# Appendix A : Evidence Summary

## Key Findings

### 1. Alignment with OPHS

The Ontario Public Health Standards (OPHS) incorporate the ISPA and the Child Care and Early Years Act (CCEYA) legislations and are supported by two protocols (Immunization Management Protocol and the Vaccine Storage and Handling Protocol**)** which provide direction to the Board of Health (BOH) on how to operationalize the specific requirement(s) identified in the standard. The current activities of the VPD program were compared to the OPHS and Immunization Management Protocol. The Vaccine Storage and Handling Protocol was considered outside the scope of this review.

**a.** There are 13 requirements under the Vaccine Preventable Disease Standard
- 7 requirements are met, 4 requirements are partially met, and 2 requirements are not met

**b.** There are 35 elements under the Immunization Management Protocol
- 5 out of the 35 elements are not met
- 1 out of the 35 elements is partially met

More complete compliance with the ISPA and CCEYA, enhanced data entry, improving the public's knowledge and confidence in immunization programs and providing education to health care providers related to Adverse Effects Following Immunization (AEFI) were identified as areas where improvements could be made. It was identified that the provision of Tuberculin Skin Tests (TST) exceeds the requirements of the OPHS.

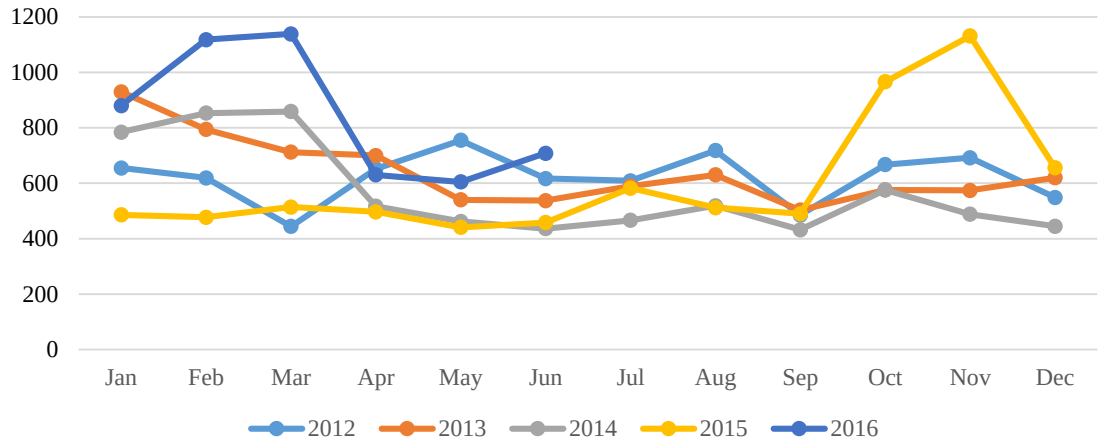
### 2. Immunization Clinic

The Immunization Clinic offers publicly funded and paid vaccines. The 50 King Street Clinic operates on an appointment and walk-in basis on Mondays, Wednesdays and Fridays. The Strathroy site operates on a walk-in basis on the first Tuesday of every month.

Clinic Trends

- Client demographics and volume were assessed to characterize the population seen in the Immunization clinics. In the first six months of 2016, the total number of visits to the Immunization Clinic was 5,080, which was 43% higher than the total number of visits in the first six months of 2015 (n=2,873) (Figure 1). School aged children accounted for 58% of 2016 visits compared to 46% of 2015 visits. The increased proportion of school aged children attending the clinic in 2016 is at least partially due to ISPA-related screening and suspension activities.

Figure 1. Number of Immunization Clinic vists by month, January 2012- June 2016




Clinic Survey

- The survey was conducted at the 50 King Street Immunization Clinic between September and November 2016. The purpose of the survey was to understand the reasons why individuals and families visited the Immunization Clinic rather than their HCP or a community clinic.

- Overall, 343 clients were approached to participate in the survey; the response rate was 93% (319/343). Not being fluent in English was the most commonly reported reason clients declined to participate in the survey.

- Majority (96%, 300/312) of the respondents indicated residing in the MLHU catchment area.

- The most commonly reported ways in which clients reported hearing about the Immunization Clinic was through their HCP, the MLHU website and word of mouth.

- Routine immunization was the most common (76%, 237/312) reason why respondents were receiving immunizations. One-tenth of respondents (34/312) reported receiving immunizations to meet the requirements of an organization or placement. Other reasons clients reported were due to an injury, travel or recommended by their HCP.

- Most of the respondents who attended the Clinic during the survey period reported having a valid health card (97%, 294/304) and a HCP (86%, 269/313).
    - Most clients (79%, 213/269) with a HCP reported they were aware that they could receive immunizations through their HCP.

- Clients with a HCP were also asked to specify their reasons for choosing the Immunization Clinic over their HCP for their immunization needs. The three most commonly reported reasons were that the immunization was not available from their HCP, flexibility to walk-in fit with their schedule and the location of the Immunization Clinic was accessible.

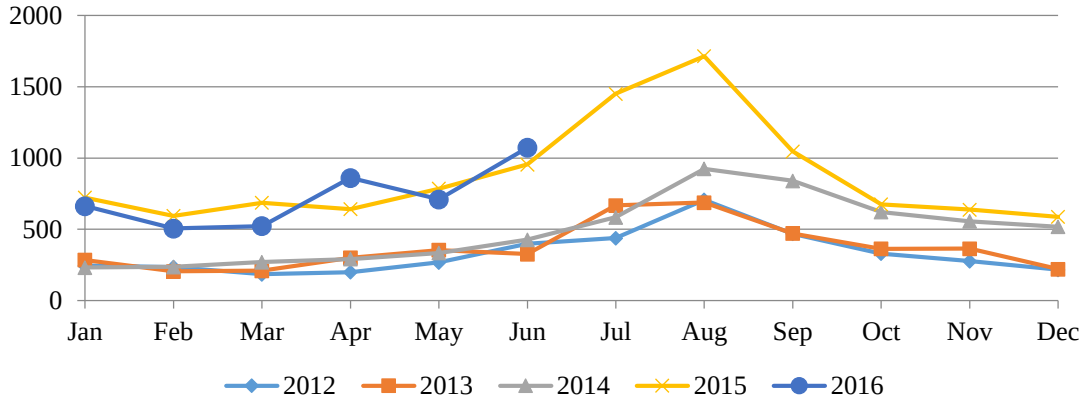
## 3. Tuberculin Skin Test (TST) Clinic

Clinic Trends

The TST Clinic offers tuberculin skin tests, with the option of appointments. Clients receiving a TST are also assessed to ensure their immunizations are up to date. The TST Clinic is cost-neutral, and is staffed by causal nurses. No TST services are offered by the Health Unit at the Strathroy site.

- Changes made to the criteria for publically-funded Tubersol in 2014 contributed to an increase in TST administered by the Health Unit for educational purposes.
- The number of TST administered and read each year by MLHU has increased from a total of 3,969 client interactions in 2012 to 10,499 in 2015. In the first six months of 2016, 4,335 client interactions have occurred. August has consistently been the month with the most client interactions (Figure 2).

Figure 2. Number of TB skin tests and reads (interactions) at MLHU by month and year, January 2012-June 2016



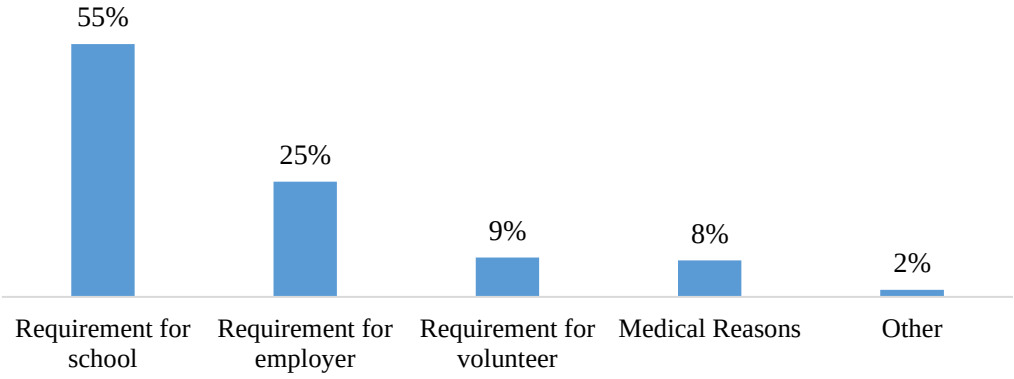

- Two thirds (66%) of TSTs administered in 2014 and 2015 were required for educational purposes

TB Clinic Survey

- Overall, 343 clients were approached to participate in the survey between August and November 2016. The response rate was 94% (327/347). Language was the most commonly reported reason clients declined to participate in the survey.

- The most frequently reported reason for requiring a TST was educational purposes (Figure 3). The majority (83.5%, 152/182) of clients receiving a TST for educational purposes were enrolled at a post-secondary institution in the Middlesex-London area.

Figure 3: Reported Reason for TST (n=327)




**Note**: Percentages were calculated based on the total number of respondents each month. Because respondents were able to choose multiple options, the sum of the percentages exceeds 100%.

- The most frequently reported ways in which clients heard about the TST Clinic was through their HCP, word of month, and the MLHU website.

- An identified barrier was that although most clients reported having a HCP, the test was not available through their HCP. There was also low awareness of availability of TST services outside of the Health Unit. Of those that were aware of community clinics, cost was identified as a barrier.

- Consultations with HCP offices identified cost, lack of interest, and low awareness of the purchase and administration processes of providing TSTs as barriers.

## Refugee Clinic

The Health Unit collaborates with the London InterCommunity Health Centre (LIHC) and the Cross Cultural Learner Centre (CCLC) to provide immunization screening and administration to refugees. From January 1, 2012 to June 30, 2016, the Immunization Clinic has held 63 immunization clinics for refugees. A review of best practices of screening and immunizing refugees was conducted to align with the Evidence Based Clinical Guidelines for Immigrants and Refugees document. Collaboration will continue with community partners to provide immunization services to this population.

## Reportable Disease Follow-up

Discussions with the team have highlighted that the rotational structure does not allow of follow-up to be performed efficiently. Since the team works off-site and on-site, the PHNs rotate to complete team activities. This arrangement results in case management and follow-up to be passed on from one Public Health Nurse (PHN) to another, reducing the consistency of care and

follow-up. In addition, because reportable disease follow-up is a small component of the team's work, this was also described to be time intensive and requiring additional staff to work together to best proceed with the follow-up. These challenges have resulted in delaying the follow-up and timely reporting of the reportable disease to the Ministry. In addition, this also has implications on other program activities (e.g. screening, immunization clinic) that the team is mandated to provide.

**Recommendations**

Based on the information gathered, recommendations were developed in consultation with the VPD team. These recommendations have been further refined in consultation with the Environmental Health and Infectious Disease Director and Associate Medical Officer of Health.

1. **Collaborate with the Health Care Provider Outreach Team to develop a coordinated strategy to engage HCPs**
   - Developing a coordinated strategy to engage physician would allow the team to:
     - Assess the information needs (e.g. immunization schedules, AEFIs, ISPA screening letters, appropriate diagnostic test for a suspected disease) and provide education around the identified areas
     - Identify the challenges and barriers to administering immunizations and provide ongoing support as needed.

2. **Enhance partnership with HCPs and provide on-going support to enable them to administer immunizations**
   - Enhancing partnerships will allow HCPs to be supported in administering immunizations to their clients. In addition, it is important that partnerships are established with HCPs in light of the Immunization 2020 strategy, as HCPs will be required to report client immunizations to the Health Unit.
   - This will include targeted outreach to HCPs who direct clients to the Health Unit for immunization services

3. **Screen clients while booking appointments to identify those with a HCP and redirect them back to their HCP for their immunization and TST needs**

4. **Identify priority populations and collect data to determine the reach of the Immunization Clinic**
   - As part of requirement 2 of the OPHS, the Health Unit is responsible for conducting epidemiological analysis to identify priority populations that may face barriers to immunization. Currently there are information gaps which limit the ability to assess if the Immunization Clinic is reaching the appropriate priority populations.

5. **Develop a strategy to meet the legislative requirements**
   - The Health Unit is not fully compliant with the ISPA and CCEYA legislations. A strategy is warranted to meet the legislative requirements as compliance will be monitored under the Immunization 2020 strategy.

6. **Consider realignment of reportable disease follow up to Infectious Disease Control Team**
   - Challenges were identified that limited or delayed the follow-up of reportable diseases. Realignment of reportable disease follow-up to a team that is more equipped can improve consistency of how reportable diseases are followed-up.

7. **Gather the perspectives of those with a language barrier to identify challenges to seeking immunization and TST services from their HCP.**
   - Investigation of those with a language barrier will help identify challenges to receiving immunizations and TSTs in primary care clinics and determine how public health can play a role in reducing the challenges.

8. **Consider offering designated immunization clinics for school aged children**
   - Following the assessment of immunization records, there is an increase in school aged children attending the Immunization Clinic. Designated clinics may need to be explored to manage client volume and ensure that client needs are met.

9. **Engage post-secondary institutions to understand the challenges and capacity of providing TSTs to their students**

10. **Increase awareness of community clinics that offer TSTs**

11. **Further explore the need for TST services in the County**

Update: The recommendations 9, 10 and 11 have been impacted by the MOHLTC changes to the criteria for publicly funded Tubersol.

12. **Maintain an on-going relationship with LIHC**
    - Collaborate with LIHC around the exchange of immunization information for children from refugee families and the feasibility of incorporating LTBI screening in refugee assessment clinics.

13. **Explore measures to enhance the quality of clinic data to support the proposed recommendations and future decision making**

14. **Revise client registration form to identify language barriers and clients with a HCP**

15. **Investigate feasibility of Interferon Gamma Release Assay (IGRA) as an alternative to TSTs in refugees**

16. **Develop a communication plan to communicate the changes made to the Immunization Clinic as a result of the Program Review**