AGENDA
MIDDLESEX-LONDON BOARD OF HEALTH

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

Thursday, 7:00 p.m.
2015 March 19

MISSION - MIDDLESEX-LONDON BOARD OF HEALTH

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

MEMBERS OF THE BOARD OF HEALTH

Mr. Ian Peer (Chair)
Mr. Jesse Helmer (Vice Chair)
Ms. Patricia Fulton
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

BUSINESS ARISING FROM THE MINUTES

DELEGATIONS

7:05 p.m. - 7:20 p.m. Ms. Heather Lokko, Associate Director, Oral Health Communicable Diseases and Sexual Health Services re Information regarding Population Health Collaborative

Item #	Report Name and Number	Link to Additional Information	Delegation	Recommendation	Information	Brief Overview
Committee Reports						
	None this month					
Delegations and Recommendation Reports						
1	Screening, Assessment And Intervention - Revised 2015 Program Budget Template (Report 020-15)	Appendix A		x		To request Board of Health approval for the revised Program Budget Template for the Screening, Assessment, and Intervention Team
2	Panorama and Vaccine Preventable Diseases Standard Compliance (Report 021-15)			x		To request that the Board of Health indicate to the Ministry its non-compliance with the Vaccine Preventable Diseases Standard for the 2014/15 school year and its expected compliance for the 2105/16 school year
Information Reports						
3	Middlesex-London 2013/2014 School-Based Dental Screening Results (Report 022-15)	Appendix A			x	To report on the results of the school-based dental screening program
4	STI Clinic Review Results (Report 023-15)	Appendix A			x	To report on the Consultant's findings of the STI Clinic review
5	Summary Information Report for March 2015 (Report 024-15)	Appendix A Appendix B			x	To provide a summary of information from Health Unit programs in Family Health Services
6	Medical Officer of Health Activity Report – March (Report 025-15)	-			x	To provide an update on the activities of the MOH for March 2015

CONFIDENTIAL

OTHER BUSINESS

- Next Finance and Facilities Committee Meeting: Thursday, April 2, 2015 @9:00 a.m.
- Next Governance Committee Meeting: Thursday, April 16, 2015 @6:00 p.m.
- Next Board of Health Meeting: Thursday, April 16, 2015 @7:00 p.m.

CORRESPONDENCE

a) Date: 2015 February 19 (via email 2015 February 20)
Topic: Naloxone Distribution Program
From: Mr. Gary McNamara, Chair, Board of Health, Windsor-Essex
To: Copy of correspondence to The Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care

Background:
The Middlesex-London Health Unit, Regional HIV/AIDS Connection, London Area Network of Substance Users and the London InterCommunity Health Centre launched The Naloxone Program in June of 2014. This collaborative effort is supported by the Ontario Ministry of Health and Long-Term Care. The intention of this multi-agency partnership is to prevent opioid overdose and save lives. In Middlesex-London, between 2008 and 2013, there were 146 fatal opioid overdoses.

Recommendation:
Endorse

b) Date: 2015 February 23 (via email)
Topic: Proceedings from Boards of Health Section Orientation Session February 5, 2015
From: Ms. Linda Stewart, Executive Director, Association of Local Public Health Agencies (alPHa)
To: All Board of Health Members

Background:
A Boards of Health orientation session was held by the Association of Local Public Health Agencies (alPHa) on February 5, 2015. Approximately 16 out of 36 health units participated. The session provided an overview of the Ontario public health environment, Board of Health accountability, Board of Health liability, and the role of the Board of Health beyond meetings.

Recommendation:
Receive

c) Date: 2015 February 23 (via email)
Topic: Ministry of Education Release of Updated Health and Physical Education Curriculum
From: Ms. Linda Stewart, Executive Director, Association of Local Public Health Agencies (alPHa)
To: All Board of Health Members

Background:
The Ministry of Education released the updated Health and Physical Education curriculum that will be implemented starting September 2015. This follows extensive consultation with stakeholders, including the Ontario Public Health Association and the Ontario Healthy Schools Coalition. Updates to the curriculum include healthy relationships, consent, mental health, online safety, "sexting", being more inclusive of Ontario's diverse population.

Recommendation:
Receive.

d) Date: 2015 February 25 (via email)
Topic: One-time funding (up to $129,202) for 2014-15 Funding Year
From: The Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care
To: Mr. Marcel Meyer, 2014 Chair, Middlesex London Board of Health

Background:
This letter outlines additional one-time funding to support costs associated with delivery of mandatory and related public health programs.

Recommendation:
Receive.

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

ADJOURNMENT

PUBLIC SESSION – MINUTES

MIDDLESEX-LONDON BOARD OF HEALTH

2015 February 19

MEMBERS PRESENT:	Ms. Trish Fulton Mr. Marcel Meyer (via online) Mr. Ian Peer Ms. Viola Poletes Montgomery Mr. Kurtis Smith Mr. Mark Studenny Ms. Joanne Vanderheyden
REGRETS:	Mr. Jesse Helmer Ms. Nancy Poole Mr. Stephen Turner
OTHERS PRESENT:	Dr. Christopher Mackie, Medical Officer of Health & CEO 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. Laura Di Cesare, Director, Human Resources and Corporate Strategy Mr. Dan Flaherty, Manager, Communications Dr. Gayane Hovhannisyan, Associate Medical Officer of Health Ms. Heather Lokko, Associate Director, Oral Health, Communicable Disease and Sexual Health Services Mr. John Millson, Director, Finance and Operations Ms. Debbie Shugar, Manager, Family Health Services Ms. Linda Stobo, Manager, Chronic Disease Prevention and Tobacco Control Mr. Alex Tyml, Online Communications Coordinator
MEDIA OUTLETS:	None

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 Mr. Studenny seconded by Ms. Fulton *that the **AGENDA** for the February 19, 2015 Board of Health meeting be approved as amended.*

Carried

APPROVAL OF MINUTES

It was moved by Mr. Smith, seconded by Ms. Fulton *that the **MINUTES** of the January 15, 2015 Board of Health meeting be approved.*

Carried

BUSINESS ARISING FROM THE MINUTES - none

Dr. Mackie introduced Dr. Aric Sudicky, a medical student from the University of Calgary, who will be working with Dr. Mackie for two weeks. Upon graduation, Dr. Sudicky plans to return to Ontario to practice rural family medicine.

COMMITTEE REPORTS

1) Governance Committee – verbal report

Committee Chair, Mr. Mark Studenny, reviewed the agenda of Governance Committee meeting that was held prior to the Board of Health meeting (February 19th Agenda).

It was moved by Mr. Studenny, seconded by Ms. Poletes Montgomery *that members of the Board of Health will complete the Self-Assessment survey attached as Appendix A to Report No. 06-15GC in March 2015 and that the Governance Committee review results at its April meeting in order to propose recommendations to improve Board effectiveness and engagement.*

Carried

Mr. Studenny also reported that members of the Governance Committee are reviewing the draft MOH Performance Appraisal Tool, with the goal of initiating the process according to the proposed timeline attached as Appendix B to Report No. 05-15GC.

2) Finance and Facilities Committee (FFC) Report, January 29th Meeting (Report 09-15)

Committee Chair, Ms. Trish Fulton, assisted Board members with their understanding of Reports No. 09-15 and 010-15.

It was moved by Ms. Fulton, seconded by Ms. Poletes Montgomery *that the Board of Health receive the 2015 Planning and Budget Templates for the Office of the Medical Officer of Health, Finance and Operations, and Family Health Services attached as Appendix A, B and C to Report No. 02-15FFC.*

Carried

3) Finance and Facilities Committee (FFC) Report, February 12th Meeting (Report 010-15)

Report No. 04-15FFC 2015 Budget Process

Ms. Joanne Vanderheyden expressed support for the budget, and indicated appreciation for the efforts to address her questions about the changes to the reception coverage at the Strathroy offices of the Health Unit.

It was moved by Mr. Fulton, seconded by Ms. Poletes Montgomery *that the Board of Health approve all Planning and Budget Templates for the 2015 budget, attached as Appendix A to Report No. 010-15.*

Carried

Report No. 06-15FFC 2014 Fourth Quarter Budget Variance Report

It was moved by Ms. Fulton, seconded by Mr. Smith *that the Board of Health receive Report No 06-15FFC 2014 Fourth Quarter Budget Variance Report for information.*

Carried

Report No. 07-15FFC 2014 Board of Health Remuneration

It was moved by Ms. Fulton, seconded by Mr. Studenny *that the Board of Health receive Report No. 07-15FFC 2014 Board of Health Remuneration for information.*

Carried

Report No. 08-15FFC Public Sector Salary Disclosure Act

It was moved by Ms. Fulton, seconded by Mr. Studenny *that the Board of Health receive Report No. 08-15FFC Public Sector Salary Disclosure Act – 2014 Record of Employee's Salaries and Benefits for information.*

Carried

It was moved by Ms. Fulton, seconded by Mr. Smith *that the minutes of the February 12, 2015 Finance and Facilities Committee be received for information.*

Carried

4) Report No. 05-15FFC Budget Summary

Mr. John Millson, Director, Finance and Operations, assisted Board members with their understanding of this report using a PowerPoint presentation. Mr. Millson also presented Appendix B to Report No. 010-15 which is a summary of the 2015 Proposed Budget with links to all of the Program Budget Templates that were discussed in detail at the Finance and Facilities Committee Meetings on January 8, 29 and February 12, 2015.

It was moved by Ms. Fulton, seconded by Mr. Studenny *that the Board of Health approve the 2015 Operating Budget in the gross amount of $34,670,537.*

Carried

It was moved by Ms. Fulton, seconded by Mr. Studenny *that the Board of Health direct the Middlesex-London Health Unit not to hold back on Program reinvestment decisions until Ministry approval is received.*

Carried

It was moved by Ms. Fulton, seconded by Ms. Vanderheyden *that the Board of Health:*

1. *Forward Report No. 05-15FFC to the City of London and the County of Middlesex for information; and*
2. *Direct staff to submit the 2015 Operating Budget in the Ministry of Health and Long-Term Care's Program Based Grant format.*

Carried

RECOMMENDATION REPORTS

5) Bill 45, The Making Healthier Choices Act, 2014 (Report 012-15)

Ms. Linda Stobo, Manager, Chronic Disease Prevention and Tobacco Control Team, assisted Board members with their understanding of this report. She highlighted the major points of Bill 45, The Making Healthier Choices Act, 2014.

It was moved by Ms. Fulton, seconded by Ms. Vanderheyden:

1. *That the Board of Health receive Report No. 012-15 re Bill 45, the Making Healthier Choices Act, 2014; and further*

2. *That the Board of Health recommend that the Ministry of Health and Long-Term Care amend the menu labelling legislation to include clear, prominent labelling of both calories and sodium content on menus, including reference values, based on emerging best practices for menu labelling; and further*

3. *That the Board of Health communicate its support for Bill 45 and for amendments to Bill 45 to include both calories and sodium content on menus by sending a letter to the Premier of Ontario, the Minister of Health and Long-Term Care, the Associate Minister of Health and Long-Term Care (Long-Term Care and Wellness), local members of Provincial Parliament, and others.*

Carried

6) Reducing Second-Hand Smoke Exposure in Multi-Unit Housing (Report 013-15)

Ms. Stobo assisted Board members with their understanding of this report.

In response to a question about the current legislation, Ms. Stobo responded that the legislation prohibits smoking in common areas of multi-unit housing. Health Unit staff has talked to some owners about how to develop policies and to deal with concerns/complaints of smoke drifting from one unit to another.

It was moved by Mr. Studenny, seconded by Ms. Poletes Montgomery:

1. *That the Board of Health receive Report No. 013-15 re Reducing Second-Hand Smoke Exposure in Multi-Unit Housing; and further*

2. *That the Board of Health endorse the actions and priorities outlined in the Smoke-Free Housing Ontario Coalition letter "Act now to reduce the impact of second-hand smoke exposure in multi-unit housing in Ontario," attached as Appendix A, communicating its support for the Smoke-Free Housing Ontario Coalition.*

Carried

7) Healthy Child Development Program Information Video for Families (Report 014-15)

Ms. Debbie Shugar, Manager, Family Health Services, assisted Board members with their understanding of this report. The video discussed in this report was played at the meeting.

It was moved by Ms. Poletes Montgomery, seconded by Mr. Smith that *the Board of Health endorse a request to the Ministry of Children and Youth Services (MCYS) for additional funding for accessibility as outlined in Report No. 014-15 re HCD Program Information Video for Families.*

Carried

INFORMATION REPORTS

8) Ontario's Special Needs Strategy (Report 015-15)

9) Summary Information Report for February 2015 (Report 016-15)

10) Medical Officer of Health Activity Report –February (Report 017-15)

It was moved by Mr. Studenny, seconded by Mr. Smith *that the Board of Health receive Report No. 015-15 re Ontario's Special Needs Strategy, Report No. 016-15 re Information Summary Report for February and Report No. 017-15 re Medical Officer of Health Activity Report – February for information.*

Carried

CORRESPONDENCE

Re: Item d) 2015 January 28 Coalition of organizations call for the reinstatement of long-form census from Mr. Bill Jeffery, National Coordinator, Centre for Science in the Public Interest (CSPI)

It was moved by Ms. Fulton, seconded by Ms. Poletes Montgomery *that the Board of Health communicate its endorsement of the reinstatement of the long-form census to the Centre for Science in the Public Interest.*

Carried

OTHER BUSINESS

Upcoming meetings:
1. Board of Health – Thursday, March 19, 2015 7:00 p.m.
2. Finance and Facilities Committee – Thursday, April 2, 2015 9:00 a.m.
3. Governance Committee – Thursday, April 16, 2015 6:00 p.m.

CONFIDENTIAL

At 8:10 p.m., it was moved by Mr. Studenny, seconded by Mr. Smith *that the Board of Health move in camera to discuss personal matters about an identifiable individual, including Board employees; and matters concerning litigation or potential litigation, including matters before administrative tribunals, affecting the Middlesex London Health Unit.*

Carried

At 8:50 p.m., it was moved by Mr. Studenny, seconded by Ms. Poletes Montgomery *that the Board of Health return to a public forum and report that progress was made regarding personal matters about an identifiable individual, including Board employees; and matters concerning litigation or potential litigation, including matters before administrative tribunals, affecting the Middlesex London Health Unit.*

Carried

ADJOURNMENT

At 9:00 p.m., it was moved by Ms. Fulton, seconded by Mr. Smith *that the meeting be adjourned.*

Carried

_____ _____

IAN PEER
Chair

CHRISTOPHER MACKIE
Secretary-Treasurer

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 020-15

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2015 March 19

SCREENING, ASSESSMENT AND INTERVENTION - REVISED 2015 - 2016 FTE ALLOCATION

Recommendation

It is recommended that the Board of Health approve the revised 2015-2016 FTE allocation for the Screening, Assessment, and Intervention Team as appended to Report No. 020-15 re Screening, Assessment and Intervention – Revised 2015-2016 FTE Allocation.

Key Points

- In October 2014 the Ministry of Children & Youth Services announced increased funding to address both assessment and treatment waitlists.
- In the 2015 – 2016 funding period, an additional $158,717 has been approved to address the waitlists.
- Appendix A provides the revised FTE allocation for the Screening, Assessment and Intervention Team.

Background

In November 2014, the Board of Health reviewed Report No. 046-14FFC, re "Preschool Speech and Language Program – Base Funding Increase" and approved the revised 2014-2015 budget to address waitlists.

2015 – 2016 MCYS funding

For the 2015 – 2016 funding period, the Ministry of Children & Youth Services (MCYS) added an additional $158,717 to the Screening, Assessment and Intervention base budget. This additional grant was incorporated in the Program Budget Template and approved by the Board of Health on February 19th, 2015. However, these estimates were provided prior to meeting with service providers which occurred in February/March 2015. At that time, staff committed to providing more analysis and recommendations about how the increased funding should be allocated for 2015-16.

Attached as Appendix A is a schedule showing the revised FTE allocation for the Screening, Assessment and Intervention Team after consulting with the various service providers. As can be seen, the program is employing more resources for Speech & Language Pathologists (2.26 FTEs), Hearing Screeners (0.30 FTEs), Communication Disorder Assistants (0.40 FTEs), and Administrative Support (0.71 FTEs) for a total increase of 3.67 FTEs which is consistent with the intended purposes to reduce waitlists.

This report was prepared by Ms. Debbie Shugar, Manager, Screening, Assessment and Intervention, and Mr. John Millson, Director of Finance & Operations.

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

Appendix A

Schedule 1 – Screening, Assessment and Intervention FTE Allocation

	Revised 2014-2015 FTEs	Revised 2015-2016 FTEs	Increase / (Decrease)
MLHU Staff:			
System Facilitator (Prg. Manager)	1.00	1.00	
Program Assistants	2.00	2.40	0.40
Intake Coordinator	1.00	1.00	
Contract Staff:	0.58	0.58	
Family Support Workers	2.30	2.30	
Early Childhood Vision Consultants	11.12	13.38	2.26
Speech & Language Pathologists	3.10	3.41	0.31
Administrative Support	2.80	3.20	0.40
Communication Disorder Assistants	0.50	0.50	
System Coordinator (Hearing Screening)	1.74	1.74	
Audiologists	2.35	2.65	0.30
Hearing Screeners			
Total	**28.49**	**32.16**	**3.67**

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 021-15

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2015 March 19

PANORAMA AND VACCINE PREVENTABLE DISEASES STANDARD COMPLIANCE

Recommendation

It is recommended that Report No. 021-15 re Panorama and Vaccine Preventable Diseases Standard Compliance be received for information and that the Board of Health indicate to the Ministry their non-compliance with the Vaccine Preventable Diseases Standard for the 2014/15 school year and their expected compliance for the 2105/16 school year.

Key Points

- Boards of Health are being asked to confirm their compliance with the Vaccine Preventable Diseases Standard of the Ontario Public Health Standards
- MLHU is not compliant with the Standard for the 2014/15 school year because of the activities required to implement Panorama, the new provincial electronic database
- It is anticipated that MLHU will resume the assessment of immunization records beginning with the 2015/16 school year

Background

The Public Health Division of the Ministry of Health and Long Term Care has recently asked Boards of Health to confirm their compliance with the requirements of the Vaccine Preventable Diseases Standard of the Ontario Public Health Standards (OPHS) and their immunization assessment and suspension plans under the Immunization of School Pupils Act (ISPA). Boards of Health are being asked specifically whether they will be completing the assessment of immunization records for school pupils outlined in the Immunization Management Protocol, with consideration of suspension of students where appropriate under the ISPA for the 2014/15 school year. This request is being been made as a result of recent public interest regarding local public health units' compliance with the assessment and suspension requirements under the ISPA.

Health Units are responsible for maintaining the immunization records of children in licensed child care settings, elementary and secondary schools. Panorama is a comprehensive, secure, web-based information system designed to more efficiently manage immunization information, vaccine inventory and cases and outbreaks of communicable diseases. The immunization component of Panorama was implemented in health units in Ontario in phases beginning in August 2013; Middlesex-London implemented the immunization component at the end of July, 2014 in the last phase of implementation.

In January 2015, Immunization Branch staff conducted an informal survey of health units' intent to assess immunization records and suspend students, when appropriate, during the 2104/15 school year. Approximately half of the health units indicated that they were planning to assess but not suspend; four (including MLHU) indicated that they could not assess or suspend; the remainder which included the health units who implemented Panorama in 2013 indicated that they planned to assess all records with varying levels of suspension (e.g., all students when appropriate or students in specific grades). Of those that implemented Panorama in 2013, a number of health units did not complete assessment requirements and none were able to complete the suspension process for the 2013/14 school year.

Middlesex-London Health Unit Compliance

Up until the planning and implementation of Panorama, the immunization records of students attending schools in the Middlesex-London Health area were assessed annually. Parents were notified when their child's immunization record was not complete according to the ISPA; they were asked to provide proof of immunization, attend a health unit clinic or community health care provider to obtain missing immunization, or provide an exemption affidavit. Students who did not meet those requirements were suspended from school until the missing information was provided to the Health Unit. As well, the Health Unit worked with child care operators to assess the immunization status of children attending a licensed child care setting under the Day Nurseries Act.

The implementation of Panorama at MLHU has resulted in the need for the following:

1) Resolution of a large number of duplicate records as the system moved from a local to a provincial database of immunization records,
2) Reconciliation of exemption affidavits in the new database,
3) Entry of back-log of data (immunization records for new school enterers and updates to existing records), and
4) Significant changes in business practices.

Funding (100%) was provided to health units to assist in the implementation activities. However, this funding has not been sufficient to cover all potential staff-related costs. Staff have been working diligently to complete the activities described above but much work remains to be done.

As a result, the assessment of immunization records for children in licensed child care settings, elementary and secondary schools for the 2104/15 school year cannot be completed. It is anticipated the Health Unit will resume that the assessment of immunization records in the 2105/16 school year.

Revisions to the ISPA in July 2014 will also impact the assessment and suspension process. The revised Act includes requirements for three additional vaccines and additional doses of existing vaccines included in the Act. Funding has been requested to assist with the additional requirements under the revised ISPA; communication regarding access to these funds will be provided through the 2015 provincial budget notification process.

Although implementation of Panorama has delayed the normal assessment and suspension processes, in the event of an outbreak at a school or child care centre, MLHU is able to identify, through a time-intensive process, which students have incomplete immunizations and exclude them from school when necessary.

Conclusion

Activities required to complete the implementation of Panorama have caused the assessment of immunization records for children and students to be suspended for the 2014/15 school year. As well, additional immunization requirements under revised Immunization of School Pupils Act, which came into effect in July 2014, add to the workload required for the assessment of immunization records for students. It is anticipated that the assessment of immunization records will resume with the 2105/16 school year.

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

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

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 022-15

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2015 March 19

MIDDLESEX-LONDON 2013/2014 SCHOOL-BASED DENTAL SCREENING RESULTS

Recommendation

It is recommended that Report No. 022-15 Middlesex-London 2013/2014 School-based Dental Screening Results be received for information.

Key Points

- During the 2013-2014 school year, the Health Unit screened 15,797 students (84%) in 129 elementary schools through the school-based dental screening program.
- The percentage of students screened in Junior Kindergarten who were *caries-free* (i.e., have not had cavities, or the removal or filling of a tooth because of tooth decay) was 80%. The percentage of caries-free students in Grade 2 was 57%. These percentages are slightly lower than the previous school year.
- Similar to the previous year, 632 students (4%) were found to have urgent dental needs which made them clinically eligible to receive Children in Need of Treatment (CINOT) funding for their dental care.
- In response to the declining caries-free rate as students move from Junior Kindergarten to Grade 2, the Health Unit is implementing a pilot fluoride varnish program in up to eight "High Intensity" schools.

Background

One hundred and twenty-nine elementary schools participated in the school-based dental screening program in the 2013-2014 school year. Students in Junior Kindergarten, Senior Kindergarten, and Grade 2 at elementary schools were screened in accordance with the Oral Health Assessment and Surveillance Protocol of the OPHS. This screening involves a Registered Dental Hygienist looking in each child's mouth to assess their past history of dental caries and whether any teeth need urgent attention. The need for and urgency of dental care is recorded and parents advised of the required follow-up. Based on each school's Grade 2 screening results, each school is categorized into "Low", "Medium", or "High" levels of screening intensity, as per the Protocol. Increased screening intensity level requires that additional grades be screened.

Results of the 2013-2014 School Year Screening

Participation. The Ministry of Health and Long-Term Care reported that 722,425 students in Ontario were offered dental screening during the 2013-2014 school year. The actual number of children screened was 641,138 (89%). Of the 18,902 students who were offered dental screening at the schools that participated in the school-based dental screening program, in London and Middlesex County, 15,797 (84%) were screened (Figure 1, Appendix A). The numbers of students screened in Junior Kindergarten, Senior Kindergarten, and Grade 2 were 3,841, 4,072, and 3,906.

The provincial percentages of students excluded from screening for consent reasons and absenteeism were 5% and 6% respectively for the 2013-2014 school year. Within Middlesex-London, the Health Unit did not have parental consent to screen 1,928 (10%) students and 1,177 (6%) students were absent on the day(s) that staff were screening at their schools. The percentage of absent and excluded students in the 2013-2014 school year was lower than the previous year's percentages which were 12% and 7% respectively.

Screening intensity. Among the 125 elementary schools with Grade 2 in the Health Unit's jurisdiction, 98 were categorized as Low intensity, 13 as Medium intensity, and 14 as High intensity as per the Oral Health Assessment and Surveillance Protocol.

Dental caries. The percentages of Junior Kindergarten, Senior Kindergarten, and Grade 2 students screened who were caries-free, (i.e., have never had cavities, or the removal or filling of a tooth because of tooth decay) were 80%, 70%, and 57%, respectively (Figure 3, Appendix A). This demonstrated a decrease from the percentages from the previous school year which were 81%, 72%, and 60% respectively. Almost 6% of Grade 2 students screened had two or more teeth with tooth decay (Figure 4, Appendix A).

Urgent dental needs. The Ministry of Health and Long-Term Care reported that 40,552 students (6%) among those screened in Ontario were found to have Urgent dental needs which deemed them clinical eligible to receive Children in Need of Treatment (CINOT) funding for their dental care. In London and Middlesex County, 632 students (4%) of those screened were found to have Urgent dental needs which deemed them clinically eligible to receive Children in Need of Treatment (CINOT) funding for their dental care (Figure 5). Five hundred and seventy-eight students (92%) of those found to have Urgent dental needs were referred to and accepted at local dental offices for treatment. These percentages are similar to the findings and outcomes from the previous school year.

These findings are outlined more fully in the Annual Oral Health Report (Appendix A).

Next Steps

Findings from the 2013/2014 school-based dental screening program as outlined in the "Annual Oral Health Report" (Appendix A) will be shared with local dental and healthcare providers, partner agencies, and the general public. The Health Unit is currently working to improve the percentage of eligible students screened by implementing strategies such as working with the school staff to revise the consent forms and consent collection processes (within an active consent framework), and more actively promoting the school-based screening program. In response to the declining caries-free rate as students move from Junior Kindergarten to Grade 2, the Health Unit is working to implement a pilot fluoride varnish program in up to eight "High Intensity" schools.

This report was prepared by Dr. Maria van Harten, Dental Consultant and Mr. Chimere Okoronkwo, Manager, Oral Health Team.

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

Purpose

To provide information about the findings of the Health Unit's school-based screening program from the last school year: September 2013 to June 2014.

Methodology

Publicly funded elementary schools and three private schools participated in the school-based screening program. Students in Junior Kindergarten, Senior Kindergarten, and Grade 2 at publicly funded schools were screened in accordance with the Oral Health Assessment and Surveillance Protocol of the Ontario Public Health Standards.

Based on the screening results of the Grade 2 students at each school, the school was categorized into the following levels of screening intensity: "Low", "Medium", or "High", as per the Protocol. Increased screening intensity level requires that additional grades be screened.

The parents of the students in these grades who decline to have their children screened advise their school administrators who then pass this information on to Health Unit staff. Children whose parents have consented to screening but who are absent on the day of screening may be screened on a subsequent screening day.

Student level data was collected by five Registered Dental Hygienists employed by the Health Unit The need for and urgency of dental care was recorded and the parents advised of the required follow-up. As well, indicators of previous dental caries were recorded. Data was collected and stored in accordance with the Oral Health Assessment and Surveillance Protocol, the Health Protection and Promotion Act, the Municipal Freedom of Information and Protection of Privacy Act, and the Personal Health Information Protection Act.

The Ministry of Health and Long-Term Care's Oral Health Information Support System was used to generate summary statistics from the student level data. Historical aggregate data was accessed from archived Health Unit spreadsheets. These data were further analysed using Microsoft Excel.

ANNUAL ORAL HEALTH REPORT December 2014

Key Findings

Participation. Of the 18,902 students who were offered dental screening at the schools that participated in the school-based dental screening program, 15,797 or 84% were screened (Figure 1). For the 2013-2014 school year, the Health Unit did not have parental consent to screen 1,928 (10%) students and 1,177 (6%) were absent on the day(s) that staff were screening at their schools. The percentage of excluded and absent students is lower than the previous year's percentages which were 12% and 7% respectively.

Screening intensity. Among the 125 elementary schools with Grade 2 in the Health Units jurisdiction, 98 (78.4%) were categorized as Low intensity, 13 (10.4%) as Medium intensity, and 14 (11.2%) as High intensity as per the Oral Health Assessment and Surveillance Protocol which is described in the sidebar (Figure 2).

Dental caries. The percentages of Junior Kindergarten, Senior Kindergarten, and Grade 2 students screened who were caries-free, (i.e. have never had tooth decay or the removal or filling of a tooth because of caries) were 80%, 70%, and 57%, respectively (Figure 3). This demonstrated a drop from the proportions from the previous school year which were 81%, 72%, and 60% respectively. Almost 6% of Grade 2 students screened had two or more teeth with tooth decay (Figure 4).

Urgent dental needs. Six hundred and thirty-two (632) students or 4% of those screened were found to have Urgent dental needs which deem them clinically eligible to receive Children in Need of Treatment (CINOT) funding for their dental care (Figure 5). Five hundred and seventy-eight (578) students or 92% of those found to have Urgent dental needs were referred to and accepted at local dental offices for treatment. These percentages are similar to the findings and outcomes from the previous school year.

Next Steps

- The Health Unit is currently implementing strategies to improve the percentage of eligible students screened such as working with the school staff to redesign consent forms and revising consent collection processes, developing brochures to promote school-based screening program.
- In response to the declining caries-free rate as students move from Junior Kindergarten to Grade 2, the Health Unit is implementing a pilot fluoride varnish program in eight High screening intensity schools.

Results

Figure 1. Percentages of students screened, absent and refused for the 2011-2012, 2012-2013 and 2013-2014 school years

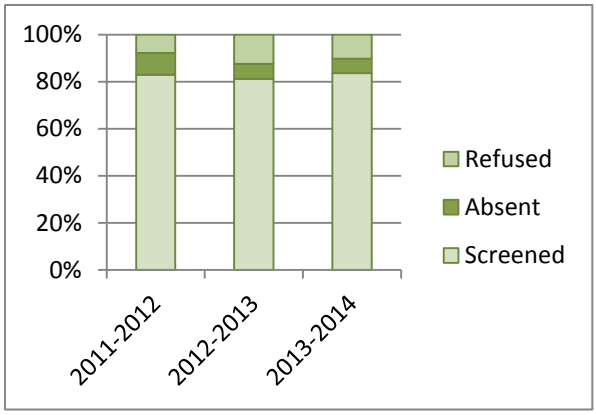


Figure 2. Screening intensity of schools by school year

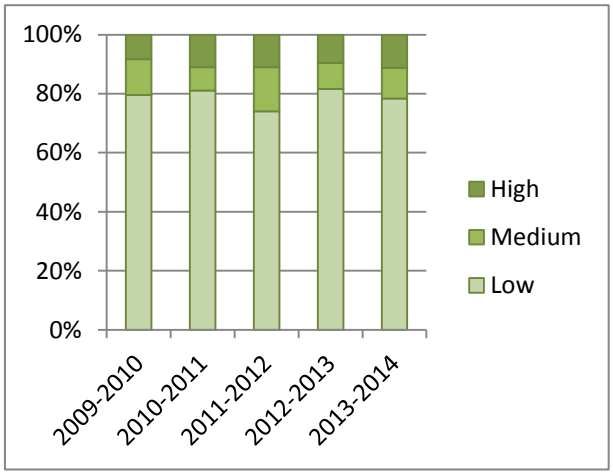


Figure 3. Percentage of students screened who were caries-free by grade for the 2011-2012, 2012-2013 and 2013-2014 school years

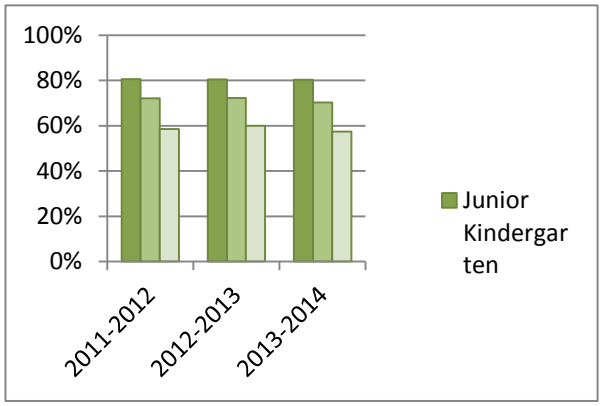


Figure 4. Percentage of Grade 2 students screened with two or more teeth affected by caries (decay, removals, or fillings) by school year

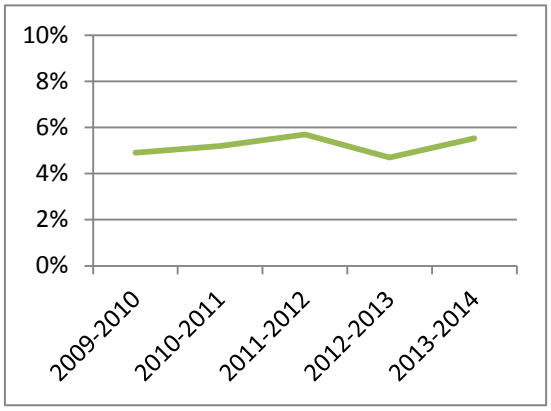
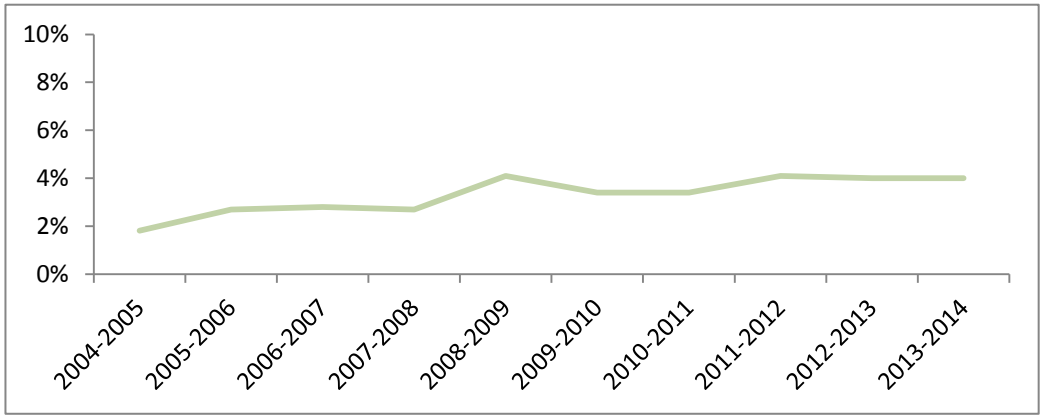


Figure 5. Percentage of students screened with Urgent dental needs by school year



MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 023-15

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2015 March 19

STI CLINIC REVIEW RESULTS

Recommendation

It is recommended that Report No. 023-15 re STI Clinic Review Results be received for information.

Key Points

- Overall, the consultant found that the STI Clinic is a well-functioning, focused clinic, providing a limited range of services, delivered efficiently, and with reportedly high patient/client satisfaction.
- Final recommendations in the STI Clinic Review report (Appendix A) validate areas of strength in the STI Clinic, and highlight areas where administration and implementation of services could be enhanced.

Background

In September 2014, the Board of Health was advised that the Health Unit would be undertaking an independent review of how the STI Clinic operates with the view of ensuring services provided are client centered, based on evidence and performed as efficiently and effectively as possible. The Health Unit engaged the services of Epirus Consulting Inc. to conduct the review (see *Finance and Facilities Committee Report No. 036-14FFC*). This review is now complete, and recommendations have been identified.

Elements included in the review process included 1) interviews with STI Clinic physicians, the Sexual Health Team program manager, Public Health Nurses, and Clinical Team Assistants; 2) information-gathering from key informants at a small number of other health units; and 3) an STI Clinic chart review.

Key Findings

The consultant completing the review concluded that the STI Clinic is a well-functioning, focused clinic, efficiently providing a limited range of services, and with reportedly high patient/client satisfaction.

Health care providers working in the Clinic report high satisfaction, although they would welcome increased space. Medical directives are comprehensive and no risk concerns were identified by providers. The current quasi-contractor relationship between MLHU and the physicians working in the Clinic appears to be mutually beneficial when viewed in operational terms. Although no students were present in the Clinic at the time of the review, the STI clinic has played an important role for health care professional trainees. The chart review did not identify any areas where care provided failed to meet current practice guidelines. However, due to the small sample size, it was not possible to ascertain the degree to which treatment provided to persons diagnosed with STI's in the MLHU STI Clinic is consistent with treatment guidelines and/or recommendations of Health Canada or the MOHLTC.

Recommendations

Final recommendations in the STI Clinic Review report (Appendix A) validate areas of strength in the STI Clinic, and highlight areas where administration and implementation of services could be enhanced. In brief, the consultant recommends the following:

1) Continue with the efficient STI Clinic model, and complete analyses to determine any unmet needs and/or benefits to expansion of clinic hours /locations
2) Review overall workflow related to the management of clinic client files and reportable disease case files
3) Complete ongoing client satisfaction surveys and consider involvement of clients in quality improvement efforts
4) Regularize documentation and supervision processes for health care professional trainees, jointly with their educational institutions, and issue photo identification cards for all contracted physicians and trainees
5) Review the existing contract documentation for physicians working in the clinic and ensure relevant licensure and malpractice insurance documentation is provided to the health unit annually, and explicitly document responsibilities for the medical director managing the physician workforce
6) Examine clinic billing practices to ensure alignment with MOHLTC guidelines
7) Consider offering a workshop for staff from STI clinics in different public health units to exchange learnings and support innovation

Conclusion/Next Steps

The STI Clinic review conducted by Epirus Consulting Inc. has been completed and recommendations have been identified. The consultant completing the review concluded that the STI Clinic is a well-functioning, focused clinic, providing a limited range of services, delivered efficiently, and with reportedly high patient/client satisfaction. Final recommendations in the STI Clinic Review report (Appendix A) validate areas of strength in the STI Clinic, and highlight areas where administration and implementation of services could be enhanced. Steps will be taken to consider and address each of the recommendations included in this review.

This report was prepared by Ms. Heather Lokko, Associate Director, OHCDSH and Ms. Shaya Dhinsa, Manager, Sexual Health Team, OHCDSH.

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

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MIDDLESEX-LONDON HEALTH UNIT STI CLINIC REVIEW
STI CLINIC REVIEW – Sept-Dec 2014

BACKGROUND

- Middlesex-London Health Unit (MLHU) contracted Epirus Consulting to complete a review of clinic organization and operations for its sexually transmitted infection (STI) clinic.

- Three of the physicians and MLHU staff, including the clinic manager, nurses, and administrative personnel who work in the clinic, were interviewed. Additional input was gathered from key informants from other public health units (PHUs). The physicians who work with MLHU staff at the STI clinic are not MLHU employees. One of the physicians has been named Medical Director. No compensation is attached to this role. Appendix A summarizes the input received from the physicians and MLHU staff working in and managing the STI clinic.

- The consultant reviewed a sample of 53 client charts from the 1990s through 2014 randomly selected by a non-clinic administrative assistant, with a view to assessing demographic features of clinic clients, reasons for visits, and clinical quality. Appendix B summarizes the findings of the chart review.

- Based on conversations with key informants during the course of the review, physician reimbursement for clinical services arose as a potential risk issue. Appendix C summarizes relevant background on this issue.

- Under the Ontario Public Health Standards (OPHS), each PHU provides STI clinic services as part of its efforts to improve the health of the population it serves. Comparator PHUs were approached to provide data on what was defined as the ‘epidemiologic yield’ of clinic services, i.e. what proportion of reportable STIs are diagnosed at STI clinics. Appendix D summarizes these findings.

KEY FINDINGS

- MLHU's STI clinic sees significant numbers of clients during its 6 weekly hours of operation. Operationally, it is a well-functioning, focused clinic, providing a limited range of services, delivered efficiently, and with reportedly high patient/client satisfaction.

- Providers (both physicians and MLHU staff) report high degrees of provider satisfaction, noting that increased space would be welcome. Medical directives are felt to be comprehensive and to cover the services provided to clinic clients. No risk concerns were identified by providers.

- Due to the small number of people seen for treatment of documented STIs, it was not possible to ascertain the degree to which treatment provided to persons diagnosed with STIs is consistent with treatment guidelines and/or recommendations of Health Canada or the Ministry of Health and Long-Term Care (MOHLTC). In the charts provided for the chart review, care provided met current practice guidelines. Documentation, while brief, appears succinct and adequate. Treatments noted to be prescribed are appropriate for the conditions being diagnosed.

- The quasi-contractor relationship between MLHU and the physicians working in the clinic appears to be mutually beneficial when viewed in operational terms. Physicians working in the STI clinic draw blood from patients, sparing MLHU the cost of hiring or contracting a venipuncture technician to do this work. At this time, MLHU charges no overhead and the physicians manage their own billing, submitting claims directly to the provincial payer under the STI clinic billing number.

- The STI clinic had played an important role for health care professional trainees including medical students and residents (physicians completing their post-medical school, pre-licensure training). At the time of the review, trainees were reported to be not regularly present in the STI clinic.

RECOMMENDATIONS

1. MLHU's STI clinic model is efficient. Compared to other PHUs, MLHU's clinic yields a higher proportion of diagnosed cases of reportable STIs, and it is recommended that this model continue. Further analyses to determine whether there are any unmet needs and/or it would be beneficial to expand clinic hours of operation and/or offer STI clinic services in other locations could be considered.

2. The management of clinic client files and reportable disease case files, as described by staff, may include substantial rework and duplication. A review of the overall workflow for these two distinct but related processes

is recommended to ensure that human resources are not misallocated to duplicative work.

3. Client satisfaction data were provided to the consultant from a one-time survey in 2011. Consistent with an increasing client/patient focus across the health sector, ongoing client satisfaction surveys, including consideration of involving clients in prioritizing quality improvement efforts in the STI clinic, are recommended.

4. The STI clinic can provide important training opportunities for health care professional trainees. If this opportunity is still deemed desirable by MLHU, regularizing the documentation and supervision process for trainees with their educational institutions would be recommended as a joint effort of MLHU and the institutions where trainees are formally enrolled. A simple documentation checklist for trainees and HU-issued ID cards with photographs for all staff, whether MLHU employees, contracted physicians, or trainees, are recommended.

5. As a matter of prudent risk management, review of the existing contract documentation with physicians working in the clinic and review to ensure that MLHU has copies of relevant licensure and malpractice insurance documentation for all contracted physicians are recommended. Physicians should be expected to update this documentation annually by the MLHU as a condition of continuing work in the STI clinic. Explicit documented responsibilities for the medical director managing the physician workforce are needed. Options for the Medical Director role would be i) include this within the responsibilities of the MOH or AMOH or ii) contract with an outside physician to perform this role.

6. The custom that liabilities arising from physician billing practices do not generate vicarious liability for hospitals or other settings where non-employed physicians practice may not apply to STI Clinics operated by PHU in light of the designation of STI clinics by the MOHLTC and the associated assignment of a specific STI clinic billing number to the PHU clinic by the Ontario Health Insurance Program (OHIP). Therefore, it is recommended that MLHU examine clinic billing practices to ensure alignment with MOHLTC guidelines.

7. PHUs provide a range of services in to meet the requirements of the OPHS. Reflecting the range of communities and needs in Ontario, the OPHS are largely silent on the operational aspects of these services. Given MLHU's relatively large size and prominence in Ontario, coupled with its STI clinic's operational efficiency, consideration of an operational workshop to bring together staff from STI clinics in different PHUs to exchange learnings and support innovation is recommended.

ACKNOWLEDGMENTS

I would like to thank MLHU staff and the physicians who work in the STI clinic for their assistance, input and enthusiasm for the work they do. Colleagues in comparator health units and organizations also gave freely of their time and provided valuable insights.

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APPENDIX A: Summary of MLHU Staff & Physician Interviews

The program manager for the STI clinic provided an overview of the service organization as follows:

- Clinics run M 1700-1900, W 1700-1900, F 0800-1000 in clinic space within the MLHU premises. Four public health nurses (PHNs) and four clinical team assistants (CTAs) work at the Monday and Friday clinics and this increases to 5 of each for the Wednesday clinic. PHN standard work includes one evening per week to provide staffing for the clinic

- A client satisfaction survey was completed in 2011 and reported high levels of satisfaction overall; concerns about feeling rushed at Wednesday clinics led to the decision to increase PHN/CTA staffing at that clinic; confidentiality was enhanced by using 'butcher number' system rather than calling out names

- Left without being seen (LWBS) rate is used as a key metric to identify opportunities for improvement; clients can make complaints via a phone number on a business card provided to them

- Medical directives are in place for testing and treatment enabling nurses to work with physician supervision. Currently, however, nurses do not work under medical directives when doctors are present in the clinic.

The three physicians currently working in the MLHU STI clinic were interviewed individually by the consultant using a standard template (questions below). All are specialists in Medical Microbiology and their comments are summarized below.

- All expressed a high level of satisfaction, describing the clinic as busy, satisfying work that involves client contact and good collegial working relationships with PHNs and CTAs

- All described an efficient STI clinic model with 6 examination rooms, physicians doing microscopy and venipuncture, providing medication for STIs, treatment for warts (liquid nitrogen), and referring HIV and HCV care to other providers

- When asked about the value of electronic health records (EHR), physicians agreed that the amount of typing would likely slow the clinical workflow with no identifiable gains for clients or for efficiency

- When asked about present and future needs, physician respondents identified the need for a female physician to address the preferences of

some clients for a female MD and more physical space. When asked about risk concerns, physician respondents did not identify any risk concerns

Three PHNs and one CTA selected by MLHU staff participated in a group interview. They described clinical workflows and their experiences working in the STI clinic.

- PHNs and CTAs are adequate for workload; PHNs work two clinics per week; CTAs are assigned to specific tasks (e.g. registration, lab) for each clinic

- All appointments are walk-in; clients prefer this and walk-in appointments avoid suggestion of repercussions if appointment missed. Workflow is sequential: registration (CTA) to PHN to MD; 5-10% revisit PHN after MD, otherwise clients are discharged by MD

- Point-of-care results (i.e., microscopy) highly valued by clients; technology (EHR) would slow care delivery down and not yield any benefits

- Improvement efforts are ongoing; as an example, LWBS data were analyzed to distinguish between LWBS and 'pulled in error' (client takes two numbers); monthly scorecard exists but not looked at by PHNs

- No gaps in medical directives identified; recently developed one for treatment to enable PHNs to dispense meds outside clinic hours (10 to a - few dozen cases per year); PAP smears requiring follow-up referred for colposcopy, and those interviewed stated this process works well and there are no concerns

- Room restocking with consumable supplies done by CTA in advance of every clinic day from in-clinic stock; basement inventory used to replenish clinic stock outside operational hours

- Positive test results reviewed at noon daily (Monday-Friday) and clients then called; PHN pulls charts for 'positives' to verify if clients need to be called back for treatment (most noted to be already treated); PHN documents positive results and follow-up plan, if any, in client chart

- Duplicate lab result goes to reportable disease 'section' where same PHN manages results; working notes with reportable disease copy provide additional details regarding contacts and efforts to reach them

- Weekly quality assurance review by CTA to pull any pending results greater than seven days to determine why no results yet available

- At end of clinic, each client record in Hampson clinic Service software is updated (staff report this software is not performing as expected); CTA creates record at registration and updates it regarding tests ordered/sent; software has HL7 (a standard format for exchanging confidential health information) inbound message capability but Public Health Laboratory cannot send results in HL7 format so no meaningful information exchange at this time; all records updated manually

QUESTIONS FOR PHYSICIAN INTERVIEWS

1. Please describe how the STI clinic is organized from your perspective as a physician and your concerns, if any.

2. How many patients would you see in a usual clinic? How are patient charts and billing managed?

3. What if any risk concerns would you identify based on your experience in the STI clinic?

4. Do you identify any current or future needs? If yes, please describe.

5. From your perspective, what would be the advantages and disadvantages of electronic health records in the STI clinic?

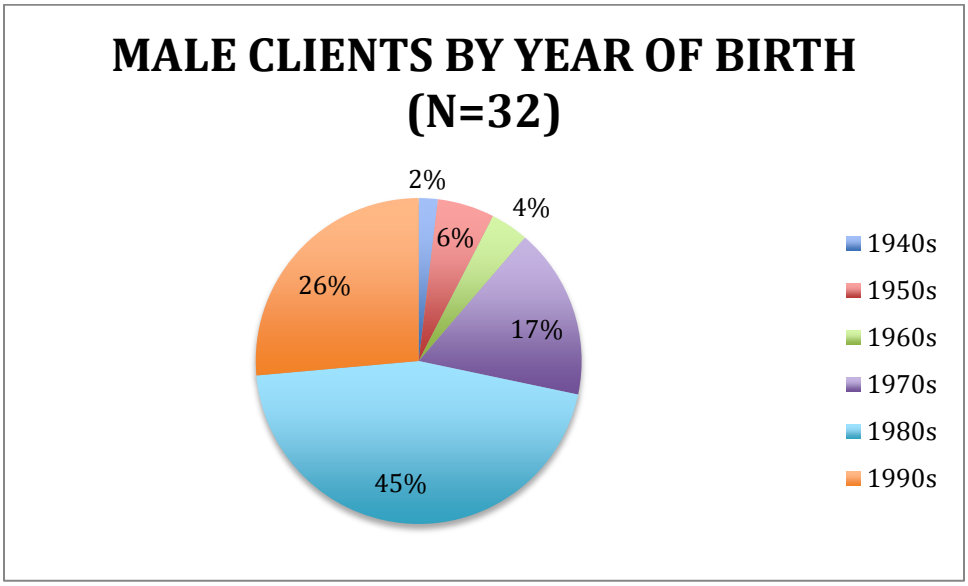
APPENDIX B: Summary of STI Clinic Chart Review

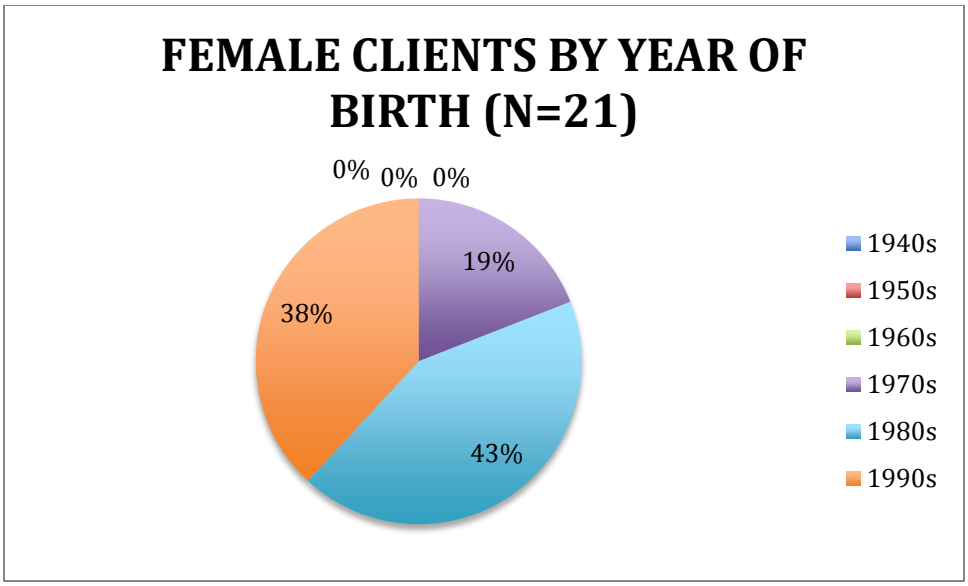
Background

Clinic staff provided a sample of 53 client charts for review by the consultant. Some charts contained records of multiple visits by the client, while others contained records for a single visit. The data abstracted from the charts contained no personal health information or identifiers beyond age and gender. The chart review findings are summarized in the following sections: demographics, reasons for visit, clinical quality and summary with recommendations.

Demographics

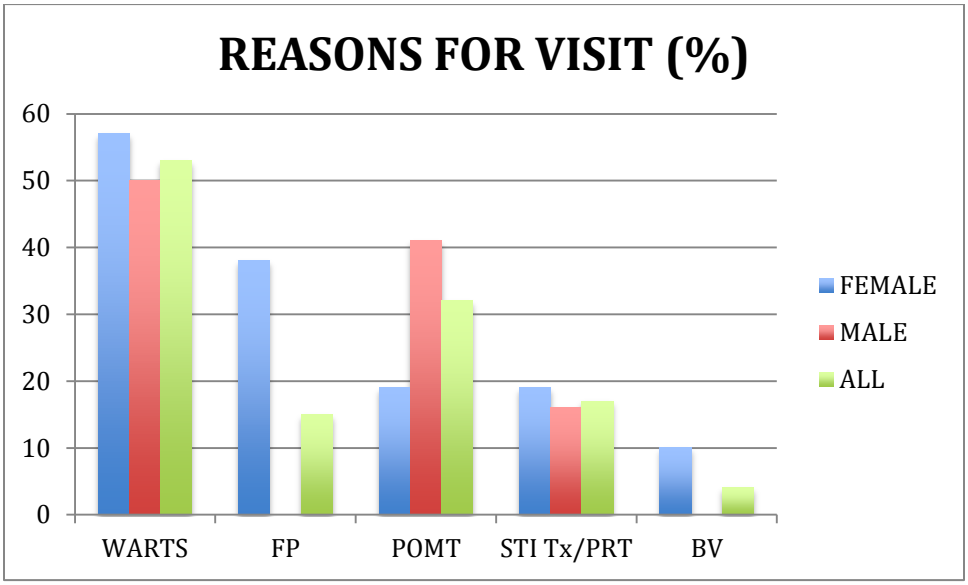
Among 53 client charts, 32 were for male clients and 21 for female clients. Because the charts were drawn from a period of several years of clinic operations, the results below report the proportion of clients born in each decade, by gender. Overall, the male clients tend to be somewhat older than female clients in this sample of charts.





Reasons for Visit

Clients may have more than one reason for visit (e.g. piece-of-mind testing and concern regarding warts or desire for family planning). Reasons for visit were different for male and female clients and the figures below provide reasons for visit by gender. Because clients may have more than one reason for visit, totals are greater than 100% (FP: family planning, POMT: piece-of-mind testing, STI Tx/PRT: STI treatment or partners seeking testing/treatment, BV: bacterial vaginosis)



Clinical Quality

All 53 client charts reviewed contained a combination of handwritten clinical notes and standard forms. Due to the small number of people seen for treatment of documented STIs, it was not possible to ascertain the degree to which treatment provided to persons diagnosed with STIs is consistent with clinical practice guidelines and/or recommendations of Health Canada or the Ministry of Health and Long-Term Care (MOHLTC).

Nevertheless, charts in this sample consistently documented presumptive treatment for possible STIs consistent with federal guidelines regarding syndromic treatment.[1] Where patients consent to testing, appropriate samples are sent. Given the relatively higher prevalence of STIs among clinic attendees as compared to the MLHU population, this strategy appears to strike a reasonable balance between resource use and disease control – persons who subsequently test negative are unlikely to experience adverse effects from a single dose of antibiotics for STI treatment and prompt treatment of persons who subsequently test positive reduces resource use associated with followup and more effectively reduces the risks of onward transmission than a test-and-call-back-for-treatment strategy.

On the matter of physical examinations, current clinical guidelines may create conundrums for front-line providers. The Health Canada STI guidelines[2] state

> Effective prevention and management of STIs requires the following elements on the part of the health care practitioner:
>
> 1. Assessing the reason for a consultation.
> 2. Knowing about STI risk factors and epidemiology.
> 3. Performing a brief patient history and STI risk assessment.
> 4. Providing patient-centred education and counselling.
> 5. Performing a physical examination.
> 6. Selecting appropriate screening/testing.
> 7. Diagnosing by syndrome or by organism and post-test counselling.
> 8. Treating.
> 9. Reporting to public health and partner notification.
> 10. Managing co-morbidity and associated risks.
> 11. Following up.

Notably, this guideline does not admit the possibility that physical examination may not be indicated for some clients or may be declined by some clients. STI practice, as with any practice, involves important elements of judgment and absolute respect for legal and ethical codes that ensure patients are not subject

[1] http://www.phac-aspc.gc.ca/std-mts/sti-its/cgsti-ldcits/section-2-eng.php#a7
[2] http://www.phac-aspc.gc.ca/std-mts/sti-its/cgsti-ldcits/section-2-eng.php#a5

to examinations of no benefit or against their will, except in narrowly-defined exceptional circumstances.

Ontario's Public Health Standards covering STI[3] and accompanying protocols[4] are silent on the matter of physical examination, perhaps recognizing that general professional standards that providers complete relevant physical examinations may suffice.

Given the reasons for visit in the chart sample, each chart was reviewed to identify what if any physical examination was documented. Documentation may be in narrative form or a sketch of the affected area. These findings are summarized below:

Reason for Visit	Number of Clients	Documentation Review
Warts	28	26 of 28 with documented exams; in one case valtrex prescribed and no exam documented (appears patient may have described recurrence of previously diagnosed genital herpes), in one case, chart coded as HSV concern and no exam or treatment documented
Family Planning	8	Exams documented, where STI (3/3), wart (4/4), or BV (2/2) concerns present
Piece-of-Mind Testing	17	Patients by definition asymptomatic; exams documented where other concerns present
STI Treatment/Partner	9	1 case of syphilis treatment of contact of case: no exam documented 1 case of syphilis treatment; no exam documented 1 partner of chlamydia case; no exam documented
Bacterial Vaginosis	2	2 of 2 noted exam & wet prep done

In several charts, documentation of referral for conditions outside the scope of the STI clinic in the form of referral letters was noted. For any focused clinic model, a process must be in place to connect clients with care they require that is outside the 'focus' and the chart sample indicated this was done for clients with liver disease and for women requiring colposcopy consultation.

[3] http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/ophs_2008.pdf

[4] http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/sexual_health_sti.pdf

Summary & Recommendations

- Due to the small number of people seen for treatment of documented STIs, it was not possible to ascertain the degree to which treatment provided to persons diagnosed with STIs is consistent with treatment guidelines and/or recommendations of Health Canada or the Ministry of Health and Long-Term Care. In the 53 client files reviewed, however, the care provided was consistent with current clinical practices and included appropriately documented physical examinations of clients where warranted.

- Charts contained inconsistent documentation of clients' sexual partner and practice preferences. This may be relevant for some clients in equipping them to reduce risks associated with sex. Consideration of a standardized, patient-completed sexual preference and practice form that would become part of the client chart may be warranted

- In the absence of a cumulative patient profile (CPP) or electronic health record, it was difficult to determine from client charts whether a client had had repeated visits for reportable STIs or whether repeated visits were for POMT and/or wart treatment. Clinic staff may, by liaising with surveillance and reportable disease staff, have other means by which to ascertain this so it is recommended that this be clarified, given the degree to which repeated reportable STIs in the same client may be understood as a 'treatment failure' attributable to public health's efforts.

APPENDIX C: Physician Reimbursement Considerations

Background

In the course of interviews with key informants, several posed questions about how physicians working in the MLHU STI Clinic are compensated. Discussions with MOHs from other health units provided additional insights about how this is managed in similar organizations.

Relevant Policy and Information

The Ontario Public Health Standards[5] state:

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

The Sexual Health Clinic Services Manual, 2002 is not available online. MOHLTC staff kindly provided a copy of the manual and the section regarding physician payment is excerpted below:

5.3 Physician Reimbursement and OHIP Billing

- Designated STD Clinics:
  Many health units have clinics that are specifically designated by OHIP as STD clinics. These clinics have an OHIP STD Clinic billing number that allows the health unit to submit claims directly to OHIP for physician services. Physicians working within this setting receive a salary from the health unit based on an hourly rate or from revenues generated from the OHIP billings.

- Sexual Health Clinic (Birth Control):
  Clinics that provide only birth control services do not have designated OHIP billing numbers. Physicians working in this setting are reimbursed for services either on a fee-for-service basis (clinic physicians bill OHIP for their services) or directly from the health unit based on an agreed upon hourly rate. If the physician is reimbursed on a fee-for-service basis the client must provide an OHIP number. However, health units must also build into their budget the cost of providing services to clients without an OHIP number.

  Many health units have Public Health Nurses (PHN) who work in the clinical setting under medical directives, while other health units have hired Registered Nurses with Extended Class (RN (EC)) preparation as Nurse Practitioners (NP). Neither the PHN nor the NP can bill OHIP for the provision of services.

- Integrated Clinics
  Many health units have integrated their birth control and STD clinic services. For those clinics that have an OHIP STD Clinic billing number, the health unit submits claims directly to OHIP for physician services for those clients who only receive STD related services. For clients receiving mainly birth control services see previous page "Sexual Health Clinic (Birth Control)".

[5] http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/shstibb.aspx (requirement 7)

A draft revision dated 2010 was never finalized but includes the same language as the 2002 version with a change from STD to STI. MLHU staff have confirmed that the STI Clinic is a ‘Designated STD/STI Clinic’ as described above and in the 2010 draft revision.

The OPHS further direct that services at STI clinics be provided to all clients without the need for OHIP numbers or provision of personal information. Clinic management states that OHIP numbers are not collected and that clients may register with any name they choose.

The physicians who work at the MLHU STI clinic state that they currently submit billings to OHIP under the provisions governing designated STI clinics. OHIP submissions are prepared by administrative staff available to the physicians through their other roles as university-affiliated faculty and/or hospital-affiliated medical microbiologists and submitted. The MLHU has neither responsibility for nor visibility into these submissions.

The MOHLTC has indicated that they are planning a consultation and review of physician billing practices in designated STI clinics in 2015.

APPENDIX D: Comparator Health Units

The OPHS identify two high level goals to which the MLHU's STI clinic contributes:

> To prevent or reduce the burden of sexually transmitted infections and blood-borne infections
>
> To promote healthy sexuality

The OPHS leaves operational considerations and arrangements largely to individual health units. To understand better the impact of clinic services on reportable STI incidence, (i.e. what proportion of reportable STIs are first diagnosed in STI clinics such as at MLHU), three comparator public health units (PHUs) were selected: Windsor-Essex, Region of Waterloo, and City of Hamilton. All 3 were requested to provide data on the epidemiologic yield for reportable STIs. Windsor & Hamilton kindly provided data summarized below:

<u>City of Hamilton Public Health Services</u>

Year	Total Number of Cases (Gonorrhoea & Chlamydia)	Cases Diagnosed at PHU STI Clinics	Proportion of all cases diagnosed at PHU STI Clinics (%)
2012	1858	377	20
2013	1672	286	17
Jan 1 - Dec 3, 2014	1524	287	19
Overall	5054	950	19

Data extracted: Dec 3, 2014 from iPHIS.

Windsor-Essex County Health Unit

2014 (Jan 1 – Dec 9, 2014)	Total Number of Cases	Cases Diagnosed at PHU STI Clinics	Proportion of all cases diagnosed at PHU STI Clinics
Gonorrhoea	54	7	13%
Chlamydia	805	102	13%
TOTAL	859	109	13%

Middlesex-London Health Unit

Year	Chlamydia			Gonorrhea		
	Number reported (all reporting sources) (M-L residents)	Number diagnosed at MLHU clinics* (includes M-L & non-M-L residents)	Percent diagnosed at MLHU clinics	Number reported (all reporting sources) (M-L residents)	Number diagnosed at MLHU clinics* (includes M-L & non-M-L residents)	Percent diagnosed at MLHU clinics
2009	1,311	374	28.5	210	89	42.4
2010	1,383	475	34.3	178	54	30.3
2011	1,488	534	35.9	110	49	44.5
2012	1,567	659	42.1	106	29	27.4
2013	1,320	536	40.6	82	31	37.8
2014 (Jan to Jun)	690	296	42.9	29	11	37.9

Observations

- Recognizing that data management differences may affect these results among PHUS, the 'epidemiologic yield' of MLHU's STI clinic (on the order of 40%) is nevertheless substantially higher than that of STI clinics in comparator PHUs (13-20%)

- STI clinic services in the MLHU territory are diagnosing decreasing numbers of gonorrhoea cases, reflecting trends across Ontario, while the volume of chlamydia diagnoses appears to be steady. Given MLHU's relatively stable population and migration patterns and that chlamydia is often asymptomatic in females, expanded testing of at-risk women could be expected to reduce rates over time.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 024-15

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2015 March 19

SUMMARY INFORMATION REPORT FOR MARCH 2015

Recommendation

It is recommended that Report No. 024-15 re Information Summary Report for March and the attached appendices be received for information.

Key Points

- The Ministry of Children and Youth Services has introduced a Continuous Quality Improvement (CQI) reporting requirement for Health Units related to Healthy Babies Healthy Children programs starting in 2015.
- Smart Start for Babies (SSFB) Teen Program provides intensive support program for over 100 pregnant adolescents. Two new components of the program include nicotine replacement therapy and fatherhood education and support.
- Over 1,000 couples participate each year in a variety of prenatal education and support programs. In 2015, a pilot program will be initiated which combines e-learning sessions with skill-based groups.

Background

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

Ministry of Children and Youth Services (MCYS) Requirements

The HBHC Program, provided by the Best Beginnings Teams in Family Health Services (FHS), is a mandated program for vulnerable pregnant women and families with children from birth to school entry. Home visiting services are provided, through a combined public health nurse and lay visitor model to support healthy child development and effective parenting.

As a strategy to improve the quality and consistency of how the Healthy Babies Healthy Children (HBHC) Program is implemented by Health Units in Ontario, MCYS has introduced a Continuous Quality Improvement (CQI) Requirement commencing in 2015. Health Units have been provided with a process and template (Appendix A) for developing a CQI Plan with the following program components being considered as priorities for improvement:

- Accurate screening and screening practices
- Standardized Service Implementation
- Training and Education

The CQI plan will be submitted to MCYS along with the financial reporting for the 100% HBHC funding that is provided to MCYC in April of 2015.

Smart Start for Babies (SSFB) Teen Program

The SSFB program provides prenatal education and support to pregnant women who have multiple risk factors which make them and their babies vulnerable for poor outcomes (Appendix B). In addition to offering this program at 5 locations in London and Strathroy, SSFB offers a teen-only session for pregnant teens and their support persons. In 2014, 110 pregnant teens attended the program, representing 46% of the total SSFB participants at all sites. Through the 2015 PBMA process, resources have been re-directed within the SSFB budget in order to focus on smoking cessation. One recent change in the program includes making referrals to the Healthy Babies Healthy Children home visiting Nicotine Replacement Therapy (NRT) program for all SSFB participants who want to reduce or quit smoking. Whenever appropriate during SSFB sessions, Public Health Nurses (PHN) emphasize the importance of creating smoke-free environments for infants and families. A second adjustment to the program will be focused on providing support to male partners who attend the SSFB program. A male PHN is now involved with the teen sessions and plans are underway to provide periodic "men-only" sessions where men can learn about supporting their pregnant partner and discuss their being involved as positive fathers.

Combined E-Learning and Skill Based Prenatal Program

The Prenatal Education Programs offered by the MLHU provide prenatal health information and support to approximately 1000 families in London-Middlesex each year. Clients are able to choose from 6-week in-class sessions, weekend workshops, e-learning options as well as individual class sessions for breastfeeding and preparing for parenthood. Through the collaborative efforts of multiple teams at MLHU, changes to the current format of 6-week sessions have been proposed which will streamline the series into a 4 week combined e-learning and skill based program to provide a more client centered approach. Enhanced emphasis on adult learning and skill-building activities will allow clients an opportunity to network with other childbearing families and building confidence in their knowledge and ability to navigate labour and birth, the first 6 weeks postpartum, feeding their baby and caring for their newborn. The combined e-learning and in-class sessions will be piloted and evaluated at five sites during the months of April and May, 2015. If successful, full implementation of the combined e-learning and four in-class sessions will begin in January of 2016.

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

Healthy Babies Healthy Children **Continuous Quality Improvement Plan**

Public Health Unit Name: __Choose an item._____ Based on data from Calendar Year: __Choose an item.

Program Component, Targets and Indicators	**PHU Performance to Targets and Indicators (previous year)**	**Current year plan**						
		***Change* – What change can be made that will result in an improvement?** **(see PDSA cycle)**	**Opportunities that will be addressed to reach in-year target**	**Identify tools used to support analysis and/or decision making**	***Measure* – What measure(s) will be used to demonstrate improvement?** **(see PDSA cycle)**	**Identified mid-year target (if any)**	***Aim* - Identified in-year target**	***Benchmarks*** Values are based on provincial performance and/or best practice
Screening - Targets								
☐ Prenatal - 25% of provincial births screened	Report from planning worksheet	Based on findings from the sub-structures of the HBHC CQI Framework (See planning worksheet)	(e.g. Partnership Development, education/training, data sharing)	(e.g. Root Cause Analysis, Decision Matrix)				9% of provincial births are screened
☐ Postpartum – 100% of provincial births screened								A minimum of 80% establishes universal screening
☐ Early Childhood – 25% of the population of children 6 weeks to 6 years old screened								5% of the early childhood population is screened.
Screening – Outcome Indicators								
☐ Number of screens completed at: (a) prenatal, (b) postpartum, (c) early childhood								
☐ Number of screens received as: ○ (a) inconclusive because no responses, ○ (b) inconclusive because of less than 36 responses, ○ (c) conclusive because only								Minimizing inconclusive screens reduces rework and false positive identification. Benchmarks will be individually determined by health units.

question #36 completed ○ (d) conclusive because 2 risk factors identified but less than 36 responses and ○ (e) conclusive because all 36 responses were completed.								
☐ 10-25% of total HBHC Screens received are confirmed with risk during assessment.								10% of families screened should be confirmed with risk.
☐ Number of HBHC Screens completed from community resource during the (a) prenatal, (b) postpartum and (c) early childhood								
Assessment – Target								
☐ 100% of families, who received IDA Contact, and consenting to service, have a completed In-Depth Assessment.								The predicted false positive rate is between 10% and 33%. IDA completed rate should reflect this with a minimum of 70%
Assessment – Outcome Indicator								
☐ 10-25% of total HBHC Screens received are confirmed with risk during assessment.								10% of families screened should be confirmed with risk.
Support Services – Target								
☐ 100% of families identified with risk,								Universal contact is achieved

and consenting to service, receive a postpartum IDA Contact within 48 hours of being discharged from birth admission.								with a minimum of 80% contact.
Blended Home Visiting Services - Targets								
100% of families confirmed with risk using the In-Depth Assessment, and consenting to service receive Blended Home Visiting Services								To limit loss of service to families confirmed with risk, benchmark is set for 80%
100% of families who receive Blended Home Visiting have a Family Service Plan initiated								To support effective support to families confirmed with risk, benchmark is set for 90%
Blended Home Visiting Services – Outcome Indicators								
The Family Service Plan goals reflect the Family Assessment Instrument results.								
Average frequency, duration and length of home visits as well as completion rate of scheduled home visits.								
Number of families that receive long term services equal to or less than 18 months, compared to number of families that discharge at equal to or less than 6 months								
As a population health indicator, increased number of prenatal HBHC clients with children born at >2500gm								

and >37 weeks gestation.								
☐ Improvement in pre-service and post-service scores of NCAST Parent-Child Interaction Feeding and Teaching scales.								
☐ Consistent NDDS completion demonstrating children receiving Home Visiting services are meeting milestones.								
Referral and Recommendations – Outcome Indicators								
☐ Increased "referred to and accessed" response rate to community referrals.								
Service Integration – Outcome Indicators								
☐ Public health units involved in an increasing number of community planning boards and tables.								

smartstart FOR BABIES

Canada Prenatal Nutrition Program

A FREE PRENATAL NUTRITION PROGRAM

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- How to care for yourself during pregnancy and after baby is born.
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MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 025-15

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2015 March 19

MEDICAL OFFICER OF HEALTH ACTIVITY REPORT – MARCH

Recommendation

It is recommended that Report No. 025-15 re Medical Officer of Health Activity Report – March be received for information.

The following report highlights activities of the Medical Officer of Health (MOH) from the January Medical Officer of Health Activity Report to March 6, 2015.

The first part of February kept Health Unit staff, including the MOH busy with media requests for interviews and attending many teleconference meetings regarding two London residents from West Africa who were being quarantined until Ebola could be ruled out. As expected, both persons were found to have not contracted the Ebola virus.

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

February 9	Attended a meeting of the Partnering in Transformation "Code Red" Steering Committee
February 11	Presented at Grand Rounds, Paediatrics about current public health issues of concern including Ebola and measles, as well as Health Unit programs and services Senior Leadership Team met for the afternoon for a Strategic Planning meeting
February 12	Attend the Finance and Facilities Committee meeting
February 13	Met with Dr. Ray Copes, Public Health Ontario before a tour of the London Water Research Facility
February 17	Welcomed 4th year medical student Aric Sudicky to the Health Unit for a 2 week placement Participated in 2nd interview for Manager of Family Health Services
February 18	Attended a Partnering in Transformation "Code Red" meeting at LHSC
February 20	Met with Health Unit staff and Board of Health member Jesse Helmer to discuss Smoke Free Movies. This meeting was organized in preparation for the February 25th meeting of several MOH's with Mr. Bruce Davis, Chair of the Ontario Film Review Board, to discuss advocacy opportunities for smoke-free movies.
February 26	Attended a Youth Opportunities Unlimited (YOU) Board meeting Met with Health Unit staff to discuss revision to the Nicotine Replacement Therapy Policy Participated in a telephone conference to discuss the 2015 Symposium at the Sheela Basrur Centre occurring March 25th in Toronto. The MOH will present at the event.

March 2 Lectured at the Schulich School of Medicine in regards to the role of the Medical Officer of Health.

March 3 Met with Brian Dunne of Participation House to discuss the work of the LHIN 2 Health System Leadership Council advisory body to the LHIN, which is co-chaired by the MOH and CEO.

March 5 Met with Dr. Bob Bell, Deputy Minister of Health and Long-Term Care, as well as other members of his ministry and members of the LHIN 2 Health System Leadership Council to discuss the healthcare system and its relationship with local public health.

March 6 Hosted and participated in the Health Unit-led Poverty Simulation event providing municipal and other elected officials and community leaders with a simulated experience of living a month in the life of a person on low-income.

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