AGENDA
MIDDLESEX-LONDON BOARD OF HEALTH

399 RIDOUT STREET NORTH   Thursday, 6:00 p.m.
SIDE ENTRANCE, (RECESSED DOOR)   2015 December 10
Board of Health Boardroom

MISSION - MIDDLESEX-LONDON HEALTH UNIT

The mission of the Middlesex-London Health Unit is to promote and
protect the health of our community.

MEMBERS OF THE BOARD OF HEALTH

Mr. Ian Peer (Chair)
Mr. Jesse Helmer (Vice Chair)
Ms. Patricia Fulton
Dr. Trevor Hunter
Mr. Marcel Meyer
Ms. Viola Poletes Montgomery
Ms. Nancy Poole
Mr. Kurtis Smith
Mr. Mark Studenny
Mr. Stephen Turner
Ms. Joanne Vanderheyden

SECRETARY-TREASURER

Dr. Christopher Mackie

DISCLOSURE OF CONFLICTS OF INTEREST

APPROVAL OF AGENDA

APPROVAL OF MINUTES

DELEGATIONS

6:05 – 6:20 p.m**.**   Ms. Trish Fulton, Chair, Finance and Facilities Committee re Item #1 - Finance and
                              Facilities Committee Meetings November and December

6:20 – 6:35 p.m**.**   Ms. Laura DiCesare, Director of Human Resources and Corporate Strategy and Dr.
                              Chris Mackie, Medical Officer of Health and CEO, re Item #2 - Middlesex-London
                              Health Unit Organizational Structure

1

Item #	Report Name and Number	Link to Additional Information	Delegation	Recommendation	Information	Brief Overview
Committee Reports						
1	Finance and Facilities Committee Meetings November and December (67-15)	Appendix A Appendix B	x	x		To receive information and consider recommendations from the November and December FFC meetings
Delegations and Recommendation Reports						
2	Middlesex-London Health Unit Organizational Structure (68-15)	Appendix A Appendix B1 Appendix B2	x	x		To request the Board of Health to approve a new MLHU Organizational Structure
3	Middlesex London Health Unit and Ontario Nurses' Association (ONA) Pay Equity Plan (73-15)	Appendix A			x	To request approval of the ONA MLHU Pay Equity Plan
Information Reports						
4	Sexual Health Services Review (69-15)	Appendix A			x	To provide a summary of the review that was conducted for Sexual Health Services to validate current evidence-informed approaches and increase effectiveness and efficiency of programs and services
5	Summary Information Report for December 2015 (70-15)				x	To provide a summary of information from Health Unit programs
6	Medical Officer of Health Activity Report December (71-15)				x	To provide an update on the activities of the MOH for December 2015

CONFIDENTIAL

The Board of Health will move in camera to discuss matters concerning an identifiable individual.

OTHER BUSINESS

- Next Finance and Facilities Committee Meeting: Thursday, January 14, 2016 @ 9:00 a.m.
- Next Governance Committee Meeting: Thursday, January 21, 2016 @ 6:00 p.m.
- Next Board of Health Meeting: Thursday, January 21, 2016 @ 7:00 p.m.

CORRESPONDENCE

a) Date: 2015 October 21 (via email)
   Topic: Changes to the Municipal Act to Authorize the Use of Electronic Means of Participation of Local Boards and Committees of Local Boards
   From: Mr. James King, Acting Correspondence Writer, Ministry of Health and Long-Term Care
   To: Ms. Sherri Sanders, Executive Assistant to the Board of Health, MLHU

   Background:
   At the September 17th, 2015 meeting, the Middlesex-London Board of Health passed a motion to endorse a letter from the Chair of Wellington-Dufferin-Guelph Public Health and drafted correspondence to the Ministry of Health and Long-Term Care requesting changes to the Municipal Act to authorize the use of electronic means for participating in board of health meetings.

   Recommendation:
   Receive.

b) Date: 2015 October 26 (Received 2015 October 27)
   Topic: Northern Ontario Evacuations of First Nations Communities
   From: Copy of Correspondence from Ms. Teresa Barresi, Chair, Board of Health, Perth District Health Unit
   To: The Honourable Kathleen Wynne, Premier of Ontario

   Background:
   First Nations communities in Northwestern Ontario and the James Bay coast require seasonal evacuation and relocation on a nearly annual basis. This is done in a reactionary manner without a proactive strategy to resource and maintain evacuation centres in host municipalities.

   Recommendation:
   Receive.

c) Date: 2015 October 27 (Received 2015 November 2)
   Topic: Changes to the Municipal Act to Authorize the Use of Electronic Means of Participation of Local Boards and Committees of Local Boards
   From: Ms. Nancy Manthei, Administrative Coordinator, Ministry of Municipal Affairs and Housing
   To: Mr. Ian Peer, Chair, Middlesex-London Board of Health

   Background:
   See item (a) above.

   Recommendation:
   Receive.

d) Date: 2015 October 28 (Received 2015 November 6)
   Topic: Northern Ontario Evacuations of First Nations Communities
   From: Copy of Correspondence from Mr. Lee Mason, Chair, Board of Health, Algoma Public Health
   To: The Honourable Kathleen Wynne, Premier of Ontario

   Background:
   See correspondence item (b).

   Recommendation:
   Receive.

e) Date: 2015 October 30 (via email)
   Topic: Second-hand Smoke in Multi-Unit Dwellings
   From: Ms. Cindy Crandall, Executive Assistant to MOH/BOH, Northwestern Health Unit
   To: All Ontario Health Units

Background:
The Smoke-Free Ontario Act prohibits smoking in common areas and ensures that signage is posted in appropriate locations. However, people who live in multi-unit housing are at risk of being negatively affected by second-hand smoke from adjacent units. Few buildings designate their units to be smoke-free and tenants can have very little choice in their housing arrangements.

Public health units and organizations like the Non-Smokers Rights Association and Smoke-Free Housing Ontario advocate for tenant protection in these multi-unit dwellings through voluntary no-smoking policies and future development of governmental policy to facilitate the provision of smoke-free housing.

The Middlesex-London Health Unit Board of Health previously endorsed correspondence to The Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care at the June Board of Health meeting.

Recommendation:
Receive.

f) Date: 2015 October 30 (Received 2015 November 2)
   Topic: Special Needs Strategy Proposal
   From: Copy of correspondence from Ms. Alison Morse and Ms.Vesna Fernandez, Co-Chairs, Special Needs Strategy Implementation Committee
   To: Ontario Ministries of Children and Youth Services, Health and Long-Term Care, Community and Social Services, and Education

Background:
This correspondence was sent regarding the Special Needs Strategy Proposal and suggested that an increase of funding was needed to optimally meet the needs of children in the community and at school. The Board of Health considered a report on this matter at the October meeting and requested a letter be sent to indicate we do not support a decrease in our funding.

Recommendation:
Receive.

g) Date: 2015 November 2 (Received 2015 November 6)
   Topic: Public Health Funding
   From: Copy of correspondence from Ms. Heather Jackson, Chair, Elgin St. Thomas Board of Health
   To: The Honourable Eric Hoskins, Minister of Health and Long-Term Care

Background:
A funding review workgroup was struck in 2010 to investigate the status of public health funding in Ontario and to advise the ministry on a potential funding model and principles to guide its implementation. The report produced by the workgroup was accepted and the Ministry will begin to implement the new model in 2015. Two percent growth funding (approx. $11 million) for mandatory programs is being distributed to public health units who have not reached their model-based share – the Middlesex-London Health Unit is one of these health units.

Several health units across the province have expressed concern for the new funding model and called for the Ministry of Health and Long-Term Care to revise the funding formula. This new funding formula has been seen as biased against smaller, northern and rural health units. At the September 17th meeting, the Board of Health approved writing a letter to the Minister of the Ministry of Health and Long-Term Care expressing the Health Unit's appreciation for supporting a more equitable approach to public health funding.

Recommendation:
Receive.

h)   Date: 2015 November 3 (via email)
     Topic: Public Health Funding Model
     From: Copy of correspondence from Mr. Lorne Coe, President, Association of Local Public Health
              Agencies
     To: The Honourable Eric Hoskins, Minister of Health and Long-Term Care

Background:
Similar to item (g), the Association of Local Public Health Agencies (alPHa) provided comments regarding the implementation of the Public Health Funding Formula and calls for annual cost of living adjustments to grant funding, upward adjustment of the overall Ministry of Health and Long-Term Care allocation for public health programs and implementation of a comprehensive monitoring strategy to evaluate the new funding model.

Recommendation:
Endorse.

i)   Date: 2015 November 4 (Received 2015 November 10)
     Topic: Results of 2015 Nutritious Food Basket for Wellington-Dufferin-Guelph Public Health
     From: Copy of correspondence from Mr. Doug Auld, Chair, WDGPH Board of Health
     To: The Honourable Deb Matthews, Minister Responsible for the Poverty Reduction
              Strategy/Deputy Premier

Background:
All public health units in Ontario conduct a Nutritious Food Basket (NFB) survey in accordance with the Ontario Public Health Standards to measure the cost of basic healthy eating. Annual results repeatedly show that incomes for our most vulnerable residents are insufficient to afford basic needs.

The Board of Health considered a report at the September 17th meeting and approved that the Board: 1) Send a letter to the Prime Minister of Canada, the Premier of Ontario and the Ontario Minister Responsible for the Poverty Reduction Strategy requesting they prioritize consideration and investigation into a joint federal-provincial basic income guarantee; 2) Send a letter to the Premier of Ontario requesting the province increase social assistance rates to reflect the rising cost of nutritious food & safe housing; 3) Send a letter to all London and Middlesex County federal election candidates requesting they take Food Secure Canada's Eat Think Vote candidate pledge; and 4) Forward Report No. 50-15 re 2015 Nutritious Food Basket Survey Results and Implications for Government Public Policy to the City of London, Middlesex County & appropriate community agencies.

Recommendation:
Receive.

j)   Date: 2015 November 4 (Received 2015 November 10)
     Topic: Healthy Babies Healthy Children Program Funding
     From: Copy of correspondence from Mr. Doug Auld, Chair, WDGPH Board of Health

To: The Honourable Tracy MacCharles, Ministry of Children and Youth Services/Ministry Responsible for Women's Issues

Background:
The Healthy Babies Healthy Children Program helps children get a healthy start in life by providing screening, assessment and referral to community programs and services, supporting new parents and helping to find community resources for breastfeeding, nutrition, health services, parenting programs and family literacy programs.

The Board of Health endorsed correspondence regarding HBHC funding challenges from Dr. Penny Sutcliffe, MOH & CEO, Sudbury and District Health Unit at the September 17th meeting.

Recommendation:
Receive.

k) Date: 2015 November 6 (Received 2016 November 9)
    Topic: Electronic Participation at Board of Health meetings
    From: Copy of correspondence from Ms. Lesley Parnell, Chair, Board of Health, Peterborough County-City Health Unit
    To: Mr. Lorne Coe, President, Association of Local Public Health Agencies

Background:
See item (a) above.

Recommendation:
Receive.

l) Date: 2015 November 6 (Received 2015 November 9)
    Topic: Food Security and the Transformation of Social Assistance in Ontario
    From: Copy of correspondence from Ms. Lesley Parnell, Chair, Board of Health, Peterborough County-City Health Unit
    To: The Honourable Helena Jaczek, Ministry of Community and Social Services.

Background:
See item (i) above.

Recommendation:
Receive.

m) Date: 2015 November 6 (Received 2015 November 9)
    Topic: Food Security and Basic Income Guarantee
    From: Copy of correspondence from Ms. Lesley Parnell, Chair, Board of Health, Peterborough County-City Health Unit
    To: Ms. Evelyn Vaccari, Chair, Ontario Society of Nutrition Professionals in Public Health (OSNPPH), and Ms. Lyndsay Davidson, Chair, OSNPPH Food Security Workgroup

Background:
Similar to item (i) above, the Peterborough County-City Health Unit thanked the Ontario Society of Nutrition Professionals in Public Health for their position paper on Responses to Food Insecurity and their leadership in this area across Ontario.

Recommendation:
Receive.

n) Date: 2015 November 6 (Received 2015 November 9)
   Topic: Results of 2015 Nutritious Food Basket for Peterborough County-City Health Unit
   From: Copy of correspondence from Ms. Lesley Parnell, Chair, Board of Health, Peterborough County-City Health Unit
   To: The Honourable Tracy MacCharles, Ministry of Children and Youth Services/Ministry Responsible for Women's Issues

Background:
See item (i) above.

Recommendation:
Receive.

o) Date: 2015 November 16 (via email)
   Topic: Modernization of the Ontario Public Health Standards (OPHS)
   From: Dr. Eric Hoskins, Minister of Health and Long-Term Care
   To: Board of Health Chairs and Medical Officers of Health

Background:
The Ontario Public Health Standards (OPHS) and Protocols establish the minimum requirements for public health programs and services to be delivered by Ontario's 36 boards of health, which include assessment and surveillance, health promotion and policy development, disease and injury prevention, and health protection. The OPHS and Protocols are published by the Minister of Health and Long-Term Care, pursuant to Section 7 of the Health Protection and Promotion Act, R.S.O. 1990, c. H.7.

The OPHS and Protocols replaced the Mandatory Health Programs and Services Guidelines (MHPSG) on January 1, 2009. This review will be responsive to emerging evidence and priority issues in public health since that time.

Recommendation:
Receive.

p) Date: 2015 November 19 (via email)
   Topic: Proceedings from November 5, 2015 BOH Risk Management Workshop
   From: Ms. Susan Lee, Manager, Administrative & Association Services, Association of Local Public Health Agencies (alPHa)
   To: All Board of Health Members

Background:
This workshop helped participants explore risk management and governance and learn from the case studies of Algoma and KFL&A Public Health. Speakers and topics included: 1) Graham Scott, Institute for Research in Public Policy, Canada Health Infoway / Algoma Public Health Assessor – Corporate Governance and Risk; 2) Corinne Berinstein, Senior Audit Manager, Ontario Audit Division, Treasury Board Secretariat – Managing Uncertainty; 3) Tony Hanlon, CEO and Justin Pino, CFO, Algoma Public Health – "The Perfect Storm": Lessons Learned; and 4) Hazel Gilchrist, Director, Corporate Services, KFL&A Public Health – Risk Management: A Process Perspective.

Recommendation:
Receive.

q) Date: 2015 November 19 (Received 2015 November 20)
   Topic: Public Health Funding

From: Copy of correspondence from Mr. Mark Lovshin, Chair, Board of Health Haliburton, Kawartha, Pine Ridge District Health Unit

To: The Honourable Eric Hoskins, Minister of Health and Long-Term Care

Background:
See item (h) above.

Recommendation:
Receive.

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

ADJOURNMENT

MEMBERS PRESENT:	Mr. Ian Peer (Chair)
	Mr. Jesse Helmer (Vice Chair)
	Ms. Trish Fulton
	Dr. Trevor Hunter
	Mr. Marcel Meyer
	Ms. Viola Poletes Montgomery
	Ms. Nancy Poole
	Mr. Kurtis Smith
	Mr. Mark Studenny
	Mr. Stephen Turner
	Ms. Joanne Vanderheyden
OTHERS PRESENT:	Dr. Christopher Mackie, Medical Officer of Health & CEO
	(Secretary Treasurer of the Board)
	Ms. Sherri Sanders, Executive Assistant to the Board of Health (Recorder)
	Mr. Wally Adams, Director, Environmental Health and Chronic Disease Prevention Services
	Ms. Mary Lou Albanese, Manager, Healthy Communities and Injury Prevention
	Ms. Brook Clark, Public Health Nurse
	Ms. Laura Di Cesare, Director, Human Resources and Corporate Strategy
	Ms. Laura Dueck, Public Health Nurse
	Mr. Dan Flaherty, Manager, Communications
	Dr. Gayane Hovhannisyan, Associate Medical Officer of Health
	Ms. Heather Lokko, Associate Director, Oral Health, Communicable Disease & Sexual Health Services
	Ms. Brenda Marchuk, Acting Chief Nursing Officer
	Ms. Bernie McCall, Public Health Nurse
	Mr. John Millson, Director, Finance and Operations
	Ms. Marlene Price, Manager Vaccine Preventable Disease
	Ms. Deb Shugar, Manager, Screening, Assessment and Intervention
	Mr. Alex Tyml, Online Communications Coordinator
	Ms. Suzanne Vandervoort, Acting Director, Family Health Services

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

DISCLOSURES OF CONFLICT(S) OF INTEREST

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

APPROVAL OF AGENDA

It was moved by Ms. Fulton, seconded by Ms. Vanderheyden *that the AGENDA for the October 15, 2015 Board of Health meeting be approved.*

Carried

APPROVAL OF MINUTES

It was moved by Mr. Turner, seconded by Mr. Helmer *that the **MINUTES** of the September 17, 2015 Board of Health meeting be approved with the correction on Page #5 to Mr. Smith.*

Carried

DELEGATIONS and COMMITTEE REPORTS

1.   Finance and Facilities Committee Meeting – October (Report 59-15)

Chair of the Finance and Facilities Committee, Ms. Trish Fulton, reported on the outcomes of the Finance and Facilities Committee.

2016 Budget Parameters (23-15FFC)

It was moved by Ms. Fulton, seconded by Mr. Meyer *that the Board of Health recommend an assumption of a 2% provincial increase on cost-shared funding and a 0% change to the municipal request for the 2016 Board of Health budget.*

<div align="right">Carried</div>

2015 Budget Adjustments (24-15FFC)

It was moved by Ms. Fulton, seconded by Ms. Poletes Montgomery *that the Board of Health approve $201,000 in additional 2015 expenditures as outlined in Appendix A to Report No. 24-15FFC.*

<div align="right">Carried</div>

It was moved by Ms. Fulton, seconded by Ms. Vanderheyden *that the draft minutes of the October 1, 2015 Finance and Facilities Committee be received.*

<div align="right">Carried</div>

RECOMMENDATION REPORTS

2.   City of London Cycling Master Plan (Report 60-15)

In response to a question about the status of the cycling master plan for Middlesex County, Ms. Mary Lou Albanese, Manager, Healthy Communities and Injury Prevention, responded that Mr. Chris Traini, Middlesex County Engineer, is engaged with the City to ensure that a Middlesex plan would merge with City plans. Ms. Vanderheyden reported that County Council approved to conduct a study for the stretch of road from the Thames River to Komoka.

In response to a question about safe cycling facilities versus multi-use, Ms. Bernie McCall, Public Health Nurse, reported that City Engineers are looking at various types of cycling facilities, as the type depends on traffic flow and traffic use. Ms. McCall explained that the Health Unit staff deal with continuity and safety; however, City Engineers are more qualified to determine the best type of cycling facilities for each traffic situation.

The **London Bikes website** was forwarded to Board of Health members on October 20, 2015 via email.

It was recommended by City of London representatives on the Board, Mr. Turner and Mr. Helmer, that the following information be added to the letter on page 2:
- Provides separate cycling facilities, particularly protected bike lanes, as much as possible
- Provides year round maintenance of cycling facilities, including the Thames Valley Parkway

It was moved by Mr. Helmer, seconded by Mr. Studenny *that the Board of Health:*

1) *Endorse Report No. 60-15 re City of London Cycling Master Plan, and*

2) *Submit the attached letter of support and recommendations to the City of London for consideration in the development of the Cycling Master Plan (Appendix A) subject to additions to the letter concerning supporting year round maintenance and encouragement to use separated cycling lanes whenever possible.*

<div align="right">Carried</div>

INFORMATION REPORTS

3.   Internal Scan of Programs and Services Offered to Local First Nations Communities (Report 61-15)

Ms. Brenda Marchuk, Acting Chief Nursing Officer, and Ms. Brook Clark, Public Health Nurse, assisted Board members with their understanding of this report. To clarify the wording in Appendix A to the Report, Ms. Clark explained that the administration of the First Nations Community determines whether it wants the health unit or Health Canada to provide public health services in its jurisdiction.

It was also clarified that each First Nations Community would have its own Memorandum of Understanding with different criteria as requested by the Community Administration.

In response to a question about timeline for discussions, Dr. Mackie explained that each First Nations Community has different infrastructures; therefore, timelines will vary due to readiness. Board members expressed gratitude to Health Unit staff for dealing with this issue as soon as possible.

It was moved by Mr. Turner, seconded by Mr. Meyer *that Report No. 61-15 re Internal Scan of Programs and Services Offered to Local First Nations Communities be received for information.*

Carried

4.   Influenza: 2014/2015 Season Report and 2015/2016 Season Plans (Report 62-15)

5.   Middlesex London 2014/2015 School-Based Dental Screening Results (Report 63-15)

It was moved by Dr. Hunter, seconded by Mr. Smith *that Report No. 62-15 re Influenza: 2014/2015 Season Report and 2015/2016 Season Plans and Report No. 63-15 re Middlesex London 2014/2015 School-Based Dental Screening Results be received for information.*

Carried

In response to a question about how the influenza rates and dental screening results compare to similar sized communities, Dr. Mackie responded the influenza vaccine rate is higher. Ms. Heather Lokko, Associate Director, Oral Health, Communicable Disease & Sexual Health Services, explained that because one of the school boards requires signed parental consent to participate in the dental screening program, Middlesex-London does have lower rates of screening than similar areas of the province.

6.   Summary Information Report for October (Report 64-15)

Dr. Mackie reported that external assessors for the Baby-Friendly Initiative will be visiting the Health Unit October 28 to 30, 2015.

Dr. Mackie also clarified that the additional funding from the Ministry of Health and Long-Term Care outlined in Report 64-15 will be used to make a part-time position full-time to deal with the Electronic Cigarettes Act, 2015.

It was moved by Mr. Studenny, seconded by Ms. Poletes Montgomery *that Report No. 64-15 re Summary Information Report for October be received for information.*

Carried

7. Medical Officer of Health Activity Report – October (Report 65-15)

Dr. Hunter represented the Health Unit at the World Homeless Action Day on October 7, 2015, organized by London Homeless Coalition. Dr. Hunter explained his experiences when visiting the various stops, such as the London Coffee House on Hamilton Rd and the London InterCommunity Health Centre. He reported that it was a very worthwhile and educational event.

It was moved by Mr. Meyer, seconded by Mr. Turner *that Report 65-15 re Medical Officer of Health Activity Report – October be received for information.*

Carried

CONFIDENTIAL

At 7:55 p.m. it was moved by Mr. Turner, seconded by Mr. Meyer *that the Board of Health move in camera to discuss matters concerning identifiable individuals.*

Carried

At 8:20 p.m. it was moved by Mr. Meyer, seconded by Mr. Smith *that the Board of Health rise and return to public session to report that progress was made in matters concerning identifiable individuals.*

Carried

CORRESPONDENCE

It was moved by Ms. Fulton, seconded by Mr. Studenny *that correspondence items a) through e) be received for information.*

Carried

OTHER BUSINESS

Upcoming meetings:
  a) Finance and Facilities Committee – Thursday, November 5, 2015 @ 9:00 a.m.
  b) Board of Health Education Session re Governance – Thursday, November 19 @ 4:30 p.m.

ADJOURNMENT

At 8:25 p.m., it was moved by Mr. Meyer, seconded by Mr. Studenny *that the meeting be adjourned.*

Carried

_____   _____
IAN PEER   **CHRISTOPHER MACKIE**
Chair   **Secretary-Treasurer**

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 67-15

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2015 December 10

FINANCE AND FACILITIES COMMITTEE MEETINGS NOVEMBER AND DECEMBER

The Finance and Facilities Committee met at 9:00 a.m. on November 5 (**Agenda**) and December 3, 2015 (**Agenda**). The minutes from the November meeting are attached as **Appendix A**. The draft minutes from the December meeting are attached as Appendix B. The following items were discussed at the meetings and recommendations made:

November FFC Reports	Recommendations for Board of Health's Consideration
Draft Factual Certificate (No. 25-15FFC)	*It is recommended that the Board of Health* *1) Approve the draft Factual Certificate template as appended to Report No. 25-15FFC ; and* *2) Approve the process outlined in Report No. 25-15FFC.*
Third Quarter Financial Update (No. 26-15FFC)	FFC received for information
Proposed Resource Reallocation for the 2016 Budget (No. 27-15FFC)	FFC received for information
Funding for Panorama Implementation (No. 28-15FFC)	It is recommended that *the Board of Health accept the terms and conditions to receive $203,900 in one-time Panorama funding as detailed in the funding letter appended to Report No. 028-15FFC.*

In November, the Finance and Facilities Committee moved in camera to discuss matters concerning a proposed or pending acquistion of land by the Middlesex-London Board of Health and matters concerning an identifiable individual.

December FFC Report	Recommendations for Board of Health's Consideration
2016 Budget – PBMA Proposals (No. 31-15FFC)	It is recommended *that the Board of Health:* *1) Approve in principle PBMA investments totaling $527,289 as identified in Appendix A to Report No. 31-15FFC, and further* *2) Approve in principle PBMA one-time investments totaling $206,953 as identified in Appendix B to Report No. 31-15FFC, and* *3) Approve in principle PBMA disinvestments totaling $281,597 as identified in Appendix C to Report No. 31 – 15FFC.*

In December, Ms. Laura Di Cesare provided a verbal report on Pay Equity with the the Finance and Facilities Committee. Ms. Di Cesare announced that ONA members had ratified the plan.

The next meeting of the Finance and Facilities Committee has been scheduled for Thursday, January 14, 2016 at 9:00 am..

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

COMMITTEE
MEMBERS PRESENT: Ms. Trish Fulton (Committee Chair)
                         Mr. Marcel Meyer
                         Mr. Ian Peer
                         Ms. Joanne Vanderheyden

REGRETS: Mr. Jesse Helmer

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

At 9:00 a.m., Ms. Trish Fulton, Committee Chair, welcomed everyone to the meeting.

1. DISCLOSURES OF CONFLICT(S) OF INTEREST

Ms. Fulton 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. Peer, seconded by Ms. Vanderheyden *that the **AGENDA** of the October 1, 2015*
Finance and Facilities meeting be approved.

                                                                          Carried

3. APPROVAL OF MINUTES

It was moved by Ms. Vanderheyden, seconded by Mr. Peer *that the **MINUTES** from the September 3,*
2015 Finance and Facilities Committee Meeting be approved.

                                                                          Carried

4. NEW BUSINESS

4.1. 2016 Budget Parameters (**No. 23-15FFC**)

It was moved by Mr. Peer, seconded by Ms. Vanderheyden *that the Finance & Facilities Committee make recommendation to the Board of Health for an assumption of a 2% provincial increase on cost-shared funding and a 0% change to the municipal request for the 2016 Board of Health budget.*

Carried

Mr. Meyer arrived at 9:17 a.m.

4.2. 2015 Budget Adjustments (**No. 24-15FFC**)

Mr. Millson reviewed the report and its appendix A with the Committee which outlines additional investments for the 2015 Board of Health budget. Discussion ensued about the additional investments provided in the report.

It was moved by Mr. Peer, seconded by Mr. Meyer *that the Finance & Facilities Committee review and make recommendation to the Board of Health to approve $201,000 in additional 2015 expenditures as outlined in Appendix A to Report No. 24-15FFC.*

Carried

5. CONFIDENTIAL

At 9:35 a.m., it was moved by Ms. Vanderheyden, seconded by Mr. Meyer *that the Finance and Facilities Committee move in camera to discuss a matter concerning an identifiable individual.*

Carried

At 9:40 am, it was moved by Mr. Peer, seconded by Ms. Vanderheyden *that the Finance and Facilities Committee return to public forum and report that a matter was discussed concerning an identifiable individual.*

Carried

6. OTHER BUSINESS

The next scheduled meeting of the FFC is Thursday, November 5, 2015 at 9:00 a.m. in Room 3A.

7. ADJOURNMENT

At 9:42 a.m., it was moved by Ms. Vanderheyden, seconded by Mr. Meyer *that the meeting be adjourned.*

Carried

_____   _____

TRISH FULTON   CHRISTOPHER MACKIE
Committee Chair   Secretary-Treasurer

COMMITTEE
MEMBERS PRESENT: Ms. Trish Fulton (Committee Chair)
                        Mr. Helmer (listening via teleconference)
                        Mr. Marcel Meyer
                        Mr. Ian Peer
                        Ms. Joanne Vanderheyden

OTHERS PRESENT: Dr. Christopher Mackie, Medical Officer of Health and CEO
                          Ms. Sherri Sanders, Executive Assistant to the Board of Health
                            (Recorder)
                          Mr. Wally Adams, Director, Environmental Health and Chronic
                          Disease Prevention Services
                          Ms. Tammy Beaudry, Accounting and Budget Analyst
                          Ms. Laura Di Cesare, Director, Human Resources and
                          Corporate Strategy
                          Dr. Gayane Hovhannisyan, Associated Medical Officer of Health
                          Ms. Heather Lokko, Associate Director Oral Health, Communicable
                          Disease & Sexual Health
                          Ms. Suzanne Vandervoort, Acting Director Family Health Services

At 9:00 a.m., Ms. Trish Fulton, Committee Chair, welcomed everyone to the meeting.

1. DISCLOSURES OF CONFLICT(S) OF INTEREST

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

2. APPROVAL OF AGENDA

It was moved by Ms. Vanderheyden, seconded by Mr. Meyer *that the **AGENDA** of the December 3, 2015*
Finance and Facilities Committee meeting be approved with the addition of a verbal update about pay
equity as item 4.2.

                                                                                            Carried

3. APPROVAL OF MINUTES

It was moved by Mr. Peer, seconded by Ms. Vanderheyden *that the **MINUTES** from the November 5,*
2015 Finance and Facilities Committee meeting be approved.
                                                                                            Carried

4. NEW BUSINESS

4.1. 2016 Budget – PBMA Proposals (Report No. 31-15FFC)

Dr. Mackie outlined Appendix D and E of the Report. Appendix D of Report No. 31-15FFC should read January 14, 2016 and not January 11.

Dr. Mackie also reviewed Appendix F re The Business Case for Paying a Living Wage. Any RFP would include the stipulation of a Living Wage. In response to a question about how the Health Unit would control that a living wage is actually paid to employees by a contractor, Dr. Mackie said that the Health Unit would build a relationship with the contractor to verify that all conditions are being met. Discussion ensued about what variables exist (in addition to pay rate) that can be manipulated to create a low bid.

Dr. Mackie summarized the discussion by stating that indeed the definition of the living way includes accounting for benefits, that public communications about living wage would include discussion about the business case, and that staff would bring a report in Q1 of 2016 updating the Committee and Board of Health on living wage-related activities in our region.

It was moved by Mr. Meyer, seconded by Mr. Peer *that the Finance & Facilities Committee approve in principle PBMA investments totaling $527,289 as identified in Appendix A to Report No. 31-15FFC.*

Carried

It was moved by Mr. Meyer, seconded by Mr. Peer *that the Finance and Facilities Committee approve in principle PBMA one-time investments totaling $206,953 as identified in Appendix B to Report No. 31-15FFC.*

Carried

It was moved by Mr. Peer, seconded by Ms. Vanderheyden *that the Finance and Facilities Committee approve in principle PBMA disinvestments totaling $281,597 as identified in Appendix C to Report No. 31 – 15FFC.*

Carried

It was moved by Mr. Meyer, seconded by Mr. Peer *that the **Confidential Minutes** from the November 5, 2015 Finance and Facilities Committee meeting be approved.*

Carried

4.2 Pay Equity Update (Verbal Update)

Ms. Di Cesare provided an update about the pay equity with ONA. The play equity plan was agreed upon by ONA and resulted in no changes to pay for positions within MLHU.

5. OTHER BUSINESS

The next scheduled meeting of the FFC is Thursday, January 14, 2016 at 9:00 a.m. in Room 3A.

6. ADJOURNMENT

At 10:35 a.m., it was moved by Ms. Vanderheyden, seconded by Mr. Meyer *that the meeting be adjourned.*

                                                                                          Carried

_____   _____

TRISH FULTON   CHRISTOPHER MACKIE
Committee Chair   Secretary-Treasurer

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 68-15

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2015 December 10

_____

MIDDLESEX-LONDON HEALTH UNIT ORGANIZATIONAL STRUCTURE

Recommendations

It is recommended that the Board of Health:

1) *Receive Report No. 68-15 re Middlesex-Health Unit Organizational Structure; and further*

2) *Approve revisions to the Middlesex-London Health Unit organizational structure; and further*

3) *Delegate decision-making for organizational structure to the Medical Officer of Health and CEO, and direct the MOH and CEO to keep the Board of Health informed about the organizational structure of the health unit.*

Key Points

- The Senior Leadership Team tasked an Organizational Structure and Location Committee to conduct a comprehensive assessment of our current organizational structure and to present findings and structural change recommendations for consideration by the Senior Leadership Team.
- Utilizing the considerations from the Organizational Structure and Location Committee, the Senior Leadership Team recommends revising the Health Unit's current organizational structure.
- In order to align with the governance best practices described by Dr. Graham Scott at the Board of Health education event in November 2016, it is recommended that the Board refocus on strategic decision-making and delegate future organizational structure decisions to the Medical Officer of Health and CEO.

Background

By custom, the Board of Health of the Middlesex-London Health Unit is responsible for approving any revisions to the organizational structure of agency.

In June 2015, the Senior Leadership Team instructed staff to form an Organizational Structure and Location Committee that is representative of the Service Areas at the Middlesex-London Health Unit and the staff who support and deliver our public health programs and services.

This committee was tasked with conducting a comprehensive assessment of MLHU's current organizational structure and opportunities for changes to this structure. The committee was also tasked to serve in an advisory role to the Senior Leadership Team regarding potential future locations.

Organizational Structure Assessment Mandate

Phase one of the Organizational Structure and Location project was to explore the optimal alignment of teams, programs and program components to ensure that we are collaborating effectively, reducing duplication and enhancing coordination across the Health Unit. A program and service review, which would

assess the types of programs and services the Health Unit should or should not be providing in the community, was not within the scope of the Organizational Structure and Location Committee's mandate.

Organizational Structure Assessment Process

A comprehensive situational assessment was conducted by the Organizational Structure and Location Committee between August and November of 2015. This process included extensive internal and external data collection methods and ongoing communication and consultation with the Senior Leadership Team, Non-union Leadership Team and staff throughout the Health Unit.

The findings of this situational assessment along with feedback from the Senior Leadership Team were refined into eight key considerations for changes to our organizational structure. Additionally, a summary of process considerations that are non-structural but that are vitally important for collaboration, coordination and effectiveness was prepared to be reviewed in the future.

A detailed summary of the methodology, data sources, decision-making process, and the eight findings and considerations can be found attached as Appendix A.

Recommended Organizational Structure

Using the findings and considerations prepared by the Organizational Structure and Location Committee, the Senior Leadership Team is proposing revisions to the Middlesex-London Health Unit's structure which they believe will enhance collaboration, efficiency and the effectiveness of our public health programs and services. Revisions to Policy #2-010 – Organizational Structure which includes the revised MLHU Agency Organizational Chart can be found attached as Appendix B1 & B2.

Next Steps

Pending Board of Health approval of the recommended changes to the organizational structure, the Senior Leadership Team and Organizational Structure and Location Committee will proceed with implementation planning for the proposed changes.

The Organizational Structure and Location Committee will also shift to phase two of the project – analysis of future locations for the Middlesex-London Health Unit. This phase will be informed by previous space needs assessments that have been completed for the Health Unit, our proposed organizational structure, and additional public consultation and assessment of internal data client data. This work will continue through 2016.

In addition to the changes to the organizational structure per se, changes to the policy and procedure around setting organizational structure are recommended. In order to align with the governance best practices described by Dr. Graham Scott at the Board of Health education event in November 2016, it is recommended that the Board refocus on strategic decision-making and delegate future organizational structure decisions to the Medical Officer of Health and CEO, while directing the MOH/CEO to keep the Board informed about the structure of the organization.

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

Aligning and Enhancing Our Public Health Programs and Services:

Structural Considerations Identified by the Organizational
Structure and Location Committee

November 2015

Acknowledgements

The considerations that have been identified in this document are a result of an intensive data collection and staff consultation process between September and November of 2015.

The Organizational Structure and Location Committee drove the organizational structure process forward with an ambitious timeline and large data collection and analysis obligations. They were able quickly establish themselves as a committee, understand what deliverables were required, set to work in gathering the necessary information and throughout the process act as liaisons between the committee, the Senior Leadership Team and their colleagues throughout the health unit. Each committee member was able to provide a unique skill set which greatly assisted in allowing these recommendations to be brought forward to the Board of Health.

The Non-union Leadership Team has also been critical in allowing our organization to get to this point. Significant time and effort was necessary from this group in preparing operational process maps, participating in the organizational network analysis survey, making time available during team meetings and vigorously participating in discussions throughout the last five months.

Involvement from staff across the organization has been essential to ensure all perspectives were understood and that staff felt engaged throughout the process of identifying potential changes to our organizational structure. We continue to engage in dialogue about the proposed changes.

The Senior Leadership Team provided an open and inclusive environment for staff, Non-union Leadership and the Organizational Structure and Location Committee to explore a number of different concepts and ideas that could enhance our long-term organizational performance. From the beginning, each of these concepts and ideas were thoughtfully considered by the Senior Leadership Team and integrated into our future organizational structure or strong rationale was provided for why the concepts or ideas were not viable.

Members of the Organizational Structure and Location Committee included:

Amy Pavletic (OHCDSH)	Melody Couvillon (FOS)
Carolyn Pfaff (OHCDSH)	Nancy Forbes (FOS/IT)
Fatih Sekercioglu (EHCDP)	Nathalie Vandenheuvel (FHS)
Joanne Simpson (FHS)	Rachel Eskin (FHS)
John Millson (FOS/IT)	Suzanne Vandervoort (FHS)
Jordan Banninga (HRLR)	Tracey Gordon (FHS)
Laura Di Cesare (HRLR)	Tristan Squire-Smith (OHCDSH)
Melissa McCann (EHCDP)	Trudy Sweetzir (OMOH)

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About the Organizational Structure and Location Project

The Committee

The Organizational Structure and Location (OSL) Committee was formed in June 2015 with the mandate of overseeing a comprehensive situational assessment of the Middlesex-London Health Unit's (MLHU) organizational structure and physical location. This situational assessment was intended to inform decision-making and to assist in the development of considerations for MLHU's Senior Leadership Team regarding ideal organizational structure and physical location.

The committee is a multi-disciplinary group that represents a cross-section of MLHU service areas, teams and staff. Committee members are tasked with representing the interests of their colleagues and communicating relevant information to staff members.

Context of the Organizational Structure and Location Project

The Middlesex-London Health Unit is the largest autonomous health unit in Canada. During its history, the organization has undergone significant restructuring in response to strategic opportunities, budgetary pressures and organizational needs. Significant restructuring of the health unit most recently occurred in 2000 and again in 2010.

Since 2010, the structure has remained stable but opportunities have presented themselves to investigate a new structure. The goal of this restructuring being to increase impact in the community, enhance our strategic alignment and collaboration across divisions and programs. Reorganization is one method of accomplishing these goals - our next steps will also look to include the implementation of complimentary process and to bring our teams together in one physical location.

Public health has continued to grow in complexity and it is important for MLHU to respond to increased demands for operational effectiveness, efficiency and responsiveness to the community.

Analysis of health unit operations has been conducted over the past several years and includes: PwC shared services recommendations, Tillman Ruth Robinson Space Needs Assessment, employee engagement surveys and extensive staff consultations. This information was used to inform the decision to move forward and look at potential changes to our organizational structure.

The Organizational Structure and Location Committee was tasked with providing a situational assessment of the current organizational structure, decision-making processes, key drivers of performance at MLHU and public health at large, legislative and regulatory requirements, promising practices from Ontario public health units and internal consultation data. This report summarizes the situational assessment, decision-making processes and considerations used to inform the Senior Leaderships Team's recommendations to the Board of Health.

This project was initiated in June 2015 with deliverables (a decision to maintain current organizational structure or recommendations to the Board of Health) expected to be approved the Senior Leadership Team and presented to the Board of Health in December 2015.

Scope of the Project

The Organizational Structure and Location project intends to look at optimal alignment between teams, programs and program components.

Program and service review is beyond the scope of this project and there was no intention of this committee to determine what services we should and should not be providing. It is understood that the current compliment of MLHU programs and services has been established through separate decision-making and prioritization processes.

Following the identification and approval of a recommended organizational structure by the Board of Health, the OSL committee is also tasked with exploring future location options and advising the Senior Leadership Team on potential considerations and options.

Principles Guiding the Organizational Structure and Location Project

The guiding principles of both the organizational structure component and the location component of the OSL project are:

- *Ensure that the focus is on the community and the people who need our services;*

- *Ensure that we have a thorough understanding of our organizational structure and needs;*

- *Ensure that change is consistent with the strategic directions of our organization;*

- *Make good use of available data and information to ensure that decisions are evidence-informed;*

- *Staff engagement and involvement in the decision-making processes;*

- *Communicate effectively with all stakeholders;*

- *Commitment to the project is essential from the planning phase, through recommendations, into implementation, and ongoing follow-up; and*

- *Change is a long-term process necessary to drive improvement.*

Data Sources & Methods

The Organizational Structure and Location Committee committed from the outset to a mixed qualitative and quantitative data analysis method called triangulation. This would be used to inform organizational structure decisions. Triangulation is the term used to broadly describe the use of multiple data sources to cross-validate key themes, findings and concepts. The blending and integration of a variety of data sources and methods is seen to lead to more valid results.

The data sources used for triangulation by the Organizational Structure and location committee included:

- Employee Engagement Survey;
- Management and Team Meeting Consultations;
- Environmental Scan of Ontario Public Health Units;
- Literature Review;
- Key Informant Interviews;
- Operational Process Mapping;
- Organizational Network Analysis;
- Submissions to the Organizational Structure and Location Committee; and
- Staff Consultations.

Employee Engagement Survey

The employee engagement survey is a tool that is distributed annually to help improve our internal practices at MLHU. An "engaged employee" enjoys and is enthusiastic about their work, feels that their work is meaningful and appreciated and takes action to further the organization's reputation and goals. There is a strong correlation with organizational commitment, productivity and workplace involvement with the scores on employee engagement surveys.

The 2015 Employee Engagement Survey was distributed in June 2015 to all staff at the Middlesex-London Health Unit and asks about : benefits; career advancement; co-workers; employee health and well-being; intrinsic motivation; the person they report to; organizational reputation; pay; HR practices; physical work environment; recognition and collaboration between service areas.

Additional modules in this year's survey included readiness for change questions which asked specifically about potential changes to our organizational structure.

The readiness for change data and standard information collected with the survey was useful in determining whether or not to proceed with a restructuring and has helped to inform communications planning throughout the project.

Management and Team Meeting Consultations

Initial staff consultations took place in September and October of 2015. The purpose of these sessions was to help staff understand the purpose of the organizational structure and location project, the timeline of activities to be carried out during the Fall of 2015 and set expectations of managers and staff.

The sessions also provided an opportunity to gather baseline data on our current organizational structure from both management and staff perspectives.

A total of 23 consultations were held, consisting of five management sessions and 18 team sessions. Management staff from each service area met separately for discussion so as to not stifle feedback at team meetings.

All meetings were facilitated and minutes were recorded. Members of the Organizational Structure and Location Committee assisted with facilitation by capturing staff comments on flip chart paper. The flip chart notes along with the meeting minutes captured by the recorders were cross-referenced to ensure validity.

All meeting notes were collated by the discussion questions:

1) What is working well with how we are currently structured?
2) What are the challenges that you face in how we are currently structured?
3) What areas are there for improvement in our organizational structure and what is the rationale behind those suggested changes?

Meeting notes were analyzed using Nvivo, a qualitative analysis computer software package. Over 950 unique data points were coded and themed for each of the three questions and used to produce a codebook for reference by the OSL Committee.

Environmental Scan

It was important that the OSL committee understood the organizational structures that exist throughout the Province at other public health units. In order to facilitate this understanding, members of the committee distributed an email to Ontario public health units asking if they would share their organizational charts, if they had recently undergone a restructuring in the past 5 years and how many office locations that they provided services from.

Responses were obtained from 22 out of 35 health units and organizational charts were gathered through internet searches for 29 out of 35 health units.

The OSL committee prioritized the five most relevant organizational structures (based on population size, governance structures, urban/rural mix, etc.) to explore through a ranked voting process. These structures were then systematically examined by comparing them with our current organizational structure and the themes identified as a part of the management and team meetings.

Literature Review

The goal of the OSL committee is to determine the most optimal structure for delivering public health programs and services. In order to accomplish this, a review of the literature was carried out.

The literature reviewed included published articles which best met the search criteria as performed by the Public Health Librarians at MLHU.

Medline database search #1 included the key words: *Public Health/ or Public Administration, public health or health department or health unit; models, organization/ or workplace/, design or redesign or re-design or structure or structuring or realign.* 129 relevant articles were identified.

Health Business Elite database search #2 included the key words: *Public Health or Public Health Administration or Public Administration or Civil Service or Government Agencies or Municipal Services or Non-profit Sector; organizational structure or redesign or restructuring or infrastructure or realign.* 256 relevant articles were identified.

Following an abstract review, 15 articles were selected to be reviewed in detail by the OSL committee.

Common themes were found in the research articles reviewed. These common themes included: the importance of internal collaboration, strong epidemiological networking and utilization of management for integrating and coordinating services. All were found to be of importance for public health structuring.

Key Informant Interviews

Key informant interviews are qualitative, in-depth interviews with people who know what is happening in a particular domain of interest.

During the literature review the Organizational Structure and Location Committee identified local researchers Anita Kothari and Sandra Reagan from Western University who studied how organizations responded to the Ontario Public Health Standards over a five year period following their introduction in 2008. They had previously collected primary data through structured interviews and focus groups with front line, management and senior leaders at six different health units (rural, urban and remote).

Feedback was provided from the researchers on a number of different questions including:

1) How planning and evaluation is structured within health units?
2) How is health equity structured within health units?
3) How is health care provider outreach structured within health units?
4) What organizational practices make for the most effective health unit?
5) Span of Control – what are the different organizational levels that would optimize programs?

These findings were submitted by the researchers as a brief report to inform our organizational structure process.

Operational Process Mapping

Operational process mapping provided a standardized way of capturing the programs, program components, and activities at MLHU. This tool also allowed us to understand where internal collaboration is currently taking place, the program target populations, intended outcomes, types of staff involved and the number of FTEs.

These process maps were developed based on business literature, existing program budget templates, logic model templates and terminology used in the Ontario Public Health Standards.

Operational process maps were prepopulated by members of the Organizational Structure and Location Committee using the program budget templates and distributed to all managers to complete in consultation with their teams.

The level of detail that was collected with this tool provided the OSL committee with the ability to identify where programs and services had opportunities to enhance collaboration and to find where similar work processes existed.

Organizational Network Analysis

Organizational network analysis is a method of conceptualizing the internal connections of an organization that are not apparent when looking at formal reporting and prescribed work processes. Work in any large organization occurs in a fluid manner across functional and organizational boundaries. These informal networks of connectivity are vital for performance, learning, and innovation. It is important to understand these invisible webs so that they can be considered with any potential change to organizational structure.

The OSL committee distributed the network analysis tool to managers for completion in consultation with their teams. Each team was asked to respond to questions about their relationships to other MLHU teams in the following domains:

1) How often do you share or receive information?
2) How often do you work together on program delivery?
3) How often do you support, or are you supported?

Responses from across the health unit allowed us to produce network analysis plots that visualized the strength of relationships between various teams across these three domains. Additional organizational network analysis plots were produced to further explore themes identified using the other data sources.

Submissions to the Organizational Structure and Location Committee

Several potential organizational changes were identified early in the Organizational Structure and Location project based on feedback gathered through previous activities or ongoing work from several internal groups. These individuals and groups included the:

- Foundational Standards Committee (formerly Foundational Standard Community of Practice);
- Health Equity Strategic Plan Advisory Group; and
- Chief Nursing Officer.

Each was asked to provide a submission of structural considerations that would enhance their work and alignment within MLHU and the supporting data and rationale for such considerations. These submissions were used by the Organizational Structure and Location Committee as well as the Senior Leadership Team to inform decision-making alongside the additional data sources.

Staff Consultations

Additional cross-functional staff consultations were held starting on November 10th with the Non-union Leadership Team (NLT) and three staff sessions that were held on November 11th, November 12th and November 18th.

During these sessions, staff were presented with draft organizational structures that had been developed by the Organizational Structure and Location Committee and Senior Leadership Team using the data that had been collected. Staff were asked to provide feedback on the proposed structural considerations and the corresponding changes to MLHU's organizational charts.

Data was collated from each of the sessions using interactive clickers where participants were asked to respond to each structural consideration with the following question: Do you see some value in this organizational change? A facilitated discussion was then held based on the results of the poll. Questions and comments from this discussion were recorded for integration into future decision-making.

151 staff signed up to attend the sessions and there were over 126 unique responses using the interactive clickers. Additional opportunity for comment was also provided to staff using handouts distributed throughout the room. These handouts asked staff:

1) Was there anything you did not see that you expected to see?
2) What aspects of these changes are you most excited about?
3) What aspects of these changes are you most concerned about?
4) What is the one thing that SLT needs to consider as they start building implementation plans?
5) What do you see as the key to successfully implementing these changes?

These responses, along with the data collected from the interactive clickers and facilitated discussions were collated and themed for use by the Senior Leadership Team and Organizational Structure and Location Committee.

Additional Feedback

There were many additional opportunities for staff to provide their feedback throughout this process. Members of the Organizational Structure and Location Committee acted as liaisons with staff and gathered feedback through informal conversations, an online anonymous "suggestion box" was also created and at any time and emails could be forwarded to members of the Senior Leadership Team or the committee.

Data gathered through these means was recorded whenever possible and integrated into the data sets of either the management and team meetings or the staff consultation analysis depending on when the information was received.

Decision-making Process

The Organizational Structure and Location (OSL) Committee used the data gathered throughout September, October and November of 2015 to incorporate into intensive full-day planning sessions with the Senior Leadership Team.

The first full-day planning session with the OSL committee took place on October 16th where all available data sources were reviewed and themes to form the considerations for SLT were identified. At this meeting, OSL members were able to see the full picture of the data collected and begin to form initial ideas of the directions that the MLHU could pursue for a potential restructuring.

The second full-day planning session with OSL took place on October 26th. At this meeting, the themes were refined and triangulated with the data sources. By the end of this day, the key themes for consideration had been agreed upon and specific options for structural changes were discussed.

Using the themes identified for structural considerations and the options that had been identified at the previous OSL meeting on October 26th, the committee continued to develop specific options to be presented to the Senior Leadership Team. Several different options for each of the structural considerations were identified with a specific "preferred" option identified for each.

OSL presented their "preferred" options for structural considerations and accompanying organizational charts to the Senior Leadership Team on November 3rd during a joint OSL – SLT planning session. At this session, OSL members represented the "preferred" findings and were available for additional feedback and questions from the Senior Leadership Team.

The Senior Leadership Team continued the conversation regarding the identified themes, structural considerations and "preferred" options throughout the rest of November 3rd and applied a range of criteria to which options moved forward and which did not. Based on these deliberations, the Senior Leadership also offered some modifications to the proposed organizational structures. The results of which were made available for further consultation with members of NLT and participants in the staff consultation sessions from November 11th to November 18th.

Feedback collected from the staff consultation sessions was synthesized for Senior Leadership Team review on November 24th. Revised recommendations and the staff consultation feedback were then brought to the Organizational Structure and Location Committee for validation on November 25th.

The considerations outlined in this document represent the synthesis of a range of options that have been developed throughout the past several months. These proposed structural changes are intended to suitably represent the feedback received throughout the organizational structure situational assessment and to meet the unique needs of the Middlesex-London Health Unit.

Findings and Considerations

The considerations presented below represent a high-level overview of the organizational structure at the Middlesex-London Health Unit. Much of the details that were highlighted in the operational process mapping (programs, program components) are not identified in these considerations and will be assessed during implementation of the high level structure.

In these considerations, the term "Divisions" is used to refer to what were previously called Service Areas. This term, as well as the draft Division titles are subject to revision during the course of implementation. The finding and considerations are highlighted in the following manner:

1. *Foundational Standards*

2. *Health Equity*

3. *Chief Nursing Officer and Nursing Practice Lead Roles*

4. *Health Care Provider Outreach*

5. *Formation of a Healthy Living Division*

6. *Formation of a Preconception Early Years Division*

7. *Formation of an Environmental Health and Infectious Diseases Division*

8. *Formation of a Corporate Services Division*

1. **Foundational Standards**

Staff engaged in Foundational Standards work are currently spread across the Services Areas of the Middlesex-London Health Unit where there are a number of different direct reports. This has presented significant challenges when looking at the prioritization of agency-wide initiatives.

This consideration encourages the formation of a Foundational Standards Team that would centralize Epidemiologists, Program Evaluators, Data Analysts, Librarians, and the Resource Lending System from their currently decentralized structure.

It is important to note that advantages of the current decentralized structure would be leveraged through the use of a hybrid model. In this model, Foundational Standards staff would report centrally to the Associate Medical Officer of Health and a Manager of Program Planning, Evaluation and Surveillance but be physically located with the teams that they provide support to.

This Team would be a part of a newly established Foundational Standards Divisions that would be directed by the Associate Medical Officer of Health.

Supporting Data

> ➤ Management and Team Meetings
> ➤ Environmental Scan
> ➤ Literature Review
> ➤ Key Informant Interview
> ➤ Operational Process Mapping
> ➤ Organizational Network Analysis
> ➤ Submissions to the OSL Committee
> ➤ Staff Consultations

Potential Benefits of Proceeding with this Consideration:

> ✓ Alignment with the 2015 – 2020 Middlesex-London Health Unit Strategic Plan
> ✓ Would help to ensure consistency, efficiency and rigour in program planning, evaluation and surveillance.
> ✓ Improved coordination and prioritization of program planning, evaluation and surveillance work.
> ✓ Enhanced surge capacity when urgent priorities emerge.

Potential Challenges of Proceeding with this Consideration:

> ✘ Requires leadership at the Director level – no Director in our current structure has this portfolio.
> ✘ Requires the allocation or reallocation of resources for a Manager of Program Planning, Evaluation and Surveillance.
> ✘ Centralization could stifle the current culture of quick access and collaboration at the program level with Foundation Standards staff.

2. Health Equity

Health equity work at the Middlesex-London Health Unit is currently carried out by the Health Equity Strategy Advisory Group which has continued to meet following the completion of the 2012 – 2014 strategic plan and staff on a variety of teams who have health equity roles. This arrangement makes it difficult to drive organizational change regarding health equity and to prioritize agency-wide health equity work.

This consideration encourages the formation of a Health Equity Team that would provide centralized support for the Middlesex-London Health Unit. This group would consist of Social Determinants of Health Public Health Nurses, the Health Equity Integration Lead and potentially other social determinants of health staff.

This team would report to the Chief Nursing Officer and Division Director role but would not be aligned with a Division.

Supporting Data

- ➢ Management and Team Meetings
- ➢ Environmental Scan
- ➢ Key Informant Interview
- ➢ Operational Process Mapping
- ➢ Submissions to the OSL Committee
- ➢ Staff Consultations

Benefits of Proceeding with this Consideration:

- ✓ Alignment with the 2015 – 2020 Middlesex-London Health Unit Strategic Plan.
- ✓ Facilitates the prioritization of agency-wide health equity initiatives.
- ✓ Enhanced connectedness and collaboration between the health equity roles.
- ✓ Allows for enhanced collaboration with other agency-wide teams (i.e. Foundational Standards, Human Resources)

Potential Challenges of Proceeding with this Consideration:

- ✖ Dedicated health equity staff will no longer be embedded within teams to provide their expertise.
- ✖ Concerns that the Director & Chief Nursing Officer role will be too busy to provide enough direction and support to the Health Equity group.

3. Chief Nursing Officer and Nursing Practice Lead Roles

The Chief Nursing Officer and Nursing Practice Lead roles have shifted over the past year to accommodate other Senior Leadership Team changes. Previously, the Chief Nursing Officer was also the Director of Family Health Service and there was a separate Nursing Practice Lead called the Community Health Nursing Specialist. Due to the retirement of the Director in April 2015, these roles were combined and held by one individual. There is a necessity to look at the long-term needs of the organization and how these roles could be best structured and situated.

This consideration encourages the Chief Nursing Officer and Nursing Practice Lead being separate roles in the health unit as it was previous to April 2015. The Nursing Practice Lead would be centrally located and assessable to all nursing staff at MLHU regardless of the Division they work in.

This consideration acknowledges that the Ministry requires the Chief Nursing Officer to be a part of the senior management team and report directly to the Medical Officer of Health. This is the most common model across Ontario public health units.

Supporting Data

- ➢ Management and Team Meetings
- ➢ Environmental Scan
- ➢ Operational Process Mapping
- ➢ Submissions to the OSL Committee
- ➢ Staff Consultations

Potential Benefits of Proceeding with this Consideration:

- ✓ Greater capacity to address nursing practice issues.
- ✓ Multiple levels of problem solving for nursing leadership and professional practice issues.
- ✓ Divisional Director with Chief Nursing Officer Responsibilities ensures a well-established relationship with the Medical Officer of Health and the Senior Leadership Team.

Potential Challenges of Proceeding with this Consideration:

- ✖ Capacity to address the Chief Nursing Officer role can be limited when combined with the Director role.
- ✖ Joint role of Chief Nursing Officer and Director can be challenging when balancing organizational needs with the interests of nursing.
- ✖ Difficult to get the full picture of nursing practice and leadership when the Chief Nursing Officer and Nursing Practice Lead roles are separated.

4. Health Care Provider Outreach

Health care provider outreach is currently situated in the Reproductive Health Team of Family Health Services but looks at structures that need to be in place for an integrated healthcare provider outreach strategy at the agency level. There are challenges with the nature of this work being agency-wide and collaborating with programs across the health unit while being within the reproductive health team.

This consideration encourages the alignment of Health Care Provider Outreach role within the Communications Team in the Officer of the Medical Officer of Health.

Supporting Data

- ➢ Management and Team Meetings
- ➢ Environmental Scan
- ➢ Operational Process Mapping
- ➢ Staff Consultations

Potential Benefits of Proceeding with this Consideration:

- ✓ Increased coordination and collaboration of health care provider outreach across the agency.
- ✓ Would allow for the development of a health care provider outreach management system that facilitates better communications and coordinates office visits to avoid duplication and inefficiencies.
- ✓ Enhanced interaction and collaboration with the Communications Team.
- ✓ Strong connection to the Medical Officer of Health allows for enhanced relationships between health care providers and the health unit.

Potential Challenges of Proceeding with this Consideration:

- ✗ Some of the roles relating to health care provider outreach would still exist at the team level and this would continue to be a challenge.
- ✗ This would require a reallocation of resources from the Reproductive Health Team.
- ✗ Extensive communication would still need to take place across Divisions and Teams.

5. Formation of a Healthy Living Division

Our current organizational structure with Healthy Communities & Injury Prevention, Chronic Disease Prevention & Tobacco Control and the Southwest Tobacco Control Area Network situated in the Environmental Health & Chronic Disease Prevention Service Area, Oral Health situated in Oral Health, Communicable Disease and Sexual Health Service Area and the Child and Young Adults Team located in Family Health Service Area creates significant coordination and collaboration challenges.

There is considerable similarity in the type of strategies, interventions, settings and work performed by these teams that would be enhanced were they aligned together.

This consideration encourages the formation of a "Healthy Living" Division at the Middlesex-London Health Unit that aligns the Healthy Communities & Injury Prevention, Chronic Disease Prevention & Tobacco Control, Oral Health, Child Health and Young Adults Teams.

This Division would focus on the delivery of services and coordination of programs and services in the ages, stages and settings starting with childcare centres, continuing through school ages and across the lifespan.

Supporting Data

- ➢ Management and Team Meetings
- ➢ Environmental Scan
- ➢ Operational Process Mapping
- ➢ Staff Consultations

Potential Benefits of Proceeding with this Consideration:

- ✓ This has the opportunity to greatly enhance collaboration between the teams that would be realigned together.
- ✓ Division planning would be enhanced due to the similarity of work between the teams in this new Division.
- ✓ Similarity of strategies, interventions and work will allow for increased skill building and knowledge exchange.

Potential Challenges of Proceeding with this Consideration:

- ✖ Strong connections would need to exist between this Division and the other proposed Divisions specifically, the links between Sexual Health, Vaccine Preventable Disease and Best Beginnings.

6. Formation of a Preconception & Early Years

Our current organizational structure has the Child Health and Young Adults Teams aligned with the Best Beginnings, Reproductive Health, Early Years, Screening, Assessment and Intervention, Nurse Family Partnership and Nurse Practitioner Clinic in Family Health.

Facilitated by the realignment of the Child Health and Young Adult Teams, this consideration encourages the formation of a "Preconception & Early Years" Division consisting of the Best Beginnings, Reproductive Health, Early Years and Screening, Assessment and Intervention Teams as well as the Nurse Family Partnership and the Nurse Practitioner Clinic.

This Division would focus on health promotion, the delivery of services and coordination of programs and services in the ages, stages and settings associated with preconceptions and early years.

Supporting Data

- ➢ Management and Team Meetings
- ➢ Environmental Scan
- ➢ Operational Process Mapping
- ➢ Submissions to the OSL Committee
- ➢ Staff Consultations

Potential Benefits of Proceeding with this Consideration:

- ✓ Similar target populations and settings where these program and services are delivered could enhance collaboration and effectiveness.
- ✓ Increasing the alignment between these teams would allow for decreased duplication of messaging and service delivery.

Potential Challenges of Proceeding with this Consideration:

- ✗ A need still exists to integrate health topic content expertise from other Divisions at the Health Unit (i.e. Reproductive Health working with Healthy Communities & Injury Prevention).

7. Formation of an Environmental Health and Infectious Diseases Division

Throughout the data gathering process of the Organizational Structure and Location Committee project, the similarities between the Environmental Health Teams and the Infectious Disease Control Teams were highlighted for potential realignment. Currently, these two teams are located in separate Service Areas despite the omnipresent need to work together and collaborate. Additionally, the Infectious Disease Team has strong linkages with both Sexual Health and Vaccine Preventable Disease.

This consideration encourages the formation of the "Environmental Health and Infectious Diseases" Division which aligns our focus on health protection.

This Division would include: Food Safety, Health Hazards and Vector Borne Disease, Rabies and Safe Water, Emergency Preparedness, Infectious Disease Control, Sexual Health, Vaccine Preventable Disease and the Travel Clinic.

Supporting Data

- ➢ Management and Team Meetings
- ➢ Environmental Scan
- ➢ Operational Process Mapping
- ➢ Submissions to the OSL Committee
- ➢ Staff Consultations

Potential Benefits of Proceeding with this Consideration:

- ✓ Many of the program components being performed by the Infectious Disease Control Team have significant overlap with the work being done in Environmental Health.
- ✓ There is the potential to improve, align and enhance many similar work processes.
- ✓ Increased surge capacity with Public Health Inspectors and Public Health Nurses being in the same Division and collaborating on similar work.

Potential Challenges of Proceeding with this Consideration:

- ✗ The Emergency Management would report to a Director instead of the Medical Officer of Health as it was previously structured. Emergency management literature suggests the linkage between emergency management and the incident commander (Medical Officer of Health) must be very strong.
- ✗ This Division will require ongoing support and expertise from the Associate Medical Officer of Health.

8. Formation of a Corporate Services Division

The Human Resources and Corporate Strategy Service Area and Finance, Operations and Information Technology Service Area must work together seamlessly to provide the necessary support to our front-line services at the Middlesex-London Health Unit. These two teams are physically located with each other but conduct separate planning and prioritization processes that can be barriers to effective collaboration.

This consideration encourages the formation of a "Corporate Services" Division which would align Finance, Procurement and Operations, Information Technology, Human Resources, Privacy & Occupational Health and Safety and Strategic Projects.

This consideration is facilitated by the realignment of the Library and Data Analysts to the Foundational Standards group and the Staff Immunization Program being realigned to Vaccine Preventable Disease.

This Division would integrate the administrative and support services provided to all Divisions and teams at the health unit.

Supporting Data

- ➢ Management and Team Meetings
- ➢ Environmental Scan
- ➢ Operational Process Mapping
- ➢ Submissions to the OSL Committee
- ➢ Staff Consultations

Potential Benefits of Proceeding with this Consideration:

- ✓ This would provide opportunities for collaborative Divisional planning.
- ✓ Enhancement of agency-wide project priority setting.
- ✓ The vaccine preventable disease team has significant expertise in the planning and execution of immunization clinics.

Potential Challenges of Proceeding with this Consideration:

- ✘ This would be a large Division with a very diverse portfolio compared to its previous arrangement.

9. Other Considerations

Throughout the Organizational Structure and Location Process, other considerations (some process rather than structural) were identified that will be important to recognize now and in the future. These were prioritized by the Senior Leadership Team and include:

- Providing staff with opportunities for rotation and skill development;
- Enhancing our internal communication and collaboration frameworks;
- Investing in our management, staff recognition and performance management;
- Designating leads for specific projects, topics, or setting in the community (much like we have previously done with the Baby-Friendly Initiative);
- Review of intake lines and related processes.
- Review of Program Assistant structure and roles.

These additional considerations are items that the Senior Leadership Team will look to address in the coming years.

Next Steps

Recommendations to the Board of Health

The findings contained within this report have been used to inform the organizational structure recommendations that will go to the Board of Health on December 10, 2015.

The Board of Health is responsible for approving the high-level structure of the Middlesex-London Health Unit. This high-level is defined as our Divisions and corresponding reporting relationships with the Medical Officer of Health. This recommended structure for approval will be submitted as a Policy 2-010 and associated appendices.

Detailed organizational structure and the reporting relationships that exist between Directors, Managers and Front-line Staff are administratively approved by the Senior Leadership Team.

Implementation Planning

There are challenges associated with any change in organizational structure. These potential risks include: organizational culture, human resources implications, program and service disruption, changes to administrative policies and procedures, financial implications and other legislative and regulatory compliance obligations.

Initial implementation planning has commenced and will continue following approval of the organizational structure recommendations for the Board of Health. Implementation planning will map out critical organizational implications of a structural change and include the items noted previously as potential risks as well other considerations that are identified.

Location Analysis

The recommended organizational structure has significant implications for our potential future location. Once the Board of Health has approved the organizational structure, the OSL Committee will begin more intensive location analysis to determine the physical needs of our organizational structure.

This location analysis will integrate data that has been previously collected through space needs assessments and require the collection of additional data to fully inform decision making.

SUBJECT: Organizational Structure	**POLICY NUMBER:**	**1-050**
SECTION: Governance	**PAGE:**	**1 of 2**

IMPLEMENTATION:	November 1, 1990	**APPROVAL**	Medical Officer of Health / CEO
SPONSOR:	Medical Officer of Health	**SIGNATURE**:	
REVIEWED BY:	Senior Leadership Team	**DATE**:	December 10, 2015

PURPOSE

To describe the Health Unit's organizational structure, as well as the reporting relationships and responsibilities for Health Unit operations.

POLICY

The Middlesex-London Health Unit is led by the Medical Officer of Health and Chief Executive Officer, as defined by the Health Protection and Promotion Act, who is accountable to the Middlesex-London Board of Health for the management of public health programs and services and for the direction of employees and persons whose services are engaged by the Health Unit. In the absence of the Medical Officer of Health, the Associate Medical Officer of Health shall act as the Medical Officer of Health and assume the corresponding responsibilities.

When the Office of the Medical Officer of Health is vacant or unable to act, and there is no Associate Medical Officer of Health, the Board of Health may appoint a physician as the Acting Medical Officer of Health.

The Health Unit is organized by Divisions, with the Director of each Division reporting directly to the Medical Officer of Health or his/her designate. Directors are responsible for the administration and delivery of all aspects of the programs and services within their Divisions.

PROCEDURE

The agency-level organizational structure of the Middlesex-London Health Unit with reporting structures for the Medical Officer of Health, the Associate Medical Officer of Health and Directors are outlined with this policy.

Programs and services are organized into the Divisions as outlined in the agency-level organizational structure. These programs and services are planned and coordinated by the Division Directors in consultation with the Medical Officer of Health and approved in the Middlesex-London Health Unit budget that is submitted annually to the Board of Health.

The Medical Officer of Health and Chief Executive Officer will keep the Board of Health informed of any changes to the organizational structure of the Health Unit.

The Divisions and organization of programs and services at the Middlesex-London Health Unit are prepared and made available to staff on the HUB.
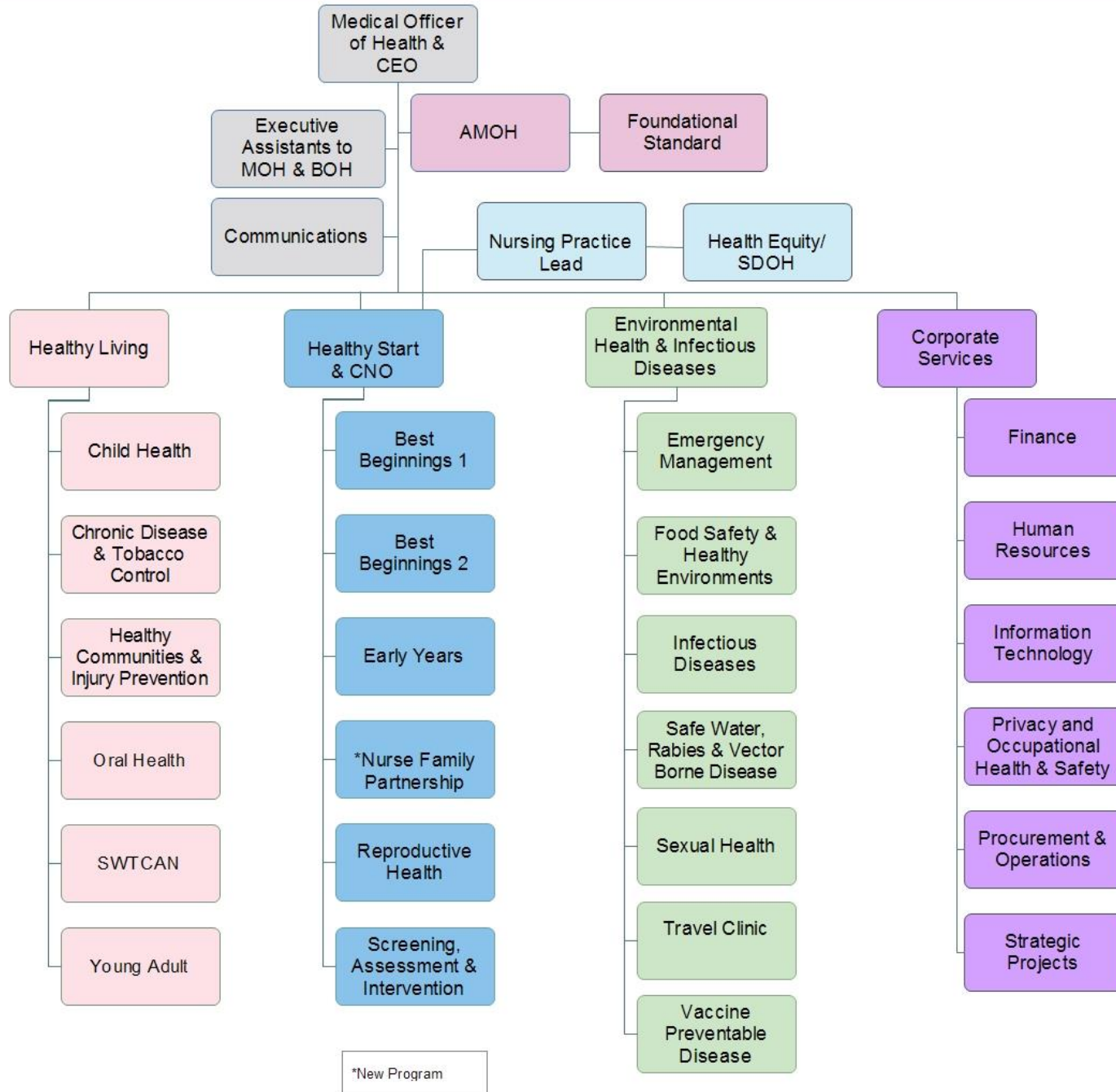
APPLICABLE LEGISLATION

Health Protection and Promotion Act. R.S.O. 1990, Chapter H.7.

Ontario Public Health Organizational Standards

RELATED POLICIES

REVISION DATES (* = major revision)**:** February 20 1995; May 4 1995; February 5 1997; June 15 2000; *September 10 2003; June 17 2004; *April 01 2009; *June 23 2010, *December 10 2015.

Proposed MLHU Organizational Chart - DRAFT

Medical Officer of Health & CEO

- Executive Assistants to MOH & BOH
- Communications
- AMOH
  - Foundational Standard
- Nursing Practice Lead
- Health Equity/ SDOH

Healthy Living
- Child Health
- Chronic Disease & Tobacco Control
- Healthy Communities & Injury Prevention
- Oral Health
- SWTCAN
- Young Adult

Healthy Start & CNO
- Best Beginnings 1
- Best Beginnings 2
- Early Years
- *Nurse Family Partnership
- Reproductive Health
- Screening, Assessment & Intervention

Environmental Health & Infectious Diseases
- Emergency Management
- Food Safety & Healthy Environments
- Infectious Diseases
- Safe Water, Rabies & Vector Borne Disease
- Sexual Health
- Travel Clinic
- Vaccine Preventable Disease

Corporate Services
- Finance
- Human Resources
- Information Technology
- Privacy and Occupational Health & Safety
- Procurement & Operations
- Strategic Projects

*New Program

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 73-15

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2015 December 10

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MIDDLESEX-LONDON HEALTH UNIT AND ONTARIO NURSES' ASSOCIATION (ONA) PAY EQUITY PLAN

Recommendation

It is recommended that the Board of Health receive Report No. 73-15 re ONA Middlesex-London Health Unit ("MLHU") and Ontario Nurses' Association Pay Equity Plan for approval.

Key Points

- Negotiation with ONA with respect to Pay Equity Compliance has been ongoing since 2009.
- A Pay Equity Plan has been drafted and Attached as Appendix A
- This plan was ratified by the ONA bargaining unit November 27, 2015
- No pay equity adjustments are required for the female job classes in the ONA employee group.

Background

The Pay Equity Plan in Appendix A covers the MLHU and the Ontario Nurses Association (ONA). MLHU and ONA jointly developed a gender-neutral job comparison system that was used to measure the value of each job class. The job comparison system is a closed, point factor system, incorporating skill, effort, responsibilities of the job and the working conditions under which the job is normally performed. The 14 job evaluation factors and the weights used are listed in Schedule I of the plan document.

The four female job classes that were evaluated were the Community Health Nursing Specialist, Nurse Practitioner, Public Health Nurse and Registered Nurse. There are no male job classes in the ONA employee group therefore male comparators were identified in the non-union and CUPE employee groups.

The evaluation of job classes was carried out by a committee representing equally the employer and ONA; facilitated by Advisors. The job evaluation involved a careful and thorough analysis of each job class. Rating rationales were provided to employees and employees were afforded an opportunity to request a reconsideration by the Committee.

Weights and points were allocated to each factor for each job and a total point score was calculated for each job class. To provide fair, equitable pay equity adjustments that are in keeping with the Ontario *Pay Equity Act*, the job-to-job method of comparison was used to determine pay equity adjustments. It has been determined that no pay equity adjustments are required for the female job classes.

Next Steps

Once pay equity is achieved, MLHU is required to maintain pay equity for the employees in female dominated job classes. Maintaining pay equity is an ongoing process whereby employers must review job classes for changes in job rate, job value, duties and responsibilities as positions are added or eliminated.

Once the Board of Health has provided their approval the final step in achieving Pay Equity for MLHU and ONA will be to post the signed plan within the workplace.

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

Pay Equity Plan for
Middlesex London Health Unit and
Ontario Nurses' Association

Date of Posting	
Establishment	This Plan covers the Middlesex London Health Unit and the Ontario Nurses' Association (ONA).
Gender Neutral Comparison System	Middlesex London Health Unit and ONA jointly developed a gender-neutral job comparison system that was used to measure the value of each job class. The job comparison system is a closed, point factor system, incorporating skill, effort, responsibilities of the job and the working conditions under which the job is normally performed. The 14 job evaluation factors and the weights used are listed Schedule I of this document.
Female Job Class	− Community Health Nursing Specialist − Nurse Practitioner − Public Health Nurse − Registered Nurse
Male Job Class	There are no male job classes in the ONA employee group. Male cross comparators were identified in the non-union and CUPE employee groups.
Gender - Neutral Job Class	There are no gender-neutral job classes in ONA the employee group.
Job Evaluation Process	The evaluation of job classes was carried out by a committee representing equally the employer and ONA; facilitated by Advisors. The job evaluation involved a careful and thorough analysis of each job class. Rating rationales were provided to employees. Employees were afforded an opportunity to request a reconsideration by the Committee. Weights and points were allocated to each factor for each job and a total point score was calculated for each job class.
Banding	Jobs of equal value or comparable value were determined by dividing the system into 50-point bands of consistent width starting at 380 points.
Permissible Difference	No permissible differences in compensation were found.

Comparison Results	To provide fair, equitable pay equity adjustments that are in keeping with the Ontario *Pay Equity Act*, the job-to-job method of comparison was used to determine pay equity adjustments. The method of comparison for each female job class is shown in Schedule II. 2015 job rates (effective April 1st) were used in the comparisons. The value of benefits were not included in the calculation of job rate given that all job classes used in the analysis are entitled to comparable benefits.
Pay Equity Adjustments Required	Pay equity was achieved using the job-to-job method of comparison. No pay equity adjustments are required for the female job classes in the ONA employee group.
Further Information	Further information and details of employer and employee obligations and rights are provided in the Ontario *Pay Equity Act*. Or you may contact the undersigned.
Signed	_____ _____ for the Employer for the Union
Dated	_____
Committee Signatures	_____ _____ _____ _____ _____ _____ _____ _____

Job Evaluation System Factors	Primary Elements of Job Worth Measurement (For Pay Equity Purposes)
Knowledge / Education / Training	Skill
Skill Gained By Experience	Skill
Problem Solving	Skill
Responsibility For Ingenuity And Creativity	Skill
Sensory Demands	Effort
Physical Skill & Effort	Effort
Responsibility For Independent Action	Responsibility
Responsibility For Financial Resources And Assets	Responsibility
Effect Of Errors	Responsibility
Responsibility For Confidential Information	Responsibility
Responsibility For Human Resources	Responsibility
Responsibility For Influencing Others (Contacts)	Responsibility
Responsibility For Well Being Of Others	Responsibility
Disruption To Lifestyle & Working Conditions	Working Conditions

Bands	Band Width			Female Job Class	Male Job Class
	From	To	Spread		
9	730	779	50	Nurse Practitioner	Manager, Strategic Projects (Non-Union)
8	680	729	50	Community Health Nursing Specialist	Public Health Inspector (CUPE)
				Public Health Nurse	
7	630	679	50		
6	580	629	50		
5	530	579	50		
4	480	529	50		
3	430	479	50		
2	380	429	50	Registered Nurse	Online Communications Coordinator (CUPE)

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 69-15

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2015 December 10

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SEXUAL HEALTH SERVICES REVIEW

Recommendation

It is recommended that Report No. 69-15 re Sexual Health Services Review be received for information.

Key Points

- MLHU Sexual Health Promotion Team and Clinical Services engage in evidence informed decision making in order to ensure the best available evidence informs our programming, services and policy work.

Background

The Sexual Health team (The Clinic and Sexual Health Promotion) conducted program reviews in an effort to validate current evidence-informed approaches, identify opportunities to enhance the use of evidence-informed strategies, and increase effectiveness and efficiency of programs and services. The program review was guided by the principles of need, impact, capacity, and collaboration and partnerships (Ontario, 2008), and framed by the National Collaborating Centre on Methods and Tools (NCCMT) Model for Evidence-Informed Decision-Making in Public Health (NCCMT, 2010), Health Promotion and Protection Act (HPPA), and Ontario Public Health Standards (OPHS). The report entitled, *Effective Health Promotion Strategies for Middlesex-London Health Unit's Sexual Health Team*, is attached as Appendix A. The report entitled, *Program Review Sexual Health Clinic*, is attached as Appendix B.

Review Components

The Sexual Health team conducted a rapid review to determine the most current and effective health promotion strategies (primarily education and awareness) for reducing sexually transmitted infections (STIs) among youth aged 15-24 in Middlesex-London. The rationale for focusing on this age group was based on the epidemiology of the infection rates from local context. This review was conducted to identify which team initiatives should be changed or discontinued, which should be continued or enhanced, and what new initiatives could be considered for implementation.

Components of the Clinic review included reviewing recent trends in sexually transmitted infections and blood-borne infections (STI/BBI) in the Middlesex-London region, determining the "reach" of The Clinic to priority populations, conducting an environmental scan of comparable health units and local community organizations offering sexual health services, reviewing best practices for harm reduction services, surveying The Clinic Physicians and clients, and reviewing literature regarding the delivery of sexual health clinic services.

Key findings

Clinic activities mostly aligned with the requirements of the Ontario Public Health Standards. Gaps in determining the reach of clinical services to priority populations and providing outreach and support to community physicians who provide care to confirmed STI cases were identified. Services offered at MLHU

Sexual Health Clinics are consistent and similar to the provision of sexual health services in the seven comparator health units. Among the literature that was reviewed outreach strategies were found to be successful in reaching populations that would not otherwise access mainstream sexual health services. Several recommendations for enhancing clinic practice and process were identified.

The Sexual Health Promotion review identified that facilitator and peer-led interventions demonstrated a reduced incidence in sexually transmitted infections (STIs) through the use of behavioural interventions. Social media and text messaging interventions are effective in increasing STI knowledge. Employing a train-the-trainer method demonstrates some effect in the reduction of the incidence of active syphilis and the prevalence of gonorrhea.

Conclusion

Next steps include accessing the applicability and transferability of the SHP review findings and conducting another rapid review to focus on advocacy and supportive environment strategies. The recommendations from the Clinic review have begun to be implemented.

This report was prepared by Mr. Chris Blain, Health Promoter; Ms. Shaya Dhinsa, Program Manager; Ms. Deborah Fenlon, Public Health Nurse and Ms. Sameena Vadivelu, Program Evaluator.

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

Effective Health Promotion Strategies for Middlesex-London Health Unit's Sexual Health Team

June 2015

For information, please contact:

Sexual Health
Middlesex-London Health Unit
50 King St.
London, Ontario
N6A 5L7
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e-mail:

Authors:

Christopher Blain, BHSc
Deb Fenlon, RN, BScN

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Acknowledgements

Executive Summary

Purpose
The Sexual Health team at the Middlesex-London Health Unit conducted a rapid review to determine the most current and effective health promotion strategies for reducing sexually transmitted infections (STI's) among youth aged 15-24 in Middlesex-London. The rationale for focusing on this age group was based on the epidemiology of the infection rates from local context (refer 1.1 Local Context for more information).

Research Question
Among youth aged 15-24 years, what health promotion strategies are effective at reducing rates of sexually transmitted infections?

Context
Currently, the Sexual Health team engages in numerous health promotion strategies intended to promote healthy sexuality in the residents of Middlesex-London. Some of these strategies include providing opportunities for education and skill building, creating and fostering supportive environments, raising awareness through mass media campaigns and using social media.

Methods and Results
The original search strategy for this review was replicated from a rapid review completed by Peel Public Health in 2012. For the Middlesex-London Health Unit review, a total of 4 databases (Medline, PsycINFO, Cochrane, and CINAHL) were searched up until March 2015. The search strategy resulted in 276articles, including best practice guidelines, meta-analysis and systematic review. Six systematic reviews were included after removal of duplicates, relevance assessment, full article review and quality assessment. Reference lists of all articles were also scanned with the inclusion and exclusion criterion.

Key Findings
The literature demonstrates that there are a multitude of effective health promotion strategies available to public health professionals to influence sexual behaviour, sexual health knowledge, condom use, self-efficacy and attitudes of youth. In turn, this may positively impact the incidence of STI rates in our population.

Key findings from this rapid review of the literature are as follows:
- Facilitator-led interventions (e.g., public health professional, teacher) demonstrate a reduced incidence in sexually transmitted infections (STIs) through the use of behavioural interventions.
- Facilitator-led interventions also show improvement in behavioural outcomes and increased knowledge, specifically with regards to an increase in condom use.
- Social media and text messaging interventions are effective in increasing STI knowledge, particularly with respect to increased familiarity with barrier methods and how they reduce the transmission of STIs. There is a positive significant effect in condom use self-efficacy and a reduction in the proportion of individuals reporting multiple or new partners.
- Employing a train-the-trainer method demonstrates some effect in the reduction of the incidence of active syphilis and the prevalence of gonorrhea.
- Utilizing a peer-led approach is effective in increasing youth sexual health knowledge for HIV/AIDS; changing knowledge for STIs and HIV/AIDS; increasing positive behaviour in regards to the use of condoms; improving prevention skills and youth sexual health knowledge and attitudes of STI prevention methods.
- Interactive-computer-based programs (ICBP) reported demonstrate non-significant improvement in knowledge and self-efficacy, and statistically significant improvement in safe sex intention and behaviour

Recommendation

It is recommended that Sexual Health team members consult with key stakeholders to further consider the above-mentioned key findings, by applying the following NCCMT tools: A Model for Evidence-Informed Decision-Making (Appendix F) and the Adaptability and Transferability Tool (Appendix G). This will facilitate the development of relevant final recommendations for sexual health programming.

I. Issue

The Sexual Health (SH) team conducted a rapid review to determine the most current and effective health promotion strategies for reducing sexually transmitted infections (STIs) among youth aged 15-24 in Middlesex-London. This review was conducted to identify which team initiatives should be changed or discontinued, which should be continued or enhanced, and what new initiatives could be considered for implementation.
As a public health unit operating in the province of Ontario, the Board of Health is required to provide mandatory, and some additional sexual health programs and services (Appendix A). Mandated programs and services are primarily based on the following requirements:

- **Provincial Legislation -** Health Protection and Promotion Act, R.S.O. 1990, c.H.7. (HPPA)
- **Provincial Standards -** Ontario Public Health Standards, 2008 (OPHS), specifically:
  - Principles: Need, Impact, Impact, Capacity, Partnership and Collaboration
  - Foundational Standard
  - Sexual Health, Sexually Transmitted Infections, and Blood-borne Infections
  - Reproductive Health (specifically decreased rate of adolescent pregnancy)
  - Infectious Diseases Prevention and Control
- A **Provincial Protocol –** Population Health Assessment and Surveillance Protocol, 2008 (PHASP)

The OPHS and PHASP, in particular, establish the requirement that health units utilize evidence-informed decision making methodology in the context of their program planning, implementation/delivery, management and evaluation activities. Applying this approach better ensures:

- Health units efficiently and effectively identify and address public health issues in their community.
- Public health programs and services are planned and implemented in such a way as to avoid unintended harm.
- Public health demonstrates accountability through its effective and transparent use of public health resources.

1. Local Context

Before the team could begin looking to the various current and effective strategies, an update on epidemiology of infection rates for Middlesex-London was needed. This update highlighted the following:

- **<u>Chlamydia:</u>** The annual reported incidence rate of chlamydia infections in Middlesex-London was significantly higher than the rate in Ontario as a whole in each year between 2009 and 2013. While this is alarming, the gap between the two rates may be becoming less wide. Between 2009 and 2013, the average annual reported incidence rate in Middlesex-London was 307.4 cases per 100,000 people. Across the five-year time period, an average of 1,414 chlamydia cases were reported annually. The average annual reported incidence rate of chlamydia infections among females for this time period was highest among 20 to 24 year olds, followed by 15 to 19 year olds. For males, the average reported incidence rate of chlamydia infections was also highest among 20 to 24 year olds for this time period, followed by 25 to 29 year olds. Finally the average annual reported incidence rate among females exceeded that for males in all age groups except those 50 years of age and over.

- **<u>Gonorrhea:</u>** The annual reported incidence rate of gonorrhea infections in Middlesex-London was significantly lower than the rate in Ontario as a whole in each year between 2011 and 2013. Between 2009 and 2013, the average annual reported incidence rate in Middlesex-London was 29.8 gonorrhea cases per 100,000 people. Across the five-year time period, an average of 137 gonorrhea cases were reported annually. For this time period, the average annual reported incidence rate of gonorrhea infections was highest among 20 to 24 year olds, followed by 25 to 29 year olds, for both females and males. In the age groups 0 to 19 years and 20 to 24 years, the average annual reported incidence rate among females exceeded that for males. In the remaining age groups, the rate among males exceeded the rate for females.

- **<u>Hepatitis C:</u>** In terms of hepatitis C, the annual reported incidence rate in Middlesex-London was significantly higher than the rate in Ontario as a whole between 2009 and 2013. Although the

Middlesex-London rate decreased in 2013, the decrease is not statistically significant compared to the other years in this time frame. Between 2009 and 2013, the average annual reported incidence rate in Middlesex-London was 53.1 hepatitis C infections per 100,000 people. Across this 5 year period, an average of 244 hepatitis C infections was reported annually. The annual reported incidence rate among females was highest among 25 to 29 year olds, followed by 20 to 24 year olds. For males, the annual reported incidence rate was highest among 30 to 34 year olds, followed by 25 to 29 year olds. Lastly, the reported incidence rate among males exceeded the rate for females in all age groups except among those 19 years of age and under.

- **Infectious syphilis:** Between 2009 and 2013, the annual reported incidence rate of infectious syphilis in Middlesex-London fluctuated over the five-year period. After being statistically higher than the provincial rate in 2011, the incidence rate of infectious syphilis in Middlesex-London was not statistically different to the Ontario rate in each of 2012 and 2013. Due to the relatively few infectious syphilis cases reported in Middlesex-London, the associated confidence intervals are quite wide. Between 2009 and 2013, the average annual reported incidence rate in Middlesex-London was 4.8 infectious syphilis cases per 100,000 people. Across the five-year time period, an average of 22 infectious syphilis cases were reported annually. During this time period, the majority of infectious syphilis cases were reported among males at 91.8%. Due to the small number of cases reported among females in this time period (n=9), it is not possible to present gender specific rates. Across the five-year time period, the reported incidence rate of infectious syphilis was highest among those 20 to 24 years of age, followed by those 25 to 29 years of age and 30 to 34 years of age.

- **HIV/AIDS:** Between 2009 and 2013, the annual reported incidence rate of HIV and AIDS infections in Middlesex-London was similar to the provincial rate in each year.. Between 2009 and 2013, the average annual reported incidence rate in Middlesex-London was 6.3 cases per 100,000 people. Across the five-year time period, an average of 29 HIV/AIDS cases were reported annually. For females, the average annual reported incidence rate of HIV/AIDS infections between 2009 and 2013 was highest among 35 to 39 year olds, followed by 30 to 34 year olds. For males, the average annual reported incidence rate of HIV/AIDS infections was highest among 30 to 34 year olds, followed by 25 to 29 year olds. The average annual reported incidence rate among males exceeded the rate for females in all age groups except those 35 to 39 year olds, where the gender-specific rates were the same.

II. Context

2. Background

The Sexual Health (SH) team is part of the Oral Health, Communicable Diseases, and Sexual Health (OHCDSH) service area. The Sexual Health team provides clinical services and engages in population health promotion initiatives. Currently, the front-line staff resources allocated to focus on planning, implementation and evaluation of population health promotion initiatives include a 0.4 FTE Program Assistant, 3.5 FTE Public Health Nurses (PHN's), 0.7 FTE Social Determinants of Health (SDOH) PHN and a 1.0 FTE Public Health Promoter. In the near future, a 0.5 FTE Health Promoter will join the team to focus on planning and implementing a comprehensive Community Drug Strategy. The annual programming budget, excluding FTE salaries, totals $28,000. This budget is primarily used for programming and campaign material expenditures throughout the year.

Currently, the SH team engages in numerous health promotion strategies to promote healthy sexuality in the residents of Middlesex-London. One such strategy includes education and skill building in regards to sexual health. The team provides presentations to community groups and work places, with different education needs, on a variety of sexual health topics. The SH Team uses the principles of health promotion, disease prevention and health protection to educate individuals, groups, networks, and organizations to influence societal norms and raise awareness of sexuality. Topics for these presentations vary but often include an introduction to reproductive health for either men and/or women, background information on STIs, birth control methods, positive space training, the importance of getting tested, how to get tested, healthy relationships, and consent.

Besides community presentations, the SH team is highly active in creating supportive environments for sexual health. Much of this work focuses on Positive Space Training and encouraging organizations and community partners to offer inclusive services and resources for the Lesbian Gay Bisexual Transgender Queer (LGBTQ) population within Middlesex London. The SH team also does a lot of work to increase the societal norms for positive

sexual health and decrease the stigma related to STI testing. The team promotes a supportive environment where all birth control methods are considered beneficial in controlling unintended pregnancies.

Lastly, the SH team develops social media and mass media campaigns to promote various sexual health messages. In the past, the team has used various health behaviour theories to develop online interactive games, engaging social media campaigns and poster displays to spread the importance of STI testing and to promote MLHU sexual health services.

III. Research Question

The research question examined in this review is as follows:

Among youth aged 15-24 years, what health promotion strategies are effective at reducing rates of sexually transmitted infections?

1. PICO Question

P (Population)	15-24 years of age
I (Intervention)	Health promotion strategies including but not limited to: social marketing campaigns, peer to peer programs, internet-computer based interventions, train the trainer, facilitator-led
C (Comparison)	No health promotion strategy
O (Outcome)	Rates of sexually transmitted infections

2. Search Strategy

The original search strategy for this review was replicated from a rapid review completed by Peel Public Health in 2012. A scoping search was performed prior to the initial literature search to verify the health promotion strategies that would be included in the PICO. For the Middlesex-London Health Unit review, a total of 4 databases (Medline, PsycINFO, Cochrane, and CINAHL) were searched up until March 2015. The search was narrowed to published literature from January 2010-present, English only, and only meta-analysis, systematic reviews and rapid reviews.

The inclusion criteria were broken down into 4 separate categories: types of studies, types of participants and settings, types of interventions, and types of outcome measures. To view the inclusion and exclusion criteria utilized in this review, please see Table 1 below.

Table 1: Inclusion and Exclusion Criteria

	Inclusion Criteria	Exclusion Criteria
Types of Studies	• Published literature from January 2010-present • English only literature • Studies only including meta-analysis • Studies only including systematic reviews • Studies only including rapid reviews	• Non-English • Non-published studies and guidelines • Single studies • Synopsis if single studies • Textbooks • Specialized registers • Consultations on current contents
Types of Participants and Settings	• A location that is similar to Middlesex-London in terms of studies in developed/western/high-resource setting	• Studies that took place in a non-developed country

Types of Interventions	• To include the 5 key interventions outlined in the PICO question:
	  o social media campaigns;
	  o peer-to-peer programs;
	  o internet computer-based programs;
	  o train-the-trainer programs;
	  o facilitator-led interventions
	• The intervention was also to be prevention based and not offer any treatment
		• Studies that did not have similar interventions to the 5 key interventions outlined in the original PICO question

Types of Outcome Measures	• Primary outcome measures (measureable outcomes):
	  o reportable infection rates for chlamydia and gonorrhea
	• Secondary outcome measures (non-measureable outcomes):
	  o sexual behaviour;
	  o attitudes;
	  o knowledge improvement;
	  o self-efficacy;
	  o safer-sex interventions;
	• condom use
		• Studies with outcome measures that were dissimilar to the primary outcome measure identified in the original PICO question
		• Studies with outcome measures that were dissimilar to the secondary outcome measures identified in the original PICO question

3. Search Results

Utilizing the National Collaborating Centre for Methods and Tools (NCCMT) method for efficiently searching the literature and the 6S Pyramid methodology (Appendix B), the search strategy (Appendix C) resulted in 276 articles. Six systematic reviews were included after removal of duplicates, relevance assessment, full article review and quality assessment. All articles were also scanned with the inclusion/exclusion criterion that was described in the above section. The final search results are outlined in Appendix D. References for the included studies are available at the end of this report. A list of the excluded reviews may be requested from the authors.

IV. Quality Assessment

1. Quality Assessment Tools and Strategy

A quality assessment of each systematic review was completed to assess the validity and usefulness of the research findings. Each article was appraised using the AMSTAR (Appendix E) and graded on a scale out of 11. A score of seven or greater was viewed as a study of high quality and a score of five or six was considered a study of medium quality. Any study scoring less than five was rated as weak and those reviews were excluded from the review. The quality assessment process was completed by two reviewers and any discrepancies were resolved by consensus.

2. Results

The search results had been narrowed down to six articles before the quality assessment process was started. Four out of the six systematic reviews were of strong methodological quality. The remaining two articles were moderately ranked and were included in the data extraction with the above four articles. In total, six articles satisfied the quality assessment and would move on to data extraction. Copies of the completed quality assessment tools are available from the authors upon request. A blank copy data extraction table can be found in Appendix H. Copies of the copied data extraction tables for all six systematic reviews are also available upon request.

V. Synthesis of Findings

This rapid review presents the results of the findings in the following ways:
*   A summary of the literature findings, quality assessment and significance (Appendix I)
*   A synthesis of the results by the outcome measures selected for the PICO (Appendix J)

1. Summary of findings by intervention type, and significance

Findings are presented by intervention type and comment is provided on their significance in regards to outcome measures (Appendix I). Clarification is provided regarding which research papers talked about each intervention. Furthermore, the main findings of each intervention are separated by author. These findings, and how they are presented, will help to formulate some recommendations at the end of the rapid review and to identify what strategies are most effective for each intervention.

2. Summary of results of interventions by outcome measures

With the six systematic reviews presented in this report, there were a number of outcome measures identified throughout. Findings were summarized based on the outcomes that were most relevant to this program review (highlighted in the PICO question at the start of this review and organized into primary and secondary outcomes based on what they actually measure) (Appendix J). In Appendix J, Table 1 presents primary outcomes in regards to STI rates. Table 2 examines the following secondary outcomes: sexual behaviour, sexual health knowledge, condom use, self-efficacy, and attitudes. This information will be valuable in the future because these outcome measures can be used to meet similar measures identified in the planning process of a new or re-evaluated program.

VI. Preliminary Program Recommendation

The research evidence demonstrates that there are a multitude of effective interventions available to public health professionals to reduce the incidence of STI rates in the community. There is also evidence to suggest that there are a variety of strategies which may influence sexual health behaviour, sexual health knowledge, condom use, sexual health self-efficacy and attitudes in youth. The key findings from this rapid review of the literature include:

- Facilitator-led interventions (e.g., public health professional, teacher) demonstrate a reduced incidence in sexually transmitted infections (STIs) through the use of behavioural interventions.
- Facilitator-led interventions also show improvement in behavioural outcomes and increased knowledge, specifically with regards to an increase in condom use.
- Social media and text messaging interventions are effective in increasing STI knowledge, particularly with respect to increased familiarity with sexual protection methods and how they reduce the transmission of STIs. There is a positive significant effect in condom use self-efficacy and a reduction in the proportion of individuals reporting multiple or new partners.
- Employing a train-the-trainer method demonstrates some effect in the reduction of the incidence of active syphilis and the prevalence of gonorrhea.
- Utilizing a peer-led approach is effective in increasing youth sexual health knowledge for HIV/AIDS; changing knowledge for STIs and HIV/AIDS; increasing positive behaviour in regards to the use of condoms; improving prevention skills and youth sexual health knowledge and attitudes of STI prevention methods.
- Interactive-computer-based programs (ICBP) were reported to demonstrate statistically significant improvement in there outcomes however this was not demonstrated upon review of the confidence intervals.

It is recommended that Sexual Health team members consult with key stakeholders to further consider the above-mentioned key findings, by applying the following NCCMT tools: A Model for Evidence-Informed Decision-Making (Appendix F) and the Adaptability and Transferability Tool (Appendix G). This will facilitate the development of relevant final recommendations for sexual health programming.

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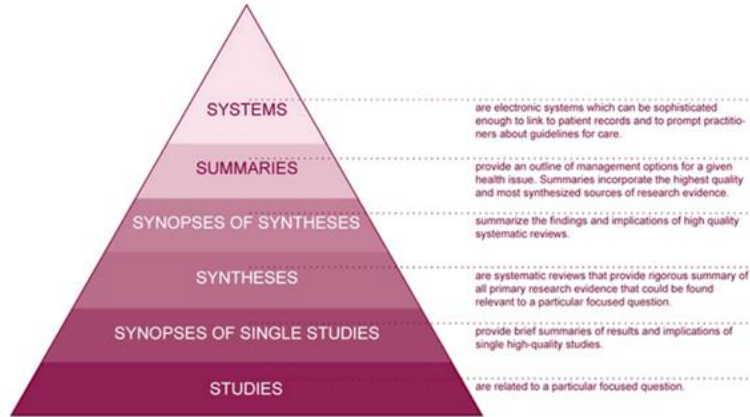# Appendix A: Public Health Requirements Associated with this Rapid Review

- **Provincial Standards -** Ontario Public Health Standards, 2008 (*OPHS*), specifically:
  - o Principles: Need, Impact, Impact, Capacity, Partnership and Collaboration
  - o Foundational Standard
  - o Sexual Health, Sexually Transmitted Infections, and Blood-borne Infections
  - o Infectious Diseases Prevention and Control
  - A **Provincial Protocol –** Population Health Assessment and Surveillance Protocol, 2008 (*PHASP*)

Governing Documents	Related Requirements
Provincial Legislation: Health Protection and Promotion Act, R.S.O. 1990, c.H.7. (*HPPA*)	Relevance is associated with the control of infectious diseases and reportable diseases, including the provision of immunization services. Included within **HPPA's mandatory health programs and services**: "2. Control of infectious diseases and reportable diseases, including provision of immunization services to children and adults." "3. Health promotion, health protection and disease and injury prevention, including the prevention and control of cardiovascular disease, cancer, AIDS and other diseases." Included within **HPPA's optional health programs and services:** "9. A board of health may provide any other health program or service in any area in the health unit served by the board of health if, a) the board of health is of the opinion that the health program or service is necessary or desirable, having regard to the needs of persons in the area;"
Provincial Standard: Ministry of Health and Long-Term Care Ontario Public Health Standards, 2008: *Principles*	"1.**Need**: The principle of need acknowledges the importance of using data and information to inform decision-making at the local level regarding program assessment, planning, delivery, management, and evaluation." "2.**Impact**: Boards of health shall assess, plan, deliver, and manage their programs and services by considering the following: -Is there reasonable evidence of the effectiveness of the intervention in the scientific literature or in reviews of best practices? Boards of health shall draw on relevant research, evidence, and best practices to support integration of the Ontario Public Health Standards' requirements within their specific context in order to achieve intended outcomes." "3.**Capacity**: Understanding local public health capacity and the resources required to achieve outcomes is essential for effective management of programs and services. All boards of health shall strive to achieve the needed capacity and resources required to meet these standards." "4. **Partnership and Collaboration**: Boards of health shall foster the creation of a supportive environment for health through community and citizen engagement in the assessment, planning, delivery, management, and evaluation of programs and services. This will support improved local capacity to meet the public health needs of the community."

Governing Documents	Related Requirements
Provincial Standard & Protocol: Ministry of Health and Long-Term Care Ontario Public Health Standards, 2008: ***Foundational Standard***	***Population Health Assessment Requirements*** "1. The board of health shall assess current health status, health behaviours, preventative health practices, health care utilization relevant to public health, and demographic indicators in accordance with the Population Health Assessment and Surveillance Protocol, 2008." "2. The board of health shall assess trends and changes in local population health in accordance with the Population Health Assessment and Surveillance Protocol, 2008." "3. The board of health shall use population health, determinants of health and health inequities information to assess the needs of the local population, including the identification of populations at risk, to determine those groups that would benefit most from public health programs and services (i.e. priority populations)." "4. The board of health shall tailor public health programs and services to meet local population health needs, including those of priority populations to the extent possible based on available resources." "5. The board of health shall provide population health information including determinants of health and health inequities to the public, community partners, and health care providers, in accordance with the Population Health Assessment and Surveillance Protocol, 2008." ***Research and Knowledge Exchange Requirements*** "8. The board of health shall engage in knowledge exchange activities with public health practitioners, policy-makers, community partners, health care providers, and the public regarding factors that determine the health of the population and support effective public health practice gained through population health assessment, surveillance, research, and program evaluation." "9. The board of health shall foster relationships with community researchers, academic partners, and other appropriate organizations to support public health research and knowledge exchange." "10. The board of health shall engage in public health research activities, which may include those conducted by the board of health alone or in partnership or collaboration with other organizations." ***Program Evaluation Requirements*** "11. The board of health shall routinely monitor program activities and outcomes to assess and improve the implementation and effectiveness of programs and services, including collection, analysis, and periodic reporting of indicators related to inputs, resources, implementation processes, reach, outputs, and outcomes." "12. The board of health shall conduct program evaluations when new interventions are developed or implemented, or when there is evidence of unexpected operational issues or program results, to understand the linkages between inputs, activities, outputs, and outcomes." "13. The board of health shall use a range of methods to facilitate public health practitioners' and policy-maker's awareness of the factors that contribute to program effectiveness."

Governing Documents	Related Requirements

Provincial Standard & Protocol:
 	
[Ministry of Health and Long-Term Care Ontario Public Health Standards, 2008: **_Sexual Health, Sexually Transmitted Infections, and Blood-borne Infections_**]
	Assessment and Surveillance Requirements
	
	"3. The board of health shall conduct epidemiological analysis of surveillance data, including monitoring trends over time, emerging trends, and priority populations, in accordance with the [Population Health Assessment and Surveillance Protocol], 2008."
	
	Health Promotion and Policy Development Requirements
	
	"4. The board of health shall increase public awareness of the epidemiology, associated risk behaviours, risk factors, and risk reduction strategies related to healthy sexuality, sexually transmitted infections, and blood-borne infections by:
	  a. Adapting and/or supplementing national and provincial health communication strategies; and/or
	  b. Developing and implementing regional/local communications strategies."
	
	"5. The board of health shall use a comprehensive health promotion approach to increase the community capacity regarding the promotion of healthy sexuality, including the prevention of adolescent pregnancies, sexually transmitted infections, and blood-borne infections, by:
	  a. Collaborating with and engaging community partners and priority populations;
	  b. Mobilizing and promoting access to community resources;
	  c. Providing skill-building opportunities; and
	  d. Sharing best practices and evidence."
	
	"6. The board of health shall collaborate with community partners, including school boards, to create supportive environments to promote healthy sexuality and access to sexual health services."

Provincial Standard & Protocol: [Ministry of Health and Long-Term Care Ontario Public Health Standards, 2008:] **_Infectious Diseases Prevention and Control_**	**_Assessment and Surveillance Requirements_** "3. The board of health shall conduct epidemiological analysis of surveillance data, including monitoring trends over time, emerging trends, and priority populations, in accordance with the [Population Health Assessment and Surveillance Protocol], 2008." _Disease Prevention Requirements_ _"12. The board of health shall supplement provincial efforts in managing risk communications to the appropriate stakeholders on identified risks associated with infectious diseases of public health importance based on local epidemiology and epidemiological information."_

Appendix B: NCCMT: Methods for Efficiently Searching Research Evidence

6S Pyramid 1

Appendix C: Search Strategy

Date of Search	Source of Search	Search Terms	# of Results
March 2, 2015	Medline	1 adolescent/ or young adult/	1813852
		2 (adolesc$ or young adult$ or youth$ or teen$ or ((university or college? or post secondary) adj1 student$)).tw.	287893
		3 or/1-2 [POPULATION]	1904614
		4 exp health promotion/ or exp health education/ or "marketing of health services"/ or social marketing/ or sex education/ or computer communication networks/ or exp internet/ or communications media/ or exp mass media/ or exp telecommunications/ or risk reduction behavior/	336126
		5 (health promotion or strateg$ or social marketing or communic$ or outreach or social media or "web2.0" or "web 2.0" or facebook or twitter or myspace or SMS or blog* or vlog* or tumblr or flickr or vine or pinterest or youtube or social bookmark* or text messag$ or iphone? or ipad? or laptop? or smartphone? or smart phone? or risk reduction or policy or policies or education or community development or advocacy or prevention or intervention$).tw.	1924803
		6 4 or 5 [INTERVENTION]	2128254
		7 exp chlamydia infections/ or exp gonorrhea/ or exp syphilis/ or exp sexually transmitted diseases/ed, pc, tm	114026
		8 (chlamydia$ or gonorrhea or syphilis or (sexual$ adj1 transm$ adj2 (diseas$ or infection$))).tw.	61513
		9 7 or 8 [STI]	139728
		10 (search$ or systematic review or medline).tw. or meta-analyis.mp,pt. or cochrane database of systematic reviews.jn.	289946
		11 3 and 6 and 9 and 10	272
		12 developing countries/ or exp "africa south of the sahara"/	197345
		13 11 not 12	231
		14 limit 13 to yr=2010-current	124
		15 limit 14 to English	119

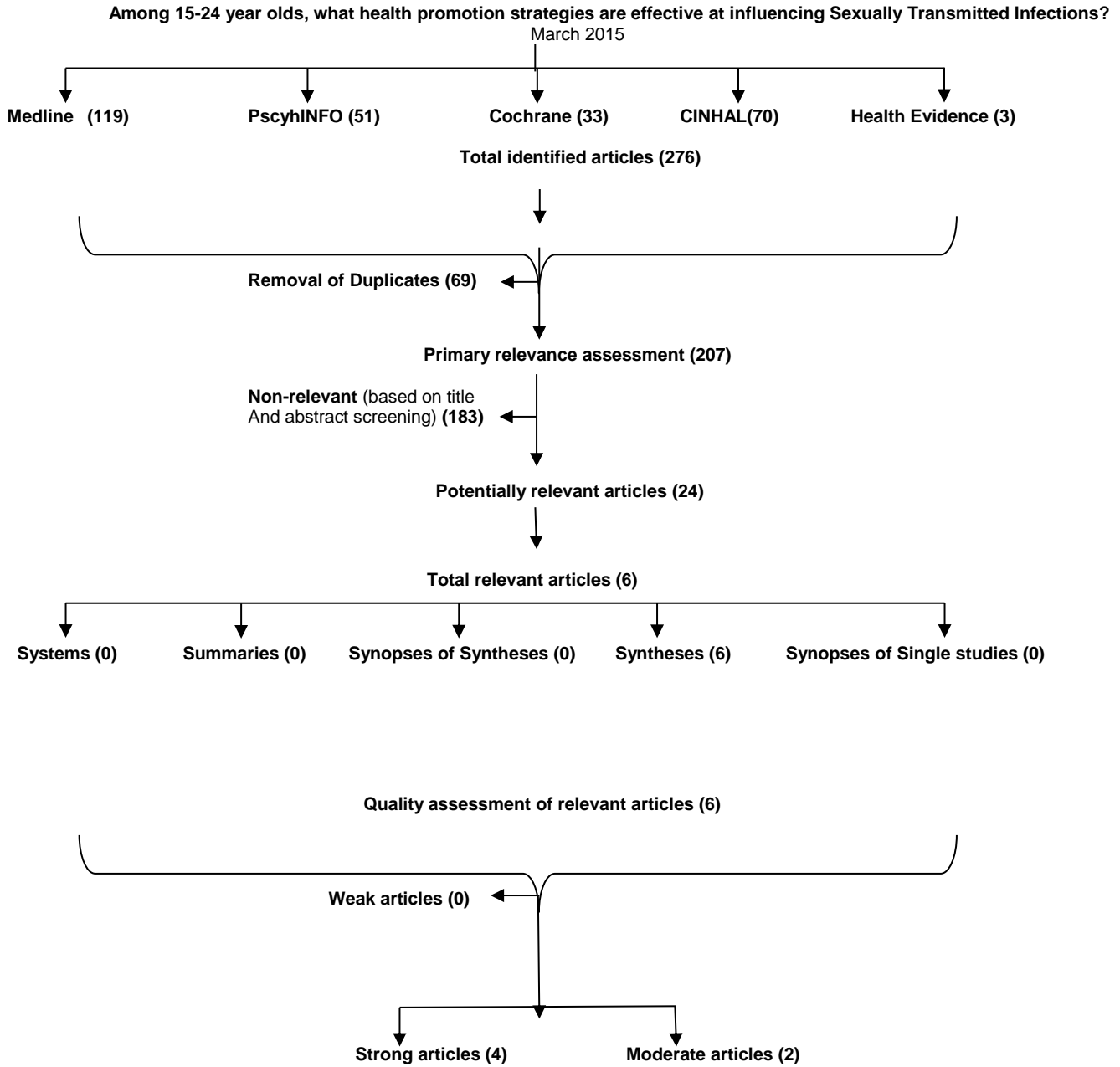| Date of Search	Source of Search	Search Terms	# of Results
March 2, 2015	PsycINFO	1 exp health promotion/ or exp health education/ or exp risk management/ or exp sexual risk taking/ or exp social marketing/ or exp sex education/ or exp intervention/	83891
		2 (health promotion or strateg$ or social marketing or communic$ or outreach or social media or "web2.0" or "web 2.0" or facebook or twitter or myspace or SMS or blog* or vlog* or tumblr or flickr or vine or pinterest or youtube or social bookmark* or text messag$ or iphone? or ipad? or laptop? or smartphone? or smart phone? or risk reduction or policy or policies or education or community development or advocacy or prevention or intervention$).tw.	590158
		3 1 or 2 [INTERVENTION]	596688
		4 exp sexually transmitted diseases/ or exp gonorrhea/ or exp syphilis/	23108
		5 (chlamydia$ or gonorrhea or syphilis or (sexual$ adj1 transm$ adj2 (diseas$ or infection$))).tw.	5239
		6 4 or 5 [STI]	24878
		7 meta analysis/ or "literature review"/	1593
		8 (meta analy$ or search$ or systematic review? or medline).tw.	

Date of Search	Source of Search	Search Terms	# of Results
			63858
		9 7 or 8 [SR]	64108
		10 (college student* or post secondary student* or university student* or young adult* or adolescen* or teen* or youth*).tw.	180774
		11 exp college students/	31593
		12 10 or 11 [POPULATION]	192849
		13 3 and 6 and 9 and 12	93
		14 exp developing countries/	3185
		15 13 not 14	91
		16 (dissertation or journal article).dt.	1495137
		17 15 and 16	82
		18 limit 17 to (English and yr=2000-current)	51

Date of Search	Source of Search	Search Terms	# of Results
March 2, 2015	Cochrane Database	1 (chlamydia* or gonorrhea or syphilis or (sexual* N11 transm* N2 (diseas* or infection*)))	61
		2 (ZU "sexually transmitted disease") or (ZU "sexually transmitted diseases epidemiology") or (ZU "sexually transmitted diseases prevention & control") or (ZU "sexually transmitted diseases transmission") or (ZU "gonorrhea epidemiology") or (ZU "gonorrhea prevention & control") or (ZU "gonorrhea control") or (ZU "syphilis transmission") or (ZU "syphilis, congenital prevention & control")	17
		3 S1 OR S2	61
		4 ("health promotion" or strateg* or "social marketing" or communic* or outreach or "social media" or "web2.0" or "web 2.0" or facebook or twitter or myspace or SMS or blog* or vlog* or tumblr or flickr or vine or pinterest or youtube or "social bookmark*" or "text messag*" or iphone# or ipad# or laptop# or smartphone# or "smart phone#" or "risk reduction" or policy or policies or education or "community development" or advocacy or prevention or intervention*)	5212
		5 (ZU "health promotion") or (ZU "health promotion methods") or (ZU "health promotion organization & administration") or (ZU "health education") or (ZU "health education methods") or (ZU "communication") or (ZU "social marketing") or (ZU "intervention") or (ZU "intervention studies") or (ZU "interventions") or (ZU "policy making")	182
		6 S4 OR S5	5261
		7 S3 AND S6	33

Date of Search	Source of Search	Search Terms	# of Results
March 2, 2015	CINAHL	1 (chlamydia* or gonorrhea or syphilis or (sexual* N11 transm* N2 (diseas* or infection*)))	12872
		2 (MH "Sexually Transmitted Diseases+/ED/PC/TM")	19526
		3 (MH "Chlamydia") OR (MH "Chlamydia Infections") OR (MH "Gonorrhea") OR (MH "Syphilis")	4039
		4 S1 OR S2 OR S3	27423
		5 (MH "Health Promotion+") OR (MH "Health Education+") OR (MH "Social Marketing") OR (MH "Social Media") OR (MH "Sex Education") OR (MH "Computer Communication Networks") OR (MH "Telecommunications+") OR (MH "Communications Media")	217348

Date of Search	Source of Search	Search Terms	# of Results
		OR (MH "World Wide Web+") OR (MH "Internet")	
		6 ("health promotion" or strateg* or "social marketing" or communic* or outreach or "social media" or "web2.0" or "web 2.0" or facebook or twitter or myspace or SMS or blog* or vlog* or tumblr or flickr or vine or pinterest or youtube or "social bookmark*" or "text messag*" or iphone# or ipad# or laptop# or smartphone# or "smart phone#" or "risk reduction" or policy or policies or education or "community development" or advocacy or prevention or intervention*)	955365
		7 S5 OR S6	1021897
		8 (MH "Adolescence") OR (MH "Young Adult") OR (MH "Students, College") OR (MH "Students, Undergraduate")	249785
		9 (adolescen* or "young adult*" or youth* or teen* or ((university or college# or "post secondary") N1 student*))	259738
		10 S8 OR S9	260603
		11 (MH "Systematic Review") OR (MH "Literature Review") OR (MH "Meta Analysis")	34736
		12 TI (search or "systematic review" or medline or "meta analy*" or "meta-analy*" or metaanaly*) OR AB(search or "systematic review" or medline or "meta analy*" or "meta-analy*" or metaanaly*)	55282
		13 PT systematic review or meta analysis	37416
		14 S11 OR S12 OR S13	74783
		15 S4 AND S7 AND S10 AND S14	70

Appendix D: Final Search Results

Among 15-24 year olds, what health promotion strategies are effective at influencing Sexually Transmitted Infections?
March 2015

Medline (119)   **PscyhINFO (51)**   **Cochrane (33)**   **CINHAL(70)**   **Health Evidence (3)**

Total identified articles (276)

Removal of Duplicates (69)

Primary relevance assessment (207)

Non-relevant (based on title And abstract screening) **(183)**

Potentially relevant articles (24)

Total relevant articles (6)

Systems (0)   **Summaries (0)**   **Synopses of Syntheses (0)**   **Syntheses (6)**   **Synopses of Single studies (0)**

Quality assessment of relevant articles (6)

Weak articles (0)

Strong articles (4)   **Moderate articles (2)**

Source: Health Evidence.org. *Keeping Track of Search Results: A Flowchart.* [Retrieved March 10, 2015]

Appendix E: Quality Assessment Tool for Systematic Reviews: AMSTAR

1. Was an 'a priori' design provided? The research question and inclusion criteria should be established before the conduct of the review.

Note: Need to refer to a protocol, ethics approval, or pre-determined/a priori published research objectives to score a "yes."

- □ Yes
- □ No
- □ Can't Answer
- □ Not Applicable

2. Was there duplicate study selection and data extraction? There should be at least two independent data extractors and a consensus procedure for disagreements should be in place.

Note: 2 people do study selection, 2 people do data extraction, consensus process or one person checks the other's work.

- □ Yes
- □ No
- □ Can't Answer
- □ Not Applicable

3. Was a comprehensive literature search performed?

At least two electronic sources should be searched. The report must include years and databases used (e.g., Central, EMBASE, and MEDLINE). Key words and/or MESH terms must be stated and where feasible the search strategy should be provided. All searches should be supplemented by consulting current contents, reviews, textbooks, specialized registers, or experts in the particular field of study, and by reviewing the references in the studies found. Note: If at least 2 sources + one supplementary strategy used, select "yes" (Cochrane register/Central counts as 2 sources; a grey literature search counts as supplementary).

- □ Yes
- □ No
- □ Can't Answer
- □ Not Applicable

4. Was the status of publication (i.e. grey literature) used as an inclusion criterion?

The authors should state that they searched for reports regardless of their publication type. The authors should state whether or not they excluded any reports (from the systematic review), based on their publication status, language etc. Note: If review indicates that there was a search for "grey literature" or "unpublished literature," indicate "yes." SIGLE database, dissertations, conference proceedings, and trial registries are all considered grey for this purpose. If searching a source that contains both grey and non-grey, must specify that they were searching for grey/unpublished lit.

- □ Yes
- □ No
- □ Can't Answer
- □ Not Applicable

5. Was a list of studies (included and excluded) provided?

A list of included and excluded studies should be provided. Note: Acceptable if the excluded studies are referenced. If there is an electronic link to the list but the link is dead, select "no."

- □ Yes
- □ No
- □ Can't Answer
- □ Not Applicable

6. Were the characteristics of the included studies provided?

In an aggregated form such as a table, data from the original studies should be provided on the participants, interventions and outcomes. The ranges of characteristics in all the studies analyzed e.g., age, race, sex, relevant socioeconomic data, disease status, duration, severity, or other diseases should be reported. Note: Acceptable if not in table format as long as they are described as above.

- □ Yes
- □ No
- □ Can't Answer
- □ Not Applicable

7. Was the scientific quality of the included studies assessed and documented?

'A priori' methods of assessment should be provided (e.g., for effectiveness studies if the author(s) chose to include only randomized, double-blind, placebo controlled studies, or allocation concealment as inclusion criteria); for other types of studies alternative items will be relevant. Note: Can include use of a quality scoring tool or checklist, e.g., Jadad scale, risk of bias, sensitivity analysis, etc., or a description of quality items, with some kind of result for EACH study ("low" or "high" is fine, as long as it is clear which studies scored "low" and which scored "high"; a summary score/range for all studies is not acceptable).

- □ Yes
- □ No
- □ Can't Answer
- □ Not Applicable

8. Was the scientific quality of the included studies used appropriately in formulating conclusions?

The results of the methodological rigor and scientific quality should be considered in the analysis and the conclusions of the review, and explicitly stated in formulating recommendations. Note: Might say something such as "the results should be interpreted with caution due to poor quality of included studies." Cannot score "yes" for this question if scored "no" for question 7.

□ Yes
□ No
□ Can't Answer
□ Not Applicable

9. Were the methods used to combine the findings of studies appropriate?

For the pooled results, a test should be done to ensure the studies were combinable, to assess their homogeneity (i.e., Chi-squared test for homogeneity, $I2$). If heterogeneity exists a random effects model should be used and/or the clinical appropriateness of combining should be taken into consideration (i.e., is it sensible to combine?). Note: Indicate "yes" if they mention or describe heterogeneity, i.e., if they explain that they cannot pool because of heterogeneity/variability between interventions.

□ Yes
□ No
□ Can't Answer
□ Not Applicable

10. Was the likelihood of publication bias assessed?

An assessment of publication bias should include a combination of graphical aids (e.g., funnel plot, other available tests) and/or statistical tests (e.g., Egger regression test, Hedges-Olken). Note: If no test values or funnel plot included, score "no". Score "yes" if mentions that publication bias could not be assessed because there were fewer than 10 included studies.

□ Yes
□ No
□ Can't Answer
□ Not Applicable

11. Was the conflict of interest included?

Potential sources of support should be clearly acknowledged in both the systematic review and the included studies. Note: To get a "yes," must indicate source of funding or support for the systematic review AND for each of the included studies.

□ Yes
□ No
□ Can't Answer
□ Not Applicable

Appendix F: NCCMT: A Model for Evidence-Informed Decision-Making

fact sheet

National Collaborating Centre for Methods and Tools

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A Model for Evidence-Informed Decision Making in Public Health

Evidence-informed decision making involves integrating the best available research evidence into the decision-making process. Additional factors – community health issues and local context; community and political preferences and actions; and public health resources – create the environment in which that research evidence is interpreted and applied.

This model for evidence-informed decision making in public health is particularly relevant at the fifth step of evidence-informed public health: Adapt the information to a local context. (see diagram on reverse)

This model recognizes that important evidence can come from a variety of sources. Evidence considered in the decision-making process could include the following possible examples:

Sources of Evidence	Examples of Evidence for Consideration
Evidence from research	The most relevant, high-quality qualitative or quantitative evidence available
	Research findings from a variety of disciplines and sectors relevant to public health
Evidence about the frequency, causes, and modifying factors of local community health issues	Surveillance data and community health status reports to determine the magnitude of the health issue in the local setting
	Significance and importance of the issue in comparison to other community health concerns
Evidence from people about community and political preferences and actions	Needs and interests of community members
	Support or opposition from the public and/or government officials
	Current political climate (local, regional, provincial, federal)
	Current organizational/corporate climate
Evidence from various governments and programs about public health resources	Financial resources
	Human resources (personnel/staffing, administrative support, support from management)
	Materials (workspace, computers, supplies)

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No two public health situations are identical. The weight and influence that each factor will have on the decision-making process will depend upon the specific circumstances, as well as the skills and values held by the individuals and groups involved in the process. The placement of Public Health Expertise at the centre of the model is intentional. Ultimately, decision makers must draw on their explicit and tacit public health knowledge and expertise to incorporate all the relevant factors into the final decision, conclusion or recommendation.

Faced with a lack of time, limited access to peer-reviewed journals, inadequate critical appraisal skills and conflicting evidence, public health professionals may not always use high quality, relevant research to inform their public health program and policy decisions. Sources of synthesized and methodologically strong research evidence can overcome some of these barriers. These sources save time and increase confidence in the value of the research findings. Evidence may include quantitative and qualitative research findings from a variety of disciplines relevant to public health (for example, epidemiology, allied health, social sciences and education). However the *best* research evidence available will be different for each public health situation.

Evidence-informed decision making in public health offers several potential benefits:

- adoption of the most effective and cost-efficient interventions;
- prudent use of scarce resources;
- better health outcomes for individuals and communities.

The NCCMT has developed a resource to help public health practitioners implement this model of evidence-informed decision making whether considering starting a new program or stopping an existing program : It worked there. Will it work here? Tool for Assessing Applicability and Transferability of Evidence. Two versions of the tool are available on the NCCMT website: A. When considering starting a new program. [http://www.nccmt.ca/pubs/A&Trevised-startEN.pdf] and B. When considering stopping an existing program. [http://www.nccmt.ca/pubs/A&Trevised-stopEN.pdf].

For more resources and information on evidence-informed decision making in public health, visit our website: www.nccmt.ca.
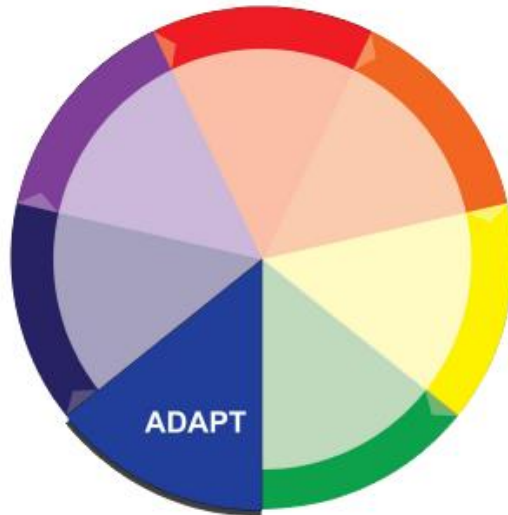
ADAPT

General References:

Ciliska, D., Thomas, H., & Buffett, C. (2010). *An introduction to evidence-informed public health and a compendium of critical appraisal tools for public health practice* (Revised). Retrieved from the National Collaborating Centre for Methods and Tools: http://www.nccmt.ca/pubs/IntroEIPH_compendiumENG_web.pdf

DiCenso, A., Ciliska, D., & Guyatt, G. (2005). Introduction to evidence-based nursing. In A. DiCenso, D. Ciliska, & G. Guyatt (Eds.), *Evidence-based nursing: A guide to clinical practice* (pp. 3-19). St. Louis, MO: Elsevier Mosby.

How to cite this resource :

National Collaborating Centre for Methods and Tools. (2012). *A Model for Evidence-Informed Decision-Making in Public Health.* [fact sheet]. Retrieved from http://www.nccmt.ca/pubs/FactSheet_EIDM_EN_WEB.pdf.

Appendix G: NCCMT: Applicability and Transferability Tool

It worked there. Will it work here?
a *tool* for assessing Applicability and Transferability of Evidence

A: When considering **starting a new program**

Purpose and target audience

To help public health managers and planners use evidence to choose appropriate programs for their community.

Where does this fit?

This tool helps you with the fifth step in the evidence-informed public health process: **Adapt** the information to a local context.

You may have found evidence about an intervention that worked, but can you apply that evidence to your situation? Do you need to adapt the intervention for your population? ... your community? ... your team?

This tool gives you a process and criteria to assess the applicability (feasibility) and transferability (generalizability) of evidence to public health practice and policy.

How to use this tool

At this stage, you will have already completed the first four steps in the evidence-informed public health process. You have defined your question (step 1), found (step 2) and appraised (step 3) the research evidence relevant to your question. You have also formed some recommendations based on the evidence that you found (step 4). (*See www.nccmt.ca/eiph for more information.*)These are all necessary steps, but you are not yet ready to decide whether to introduce, continue, or end a program or intervention in **your** local community.
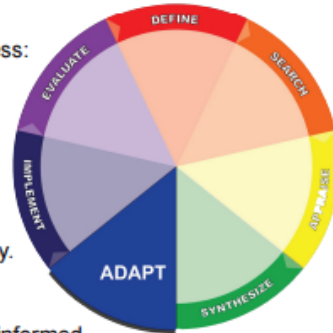
1. Decide who will be involved in the decision. Consider including partners from other sectors, disciplines and client groups. (*The remaining steps are done in collaboration with this entire group.*)

2. Orient group members to the process; establish time lines.

3. From the following list of criteria, choose the most important applicability and transferability assessment questions for the intervention of interest and the local context. Are these criteria equally important or should they be weighted differently? If so, choose what weights to assign. Not all criteria are relevant all the time. The group may decide that some criteria are more important than others at a particular time period and in a particular community.

4. Decide how final scoring will be done: Will you discuss each criterion to achieve consensus or add ratings from all group members ? In that case, you would individually rate the importance/relevance of each question on a scale of 1 to 5, where 1 is low and 5 is high. Priority would then go to the highest scoring program.

5. Be sure to document the scoring process used.

How to cite this resource

Buffet, C., Ciliska, D., & Thomas, H. (2011). It worked there. Will it work here? Tool for Assessing *Applicability and Transferability of Evidence (A: When considering starting a new program)*. Hamilton, ON: National Collaborating Centre for Methods and Tools.

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Assessment of Applicability & Transferability

Construct	Things to consider	Questions to Ask
Applicability *(feasibility)* **Can the intervention we found work for us?**	Political acceptability or influence	• Will the intervention be allowed or supported in the current political climate? • Is there a potential public relations benefit for local government? • Will the public and target groups accept and support the intervention in its current format? • Is this intervention allowed/expected or required by local or provincial legislation /bylaws?
	Social acceptability	• Will my target population be interested in the intervention? • Is the intervention ethical?
	Available essential resources (human and financial)	• Who / what is essential for the local implementation? • Who will do the work? Are these people available (or are they too busy with other projects)? Do they know how? If not, is training available (and affordable)? • How much will the intervention cost? Can we afford to deliver the program (or is our budget already committed to other projects)? • How do we need to change the intervention to suit our local situation? • What are the full costs (include supplies, systems, space requirements for staff, training, technology/administrative supports, etc.)? How much will this intervention cost per unit of expected outcome? (total cost divided by number of people we expect to help) • Are there any other incremental health benefits to consider that could offset the costs of the intervention?
	Organizational expertise and capacity	• Does the intervention fit into the organization's current strategic and operational plans? • Does the intervention fit with the organization's mission and local priorities? • Does the intervention overlap, or will it compliment, existing programs? • Will this program enhance the reputation of the organization? • What barriers/structural issues or approval processes within the organization need to be addressed? • Is the organization motivated and open to new ideas? Is it a learning organization?
Transferability *(generalizability)* **Can we expect similar results?**	Magnitude of health issue in local setting	• Does the need exist? • How many people in my local population does this issue affect now? (i.e., what is our baseline prevalence?) How does this compare to the prevalence of the issue (risk status) described in the intervention we are considering?
	Magnitude of the "reach" and cost effectiveness of the intervention	• Will the intervention effectively reach a large proportion of the target population?
	Characteristics of target population	• Is the local population comparable to the study population? • Will any differences in characteristics (ethnicity, socio-demographic variables, number of persons affected) influence the effectiveness of the intervention locally?

The National Collaborating Centre for Methods and Tools is affiliated with McMaster University and funded by the Public Heath Agency of Canada

2

It worked there. Will it work here?
a *tool* for assessing Applicability and Transferability of Evidence

B: When considering **stopping an existing program**

Purpose and target audience

To help public health managers and planners use evidence to stop doing a program when there is evidence that the program or intervention may not be effective.

Where does this fit?

This tool helps you with the fifth step in the evidence-informed public health process: **Adapt** the information to a local context.

You may have found evidence of low or no effect about an intervention that you currently do, but can you apply that evidence to your situation? What would ending that intervention mean for your population? ... your community? ... your team?

This tool gives you a process and criteria to assess the applicability (feasibility) and transferability (generalizability) of evidence to public health practice and policy.
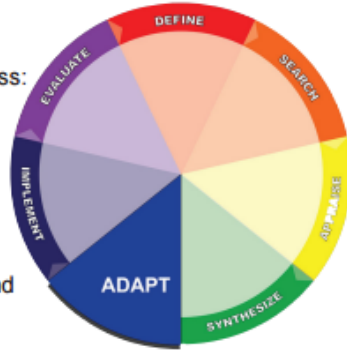
How to use this tool

At this stage, you will have already the first four steps in the evidence-informed public health process. You have defined your question (step 1), found (step 2) and appraised (step 3) the research evidence relevant to your question. You have also formed some recommendations based on the evidence that you found (step 4). (*See www.nccmt.ca/ eiph for more information.*) These are all necessary steps, but you are not yet ready to decide whether to introduce, continue, or end a program or intervention in your local community.

1. Decide who will be involved in the decision. Consider including partners from other sectors, disciplines and client groups. (*The remaining steps are done in collaboration with this entire group.*)

2. Orient group members to the process; establish time lines.

3. From the following list of criteria, choose the most important applicability and transferability assessment questions for the intervention of interest and the local context. Are these criteria equally important or should they be weighted differently? If so, choose what weights to assign. Not all criteria are relevant all the time. The group may decide that some criteria are more important than others at a particular time period and in a particular community.

4. Decide how final scoring will be done: Will you discuss each criterion to achieve consensus or add ratings from all group members ? In that case, you would individually rate the importance/relevance of each question on a scale of 1 to 5, where 1 is low and 5 is high. Priority would then go to the highest scoring program.

5. Be sure to document the scoring process used.

How to cite this resource

Buffet, C., Ciliska, D., & Thomas, H. (2011). It worked there. Will it work here? Tool for Assessing *Applicability and Transferability of Evidence (B: When considering stopping an existing program).* Hamilton, ON: National Collaborating Centre for Methods and Tools.

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Assessment of Applicability & Transferability

Construct	Things to consider	Questions to Ask
Applicability (feasibility) **Can the intervention we found work for us?**	Political acceptability or influence	• Will stopping the intervention be allowed or supported in current the political climate? • Is there a potential public relations benefit for local government to stopping this intervention if its lack of effectiveness became generally known? • Will the public and target groups accept and support the end of the program in its current format? • Is this intervention expected or required by local or provincial legislation /bylaws?
	Social acceptability	• Will my target population miss the intervention? • Is it ethical to stop the intervention?
	Available essential resources (human and financial)	• Who/what resources will be saved by stopping the program? • What are the financial and human costs of stopping the intervention? • What other options will be offered if this intervention/program is stopped? • How might people who are doing this project be redeployed?
	Organizational expertise and capacity	• Does the intervention fit into the organization's current strategic and operational plans? Will we miss an opportunity to support the strategic plans by taking away this program? • What steps will we need to take if we decide to stop this program? • What barriers/structural issues or approval processes within the organization need to be addressed? • How will using the evidence to stop the current program affect the reputation of the organization? • What is the emotional attachment of the staff to this program and how will we deal with that?
Transferability (generalizability) **Can we expect similar results?**	Magnitude of health issue in local setting	• Are there other (more effective) ways to achieve the same goals?
	Magnitude of the "reach" and cost effectiveness of the intervention	• Will we miss the opportunity to interact with a large proportion of the population if we stop doing this intervention?
	Characteristics of target population	• Is the local population comparable to the study population? • Will any differences in characteristics (ethnicity, socio-demographic variables, number of persons affected) influence the effectiveness of the intervention locally?

Appendix H: Blank Data Extraction Table

Title	
Author	
Publication Date	
Quality Rating (**AMSTAR Tool**)	

Factors	Assessment			Comments
Research question identified?	Yes	Unclear	No	
Population				
Are 15-24 year olds included?	Yes	Unclear	No	
Occur in developed countries?	Yes	Unclear	No	
Intervention				
Social Media campaign	Yes	Unclear	No	
Peer-to-peer program	Yes	Unclear	No	
Train-the-trainer program	Yes	Unclear	No	
Interactive computer-based program	Yes	Unclear	No	
Mass media campaign	Yes	Unclear	No	
Comparison				
Was a comparison included?	Yes	Unclear	No	
Outcome				
Primary — **Decrease in STI rates?**	Yes	Unclear	No	
Secondary — **Improved sexual behaviour?**	Yes	Unclear	No	
Increased knowledge?	Yes	Unclear	No	
Increased condom use?	Yes	Unclear	No	
Improved self-efficacy?	Yes	Unclear	No	
Improved attitudes?	Yes	Unclear	No	

Conclusion of the Literature	
Limitations of the Literature	
Additional Comments	

Appendix I: Summary of Findings by Primary Outcome Measure

Table 1: Primary Outcome Measure

Outcome Measured	Intervention Reference	Effectiveness on Outcome Measured	Comments
STI reduction	*Sadovszky et al.* *(2014)*	• Of the 6 studies in this systematic review that looked at biological evidence for STI reduction, all 6 found that the behavioural interventions introduced reduced the incidence of STIs (reported OR: 0.88; 1.72; 0.74)	• In 4 out of 8 studies, tailoring to gender or culture was found to be effective. • Skills training that included condom application, building assertiveness, enhancing self-efficacy or communicating with a partner was found to be effective in decreasing risky behaviour in 4 studies. (reported OR 0.63, 1.81) • Length of exposure, defined as either length of session or number of times the session was offered, was found to be effective in 3 studies as well. • Sessions with longer durations were more effective. • In terms of cost-efficiency, teacher-led interventions cost less than peer-led interventions. • In conclusion, *Sadovszky et al.* suggest that tailoring content based on ethnicity, gender and culture to reflect person and interpersonal skill building exercises and exposure to content as the most important components in obtaining the outcomes noted in the review.

Outcome Measured	Intervention Reference	Effectiveness on Outcome Measured	Comments

STI reduction	***Lopez et al.***
	
	 (2013)
		• Four trails in this systematic review assessed the incidence or prevalence of HIV and HSV-2
		    • The investigators did not find any statistically significant differences in HIV outcomes between the study groups.
		 • Three other trails in this review examined other STIs besides HIV
		    • 1/3 study found that the incidence rate of active syphilis (95% CI 0.35 to 0.96) was lower with the intervention group that had the STI program
		    • The same study above found the prevalence of gonorrhea was also lower for the intervention group (95% CI 0.11 to 0.70)
			• This STI program focused on the Behavioral Change Theory of Interventions and offered community monthly meetings that incorporated group and individual activities as well as educational videos and pamphlets for distribution.
			 • This program was comprised of 16 topics that included condom use, STI information and family planning.

Appendix J: Summary of Findings by Secondary Outcome Measure

Table 2: Secondary Outcome Measures

Outcome Measured	Intervention Reference	Effectiveness on Outcome Measured	Additional Comments
Sexual behaviour	*Sadovszky et al.* *(2014)*	• 4 out of 13 articles reported a decrease in the frequency of sexual intercourse (reported OR 1.2) • These 4 articles were also the articles that reported a statistically significant decrease in STI incidence rates. • 3 out of 13 articles saw a decrease in the average number of sexual partners	
	Picot et al. *(2012)*	• 2 out of 5 studies reported a statistically significant difference for the intervention group. • The participants were less likely to have initiated sexual intercourse compared to the control group • When a meta-analysis was done on 4 out of the 5 articles, the pooled odds ratio was 1.03 (95% CI 0.74-1.43), indicating no significant change overall • 6 studies looked at intervention effects on the number of sexual partners and found no significant difference between the intervention and comparison groups.	

Sexual behaviour	*Shepherd et al.*
	
	(2010)
		• 5 studies examined initiation of sexual intercourse as an outcome.
		  o Three of the five studies found that there was no significant difference between the intervention and comparison group in the initiation of sexual activity among those who were virgins at baseline.
		  o The other two studies did report a statistically significant difference between groups
		    ▪ These two studies found that	

Outcome Measured	Intervention Reference	Effectiveness on Outcome Measured	Additional Comments
		young people in the control group were nearly three times more likely to have initiated sexual activity than students in the intervention group. • Overall, the fixed-effect pooled odds ratio was 1.03 (95% CI 0.74 to 1.43), with no statistically significant difference.	
	Lazarus et al. *(2010)*	• 3 out of 10 studies reported a statistically significant improvement in behaviour change. • 2 out of the overall 13 school based interventions reported having any positive effect on behaviour.	• 2 out of 3 studies used peers as the implementers of the sexual health education program while the other study was delivered by a teacher. • Youth preferred interventions led by peers and health professionals.
Sexual health knowledge	*Sadovszky et al.* *(2014)*	• 4 out of 13 articles had an increase in STI/HIV knowledge.	
	Picot et al. *(2012)*	• All 12 studies attempted to measure participants' knowledge (the test for knowledge varied due to the focus of the educational components of each intervention). • 10 out of the 12 included studies reported that the intervention had a statistically significant effect on increasing knowledge.	
	Jones et al. *(2014)*	• 7 studies examined the effectiveness of social media or text interventions on STI knowledge. • All 7 studies demonstrated significant increases in STI knowledge, particularly an increase in the understanding of sexual protection methods and transmission.	• It was noted that the highest level of knowledge increase was around the understanding of sexual protection methods and transmission.

Outcome Measured	Intervention Reference	Effectiveness on Outcome Measured	Additional Comments
Sexual health knowledge	*Shepherd et al.* *(2010)*	• 10 of the 12 included studies reported that the intervention group had a statistically significant effect on increasing knowledge. • Only 2 studies did not demonstrate a statistically significant difference in knowledge between young people in the intervention and comparison groups.	
	Lazarus et al. *(2010)*	• 11 out of 19 studies reported improvements in the sexual knowledge of the participants. Most of the peer-led interventions and teacher-led interventions improved participants' sexual health knowledge and attitudes.	• Most of the peer-led interventions and teacher-led interventions improved participants' sexual health knowledge and attitudes
Condom Use	*Sadovszky et al.* (2014)	• 11 out of 13 reviews examined condom use • They concluded that condom use is a positive health outcome of behavioural interventions to promote safer sex and reduce sexual risk behaviours.	• A major strength of their findings is that behavioral interventions were found to be effective in a wide variety of populations even when there was variation in the way the interventions were implemented.
	Picot et al. (2012)	• 11 out of 12 studies contributed information on condom use. • Statistically significant effects in favour of the intervention group were only reported by two of the studies for the condom use in terms of condom used at last sex and frequency of condom use. • When data was available from 6 studies to be included in a meta-analysis, the fixed-effect pooled odds ratio was 1.07 (95% CI 0.889-1.30).	• Overall no statistically significant difference was found between the intervention group and the control.

	Jones et al. (2014)	• Overall, 6 studies examined interventions effects on condom use.
		  o 2 found statistically significant effects;
		  o 2 studies had mixed effects;
		  o 2 found no statistically effects at all
			• Overall no statistically significant difference was found between the intervention group and the control.

Outcome Measured	Intervention Reference	Effectiveness on Outcome Measured	Additional Comments
Condom Use	*Shepherd et al.* *(2010)*	• Reported on 14 out of 15 studies that had condom use as an outcome • Only 2 studies had statistically significant results for the intervention group versus the control • One study found that participants in the intervention group had an increase on the outcome of condom use at last sex (there was no statistically significant difference in condom use at first sex and frequency of condom use for this study). • The second article reported on a statistically significant reduction in unprotected sex, likely from an increase in frequency of condom use Otherwise, the remaining studies reported that there was no significant difference in condom use .	• Otherwise, the remaining studies reported that there was no significant difference in condom use outcomes between groups or did not report on the statistical difference. • Overall, the fixed-effect odds ratio was 1.07 (95% CI 0.88 to 1.30), with no overall statistical significance.
Self-efficacy	*Sadovszky et al.* *(2014)*	• 3 out of 13 articles reported an increase in self-efficacy in the intervention group compared to the control.	• Skills training, such as building assertiveness, enhancing self-efficacy, and communication techniques with a partner were all part of the sexual education given in these sessions.
	Picot et al. *(2012)*	• 8 out of 12 studies measured self-efficacy when paired with a skills component • The self-efficacy outcomes did not always correlate with the included skills component in each intervention o Two studies reported a statistically significant outcome on a single self-efficacy measure. o Four other studies found statistically significant results for a self-efficacy measure but it was restricted to a subgroup analysis of young women.	• The skills component varied with each intervention but included decision making, risk avoidance, condom use skills, sex refusal and communication.

Outcome Measured	Intervention Reference	Effectiveness on Outcome Measured	Additional Comments
	Jones et al. (2014)	4 studies that included participant self-efficacy and/or intentions - Two studies reported significant increases in condom use self-efficacy and intention - One study additionally reporting an increase in participant's self-efficacy for delaying engagement in risky sexual encounters. - Another study reported an increase in intentions to use condoms with 23% of the participants. - The last study looking at self-efficacy as an outcome reported no significant effects on intentions to use condoms.	
Attitudes	*Shepherd et al.* (2010)	8 studies that had an assessment of participants' attitudes among their outcomes. 6 investigated participants' attitudes towards risky sexual behaviour or sexual intercourse 2 specifically focused on attitudes towards waiting to have sex	A greater number of interventions that were assessed in relation to a control group, rather than those interventions assessed in comparison with standard sex education or to teacher-led interventions, found statistically significant effects.

Program Review – Sexual Health Clinic

MIDDLESEX-LONDON HEALTH UNIT

June 2015

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Table of Contents

Acknowledgements

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Appreciation is extended to Heather Lokko, Associate Director, OHCDSH Services and Dr. Gayane Hovhannisyan, Associate Medical Officer of Health for their support and guidance throughout the program review process.

Finally, the Evaluation team acknowledges the reviewers who dedicated time to review this report and provide feedback.

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Introduction

The Ontario Public Health Standards mandate that Sexual Health Services are offered by the Middlesex-London Health Unit. The Clinic team and the Sexual Health Promotion team comprise the Sexual Health Team; its goals are to 1) prevent or reduce the burden of sexually transmitted infections and blood-borne infections, and 2) promote healthy sexuality. Services and initiatives provided by both The Clinic team and the Sexual Health Promotion team work toward achieving these goals.

The Sexual Health Team initiated a program review process in August 2014, in an effort to validate current evidence-informed approaches, identify opportunities to enhance the use of evidence-informed strategies, and increase effectiveness and efficiency of services. The program review was guided by the principles of need, impact, capacity, and collaboration and partnerships (Ontario, 2008), and framed by the National Collaborating Centre on Methods and Tools (NCCMT) Model for Evidence-Informed Decision-Making in Public Health (NCCMT, 2010).

This report focuses on the review of the Sexual Health Clinic services only. Components of this review include:

- Recent trends in sexually transmitted infections and blood-borne infections (STI/BBI) in the Middlesex-London region
- Priority populations for sexual health services
- Environmental scan of comparable health units and local community organizations offering sexual health services
- Review of best practices for harm reduction services
- Survey with The Clinic Physicians
- Client satisfaction survey
- Sexual Health Clinic Literature Summary

I. Local and Provincial Sexually Transmitted Infections / Blood-borne Infections (STI/BBI) trends

The burden of sexually transmitted infections and blood-borne infections (STI/BBIs) in the Middlesex-London region provides the context in which The Clinic offers services. To that end, regional and provincial rates for STI/BBIs between 2009 and 2013 are included in this report.

Data Source

Rates were calculated using local and provincial disease counts retrieved from the integrated Public Health Information System (iPHIS). Disease counts were used for the numerator and population estimates/population projections were used for the denominator. Population estimates for the denominator were used to calculate the 2009 to 2012 rates. For the 2013 rate, population projections (for Middlesex-London and Ontario) were used for the denominator. Population projections are less precise than population estimates, and may over- or under- estimate the total population, therefore the 2013 rates should be interpreted with caution. Rate calculations are likely to change once the 2013 population estimates become available.

Chlamydia

Chlamydia was the most commonly reported STI in the Middlesex-London region with an average annual reported incidence rate of 307.4 infections per 100,000 between 2009 and 2013 (Figure 1.1). The rate of reported Chlamydia infections in Middlesex-London was significantly higher than the Ontario rate across the five-year period, although the gap between the two rates appears to narrow in 2013, due to a significant decrease in the local rate compared to the previous year. The difference between the local and provincial rates may be influenced by a number of factors. A large number of youth and young adults attend post-secondary institutions in Middlesex-London; STI rates are known to be higher in this age group. The difference may also be related to higher testing rates by local health care providers, including those at The Clinic, and therefore increased detection. It is also possible that Chlamydia rates in the Middlesex-London population are truly higher compared to Ontario as a whole.

For both males and females, rates of reported Chlamydia infections are highest in younger age groups (Figure 1.2). Between 2009 and 2013, the highest average annual reported incidence rate is observed among males and females

20-24 years of age (F: 2,266.1 per 100,000, M: 1,201.5 per 100,000). This is followed by the 15-19 year old age group for females (1,609.4 per 100,000) and the 25-29 year old age group for males (678.8 per 100,000).

Figure 1.1: Reported incidence rate of Chlamydia infections per 100,000, Middlesex-London and Ontario, 2009 to 2013

	2009	2010	2011	2012	2013
ML	290.1	303.1	323.5	337.9	282.3
ON	220.4	253.2	271.5	269.5	253.5
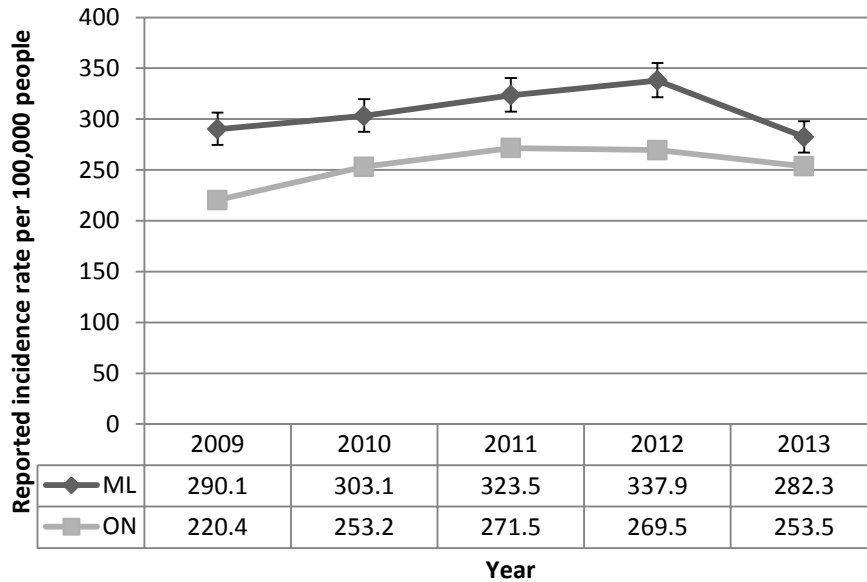
Source: Numerator: ML: MLHU iPHIS database, extracted November 13, 2014. ON: Ontario iPHIS database, extracted various dates. Denominator: ML and ON: Statistics Canada population estimates (2009-2012) and projections (2013), MOHLTC, IntelliHEALTH Ontario, extracted September 26, 2014.

Figure 1.2: Reported incidence rate of Chlamydia infections per 100,000, by age and sex, Middlesex-London, 2009 to 2013 annual average

	0-14	15-19	20-24	25-29	30-34	35-39	40-49	≥ 50
F	8.4	1,609.4	2,266.1	808.4	329.0	165.0	55.9	9.1
M	3.7	447.9	1,201.5	678.8	288.8	161.0	54.4	11.1
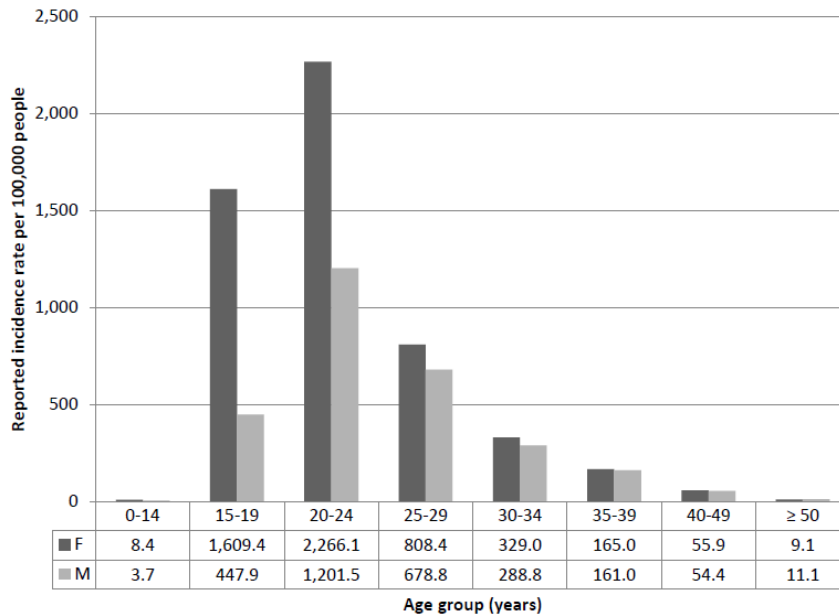
Source: Numerator: MLHU iPHIS database, extracted November 13, 2014. Denominator: Statistics Canada population estimates (2009-2012) and projections (2013), MOHLTC, intelliHEALTH Ontario extracted September 26, 2014.

Gonorrhea

Between 2009 and 2013, the average annual reported incidence rate in Middlesex-London was 29.8 cases per 100,000 (Figure 1.3). From 2011 to 2013, the annual reported incidence rate for the region was significantly lower than the annual rates in Ontario as a whole.

In Middlesex-London, the highest average annual reported incidence rate for Gonorrhea infections over the five-year time period was observed among those between the ages of 20-24, regardless of gender (Figure 1.4).Generally, the average annual reported incidence rate for males exceeded that of females in all age groups, with exception to the ≤19 and 20-24 year old age groups, where the rate for females exceed that of males.

Figure 1.3: Reported incidence rate of Gonorrhea infections per 100,000, Middlesex-London, 2009 to 2013 annual average

	2009	2010	2011	2012	2013
ML	46.5	39.0	23.9	22.9	17.5
ON	27.1	30.0	31.4	30.2	33.1
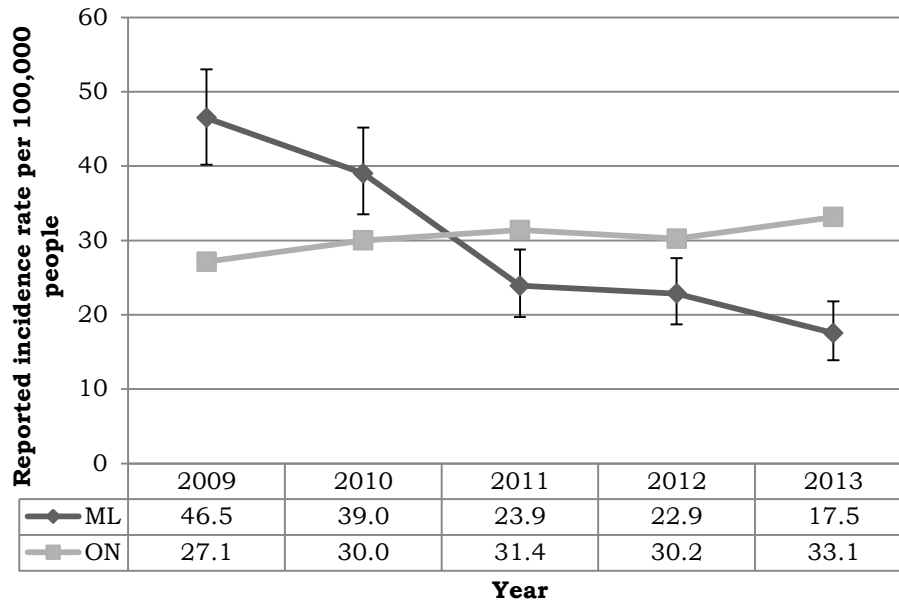
Source: Numerator: ML: MLHU iPHIS database, extracted November 13, 2014. ON: Ontario iPHIS database, extracted various dates. Denominator: ML and ON: Statistics Canada population estimates (2009-2012) and projections (2013), MOHLTC, intelliHEALTH Ontario, extracted September 26, 2014.

Figure.1.4: Reported incidence rate of Gonorrhea infections per 100,000, by age and sex, Middlesex-London, 2009 to 2013 annual average

|	0-19	20-24	25-29	30-34	35-39	≥ 40
■ F	38.3	147.1	52.8	30.7	16.1	3.6
■ M	11.3	119.9	79.6	37.7	45.6	14.2

Age group (years)
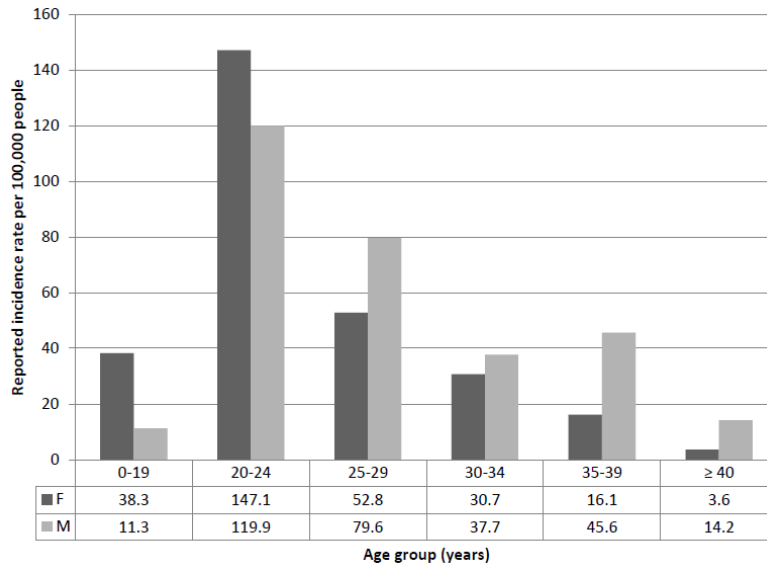
Source: Numerator: MLHU iPHIS database, extracted November 13, 2014. Denominator: Statistics Canada population estimates (2009-2012) and projections (2013), MOHLTC, intelliHEALTH Ontario, extracted September 26, 2014.

Acute Hepatitis B*

Nine cases of acute of Hepatitis B were reported in Middlesex-London between 2009 and 2013. The annual reported incidence rate of acute Hepatitis B infections was similar across the five year period (Figure 1.5). The annual reported incidence rate for acute Hepatitis B infections in Middlesex-London should be interpreted with caution due to small cell counts as there were less than five cases in each year between 2009 and 2013. There were no significant differences observed between the annual reported incidence rate of acute Hepatitis B infections in Middlesex-London and the annual reported incidence rate of acute Hepatitis B infections in the province.

During the five year period, the reported incidence rate of acute Hepatitis B infections was highest among those between the ages of 40 and 49 (1.5 per 100,000) (Figure 1.6). Gender-specific rates for Hepatitis B infections could not be calculated due to small number of cases reported across the five-year time period.

Figure 1.5: Reported incidence rate of acute Hepatitis B infections per 100,000 people, Middlesex-London and Ontario, 2009 to 2013
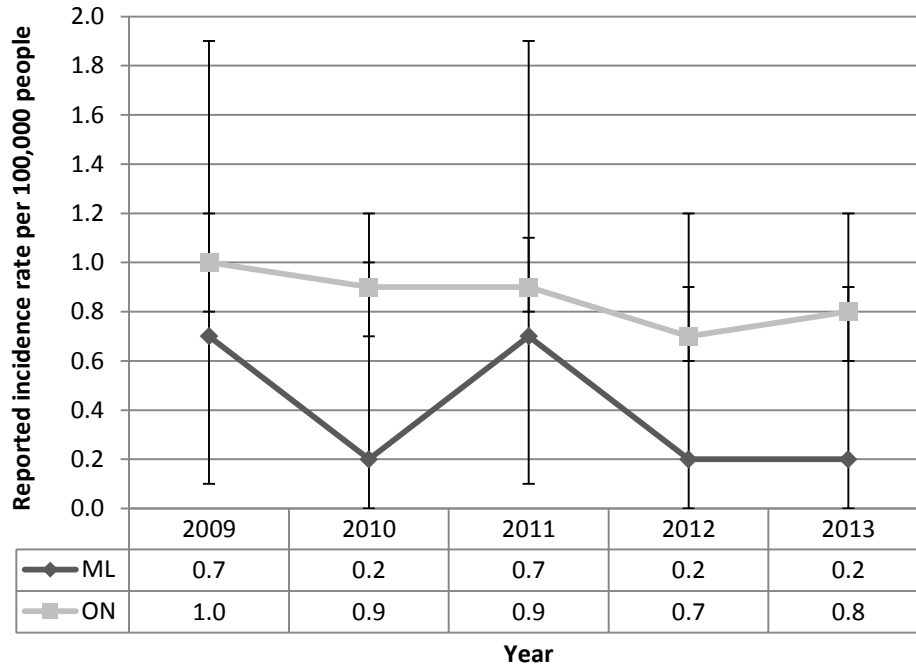
	2009	2010	2011	2012	2013
ML	0.7	0.2	0.7	0.2	0.2
ON	1.0	0.9	0.9	0.7	0.8

Year

Source: Numerator: Ontario Ministry of Health and Long-Term Care iPHIS database. Date extracted: November 11, 2015 Denominator: Population Estimates (2009-2013), Ontario Ministry of Health and Long-Term Care, IntelliHEALTH Ontario, Date Received: July 3, 2014.

Figure 1.6: Reported incidence rate of acute hepatitis B infections per 100,000 people, by age, Middlesex-London, 2009 to 2013 annual average
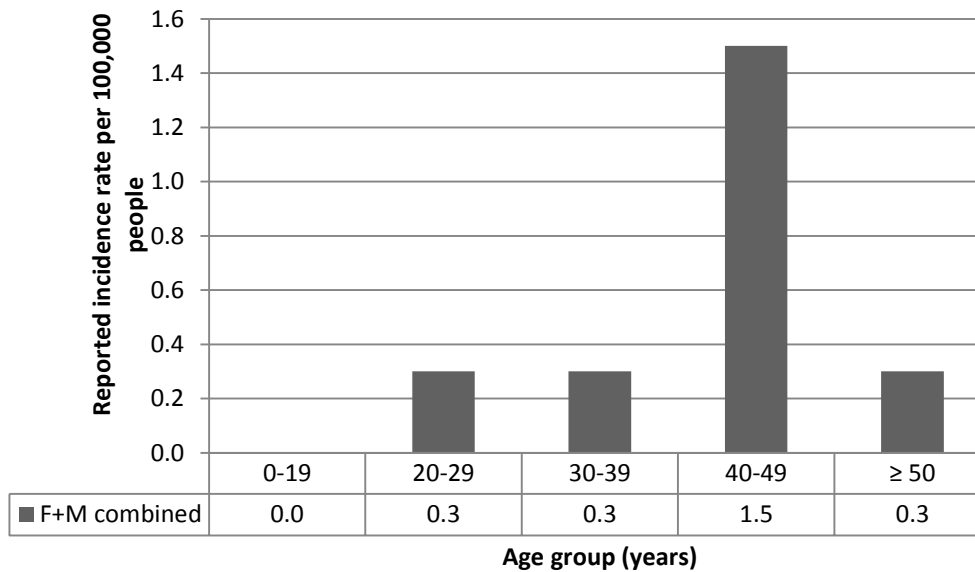
	0-19	20-29	30-39	40-49	≥ 50
F+M combined	0.0	0.3	0.3	1.5	0.3

Age group (years)

Source: Numerator: Ontario Ministry of Health and Long-Term Care iPHIS database. Date extracted: November 11, 2015 Denominator: Population Estimates (2009-2013), Ontario Ministry of Health and Long-Term Care, IntelliHEALTH Ontario, Date Received: July 3, 2014.

Hepatitis C (acute and chronic infections)

Over the five year period, the average annual reported incidence rate for Hepatitis C was 53.1 acute and chronic infections per 100,000 (Figure 1.7). The Middlesex-London rate for all Hepatitis C infections was significantly higher than the provincial rate each year between 2009 and 2013. The 2013 rate for Middlesex-London suggested a decline; however this decrease is not statistically significant compared to the local rate from the previous four years. The reasons for the Middlesex-London rate being significantly higher than the Ontario rate are not fully understood. There is an active community of people who use drugs, including injecting drugs, in London and the surrounding area. A national study that included local people who inject drugs showed that the prevalence of Hepatitis C among London participants (79.1%) was higher than the prevalence among study participants from across Canada (68.0%) (Middlesex-London Health Unit, 2013). Transmission among people who inject drugs may account for some of the difference, but there are likely other factors contributing to the higher rates of Hepatitis C infections in Middlesex-London compared to the province as a whole.

Between 2009 and 2013, the highest average annual reported incidence rate for Hepatitis C infections was among males between the ages of 30-34 (124.9 per 100,000), followed by the 25-29 year old age group (123.8 per 100,000) (Figure 1.8). For females, the highest average annual reported incidence rate for Hepatitis C infections as reported among those between the ages of 25-29 (123.8 per 100,000), followed by those between the ages of 20-24 (78.1 per 100,000). Generally, the average annual reported incidence rate for males exceeded that of females in all age groups, with exception to the ≤19 year old age group, where the rate for females exceed that of males.

Figure 1.7: Reported incidence rate of Hepatitis C infections (acute and chronic) per 100,000, Middlesex-London and Ontario, 2009 to 2013

	2009	2010	2011	2012	2013
ML	54.9	51.9	55.6	56.9	46.4
ON	33.7	34.0	30.5	30.3	30.1
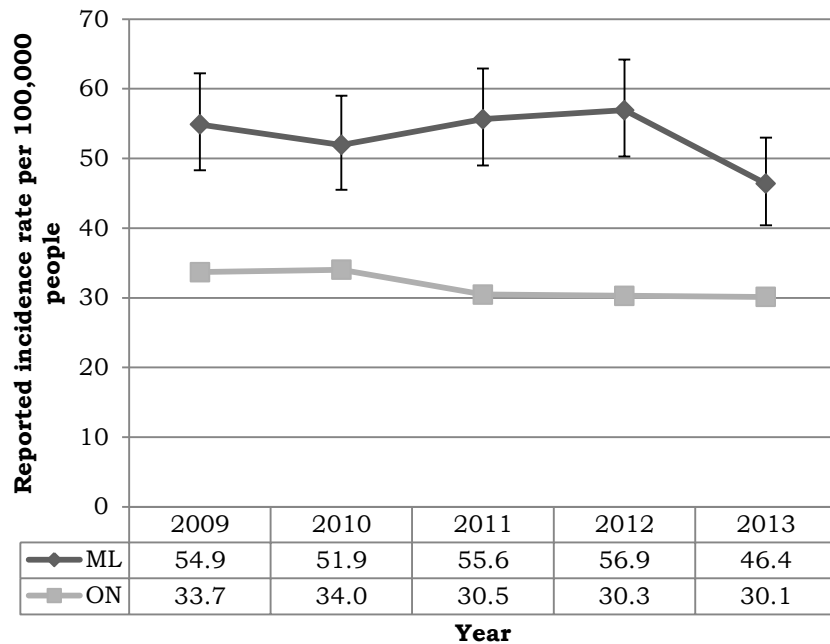
Source: Numerator: ML: MLHU iPHIS database, extracted December 17, 2014. ON: Ontario iPHIS database, extracted various dates. Denominator: ML and ON: Statistics Canada population estimates (2009-2012) and projections (2013), MOHLTC, intelliHEALTH Ontario, extracted September 26, 2014.

Figure 1.8: Reported incidence rate of Hepatitis C (acute and chronic) infections per 100,000, by age and sex, Middlesex-London, 2009 to 2013 annual average

Age group (years)	0-19	20-24	25-29	30-34	35-39	40-49	50-59	≥ 60
■ F	11.8	78.1	84.7	74.2	57.7	46.9	43.1	12.2
■ M	7.1	94.9	123.8	124.9	95.3	98.1	99.2	25.1
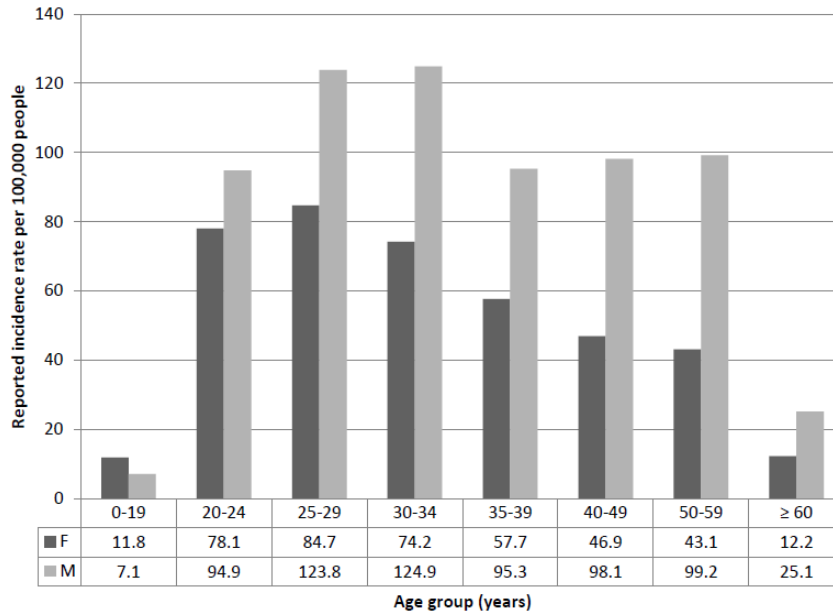
Source: Numerator: MLHU iPHIS database, extracted February 11, 2015. Denominator: Statistics Canada population estimates (2009-2012) and projections (2013), MOHLTC, intelliHEALTH Ontario, extracted September 26, 2014

Infectious Syphilis[1]

The annual reported incidence rate for infectious syphilis fluctuated between 2009 and 2013. Over this five year period, the average annual reported incidence rate was 4.8 cases per 100,000 (Figure 1.9). The only year where the Middlesex-London rate was significantly higher than the provincial rate was in 2011; in all other years, the local rate was significantly lower than, or similar to, the Ontario rate. A province wide syphilis outbreak in 2011 is a potential factor that contributed to this observed increase. Additionally, a targeted outreach campaign for syphilis implemented by the Health Unit in 2011 may have increased testing locally, resulting in an increased detection of cases.

Between 2009 and 2013, majority (91.8%) of infectious syphilis cases were reported among males (Figure 1.10). As a result, gender- and age-specific rates for infectious syphilis could not be calculated due to the small number of female cases reported in each age group. During the five year period, the reported incidence rate of infectious syphilis was highest among those between 20-24 years of age (14.4 per 100,000). This is followed by those between the ages of 25-29 and 30-34, where the average annual incidence rate was 11.0 infections per 100,000 for both age groups.

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[1] A number of stages are used to characterize syphilis infections; those that are classified as primary, secondary, and early latent infections are considered infectious

Figure 1.9: Reported incidence rate of Infectious Syphilis infections per 100,000, Middlesex-London 2009-2013

	2009	2010	2011	2012	2013
ML	2.7	4.2	8.3	5.4	3.4
ON	5.7	5.9	5.2	5.5	4.9

Year

Source: Numerator: ML: MLHU iPHIS database, extracted November 13, 2014. ON: Ontario iPHIS database, extracted various dates. Denominator: ML and ON: Statistics Canada population estimates (2009-2012) and projections (2013), MOHLTC, intelliHEALTH Ontario, extracted September 26, 2014.

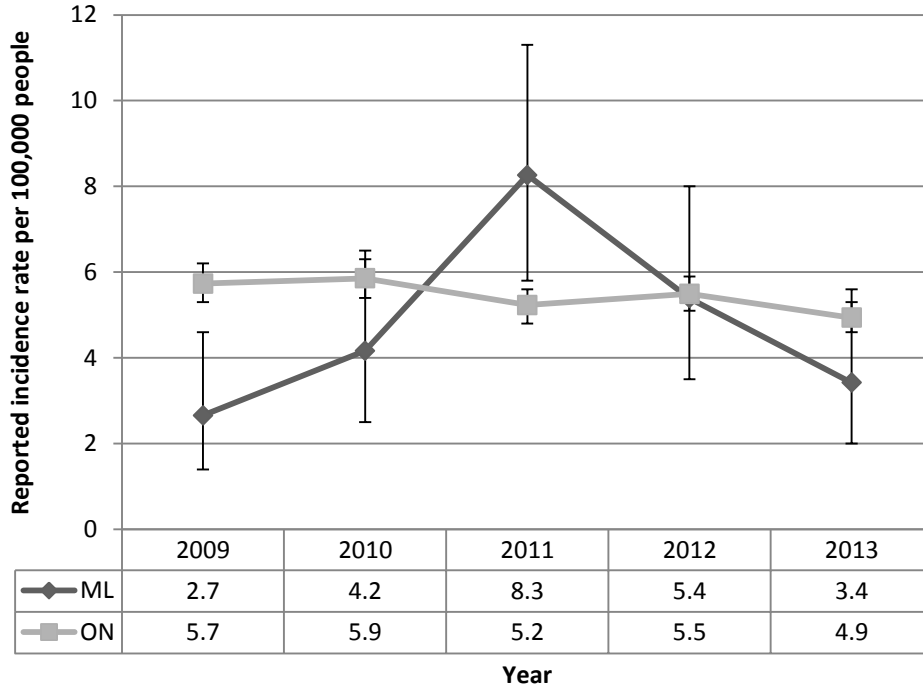*Figure 1.10: Reported incidence rate of Infectious Syphilis infections per 100,000, by age, Middlesex-London, 2009 to 2013 annual average*
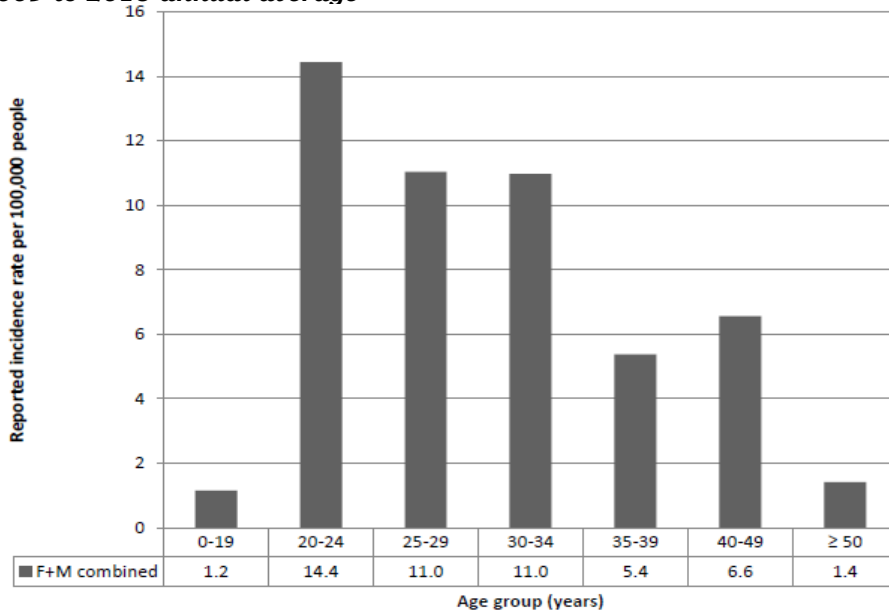
	0-19	20-24	25-29	30-34	35-39	40-49	≥ 50
F+M combined	1.2	14.4	11.0	11.0	5.4	6.6	1.4

Age group (years)

Source: Numerator: MLHU iPHIS database, extracted November 13, 2014. Denominator: Statistics Canada population estimates (2009-2012) and projections (2013), MOHLTC, intelliHEALTH Ontario, extracted September 26, 2014

HIV/AIDS Infections

Between 2009 and 2013, the average annual reported incidence rate for HIV/AIDS infections in Middlesex-London was 6.3 cases per 100,000, there were no significant differences between the local and provincial rates over the five-year time period of interest (Figure 1.11)

In order to calculate comparable gender- and age-specific rates, it was necessary to combine all cases 40 years of age and over, due to the fact that the number of reported HIV/AIDS infections among females in this age group was relatively small and less than half the number of infections reported among males. Although not shown in Figure 12, it was possible to calculate more specific rates for males over the age of 40 years.

Across the five-year period, the average annual reported incidence rate of HIV/AIDS infections was highest among the 40-49 year old age group for males, at 19.5 infections per 100,000 (data not shown), followed by those between the ages of 30-34 (16.9 per 100,000) (Figure 1.12).. For females, the highest average annual reported incidence rate was among the 35-39 year old age group (12.1 per 100,000 females), followed by the 30-34 year old age group (11.5 per 100,000)

Figure 1.11: Reported incidence rate of HIV/AIDS infections per 100,000, Middlesex-London, 2009 to 2013 annual average

	2009	2010	2011	2012	2013
ML	6.6	7.7	5.2	6.0	5.8
ON	7.8	7.2	7.0	6.0	5.8
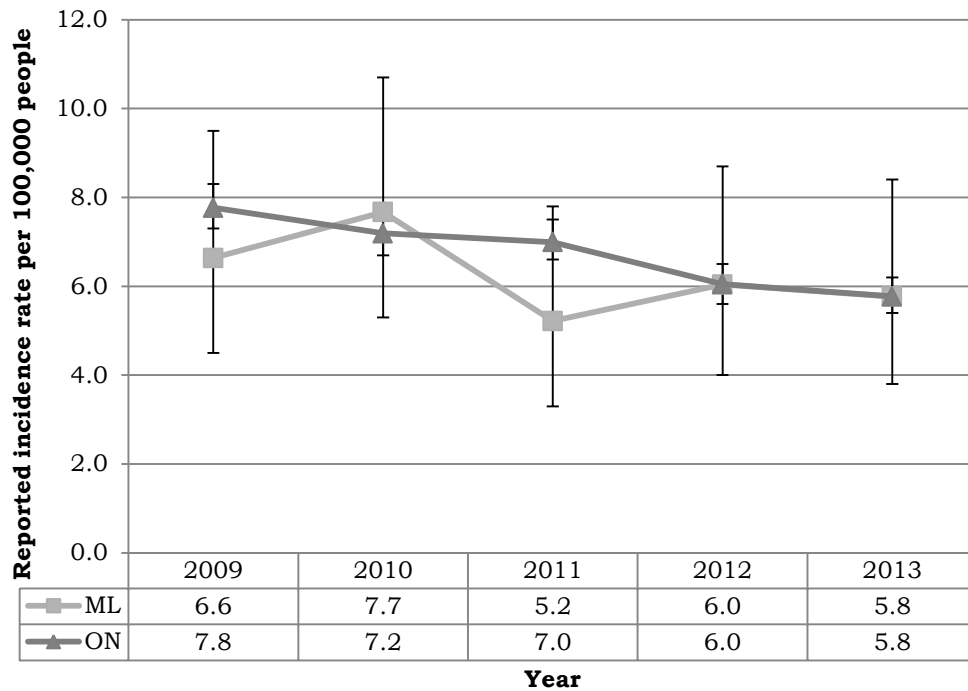
Source: Numerator: ML and ON: Ontario iPHIS database (preliminary provincial data files), extracted various dates.
Denominator: ML and ON: Statistics Canada population estimates (2009-2012) and projections (2013), MOHLTC, intelliHEALTH Ontario, extracted September 26, 2014

Figure 1.12: Reported incidence rate of HIV/AIDS infections per 100,000, by age and sex, Middlesex-London, 2009 to 2013 annual average

	0-24	25-29	30-34	35-39	≥ 40
■ F	2.0	5.5	11.5	12.1	1.7
■ M	1.1	16.6	16.9	12.1	10.2

Age group (years)
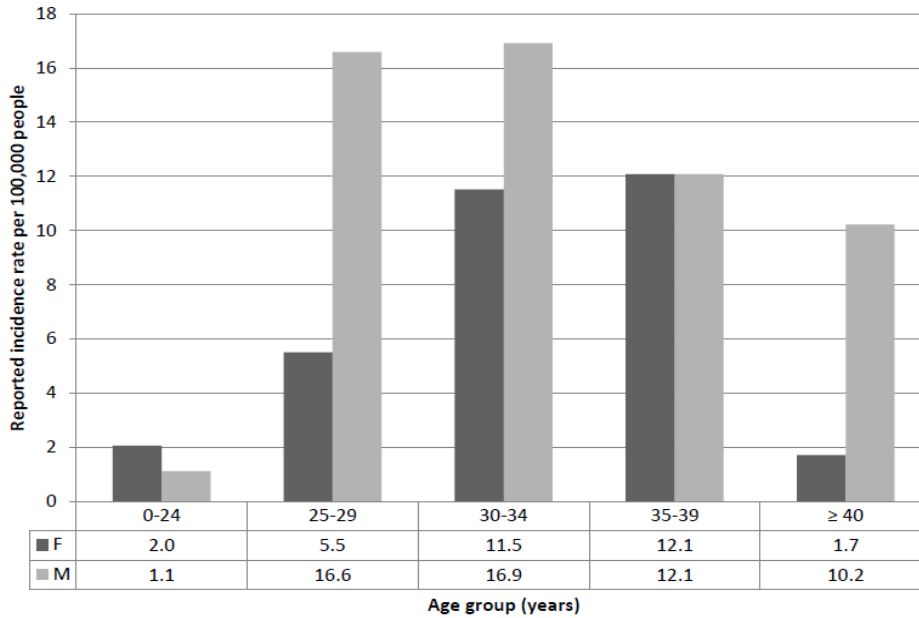
Source: Numerator: MLHU iPHIS database, extracted January 14, 2015. Denominator: Statistics Canada population estimates (2009-2012) and projections (2013), MOHLTC, intelliHEALTH Ontario, extracted September 26, 2014

Impact of Middlesex-London STI/BBI trends

- Youth and young adults under the age of 30 years are a priority population for sexual health services and promotion efforts, given the high rates of chlamydia and gonorrhea reported in this age group, and the possible long-term impacts (e.g., PID) if these STIs are not prevented and/or properly treated. Recognizing the chlamydia and gonorrhea disproportionately affects those in the younger age groups, the sexual health team plans campaigns and presentations (i.e. Toys, Lubes and Condoms Show, Guinness World Record STI testing, health fairs) to increase sexual health awareness and promote STI/BBI testing.

- Gender-specific sexual health services and health promotion may be warranted for Hepatitis C, Infectious Syphilis, and HIV. As evident in the data presented above, majority (91.8%) of infectious syphilis cases were reported among males. Similarly for HIV/AIDs the number infections reported among females was less than half the number of male cases.

- The high rates of Hepatitis C infections in Middlesex-London compared to Ontario may warrant further investigation and action.

Sexual Health Clinic Services

The Clinic team provides clinical services to address the local STI/BBI trends and the reproductive indicators. Clinical services for the provision of birth control and the diagnosis and treatment of sexually transmitted infections (STIs). Follow-up on reportable STIs are also performed by The Clinic staff to prevent transmission to others. Needle Exchange Program services are also offered at the Sexual Health Clinic. All services are confidential, non-judgmental, client-focused and easily accessible. The provision of these services are in place to ensure that the local STI/BBI trends and

The Clinic is comprised of the Sexually Transmitted Infection (STI) Clinic and Family Planning (FP) Clinic. The Clinic is located at 50 King Street and has an off-site office in Strathroy.

At the 50 King Street office:

- There are three Sexually Transmitted Infection (STI) Clinics per week. Clinics operate on a drop-in basis, and provide free and confidential testing, treatment and counselling. No health card is required. Females and males of all ages can access services offered at the STI Clinic.

- There are eight Family Planning (FP) Clinics per week. Clinics operate by appointment and provide birth control services, emergency contraception (plan B and IUD), pregnancy testing, family planning, cervical screening (pap tests) and breast examinations. A health card is usually required. Only females under 50 years of age can access services offered at the FP Clinic.

- Birth Control and the Emergency Contraceptive Pill (ECP) can be purchased on a walk-in basis Monday to Thursday 9am to 7pm and Fridays 9am to 4pm.

- Needle Exchange Program services are available on a drop-in basis Monday to Thursday 9am to 7pm and Fridays 9am to 4pm. Clients have confidential access to harm reduction supplies, including naloxone, and counselling which can be accessed through a private entrance. No health card is required.

At the Strathroy office:

- At the Strathroy office, services are available every second and fourth Thursdays of the month. No health card is required.

- Birth Control and the Emergency Contraceptive Pill (ECP) can be purchased on a walk-in basis every second and fourth Thursday of the month

- Needle Exchange Program services are available on a drop-in basis every Thursday. Clients have access to harm reduction supplies, including naloxone, and counselling, similar to those offered at the 50 King Street office. No health card is required and services are confidential.

Client Demographics

Basic demographic information of clients is collected using the Hampson Client Management System. There were a total of 10,429 clients who visited The Clinic in 2014. Females were seen in a larger number, in comparison to males, as the Family Planning Clinic services are mainly targeted for females. Nearly half (47.0%) of the clients in 2014 were youth between the ages of 15 and 24.

Table 1.1: Demographic characteristics of the clients attending The Clinic in 2014

| Age range	Female	Male
<15 years old	42	4
15 - 19 years old	1331	235
20 - 24 years old	2581	829
25 - 29 years old	1877	652
30 - 39 years old	1322	601
≥40 years old	489	466
Total	**7642**	**2787**

Source: Hamspon Client Management System, retrieved June 10, 2015. Excludes gender not specified/recorded

Clinic visit

The number of clinic visits in 2014 was higher for the STI Clinics in comparison to the Family Planning Clinics. This is due to the drop-in clinic model, which allows for a high volume of clients to be seen. In 2014, the number of visits to the STI clinic was lower in the February, April and December months. This may be due to university/college reading week, summer and Christmas holiday seasons.

The number of visits to the Family Planning Clinic was smaller in comparison to the STI Clinic. The Family Planning Clinic operates a booked appointment clinic model. The length of the appointments are also longer depending on the reason for visit – hence, only a set number of clients can be seen per clinic. The number of visits appears to be lower in the October and November months. A potential reason for this decline could be the number of one doctor clinics in comparison to previous months. The total number of clinic visits in 2014 is illustrated in Figure 1.14 by month and clinic.

Figure 1.14 Total number of visits, by Clinic and Month in 2014
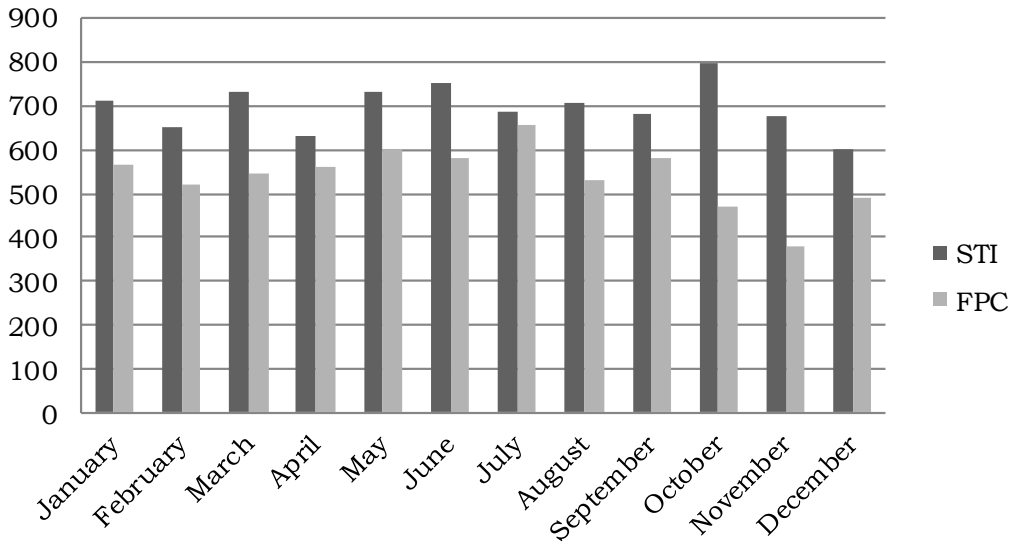
Detection of Chlamydia and Gonorrhea in The Clinic

In 2014, there were a total of 1,468 cases of Chlamydia reported in the Middlesex-London region. 41.2% of the total confirmed cases (n=1468) in Middlesex-London were diagnosed at The Clinic*. There were 8,922 clients tested for Chlamydia in The Clinic and 6.8% positivity among these tests. The percent positivity by gender and age group between 2012 and 2014 are depicted in Figure 1.15. Male clients had a higher percent positivity for Chlamydia in comparison to females in their respective age groups. For both males and females, clients aged 25 and under had a higher percent positivity than clients aged 26 and over.

In 2014, there were a total of 109 confirmed cases of Gonorrhea in Middlesex-London. 28.4% of the total confirmed cases (n=109) were diagnosed at The Clinic*. A total of 8,938 clients were tested for Gonorrhea in The Clinic, with 0.3% positivity. The percent positivity for gonorrhea by gender and age group between 2012 and 2014 are depicted in Figure 1.16. In all age groups, male clients had a higher percent positivity for gonorrhea than the female clients. The age group with the highest percent positivity varied between 2012 and 2014. In 2012, male clients 25 and under had the highest percent positivity. However in 2013, the percent positivity for males was equal for both age groups. In 2014, males 26 years of age and over had a higher percent positivity in comparison to those 25 and under.

Figure 1.15: Percent positivity of Chlamydia tests performed, by sex and age group, all MLHU clinics, 2012 to 2014
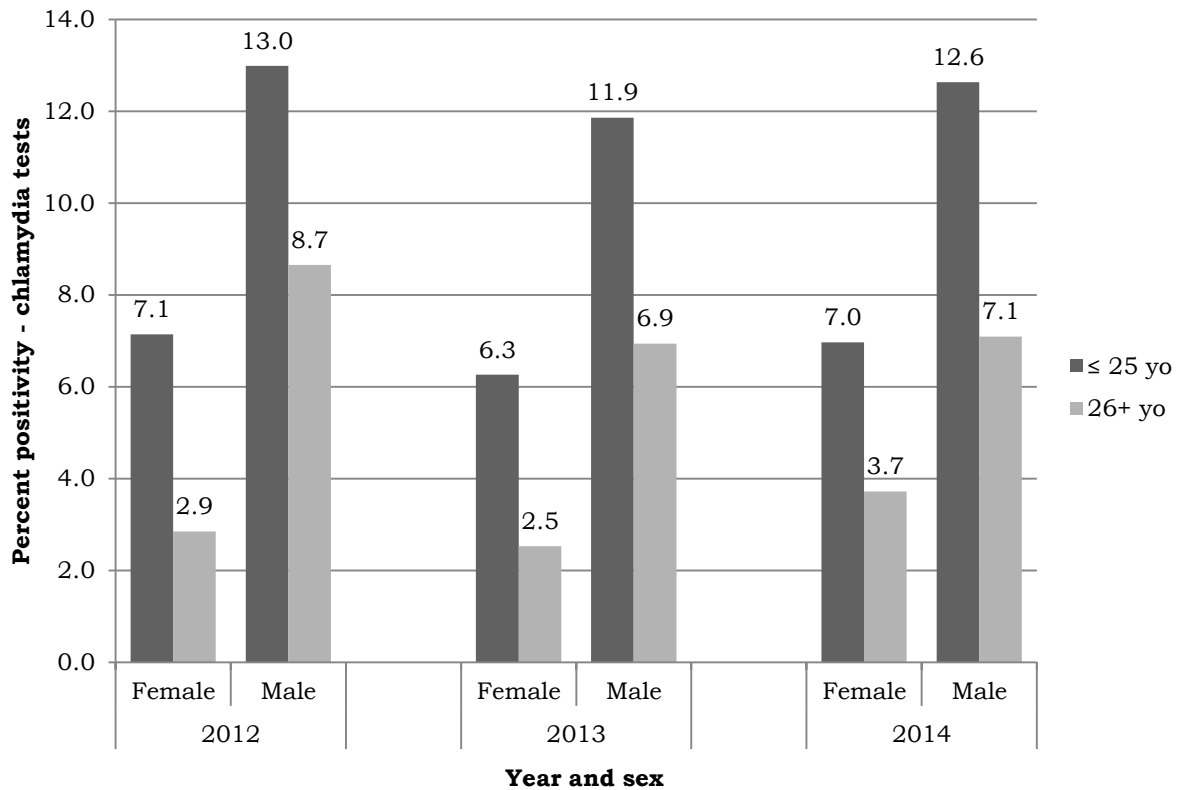
* The numerator used to calculate percent positivity includes all clients with laboratory confirmed infections diagnosed at the MLHU family planning and STI clinics, while the denominator includes laboratory-confirmed infections diagnosed among only Middlesex-London residents. Please interpret percent positivity with caution as the percentages presented may under- or over-estimate the percentage of infections among Middlesex-London residents diagnosed at MLHU clinics.

Figure 1.16: Percent positivity of Gonorrhea tests performed, by sex and age group, all MLHU clinics, 2012 to 2014
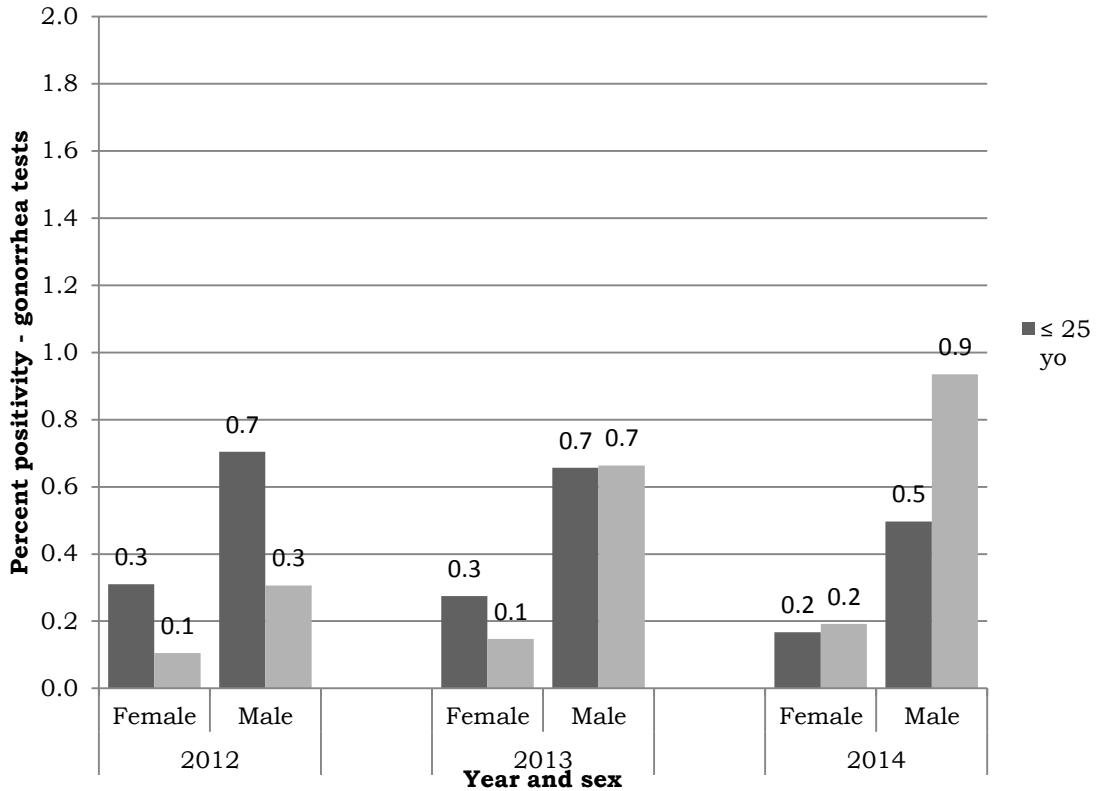
Pap tests

Pap tests are solely done in the Family Planning Clinics. The number of pap tests completed between 2012 and 2014 are illustrated in Table 1.2. In 2014, there were 1,158 Pap test conducted in the MLHU Clinics. Between 2012 and 2014 there has been a 66% decline in the number of pap tests completed at the MLHU Clinics. Changes to the screening guidelines may be a contributing factor to this observed decrease.

Table 1.2: Total number of Pap tests performed in all MLHU clinics*, by age group, 2012 to 2014

Age group (years)	2012	2013	2014
	# (column %)	# (column %)	# (column %)
< 15	4 (0.1%)	0	0
15-19	374 (11.0%)	42 (2.0%)	10 (0.9%)
20-24	1,162 (34.1%)	708 (33.4%)	373 (32.2%)
25-29	1,022 (30.0%)	735 (34.7%)	361 (31.2%)
30-34	458 (13.4%)	314 (14.8%)	208 (18.0%)
35-39	184 (5.4%)	168 (7.9%)	97 (8.4%)
40-44	114 (3.3%)	92 (4.3%)	64 (5.5%)
45-49	81 (2.4%)	60 (2.8%)	39 (3.4%)
≥ 50	8 (0.4%)	1 (0.0%)	6 (0.5%)
TOTAL	**3,407**	**2,120**	**1,158**

Pregnancy Tests

Pregnancy testing is available in both the Family Planning Clinics and the STI Clinics. The number of positive pregnancy tests between 2012 and 2014 are illustrated in Table 1.3.

Table 1.3: Number of positive pregnancy tests in Family Planning and STI Clinics, 2012 to 2014

	2012	2013	2014
Family Planning Clinic	105	164	219
STI Clinic	152	137	80

Emergency Contraceptive Pill

The Emergency Contraceptive Pill (ECP) prevents pregnancy by preventing or delaying the release of the egg. It is used to prevent pregnancy up to 72 hours after unprotected intercourse. There is some evidence that it may be taken up to 120 hours, but it may not be as effective. ECP is available for sale at The Clinic. Clients or a third party can obtain ECP following a consult with a Public Health Nurse. The number of ECP sold at The Clinic between 2012 and 2014 are illustrated in Table 1.4.

Table 1.4: Number of Emergency Contraceptive Pills sold in The Clinic, 2012 to 2014

	2012	2013	2014
Plan B	145	1	2
NovLevo	530	667	568

II. Priority Population for Sexual Health Services

The Ontario Public Health Standards (OPHS) is the overarching body that mandates the services provided for Sexual Health. The OPHS set requirements to help enable the Board of Health to reach the desired sexual health goals and outcomes. A key component of these requirements is to "identify and work with local priority populations" (Ontario, 2008). Priority populations are defined as those "at risk and for whom public health interventions may be reasonably considered to have a substantial impact at the population level" (Ontario, 2008). As per the *Population Health Assessment and Surveillance Protocol (PHASP) (2008)*, priority populations can be defined by considering the following factors:

- Socio-demographic and geographic characteristics of the population residing in Middlesex-London
- Interpretation of existing and/or acquired data and information that describe the relationship between the barriers and specific program requirements (e.g., relationship between age or education and reproductive outcomes; immigration status and tobacco use etc.)
- Program evaluation data and information which identifies program benefits and gaps for diverse populations.

Priority populations for STIs/BBIs have been well researched and defined by the Public Health Agency of Canada (PHAC). The Canadian Public Health Association (CPHA) has further refined this to include:

- Aboriginal peoples (First Nations, Inuit, and Métis peoples)
- Gay, bisexual, two-spirit, and other MSM (men who have sex with men)
- People who use substances, including injection drugs
- People who are or have been in prison
- Youth at risk
- Women at risk
- People from African, Caribbean, Black (ACB), and other countries where HIV is endemic, including newcomers
- People who are living with HIV/AIDS
- Other population groups, such as those without legal status in Canada or without health insurance and people without a family doctor

Presently, the reach of The Clinic to priority populations as defined by PHAC, cannot be formally reported due to limited data collection of pertinent variables. However, with the review of clinic activities, it is evident that focused work (i.e. visitation to the Elgin Mills Detention Centre, community presentations) is done with specific priority

populations (youth, Lesbian Gay Bisexual Transgender Queer (LGBTQ) population and at-risk women who are incarcerated). In addition, review of the client demographics indicate that the clinic services are largely accessed by youth. This suggests that the clinic services are accessed by some of the identified priority populations – however the extent of this reach cannot be reported with certainty.

As next steps, the proportion of the above identified priority population in Middlesex London will need to be estimated. In addition, a formal assessment of The Clinic's reach will need to be conducted when pertinent data becomes available. Determining the proportion of clients from priority populations who utilize clinic services will help assess whether the current clinic model/practices sufficiently reaches the priority populations. This will further help evaluate whether the board of health outcomes regarding priority populations have been achieved.

III. Alignment of clinic activities with the Ontario   Public Health Standards

A review of the OPHS was performed by The Clinic team to align its activities with the requirements under the Sexual Health, Sexually Transmitted Infections, and Blood-borne Infections component. There are 12 requirements in this component categorized into three sections: *Assessment and Surveillance, Health Promotion and Policy Development and Disease Prevention/Health Protection.* The requirements were reviewed and corresponding clinic activities were identified by the team to determine whether the current clinic practices fulfilled the requirements. This helped determine areas of strength and identify gaps. A complete table of the analysis can be found in *Appendix A.*

Overall, The Clinic meets the requirements of the Sexual Health, Sexually Transmitted Infections and Blood-borne Infections Standard, with a few identified gaps. Clinic activities met and exceeded the requirements in the *Assessment & Surveillance and Health Promotion & Policy Development* sections. However, a few gaps were identified in the *Disease Prevention/Health Protection* section from this review process:

Requirement #7:
The board of health shall provide clinical services for priority populations to address contraception, comprehensive pregnancy counselling, sexually transmitted infections, and blood-borne infections. For further information, refer to the Sexual Health Clinic Services Manual, 2002 (or as current).

Clinical services to address contraception, comprehensive pregnancy counselling and STIs/BBIs are available for priority populations. Targeted work is also done with priority populations such as women at risk, youth, LGBTQ to raise awareness and promote the use of clinical services. With the current information available, the case demographics of clients indicate that clinic services are utilized by those between 15-24 years of age.. In 2014, The Clinic was utilized by 3,912 female clients and 1,064 male clients in the 15-24 year age group. Youth between the ages of 15-24 have been considered a priority population for sexual health, as incidence rates suggests that STIs, particularly Chlamydia and Gonorrhea, disproportionately affects those in the younger age groups (refer to Local and Provincial STI/BBI trends section). Additionally the refined priority population list provided by the CPHA further indicates that youth are a priority population for sexual health (CPHA, 2012).

Requirement #9:
The board of health shall provide or ensure access to provincially funded drugs for the treatment of sexually transmitted infections, at no cost to clients, in accordance with the Sexual Health and Sexually Transmitted Infections Prevention and Control Protocol, 2008 (or as current).

Testing and treatment for STIs is consistently practiced in The Clinic, and is available to all clients. To further increase the accessibility to STI treatments, The Clinic distributes provincially funded STI medications to community health care providers. The availability of this service is communicated to physicians through MLHU's Health Care Provider Outreach initiative. With the extent of current efforts, there has been a low uptake of this service. In 2014, there were only 19 community physicians that requested provincially funded treatments from the Health Unit.

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Requirement #10:
The board of health shall communicate and coordinate care with health care providers to achieve a comprehensive and consistent approach to the management of sexually transmitted infections and blood-borne infections.

Currently, the Sexual Health Team communicates information and updates through the electronic and paper-form binder that is associated with the MLHU Health Care Provider Outreach initiative. However, the team identified concerns regarding limited engagement with and lack of use of STI best practices (i.e. incorrect use of first-line of treatment for gonorrhea) among community physicians, with current team outreach efforts.

In regards to coordination of care, it was identified that there was good coordination of care between the community health care provider, the Health Unit and support services. Health care providers connect with the Health Unit to coordinate care on an as needed basis.

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In addition to the 12 requirements under the Sexual Health, Sexually Transmitted Infections, and Blood-borne Infections Standard, The Clinic team identified additional activities routinely performed in the clinic that did not fit under the *Assessment and Surveillance, Health Promotion and Policy Development and Disease Prevention/Health Protection* sections. Hence, to comprehensively capture these practices, a section, *Knowledge Exchange and Continuous Quality Improvement (CQI)*, was developed. The Clinic performs annual chart audits to ensure documentation is consistent with the College of Nursing standards (Appendix B), quarterly meetings with the Sexual Health team for knowledge exchange and CQI purposes and annual review of professional licenses. A complete list of the additional activities is listed in Appendix A.

The Clinic's Knowledge Exchange and CQI practices are found to closely align with the Quality Assurance component of the Ministry of Health and Long Term Care's *Sexual Health Clinical Services Guidance Document* (MOHLTC, 2002). These activities met the three required components for the Quality Assurance program, as per the MOHLTC document*:*

Requirements for Quality Assurance	Clinic activities
Identification and addressing of members who are incapacitated, incompetent or unfit to practice	• Annual review of Physician License and Canadian Medical Protection Association Status • All PHN`s have current College of Nurses license
Professional development through the improvement and maintenance of competence	• In-services by physicians and other internal and external guest speakers;, learnings from staff attending conferences shared • Protocol updates (e.g., processing/ dispensing external birth control scripts • Consultation with Professional Practice Leader related to nursing practice
Improvement of patient outcomes through concentration on professional performance	• Surveys • Chart audits • Incident reports

Clinic Team Consultation and Activity

Engagement with frontline staff was a key contributor to this program review. Input was sought from The Clinic team via unstructured discussions. The objective of these discussions were to gauge the team's perspective on aspects of The Clinic and gather information on gaps and barriers that have been observed during interactions with clients. Through the discussion the following themes surfaced:

Access to Family Planning Clinic services for clients without a health card
Clients with family planning needs require a health card to access family planning services. This presents a barrier to access clinic services for clients without a health card. Although physicians are encouraged to see up to 3% of clients without a health card, there have been challenges associated with this strategy. It was identified that having a structured process in place would ensure an efficient clinic flow by equally distributing clients without a health card to each clinic physician. Further, PHNs who visit the Elgin Mills Detention Centre have received feedback from inmates regarding the challenges around accessing family planning services. The feedback suggested that individuals may not all have a fixed address to apply and obtain a health card.

Enhancements to the Electronic database
Limitations of the current electronic database were identified during the discussions. It was identified that enhancements to improve the data quality and usability of the database can be beneficial. There is limited capacity to directly download lab results from the Public Health Ontario Laboratory. As a result the current practice is to manually input the results. Although a formal audit to determine the rate of transcription errors for manual data entry was not performed, this practice introduces a potential for transcription errors. The long term sustainability of the database was identified to be limited; hence there is a need to explore other options for an electronic database, if feasible.

Expand the methods of payment accepted and birth control options and vaccines
Cash and debit are the only method of payment accepted at The Clinic. This has been a barrier for clients who prefer to pay with credit. The total amount owing can be large depending on the type of birth control purchased (i.e. IUD/IUS) or if the client purchases birth control months in advance. In such cases, clients have had to leave the site to withdraw cash. This results in some clients who do not return to complete the purchase.

Additionally, a need to expand birth control and vaccine options in The Clinic was also identified as the current vaccine stock does not align with client needs. For example, the Gardasil vaccine is only stocked in the Immunization Clinic. Clients who request this vaccine need to visit the Immunization Clinic to purchase the vaccine and have it administered. This poses challenges because the clinic hours of the Immunization Clinic and the Sexual Health Clinic do not always coincide; resulting in clients having to return to the Immunization Clinic on another day to have the vaccine administered.

Continuously engage and enhance partnerships with community health care providers
Updates regarding STI treatment guidelines are communicated to community healthcare providers through the Health Unit's Community Healthcare Outreach Provider Initiative. Through this initiative updates are communicated in a binder format, along with other Health Unit-wide updates. However it is unclear if information in the binder is reviewed by the health care provider. Challenges were identified with this approach, as there continues to be inconsistent adherence to the STI best practices guidelines. Follow-up with community physicians for confirmed STI cases often reveal that incorrect STI education is provided to clients or an incorrect treatment is prescribed.

IV. Harm Reduction Best Practices Review Summary

Background

Ontario Public Health Standards 2008

Sexual Health, Sexually Transmitted Infections, and Blood -borne Infections (including HIV) program standard - Board of health outcome:
- Priority populations have access to harm reduction services to reduce the transmission of sexually transmitted infections and blood-borne infections.

Specific requirements under this standard:
> 11. The board of health shall engage community partners and priority populations in the planning, development, and implementation of harm reduction programming.

> 12. The board of health shall ensure access to a variety of harm reduction program delivery models which shall include the provision of sterile needles and syringes and may include other evidence-informed harm reduction strategies in response to local surveillance.

Current Harm Reduction Programming at MLHU

The Counterpoint Needle Exchange Program (NEP) is operated by the Regional HIV/AIDS Connection (RHAC) and funded through the Middlesex-London Health Unit. The NEP offers clean needle/syringes and related equipment; safer inhalation kits; sharps containers and sharps collection; and information related to safer drug use, drug treatment, and general health and wellness. Overdose prevention education, training and naloxone kits are available to those at risk of opioid overdose through *The Naloxone Program*.

What is Harm Reduction?

"Harm reduction emphasizes human rights and the importance of treating all people with respect, dignity and compassion, regardless of drug use. It is a non-judgmental approach that accepts the person as they are and their right to make choices." (CNA/CNAC, 2012, pg. 1)

Harm reduction is characterized by:
- A primary goal of reducing drug-related harm rather than a primary goal of reducing drug-use
- Pragmatic strategies and interventions for people who continue to use drugs
- A net reduction in drug-related harm
- Ensuring drug users are treated with dignity. This includes a non-judgmental and non-punitive stance towards the consumption of alcohol and drugs
- A focus on realistic and achievable goals
  (Erickson et al., 1997; Lenton and Single, 1998 in Strike et al. 2006).

Using these principles, harm reduction programs are developed to reduce or eliminate the adverse health, social, and economic consequences of drug use without requiring abstinence (Strike et al. 2006).

Best Practices

Information that follows has been drawn from Canadian best practice documents. The focus of this best practice review is on the high level program structure and includes the following components: program delivery models, staffing, additional services, needle disposal and recovery, and monitoring and evaluation. Specific recommended practices related to distribution of each piece of safer drug use equipment exists, but is not reviewed here. This information can be found in the 2013 Best Practice Recommendations for Canadian Harm Reduction Programs document.

Program Delivery Models

- The design and implementation of service delivery models should be tailored to local needs, taking into account level of injection drug use, types of drugs used, and population demographics.
- Offering NSPs through health units can enhance effectiveness of services.
- Providing services at multiple sites with varied hours of operation increases access. Internationally, many of the most successful NSPs provide a mix of service delivery modes.
    - Regular hours and permanent sites ensure people know when and where to access services.
    - Mobile services and outreach expand geographic and service coverage to areas where people commonly use drugs and reach those who don't access fixed-site locations
    - Peer distribution can increase access to harm reduction supplies for people who use illegal drugs.
    - Provision of injection equipment by pharmacies can increase the availability and the use of sterile equipment. However evidence shows that there is a reluctance of pharmacists to do so.
    - Several countries, including Netherlands, Germany, Italy and Australia, use syringe vending machines to supplement fixed-site services

"Offering needle exchange services in more than one location, at different times of the day and night and from different models of delivery is likely to increase the number of IDUs who will use program services and maximize the effectiveness in terms of preventing transmission of HIV, HBV, HCV and other blood borne pathogens" (Strike et al. 2006).

Staffing

Best Practice documents are consistent in their assertion that the attitudes and knowledge held by staff are imperative to the effectiveness of NEPs and the harm reduction approach.
Staff who are approachable, friendly, non-judgemental, non-directive, knowledgeable, and have awareness of issues related to addictions and street-life are better able to develop and sustain rapport with clients (Strike et al., 2006). Ongoing staff training and development has been identified as a need internationally, nationally, and provincially (BCCDC, 2008).

It is imperative that staff have knowledge of safe injection and inhalation equipment and practices in order to educate clients. Within Ontario, a series of training webinars has been developed and held by the Ontario HIV and Substance Use Training Program (OHSUTP) in partnership with AIDS and Hepatitis C Program of the MOHLTC. Topics include: Injection drug use and equipment; Smoking crack cocaine and equipment; Harm reduction: Further strategies and issues to consider. Additionally the Best Practice Recommendations for Canadian Harm Reduction Programs document contains equipment specific chapters with detailed practice recommendations to guide NEP staff practice.

"Nurses have a responsibility to provide non-judgmental care to individuals and families affected by substance use, regardless of setting, social class, income, age, gender or ethnicity, and they can influence the development of organizational and governmental harm reduction policies related to drug use" (CNA/CNAC,2012, pg. 1).

Additional Services

People who inject drugs often have and are at risk for multiple health problems yet they experience significant barriers to accessing health services. NSPs are most effective if they provide or are linked with primary health care services, and additionally provide referrals and warm transfers to health and social services in the community who are supportive and non-judgemental. Such services for provision or referral include wound care, abscess care and other first aid; HIV, Hep C, TB testing and counselling; vaccination; sexual health services, drug treatment information and services; resources and services to meet basic needs including food and housing (BCCDC, 2008; Strike et al, 2006).

NSPs should maintain a supply of appropriate written materials including information about safer injecting practices, prevention of transmission of blood borne diseases, overdose prevention, vein care and safer sex. Provision of these materials can provide opportunity for client engagement, health promotion and other interventions (BCCDC, 2008).

Needle Disposal and Recovery

NSPs "have an obligation to provide a robust recovery and disposal system". Effective recovery and disposal practices require multiple approaches (sharps containers, drop boxes, pick-up services) and the participation of a variety of stakeholders (e.g. municipal governments, business associations, community agencies, and people who use injection drugs) (BCCDC, 2008).

The 2013 Best Practice Recommendations for Canadian Harm Reduction Programs document recommends the following practices for disposal and handling of used drug equipment:
- "Regular review and assessment of compliance with local, provincial/territorial and federal regulations regarding collection, storage, transportation, security and disposal of biomedical waste
- Educate clients and staff members on how to properly handle, secure and dispose of used injection and non-injection equipment
- Encourage clients to return and/or properly dispose of used injection and non-injection equipment
- Provide clients with tamper resistant sharps containers in a variety of sizes
- Provide multiple, convenient locations for safe disposal of used equipment in rural and urban settings. Do not penalize or refuse to provide new equipment to clients who fail to return used drug equipment.
- Visually estimate the amount of returned equipment; staff should not touch used equipment and neither staff nor clients should manually count used equipment
- Encourage staff and clients to be vaccinated against hepatitis B (HBV)
- Provide access to safety devices for staff and procedures for first aid and post-exposure prophylaxis (PEP)"

Monitoring and Evaluation

Ongoing/periodic monitoring and evaluation is important to determine to what extent the NSP is meeting the needs of clients and the community. Suggested types of information to collect include: what drugs are being used locally and modes of administration; levels of knowledge regarding risk and protective behaviours; patterns of risk and protective behaviours such as needle sharing; adverse health consequences of drug use; client demographic information including gender, age, ethnicity, Aboriginal status, gender identity, where clients live and use drugs (BCCDC, 2008; Strike et al, 2006).

It is recommended that NSP activity reports collect information such as dates, times and locations of client contacts; supplies provided; and if provision of or referral to other health services was completed (BCCDC, 2008).

V. Sexual Health Clinic Literature Summary

Key Findings

- High quality evidence on models for the delivery of sexual health clinic services is very limited.

- Outreach strategies have been found to be successful in reaching populations that would not otherwise access mainstream sexual health services.

- Due to limited high-quality literature, it is recommended that sexual health clinic models be determined based on the needs of specific populations. It is also recommended that populations not utilizing clinic services are identified, and their sexual health needs and barriers to accessing sexual health clinic services are assessed.

- If outreach clinics are incorporated into sexual health programming, it is recommended that the health unit collaborates with community organization(s) and builds trust within the target populations to ensure efficiency and success.

- Incentives were effective in increasing the uptake of STI testing; the use of incentives in non-clinical settings was more effective than in clinical settings. This approach reached populations most at risk and with limited access to services.

Sexual Health Clinical Services are guided by the principles of the MOHLTC's *Sexual Health Clinical Services Guidance Document* (MOHLTC, 2002). This document discusses various aspects of Sexual Health Clinics and provides direction for the planning and delivery of clinical services. The clinic model by which services are delivered is determined by individual Public Health Units. Hence, this literature review was initiated to identify evidence informed clinic strategies/models.

The aim of the literature review was to identify strategies/models most effective in the delivery of sexual health clinic services. Searches were conducted on the Canadian Best Practices Portal, EBSCO, EMBASE, Medline, HealthStar, Cochrane, PubMed and Public Health Grey Literature Database. Limited publications were identified for sexual health clinical services in Canada; hence, the scan was expanded to include sexual health clinic services in Australia and United Kingdom. The search strategy and the screening flowchart are documented in Appendix C.

The search generated 978 articles that were screened by title and abstract for relevancy. Full text articles were retrieved for 84 articles of which 82 articles were excluded. To align with the NCCMT 6S Pyramid only meta-analyses, systematic reviews and guidance documents were reviewed. Systematic reviews were critically appraised using the AMSTAR tool. Through this process there were two high-quality articles that were identified. The two systematic reviews identified discussed two different strategies for the delivery of sexual health clinical services: outreach clinic programs (Hengel et al., 2013) and incentivized testing (Lee et al., 2014).

Outreach

Outreach is an effective approach to deliver sexual health clinic services to populations that may not access mainstream sexual health services. Clinics situated within existing venues that are frequented by at-risk populations appear to be most successful in encouraging participation and increasing the uptake of sexual health services. Despite this approach reaching a relatively small and specific population, the yield of infection among those tested was high. The systematic review conducted by Hengel et al. (2013) identified 18 articles reporting 25 unique outreach programs implemented within various settings. For the purpose of this report, only outreach programs in Canada, US, Australia and UK are discussed.

Men who have sex with men (MSM)
Six outreach programs targeted men who have sex with men (MSM). Outreach in five out of the six programs was implemented in sex venues, and one program was implemented in a social venue. Testing for Chlamydia and Gonorrhea were offered in a sex venue in Australia over the course of 8 weeks. A low participation rate was recorded among those that attended the sex venues; however among those who participated, the testing rate was high. Of the 521 participants, 98% provided a urine sample, 97% provided a rectal swab and 100% provided a throat swab (Lister et al., 2003). Building on this outreach approach, follow-up clinics were conducted in the same sex venues, but offered comprehensive sexual health services (i.e. Hepatitis C testing, syphilis testing, STI treatment, etc.) rather than offering tests for Chlamydia and Gonorrhea only (Lister et al., 2005). The outcomes of the Chlamydia and Gonorrhea outreach clinic and the comprehensive sexual health clinic were evaluated. The

evaluation report highlighted that although the comprehensive sexual health clinic served a smaller number of MSM, a significantly higher positivity rate was found in the comprehensive clinic than the one offering Chlamydia and Gonorrhea tests only (Lister et al., 2005). Similarly an outreach program in men-only sex venues in the UK, performed 193 assessments (of which 20 were from returning clients) over 12 visits, and detected a total of 12 STI cases among the 173 unique assessments (Emerson et al., 2010). Evaluation of this model found that the outreach clinic reached a population that would not otherwise be tested. An outreach program in the US also offered a venue-based HIV/STI testing to MSM accessing sex venues, event, parties and internet sex sites. A total of 1694 clients participated, of which 1357 (80.1%) were tested for HIV and 934 were tested for Chlamydia and Gonorrhea. Among those tested there were 42 cases of HIV, and 11.6% tested positive for Chlamydia, Gonorrhea, or both (McNeely et al., 2010). In addition, an outreach initiative during events attended by MSM offered comprehensive health services, including sexual health. The participation rate was not reported due to multiple health services being offered, however there were 182 participants that provided a urine/blood sample for STIs (Blank et al., 2005).

Further to the articles included in the systematic review, an outreach program, Know on the Go, planned and implemented in Vancouver was identified in the literature search (Vancouver STOP Project, 2013). The initiative was informed with findings from a community consultation report with men in outdoor sex venues. This helped determine the need within the population and the strategies that would best address the need. Using this information, mini satellite sexual health clinics were planned and implemented by the region's health authority in collaboration with community agencies. Clinics were set up in three bathhouses and via a mobile van – offering all the services as a sexual health clinic, but outside of the traditional clinic setting. This approach was noted by nurses to provide an opportunity to address a range of issues beyond HIV and STIs. Performance reports have shown that both initiatives provide an opportunity for HIV/STI testing in populations that may not otherwise get tested (Vancouver STOP Project, 2013). This initiative was found to reach an important demographic as 10% of the people using this service had never been tested for HIV and 18% had never been tested for STIs, while 45% had not been tested for HIV in more than a year (Vancouver STOP Project, 2013). Overall this pilot project was found to be helpful in reaching those that may not otherwise access services and provided an opportunity to initiate contact with healthcare providers. Comprehensive outreach sexual health services are feasible, but are dependent on developing strong relationships, maintaining a passive approach and providing flexible and individualized services.

In summary, most of the outreach clinics targeted toward MSM were developed in response to the population's need. Although the total participation rates among total venue attendees were not reported in many of the studies, the uptake of the services among those that participated was high. Successful execution of the clinics involved partnerships and collaborations with community organizations.

Youth
There were eleven youth outreach programs that were identified in the review by Hengel et al. (2013). All eleven outreach programs were conducted in Australia and US. Four programs were conducted in street or community areas, four were conducted in service venues and three were conducted in social venues (i.e. sporting club, leisure centres). Venue-based outreach was found to be a more successful strategy than offering outreach for sexual health services in street settings for youth.

Social venue
In studies reporting outreach models in social venues, participation rate was reported in two out of the three outreach programs, with rates above 80% in both studies (Lorimere, Reid & Hart, 2009; Kong et al. 2009). Among those that participated, testing rates were the highest (100% and 85.2%) in outreach clinics conducted in sporting clubs (Gold, Hocking & Hellard, 2007; Kong et al. 2009). Outreach clinics in sporting clubs approached players in the locker rooms and asked for their participation. Among those asked, 108 agreed to participate and completed a survey about their sexual health (i.e. behaviours, partners, seeking health care), of which 92 participants provided a urine sample (Gold, Hocking & Hellard, 2007). The positivity rate was 3.9% for Chlamydia and 0 cases of Gonorrhea. The survey revealed that among the 108 participants, only 33% had ever discussed their sexual health with their physician. Similarly, a study conducted in Australia had sexual health outreach clinics in sporting clubs (Kong et al. 2009). The outreach clinic had a 95% participation rate, with 709 individuals participating. This strategy was used to screen for Chlamydia, and yielded a positivity rate of 3.9%. Upon evaluation, the outreach strategy was found to be well received by the youth population and participants found the outreach clinic useful as it increased access to testing and treatment. Furthermore, outreach services were setup in three social venues (workplace, education setting, and fitness centre) in the UK (Lorimere, Reid & Hart, 2009). Among the three settings participation was highest among outreach clinics in health and fitness centers (48%). The overall positively rate was 4.4% for Chlamydia. Among those that participated, 93.4% of males and 66.6% of females reported not having tests for Chlamydia completed in the past. Overall outreach in social venues was found to be feasible and acceptable among youth. Highest participation rates were found particularly among fitness/sporting clubs among the three studies discussed.

Service Venue
Five studies reviewed in the systematic review were conducted in either service venues, street settings or both. Two of the five studies (Martin et al., 2009; Johnson et al., 2008) are excluded as the services (i.e. mail-in testing kits) offered in the outreach clinics fall outside the scope of this review. Among the three studies, only one reported a participation rate (81.3%) for outreach in service venues (Marrazzo et al., 2007) and two reported participation rates for street/community setting outreach programs – both below 25%. (Marrazzo et al.,2007; Buhrer-Skinner et al., 2009).

A study conducted in the US set up outreach programs in various settings, including a drug treatment facility and a street setting. A higher uptake of STI services was observed in the drug treatment facility (81.3%) in comparison to outreach STI services in street settings (23.9%) (Marrazzo et al., 2007). Positivity rates for Chlamydia were not provided in this study. Similarly a study by Morris et al. (2010) provided outreach clinics in service venues and street/community settings. A total of 1632 individuals were screened at venues located in high STI prevalent areas. Highest numbers of participants were tested in a community area, followed by parenting centres and drug treatment centres. Participation rates were not reported; hence it is unclear which setting had a higher uptake of services. Outreach initiatives in drug treatment and corrections centres yielded the highest positivity rate (11.1%). This was followed by individuals reached in parenting centres (6.3%) and finally outreach in community areas (4.9%) (Morris et al., 2010). This study also highlighted that using peer volunteers increased Chlamydia case detection by 3.2% in comparison to outreach where peer volunteers were not used. In addition, Buhrer-Skinner et al. (2009) provided outreach services in street settings and service venues targeted toward youth. The street outreach program resulted in participation rate of 21.3%, while a participation rate for the service venues was not reported. No cases of Chlamydia were detected in the street outreach program, however a 13% positivity rate was found in the outreach program in the service venue (Buhrer-Skinner et al., 2009).

Further to studies discussed in the systematic review, an evaluation report of an outreach clinic was identified in the literature search. In the UK, outreach clinics have been provided in youth clubs to provide sexual health services in an accessible and user-friendly manner (Hayter, 2005). The clinics were set up in areas where levels of teen pregnancy and STI rates were high. These services were provided by nurses as well as youth workers (who were trained in counselling, provided education on safer sex, condom use and provided information on contraception, and STIs). The clinics were staffed by a nurse and two youth workers once a week. An evaluation of this clinic revealed that youth found the outreach clinics to be confidential, a place where they were listened to and a safe place to discuss sexual health and relationship issues. The evaluation highlighted that situating outreach clinics where youth would normally attend for social reasons was reported to be helpful by many respondents. Although youth indicated that they attended the venue to "chill out", many subsequently used sexual health services. This evaluation found that situating an outreach clinic in a social setting to be successful in reaching youth (Hayter, 2005). However, because baseline data is not provided, it is difficult to determine whether a higher percentage of youth utilized the outreach services in comparison to non-outreach clinics.

Additional venues for at-risk populations
Shelters are also potential venues for outreach services. Outreach clinics were implemented in two cities in USA. Outreach was used to provide sexual health services to adults accessing services at the shelter (Grimley, 2006). This strategy yielded a high participation (96.7%) rate, a high testing (98.6%) and a high rate of test result retrieval over the three month period. A $12 food coupon was provided as an incentive to participants, and may be a contributing factor to the high participation rate. Through the outreach clinic, 32 cases of Chlamydia, 23 cases of Gonorrhea, 3 cases of Syphilis and 2 cases of HIV were detected. All individuals that were positive were asymptomatic. In addition, Hengel et al. (2013) reviewed a study where sexual health services were provided at a community venue targeted toward the transgender community and women (Rusch et al., 2008). Screening for STIs occurred during a weekly program that provided food and general health care services. Participation rates were not included however, among those that participated (n=126), the testing rate was 73%. The positivity rate of Chlamydia was 2.2% and no cases of Gonorrhea were detected.

Possible Implications for Practice
Based on the literature available, outreach clinics appear to be beneficial in reaching populations that may not actively seek out sexual health services. Outreach clinics organized in existing venues appear to be more successful in encouraging participation than street-based settings. The studies discussed above have provided outreach services to those that are identified as priority populations by Canadian Public Health Association (please refer to the Priority Population for Sexual Health Services section). Hence it may be worthwhile to identify populations that have limited access to sexual health services in the Middlesex-London region and consider offering outreach services. In addition, it is recommended that a focus group or discussions be held with the target priority population to determine the feasibility of outreach services in the local context prior to implementation.

HIV/STI Incentivized testing strategy

The provision of incentives to increase the uptake of STI/HIV testing has also been identified as an effective strategy among various populations. A systematic review was identified, where the impacts of incentivizing HIV/STI testing in clinical and non-clinical settings was assessed. Lee et al. (2014) reviewed seven articles, two of which were from developing countries. Hence for the purposes of this report, the findings of these two articles are excluded. Of the remaining five studies, four were conducted in various locations across the US and one in Australia. Studies were conducted in clinical settings in three out of the five articles (Chacko et al., 1987; Haukoos et al.,2005; Malotte et al.,2004), and the remaining two were in non-clinical settings (Geringer & Hinton, 1993; Currie et al., 2010). Incentives varying between 5$ to 25$ was provided in four of the reviewed studies, and an incentive to enter into a $50 lottery was provided in the remaining study.

A higher rate of STI/HIV testing was reported in the incentivized group in comparison to the control in all five of the reviewed studies (Table 2). Studies in clinical settings had a modest point difference between the incentivized and non-incentivized group (Chacko et al., 1987; Haukoos et al.,2005; Malotte et al.,2004). In comparison, studies in non-clinical settings reported a larger point difference between the two groups (Geringer & Hinton, 1993; Currie et al, 2010). In two of the studies conducted in a clinical setting, a non-significant difference was found among the incentivized and non-incentivized group. The incentives ($20 and entrance into 50$ lottery) in both studies were provided during re-tests. Only one study conducted in a clinical setting reported a significant different between the two groups. The incentivized group in this study received a 25$ incentive. In contrast, the two studies conducted in non-clinical setting were found to have significant difference between the incentivized and non-incentivized group – one study offering a 5$ incentive and the other offering a 10$ incentive.

Overall, incentives were effective in increasing the uptake of STI testing, with a great effect found with incentives provided in non-clinical settings in comparison to clinical settings. This approach reached populations most at risk and with limited access to services. Implementation of incentivized non-clinical testing can provide opportunities to increase STI testing and reach populations previously missed via traditional testing methodologies.

Table 5.1: Characteristics of HIV/STI Incentivized testing studies reviewed

Study Author	Setting	Population	Outcome measure	Control group	Intervention group	Outcome of intervention group	Outcome of control group	Statistical analyses between the groups
Chacko et al.	Clinical, Baltimore USA	Teenagers treated at an STI clinic	Test of cure rate	Request for test of cure	Control group with the incentive of entrance into 50$ lottery	33%	31%	Non-significant
Currie et al.	University setting, Australia	Sexually active university students	Screening rate	Screening offered at campus activities	10$ incentive for on-campus screening and result retrieval via text messages	42.4%	22.9%	Significant
Geringer & Hinton	Shelters and Drug treatment centres, Philadelphia USA	Population in shelters and drug treatment centres	Test result retrieval rate	Testing and result retrieval at shelters and STI centres	Control group with $5 incentive for test result retrieval	69%	47%	Significant
Haukoos et al.	Clinical, Los Angeles, USA	Emergency Department patients with high HIV risk	Screening rate	Referral for voluntary counseling and testing 1 week after ED visit	Control group with 25$ incentive for the fulfillment of voluntary counseling and testing referral	23%	8%	Significant
Malotte et al.	Clinical, Prince George's County and Los Angeles	Patients treated in an STI clinic	Repeat testing rate	Request for 3 month retesting	Control group with 20$ incentive for retesting	13.2%	11.4%	Non-significant

Limitations

- There is limited high-quality evidence and research published on sexual health clinic models. Among the two systematic reviews that were identified, two different strategies were discussed.

- All studies that utilized an outreach model did not have a control group, making it difficult to determine whether the uptake of clinical services by a population is truly higher in the outreach model.

- Prevalence of STI/BBIs and uptake statistics reported in the individual studies may not be reflective of the uptake of services if the Health Unit were to adopt a similar strategy as the Middlesex County and London population may be different. The generalizability of the findings are weak as many of the studies, because they were venue-based, used a convenience sample.

- Definition of outreach clinic/program varied across the studies, as some offered complete clinical services in outreach settings, while others only offered specific services (i.e. Chlamydia testing). In addition, the length of time outreach clinics were implemented varied across the studies.

- Participation rates in outreach models were recorded by some of the studies; however percentages were not recorded with reference to the total number of participants approached. Hence high participation rates may not reflect increase uptake of outreach services. In addition, studies that reported an evaluation of the outreach clinics did not specify how the sample size was calculated. Hence the sample size may not be truly representatives of those that used the outreach services.

Factors that impact local applicability

- A mobile sexual health clinic service was organized in 2010 in collaboration with a faculty member at Western University. It is unclear why this initiative was unsuccessful as there are no documents on the planning of this initiative or any formal evaluations conducted. Hence prior to the planning or implementation of outreach services, it is important to assess this strategy within the local context (i.e., focus group with target population). It is recommended that the Applicability and Transferability of Evidence Tool by NCCMT be used to assess the local applicability of the strategy discussed.

- Populations and settings where strategies were effective may not truly be representative of the London and Middlesex County populations and environment, and may lead to a different result.

- Studies from the systematic reviews focused on specific populations (i.e. MSM, youth), hence the success of the strategy may not be generalized to other populations. The success of outreach strategies discussed in the literature review highlight the importance of clearly defining the population need, forming community/venue partnerships and building trust with the population.

VI. Environmental Scan - Comparative Health units

An environmental scan of seven comparator health units in Ontario was conducted: Region of Waterloo Public Health (ROWPH), Wellington-Dufferin Guelph Public Health (WDGPH), Windsor-Essex County Health Unit (WECHU), Niagara Region Public Health, City of Hamilton Public Health, Peel Public Health and York Region Public Health. Three of health units, Niagara Region Public Health, City of Hamilton Public Health and Windsor-Essex County Health Unit, are part of the same peer group as Middlesex-London Health Unit. The goal of the environmental scan was to gather details on provision of sexual health and harm reduction services among the comparator health units.

Two Public Health Nurses from The Clinic contacted representatives (i.e. Public Health Nurse, Manager) from each of the health units. Environmental scans for five health units were completed via a phone discussion and two were completed by the comparator health unit's representative. To corroborate the results, the completed environmental scans were sent back to the health unit's representative and the program manager for review. This process ensured that accurate information was captured, and also provided an opportunity for the representatives to include additional information, if needed. Only

responses of one comparator health unit were not validated through this process. The results of the environmental scan are presented in aggregate format.

Harm Reduction Services

Only one out of the seven health units did not offer harm reduction services; all harm reduction services for the area served by this health unit was planned and organized by the region's AIDS Committee. Harm reduction services in the remainder of the health units were offered at fixed sites, via mobile services, or both. Two of the comparator health units provided harm reduction services at fixed sites only, one health unit offered two mobile services and the remaining three health units offered services at fixed and mobile sites. Three of the mobile harm reduction services were operated by the health unit and two were operated in collaboration with community agencies. Two out of the four comparators that offered mobile service had a Public Health Nurse on-site (not every day) to provide STI testing, treatment and counselling as needed. The types of harm reduction supplies distributed varied across the six health units. None of the comparator health units offered both Naloxone and safer inhalation kits in addition to the standard harm reduction supplies – two of the comparators only offered Naloxone and two others offered safer-inhalation kits only. Supplies were accessible via community partners in all six health units, whereas walk-in access to fixed health unit sites was only available in five out of the six health units. Harm reduction supplies were accessible in a public reception area in four out of the five health units that offered walk-in access. Only one comparator provided access to supplies in a private room; clients walked-in to main reception and then taken to a private room for assessments, health teaching and supplies. Almost all the health units indicated collecting information on the client's gender, new/returning client and the number of supplies provided. In addition, a few health units also collected the client's date of birth, drug of choice, education/counselling provided, type of referral made, GPS coordinates of where needle exchange occurred (for mobile service).

Outreach initiatives for harm reduction services are in place in all six of the comparator health units. In three comparators, the program manager(s) was responsible for planning the outreach initiatives. In the remaining three health units, outreach initiatives were planned in collaboration with community organizations, the health unit's harm reduction team or outreach nurses. Outreach initiatives in most health units entail mobile needle exchange services. However, initiatives in some health units also included condom distribution and outreach services in shelters, street health centres, drop-in centres, services for sex workers and community organizations that serve target populations.

Harm reduction services offered by MLHU has some distinct differences in comparison to the six comparator health units. Similar to three of the comparator health units, MLHU offers both fixed and mobile harm reduction services. The mobile service is operated in collaboration with Regional HIV/AIDS Connection (RHAC) between 11am to 6pm Monday through Friday. No STI/HIV testing or treatment is available on the mobile van. Harm reduction supplies are accessible via three community partners (My Sister's Place, RHAC and Youth Opportunities Unlimited), walk-in to the two health unit sites (London and Strathroy), and RHAC's Mobile Van. The Health Unit is the only one among the comparators that offers a private entrance with a doorbell for clients to access supplies. Clients can directly walk to the private entrance, by-passing main reception. In addition, MLHU is the only health unit to provide clients with on-site access to both Naloxone and safer inhalation kits (along with standard Ministry funded harm reduction supplies). Similar to the comparator health units, MLHU collects information on the client's gender, date of birth, new/returning client and the number of supplies (needle tips, crack pipe kits, sharps container, piercing kits) returned and given out. A code word unique to each client is also collected to record the number of returning clients. Currently, the mobile service operated in collaboration with RHAC is the only outreach initiative available at MLHU.

Sexual Health and Family Planning Clinic

Clinic Model and Documentation

All seven health units have combined sexual health and family planning clinics. The reasons for having combined clinics include either a decreased need for birth control services, clients requesting "one-stop shop" type service or birth control and STI/BBI services being too intertwined to separate. There were no comparator health units that have protocols regarding the availability of female/male physicians. However, four of the comparators clinics had primarily female physicians. Among the seven health units,

five had clinical team assistants (CTA) or administrative assistants (AA) or receptionists. Clinic chart documentation processes/tools varied across the health units. Clinics in three of the health units were completely electronic (e.g., OSCAR database), two health units used half paper and half electronic documentation and the remaining two only used paper charts.

In comparison to the seven health units, MLHU is the only health unit to offer sexual health and family planning services through two separate clinics (STI Clinic and FP Clinic). Neither the STI nor the FP Clinics have protocols regarding the availability of male/female physicians. However, there are only female physicians in the FP Clinic and a combination of male and female physicians in the STI Clinic. Female clients are accompanied by a CTA when male physicians conduct examinations in the STI Clinic. The Health Unit has CTA and AA support, similar to five comparator health units. There are two CTAs available during the FP Clinic, 4-5 CTAs during the STI Clinic and 1 part-time AA. The STI and FP Clinic's use both paper and electronic documentation.

Specific Clinic Services

In three out of the seven combined clinics, clients require a health card for Pap tests and breast examinations. However, one of the comparators noted that if a client does not have a health card, the health unit will absorb the costs and provide the service (i.e. Pap test). On-site phlebotomy is available at all seven health unit clinics. Due to all seven of the comparators offering combined clinic services, phlebotomy is available to clients accessing both STI and family planning services. This procedure is performed by a clinic nurse in six of the comparators, whereas at one health unit, phlebotomy can be performed by either a physician or a clinic nurse. Microscopy is only offered on-site by one comparator health unit. Therapeutic abortions are not available at any of the comparator health units.

At MLHU, clients accessing services at the STI Clinic do not need a health card; however a health card is requested for Pap tests and breast examinations done in the FP Clinic. FP Clinic physicians are encouraged to see up to 3% of clients without a health card. Phlebotomy is only available on-site to STI clients. Family planning clients are provided a requisition form for phlebotomy services at an external site. In comparison to the comparator health units, MLHU is the only health unit where phlebotomy is not available on-site for clients with family planning related appointments. In addition, MLHU offers on-site microscopy in both clinics. All STI physicians and one FP physician are able to perform this. Therapeutic abortions are not available at MLHU.

Nurse-Led Clinics

There are four health units that offer a combination of nurse-led and physician-led clinics in varying ratios and services. Nurse's scope of practice in nurse-led clinics varies across the comparator health units. However, STI testing was a common practice completed by nurses in all four health units reporting nurse-led clinics. In one of the comparator health units, only clinics in schools were nurse-led, similar to MLHU. At MLHU the school outreach clinic offers combined clinic services. Public Health Nurses in school settings have a medical directive to provide STI testing and treatment, pregnancy testing and one month starts on oral contraceptives.

Service Billing

Five health units pay physicians an hourly rate ranging between $100/per hour and $110 /per hour. In the remaining two health units, physicians are only paid through OHIP billing. Administrative Assistants complete the billing process in four health units. Additionally, nurse practitioners are available at five of the health units, and all are salaried.

Overhead costs are only charged by one of the comparator health unit with a percentage ranging between 3% and 5%. The remaining six health units do not charge overhead costs. One health unit specified that this was because physicians are not employees of the health unit, but rather employed as vendors and have no ownership over the clinical sites. Each physician enters into a contract with the comparator health unit.

MLHU has a similar billing practice/model as two of the comparator health units. Physicians at MLHU were paid through OHIP, with billing for FP Clinic physicians completed by MLHU, and billing for STI Clinic physicians completed externally. MLHU does not charge overhead costs.

Clinic statistics

The seven health units were asked to provide statistics regarding to the populations that access STI clinic services, number of clients seen for STI related purposes and the number of STIs diagnosed at the health unit relative to the jurisdiction.

Populations seeking STI clinic services
Clients of all ages are seen at all seven health units, with two health units specifying MSM as a particular population who access clinic services. At MLHU all ages are seen at the STI Clinic and females under 50 years are seen at the FP Clinic. Currently, MLHU does not collect pertinent data to identify specific populations that access services.

Number of clients seen STI related purposes
The reported number of clients seen for STI related purposes varied largely across the seven health units. The numbers are not provided in this report as all the health units had a combined clinic model and hence the respondents only provided an estimate. In addition since all the health units had multiple off-site locations, the numbers reported may/may not be reflective of all clinic sites.

In 2014, there were 8,742 clients seen in the STI Clinic at MLHU.

Number of STIs relative to jurisdiction
Only one comparator health unit provided the number of STIs diagnosed relative to its jurisdiction. It was reported that 22% of all Chlamydia cases and 28% of all Gonorrhea cases were diagnosed at the comparator health unit's clinics.

In 2013, MLHU diagnosed 40.6% of the total Chlamydia cases (n=1,320) and 37.8% of the total Gonorrhea cases (n=82) at The Clinic.

Emergency Contraception and Birth Control

Plan B for emergency contraception is available at a reduced cost ($10 or $15) or for free at all seven health units. One of the comparators only offers Plan B prophylactically to clients. Plan B is not provided to a third party in six of the seven comparator health units. MLHU offers Plan B to clients for $10 or for free following a consultation with a PHN each time. Plan B can be provided to a third party following a similar consultation process – MLHU is one of the only health units among the comparators to do this.

IUD insertions are only offered by three out of the seven comparator health units. Among these health units, only one indicated that all its physicians were trained to perform IUD insertions. In addition, IUDs are not available for emergency contraception in any of the three health units offering IUD insertions services. IUD insertions are available at MLHU, with three out of the seven FP physicians trained to insert. In 2014, 56 clients had IUD insertions in the FP Clinic. MLHU is the only health unit among the comparator health units to offer IUDs for emergency contraception.

Birth control options are offered at a reduced cost at all seven comparator health units. Overall the prices for birth control are fairly consistent across all seven health units. External scripts for birth control are filled by four comparators, while the remaining three only fill external birth control scripts for clients of the health unit. The birth control options available at MLHU are similar to the seven health units and comparable in prices. External scripts for birth control are filled at MLHU, without having to become a client. In 2014, MLHU filled 1,375 external scripts for birth control.

Depo-Provera

Nurses only administer Depo-Provera via Medical Directive in two comparator health units. In the remaining five health units, nurses cannot order Depo-Provera via Medical Directive. However, three of

the five health units indicated that nurses can administer or dispense Depo-Provera if there was a nurse practitioner or physician order on file.

PHNs at MLHU do not have a medical directive to administer Depo-Provera. Depo-Provera is only administered by physicians at the Health Unit.

STI Treatment

There are limited STI treatments (excluding those that are provincially-funded) which are provided for free by the seven health units. Only one health unit provides Metronidazole for free. Valtrex is not provided for free by any of the comparator health units. It is either unavailable at the health unit or available for purchase. Liquid nitrogen is available at six of the health units. All seven of the comparator health units offer STI medications to community physicians to provide free treatment to clients.

In comparison to the seven health units, MLHU offers a greater number of STI medications for free. Currently, Metronidazole, Valtrex, Fluconazole and Cipro are provided to clients for free in addition to the provincially-funded medications. Similar to the seven comparator health units, MLHU distributes STI medications to community physicians. In 2014, MLHU distributed STI medication to 19 community physicians upon their request. Community physicians are made aware of this service by the Health Unit's Health Care Provider Outreach initiative.

HIV Testing and Post Exposure Prophylaxis (PEP)

All seven health units offer more than one type of HIV testing. Nominal testing is available in six of the comparator health units and non-nominal testing is available at three health units. Anonymous testing (via Point-of-Care (POC) HIV testing) is available at five out of the seven comparators. Post-exposure prophylaxis is unavailable at all seven comparator health units.

Similar to two of the comparator health units, MLHU offers nominal and non-nominal HIV testing. The health unit does not offer POC testing; this is available to clients through the Options Clinic at London Intercommunity Health Centre. MLHU is the only health unit among the comparators that offered post-exposure prophylaxis at on-site.

Polymerase Chain Reaction (PCR) Testing

PCR testing for Hepatitis C was available in clinics at five health units. Two out of the five health units offered this service only to clients who met specific criteria. MLHU also offers PCR testing in its clinics. Testing is used to confirm a diagnosis and is provided with the referral.

Screening

There are a number of screening tools that are integrated within the clinic services at the seven health units. Screening for abuse is done in two health units, with one specifying the Routine Universal Comprehensive Screening (RUCS) tool for this. Three comparator health units performed alcohol screening and four performed screening for smoking cessation. Only MLHU and one other comparator health unit screened for alcohol, abuse and smoking cessation.

Case management and contact tracing practices

There are multiple strategies utilized for contact tracing by the seven health units. One primarily contacted clients via letter and/or phone call. Other forms of technology, such as text, email and Facebook, are used as a last resort in five of the comparator health units. Home visits are also done on a need basis by one health unit. In most health units, PHNs work in the clinic and perform case management. However in one comparator health unit, PHNs on the STI team worked exclusively on case management.

MLHU uses all forms of technology (e.g., email, Facebook, text messaging) to connect with clients and complete contact tracing. Like the majority of comparator health units, PHNs at MLHU work in the clinic and do case management.

Section 22

Section 22 for HIV and STIs are served by three comparator health units whereas three others give out sections for HIV only. Among the six health units that provided a response, two specified that Section 22's were delivered by a process server. At MLHU, Section 22's are served for HIV only and are delivered by a PHN or the Program Manager.

Summary

Overall the services offered at the MLHU clinic are consistent and similar to the provision of sexual health services in the seven comparator health units. All seven of the comparator health units have a combined clinic model, with three health units reporting one doctor clinics with varying rations of PHNs/RNs. Clinic hours varied across the health units ranging between 3.5 hours and 6 hours. With two health units that (clinic operating for 3.5 hours and 6 hours) reported seeing 35 clients on average per clinic. MLHU is the only health unit among its comparator to have a separate clinic model. Clinics are staffed based on the type of clinic. Typically, STI Clinics are run by 2-3 physicians, 4 PHNs and 4-5 CTAs and FP Clinics are run by 2 physicians, 3 PHNs and 2 CTAs. With the current model, there were 8,742 clients seen in 2014 for STIs purposes. With the current clinic model, MLHU diagnosed 41.2% (605) of the total Chlamydia cases (n=1,468) in 2014 and 28.4% (31) of the total Gonorrhea cases (n=109) in 2014 in its clinics. These percentages were higher in comparison to the one other health unit who provided this statistic. Another health unit also indicated diagnosing a lower number of STIs in its clinic in comparison to the region (without providing statistics).

MLHU also offers additional services (not largely provided in the other health units) which are intended to increase accessibility for clients. In summary, MLHU provides a larger number of free STI medications, microscopy on-site, fills external birth control scripts at a lowered cost to non-clients, offers third party emergency contraception and IUD insertions for emergency contraception. MLHU was the only health unit where IUDs were inserted for emergency contraception. This service is provided at MLHU in accordance with best practices (i.e. SOGC). In addition, MLHU is the only health unit to provide a separate private entrance for clients accessing harm reduction supplies and offer both Naloxone and safer inhalation kits on-site.

The information from the environmental scan highlighted that MLHU was the only health unit that did not offer phlebotomy services on-site to clients accessing family planning services. In addition, all health units had off-site clinic locations within the community, with three health units having targeted clinics (i.e. clinics for street-involved populations, clinic in a priority neighbourhood, youth only clinic).

Environmental Scan – Community organizations

Further to the environmental scan with comparator health units, community organizations in London were contacted to participate in an environmental scan. Twelve community organizations were contacted to participate, of which eleven participated: London Intercommunity Health Centre (Options and Hepatitis C Care Program), Centre for Hope, Oxford Walk-in Clinic, Wharncliffe Walk-in Clinic, MLHU-Nurse Practitioner Clinic, Western Student Health Services, Fanshawe Student Health Services, Health Zone, My Sister's Place, Infectious Disease Care Program and Regional HIV/AIDS Connection. The purpose of the community environmental scan was to identify the target populations and the services available through the organization. This information may be helpful in determining opportunities for future collaborations related to sexual health initiatives. All environmental scans were completed via phone discussions. For the purpose of this report, only information pertaining to harm reduction and sexual health/birth controls services are reported.

Organizations offering primary care services

Populations that utilize services

Six community organizations primarily offered primary care services which included sexual health services. Two of the six community organizations were targeted and accessed by marginalized populations, such as homeless/unstably housed, sex workers, immigrants, young families, clients without a family physician/health card, children under 6 years of age and their immediate family. Both of these organizations also provided services to those covered by the Interim Federal Health Program. In addition, both organizations had outreach sites across the community and within other community agencies (i.e. Rothlome's House, My Sister's Place and Women's Community House).

The remaining four organizations (2 walk-in clinics and 2 student health centres) that provided primary care services was largely accessed by students (in late teens to early twenties and mature students). A health card (or UNIP coverage) is required for all services offered through the four agencies. Clients covered through the Interim Federal Health Program are provided service in two out of the four organizations. The remaining two organizations were unsure, as they have not encountered this in the past.

Clinic Model

None of the clinics were nurse-led in the six community organizations. However, in two of the organizations, clinics are nurse practitioner (NP)-led. Protocols regarding the presence of a female/male physician did not exist in any of the six organizations. The two organizations that are NP-led mainly consisted of female NPs, while the remaining four organizations provided clients with the option of having a nurse/staff sit in during the appointment when a female physician was unavailable.

Physicians were only available in four out of the six organizations. Physicians in three of the clinics were paid only by OHIP. In the remaining clinic, most physicians were paid by OHIP – with exception of two physicians who were salaried.

Emergency Contraception and Birth Control

Plan B was the only form of emergency contraception available at the two organizations that offered emergency contraception. Plan B was only provided to a third party in one of the organizations following a consultation. Although Plan B was available through two community organizations, only one consistently had this available. The remaining four community organizations did not offer Plan B through their clinics; however clients were directed to the clinic's pharmacy to purchase the morning after pill.

IUDs were available in three of the six community organizations, however none offer IUDs for emergency contraception. In two of the three community organizations, not all physicians or NPs were trained to insert. In the remaining organization, clinics were run by one NP, who was able to perform IUD insertions.

In addition, low cost contraception was not widely available through the community agencies. Contraception was only available at a lowered cost or for free through one clinic. This clinic was run by a NP from MLHU who obtained the birth control pills from the MLHU Clinic. The remaining five organizations provided clients with a script for birth control.

STI Treatment

Organizations that are NP-led provided free treatments for STIs. In the remaining organizations, two provided free treatments for Gonorrhea, one provided medications received from the MLHU Clinic for free (did not specify which ones) and one agency did not provide any free STI treatments.

HIV Testing

Nominal HIV testing was the most common method among the six community organizations. Only one organization offered non-nominal HIV testing, using the date of birth and student number. Post-exposure

prophylaxis or anonymous HIV testing was not available through any of the six community agencies providing primary care services.

Case management and contact tracing practices

Case management and contact tracing practices were similar across the six community organizations. All six agencies contacted clients via phone. In addition to a phone call, a few organizations reached clients through email or text messaging.

Organizations offering STI/Blood-Borne Infection (BBI) testing

There were two community organizations out of the eleven that primarily provided STI/BBI testing: London Intercommunity Health Centre (LIHC) (Options Clinic and Hepatitis C Care Program) and Infectious Disease Care Program (IDCP). Birth control and Family Planning services are not available through these organizations.

Populations that utilize services

Services offered through both organizations are primarily utilized by marginalized populations (i.e individuals on income support, low education, unstably housed and persons with past/current injection drug use). Both organizations offered a variety of outreach initiatives across a number of organizations within the community: My Sister's Place, Bathhouse, RHAC, At^lohsa, on-reserves, London Housing and Elgin-Middlesex Detection Centre.

STI/BBI Testing available

Both organizations primarily offered STI/BBI testing in addition to a variety of support services (i.e. medication counseling, medical and psychiatric consult, nutritional assessment). One of the organizations offered Syphilis testing, Hepatitis C testing and Point-of-Care (POC) HIV testing. The other organization did not offer testing for Syphilis, Hepatitis C or POC HIV Testing, but did provide nominal and non-nominal testing for HIV. PEPs were available through both organizations. Testing for STIs such as Chlamydia and Gonorrhea were not available at both community organizations.

Organizations offering harm reduction services

Two of the eleven community organizations provided harm reduction services: My Sister's Place and Regional HIVAIDS Connections. Harm reductions services are funded by MLHU and operated by Regional HIV/AIDS Connections. My Sister's Place is a satellite location.

Populations that utilize services

Among the two organizations that offered harm reduction services, one only saw women over the age of 16 years and the other organization primarily saw males at its fixed site and females at its mobile service.

Harm reduction services

Both organizations offered on-site access to harm reduction services. Supplies could be obtained through walk-in. In one organization client's walk-in to the main reception area to access supplies, while the other organization has a similar process to the Health Unit. Clients, if comfortable, were able to access supplies at the reception or could use the private entrance. Supplies were also accessible via mobile services in one of the community organizations. Both community agencies offered similar supplies to the Health Unit.

Summary

The findings highlighted that sexual health and family planning services offered by The Clinic are not replicated in full within the community. Among these organizations, The Clinic is one of the only local organizations that consistently offered birth control and the emergency contraception pill for free or at a

lowered cost. In addition to this, a variety of options for birth control and emergency contraception are available to meet client need. Currently The Clinic is the only local organization which offered STI medications, Metronidazole, Valtrex, Fluconazole and Cipro, for free. Although The Clinic distributed STI medications to community healthcare providers, among the organizations in the environmental scan only some provided free STI treatments.

Harm reduction services within the community are fairly consistent and similar to services offered at The Clinic. This may largely be due to MLHU funding the harm reduction services and closely collaborating with the two community organizations discussed.

It is worth noting that most organizations had a number of outreach sites within the community and within other community organizations. Organizations with outreach programs reported reaching marginalized populations in a greater number. In addition, organizations listed above that offered STI/BBI services primarily provided testing for blood-borne infections (at both fixed and outreach sites) and testing for bacterial STIs was not widely available.

Overall, the community environmental scan highlighted that there is a large inventory of services available locally, offering sexual health and harm reduction services in varying degrees. However, further investigation is warranted to determine if the sexual health and harm reduction needs of the local population are adequately met by the current provision of services by the community organizations. Additionally as bacterial STI testing (without a health card) is not widely available in the community; it may be worth investigating if this service is needed by the populations that utilize the outreach sites of community organizations.

VII. Clinic Physicians Survey

Key Findings

- 8 clinic physicians (n=9) indicated that the current clinic hours were sufficient to meet client needs

- 5 clinic physicians (n=7) disagreed with offering clinic services in additional locations

- 4 Family Planning physicians (n=6) provided a percentage (ranging between <3% - 10%) of clients they are willing to see without a health card

- 4 clinic physicians (n=7) are supportive of MLHU exploring other payment options

- 5 clinic physicians (n=8) were satisfied with their physical working conditions

Background

The Clinic physician's engagement and perspectives was identified as an important component to inform this review process. To help capture their perspectives, a physician survey was conducted. The purpose of the survey was to gather FP and STI physician's opinions and feedback on various aspects of The Clinic, such as hours, services, payment models and assessments/medical directives.

Methodology

Survey design and data collection

In reviewing the information gathered for the program review, a set of questions were developed regarding the clinic's structure and services. The questions were tailored into two separate surveys to account for the different roles and services provided by the STI and FP physicians. Each survey question was collaboratively assessed and revised by the service area Director, Program Manager and Program Evaluator. The survey was not piloted due to time limitations. However, the findings were presented and

discussed with the clinic physicians in a group setting to ensure the results were interpreted accurately. This process was completed to validate the results and provide an opportunity to gain more detailed comments.

The Clinic manager contacted all the clinic physicians via E-mail and requested their participation in the survey. The survey was only administered electronically via FluidSurveys and available between February 20th and February 26th. The findings of the survey were presented to physicians, during which time nine of the twelve clinic physicians attended.

Data analysis

Quantitative survey data was analyzed directly in FluidSurveys. Information was presented as frequency data. Qualitative responses were exported to Excel and analyzed for commonality and reported based on underlying themes. Results for both FP and STI physicians are reported together for each survey item. Missing data was stated for each question, if any existed.

Results

There are a total of 12 clinic physicians, all of which were eligible to participate - four physicians worked exclusively in the STI Clinic and the remaining 8 physicians worked exclusively in the FP Clinic. The response rate was 75%, as 9 out of the 12 physicians participated (Table 7.1). The reasons for non-participation were not collected.

Table 7.1: Number of physicians who responded

Clinic	# of respondents (%)
Family Planning	7 (88%)
STI	2 (50%)

Operational hours of the Clinic

Three survey items examined the operational hours of The Clinic and the physician's flexibility with increasing clinic hours. 6 out of 7 FP physicians and both STI physicians either agreed or strongly agreed that the current clinic hours were sufficient to meet client needs. FP physicians commented on offering family planning appointments over the lunch hour, or increase the availability of morning and afternoon appointments (i.e. 8:50am to 12pm or 12:50pm to 4pm). Four out of seven FP physicians were supportive of formally increasing the operational hours of the clinic to 3 hours. The remaining three FP physicians and both STI physicians indicated that current clinics operate for 3 hours on average. FP physicians provided comments which suggest that they would consider 3 to 4 hour clinics if there was a 30 minute overlap between physicians, if physicians working the morning/afternoon shifts were not adversely affected (i.e. lose a shift) or if the lunch hour was better utilized. Six FP physicians and one STI physician agreed to have flexibility with their schedules if the operational hours of the clinics were to change. Two physicians (one FP physician and one STI physician) either disagreed or strongly disagreed with having this flexibility in their schedules.

Additional Clinic locations

A large number of The Clinic physicians disagreed with offering additional clinic locations. Physicians indicated that the needs of the community needed to be established to determine if additional locations are warranted. Four FP physicians and one STI physician disagreed with offering sexual health clinics in additional locations. A FP physician indicated that additional locations would only be feasible if the clinic shifted to a paperless system. A STI physician also noted that the current location was accessible to young people given the attendance rate. Only two FP physicians agreed with offering additional clinic locations.

Services to clients without a health card

Physicians in the FP Clinic were asked about the percentage of clients they currently saw without a health card, and the percentage of clients they were willing to see without a health card. As clients of the STI Clinic did not need a health card for service, STI physicians were not asked this question. The Clinic encourages FP physicians to see up to 3% of clients without a health card. FP physicians provided different percentages of clients they current saw and were willing to see without a health card. Majority of the physicians indicated not knowing the percentage of clients they currently saw without a health card. A summary of the physician responses are provided in Table 7.2.

Table 7.2: Responses for the percentage of clients without a health card physicians currently see and the percentage of clients without a health card physicians are willing to see

	% of clients physician currently see	**% of clients physician willing to see**
Respondent 1	2%	<3%
Respondent 2	Has not occurred	10%
Respondent 3	Not sure, 1%	No response
Respondent 4	Not sure. Staff direct clients to take care of this prior to appointment	No reason for physicians to see clients without a health card as the clinic has salaried PHNs
Respondent 5	Don't know	5%
Respondent 6	<5%	<5%
Respondent 7	Not sure	None, if overhead costs are charged based on billings. If the patients are willing to pay for service then it would depend

Payment models

Five FP physicians and two STI physicians responded to the question regarding physician payment models. Three FP physicians were supportive of the health unit exploring other payment options and two FP physicians either disagreed or strongly disagreed with this. Overall FP physicians indicated that their support for overhead costs would be dependent on the percentage and the amount of autonomy physicians received. Of the three physicians that were supportive of the Health Unit exploring other payment models, only one would continue to work at The Clinic and the remaining two were unsure. Among the two physicians who were not supportive of exploring other payment options, one would continue to work at the Health Unit.

One STI physician was supportive of the Health Unit exploring other payment options. Similar to the comments provided by the FP physicians, the STI physician indicated that their support is dependent on the percentage of overhead cost charged. The other STI physician strongly disagreed and commented that they do not wish to see a change from the current remuneration system. Both STI physicians were not sure about continuing to work at the clinic if another payment model was implemented.

The findings regarding payment models should be interpreted with caution as the survey question may have been leading to respondents. The question was intended to be comprehensive of all payment models, however only overhead cost was included as an example. This may have led physicians to provide their response specific to the overhead cost model. In addition, it is worth noting that the question regarding continuing to work at the Health Unit was not posed toward a specific payment model, hence physician responses may be different once a payment model is decided upon.

IUD Insertions

IUD insertions are not performed in STI Clinics; as a result only FP physicians were asked questions pertaining to this service. Four physicians indicated that insertions should be incorporated into regular clinic hours. The remaining three FP physicians were not in support of this, due to unpredictable complications during the procedure that could be disruptive to the flow of the clinic. Additional training/resources for IUD insertions were needed by four physicians, if the clinic were to shift to a model where most/all physicians performed this procedure. Two of the four physicians commented that they should have a choice on whether or not they want to perform this procedure. Only one physician indicated not needing any additional training/resources. Of the remaining two physicians, one did not respond, and one physician was unsure and indicated that the issue was personal risk aversion rather than individual skill.

Phlebotomy Services

Phlebotomy is only available to clients on-site during the STI Clinics. FP clients receive a requisition form to have the procedure done at an external lab. Hence, FP physicians were only asked if bloodwork for STIs would more likely be ordered if someone was on-site to perform this procedure. Four physicians indicated that they would not be more likely to order bloodwork for STIs if services were available on-site. These physicians noted that phlebotomy requisitions are ordered as required and not based on availability of the service on-site. Of the remaining three physicians, two indicated that they would be more likely to order bloodwork for STIs if someone was available on-site, and one physician was unsure. During the group discussion with the physicians, it was noted that the physicians interpreted this question as questioning their practice as phlebotomy requisitions are ordered based on need rather than on-site availability. The group discussion clarified this, and comments indicated that phlebotomy services on-site during FP clinics would increase access to clients but not influence the physician's practice to order phlebotomy service.

Review of Nurse and Physician assessments

Six FP physicians and one STI physician either agreed or strongly agreed that it would be beneficial to examine nurse and physician assessments to ensure there were no duplications. Only one FP physician strongly disagreed with this statement and commented that physicians are obligated to perform an assessment as per their license and malpractice insurance and that often times there are discrepancies between what the nurses are told and what the physicians are told by the client; hence physicians need to perform assessments to determine the appropriateness of a treatment/procedure. One STI physician also disagreed with examining nurse and physician assessments to ensure that there was no duplication. Additionally, clinic physicians were given the opportunity to choose assessments they would prefer PHNs to complete, prior to them seeing the client. All FP physicians agreed with having PHNs complete blood pressure measurements, Pap test eligibility, RUCS screening and pregnancy testing. FP physicians were less supportive of PHNs performing STI and birth control counselling. Both STI physicians were supportive of PHNs performing symptom review, sexual health history, sexual health risk factor and STI counselling. A complete list of assessments and physician responses are summarized in Table 7.3.

Table 7.3: Assessment to be performed by PHNs

Type of assessment	# of FP Physicians	# of STI Physicians
Blood Pressure measurement	7	
Pap test eligibility	7	
Birth control counselling	3	
Symptom review	6	2
Sexual Health history	6	2
Smoking	6	1
Alcohol/Drug use	6	1
RUCS screening	7	1
Sexual health risk factor	5	2
Pregnancy testing	7	None
STI counselling	3	2
Other	▪ On time for Depo-Provera ▪ Provide post STI counselling & extra counselling for new birth control starts	▪ Counselling regarding HIV testing

Medical Directives

Currently, there are some medical directives (i.e. ECP) in place that nurses practice under. To determine whether physicians were in support of expanding nurse's scope with medical directives, all clinic physicians were asked which services they were supportive of nurses carrying out under medical directive. Responses were only provided by FP physicians. 6 FP physicians were supportive of nurses carrying out pregnancy testing and dispensing the emergency contractive pill under the medical directive. Physicians were less supportive of nurses performing Depo-Provera injections and 3-month pill starts under the medical directive (Table 7.4). One FP physician did not select any of the listed medical directives, but noted that they would support "nurses ordering pregnancy tests, emergency contraception, urine STI vs swabs".

Both STI physicians did not choose any of the listed medical directives. STI physicians noted that having nurses perform these services would reduce the need for physicians in the clinic, and that nurses are already busy during clinics.

*Table 7.4: **Number of FP physician supportive of nurses performing the following medical directives***

Medical Directives for:	# of FP Physicians
Pregnancy testing	6
Emergency contraceptive pill	6
STI treatment for positive Chlamydia & Gonorrhea	5
Hepatitis A and Hepatitis B injections	5
Depo-Provera injections	2
STI testing in asymptomatic clients	3
3-month pill starts	2

Sexual Health Clinic Best Practices

A large number of the clinic physicians did not respond to the question regarding sexual health best practices that could be used more consistently in the clinic. Only two physicians responded, of which both were from the FP Clinic. The physicians suggested the clinic promote HPV vaccines and move toward evidence-informed guidelines. Although none of the STI physicians responded to this question, one indicated that they did not understand the question. A discussion to determine sexual health clinic best practices will be held at a later date.

Electronic documentation

Four out of the nine clinic physicians either agreed or strongly agreed that using electronic documentation would provide significant benefits to The Clinic. The remaining five clinic physicians (three FP and two STI) either disagreed or strongly disagreed with electronic documentation having significant benefits to The Clinic.

One FP physician was unsure and four FP physicians were supportive of moving toward electronic documentation in The Clinic. The remaining two FP physicians and both STI physicians either strongly disagreed or disagreed with moving toward electronic documentation. STI and FP physicians had similar reasons for not supporting the move to electronic documentation. Physicians indicated that the current layout of the clinic room will not comfortably accommodate the client and EMR and that introducing electronic documentation may result in longer clinic visits. If The Clinic were to shift to a model where most/all documentation was electronic, one FP physician and both STI physicians indicated needing training/resources.

Healthcare provider outreach

Three FP physicians indicated a need for the Health Unit to actively engage in outreach with community healthcare providers. All the FP physicians who indicated this expressed an interest in being involved with outreach work. Three FP physicians and one STI physician were not sure if there was a need for outreach, however two (one FP and one STI) physicians were interested in being involved with outreach. The STI physician also commented that a needs assessment survey could help determine if this service is warranted by community healthcare providers. In contrast, one FP physician and one STI physician did not think there was a need for healthcare provider outreach. Both physicians were not sure if they would be interested in being involved and commented that outreach initiatives for healthcare providers are already done by the Health Unit.

Satisfaction with physical working conditions

Five FP physicians were satisfied with their physical working conditions. The remaining two were not satisfied, both commented on the need to increase space as a means to improve their physical working conditions. In addition, one STI physician stated that they were not satisfied with their physical working conditions and the other STI physician did not respond. Both physicians noted that an enlargement to the physician's working area will improve their working conditions.

VIII. Client Satisfaction Survey

Key Findings

Family Planning Clinic
- The overall quality of service provided in the FP Clinic was rated as very good or excellent by 87.9% (269/306) of respondents
- Over half (57.7%, 188/326) of the respondents chose The Clinic to meet their needs either because they could not get an appointment with their health care provider (HCP), did not have a HCP or did not want to talk about their sexual health with their HCP
- The current location of The Clinic was reported to be accessible by 95.0% (303/319) of FP respondents
- The most valued aspect of The Clinic was the staff, with over half (58.9%, 151/260) of the respondent indicated this
- Nearly half (47.5%, 77/162) of the respondents noted that no changes needed to be made to The Clinic. Extending clinic hours and reducing wait time between seeing nurse and doctor were some of the comments for improvement provided by a small number of respondents.

Sexually Transmitted Infection Clinic
- The overall quality of service provided in the STI Clinic was rated as very good or excellent by majority (88.1%, 280/318) of respondents
- Over half (54,3%, 204/376) of the STI respondents chose the STI Clinic to meet their needs because they could get here easily
- STI clients preferred the drop-in clinics, with 56.5% (205/363) of respondents indicating a preference for this model
- The location of The Clinic was reported to be accessible by 96.2% (354/368) of the STI respondents
- Similar to FP clients, STI clients noted that staff were the most valued aspect of The Clinic, followed by the speed and convenience of the service.
- Nearly a third of respondents (56/173) indicated that no changes needed to be made to The Clinic. Improvements to wait times, longer clinic hours and the clinic environment were suggested by a small number of respondents.

Client satisfaction surveys are a component of quality assurance, as reported by the *MOHLTC's Sexual Health Clinical Services Guidance Document* (Ontario, 2010). The Clinic conducted a client satisfaction survey in 2010 and obtained valuable feedback, which helped inform decisions to improve clinic services. Given that the previous survey was conducted five years ago, it was deemed appropriate to reassess client satisfaction.

The objectives of client satisfaction survey were to:

- Determine clients' accessibility to The Clinic and their preference for clinic structure, hours and appointment booking styles
- Gather clients' perspective on the quality of service and interaction with clinic staff
- Gather feedback on the strengths of The Clinic and areas for improvement

Methodology

Sampling strategy and data collection

A convenience sample was used for this survey. All clients accessing services at the STI and FP Clinics between May 20 and June 15, 2015 were invited to participate in the survey by the Clinical Team Assistants, at the time of registration. Those agreeing to participate were given a lip balm, as a small token of appreciation. The number of surveys distributed and the number of clients refusing to participate were tracked on a log sheet. The demographic characteristics of those who declined and their reasons for declining to participate were not recorded.

The estimated sample size was 367 for the STI Clinic and 362 for the FP Clinic. Sample size was calculated using the sample size calculation reported by Krejcie & Morgan (1970) (Table 8.1):

$$\text{Sample Size} = \frac{X^2 * N * P * (1 - P)}{(d^2(N - 1)) + (X^2 * P * (1 - P))}$$

Table 8.1: Sample size calculation for FP and STI Clinics

Clinic	Total # of client visits in 2014 (Population size , N)	X² (df=1, 95% CI)	Population proportion (P) assumed	Degree of accuracy (d)	Estimated sample size
Family Planning	6474	3.84	0.5	0.05	362
STI	8363	3.84	0.5	0.05	367

Respondents were instructed to complete the first component of the survey (Questions 1 through 13) in the waiting room prior to seeing the nurse/doctor. The second component, focusing on their interaction with clinic staff, overall rating of clinic service and basic demographic information were to be completed in the exam room after their appointment with the nurse and doctor. Respondents were asked to place the survey in a box at the front of the clinic as they exited.

Data analysis

Survey responses were entered into FluidSurveys by the team's Administrative Assistant. Quantitative data was analyzed in FluidSurveys and reported as frequency data. Qualitative data was analyzed for commonality and reported based on underlying themes. Survey findings are reported based on the clinic as different services are provided in the STI and FP Clinics.

Results

Family Planning Clinic Clients

Surveys were conducted over the 25 FP Clinics in order to reach the estimated sample size. 11% (46/416) of FP clients who were asked to participate in the survey declined. The demographic characteristics of clients who declined and their reasons for declining were not recorded. For the purpose of this section, only responses from female respondents are reported, as services provided in the FP Clinics are largely utilized by females. There were a total of 370 surveys completed in the FP Clinics, of which 42 responses were excluded from the analysis for this report. Majority (92.9%, 39/42) of responses were excluded because respondents did not specify their gender and a small portion (7.1%, 3/42) of responses were excluded because respondents were male. There were a total of 328 female FP respondents.
A comparison between the demographic characteristics of clients attending the FP Clinic in 2014 and the survey sample highlighted that females 15 to 19 years of age were slightly underrepresented in the sample and females 30 to 39 years of age were slightly overrepresented in the sample. The demographic characteristics are summarized in Table 8.2.

19.7% (64/325) of the survey respondents were new clients and the remaining 80.3% (261/325) of respondents were returning clients. Among these returning respondents, 49.8% (130/261) had been to the FP Clinic, 8.4% (22/261) had been to the STI Clinic and 28.0% (73/261) had been to both FP and STI Clinics in the past.

Table 8.2: Demographic characteristics of female FP respondents and female clients attending FP Clinics in 2014

Age range	% of female respondents (#)	% of female clients attending FP Clinics in 2014 (#)
<15 years old	0.3% (1)	0.6% (28)
15 - 19 years old	12.8% (42)	16.0% (783)
20 - 24 years old	31.4% (103)	32.9% (1608)
25 - 29 years old	27.4% (90)	27.3% (1334)
30 - 39 years old	22.9% (75)	18.2% (891)
≥40 years old	5.2% (17)	5.1% (248)
Total	**328**	**4892**

Hearing about the clinic

Promotion of The Clinic and increasing awareness of its services in the community is done through various platforms. To determine how clients hear about The Clinic and its services, a question pertaining to this was asked in the survey. A complete summary of the reported responses are presented in Table 8.3.

Word of mouth was reported by more than half of the respondents (57.4%, 187/326). This was followed by 37.4% (122/326) of respondents who heard about The Clinic through the Middlesex-London Health Unit Website. Similarly among respondents who were new to the FP Clinic, word of mouth was also the most commonly cited response, with nearly half (48.4%, 31/64) of new clients reporting this. This was followed by the Health Unit website, which was reported by nearly a third (31.3%, 20/64) of new respondents.

Table 8.3: Responses to "How did you hear about The Clinic?"

Response	% of FP respondents
Word of mouth (friend, family etc.)	57.4% (187/326)
Middlesex-London Health Unit website	37.4%(122/326)
Referred by doctor, clinic or emergency department	12.0% (39/326)
Clinic poster or ad	10.4% (34/326)
Other (i.e. Google/Internet, used other MLHU services)	8.6% (28/326)
Referred by school nurse	4.6% (15/326)
Community presentation	3.7% (12/326)
Facebook	2.8% (9/326)
Twitter	0% (0/326)

Note: Percentages were calculated based on the total number of respondents (n=326). Because respondents were able to choose multiple options, the sum of the percentages exceeds 100%.

Purpose of Clinic Visit

Nearly all (99.4%, 326/328) FP respondents specified the purpose of their visit to The Clinic (Table 8.4). Low cost birth control was the purpose of visit for half of the respondents (50.6%, 165/326). The least cited reason for visit was to obtain free condoms, with only 1.8% (6/326) of respondents who indicated this. Apart from the options provided, nearly a fifth (18.1%, 59/326) of the respondents provided other

reasons for their clinic visit. 66.1% (39/59) of the other reasons reported by respondents were birth control related consults (i.e. IUD removal, side effects and refill on scripts).

Table 8.4: Responses to "Why did you come to The Clinic today?"

Response	# of FP respondents
Low cost birth control	50.6% (165/326)
Other reason	18.1% (59/326)
PAP test	17.5% (57/326)
Annual exam	15.3% (50/326)
Testing or checking for infection	14.4% (47/326)
Counselling or information	12.6% (41/326)
Pregnancy Test	8.9% (29/326)
Free treatment	5.5% (18/326)
Morning After Pill (Emergency Contraceptive Pill)	4.0% (13/326)
Free condoms	1.8% (6/326)

Note: Percentages were calculated based on the total number of respondents (n=326). Respondents were able to choose multiple options; hence the sum of the percentages exceeds 100%.

Reasons for choosing The Clinic

There 326 respondents who provided reasons for why they chose The Clinic to meet their needs (Table 8.5). More than half (57.7%, 188/326) of these respondents indicated that they chose The Clinic because they did not have a health care provider (HCP), could not get an appointment with their regular HCP or did not want to talk about their sexuality with the regular HCP. None of the FP respondents indicated not having a health card as the reason for their visit to The Clinic.

Table 8.5: Responses to "Why did you choose The Clinic instead of somewhere else?"

Response	Total
I do not have a HCP/ I do not like to talk about my sexuality with my regular HCP/ I was not able to get an appointment with my regular HCP	57.7% (188/326)
I can get here easily	49.7% (162/326)
I trust the nurses and doctors here	38.3% (125/326)
I cannot get the service I need anywhere else	12.3% (40/326)
Other reason (i.e. women's only clinic, fast, affordable)	10.4% (34/326)
I was referred here by someone (i.e. friend/family, healthcare centre/professional)	8.3% (27/326)
I do not want my parents/guardian/partner/others to know that I need sexual health services	6.4% (21/326)
I do not have a Health Card	0% (0/326)

Note: Percentages were calculated based on the total number of respondents (n=326). Respondents were able to choose multiple options; hence the sum of the percentages exceeds 100%.

Accessibility of The Clinic location

The current location of The Clinic was reported to be accessible by majority (95.0%, 303/319) of the FP respondents. 5.0% (16/319) of the respondents indicated that The Clinic was not easily accessible to them. Among these respondents, 10 specified areas in London that would be the most accessible to them, with 60% (6/10) preferring the Northeast London region.

These results need to be interpreted with caution as there is a potential for bias. As this survey used a convenience sample, there is a potential for over-representation or under-representation. Although respondents from our sample reported that the clinic was accessible, this may not truly reflect the responses of clients who did not complete the survey.

Preferred clinic model and preferred method of booking appointments

The current FP Clinic model of booked appointments was preferred by more than half (52.0%, 169/325) of the respondents. For 38.8% (126/325) of the respondents, the clinic model did not matter to them. The remaining 9.2% (30/325) of respondents preferred drop-in FP Clinics.

Majority (86.4%, 273/316) of the respondents preferred to book appointments via telephone. This was followed by nearly a third (32.9%, 104/316) of respondents who preferred to book appointments on-line and 27.8% (88/316) of respondents who preferred to book appointments in-person. Email (22.8%, 72/316) and text (20.3%, 64/316) was the least preferred method to book appointments, with approximately a fifth of respondents preferring this. A cross tabulation between the preferred method of book appointments and the preferred clinic model highlighted that booking appointments by telephone continued to be the most preferred irrespective of the clinic model preferred.

Note: *Respondents were able to select multiple methods to book appointments; hence the sum of the percentages exceeds the number of the respondents.*

Clinic Type

Clients were asked the type of clinic (i.e. Female-only Clinics, Male-only Clinics) they would feel most comfortable attending, and if they had a preference to be seen by a female or male physician (Table 8.6). Over half (58.3%, 189/324) of the respondents indicated that the type of clinic did not matter to them.
However, a large percentage (69.1%, 224/324) of respondents indicated a preference to be seen by a female physician

Table 8.6: Clinic type vs gender of physician providing care

		Preferred gender of physician			
		Female doctor # (column %)	Male doctor # (column %)	Does not matter to me # (column %)	Total
Type of Clinic	Female-only Clinics	114 (50.9%)	0 (0%)	10 (10%)	124
	Male-only Clinics	0 (0%)	0 (0%)	0 (0%)	0
	Female & Male Clinics	6 (2.7%)	0 (0%)	5 (5%)	11
	Does not matter to me	104 (46.4%)	0 (0%)	85 (85%)	189
	Total	225	0	100	

Clinic hours

Clients were asked their preference for FP Clinic hours. A list of hours were provided and respondents were asked to indicate their first, second and third choices. Nearly all (98.5%, 323/328) of the respondents indicated their preference. A summary of the responses (Figure 8.1) and the ranks of the top three choices (Table 8.7) are provided below.

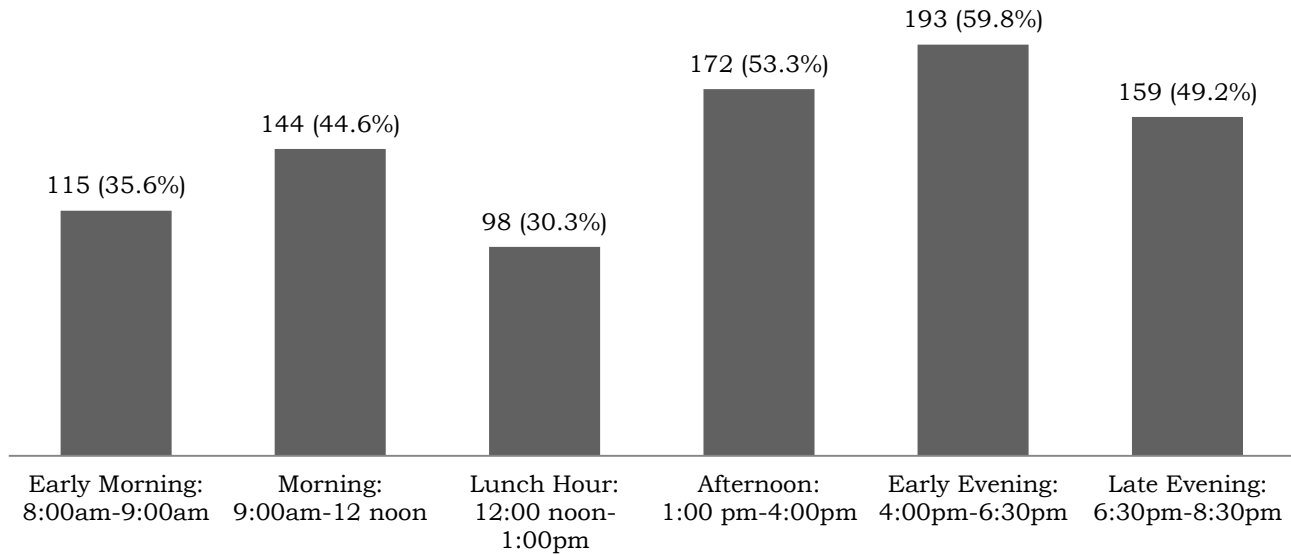*Figure 8.1: Preferred clinic hours by female FP respondents*

Table 8.7: Female respondent's preference and rank for FP Clinic hours

	First Choice % (#)	Second Choice % (#)	Third Choice % (#)	Did not specify preference % (#)	Total
Afternoon (1:00pm to 4:00pm)	32% (55)	19.8% (34)	32% (55)	16.3% (28)	172
Early Evening (4:00pm to 6:30pm)	32.6% (63)	27.5% (53)	22.3% (43)	17.6% (34)	193
Late Evening (6:30 to 8:30pm)	13.8% (22)	38.4% (61)	27.0% (43)	20.8% (33)	159

These findings need to be interpreted with caution as there is a potential for bias. Cross-tabulating the preferred clinic hours with the clinic the respondent attended highlighted that 47.7% (92/193)of respondents who preferred early evening clinic also completed the survey while attending an early evening clinic. Similarly, 60.5% (104/172) of respondents who indicated a preference for afternoon clinics completed the survey while attending an afternoon clinic. As currently late evening clinics are not offered, none of the respondents who indicated a preference for late evening clinics attended a late evening clinic.

Clinic hours – Youth (15-24 years old)

Further analysis was conducted to determine the FP clinic hours preferred by youth, a population identified as a priority population for sexual health services (Table 8.8). Nearly all (97.9%, 142/145) of the FP respondents between the ages of 15 and 24 indicated their preference. More than half (58.5%, 83/142) of these respondents indicated that they preferred the afternoon clinic hours (Figure 8.2). This was followed by 55.6% (79/142) who preferred the early evening clinic hours and 49.2% (70/142) of respondents who preferred the morning clinic hours.

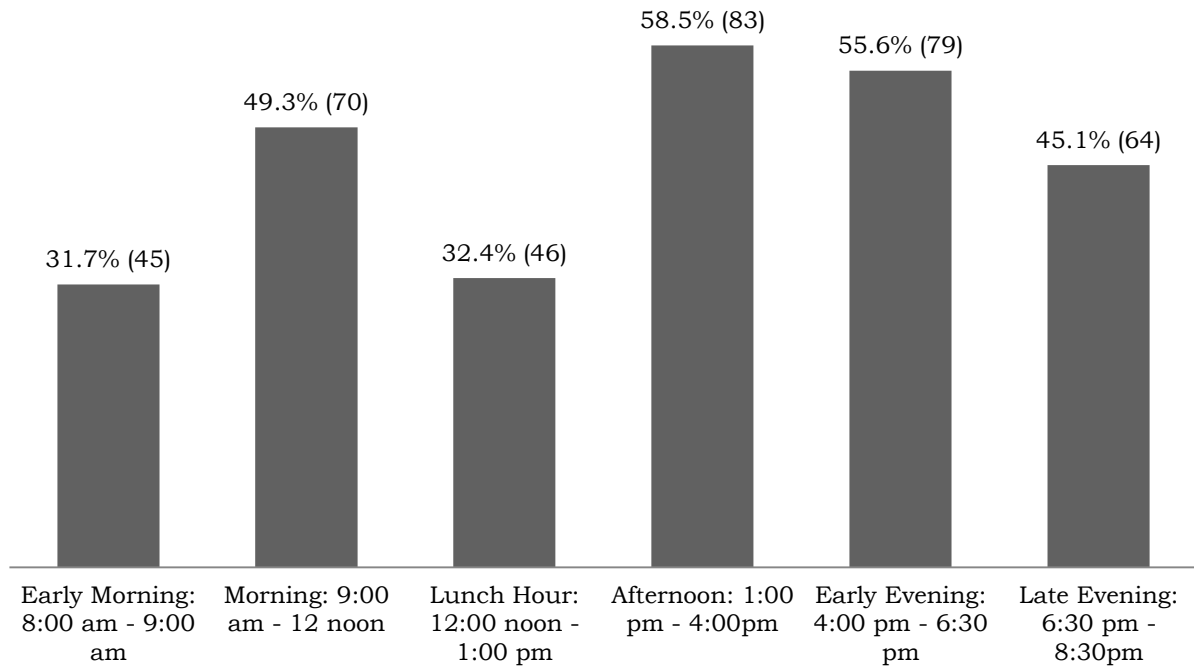*Figure 8.2: Preferred clinic hours by FP respondents between 15-24 years*

Table 8.8: Female youth's preference and rank for FP Clinic hours

	First Choice % (#)	Second Choice % (#)	Third Choice % (#)	Did not specify preference % (#)	Total
Morning (9:00am to 12 noon)	37.1% (26)	22.9% 16)	28.6% (20)	11.4% (8)	70
Afternoon (1:00pm to 4:00pm)	38.6% (32)	19.3% (16)	30.1% (25)	12.0% (10)	83
Early Evening (4:00pm to 6:30pm)	31.6% (25)	30.4% (24)	25.3% (20)	12.7% (10)	79

These findings need to be interpreted with caution as there is a potential for bias. Cross-tabulating the preferred clinic hours with the clinic the respondent attended highlighted that 60.2% (50/83) of youth who preferred afternoon clinic hours, also completed the survey while attending an afternoon clinic. Similarly, 49.4% (39/79) of respondents who preferred early evening clinic hours completed the survey during an early evening clinic and for those who preferred morning clinic hours, 22.9% (16/70) completed the survey in a morning clinic.

Reception

Nearly all (99.1%, 319/322) FP respondents indicated that they were greeted politely while checking in for their visit. The wait time between check-in and seeing the nurse was less than 15 minutes for 82.6% (256/310) of respondents who reported their wait time. 14.5% (45/310) of FP respondents indicated waiting between 15 and 30 minutes to see a nurse and the remaining 2.9% (9/310) of respondents waited more than 30 minutes.

In addition to the wait times, the survey sample was asked whether they were okay with the time they waited to see the nurse. For majority (96.2%, 302/314) of the respondents the wait time to see a nurse was acceptable. However, 3.8% (12/314) of the respondents were not okay with the length of time they waited to see the nurse. The wait times reported by these 12 respondents varied from 15-30 minutes to more than 45 minutes.

Interaction with Nurse and Doctor

Respondents were provided with a set of statements regarding their interaction with the nurse and doctor. Responses for these statements are provided in Table 8.9. Majority of respondents either agreed or strongly agreed with the statements provided. A little over 6% of respondents either disagreed or strongly disagreed with each statement for their interaction with the nurses and doctors. These responses were further reviewed to determine if there were any concerns specified throughout the survey. All respondents who strongly disagreed or disagreed rated the overall quality of service as good, very good or excellent. Language barriers and literacy levels are possible explanations for this discrepancy.

Table 8.9: Interaction with the Nurse and Doctor

	Nurse					Doctor				
	Strongly Disagree	Disagree	Neither disagree nor agree	Agree	Strongly Agree	Strongly Disagree	Disagree	Neither disagree nor agree	Agree	Strongly Agree
The nurse/doctor listened to my concerns	6.6% (21/318)	0	0.6% (2/318)	18.6% (59/318)	74.2% (236/318)	6.3% (18/286)	0	1.0% (3/286)	21.3% (61/286)	71.3% (204/286)
The nurse/doctor treated me with respect	7.0% (22/316)	0	0	14.9% (47/316)	78.2% (247/316)	6.3% (18/286)	0	0	17.8% (51/286)	75.9% (217/286)
The nurse/doctor was helpful	6.7% (21/313)	0	1.6% (5/313)	16.9% (53/313)	74.8% (234/313)	6.4% (18/280)	0	1.1% (3/280)	17.5% (49/280)	75% (210/280)
The nurse/doctor gave me the information I needed to make the best decision	6.6% (21/316)	0	4.4% (14/316)	19.3% (61/316)	69.6% (220/316)	6.25% (18/288)	0	1.7% (5/288)	21.5% (62/288)	70.5% (203/288)
I had enough time to discuss my concerns and questions with the nurse/doctor	6.7% (21/315)	0	1.0% (3/315)	20.3% (64/315)	72.1% (227/315)	6.0% (17/285)	0.4% (1/285)	1.4% (4/285)	20% (57/285)	72.3% (206/285)

Phlebotomy Services

As phlebotomy services are not currently offered in FP Clinic, clients were asked where they would prefer to have it completed, if they required bloodwork. 4.9% (14/288) or respondents needed phlebotomy services during their visit. Among these respondents, more than half (57.1%, 8/14) indicated a preference to have the blood work completed on-site.14.3% (2/14) preferred an off-site lab and for the remaining 28.6% (4/14) respondents the location did not matter.

Quality of FP Clinic Service

The overall quality of service was rated as excellent or very good by 87.9% (269/306) of FP respondents. 11.4% (35/306) of respondents reported receiving good service and less than 1% (2/306) reported receiving fair service. Suggestions for improvement were retrieved for the two respondents who indicated receiving fair service. Among the two, only one provided a comment for improvement. The comment was in reference to the respondent's specific FP appointment and not related to the overall FP Clinic.

Clients were asked to report what they liked or valued most about The Clinic. Responses were categorized based to common themes. Over half (58.1%, 151/260) of FP respondents valued the staff at The Clinic. 42.3% (110/260) of respondents valued the service, and commented on the confidential and non-judgemental nature of the clinic. A fifth (20.7%, 54/261) of the respondents also valued the convenience and speed of the services offered at The Clinic.

Suggestions for improvement were completed by 162 respondents, among which 47.5% (77/162) noted that no changes needed to be made. Other comments for improvements were made in small numbers. 11.7% (19/162) of respondents commented on having longer clinic hours and 10.5% (17/162) of respondents commented on improving wait times (between seeing the nurse and doctor).

STI Clinic

A total of 380 respondents completed the survey over 10 STI Clinics. 17.2% (79/459) of STI clients who were asked to participate in the survey declined. The demographic characteristics of clients who declined and their reasons for declining were not recorded.

91.1% (346/380) of the STI respondents reported their gender and 91.6% (348/380) reported their age range. There were fairly equal numbers of female and male respondents, with a slightly higher number of respondents identifying as male. The demographic characteristic of the STI respondents are summarized in Table 8.10. A comparison between the demographic characteristics of clients attending the STI Clinic in 2014 and the survey sample highlighted that females and males in the 15-19 year age group were underrepresented in the survey sample. Additionally, females between the ages of 25 and 29 years were slightly overrepresented in the sample.

Table 8.10: Demographic characteristic of STI Clinic respondents

	Female % (n)	Male % (n)	I do not wish to answer	Total
<15 years old	0	0.6% (1)	0	**1**
15 - 19 years old	9.5% (16)	4.6% (8)	0	**24**
20 - 24 years old	38.7% (65)	29.1% (51)	33% (1)	**117**
25 - 29 years old	27.4% (46)	22.9% (40)	33% (1)	**88***
30 - 39 years old	17.3%(29)	24% (42)	0	**72***
≥40 years old	6.5% (11)	18.3% (32)	0	**45***
I do not wish to answer	0	0	33% (1)	**1**
Total	**168**	**175**	**3**	

* Total included respondent(s) who did not indicate their gender, but provided their age group

Note: In 2014, approximately 18% of the clients attending the STI Clinic were females between the ages of 15 and 19 years, and 8% of STI Clinic clients were males between the ages of 15 and 19 years. Additionally, in 2014 a fifth of the STI Clinic clients were females aged 25 to 29 years.

37.2% (139/374) of the STI respondents were new clients and the remaining 62.8% (235/374) of respondents had previously been to The Clinic. Among the returning respondents, 68.5% (161/235) had been to the STI Clinic, 11.9% (28/235) had been to both the STI and FP Clinics and 9.4% (22/235) had previously been to the FP Clinic. The remainder (10.2%, 24/235) of the respondents did not specify which clinics they had previously attended.

Hearing about The Clinic and purpose of clinic visit

Similar to FP respondents, over half (54.7%, 208/380) of STI respondents heard about The Clinic through word of mouth. Facebook and Twitter were the least common sources through which the respondents heard about The Clinic. There were 8.7% of respondents who noted other modes through which they heard about The Clinic - Google and other community organizations/events were some of the reported sources. (Table 8.11)

Nearly all (99.2%, 377/380) STI respondents provided the reason for their visit. Testing or checking for infection was the most commonly reported, as 78.8% (296/377) respondents specified this as the reason for their visit. A fifth (18.6%, 70/377) of the respondents visited the STI Clinic for free treatment and 9.8% (37/377) of respondents visited for an annual exam which would include a breast exam and Pap test. The least cited reason for visit was for the morning after pill (Plan B), with only 1.3% (5/377) of respondents visiting the STI clinic for this.

Table 8.11: Response to "How did you hear about The Clinic?"

Response	# of clients
Word of mouth (friend, family etc.)	54.7% (208/380)
Middlesex-London Health Unit website	43.4% (165/380)
Clinic poster or ad	8.7% (33/380)
Other	8.7% (33/380)
Community presentation	6.1% (23/380)
Referred by doctor, clinic or emergency department	5.5% (21/380)
Referred by school nurse	3.9% (15/380)
Facebook	1.8% (7/380)
Twitter	0.3% (1/380)

Note: Percentages were calculated based on the total number of respondents (n=380). Respondents were able to choose multiple options; hence the sum of the percentages exceeds 100%.

Reasons for choosing The Clinic

Majority (98.9%, 376/380) of the survey respondents specified their reason(s) for choosing The Clinic to meet their needs (Table 8.12). Among these respondents, the most commonly reported reason was being able to get to The Clinic easily (54.3%, 204/376). Not having a health card was the least commonly cited reason for choosing The Clinic, with 2.7% (10/376) of respondents indicating this. In addition, 10.4% (39/376) of respondents specified other reasons for choosing The Clinic. The most common other reasons specified among these respondents were receiving great service in the past (43.6%, 17/39) and the convenience and speed of service (43.6%, 17/39).

Table 8.12: Responses to "Why did you choose The Clinic instead of somewhere else?"

Response	% of clients (#)
I can get here easily	54.3% (204/376)
I trust the nurses and doctors here	29.5% (111/376)
I do not like to talk about my sexuality with my regular health care provider	24.7% (93/376)
I do not have a family doctor or other health care provider	15.2% (57/376)
I do not want my parents/guardian/partner/others to know that I need sexual health services	13.6% (51/376)
I was not able to get an appointment with my doctor or regular health care provider	11.4% (43/376)
Other	10.4% (39/376)
I cannot get the service I need anywhere else	9.3% (35/376)

I was referred here by someone (i.e. Friend, Healthcare Centre/professional)	4.5% (17/376)
I do not have a Health Card	2.7% (10/376)

Note: Percentages were calculated based on the total number of respondents (n=376). Respondents were able to choose multiple options; hence the sum of the percentages exceeds 100%.

Accessibility of The Clinic location
The location of The Clinic was reported to be accessible by majority of the STI respondents. 96.2% (354/368) of respondents indicated that the location of The Clinic was easy for them to get to. The remaining 3.8% (14/368) of respondents reported that The Clinic was not easily accessible to them. Of these respondents, 71.4% (10/14) indicated areas on the map that would be the most accessible to them. Majority (42.9%, 6/14) of the respondents preferred locations in Southwest and Southeast London. This is contrary to the areas requested by FP respondents, as most (60%, 6/10) FP respondents indicated Northeast London as being most accessible to them.

These results need to be interpreted with caution as there is a potential for bias. As this survey used a convenience sample, there is a potential for overrepresentation or underrepresentation. Although majority of the STI respondents reported that the clinic was accessible, this may not truly reflect the responses of STI clients who did not complete the survey. It is possible that the accessibility of the clinic is overrepresented.

Preferred clinic model and preferred method of booking appointments

Drop-in clinics were the most preferred, as 42.3% (159/376) of STI respondents indicated a preference for this model. This was followed by over a third (36.2%, 136/376) of respondents who reported that the clinic model did not matter to them. Booked appointment clinics were the least preferred (21.5%, 81/376) clinic model by STI respondents.

Overall, the majority (56.5%, 205/363) of STI respondents preferred to book appointments via telephone. This was followed by 43.0% (156/363) who preferred to book appointments in-person and 35.8% (130/363) who preferred to book appointments online. A small percentage (2.75%, 10/363) of STI respondents chose "other", of which majority (70%, 7/10) of the responses indicated that they preferred walk-in and no booked appointments.

Clinic Type

98.9% (376/380) of the respondents specified the type of clinic (i.e. female-only, male-only clinic) they preferred and 97.9% (372/380) of respondents specified the gender of the physician they prefer to be seen by (Table 8.13). For a large percentage (73.1%, 275/376) of STI respondents, the type of clinic did not matter to them. Similarly the gender of the physician providing care also did not matter to more than half (57.3%, 213/372) of the STI respondents.

Table 8.13: Preference for clinic type vs gender of physician providing care

		Preferred gender of physician			
		Female doctor # (% column)	Male doctor # (% column)	Does not matter # (% column)	Total
Type of Clinic	Female-only Clinics	49 (38.6%)	0 (0%)	11 (5.2%)	60
	Male-only Clinics	2 (1.6%)	9 (28.1%)	0 (0%)	11
	Female & Male Clinics	8 (6.3%)	6 (18.8%)	16 (7.5%)	30
	Does not matter	68 (53.5%)	16 (50%)	184 (86.4%)	275*
	Total	127	32**	213**	

* Total includes respondents who indicated the type of clinic but did not indicate the gender of the physician they prefer to see
** Total includes respondents who indicated that the gender of the physician they prefer to see but did not indicate the clinic type they are most comfortable with

STI Clinic hours

A list of hours was provided for respondents to specify their preference for STI Clinics. Nearly all (97.9%, 372/380) STI respondents indicated their preference. A summary of these responses (Figure 8.3) and a tally of the ranks (Table 8.14) are provided below.

These findings need to be interpreted with caution as there is a potential for bias. Cross-tabulating the preferred clinic hours with the clinic the respondent attended highlighted that 84.4% (216/256) of respondents who preferred early evening clinics completed the survey while attending an early evening clinic.
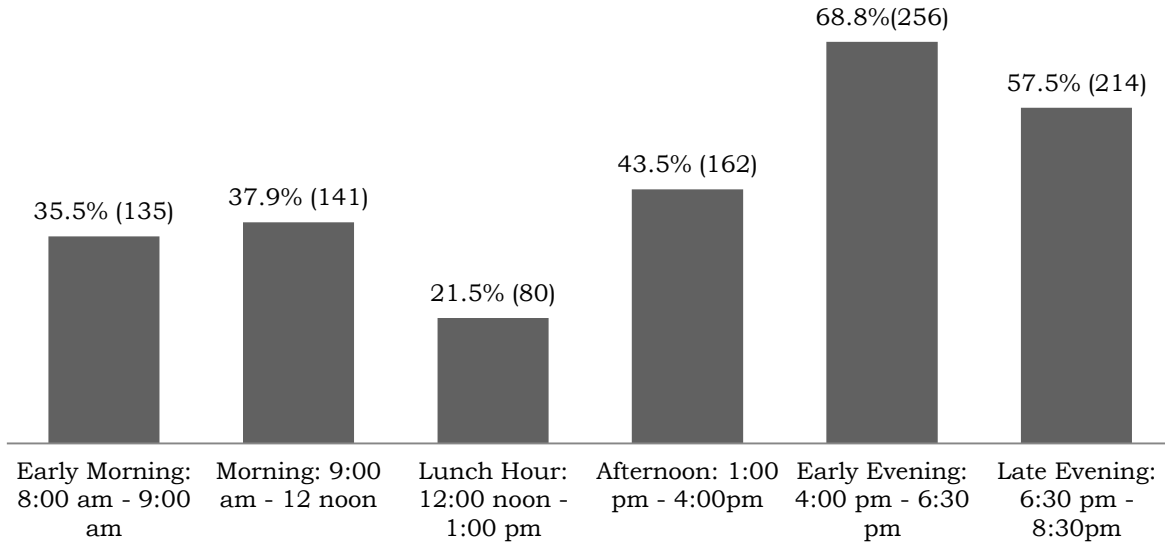
Figure 8.3: Preference for STI Clinic hours

Table 8.14: Ranks of top three clinic hours preferred by STI Clinic respondents

Clinic hours	1st choice % (#)	2nd choice % (#)	3rd choice % (#)	Did not specify a rank % (#)	Total
Afternoon (1:00pm-4:00pm)	24.1% (39)	17.3% (28)	49.4% (80)	9.3% (15)	162
Early Evening (4:00pm-6:30pm)	29.7% (76)	41.4% (106)	15.6% (40)	13.3% (34)	256
Late Evening (6:30pm-8:30pm)	34.6% (74)	30.4% (65)	23.4% (50)	11.7% (25)	214

Reception

97.3% of STI respondents (365/375) indicated that they were greeted politely when they checked-in for their visit. The remaining 2.7% (10/375) respondents indicated that they were not greeted politely during check-in.

The wait time from check-in to the time the client met with the nurse was less than 30 minutes for 79.0% (274/347) of STI respondents. For more than 90% (321/350) of respondents the wait time to see the nurse was okay, while the remaining 8.3% (29/350) of respondents did not find the wait time okay. Wait times reported by these respondents varied between 15-30 minutes to more than 45 minutes.

Interaction with Nurse and Physician

Majority of respondents either agreed or strongly agreed with the statements regarding their interaction with the nurse and physician. Similar to the FP Clinic results, a small percentage of STI respondents disagreed or strongly disagreed with the statements (Table 8.15). These responses were further reviewed to determine if there were any concerns specified throughout the survey. All respondents who strongly disagreed or disagreed rated the overall quality of service as good, very good or excellent. Language barriers and literacy levels may be potential explanations for this discrepancy.

Table 8.15: Interaction with the Nurse and Doctor

	Nurse					Doctor				
	Strongly Disagree	Disagree	Neither disagree nor agree	Agree	Strongly Agree	Strongly Disagree	Disagree	Neither disagree nor agree	Agree	Strongly Agree
The nurse/doctor listened to my concerns	5.7% (19/ 336)	0.3% (1/ 336)	1.5% (5/ 336)	20.2% (68/ 336)	72.3% (243/ 336)	6.5% (18/ 279)	0	2.9% (8/ 279)	24.0% (67/ 279)	66.7% (186/ 279)
The nurse/doctor treated me with respect	6.0% (20/ 335)	0.6% (2/ 335)	0.3% (1/ 335)	13.7% (46/ 335)	79.4% (266/ 335)	6.7% (19/ 282)	0.4% (1/ 282)	1.4% (4/ 282)	15.2% (43/ 282)	76.2% (215/ 282)
The nurse/doctor was helpful	6.0% (20/ 332)	0	0.6% (2/ 332)	19.0% (63/ 332)	74.4% (247/ 332)	6.6% (18/ 274)	0	1.5% (4/ 274)	20.8% (57/ 274)	71.2% (195/ 274)
The nurse/doctor gave me the information I needed to make the best decision	6.0% (20/ 331)	0.3% (1/ 331)	3.3% (11/ 331)	19.6% (65/ 331)	70.7% (234/ 331)	5.8% (16/ 276)	0.7% (2/ 276)	2.2% (6/ 276)	20.3% (56/ 276)	71.0% (196/ 276)
I had enough time to discuss my concerns and questions with the nurse/ doctor	6.0% (20/ 331)	1.2% (4/ 331)	0.9% (3/ 331)	18.7% (62/ 331)	73.1% (242/ 331)	6.5% (18/ 279)	1.1% (3/ 279)	2.2% (6/ 279)	21.5% (60/ 279)	68.8% (192/ 279)

Phlebotomy Services

60.5% (184/304) of STI respondents needed phlebotomy services during their visit. Among these respondents, 67.8% (122/180) preferred to have bloodwork completed on-site and for 32.2% (58/180) of respondents the location did not matter. 2.2% (4/184) of respondents who reported needing bloodwork did not specify where they would prefer to have it completed.

Quality of STI Clinic service

83.7% (318/380) of STI respondents completed the question regarding the overall quality of service. Majority (88.1%, 280/318) of these respondents rated the quality of service as very good or excellent. 10.7% (34/318) of respondents reported receiving good service and a little over 1% (4/318) of respondents noted receiving fair or poor service. Suggestions for improvement were retrieved for those who reported receiving poor or fair service. Among

these respondents, two did not provide any comments for improvement. Of the remaining two respondents, one mentioned that The Clinic was not accessible by wheel-chair and another respondent suggested improving the wait times for bloodwork.

STI respondents most valued the staff at the clinic, with 44.4% (115/259) of respondents who reported this. The second most valued aspect was the speed, convenience and easy of the service, with over a third (34.7%, 90/259) of respondents who reported this. This was closely followed by 30.1%, (78/259) of respondents who valued the confidential and non-judgmental nature of the clinic. Other aspects of the clinic that were valued were reported in small numbers and include the location, affordability, hours, and clinic environment.

Less than half (45.8%, 174/380) of the STI respondents provided suggestions for improvement.
Among these respondents nearly a third (32.2%, 56/174) noted that The Clinic did not need any changes. Suggestions were made in small numbers. A fifth (35/174) of the suggestions were around improving wait times and 16.7% (29/174) of the comments were regarding longer clinic hours. Other suggestions for improvement include improving the clinic environment (offering coffee/snacks, waiting room) and location.

Implications for Family Planning STI Clinic Practice

Overall, a majority (88.0%) of The Clinic respondents (n=624) rated the quality of the services received in both the STI and FP clinics as excellent or very good. Most respondents indicated that the nurse and doctor listened to their concerns, treated them with respect, was helpful and provided the information needed to make the best decision. This was further iterated in the comments provided by clients, where the most commonly valued aspect of The Clinic was the staff.
Although majority of the respondents indicated that changes did not need to be made, a small number suggested improvement related to decreasing wait times and extending clinic hours. Most respondents preferred the current clinic model of drop-in for STI Clinics and booked appointments for FP Clinics. For booked appointments in FP Clinics, a majority of respondents preferred to booked appointments via telephone, however a fairly large number also expressed interest in booking appointments online. Hence exploring online tools to book appointments may need to be considered.

Limitations

- Respondents for this survey were selected using a **convenience sampling strategy**. This was deemed appropriate for the purpose of this survey; however a convenience sample may not be truly representative of all the clients who access The Clinic.

- **Seasonal variations** in clinic users may exist. As the survey was administered between May and June, it is possible that clients accessing services in other time periods have different opinions/feedback about the quality of the service.

- **Self-selection bias** is also a potential limitation. There were a total of 125 STI and FP clients who declined the survey. The reasons for declining the survey were not recorded. Due to clients self-selecting themselves into the survey, the preferences of those who did not complete the survey may be different from those that completed the survey.

- **Non-response bias** is also a possible limitation to consider. Some questions (i.e. nurse/doctor interaction, areas for improvement) were not completed by respondents. The reasons for skipping these questions are unclear; hence respondents who did not answer these questions may have had a different opinion.

- Surveys were not formally piloted, validated or tested for reliability. The survey was not tested to determine whether questions measured what was intended and if the responses are reproducible and consistent.

- The survey did not capture the opinions and perspectives of those who currently do not utilize The Clinic but are in need of FP and STI services.

IX. Recommendations

The following recommendations are proposed given the information gathered for this program review. Recommendations are provided using the principles of the Ontario Public Health Standards: Need, Impact, Capacity, Partnership and Collaboration.

Recommendation: Provide phlebotomy services on-site at both STI and Family Planning Clinics

Need: On-site access to phlebotomy services is currently only available during STI Clinics. For FP clients phlebotomy requisitions are provided to complete at an external lab. Consistent delivery of phlebotomy services in both STI and FP clinics was identified as a need as MLHU was the only health unit among its comparator that did not offer phlebotomy services to FP clients. This need was further re-iterated in the client satisfaction survey, where over half of the FP clients who needed bloodwork during their visit indicated that they would prefer to have it completed on-site. Additionally, the physician survey and discussion highlighted that offering this service on-site would increase client access to phlebotomy services.

Impact:
- Increase completion of phlebotomy requisitions among FP clients by reducing barriers (i.e. transportation costs, time)

Capacity: The current layout of the clinic will accommodate this recommendation, as phlebotomy services are already offered during STI Clinics. Upon determining the staff(s) involved with performing phlebotomy during FP Clinics, additional training/resources may need to be considered.

Partnership and Collaboration: None currently identified.

Possible indicators to consider for monitoring:
- # of phlebotomy requisitions completed on-site
- # of phlebotomy requisitions provided
- Rate of completion in clients who choose to have phlebotomy requisition completed at an external lab

Recommendation: Maximize the value of PHN practice to ensure the full extent of knowledge and expertise is utilized, and services are provided as efficiently as possible

Need: There is a need to increase the PHNs scope of practice to increase access to clinic services. Currently clinical services such as pregnancy testing can only be accessed during physician led clinics. This is a barrier for clients who seek time-sensitive services (i.e pregnancy testing, ECP), as they have to return to The Clinic at a later time/day or attending another health clinic. In addition, the physician survey highlighted that the physicians were supportive of expanding the PHN's scope of practice with medical directives for pregnancy testing, ECP, STI treatment for positive Chlamydia and Gonorrhea cases and Hepatitis A and Hepatitis B injections.

Impact:
- Increase clinic service availability to clients, as they will no longer need to book to see a physician unless client needs are outside the scope of the PHN.

Capacity: Currently there are some medical directives in place for the PHNs to work under. Following the implementation of additional medical directive, the capacity for this recommendation will need to be reassessed to determine if additional training will be needed to meet competency requirements.

Partnership and Collaboration: None currently identified

Possible indicators to consider for monitoring:
- # of clients seen by PHNs for pregnancy testing, ECP and Depo-Provera related purposes
- # of clients who were referred to see a clinic doctor after being seen by the nurse under medical directive.

Recommendation: Review clinic services offered at the Strathroy office to determine whether the current services appropriately address the sexual health needs of the clients

Need: Limited clinics are offered to clients at the Strathroy office, as clinics with a physician are only available on the third Thursday of each month by appointment and nurse only clinic the other three Thursdays of the month. This limits timely access to sexual health and harm reduction services (i.e. ECP, pregnancy testing, birth control, needle exchange). Clients utilizing services at the Strathroy office have also expressed a need to increase services during interactions with clinic staff. It is recommended that the clinic services in Strathroy be reviewed, to ensure that the needs of clients are appropriately addressed.

Impact:
- Improve sexual health outcomes by increasing timely access to sexual health services
- Reduce the transmission of STI/BBI, by increasing access to harm reduction supplies

Capacity: There is limited capacity for physicians as they are only available on-site on the third Thursday of each month. PHNs in The Clinic have medical directives to provide specific sexual health services. Hence capacity can be increased by exploring clinic models where PHN provide specific sexual health services under their medical directives and refer clients beyond their scope to physicians during physician-led clinics. This model has been utilized by other health units to increase capacity and meet client needs.

Partnerships and Collaboration: None currently identified

> *Possible indicators to consider for monitoring:*
> - # of client visits during nurse-led clinics
> - # of clients referred by PHN to physician
> - # of birth control dispensed
> - # of ECP dispensed
> - # of STI tests administered
> - # of STI treatments dispensed

Recommendation: Identify strategies to increase access and utilization of clinic services by persons without a health card

Need: A health card is requested for services offered through the FP Clinics, resulting in clients without health cards having limited to no access to FP services. This was identified as a need by The Clinic team, as there have been instances where young clients in need of FP services do not have a health card as their parents hold on to it. Also PHNs who attend the Elgin-Middlesex Detention Centre have received feedback from inmates who have indicated that they may not have a fixed address to obtain a health card, making it difficult to utilize these services. Populations that have expressed this need are vulnerable populations in need of sexual health services. This recommendation will help address this need by identifying, assessing and determining the strategy that would be most effective in increasing access to populations without a health card.

Impact:
- Increase access to sexual health services for populations without a health card (priority population)
- Reduce unplanned pregnancies, teen pregnancies rates, and abortion rates
- Improve health outcomes, by increasing coordination of care to other required services on a need basis (i.e. primary care, support services)

Capacity: There is capacity to provide care to clients without a health card in The Clinic. In the physician survey and discussion, four out of seven FP physicians indicated that they were willing to see clients without a health card, and provided percentages varying from <3% to 10%. In efforts to address this need and ensure clinic services are accessible to all individuals in the community, the billing model for The Clinic was reviewed. The outcome of the review was to shift from a fee-for-service model to a blended model. With this model, physicians in the FP clinic will be provided with an hourly rate. The shift to a blended billing model aligns services with the MOHLTC's Clinical Services Guidance Document. In addition to ensuring closer alignment with Ministry guidelines, this billing model is intended to increase access to those without a health card, as many of the services offered in the FP Clinics will no longer require a health card.

Partnerships and Collaboration: Collaborate with community organizations that offer services (i.e. support services, housing support, primary care services) to refer populations without a health card to appropriate services as needed.

> *Possible indicators to consider for monitoring:*
> - # of clients without a health card who use clinic services

Recommendation: Train all physicians in IUD/IUS insertions, to expand the availability of this service across all Family Planning clinics. In addition, develop a written protocol to determine whether referral to a specialist for insertion is needed.

Need: MLHU offers copper IUD for emergency contraception consistent with best practice guidelines. It is the most effective method of emergency contraception if inserted within five days after an unprotected intercourse. Commonly used emergency contraceptive pills (e.g. Plan B) have reduced effectiveness in women weighing between 75-80 kg and lack of effectiveness in women weighing over 80kg and over. Copper IUD is the only effective emergency contraceptive option for overweight and obese women. Considering high obesity prevalence in Canada especially in vulnerable populations, such as low SES and Aboriginal women, there is a need to increase timely access to effective emergency contraception. Additionally, The Society for Obstetrician and Gynecologists of Canada recently recommends intrauterine devices as first line contraceptive agent for adolescents.

Impact:
- Reduction in unplanned pregnancies and abortion; reduction in teen pregnancy rates
- Higher client satisfaction due to long-term contraception
- Decreased number of visits due to emergency contraception and pregnancy testing

Capacity: Currently, the clinic has limited capacity to provide IUD insertions. Two work regular clinics and able to insert one IUD per clinic. There are IUD only clinics offered three times a month with 4-5 IUD insertion per clinic. In 2014, 56 clients had IUD insertions in the clinic and 117 clients were referred to other providers. Available appointments for IUD/IUS insertion services are filled quickly and wait times may be longer than desirable. This recommendation will help the clinic to meet the increasing demand for IUD/IUS insertions.

Partnership and collaboration: We will be sharing physician best practice guidelines regarding IUD insertions for emergency contraception with community physicians during physician outreach.

> *Possible indicators to consider for monitoring:*
> - # of IUD request/consults
> - # of IUDs inserted
> - # of failed IUD insertions
> - # of clients who have IUD removed after 6 months post insertion
> - # of IUDs referred to community providers
> - # of IUDs inserted for Emergency Contraception

Recommendation: Increase availability for clients to purchase other forms of birth control and vaccines (not covered) through various payment methods (i.e., credit).

Need: Cash and debit are the only methods of payment accepted at The Clinic. This presents a barrier to those who prefer to pay via credit, specifically for large amounts, where the client leaves the site to withdraw cash for the purchase. This barrier was identified during the staff consultations as clients have increasingly expressed a preference to pay by credit. A need to expand the availability of birth control and vaccines options was also identified. The community organization environmental scan highlighted that the Health Unit was one of the only organizations that offered low cost contraceptives and emergency contraception. Medical Clinics in the community provide a prescription for birth control/emergency contraception for clients to fill. Filling the prescriptions at pharmacies can be expensive for clients without coverage. Hence there is a need to ensure that the birth controls options stocked in the clinic align with the client`s requests. Additionally, expanding the vaccine options (covered and not covered) need to be explored as clients who request to have specific vaccines (non-publicly funded Hepatitis B vaccines, Tdap for STI and IDU clients, Gardasil) have to visit the Immunization clinic to purchase the vaccine.

The clinic hours between the Immunization Clinic and the Sexual Health Clinic don't always overlap and pose a barrier for clients.

Impact:
- Decrease unplanned pregnancies; decrease adolescent pregnancy rates
- Increase client access by offering various affordable birth control options that align with their needs
- Increase accessibility to vaccines (publicly funded and non-publicly funded) for clients who request this

Capacity: Capacity to expand the payment methods will need to be determined by the team in collaboration with the Finance department. In addition, the capacity to increase the availability of birth control options and vaccines will also need to be assessed once consults with pharmaceutical companies have occurred and the associated cost of increasing birth control options have been discussed.

Partnerships and Collaboration: A relationship with pharmaceutical companies will need to be established to determine the cost associated with increasing birth control options.

Recommendation: Determine the reach and utilization of sexual health clinic services by priority populations

Need: The Ontario Public Health Standards mandates that health units provide sexual health services for priority populations and ensure that priority population have the capacity to adopt behaviours for healthy sexuality and the prevention of STI/BBIs. Priority populations for sexual health have been well researched and defined by the Public Health Agency of Canada. The extent to which these populations utilize clinic services in Middlesex-London is currently unclear. Although the clinic team has an idea of the populations that utilize sexual health service, due to limited data collection, the level of reach cannot be accurately reported. Hence, a need to collect pertinent data to accurately determine the reach and utilization of services is recommended. This recommendation will assist future clinic programming to determine populations that underutilize sexual health services and identify approaches to tailor service provision accordingly.

Impact:
- Inform clinic programming by identifying evidence-informed strategies to deliver and increase utilization of sexual health services by priority populations that are not reached with the current clinic model
- Tailoring services to align with the sexual health needs of priority populations will increase access – ultimately improving sexual health outcomes within these populations by reducing unplanned pregnancies, teen pregnancies and transmission of STI/BBIs.

Capacity: Need to consider the capacity of the Hampson Client Management system to electronically capture data pertaining to priority populations. The PHNs in The Clinic have started to collect additional information (i.e. no health care provider, unstably housed) during client consultations. Once adequate time has elapsed, analysis of this information will help inform programming focuses.

Partnerships and collaborations: Consider collaborating with organizations that offer services to the priority populations to determine the need and gather input and feedback on approaches/strategies to address the need.

Recommendation: Assess and identify the needs of the local population (including priority populations) who have sexual health needs but currently do not access any sexual health related services

Need: The Clinic services are accessed by a large number of clients, many of whom are returning clients. In 2014 over 50% of the total clinic visits (15,795, includes FP and STI clinics) were by returning clients. This was also evident in the client satisfaction survey, where >60% of STI clients and >80% of FP clients had previously been to The Clinic for either STI or FP services. Despite the large volume of clients, it is unclear whether the services are accessible to non-clients in need of FP and STI services. Further, the community environmental scan highlighted sexual health services were available in varying degrees locally. Given the current programming of the Clinic and the current availability of local services, it is unclear whether this is sufficient to meet the sexual health needs of the community. This was further iterated in the physician survey. Physicians highlighted that the needs of the community need to be identified prior to determining whether the current model of The Clinic is sufficient or if additional clinic locations is warranted.

Impact:
- Improve the sexual health outcomes (reduce unplanned pregnancies, decrease transmission of STIs/BBIs, reduce long-term impacts of untreated STIs/BBIs) of populations with sexual health needs by identifying the gaps and barriers that contribute to the non-utilization of services
- Improve the provision of services by tailoring services to align with population needs

Capacity: Capacity for this recommendation would need to be determined upon identifying the approach (i.e. focus group) that will be utilized to assess the need within the community. Based on the approach, training will need to be provided to ensure data collection is conducted in a systematic manner.

Partnership and Collaboration: Consider collaborations with community organizations (i.e. RHAC) to gather information from various target populations.

Recommendation: Enhance partnership with community physicians and identify strategies (i.e. fax updated STI guidelines, phone discussion and targeted academic detailing workshops with physicians who have poor compliance to the updated guidelines) to ensure physicians providing care to STI cases are aware and feel supported to provide STI treatments as per the updated guidelines

Need: The Health Unit offers free provincially funded STI medication to community physicians, upon their request. MLHU's Health Care Provider Outreach Coordinator relays information regarding the availability of this service to community health care providers. With the current approach, 19 community physicians request free STI medication from The Clinic. Among these physicians, requests continue to be made for Gonorrhea medication (Cefixime) that is not the recommended first line of treatment, as per STI Guidelines. Further to this, discussions with physicians during STI follow-up have revealed that misinformation is communicated to clients regarding the appropriate testing and treatment. The Sexual Health Protocol also states the need to consult with community health care providers to ensure cases of STI receive the appropriate testing and treatment as recommended by Canadian Guidelines on Sexually Transmitted Infections, 2006 Edition (or as current)

Impact:
- Enhancing partnerships will ensure that treatment for STIs are provided in accordance with the STI Guidelines.
- Consistently prescribe medication as per the updated STI Guidelines
- Increase the communication of accurate sexual health information to clients
- Increase the number of requests made for free STI treatments – thereby reducing barriers (i.e cost of medication) and increasing access to STI treatments

Capacity: There is capacity within the Clinic to enhance partnerships with community physicians. An interest in being involved in health care provider outreach was expressed by four physicians that completed the clinic survey.

Partnerships and Collaborations: Partnerships will be made with community physicians through the MLHU Health Care Provider Outreach Coordinator to identify strategies most effective in ensuring physicians are aware of the updated guidelines and feel supported to provide recommendations treatments.

Possible indicator for evaluation
- # of physicians who do not comply with STI treatment guidelines retrieved from iPHIS
- # and types of STI medication distributed to health care provider
- Test of cure results

Recommendation: Make enhancements to the current electronic database.

Need: Limitations with the current electronic database were identified during staff consultations. The database is used for basic data collection. It was identified that enhancements to ensure data quality of the reports generated by the database and the overall usability would be beneficial. Enhancements would also allow pertinent data regarding clinical services to be collected to assist in future monitoring and evaluation projects.

The long term sustainability of the electronic database was identified to be limited. Hence, if feasible, consideration needs to be given to shifting to an EMR. This shift would be beneficial in maintaining consistent documentation. The clinic chart audit (Appendix B) identified inconsistencies in the date format and the types of abbreviations used. The shift to a paperless system would allow data collection fields to be validated and ensure consistent documentation across all clinic charts. In addition, shifting to an EMR would provide the capacity to directly download laboratory results to the database and minimize the potential for transcription errors.

Impact:
- Collect indicators (i.e. number of IUDs referrals made, number of PHN referrals to clinic doctor in nurse-led clinics, priority populations that access clinic services) for on-going monitoring and future evaluations

Capacity: Collaborations between the Manager and host provider to implement the identified enhancements

Partnership and Collaborations: None currently identified

Recommendation: Develop a logic model for each pilot program and develop and monitor indicators for projects

Need: Pilot projects have been planned as a result of this Program Review. To help determine if the pilot projects are having the intended impact, there is a need for on-going monitoring of indicators and evaluations, as needed. The development of a logic model is highly recommended to ensure that the planned activities of the pilot projects are clearly linked with the intended outcomes. Further, this will aid the monitoring and evaluation of the pilot projects to identify challenges/areas for improvement and assess the overall effectiveness.

Impact: Align with the client-centred approach and deliver high-impact services – thereby improving the population's sexual health outcomes

Capacity: Assistance would be required from The Clinic staff to collect data for the indicators identified in the project logic model. Support from the Program Evaluator and Epidemiologist will also be required to develop the logic model, develop and monitor program indicators and evaluate outcomes.

Partnerships and Collaborations: None currently identified.

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Appendix A: OPHS Requirements & Team

	OPHS Standard	Clinic Activities
Assessment and Surveillance	Requirement #1: The board of health shall report data elements on sexually transmitted infections and blood-borne infections in accordance with the Health Protection and Promotion Act and the Sexual Health and Sexually Transmitted Infections Prevention and Control Protocol, 2008 (or as current).	Full-time PHNS input data r/t reportable STIs to iPHIS reports created by OHCDSH Epidemiologist
	Requirement #2: The board of health shall conduct surveillance of: • Sexually transmitted infections; • Blood-borne infections; • Reproductive outcomes; • Risk behaviours; and • Distribution of harm reduction materials/equipment in accordance with the Population Health Assessment and Surveillance Protocol, 2008 (or as current) and the Sexual Health and Sexually Transmitted Infections Prevention and Control Protocol, 2008 (or as current).	• Surveillance done by OHCDSH Epidemiologist based on data obtained at The Clinic and external reportable cases • Needle Exchange stats RHAC
	Requirement #3: The board of health shall conduct epidemiological analysis of surveillance data, including monitoring of trends over time, emerging trends, and priority populations, in accordance with the Population Health Assessment and Surveillance Protocol, 2008 (or as current).	• Done by OHCDSH Epidemiologist
Health Promotion and Policy Development	Requirement #4: The board of health shall increase public awareness of the epidemiology, associated risk behaviours, risk factors, and risk reduction strategies related to healthy sexuality, sexually transmitted infections, and blood-borne infections by: a. Adapting and/or supplementing national and provincial health communications strategies; and/or b. Developing and implementing regional/local communications strategies.	• Sexual Health Promotion Campaigns • General Web/Social Media updates (i.e. Adventures in Sex City)

OPHS Standard	Clinic Activities

Requirement #5:
The board of health shall use a comprehensive health promotion approach to increase the community capacity regarding the promotion of healthy sexuality, including the prevention of adolescent pregnancies, sexually transmitted infections, and blood-borne infections, by:
    a. Collaborating with and engaging community partners and priority populations;
    b. Mobilizing and promoting access to community resources;
    c. Providing skill-building opportunities; and
    d. Sharing best practices and evidence.
	• Pride Week: involve LGBTQ youth group, develop a float, march in parade, survey at clinic display
	• Members of LGBTQ Community Coalition
	• Member of Homophobia, Biphobia, Transphobia Coalition
	• Facilitate Trans Health Working Group
	• Member of Fanshawe College Resident Advisor Training Planning Committee
	• Collaborate with Young Families Team to provide/session on Birth Control in series of Teen Prenatal Classes
	• Triple P: Committee Member-sexual health content expert.
	• Collaborate with RHAC to plan for World AIDS Day.
	• STI Guinness Testing post-secondary campaign
	• Facilitate Positive Space Training
	• Update and develop fact sheets for website to increase access to sexual health information for clients
	• Nurse provides education at EMDC

OPHS Standard	**Clinic Activities**
Requirement #6: The board of health shall collaborate with community partners, including school boards, to create supportive environments to promote healthy sexuality and access to sexual health services.	• Teen Pregnancy Prevention-community coalition • Knowledge exchange activities with Child Health and Young Adult Teams • Education to Post-Secondary students at Althouse Teacher College Program • Facilitating focus groups for engage in needs assessment of teachers: on-line Homophobia education resources for teachers • Clinic PHN provided 3-month pill starts PRN • Young Adult Team provide ECP and pregnancy tests in schools **GAPS:** consult with Sexual Health Promotion Team

OPHS Standard	Clinic Activities
Requirement #7: The board of health shall provide clinical services for priority populations to address contraception, comprehensive pregnancy counselling, sexually transmitted infections, and blood-borne infections. For further information, refer to the Sexual Health Clinic Services Manual, 2002 (or as current).	• Sexual Health Clinics available in City and County • STI clinics confidential, free counseling, testing and treatment • Hep A & B free vaccination • Referrals to pregnancy Options Clinic • Medical Directive for 3-month pill starts • Low cost contraceptives • IUD/IUS insertions • ECP available to client or third party • IUD's for emergency contraception • Pap tests provided • Alcohol and RUCS screening, smoking cessation counselling, • Free Condoms • Harm Reduction (naloxone) • Develop a video (and/or supplementary written information to be disseminated in multiple ways) which will show the process of coming to "The Clinic" (STI) **GAPS:** Priority populations have not been clearly defined for the Sexual Health team
Requirement #8: The board of health shall ensure that the medical officer of health or designate receives reports of sexually transmitted infections and blood-borne infections and responds in accordance with the Health Protection and Promotion Act and the Sexual Health and Sexually Transmitted Infections Prevention and Control Protocol, 2008 (or as current).	• Adhere to the MOHLTC Gonorrhea Accountability Agreements • All cases entered into iPHIS • PHNS provide case management of all reportable STI's in the clinic and community. • Section's for HIV as needed.
Requirement #9: The board of health shall provide or ensure access to provincially funded drugs for the treatment of sexually transmitted infections, at no cost to clients, in accordance with the Sexual Health and Sexually Transmitted Infections Prevention and Control Protocol, 2008 (or as current).	• Free STI testing and treatment available. Government pharmacy STI medications provided to community physicians. • Free medications at STI Clinic PHNS can provide treatment for GC and CT at no cost to clients who have difficulty attending clinic. **GAPS:** A very small number of community physicians access government pharmacy STI medications. Could increase use of these medications among community physicians.
Requirement #10: The board of health shall communicate and coordinate care with health care providers to achieve a comprehensive and consistent approach to the management of sexually transmitted infections and blood-borne infections.	• Share updated MOHLTC guidelines to treat Gonorrhea to reduce resistance with health care providers. • Follow-up care of STI's i.e. Syphilis treat with Bicillin • Some information shared through MLHU's Health Care Provider Outreach initiative **GAPS:** Limited engagement with and concerns regarding lack of use of STI best practices among community physicians. Could provide more education regarding best practices and more effectively communicate MLHU role

Disease Prevention/Health Protection (vertical label)

OPHS Standard	Clinic Activities
Requirement #11: The board of health shall engage community partners and priority populations in the planning, development, and implementation of harm reduction programming.	• Opioid Overdose Prevention Program (naloxone). • RHAC mobile van • Community Drug Strategy Initiative (pending)
Requirement #12: The board of health shall ensure access to a variety of harm reduction program delivery models which shall include the provision of sterile needles and syringes and may include other evidence-informed harm reduction strategies in response to local surveillance.	• Recently added: Safer Inhalation Kits. • Harm Reduction Services offered at 5 fixed sites. • RHAC mobile van
Other Clinic Activities: **Knowledge Exchange and Continuous Quality Improvement**	• Audit of Client Charts and Pending Test (outstanding tests results not entered) • Computer Program Upgrade for The Clinic to collect metrics and SDOH data • Regular visits by PHN's of 50 King Street staff to Strathroy site to continue to build upon knowledge exchange and CQI opportunities and thereby enhancing consistencies/CQI between 50 King Street/Strathroy locations • Quarterly meetings with whole SH team to engage in knowledge and CQI activities Re: team projects/initiatives • In-services by physicians; shared learnings from staff attending conferences • Professional Practice – Review Physician License and Canadian Medical Protection Association Status annually • RIMP for SHP Team (Org standards) • Protocol updates (e.g., processing/dispensing external birth control scripts (Org standards) • Presentation/Health Fair criteria assessment tool – database upgrade. • In-services from drug companies when introducing a new birth control method

Appendix B: Audit Summary Report to MLHU Documentation Committee

Service / Team: The Clinic
Manager: Shaya Dhinsa
Date Audit(s) Completed: December 18, 2014-Jan 29, 2015

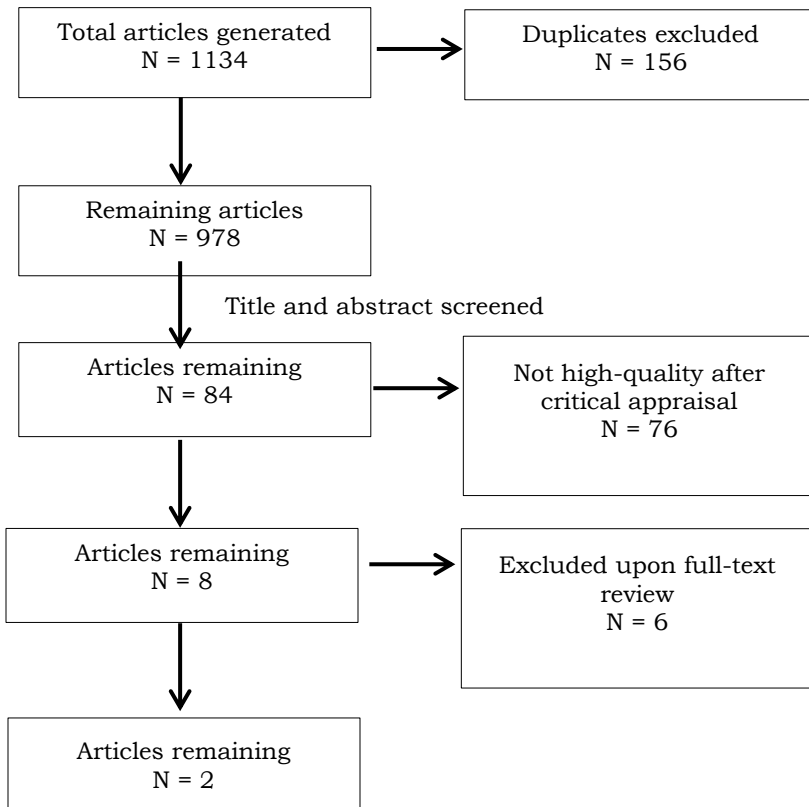| **Common Themes to be addressed** *(e.g. gaps in program standards, policies/guidelines, non-compliance issues, etc.)* |
|---|
| Audit performed by Jacqueline Eckert, Pam Hamilton and Natalie Meade, Public Health Nurses in the Clinic 23 charts 2012 and newer were randomly pulled from shelves (only examined documentation after audit March 23, 2011). 7 Strathroy, 6 STI, 10 FPC
Gaps/Non Compliance Issues
Inconsistencies in method of dating, some charts indicating Month/Day/Year, some using words vs. numbers to indicate month. Date stamp for STI chart is month, day, year which can contribute to confusion
Notice of Collection done and documented at initial visits but not at subsequent visits
Use of abbreviations not from clinic approved list in most charts
Smoking cessation counselling not always documented in FPC charts
Strengths
Improvement in the number of charts indicating the time an interaction occurred over last audit
Improvement with indicating the end of an entry with a line.
All notes are legible and signed with designation
HIV pretest counselling documented consistently
Priorities For Action
Disseminate audit results to staff and manager
Update audit tool to reflect unambiguous dating that is consistent with practice and Standards
Update abbreviation list with current regularly used abbreviations
Update audit tool to include more electronic documentation relevant to current practice
Develop documentation committee within service area to ensure more consistent practice.
Next audit planned for: |

Appendix C: Literature Review Flow Chart

Question: "What are effective models/strategies for the delivery of sexual health clinic services?"
Search Strategy

(Sexual health OR family planning OR Sexually transmi* infection* OR STI testing OR STI/HIV testing OR Sexual* transmi* disease* OR STD testing OR STD/HIV testing) AND clinic AND delivery

Limits:
Language: English
Year: 2000-current

Database searched	Total articles
EBSCO	430
OVID – EMBASE, Medline, HealthStar	498 – (duplicates) = 376
Cochrane	80
PubMed	124 – duplicates = 90
Canadian Best Practices Portal	1
Public Health Grey Literature Database	1

Total articles generated
N = 1134

Duplicates excluded
N = 156

Remaining articles
N = 978

Title and abstract screened

Articles remaining
N = 84

Not high-quality after critical appraisal
N = 76

Articles remaining
N = 8

Excluded upon full-text review
N = 6

Articles remaining
N = 2

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 70-15

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2015 December 10
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SUMMARY INFORMATION REPORT FOR DECEMBER 2015

Recommendation

It is recommended that Report No. 70-15 re Information Summary Report for December 2015 be received for information.

Key Points

- Only 29.5% of children 4-8 years in Ontario and Quebec are correctly restrained when riding in motor vehicles. A multi-faceted education/awareness campaign coupled with free booster seats has been a focus in child injury prevention to increase the use and decrease the risk of injury and death as a result of motor vehicle collisions.
- Between 500-1000 refugees are expected in the Middlesex-London region in the next few months. Health care organizations and community support groups participated in a planning meeting organized by the London Intercommunity Health Centre with the goal of bringing key stakeholders together. MLHU will be partnering with primary health care and other stakeholders to ensure that health care needs of refugees are met in a timely and coordinated manner.

Background

This report provides a summary of information from Health Unit programs. Additional information is available on request.

"Kids Need a Boost" Booster Seat Campaign

Motor vehicle crashes are the leading cause of death for children 1-14 years of age. In Middlesex-London, motor vehicle crashes are the leading cause of unintentional injury in all age groups. Although there is a law that requires parents to use booster seats for their children, only 29.5% of children 4-8 years of age in Ontario and Quebec are correctly restrained. In 2014 and 2015, in collaboration with the Middlesex-London Child Safety Committee, MLHU led a booster seat campaign. The campaign is multi-faceted and includes education and awareness to parents through schools, communities, health care providers and community partners. To address the barriers, an education campaign to increase the awareness and the knowledge of parents and the distribution of free booster seats were implemented. A variety of communication channels were used to reach the target population: Twitter and Facebook ads, the Health Unit website, radio ads, media releases and 32 events were attended. The campaign provided general information to parents, directed them to the Health Unit Booster Seat website, and notified them of free booster seats for families in need. In total, 860 booster seats will be distributed to families in London and Middlesex.

Syrian Refugees will be arriving to Middlesex-London

Federal government made a commitment to bring 25,000 Syrian refugees to Canada, 10,000 of which are expected by the end of 2015. London, along with five other designated refugee placement sites in Ontario, will be among the first cities to welcome refugees. It is estimated that between 500 and 1,000 refugees will arrive in the Middlesex-London region in the coming months. Immigration pre-screening, which includes screening for Tuberculosis (TB) and HIV, will be completed before their arrival. All Government Assisted Refugees will receive Interim Federal Health coverage upon arrival to Canada. It is still unclear whether privately funded refugees will receive same level of coverage as government assisted refugees.

A health care planning meeting was held at the London Intercommunity Health Centre (LIHC) with about 30 participants from over ten health care and community support organizations, including Cross Cultural Learning Centre, London Health Sciences Centre, South West Community Care Access Centre, South West Local Health Integration Network, Muslim Resource Centre for Social Support and Inclusion, to help refugees to navigate through health care system and connect them with community organizations. Several working groups emerged from this meeting, including primary care and public health, child health, mental health. MLHU will participate in these working groups along with other key stakeholders to ensure that the needs of newcomers are met in coordinated and timely manner.

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

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 71-15

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2015 December 10

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MEDICAL OFFICER OF HEALTH ACTIVITY REPORT – DECEMBER

Recommendation

It is recommended that Report No. 71-15 re Medical Officer of Health Activity Report – December be received for information.

The following report highlights activities of the Medical Officer of Health (MOH) from the October Medical Officer of Health Activity Report to December 1, 2015.

On October 5th, the MOH attended the Access to Healthcare-Body, Mind, Spirit Planning Team meeting. This group of professionals met to plan a Community Conversation Workshop entitled The People's Forum on Eliminating Poverty. They will be looking into strategies and ideas of how the group, along with the community can help impoverished residents gain better and more access to healthcare that meets their physical and mental needs. The MOH attended the forum which was held on October 17th at Huron University College.

London City Hall held an event on October 6th that the MOH attended. It was a unique mobile meeting by bike. While riding, participants discussed social and affordable housing and related opportunities in London. There were periodic stops at social housing locations and time for discussion.

At their meeting on October 19th, the MOH and members of the Senior Leadership team welcomed staff to attend an open meeting to discuss PBMA investment and disinvestment proposals. Staff were encouraged to attend the meeting to give their opinions, suggestions and input to proposals.

On October 22nd, the MOH and the Senior Leadership Team facilitated an all staff town hall meeting. Some items included on the agenda were: a discussion about policy; the Program Budgeting and Marginal Analysis (PBMA) process; 2015 Employee Engagement Survey results; and an update in regards to the Organizational Structure and Location review. Also part of the morning was guest speaker Doug George, Integrated Care Lead – Traditional Healing at the Southwest Ontario Aboriginal Health Access Centre. Mr. George gave a very memorable and emotional talk on the findings and recommendations of the Truth and Reconcilliation Commission Report.

During the week of October 26th, the MOH and staff welcomed the Baby Friendly Initiative (BFI) Assessment Team to the Health Unit. This Team spent 3 days assessing how well the Health Unit has integrated BFI best practices into their day to day work by meeting with staff, reviewing material, attending program services as well as interviewing both staff and clients. Laura Dueck, Public Health Nurse Lead for BFI was instrumental in preparing staff for the assessment.

Since the fall of 2014, the Health Unit has been undergoing a review of both space needs planning and organizational structure planning. Currently the primary focus is on completing a revised organizational structure that aligns with information obtained from staff consultations, clients and community partners, internal and external scans as well as a literature review. Early in the summer, an advisory group was established consisting of staff from all Service Areas, including both, union and non-union as well as

Senior Leaders and Managers. This group, the Organizational Structure and Location Committee (OSL) were given the daunting task of compiling all of the data and presenting the Senior Leadership Team (SLT) with a draft org chart. Once that was received, SLT met to review with OSL and then continued to meet with their Management Teams individually to further review the draft document. SLT met again before meeting as a group with the Non-Union Leadership Team (NLT) on Tuesday November 10. NLT provided great input and suggestions for the proposed org chart for SLT to consider and or implement. During the same week, the MOH facilitated 3 staff consultations sessions in which members from all Service Areas were invited to share their thoughts and suggestions. The structure being presented to the Board of Health this evening has been substantially impacted by these consultations.

Throughout the month of November the MOH and staff participated in various events to help support the London Women's Abuse Centre's (LAWC) *Shine The Light Program.* With raffles, photo booths, wearing purple, purchasing purple swag and decorating offices at all Health Unit locations, MLHU staff raised over a thousand dollars that will go directly to LAWC to help women in crisis. November 27th marked the final event of the

On November 25th the MOH, several staff, and Board of health member Stephen Turner attended the 2015 Pillar Community Innovation Awards Ceremony at the Convention Centre. Staff from the Health Unit were nominated in the Collaboration category for the Naloxone Program. Also included in this nomination were staff from the Regional HIV/AIDS Connection and the London InterCommunity Health Centre. At this event, the Naloxone Program was awarded the Pillar Award for Community Collaboration, and Dr. Mackie spoke on behalf of the team that accepted the award.

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

October 5	Introductory meeting with Sheryl Rooth of the Salvation Army Met with the Nurse Family Partnership Steering Committee via teleconference Met with Middlesex County staff to discuss new E-Agenda software
October 6	Attended a Circles Leadership meeting
October 7	Met via the phone with BOH Chair Ian Peer to discuss the upcoming meeting agenda Attended a meeting of the Mayor's Advisory Panel on Poverty (MAPOP)
October 8	Met with other South West Medical Officers of Health in Sarnia for a quarterly meeting Attended The London Diversity & Race Relations Advisory Committee (LDRRAC) meeting at City Hall
October 13	The MOH Chaired the first meeting of the Nurse Family Partnership Committee.
October 14	Attended a MAPOP meeting held at the YOU Boardroom
October 15	Participated in the Youth Opportunities Unlimited (YOU) Strategic Planning session Met with Heather Spratt, Director of Programs and Operations, Loran Scholars Foundation
October 16	As a member of The Ontario Public Health Convention (TOPHC) 2016 Planning Committee, met in Toronto to begin planning for the event
October 20	Introductory phone meeting with Doug George, Integrated Care Lead – Traditional Healing at the Southwest Ontario Aboriginal Health Access Centre

Met with Megan Walker via phone about a London Abused Women's Centre research proposal

Was interviewed for the *Ask the Experts Radio Show.* Also participating in the interview was Josh Archer from the City of London & inMotion Coordinator. The InMotion campaign was the focus of the interview

October 21   Attended a MAPOP Debrief meeting at City Hall

October 22   Participated in a YOU Board meeting
Attended the Master of Public Health's Brown Bag Series event featuring David Butler-Jones, MD, LLD, MHSc, CCFP, FRCPC, FACPM and Former Chief Public Health Officer of Canada
Met with Regional HIV/AIDS Connection (RHAC) CEO Brian Lester

October 23   Introductory meeting with Beth Mitchell, Interim CEO at Canadian Mental Health Association (CMHA)
Telephone meeting with Lacey Dharshi from Pillar Non Profit in regards to MAPOP

October 26   Attended MAPOP pre meeting at City Hall
Participated in an interview with reporter Chuck Dickson regarding influenza, the seasonal flu shot and the decision to not have community influenza immunization clinics this year.
Met with Marnie Wedlake of CMHA to discuss the MAPOP

October 27   Met via a telephone with Sharon Jolliffe, Program Consultant with Physical & Health Education Canada (PHE Canada) in regards to being Key Note Speaker at the 2015 Healthy School Communities National Forum in Ottawa
Participated in an on camera interview regarding the impact of the London Community CARes Program
Met with Sheila Simpson from the Thames Valley Ontario Trillium Foundation

October 28   Attended a full day meeting of the South West LHIN Health System Leadership Council in Stratford

October 30   Met with Bill Rayburn, CAO Middlesex County
Participated in a staff-led Halloween Hike in downtown London as part of inMotion

November 2   Hosted a meeting of the Collaborative Champions
Attended the Lighting of the Tree of Hope ceremony at Victoria Park

November 5   Via a teleconference call, participated in Nurse Family Partnership Steering Committee meeting
Met with Gil Clelland and Darrel Rekman from Sanctuary London in regards to poverty and the Nurse Family Partnership
Met with Forrest Bivens and Susan Toth , PCS Barristers and Solicitors
Attended a meeting of the Mayor's Advisory Panel On Poverty

November 6   Participated in a teleconference call with organizers of the Healthy School Communities National Forum

November 9   Attended a meeting of the London Homeless Prevention System Implementation Team
Attended the Strategic Priorities and Policy Committee (SPPC) meeting at City Hall

November 12   Attended the Business Leader Breakfast Series "Doing Great by Doing Good" at the
               Goodwill Centre
               Lectured at Western University for the Masters of Public Health Program
               Attended a meeting of the Mayor's Advisory Panel on Poverty (MAPOP) – Community
               Conversations
               Attended a MAPOP Community Conversation Session

November 17   Participated in the summary panel for Healthy Schools Forum in Ottawa

November 18   Met with Tanya Park, London City Councillor for Ward 13 to discuss the Poverty Panel

November 19   Attended the Family-Centred Service System Leaders' Breakfast
               With the Associate Medical Officer of Health, attended a lecture at Western University
               given by Peter Donnelly, President & CEO of Public Health Ontario
               Attended the Board of Health Governance Education Session

November 20   Participated in the You Opportunities Unlimited Strategic Planning session
               Attended a meeting of the Community Health Collaborative

November 23   Attended a meeting of the Mayor's Advisory Panel on Poverty

November 24   Attended the inMotion Community Challenge Breakfast. Results of the month long
               challenge were announced. The MOH is a co-champion.

November 25   Attended a United Way Cabinet Meeting
               Provided opening remarks at the Community Drug Strategy event at BMO Centre
               Attended a meeting of the South West LHIN Health System Leadership
               Initial meeting with Charmaine Dean, Dean of Science at Western University

November 30   Met with Melissa Sheenhan about the Poverty Panel
               Attended a Northeast Community Conversations meeting about the work of the Poverty
               Panel

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