related to the mandate of public health can be found in the Community Health Status Resource.

Socioeconomic status indicators suggest that there is not a large difference between Middlesex-London and Ontario as a whole; however local data shows there are considerable differences in health status by socioeconomic status (SES) and that there is a substantial proportion of the population living in low SES conditions.

Middlesex-London is quite similar to Ontario in areas such as employment, education level and food security. The local population, however, had higher proportions of lone parents, one person households and a lower median income level compared to the province (MLHU, n.d.). Maps of socioeconomic distress indicate that there are vast differences across neighbourhoods. Some parts of London and Middlesex County have very high socio-economic distress, a measure combining education, unemployment, lone parenthood and low income, while other areas have very low levels. This is important to note because local data show that there are great disparities in health outcomes across the SES spectrum in the London region. For instance, the group with the lowest SES had 4.7 times the rate of hospitalizations for chronic obstructive pulmonary disease (COPD) than the group with the highest SES. Those with the lowest SES also had higher rates of anxiety disorders (4.5 times higher), substance-related disorders (4.2 times higher), diabetes (3.5 times higher) than the group with the highest SES. Some health behaviours follow similar trends to health outcomes. The rate of smoking was 2.5 times higher in the group with the lowest SES than in the group with the highest SES. Those with the lowest SES also had higher rates of multiple risk factors (three or more of: physical inactivity, being overweight or obese, smoking, or alcohol bingeing), with the rate being 2.1 times higher than the group with the highest SES (CIHI, 2008).

The population of Middlesex-London is growing, but not uniformly. There is an increasing older adult population while the under 19 demographic has shrunk in recent years. The City of London is culturally and linguistically diverse with Londoners reporting to speak over 48 different languages and backgrounds from 150 distinct ethno cultural communities (City of London, 2014).

QUADRANT 2 – COMMUNITY ENGAGEMENT



The primary purpose of this quadrant is to understand the views of the community served. This includes input from relevant agencies, health care providers and the general public (Woodward, Manuel & Goel, 2004). The views provided by individuals and stakeholders an organization seeks to serve help to maintain accountability and improve service delivery. Since public health initiatives often target entire populations, the public health balanced scorecard emphasizes community engagement—that is, assessing community awareness and preferences, and ensuring community input into planning and service delivery.

What the literature says:

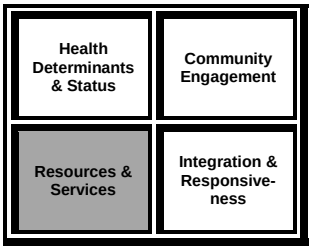
Higher performing public health units were found to have greater community interaction (Erwin, 2008). Kanarek et al (2006) suggest that a public health department that prioritizes the community's needs and partners with the community will see differences in health outcomes.

What the local data says:

The majority of people in Middlesex-London reported awareness of the health unit. In 2011, Rapid Risk Factor Surveillance System (RRFSS) data indicated nearly three quarters (74.3%) of the population was familiar with the health unit. Over half of respondents (57.3%) reported having ever used a health unit program or service; females and those with children in the household were more likely than others. According to a 2012 survey, 64% of London residents were satisfied with Public Health services, (28% were very satisfied and 36% were somewhat satisfied). This was in line with the 67% average for all the cities surveyed (Bozinoff, 2012). Although the majority are satisfied, the performance of local government agencies and value for tax dollars is a significant concern amongst Londoners (Environics, 2013). The survey found that 37% of residents felt that public health spending should increase, 49% felt it should stay the same and 9% felt that funding should be decreased.

The 2011 MLHU Discovery Report engaged community partners and volunteers to gather highlights of working with MLHU and priorities that MLHU should consider. Public health service delivery that was high quality, met the needs of diverse and vulnerable populations and is evidence-informed was valued. Partnering with the community to leverage resources, reduce duplication and improve quality was also highlighted. The feedback indicated that it is also important to be responsive to stakeholder concerns and feedback.

QUADRANT 3 – RESOURCES AND SERVICES



The primary purpose of this quadrant is to understand the amount of resources and services that are delivered within the organization (Woodward, Manuel & Goel, 2004). Some of the measures include financial performance, staff recruitment, retention and development, as well as other factors that influence organizational capacity.

What the literature says:

Allocation and expenditure of resources was found to be one of the most important predictors of performance (Brownson, 2012). Several authors found that the presence of a local board of health with policy making authority was associated with positive performance of essential public health standards (Hyde & Shortell, 2012; Brownson, 2012). These factors are considered to be fairly difficult to modify in the short term. Funding models and board structure are part of complicated systems beyond the control of the local public health agency.

The majority of modifiable factors that affect public health agency performance or health status of the population are relevant to the Resources and Services quadrant. Four of five major administrative domains that affect an organization's ability to conduct evidence based decision making fit in this quadrant as: workforce development; leadership; climate and culture; and, financial (Brownson, 2012). Erwin (2013) emphasizes that a full understanding of these factors is a necessary step in improving the competency of the workforce in administrative evidence based practices.

Sosnowy (2013) found strong leadership and workforce capacity to be associated with EBDM. Hajat et al. (2009) note that the presence of an experienced staff with diverse training, including some outside of public health, is positively associated with high performance. Brownson et al. (2012) indicated that to improve EBDM in the current workforce it is key to have in-service training in quality improvement and EBDM in a multidisciplinary setting. The training must be aligned with the work being done by staff. Further workforce development indicators were; use of knowledge brokers, interactions to share learning and incorporation of process-improvement activities.

Leadership features such as higher academic degrees for leaders (Hyde & Shortell, 2012; Brownson, 2012; Bekemeier, 2012; Ransom, 2012) are critical for performance. Improved performance was seen when leaders operated within a management team and used non-hierarchical decision-making while incorporating employee input (Erwin, 2008). The leadership must also support quality improvement and EBDM initiatives for that culture to permeate throughout the organization (Orton, 2011). Over the long term common terminology should be adopted in the organization.

Organizational climate and culture has been described by Brownson (2012) as consisting of access and free flow of information, support for innovation and having an orientation to learning as the three administrative evidence based practices. This areas is the least likely to be present in local health departments indicating it may be one of the more difficult to influence (Brownson, 2014)

Financial recommendations to enhance EBDM include using diverse funding sources, allocating resources to quality improvement and EBDM and incorporating transparent financial processes (Brownson, 2012).

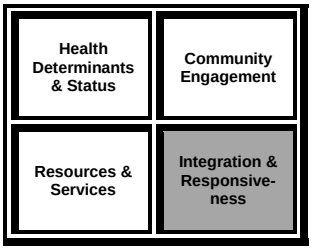
What the local data says:

As described in the literature by Erwin (2008) staff input in decision making enhances performance. The following themes were identified from the staff responses at the launch of the strategic plan regarding what we must do: increase health unit awareness; ensure relevance to current work; think broadly and long term; be innovative; be evidence-informed; and, ensure evaluation. The main themes that describe how the strategic plan should be developed were: create authentic engagement; communicate at all phases of the strategic plan; be transparent in our process; and, follow-through on the plan.

The Ontario Municipal CAO's Benchmarking Initiative (2013) creates benchmark data to be used by municipal staff to improve service and value for the community and allows councils, boards and management staff to improve performance. The OMBI report suggests development of metrics for operational performance in the areas of accounts payable, general government, information technology and payroll.

In the 2011 MLHU Discovery Report, the Leadership of MLHU provided feedback on highlights of working for the MLHU, described their vision for MLHU in ten years' time and provided feedback with respect to priorities that MLHU should consider. Strategic Priorities that were identified included: 1) organizational effectiveness and culture that is defined by planning and follow-though, efficacy and accountability, leadership and management models that break down silos, up-to-date technology and strong communication; and 2) developing funding priorities in tight fiscal environments and acknowledgement of political concerns that could prove challenge to MLHU at all levels.

QUADRANT 4 – INTEGRATION & RESPONSIVENESS



The primary purpose of this quadrant is to describe partnerships, collaboration, coordination and the capacity to be integrated with the health care system and responsive to community needs (Woodward, Manuel & Goel, 2004). This primarily relates to the structural capacity of public health to integrate into the associated health care system as well as the capacity to continually transform services in response to evolving needs, issues and evidence. This is linked to the ability to work with other healthcare sectors and community agencies, a commitment to research and continuing professional development, and emergency preparedness and response.

What the literature says:

Hyde and Shortell (2012) and Cilenti (2012) found that partnerships with universities and other academic institutions were associated with improved performance. This finding was echoed by the review done by Brownson et al. (2012) suggesting that partnerships not only with academia but also with hospitals, community organizations, social services, private businesses and law enforcement are important. This is the last of Brownson's five key domains that enhance administrative evidence based practices. Halverson et al (1996) indicated that engaging outside agencies in planning of program and service delivery is significantly related to public health performance. The longer that public health agencies have been engaging in partnerships, the better their performance metrics related to partnership development (Downey, 2013).

What the local data says:

In the 2011 MLHU Discovery report community partners were asked a series of questions about the quality of their working relationship. The following themes stood out:

- Increasing communication with partners will help develop already strong relationships.
- There needs to be a more concrete understanding of how partnerships work and how they are structured. Partnership agreements are a means of defining these relationships.
- Ensuring staff consistency and availability helps to build trust and familiarity over the long term with partners.
- MLHU should also strive to understand community needs and the work that our partners do in the community.

NEXT STEPS

Review of the research findings and local data by Senior Leadership and the Strategic Plan Advisory Committee will facilitate the development of a balanced scorecard and help to identify strategic priorities for MLHU. Once the quadrants and priorities are drafted and validated, staff will be engaged to define activities and develop recommendations for monitoring progress on the priorities.

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APPENDIX A

Databases searched included Academic Search Premier, MEDLINE, Health Business Elite, CINAHL Plus with Full Text for all English language publications between 1994 and 2014.

The search strategy was as follows: (((TI ((local or municipal* or city) N3 ("health unit*" or "health department*" or "public health")) OR AB ((local or municipal* or city) N3 ("health unit*" or "health department*" or "public health"))) AND ((framework* or model* or accomplished or characteristic* or "best practice*" or excellence or "high perform*" or distinction or distinguish* or quality or qualities or attribute* or factor*))) AND ("public health administration" or "public health practice"))

COVER PHOTOGRAPHY

Courtesy of Tourism London.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 02-15GC

TO: Chair and Members of the Governance Committee

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2015 January 15

BOARD OF HEALTH ORIENTATION

Recommendation

It is recommended that Report No. 02-15GC re "Board of Health Orientation" be received for information.

Key Points

- The Board of Health Orientation will consist of online self-paced learning as well as a one-day orientation session at the Middlesex-London Health Unit office.
- An orientation will allow new Board members to contribute effectively to Board of Health governance and improve performance of the Middlesex-London Health Unit.

Background

As a result of the 2014 municipal elections, there will be five new members appointing to the Middlesex-London Health Unit Board of Health beginning in January 2015. It was moved at the September 2014 Governance Committee meeting that the on-site orientation be reduced to one day and that online components be developed to meet the needs of Board Members.

Online Self-Paced Learning

To facilitate self-paced learning and provide a library of easily accessible priority documents to Board of Health members, an online orientation page has been developed. Content is broken down into the following modules:

- Essential reading;
- Recommended Priority reading;
- Legislation specific to public health;
- Provincial public health reports;
- Middlesex-London Health Unit documents; and
- Web-based resources for Board of Health Members.

These materials are available to all Board of Health members and can be accessed by going to: https://www.healthunit.com/board-of-health-orientation and using the credentials provided by the Manager of Strategic Projects.

On-Site Orientation

The traditional Board of Health orientation will be compressed to one day of on-site learning at the Middlesex-London Health Unit where new members will complete necessary administrative tasks and become familiar with the organization. A sample agenda for this on-site orientation can be found in Appendix A.

Next Steps

Each component of the Board of Health Orientation is intended to give members a thorough understanding of the organization, their roles and responsibilities and to provide them with relevant information that will prove helpful useful in providing effective governance to the Middlesex-London Health Unit.

To enrich this content, MLHU staff would like to gather input from the Board of Health regarding:

- Potential agenda items for on-site orientation;
- Scheduling of the orientation date or dates should the Committee decide to break up the date into multiple meetings; and
- Other potential resources that would assist Board of Health members.

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

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

A G E N D A

MLHU Board of Health Orientation Session

2015-Month-Day **9:00am – 4:00pm** **MLHU Board Room**

	Continental Breakfast	*8:00-8:30*	*MLHU Boardroom*
	Welcome and Introductions	*8:30-8:45*	*MLHU Boardroom*
	The Middlesex-London Health Unit a) Structure, mission and vision; b) Historical context; c) Community Demographics & Health Status; d) Major trends with implications for public health; e) Fiduciary duties, roles and responsibilities; f) Board of Health structure, organization, bylaws and processes; g) Strategic Plan, Operational Planning Process, Performance Monitoring h) Budgeting Processes and Funding Streams	*8:45-12:00*	*MLHU Boardroom*
	Lunch	*12:00-1:00*	*MLHU Boardroom*
	Corporate Services a) Structure & Programs b) Staffing c) Budgeting d) Key Projects e) Strategic Initiatives	*1:00-1:30*	*Room 3D*
	Office of the Medical Officer of Health a) Structure & Programs b) Staffing c) Budgeting d) Key Projects e) Strategic Initiatives	*1:30-2:00*	*3D*
	Walking Tour/Break		
	Family Health Services a) Structure & Programs b) Staffing c) Budgeting d) Key Projects e) Strategic Initiatives	*2:15-2:45*	*Room 2B*
	Oral Health, Communicable Disease, Sexual Health Services	*2:45-3:15*	*Room 2B*

	a) Structure & Programs b) Staffing c) Budgeting d) Key Projects e) Strategic Initiatives		
Walk to 201 Queens/Break			
	Environmental Health, Chronic Disease and Injury Prevention a) Structure & Programs b) Staffing c) Budgeting d) Key Projects e) Strategic Initiatives	*3:45-4:15*	*201 Queen Boardroom*
	Wrap Up a) Evaluation b) Personal Learning Plans	*4:15-4:30*	*201 Queen Boardroom*

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 03-15GC

TO: Chair and Members of the Governance Committee

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2015 January 15

MEDICAL OFFICER OF HEALTH AND CHIEF EXECUTIVE OFFICER PERFORMANCE APPRAISAL 2015

It is recommended that:

1) ***The Governance Committee receive Report 03-15GC; and***

2) ***The Governance Committee recommend that a sub-committee be formed to initiate the performance appraisal process for the Medical Officer of Health (MOH) and Chief Executive Officer (CEO).***

Key Points

- The Terms of Reference for the Governance Committee identifies this committee as having responsibility for the Performance Evaluation of the MOH & CEO.
- A Performance discussion was held between the MOH & CEO, the Board Chair and the Past Chair of the Board 6 months after the appointment of the MOH & CEO.
- The incumbent started in May of 2013 and as per the Ontario Public Health Organization Standards a Performance Appraisal will be required in 2015.

Background

Historically, a sub-committee comprised of the Board Chair, the Vice Chair and the Immediate Past Chair of the Board has been responsible for initiating and conducting the performance appraisal of the Medical Officer of Health.

The Performance Appraisal Tool for Medical Officers of Health as developed by The Association of Local Public Health Agencies (alPHa) is attached as Appendix A. This tool has been used in the past by MLHU when conducting the performance appraisals of the MOH. Appendix B is the position description for the MOH & CEO.

Process

1. The Board Report alerts Board Members that this process needs to be initiated.
2. The Governance Committee strikes a performance appraisal sub-committee.
3. The sub-committee reviews the appraisal tool and supporting documentation covering the appraisal timeframe including the position description, the MOH Monthly Activity Reports and listings of the Board of Health Report Titles both public and in-camera.
4. The subcommittee confirms the use of the tool and the contents of the package which is then given to the MOH/CEO to complete his portion of the performance appraisal (PA).
5. The sub-committee meets to complete the Board portion of the PA.

6. Once the MOH/CEO has completed his portion of the PA and submitted it to the sub-committee, the sub-committee meets to discuss the MOH/CEO's completed portion of the PA.
7. The two documents are then merged and sent to the sub-committee to review.
8. The sub-committee can meet with the MOH/CEO to discuss any questions or concerns that they may have with the PA.
9. Once the sub-committee has concluded their review of the materials, a summary document is drafted by the Committee and presented in-camera to the entire Board for their review and approval.
10. The Board Members reach agreement on all contents of the review.
11. The Board Chair meets with the MOH to discuss the PA and provide feedback.

This report was prepared by Ms. Laura Di Cesare, Director, Human Resources and Corporate Strategy.

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

The Association of Local Official Health Agencies

MEDICAL OFFICER OF HEALTH PERFORMANCE AND DEVELOPMENT APPRAISAL

It is the policy of this Board that all employees shall have an annual performance and development appraisal.

THE PERFORMANCE APPRAISAL PROCESS

The Board of Health shall conduct the performance appraisal of the Medical Officer of Health.

The Board of Health reviews the performance of the Medical Officer of Health six months after appointment of a new incumbent and annually thereafter.

The Board Chair, and two other Board members as selected by the Board, are responsible for initiating the process by meeting to discuss performance and draft an appraisal document. The Medical Officer of Health is invited to provide input from his/her perspective at this stage. The draft performance appraisal is then reviewed by the whole Board in camera.

The Board Chair meets with the Medical Officer of Health to discuss the appraisal document approved by the Board and provide an opportunity for the Medical Officer of Health to provide additional verbal or written comments on the appraisal.

PERFORMANCE AND DEVELOPMENT APPRAISAL

MEDICAL OFFICER OF HEALTH NAME:

REVIEWER NAMES: TITLE APPRAISAL PERIOD: TO

1.

2. DATE ENTERED PRESENT POSITION:

3.

☐ Body of knowledge and professional conduct required by licence are givens.
☐ The appraisal is backed by objective standards established by professional body or Health Unit policies and practices.
☐ This form is to assist the employee with clear, realistic feedback on performance and career expectations, to help plan his/her development, and to document the performance and development appraisal discussion.

OVERALL PERFORMANCE

The objectives of this section are: to provide the Medical Officer of Health with clear feedback about overall performance; to explain the considerations that go into it; and to assure that career expectations are in line with present performance.

Check the box below which best summarizes the Medical Officer of Health's performance against overall expectations. Your ratings should consider: how well work objectives/assignments are achieved; how the Medical Officer of Health goes about achieving them; what other results are being achieved apart from planned objectives/assignments. (Take into consideration experience with other employees in similar jobs and along the same factors.) The rating scale includes three ranges of acceptable and one level of unacceptable performance, defined as follows:

Exceeding Expectations..... Achievements consistently exceed the position's requirements.

Achieving Expectations ..... Achievements consistently meet the position's requirements. In some areas, accomplishments may exceed work expectations; in others, they may fall short. Overall, however, the position's objectives or requirements are being met.

Partially Achieving Expectations ..... Achievements partially meet the position's requirements. With improvements specified, areas of performance should become satisfactory. If improvement does not occur, performance will be considered not acceptable.

Not Acceptable ..... Achievements do not meet the position's requirements. Performance improvement is necessary and a re-evaluation period should be established.

Performance Rating Summary

Performance Factor	Not Acceptable	Partially Achieving Expectations	Achieving Expectations	Exceeding Expectations
Rating	0	1	2	3
Reporting to the Board				
Overall Administration				
Planning				
Supervision				
Board Relations				
Community Relations				
Statutory Responsibilities				
Medical Advice				
Health Planning				
Communications				
Personal Development				

PERFORMANCE RATING SUMMARY

PERFORMANCE FACTORS	COMMENTS	RATING
REPORTING TO THE BOARD ☐ provides appropriate and timely reports as requested ☐ MOH Report at each Board Meeting ☐ informs Board of any important developments affecting the Health Unit (e.g. legislative changes, public health emergencies, organizational problems) ☐ meets regularly with Board Chair		
OVERALL ADMINISTRATION ☐ human resource management (e.g. no 'bad' grievances, good staff morale and productivity, reasonable staff turnover, effective staff hiring, etc.) ☐ financial management (e.g. policy for expenditures and allocations) ☐ program management (achieves objectives or actions of the Plan of the Board of Health) ☐ effective implementation of Board decisions ☐ regular and effective meetings of Management Committee		
PLANNING ☐ completion of annual tactical and strategic planning (including review of previous year's plan) ☐ anticipates and plans for major trends in needs and services		
SUPERVISION ☐ completes Performance Appraisals on senior staff ☐ provides appropriate ongoing staff supervision ☐ accessible to staff ☐ encourages professional development ☐ leadership skills		
BOARD RELATIONS ☐ promotes productive relations between Board and Health Unit		

PERFORMANCE FACTORS	COMMENTS	RATING
COMMUNITY RELATIONS ☐ promotes productive relations between Health Unit and other groups and organizations (e.g. health care providers, community organizations, citizen groups, etc.) ☐ promotes productive relationships between the Health Unit and the Ministry of Health ☐ promotes productive relationships and acts as a resource between the health unit and the Boards of Education, business, labour, government, media ☐ responds effectively to public concerns and issues		
STATUTORY RESPONSIBILITIES ☐ responds effectively to health hazards under the Health Protection and Promotion Act ☐ provides effective control of communicable diseases under the HPPA ☐ maintains greater than 95% adequate immunization under the Immunization Act of School Pupils Act ☐ and other statutory obligations		
MEDICAL ADVICE ☐ maintains effective communications with health care workers in region ☐ serves as a resource for professional and technical advice		
HEALTH PLANNING ☐ assesses the health status and needs of the community ☐ develops programs and services to meet needs		
COMMUNICATIONS ☐ internal/external ☐ written/verbal ☐ media and presentation skills ☐ evaluating and disseminating information		

PERSONAL DEVELOPMENT ☐ ensures knowledge & skills remain current & relevant to the needs of the Health Unit		

COMMENTS: Document your rating in a manner which will satisfy this section's objectives.

_____

_____

_____

APPRAISAL SUMMARY

1. SPECIAL OR PROJECT ACTIVITIES:

_____

_____

_____

Recommendations: _____

_____

_____

_____

2. AREAS OF SPECIAL ABILITY:

_____

_____

_____

Recommendations: _____

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_____

3. DEVELOPMENTAL REQUESTS A Contract for a Personal/Professional Development Program for the Coming 12 Months

_____

_____

_____

Recommendations: _____

_____

_____

_____

4. AREAS REQUIRING IMPROVEMENT A Contract to Focus on Specific Performance Factors for the Coming 12 Months

_____

_____

_____

Recommendations: _____

_____

_____

5. BOARD OF HEALTH COMMENTS:

_____

_____

_____

6. MEDICAL OFFICER OF HEALTH'S COMMENTS:

_____

_____

_____

_____	_____	_____
BOARD OF HEALTH	MED. OFFICER OF HEALTH	REVIEWER (IF REQUIRED)
Date:	Date:	Date:

Position Description

Title: **MEDICAL OFFICER OF HEALTH & CHIEF EXECUTIVE OFFICER**	HR Code: NU18 Page: 1 of 2
Salary Range: negotiated	Status: Non-union
Reports to: Board of Health	Salary Band: No established band
Original Date Approved: September/97	Revision Date: April/00 January 1, 2001 March 16, 2006 October 19, 2006 August 2010 October 2014

Signature: _____
Chair, Board of Health

_____
Director, Human Resources & Labour Relations

Summary: Reporting directly to the Board of Health the Medical Officer of Health, as Executive Officer of the Board of Health is responsible for the administration of all Health Unit programs and services including overseeing all human resource and budgetary matters.

The Medical Officer of Health provides community leadership in public health and is responsible for the execution of public health legislation. The Medical Officer of Health is a consultant to health care providers, agencies and the public on communicable disease, chronic disease and injury prevention, environmental health and health promotion matters.

Staff: 1 Director, Family Health Services; 1 Director, Environmental Health & Chronic Disease Services; 1 Director, Finance & Operations Services; 1 Director, Human Resources & Corporate Strategy; 1 Associate Director, Communicable Disease & Sexual Health Services; 1 Associate Medical Officer of Health; 1 Communications Manager; 1 Manager, Emergency Preparedness; 1 Executive Assistant to the Medical Officer of Health. Total staff=9. (3 staff report to the managers who report to the MOH.)

Responsibilities:

1. To keep the Board of Health apprised, in a timely fashion, of administrative and public health issues and provide advice to the Board in their decision making regarding same.

2. To oversee the implementation of the Board of Health Strategic Planning Cycle and the preparation of a Health Unit strategic plan.

3. To ensure the development, implementation and regular review of Board of Health and Health Unit policies and procedures.

4. To prepare and present an annual budget for Health Unit activities to the Board of Health, London City Council, Middlesex County Council and the appropriate ministries.

5. To oversee the application of the Board of Health approved annual budget.

6. To supervise, including hiring, conducting performance evaluations and, when necessary, disciplining those staff which directly report to the Medical Officer of Health and to ensure the supervision of all staff.

7. To ensure the development, implementation, monitoring and evaluation of all programs and services provided by the Health Unit.

8. To establish an effective and credible relationship with the general public, health care providers, community associations, agencies, and institutions including neighboring Health Units.

9. To represent the Health Unit on appropriate committees, boards and groups.

10. To provide leadership and act as a spokesperson and advocate on public health matters.

11. To consult with directors and staff members appropriately in carrying out administrative responsibilities.

12. To determine human resources requirements making optimum use of existing human resources to achieve program and service goals of the Health Unit.

13. To carry out specific statutory responsibilities under the Health Protection and Promotion Act, and other relevant public health legislation.

14. To ensure the Board of Health is in compliance with all applicable statutory requirements.

15. To be on call after hours, including weekends and statutory holidays.

Qualifications:

- License to practice medicine in the Province of Ontario.

- Fellowship, Community Medicine, Royal College of Physicians and Surgeons of Canada or equivalent.

- A minimum of five years experience in Community Medicine practice.

- Eligible for appointment to the University of Western Ontario, Faculty of Medicine.

- Proven leadership ability.

- Excellent written and oral communication skills.