

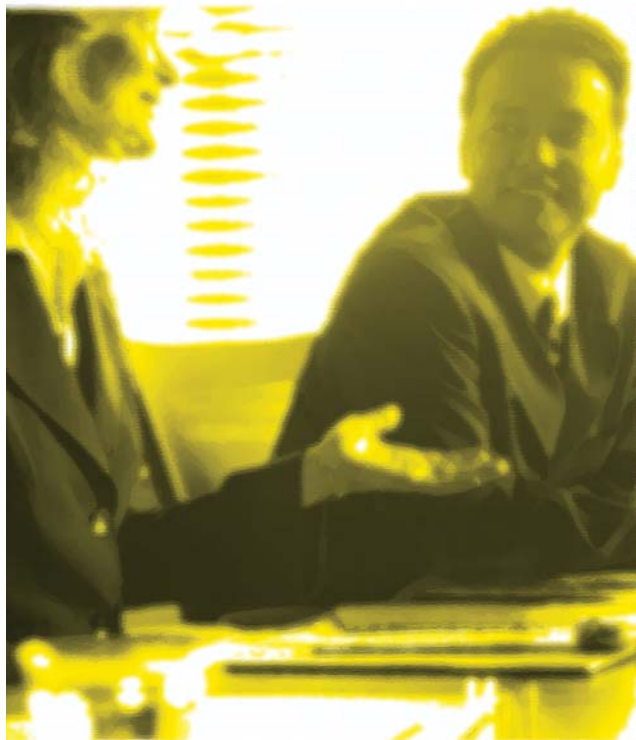
HEALTH DETERMINANTS and STATUS

RESOURCES and SERVICES

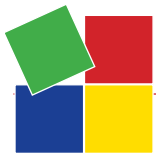
# BALANCED SCORECARD

COMMUNITY ENGAGEMENT

INTEGRATION and RESPONSIVENESS



Prepared by the  
Public Health Branch  
Community and Health Services Department  
The Regional Municipality of York



# ACKNOWLEDGEMENTS

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*A Balanced Scorecard for York Region Public Health 2007* was prepared under the guidance of Joann Simmons, Commissioner of the Community and Health Services Department, and Dr. Karim Kurji, Medical Officer of Health and Director, Public Health Programs.

The project was developed and managed by Dr. Erica Weir, Associate Medical Officer of Health, with assistance from staff of the Office of the Medical Officer of Health and the Office of the Associate Medical Officer of Health.

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# EXECUTIVE SUMMARY

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*A Balanced Scorecard for York Region Public Health 2007* is the Public Health Branch's first attempt at applying the balanced scorecard framework to the development of annual performance measures. It provides a baseline look at a selection of key activities delivered in 2007 by the Branch under the Ministry of Health and Long-Term Care Mandatory Health Programs and Services Guidelines.

The balanced scorecard framework was initially developed as a business tool that looked beyond financial measures to provide a more inclusive and balanced perspective on an organization's performance. It was quickly adapted for fields beyond business including hospitals, the public sector, and public health. It is made up of a set of measures, grouped into four quadrants, that give an overall picture of the mandate, effectiveness and efficiency of an organization.

The four quadrants of the Public Health Branch Balanced Scorecard are based on those proposed for public health by the Institute for Clinical Evaluative Sciences in 2004:

The *Health Determinants and Status* quadrant encompasses a selection of measures that make up traditional community health status reports, such as rates of disease and health behaviour patterns among York Region residents.

The *Resources and Services* quadrant contains measures on inputs, including financial and human resources, as well as outputs, such as key activities and level of service.

The *Community Engagement* quadrant includes measures of client and community satisfaction and participation in program planning and delivery.

The *Integration and Responsiveness* quadrant includes measures of health unit responsiveness to emerging issues and evolving evidence.

Performance measure indicators for this first balanced scorecard report were developed using a consensus-building process with staff from all divisions of the Public Health Branch and from other Regional departments. Measures selected through this process to describe Public Health Branch key activities were categorized into five themes:

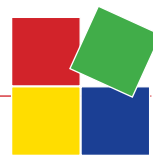
1. Control and Prevention of Infectious Disease and Health Hazards
2. Reproductive Health and Infant/Early Childhood Development
3. Chronic Disease and Injury Prevention
4. Nutrition and Physical Activity
5. Inclusivity, Immigration and Population Growth

In this report, where available, measures of service delivery level, reach, and effectiveness have been provided. Per capita costs and staffing levels for mandated programs, as well as level of community engagement and responsiveness, are also reported.

This baseline report presents an initial snapshot of the York Region Public Health Branch's key programs and services. The implications of performance measures identified in this balanced scorecard will be examined by program staff as part of ongoing quality improvement efforts and a commitment to increased accountability. Over time, indicators will be refined and future reports will identify trends and benchmarks to provide a better basis for informed decision-making that better aligns activities and performance with the health unit's mandate and resources.

# 1. INTRODUCTION and BACKGROUND

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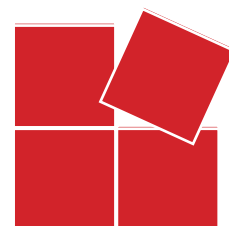


## 1.1 York Region

## 1.2 Public Health Mandate

## 1.3 The origins of the Balanced Scorecard performance framework lie in business

## 1.4 Adapting the Balanced Scorecard for Public Health performance measurement



## 1.5 Introducing the four quadrants of the Balanced Scorecard

## 1.6 Purpose

## 1.7 Scope



## 1.1 York Region

York Region is the third largest health unit in Ontario, composed of a population of 892,710\*<sup>1</sup> and spanning an area that extends from Steeles Avenue up to the southern tip of Lake Simcoe. It is one of the 14 health units in Ontario where the board of health is aligned with a regional or municipal government structure.<sup>2</sup> The remaining 22 health units in Ontario have independent boards of health.

\* Statistics Canada traditionally undercounts the total population; that is, a portion of the population is missed on Census day. Some people are not counted since they may not receive a Census questionnaire (i.e. a household living in a separate apartment in a house), or they were not included in the questionnaire that was completed (i.e. a boarder or lodger).

## 1.2 Public Health Mandate

Public health has the very broad goal of promoting and protecting health and preventing disease. In Ontario, the limits and bounds of local public health programs and services delivered to residents of health units are defined through the *Health Protection and Promotion Act*, R.S.O. 1990, Chapter H.7, the principal legislation related to public health in Ontario. The *Act* gives legal authority to the Minister of Health and Long-Term Care to publish guidelines on mandatory public health programs, services and standards and mandates boards of health to comply with these guidelines.

The public health mandate in Ontario is based on the population health approach, which seeks to improve the health of the entire population and to reduce health inequities among population groups.<sup>3</sup> Many factors determine health<sup>4</sup> including level of income and education, type of employment, quality of the social and physical environments, genetic and gender predispositions, lifestyle choices and health practices, cultural beliefs, access to health care and simple random chance. No one institution or organization can influence all these determinants or be accountable for all health outcomes. The general level of health of a population reflects the quality of the system of healthcare in place to promote health, and prevent and treat disease.

In order to rationalize public health programming, in 1997 the Ministry of Health and Long-Term Care adopted the principles of need, impact, appropriateness, and capacity to set strategic direction for local public health units.<sup>5</sup> Through assessment of health needs, their influencing factors and identification of effective and appropriate interventions, the Ministry set out minimum standards for public health programs and services.

The existing guidelines that mandate public health activity in the province, the *1997 Mandatory Health Programs and Services Guidelines*, are made up of 17 standards, each with a specific goal (see page 6).<sup>6</sup>

The guidelines for public health programming laid out in 1997 that have shaped existing programs are currently under revision. It is anticipated that new program standards and protocols will be implemented next year.<sup>7</sup> The new standards will likely involve only slight modification and enhancement of existing programs, since safe water and food, control of infectious disease, promoting healthy lifestyles and supporting healthy child development remain the foundation of essential public health programs. New areas include increased emphasis on emergency preparedness and environmental health.



## 1997 Mandatory Health Programs and Services Guidelines - Standards and Goals

STANDARD	GOAL
Equal Access	To ensure that all Ontarians have access to public health programs.
Health Hazard Investigation	To prevent or reduce adverse health outcomes resulting from exposure to health hazards as defined in the <i>Health Protection and Promotion Act</i> and including biological, physical, and chemical agents, natural or manmade.
Program Planning and Evaluation	To ensure that local programs address the health needs of the community, with cost-effective, efficient, evidence-based approaches.
Chronic Disease Prevention	To reduce the premature mortality and morbidity from preventable chronic diseases.
Early Detection of Cancer	To reduce mortality from breast cancer and cervical cancer by increasing early detection.
Injury Prevention Including Substance Abuse Prevention	To reduce disability, morbidity and mortality caused by motorized vehicles, bicycle crashes, alcohol and other substances, falls in the elderly and to prevent drowning in specific recreational water facilities.
Sexual Health	To promote healthy sexuality.
Reproductive Health	To support healthy pregnancies.
Child Health	To promote the health of children and youth.
Control of Infectious Diseases	To reduce the incidence of infectious diseases of public health importance.
Food Safety	To improve the health of the population by reducing the incidence of food-borne illness.
Infection Control	To reduce transmission of infectious diseases.
Rabies Control	To prevent the occurrence of rabies in humans.
Safe Water	To reduce the incidence of water-borne illness in the population.
Sexually Transmitted Infections (STIs) Including HIV/AIDS	To reduce the incidence of and complications from all sexually transmitted infections (STIs) including HIV/AIDS.
Tuberculosis (TB) Control	To reduce the incidence of tuberculosis (TB).
Vaccine Preventable Diseases	To reduce the incidence of vaccine preventable diseases.



### 1.3 The origins of the Balanced Scorecard performance framework lie in business

The balanced scorecard is a performance tool. It is made up of a set of measures, grouped into four quadrants, that gives an overall picture of the efficiency and effectiveness of an organization. Within each quadrant, indicators are chosen to reflect an organization's vision and mandate, so that performance may be measured in relation to organizational goals. As the balanced scorecard's overarching view of performance can be used by management, staff, and stakeholders, it is useful as both a measurement system and a public reporting tool.

The balanced scorecard was initially developed as a business tool, but was quickly adapted for fields beyond business, including hospitals and the public sector. For example, the Ontario Hospital Association uses the balanced scorecard approach in its *Hospital Report* series of report cards to measure performance within and among Ontario hospitals.<sup>8</sup> Organizations such as Cancer Care Ontario and the Canadian Physiotherapy Association have also adopted the balanced scorecard model to measure progress toward their strategic goals.

### 1.4 Adapting the Balanced Scorecard for Public Health performance measurement

A 2004 Institute for Clinical Evaluative Sciences (ICES) report, "Developing a Balanced Scorecard for Public Health," introduced a public health-specific balanced scorecard framework that includes traditional measures of health status as well as measures relating to structure and processes.<sup>9</sup> The Capacity Review Committee, appointed to lead a review of the organization and capacity of Ontario's local public health units, recommended in its final report that health units be required to produce an annual report for their funders and the general public based on the ICES balanced scorecard framework.<sup>10</sup> This framework is being considered by the Public Health Performance Management Working Group established by the province to develop performance measures for the proposed *Ontario Public Health Standards*.

At least five other Ontario health units have already adopted the balanced scorecard framework, or are in the process of developing a balanced scorecard: Simcoe Muskoka, Brant County, North Bay-Parry Sound, Huron County and Peel Region.

### 1.5 Introducing the four quadrants of the Balanced Scorecard

The four quadrants of the York Region Public Health balanced scorecard are based on those proposed by ICES: Health Determinants and Status, Resources and Services, Community Engagement, and Integration and Responsiveness.<sup>11</sup>

**Figure 1:** The Four Quadrants of the Balanced Scorecard





The project required asking key questions about York Region and York Region Public Health in each of the following four quadrants:

### **Health Determinants and Status**

This quadrant contains measures that make up traditional community health reports, such as rates of disease mortality and morbidity, and health behaviours and comparisons with standard populations such as peer groups or provincial averages. These data guide decisions about local program planning by helping to answer questions about demographics and health needs:

- Who does the York Region Public Health Branch serve?
- What are their health needs?

While all mandated programs in Ontario are based on an identified need, there are differences in the local context and characteristics of each health unit which will make some programs more crucial than others in local communities. The health determinants and status quadrant helps to identify unique health characteristics of York Region.

### **Resources and Services**

The Resources and Services quadrant contains measures on inputs, including financial and human resources, as well as outputs, or level of service delivery. These indicators allow reporting on major activities and provide some measure of the level of service delivery, reach, effectiveness, and resource utilization.

#### **Questions used to frame the development and choice of indicators included:**

- What can public health do about the health needs identified (i.e. what influencing factors fall under our mandate)?
- What are our key activities?
- Who is our target population and how do we know we are reaching them?
- How do we know our activities are effective?
- Where are the bulk of our resources going?

### **Community Engagement**

Understanding the views of the people a program serves is a fundamental principle of accountability and can improve the way services are delivered. All balanced scorecards include a quadrant on client satisfaction. Ideally, activities to engage the community go far beyond client satisfaction surveys.

#### **Questions used to develop indicators for this quadrant included:**

- How are we engaging the community?
- How do we ensure community input into public health planning and service delivery?

### **Integration and Responsiveness**

This final quadrant relates to the structural capacity of public health to keep it well integrated into the associated health care system as well as the capacity to continually transform services in response to evolving needs, issues and evidence. This is achieved through the development of community partnerships, commitment to research and quality, and continuing professional development.

#### **Key guiding questions that informed indicator development for the Integration and Responsiveness quadrant included:**

- How do we increase the capacity of community partners to address public health needs?
- How do we identify and respond to emerging issues?
- How do we ensure employees continue to develop their professional competency?



## 1.6 Purpose

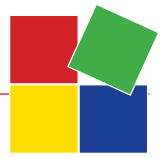
*A Balanced Scorecard for York Region Public Health 2007* is York Region's first attempt at applying the balanced scorecard framework to the development of public health performance measures at the health unit level through a participatory process. It provides a baseline look at a selection of activities that the Public Health Branch delivers under the 1997 *Mandatory Health Programs and Services Guidelines*. Over time, a set of indicators of performance will be identified that might be replicated by other health units and that will feed into continuous quality improvement.

## 1.7 Scope

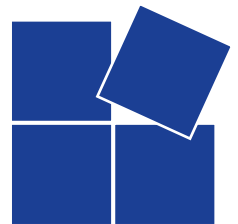
This report does not provide a comprehensive review of all the programs and services provided by the York Region Public Health Branch under the 1997 *Mandatory Health Programs and Services Guidelines*. Indicators reflect a selection of key activities of the Public Health Branch in 2007 as identified by branch staff. If 2007 data were not available, the most recent available data are reported. For certain indicators, data were not available or retrievable. These are indicated in the tables with "NA" (not available).

## 2. METHOD

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2.1 The Modified Delphi method ensures staff participation and develops consensus over indicator selection





## 2.1 The Modified Delphi method ensures staff participation and develops consensus over indicator selection

In the spring of 2007, the York Region Public Health Branch invited staff from all divisions of the Public Health Branch and from other Regional departments to participate in a modified Delphi exercise to reach consensus on balanced scorecard indicators for the four quadrants.

The Delphi method is a systematic consensus-building exercise among a panel of experts. The panel members answer questionnaires in two or more rounds. After each round, a facilitator provides an anonymous summary of the members' responses from the previous round. Participants, thus, are encouraged to revise their earlier answers in light of the replies of other members of the group. During this process, the range of answers decreases and the group moves towards consensus.<sup>12</sup>

Panel membership included a director, manager and front-line staff person from each division: Healthy Lifestyles, Child and Family Health, Infectious Diseases Control, Health Protection, Dental and Nutrition Services, and Community Development. With the assistance of a consultant familiar with the content and process,<sup>13</sup> each panel member completed a questionnaire, ranked their preference for indicators and participated in a facilitated discussion. Through a series of iterations, discussion and consideration of criteria for indicator selection (listed below), the panel reached consensus.

Panel members were advised to identify balanced scorecard indicators that would be easy to collect, sustainable over time, and acceptable at various levels of the organization. Representatives from peer health units, including Peel, Ottawa, and Durham,<sup>14</sup> the Ministry of Health and Long-Term Care, the Central Local Health Integration Network and The Health Communication Unit of the University of Toronto's Centre for Health Promotion also participated as observers.

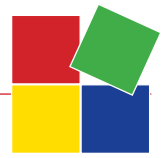
### Criteria for indicator selection<sup>15</sup>

The following criteria were considered when selecting balanced scorecard indicators. Indicators needed to be:

- Built on consensus
- Based on a conceptual framework
- Valid
- Sensitive
- Specific
- Feasible
- Reliable and sustainable
- Understandable
- Timely
- Comparable
- Flexible for use at different organizational levels

# 3. MEASURE of KEY ACTIVITIES and SERVICE DELIVERY

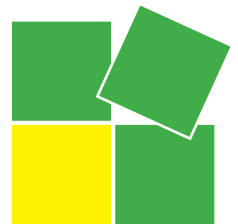
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3.1 Measure of Key Activities and  
Service Delivery

3.2 Control and Prevention of  
Infectious Diseases and  
Health Hazards

3.3 Reproductive Health and  
Infant/Early Child  
Development



3.4 Chronic Disease and  
Injury Prevention

3.5 Nutrition and Physical Activity

3.6 Inclusivity, Immigration  
and Population Growth



### 3.1 Measure of Key Activities and Service Delivery

A large number of indicators were discussed and selected. On review, most of the indicators for the “Health Determinants and Status” and “Resources and Services” quadrants could be classified into one of five predominant themes that emerged to populate this year’s balanced scorecard.

#### **The five themes that emerged were:**

- Control and Prevention of Infectious Diseases and Health Hazards
- Reproductive Health and Infant/Early Child Development
- Chronic Disease and Injury Prevention
- Nutrition and Physical Activity
- Inclusivity, Immigration, and Population Growth

In this section of the report, each theme will be discussed individually, along with the key activities under the themes and the target population that receive the activity.

Indicators of financial resources will be discussed in a separate section as these are reported by mandatory program area rather than by key activities.

## 3.2 CONTROL and PREVENTION of INFECTIOUS DISEASES and HEALTH HAZARDS

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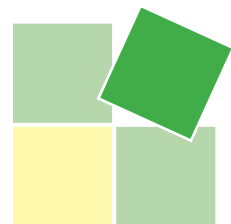


### 3.2 Control and Prevention of Infectious Diseases and Health Hazards

**What do the statistics tell us?**

**What are we doing about it?**

1. Ensuring safe water quality in drinking and recreational water
2. Ensuring safe food handling
3. Reducing vector-borne and zoonotic diseases
4. Reducing person-to-person transmission
5. Maintaining and disseminating surveillance on disease activity levels
6. Ensuring proper infection control and prevention practices
7. Investigating health hazards





## 3.2 Control and Prevention of Infectious Diseases and Health Hazards

This section includes key activities from the following areas of the 1997 *Mandatory Health Programs and Services Guidelines*:

- Safe Water
- Food Safety
- Rabies Control
- Health Hazard Investigation
- Sexual Health
- Control of Infectious Diseases
- Infection Control
- Sexually Transmitted Infections (STIs) including HIV/AIDS
- Tuberculosis (TB) Control
- Vaccine Preventable Diseases

### What do the statistics tell us?

The risk of illness to the general public from exposure to infectious organisms is an ongoing public health concern. Infectious organisms may be transmitted through water, food, from animals and by person-to-person contact. The tremendous advances that the public health system has made to ensure food and water safety, control animal vectors, detect sexually transmitted infections and bolster immunity to vaccine-preventable diseases require constant vigilance and surveillance to maintain standards, safeguard the public and rapidly identify and mitigate potential outbreaks.

The effectiveness of these public health measures is paradoxically reflected in low incidence of disease and of low rates of secondary transmission from one source to another. In the absence of experiential threat, members of the public can grow complacent about necessary precautions such as immunizations, hand hygiene, safe food handling and water disinfection. It is incumbent on public health to continually promote awareness of the need for these measures, enforce protection standards and promptly identify and control potential outbreaks.

**Table 1: INFECTIOUS DISEASES**

INDICATOR	YORK REGION	ONTARIO
Enteric disease incidence rate, 2006 <sup>i</sup>	91.1 confirmed cases per 100,000	79.5 confirmed cases per 100,000
Vaccine preventable disease incidence rate, 2006 <sup>i</sup>	24.8 confirmed cases per 100,000	11.4 confirmed cases per 100,000
Blood borne disease and sexually transmitted infection incidence rate, 2006 <sup>i</sup>	189.7 per 100,000	251.1 per 100,000*
Zoonotic and vector borne disease incidence rate, 2006	0.8 per 100,000	2.2 per 100,000
Respiratory disease incidence rate, 2006 <sup>i</sup>	32.0 per 100,000	42.2 per 100,000
Pneumonia and Influenza mortality rate, 2001 <sup>b</sup>	15.4 per 100,000	12.9 per 100,000

<sup>i</sup>Integrated Public Health Information System, <sup>b</sup>Canadian Vital Statistics Program (PHPDB).

\*The number of chronic hepatitis B cases are not collected at the provincial level and are not included in these statistics. Also, whereas HIV/AIDS is reported for York Region, Ontario statistics only include AIDS.

\*\*The number of human rabies cases for 2006 are currently pending at the provincial level and are not included in these statistics.



## What are we doing about it?

Key activities under the theme of Control and Prevention of Infectious Diseases and Health Hazards include:

### 1. Ensuring safe water quality in drinking and recreational waters

The goal of the Safe Water Program is to reduce the incidence of water-borne illness in the population. This is accomplished by:

- Receiving all reports of adverse drinking water test results from drinking water system operators and providing direction on corrective actions
- Interpreting drinking water test results for owner/occupier of private water systems and providing information regarding the potential health effects
- Inspecting public bathing beaches, including the taking of water quality samples and posting the public bathing beaches “unsafe for swimming” when water quality test results and/or conditions indicate so
- Inspecting public pools, spas and wading pools to ensure these recreational facilities are maintained and operated in accordance with ministry regulations and standards
- Interpreting water analysis reports, providing information regarding the potential health effects, providing information about the health-related parameters and providing educational sessions to owners/operators of water facilities and the general public

**Table 2:** KEY ACTIVITY: Educating, inspecting and enforcing to ensure safe water (target: owners/operators and general public)

TYPE	INDICATORS for 2007	VALUE
Level of Service Delivery Indicators	Total number of adverse water quality investigations per year	146
	Total number of inspections of pools, spas, and wading pools per year	938
	Total number of public bathing beaches inspections per year	1,730
	Total number of inquiries regarding private drinking water systems per year	1,190
	Total number of complaints per year	36
	Total number of educational sessions provided	NA*
	Total number of media activities	NA*
Reach Indicators	Total number of hits on the website per year for beach posting information	NA
	Total number of people sampling private water systems per year	> 5,000
Effectiveness Indicators	Total number of beach postings and closures per year	70
	Total number of re-inspections of pools, spas, and wading pools per year	131
	Total number of boil water advisories/orders	38

\*NA = Not available

### 2. Ensuring safe food handling

To reduce the incidence of food-borne illness, inspections and enforcement activities are conducted at high, medium and low risk food premises using the Food Premise Regulation (O.Reg 562) under the *Health Protection and Promotion Act*. Furthermore, additional inspections of food premises are conducted for suspect food poisonings, outbreaks and food recalls. Food handler training is offered through workshops and self-study workbooks to affirm safe food handling practices.



**Table 3: KEY ACTIVITY: Inspecting food premises (target: food premises owners and staff)**

TYPE	INDICATORS for 2007	VALUE
Level of Service Delivery Indicators	Total number of inspections per year	12,084
	Total number of Provincial Offence orders issued	177
	Total number of participants in the food handler training program	1,741
	Total number of food handlers certified	1,473
	Total number of food complaints per year	661
	Total number of investigations for food recalls	627
Reach Indicators	Proportion of mandated 'high' risk inspections conducted per year (3x/year)	89%
	Proportion of mandated 'medium' risk inspections conducted per year (2x/year)	91%
	Proportion of mandated 'low' risk inspections conducted per year (1x/year)	82%
	Proportion of staff employed in high risk premises that are certified food handlers (based on attending training workshops or self-study & examination)	Cannot capture that data currently
Effectiveness Indicators	Total number of critical infractions	2,415
	Total number of re-inspections per year for 'high', 'medium', and 'low' risk premises	2,310

### 3. Reducing vector-borne and zoonotic diseases

In order to keep the incidence of rabies to zero in the human population, the Public Health Branch investigates all animal-to-human exposure incidents through the enforcement of rabies regulations. In addition, educational programs aimed at elementary students and daycares assist in identifying ways children can reduce their exposure to rabies.

To reduce the spread of West Nile Virus to humans, stagnant water complaints are investigated in conjunction with municipal partners. This also provides an opportunity to educate the public. Bird surveillance, adult mosquito trapping and larviciding of potential mosquito breeding sites are also conducted.

**Table 4: KEY ACTIVITY: Investigating animal rabies incidents (target: human contacts)**

TYPE	INDICATORS for 2006	VALUE
Level of Service Delivery Indicators	Total number of rabies vaccine dispensed per year	129
	Total number of rabies investigations completed per year	925
Reach Indicators	Total number of requests for educational sessions from community per year	78
	Total number of hits to the website	NA
Effectiveness Indicators	Proportion of domestic animals investigated that had up-to-date vaccinations	Data very difficult to retrieve

**Table 5: KEY ACTIVITY: Preventing West Nile virus (target: general public)**

TYPE	INDICATORS for 2006	VALUE
Level of Service Delivery Indicators	Total number of mosquito breeding sites treated per year	82,089
	Total number of mosquito breeding site monitoring visits	278
	Total number of positive mosquito traps	0
	Total number of complaints investigated per year	106
Reach Indicators	Total number of requests for educational workshops	8
	Total number of hits to the website	NA
Effectiveness Indicators	Average response time from complaint to treatment (if required)	24 hours



#### 4. Reducing person-to-person transmission

Infectious Diseases Control Division resources are dedicated to the prompt investigation and treatment of individuals with confirmed/suspected infectious diseases and the identification and follow-up of contacts.

For example, individuals diagnosed with active tuberculosis (TB) are contacted within 1 to 2 business days from receipt of the report in order to ensure that they are remaining isolated until they are no longer infectious, are taking their medication as prescribed and are provided with basic information on TB. Active cases of TB may require six to nine months of treatment and nurses provide directly observed therapy (watch the individual taking their medication) for some or all of the medication taken during this time. Contacts of cases often require laboratory testing and medical assessment in order to ensure that they do not have active disease. Individuals newly arrived in Canada may have been referred for medical surveillance for TB by Citizenship and Immigration Canada because of a previous history of TB or an abnormal chest x-ray suggestive of inactive TB. Following their arrival in Canada, these persons are required to report to the local public health authorities to establish whether or not active TB currently exists and to determine the appropriate course of medical care, which may include treatment of latent TB infection (LTBI).

The Infectious Diseases Control Division also works to reduce the incidence of vaccine preventable diseases. School based (hepatitis B, meningitis and Gardasil) and community immunization clinics (influenza) are offered throughout the year. Inspections are conducted in premises that hold publicly-funded vaccines to ensure the maintenance of the "cold chain," which is the continuum of safe handling practices that keep vaccines at the proper temperature to maintain their effectiveness. To ensure that children are fully vaccinated according to age, a review of the immunization status of children attending schools in York Region is conducted on an annual basis.

**Table 6:** KEY ACTIVITY: Providing sexual health clinical services (target: individuals 15-24)

TYPE	INDICATORS for 2007	VALUE
Level of Service Delivery Indicators	Total number of new visits for birth control per year	601
	Total number of return visits for birth control per year	3,712
	Total number of new visits for STIs per year	618
	Total number of return visits for STIs per year	1,037
	Total number of STI tests per year	4,354
	Total number of clinic hours per week (weekly average)	47 hrs (School year) 29 hrs (Schools closed)
	Total number of clinics per year	468 clinics
Reach Indicators	Proportion of clinic visits that service target population	69%
Effectiveness Indicators	Proportion of visits by target population for STI issues	15%

**Table 7:** KEY ACTIVITY: Providing management and investigation of institutional and community outbreaks (target: York Region residents and long-term care homes, retirement homes and acute care facilities)

TYPE	INDICATORS for 2007	VALUE
Level of Service Delivery Indicators	Total number of investigations of institutional outbreaks per year	101
	Total number of investigations of community outbreaks per year	16
Reach Indicators	Proportion of investigations initiated within established response times	100%
Effectiveness Indicators	Average number of days per investigation	20.1 days (SD = 10.5 days)

\*SD = Standard deviation



**Table 8: KEY ACTIVITY: Providing management of reported and identified individual cases (target: York Region residents)**

TYPE	INDICATORS for 2007	VALUE
Level of Service Delivery Indicators	Total number of case investigations per year	1,570 investigations
Reach Indicators	Proportion of reported cases that are reported to Public Health by legislated mechanisms (i.e. hospitals, labs)	95%
Effectiveness Indicators	Proportion of case investigations initiated within established response times	100%

**Table 9: KEY ACTIVITY: Providing case management to York Region residents with STIs (target: York Region residents with STIs)**

TYPE	INDICATORS for 2007	VALUE
Level of Service Delivery Indicators	Total number of case investigations per year	2,184
	Total number of confirmed cases per year	1,927
Reach Indicators	Proportion of reported cases that Public Health successfully reaches/contacts	94.9%*
Effectiveness Indicators	Proportion of STI cases with at least one repeat infection within the previous 3-year period	9%
	Total proportion of clients for which counselling and/or referral session requirements are evaluated	100%
	Average length of time between episodes of repeat infection within a 3-year period	12.9 months

\*335 reported cases are excluded due to a Disposition = 'Open' or 'Pending'

**Table 10: KEY ACTIVITY: Investigating individuals on medical surveillance for tuberculosis (TB) (target: new immigrants)**

TYPE	INDICATORS for 2007	VALUE
Level of Service Delivery Indicators	Total number clients currently on medical surveillance for tuberculosis	396 clients
	Total number of new individuals on medical surveillance per year	369 clients
Reach Indicators	Proportion of clients on medical surveillance with whom contact was made as required by Public Health	89%
Effectiveness Indicators	Proportion of clients on medical surveillance for whom a medical assessment was reportedly completed	75%

**Table 11: KEY ACTIVITY: Providing case management for active tuberculosis cases (TB) (target: population with TB)**

TYPE	INDICATORS for 2007	VALUE
Level of Service Delivery Indicators	Total number of new cases of active TB per year	64
	Total number of existing cases of active TB per year	99
	Total number of cases on Directly Observed Therapy	46
Reach Indicators	Average time from notification of case of TB to initial contact	<48 hours
Effectiveness Indicators	Proportion of active cases that complete treatment within recommended time frame	100%

**Table 12: KEY ACTIVITY:** Identifying and managing contacts of active cases of tuberculosis (TB) (target: contacts of TB cases)

TYPE	INDICATORS for 2007	VALUE
Level of Service Delivery Indicators	Total number contacts identified per year	1,062*
	Total number of identified contacts assessed at clinics per year	665
Reach Indicators	Proportion of identified contacts that are assessed at clinics per year	62.6%
Effectiveness Indicators	Proportion of identified contacts testing positive that have active TB ruled out	100%

\*This number excludes correctional facility contacts

**Table 13: KEY ACTIVITY:** Providing targeted immunization clinics (target: schools and community)

TYPE	INDICATORS for 2006/2007 school year	VALUE
Level of Service Delivery Indicators	Total number of routine immunizations administered to students at school-based and community clinics per year	22,781
	Total number of vaccines administered at influenza clinics per year	13,423
Reach Indicators	Proportion of population receiving flu immunization through health unit clinics Proportion of eligible school population receiving voluntary immunizations through clinics per year	1% Hep B - 72%, Menig C - 55% HPV - 51%
Effectiveness Indicators	Rate of immunization uptake for school-based voluntary immunizations	607 immunizations per 1,000 eligible students

**Table 14: KEY ACTIVITY:** Inspecting for maintenance of cold chain\* requirements (target: premises holding publicly-funded vaccines)

TYPE	INDICATORS for 2007	VALUE
Level of Service Delivery Indicators	Total number of inspections per year	380
Reach Indicators	Numbers of premises inspected	349
Effectiveness Indicators	Proportion of vaccine wastage	3.6%
	Proportion of premises with cold chain failure	6%
	Total number of re-inspections per year	31

\*"Cold chain" is the continuum of safe handling practices that maintain vaccines at the proper temperature to maintain their effectiveness.

**Table 15: KEY ACTIVITY:** Reviewing and enforcing mandatory childhood school immunizations (target: school age children, parents and caregivers – mandated immunizations)

TYPE	INDICATORS for 2006/2007 school year	VALUE
Level of Service Delivery Indicators	Total number of students receiving immunization questionnaires	50,703
	Total number of students suspended from attendance at school because they have not provided appropriate immunization documentation	5,444 suspensions
Reach Indicators	Proportion of school-aged population who have an incomplete immunization record	14%
Effectiveness Indicators	Proportion of school-aged population that are up-to-date for mandatory immunizations	80%



**Table 16: KEY ACTIVITY: Distributing vaccine (target: Community physicians, hospitals, long-term care homes and nursing agencies)**

TYPE	INDICATORS for 2007	VALUE
Level of Service Delivery Indicators	Total number of vaccine doses distributed per year	557,643
Reach Indicators	Total number of physician offices that receive publicly-funded vaccine	413
	Proportion of hospitals (4) that receive publicly-funded vaccine	100%
	Proportion of LTCHs (29) that receive publicly-funded vaccine	100%
	Total number of nursing agencies that receive publicly-funded vaccine	22
Effectiveness Indicators	Average time from receipt of order to shipping of vaccine	<48 hours

### 5. Maintaining and disseminating surveillance on disease activity levels

The Infectious Diseases Surveillance Unit coordinates the receipt and processing of all reportable disease reports in York Region, in collaboration with laboratories, physicians, hospitals and long-term care homes. Reportable disease information is complemented with data from several novel early warning surveillance systems in York Region, including pharmacy-based syndromic surveillance and sentinel school absenteeism surveillance systems. Information garnered from these systems is used to identify outbreaks within York Region and dedicate case management resources to investigate exposures, cases and contacts and recommend control and remediation measures to mitigate the spread of infectious diseases in the community.

**Table 17: KEY ACTIVITY: Conducting surveillance (target: York Region residents)**

TYPE	INDICATORS for 2007	VALUE
Level of Service Delivery Indicators	Total number of surveillance reports produced	14
	Total number of reports provided to internal and external stakeholders on reportable disease information per year	14
Reach Indicators	Proportion of identified stakeholders receiving surveillance documentation	100%
Effectiveness Indicators	Total number of surveillance activities that were evaluated	2
	Proportion of IDCD programs using surveillance data in planning and programs	100%
	Average time from receipt of report to input of data	48 hours

### 6. Ensuring proper infection control and prevention practices

In settings where vulnerable individuals reside, visit or stay for short periods of time or in which high risk procedures are performed by non-regulated professionals, public health inspectors inspect, conduct audits and follow up on complaints to ensure the risk of infection transmission is reduced. Requests for training on infection prevention and control practices are fulfilled as requested by community groups, and ongoing workshops for daycare workers and infection control delegates in long-term care facilities are provided on an annual basis.



**Table 18: KEY ACTIVITY:** Inspecting long-term care homes, group homes and daycares, and educating operators  
(target: operators of long-term care homes, group homes and daycares)

TYPE	INDICATORS for 2007	VALUE
Level of Service Delivery Indicators	Total number of audits in long-term care homes (LTCH) that are conducted per year	26
	Total number of audits in group homes that are conducted per year	55
	Total number of daycare audits conducted per year	764
	Number of attendees for Education Day	230
	Number of attendees for Daycare Workshop	72
	Total number of complaints per year	28
Reach Indicators	Proportion of LTCH audits conducted per year	92%
	Proportion of group home audits conducted per year	79%
	Proportion of daycare audits conducted per year	86%
Effectiveness Indicators	Total number of re-inspections per year	207

**Table 19: KEY ACTIVITY:** personal services settings: tattoo parlours, body piercing salons, nail salons, hair salons  
(target: Operators of personal services settings)

TYPE	INDICATORS for 2006	VALUE
Level of Service Delivery Indicators	Total number of personal services settings (PSS) inspections per year	1,834
	Total number of complaints per year	19
Reach Indicators	Proportion of High Risk PSS inspections conducted per year	84%
	Proportion of PSS inspections conducted per year	73%
Effectiveness Indicators	Total number of re-inspections per year	45

## 7. Investigating health hazards

The Health Protection Division conducts inspections and investigations in the community in order to reduce the risk of adverse health outcomes from exposures to potential health hazards. Potential health hazards may include biological, physical, chemical and radiological agents. Controlling health hazards involves identifying the health hazard, analyzing the risk of exposure to the health hazard, and ensuring that the appropriate control measures are implemented.

**Table 20: KEY ACTIVITY:** Investigating potential health hazards (target: general public)

TYPE	INDICATORS for 2006	VALUE
Level of Service Delivery Indicators	Total number of health hazard investigations (HHIs) and inspections/inquiries per year	348
Reach Indicators	Proportion of total number of investigations initiated on the basis of community inquiry	92%
Effectiveness Indicators	Average number of follow ups per investigation/inquiry	Current system does not capture this information



## 3.3 REPRODUCTIVE HEALTH and INFANT/ EARLY CHILD DEVELOPMENT

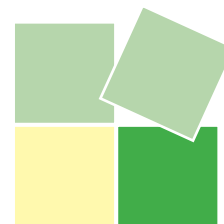


### 3.3 Reproductive Health and Infant/ Early Child Development

What do the statistics tell us?

What are we doing about it?

1. Parenting and screening services  
for families and individuals
2. Parenting and prenatal group education programs
3. Raising awareness about reproductive  
and child health
4. Building community capacity to  
support child development





### 3.3 Reproductive Health and Infant/Early Child Development

This section includes key activities from the Reproductive Health and Child Health standards of the 1997 *Mandatory Health Programs and Services Guidelines*.

#### What do the statistics tell us?

Infant and early child development plays a significant role in future health outcomes.<sup>16</sup> Lifelong wellbeing begins with preconception and pregnancy planning and care. Successful breastfeeding and good parenting are also contributors (Table 21). Children born at low birth weight are at an increased risk for developmental delays.<sup>17</sup> Some populations, such as teen parents and new immigrants, require extra support.

Early childhood tooth decay is one of the most common diseases of childhood and can affect a child’s ability to sleep, concentrate and eat. Good oral health contributes to overall health, growth and development, self-esteem and social well-being.

**Table 21: PERINATAL HEALTH and EARLY CHILDHOOD DEVELOPMENT**

INDICATOR	YORK REGION	ONTARIO
Percent of recent and expecting mothers (aged 18-49 years) who took folic acid supplementation prior to becoming pregnant, 2006 <sup>m</sup>	59.0%	no provincial comparison available from RRFSS <sup>m</sup>
Percent of mothers (aged 18-49 years) who breastfed their last baby (born within the last five years) for six months or more, 2006 <sup>m</sup>	53.5%	no provincial comparison available from RRFSS
Crude birth rate, 2004 <sup>b,l</sup>	10.8 per 1,000 population <sup>**</sup>	10.6 per 1,000 <sup>**</sup>
Low birth weight rate, 2004 <sup>b</sup>	55.1 per 1,000 live births <sup>**</sup>	58.6 per 1,000 live births <sup>**</sup>
Pregnancy rate, 2004 <sup>b,l</sup>	49.8 pregnancies per 1,000 women aged 15-49 years <sup>**</sup>	52.6% pregnancies per 1,000 women aged 15-49 years <sup>**</sup>
Teen pregnancy rate, 2004 (young women aged 15-19 years) <sup>b,l</sup>	14.2 pregnancies per 1,000 young women aged 15-19 years <sup>**</sup>	25.6 pregnancies per 1,000 young women aged 15-19 years <sup>**</sup>
Percent of screened children with urgent dental needs, 2006 <sup>g</sup>	4.2%	no provincial comparison available

<sup>m</sup>Rapid Risk Factor Surveillance System, <sup>b</sup>Canadian Vital Statistics Program (PHPDB), <sup>l</sup>Population Estimates (PHPDB), <sup>g</sup>Dental Screening, <sup>\*</sup>Duration only, not exclusivity, <sup>\*\*</sup>Extracted August 2007

#### What are we doing about it?

In 2004, Ontario launched a Best Start Strategy to address early learning, childcare services, and healthy development during a child’s first years.<sup>18</sup> It is made up of a variety of services to support families with young children, and includes an infant hearing program, a preschool speech and language program, services for children who are blind or have low vision, as well as early learning and childcare opportunities. The goal is to have various community agencies, such as school boards, public health units, municipalities, childcare providers and children’s services providers, work together to ensure a seamless network of services for parents and children. The provision of Healthy Babies, Healthy Children, a prevention and early identification program, which encompasses screening and assessments, referrals to community programs and resources, and supports for new parents, is the responsibility of public health units.

Additionally, public health units are required to use a range of health promotion strategies in order to support healthy pregnancies, improve developmental outcomes for children, increase the rate of breastfeeding, reduce prevalence of dental disease, link families with community services and increase effective parenting. Health units also provide dental screening and referral and clinical preventive services, and promote increased access to care.



## Key activities under the theme of Reproductive Health and Infant/Early Child Development include:

### 1. Parenting and screening services for families and individuals

Child and Family Health programs provide home visiting, telephone counselling, centre and school-based services to families and individuals. A series of screening and assessments, including Larson screen (prenatal), Parkyn Screen (at birth), Nipissing Screens (children to age six years), Routine Universal Comprehensive Screening (to identify women abuse, family violence), Edinburgh Postnatal Depression Scale (postpartum mood disorder), and Brief and In-depth Family Assessments, are utilized in order to identify children at risk of poor growth, development or health as well as environments that place the child at risk. Families requiring extra support may receive telephone, home visiting or centre-based services. The breastfeeding program provides clinic support and consultation to breastfeeding mothers and families.

Dental screening and referral determines if a child has an urgent, non-urgent or preventive dental need. Children with urgent dental needs are followed up to ensure they receive necessary dental care. Dental screening is the main entry point to other dental programs, such as Children in Need of Treatment (CINOT) and clinical preventive services (topical fluoride application and pit and fissure sealants).

**Table 22:** KEY ACTIVITY: Providing one-to-one screening, assessment, support, education and referrals to community programs (target: families with children 0-6 years, prenatal parents)

TYPE	INDICATORS for 2006	VALUE
Level of Service Delivery Indicators	Total number of home visits	6,056
	Average number of home visits per family that received a home visit	2
	Total number of telephone interactions	21,127
	Total number of centre-based interactions	2,442
	Total number of clients seen in centre-based interactions	993
	Number of Nipissing screens distributed from HBHC program	44,171
	Number of Larson screens distributed in prenatal packages	659
Reach Indicators	Proportion of families with newborn(s) who were contacted	97.4%
	Proportion of families who received a visit (home/centre based)	not available
	Number of families screened	9,662
Effectiveness Indicators	Number of families with a completed in-depth assessment	384
	Number of families referred to the home visiting program	344
	Number of referrals to community programs	680

**Table 23:** KEY ACTIVITY: Conducting dental screening and referral for children (target: children 0-13 years or to end of grade 8, whichever comes later) <sup>9</sup>

TYPE	INDICATORS for 2006	VALUE
Level of Service Delivery Indicators	Number of children receiving dental screening birth to school entry	2,915
	Number of children receiving dental screening school entry to grade 8	69,244
Reach Indicators	Proportion of schools reached in the 2006/07 school year	100% of schools (and grades) mandated for screening
	Proportion of children receiving dental screening (school entry to grade 8) in the 2006/07 school year	55% of the total population of York Region elementary school students
	Proportion of urgent cases closed	99.5%
Effectiveness Indicators	Proportion of activities that are based on theory or evidence	100%



## 2. Parenting and prenatal group education programs

Education sessions for prospective parents and parents of children to age six years are provided in a variety of locations across York Region. Topics include supporting a healthy pregnancy, labour and delivery, postpartum role adjustment, parenting, breastfeeding, attachment, growth and development, safety and nutrition. Classes are offered daytimes, evenings and weekends. Classes are also offered for specific populations such as teen parents, families experiencing postpartum mood disorder and parents who speak a Chinese language. In 2006, the range of participant capacity in these education sessions was from 3 to 20 individuals.

**Table 24:** KEY ACTIVITY: Delivering prenatal and parenting education sessions (target: families with children 0-6 years, prenatal parents)

TYPE	INDICATORS for 2006	VALUE
Level of Service Delivery Indicators	Total number of educational sessions delivered to parents	845
Reach Indicators	Total number of participants (parents and caregivers) attending educational sessions	3,150
	Average number of participants per educational session delivered to parents	6
Effectiveness Indicators	Drop-out rate for series of educational sessions	22.8%
	Proportion of planned series and sessions that were completed/took place	99.5%
	Proportion of education sessions that were informed by theory or evidence	100%

## 3. Raising awareness about reproductive and child health

A variety of awareness strategies are utilized to promote child and reproductive health messages, including media campaigns, resource development and distribution, mass mailings and attendance at community events.

**Table 25:** KEY ACTIVITY: Raising awareness about reproductive and child health (target\*: families with children 0-6, prenatal parents, York Region residents of reproductive age)

TYPE	INDICATORS for 2006	VALUE
Level of Service Delivery Indicators	Number of media initiatives completed (multi-faceted and one time)	3
	Number of mass mailing initiatives directed towards clients completed	3
	Total number of mail-outs sent (e.g., Hilary, 18 month packages, PPM)D	32,967
	Number of public events (fairs) targeted towards general public in which we participated and provided information	10
Reach Indicators	Number of households reached through Rogers media initiatives	216,200
	Number of contacts at public events	746
Effectiveness Indicators	Number of media initiatives directed to clients which are informed by theory or evidence	3
	Number of mailing initiatives directed to clients which are informed by theory or evidence	3

\* Although this key activity is not targeted directly towards service providers, events covered by this activity are open to the general public and might include participants who are health professionals, early years professionals, and community agencies service providers.



#### 4. Building community capacity to support child development

Child and Family Health collaborates with health and early years professionals to provide resources and training in numerous program areas, including Red Flags, Parkyn and Nipissing screens, Solution Focused communication, Interactive Guidance, Nobody's Perfect, and *Come Grow with Us: Health Education and Resource Manual for Childcare Providers*. In 2006, a prenatal assessment was conducted with a vision to create and enhance supportive environments for healthy pregnancies within the South Asian community. The *Parenting Needs Assessment Report* provides recommendations for parenting programs. Leadership was provided in a number of coalitions and initiatives including Reproductive Health and Breastfeeding Coalitions, Service Co-ordination, York Region Planning Forum for Children, Youth and Families and in working groups of the Inclusivity Action Plan.

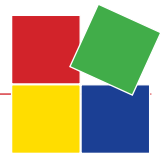
**Table 26:** KEY ACTIVITY: Building community capacity to support families through partnerships and coalitions, educational sessions, and raising awareness about reproductive and child health (target: direct – service providers such as health professionals, early years professionals and community agencies; indirect – York Region residents)

TYPE	INDICATORS for 2006	VALUE
Level of Service Delivery Indicators	Number of partnerships (coalitions, community groups) in which we were participants	19
	Total number of educational sessions delivered to service providers	81
	Number of mass mailing initiatives completed (directed towards service providers)	13
	Total number of mail-outs sent per year directed towards service providers	2,564
	Number of public events (conferences) targeted towards service providers in which we participated and provided information	2
Reach Indicators	Number of agencies/service organizations participating in partnerships	192
	Total number of resources/tools distributed	960
	Total number of participants (health professionals and other early years professionals) attending educational sessions per year	853
	Average number of participants per educational session delivered to service providers	10.5
	Number of contacts at public events targeted towards service providers	50
Effectiveness Indicators	Number of joint initiatives resulting from partnerships (e.g., advocacy, policy, education, funding proposals)	14
	Proportion of recipients utilizing resources	Not Available
	Drop-out rate for series of educational sessions	1.8%
	Proportion of planned series and sessions that were completed/took place	100%
	Proportion of education sessions informed by theory or evidence	100%
	Number of mass mailing initiatives directed towards service providers which are informed by theory or evidence	13



## 3.4 CHRONIC DISEASE and INJURY PREVENTION

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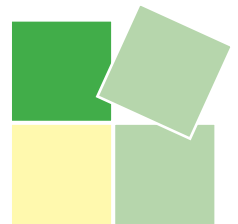


### 3.4 Chronic Disease and Injury Prevention

**What do the statistics tell us?**

**What are we doing about it?**

1. Reducing the number of smokers
2. Reducing substance abuse
3. Preventing cancer and promoting early detection
4. Reducing disability and mortality caused by injuries





### 3.4 Chronic Disease and Injury Prevention

This section includes key activities from the following areas of the 1997 *Mandatory Health Programs and Services Guidelines*: Chronic Disease Prevention, Early Detection of Cancer, and Injury Prevention Including Substance Abuse Prevention.

#### What do the statistics tell us?

Over 80% of Ontarians over the age of 45 have a chronic condition.<sup>19</sup> Cancers, cardiovascular and respiratory disease and the conditions that predispose to these outcomes, such as hypertension and diabetes, pose tremendous economic burden and high utilization of the health care system in Ontario, including York Region (Table 27). Living with disease reduces the quality of life of residents and reduces their life-expectancy and social productivity.

Unintentional injuries are the leading cause of death for children and youth in Canada.<sup>20</sup> Falls are the most common cause of injury regardless of age, and result in more than one quarter of all injury-related emergency department visits.<sup>21</sup>

**Table 27: CHRONIC DISEASE and INJURY PREVENTION**

INDICATORS for 2005	YORK REGION	ONTARIO
Teen (12-19 years) smoking rate (2005) <sup>a</sup>	6.7%*	10.6%
Adult (20+ years) smoking rate (2005) <sup>a</sup>	17.2%	22.2%
Ischemic heart disease mortality rate (2004 age-standardized rate) <sup>l</sup>	70.7 per 100,000	100.3 per 100,000
Stroke mortality rate (2004 age-standardized rate) <sup>l</sup>	30.4 per 100,000	36.3 per 100,000
Chronic Obstructive lung disease mortality rate (2004 age-standardized rate) <sup>l</sup>	14.3 per 100,000	21.6 per 100,000
Lung cancer incidence rate (2003 age standardized rate) <sup>c</sup>	37.3 new cases per 100,000 population	51.1 new cases per 100,000 population
Malignant melanoma incidence rate (2003 age standardized rate) <sup>c</sup>	11.9 new cases per 100,000 population	13.7 new cases per 100,000 population
Breast cancer incidence rate (2003 age standardized rate) <sup>c</sup>	91.3 new cases per 100,000 females	98.0 new cases per 100,000 females
Colorectal cancer incidence rate (2003 age standardized rate) <sup>c</sup>	47.4 new cases per 100,000 population	49.9 new cases per 100,000 population
Hospitalization rate for unintentional injury - child and youth (2006) <sup>n</sup>	158.7 per 100,000	234.5 per 100,000
Hospitalization rate for unintentional injury - seniors age 65 and over (2006) <sup>n</sup>	939.2 per 100,000	1363.9 per 100,000

<sup>a</sup>Canadian Community Health Survey, <sup>l</sup>Population Estimates (PHPDB), <sup>c</sup>Cancer Care Ontario, Inpatient Discharges Data 2006 (PHPDB) \*interpret with caution, high variability

#### What are we doing about it?

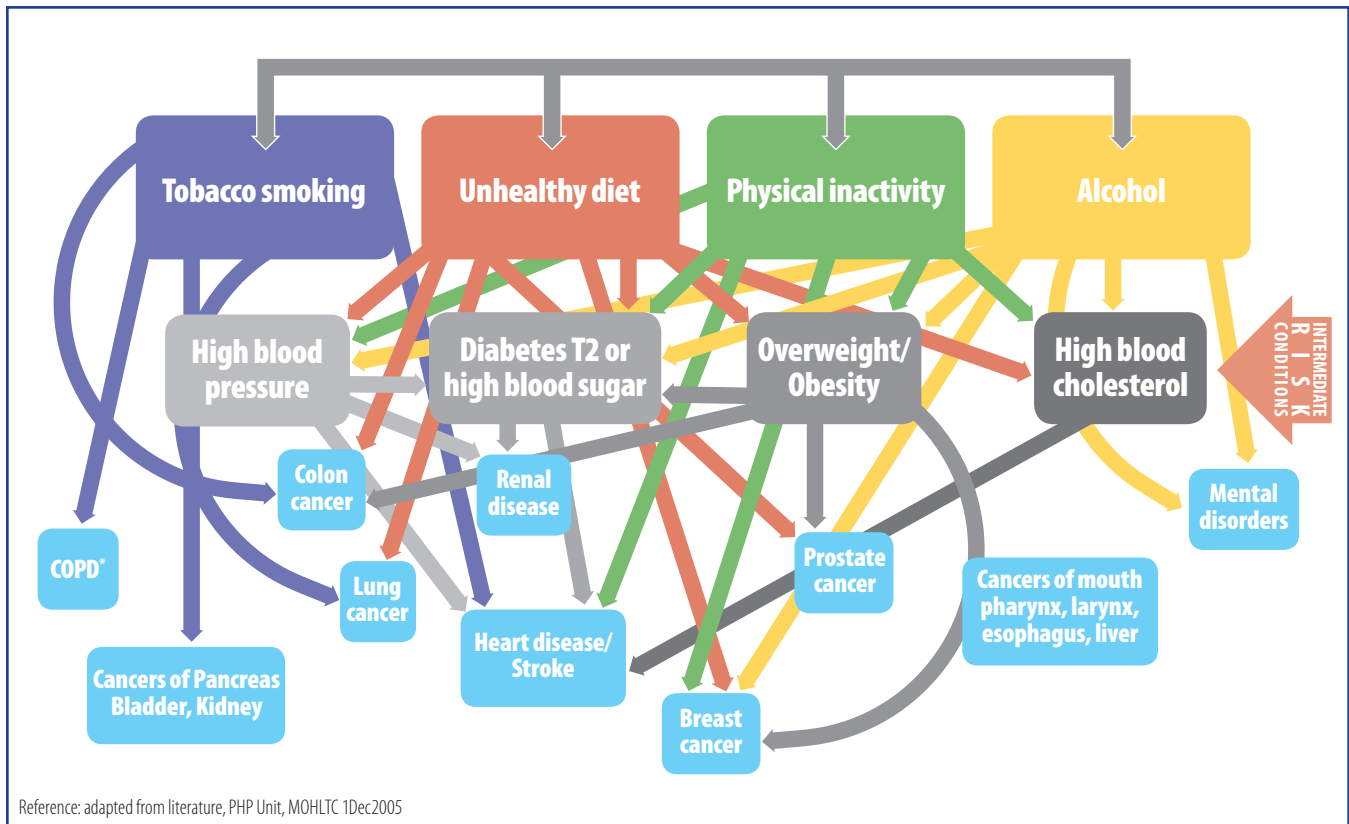
In 2007, the Ministry of Health and Long-Term Care initiated a chronic disease prevention and management strategy (Figure 2). All aspects of the health care system, including primary care, hospitals, Local Health Integration Networks and public health units have a role to play. The main emphasis in public health programming is on the primary prevention of disease, including influencing lifestyle choices at the population level and building healthy public policy.

Also in 2007, the Ministry of Health Promotion released Ontario’s Injury Prevention Strategy: Working Together for a Safer, Healthier Ontario, a framework that aims to address the wide range of personal, social and economic factors that influence the likelihood of injuries.<sup>22</sup>



The strategy encompasses key elements of the Ottawa Charter for Health Promotion: community partnerships and mobilization, public education and engagement, safe environments, and healthy public policy.<sup>23</sup> Public health units are important partners in the formulation of local initiatives suited to community needs and the promotion of health.

**Figure 2: CHRONIC DISEASE RISK FACTORS are COMMON TO MANY CONDITIONS**



\*COPD: Chronic obstructive pulmonary disease

## Key activities under the theme of Chronic Disease and Injury Prevention include:

### 1. Reducing the number of smokers

The Ontario Smoke-Free Grants program and the Tobacco Free Living program work with community coalitions, health professionals and client groups to address issues of tobacco prevention, awareness and reduction of second hand smoke exposure and the creation of supportive environments for smoking cessation. Policy development and enhancement are accomplished through education, awareness and advocacy for strengthened provincial legislation. Smoking cessation is supported through education and awareness via multilingual and multimedia approaches, as well as the promotion of nicotine replacement therapy programs.

Tobacco Education and Control is responsible for carrying out inspections and investigations of complaints in relation to the *Smoke-Free Ontario Act*, which prohibits smoking in all enclosed workplaces and enclosed public places in Ontario, strengthens measures to ensure only those 19 years of age and older can buy cigarettes, and phases out the display of tobacco products.



**Table 28: KEY ACTIVITY:** Building capacity for tobacco cessation through strategic partnerships and knowledge diffusion in the community (target: adults and youth)

TYPE	INDICATORS for 2007	VALUE
Level of Service Delivery Indicators	Total number of resources developed or adapted per year	46
	Total number of health promotion events directed at target population per year	232
	Total number of health promotion events targeted at community partners, including health professionals, per year	54
	Total number of consultations per year	63
	Total number of (external) coalitions per year (both membership or initiated by us)	3
Reach Indicators	Total number of individuals from target population that attended health promotion events	10,419
	Total number of individuals reached through media initiatives	864,300
	Total number of resource materials provided to clients and partners per year	33,272
	Total number of partnered health promotion events	75
Effectiveness Indicators	Proportion of health promotion events directed at building partner capacity	100%
	Proportion of consultations (initiatives) focused on policy development	5%
	Proportion of programs that integrate 3 or more components of the Ottawa Charter	100%
	Proportion of health promotion events that are based on theory or evidence	100%

**Table 29: KEY ACTIVITY:** Inspecting tobacco vendors, workplaces and public places (target: tobacco vendors, workplace owners and community)

TYPE	INDICATORS for 2007	VALUE
Level of Service Delivery Indicators	Total number of compliance checks per year June – Dec	882
	Total number of required vendor inspections completed per year	2,782
Reach Indicators	Proportion of required vendor inspections completed	100%
Effectiveness Indicators	Rate of vendor compliance with SFOA* (promotion and display)	99%
	Rate of vendor compliance with SFOA (sales to youth)	85%
	Proportion of vendor sites with repeated offences	2%

\*Smoke-Free Ontario Act

## 2. Reducing substance abuse

The Substance Abuse Prevention program uses a best practice harm reduction approach to support the development of policies, practices and environments which support informed decision-making related to substance use. Program services including media campaigns, educational and skill-building sessions, capacity building among coalitions, consultation and resource development, promote personal and social accountability to reduce the harm and decrease risk associated with substance misuse.

**Table 30: KEY ACTIVITY:** Promoting the use of comprehensive strategies to reduce the harm associated with substance use (target: York Region residents)

TYPE	INDICATORS for 2007	VALUE
Level of Service Delivery Indicators	Total number of resources developed or adapted per year	9
	Total number of health promotion events directed at target population per year	60
	Total number of health promotion events targeted at community partners, including health professionals, per year	13
	Total number of consultations per year	169
	Total number of (external) coalitions per year (both membership or initiated by us)	12
Reach Indicators	Total number of individuals from target population that attended health promotion events	9,130
	Total number of resource materials provided to clients and partners per year	34,098
	Total number of partnered health promotion events	36
Effectiveness Indicators	Proportion of health promotion events directed at building partner capacity	93%
	Proportion of consultations (initiatives) focused on policy development	61%
	Proportion of programs that integrate 3 or more components of the Ottawa Charter	90%
	Proportion of health promotion events that are based on theory or evidence	100%

### 3. Preventing cancer and promoting early detection

The Early Detection of Cancer program works with community coalitions, client groups and health professionals to coordinate services and strategies to improve compliance in breast, cervical and colorectal cancer screening initiatives. A variety of education and awareness strategies are utilized including educational sessions, media campaigns, resource development and site specific initiatives such as work place programs. Education materials and resources are also distributed to health professionals with the goal to increase the rates of cancer screening and referral.

**Table 31: KEY ACTIVITY:** Promoting behaviours that assist in the prevention of skin cancer (target: caregivers and children)

TYPE	INDICATORS for 2007	VALUE
Level of Service Delivery Indicators	Total number of resources developed or adapted per year	8
	Total number of health promotion events directed at target population per year	57
	Total number of health promotion events targeted at community partners, including health professionals, per year	5
	Total number of consultations per year	72
	Total number of (external) coalitions per year (both membership or initiated by us)	3
Reach Indicators	Total number of individuals from target population that attended health promotion events	7,148
	Total number of resource materials provided to clients and partners per year	7,418
	Total number of partnered health promotion events	11
Effectiveness Indicators	Proportion of health promotion events directed at building partner capacity	11%
	Proportion of consultations (initiatives) focused on policy development	100%
	Proportion of programs that integrate 3 or more components of the Ottawa Charter	100%
	Proportion of health promotion events that are based on theory or evidence	100%



**Table 32: KEY ACTIVITY: Increasing awareness of screening guidelines and cancer prevention (target: adults)**

TYPE	INDICATORS for 2007	VALUE
Level of Service Delivery Indicators	Total number of resources developed or adapted per year	4
	Total number of health promotion events directed at target population per year	26
	Total number of health promotion events targeted at community partners, including health professionals, per year	7
	Total number of consultations per year	7
	Total number of (external) coalitions per year (both membership or initiated by us)	4
Reach Indicators	Total number of individuals from target population that attended health promotion events	1,076
	Total number of resource materials provided to clients and partners per year	26,523
	Total number of partnered health promotion events	4
Effectiveness Indicators	Proportion of health promotion events directed at building partner capacity	100%
	Proportion of consultations (initiatives) focused on policy development	0%
	Proportion of programs that integrate 3 or more components of the Ottawa Charter	100%
	Proportion of health promotion events that are based on theory or evidence	100%

#### 4. Reducing disability and mortality caused by injuries

The Injury Prevention Program is responsible for the development, implementation and evaluation of comprehensive injury prevention programming in the community. Program services address public education and engagement, the development of community partnerships, the promotion of safe environments, and advocacy for healthy public policy related to the prevention of unintentional injuries. Activities may include initiatives that address road safety, as well as home and recreational injury prevention. Emphasis is placed on populations at risk.

**Table 33: KEY ACTIVITY: Promoting and advocating for the development and maintenance of safe and supportive behaviours and environments (target population: children, youth and caregivers)**

TYPE	INDICATORS for 2007	VALUE
Level of Service Delivery Indicators	Total number of resources developed or adapted	24
	Total number of health promotion events directed at target population	203
	Total number of health promotion events targeted at community partners, including health professionals	23
	Total number of consultations	72
	Total number of coalitions	12
Reach Indicators	Total number of individuals from target population that attended health promotion events	5,967
	Total number of resource materials provided to target population and partners	63,063
	Total number of partnered health promotion events	19
Effectiveness Indicators	Proportion of health promotion events directed at building partner capacity	100%
	Proportion of consultations focused on policy development	56%
	Proportion of programs that integrate 3 or more components of the Ottawa Charter	100%
	Proportion of health promotion events that are based on theory or evidence	100%



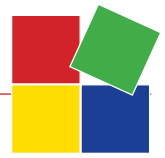
**Table 34: KEY ACTIVITY: Promoting and advocating for the development and maintenance of safe and supportive behaviours and environments (target population: seniors and caregivers)**

TYPE	INDICATORS for 2007	VALUE
Level of Service Delivery Indicators	Total number of resources developed or adapted per year	4
	Total number of health promotion events directed at target population per year	51
	Total number of health promotion events targeted at community partners, including health professionals, per year	6
	Total number of consultations per year	17
	Total number of coalitions per year	8
Reach Indicators	Total number of individuals from target population that attended initiatives and educational sessions	2,174
	Total number of resource materials provided to target population and partners per year	14,770
	Total number of partnered health promotion events	16
Effectiveness Indicators	Proportion of health promotion events directed at building partner capacity	100%
	Proportion of consultations focused on policy development	0%
	Proportion of programs that integrate 3 or more components of the Ottawa Charter	100%
	Proportion of health promotion events that are based on theory or evidence	100%



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## 3.5 NUTRITION and PHYSICAL ACTIVITY

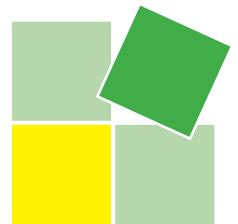


### 3.5 Nutrition and Physical Activity

What do the statistics tell us?

What are we doing about it?

1. Promotion of the comprehensive school health model
2. Promotion of comprehensive workplace wellness programming
3. Building a healthy nutrition environment





### 3.5 Nutrition and Physical Activity

This section includes key activities from the Chronic Disease Prevention standard of the 1997 *Mandatory Health Programs and Services Guidelines*.

#### What do the statistics tell us?

In 2004, Ontario's Chief Medical Officer of Health alerted Ontarians to the epidemic of overweight and obesity in Ontario, reporting that almost one out of every two adults in Ontario was overweight or obese and the numbers of obese children in Canada between the ages of 7 and 13 had tripled from 1981 to 1996.<sup>24</sup> Residents of York Region share the burden of this epidemic (Table 35). According to the Chief Medical Officer of Health, the Ontario population has lost the balance between the energy taken in and the energy expended, which is key to healthy weights. Too few people abide by the food choices and servings recommended by Canada's Food Guide or participate in the recommended amount of physical activity proposed by Health Canada (Table 35).

**Table 35:** NUTRITION and PHYSICAL ACTIVITY

INDICATORS for 2005	YORK REGION	ONTARIO
Percentage of people aged 12+ years that consumed fruits and vegetables five or more times daily <sup>a</sup>	40.7%	43.4%
Percentage of the population aged 12+ years that were physically active or moderately physically active <sup>a</sup>	53.1%	52.9%
Percentage of overweight or obese adults, aged 18+ <sup>a</sup>	45.8%	49.9%

<sup>a</sup>Canadian Community Health Survey

#### What are we doing about it?

In response to the trend to overweight and obesity, the Ministry of Health Promotion launched an *Action Plan for Healthy Eating and Active Living* that focused on four strategies: grow healthy children and youth, build healthy communities, champion healthy public policy and promote public awareness and engagement.<sup>25</sup> York Region Public Health Branch has incorporated these strategies into a number of key activities, outlined in this section.

#### Key activities under the theme of Nutrition and Physical Activity include:

##### 1. Promotion of the comprehensive school health model

Comprehensive School Health is a best practice, integrated approach that promotes opportunities for students to observe and learn positive, lifelong health attitudes and behaviours. In 2007, 55 elementary and five (pilot) secondary schools participated in the Healthy Schools Program, receiving support and resources from public health staff to assess strengths and needs, link to community partners and develop, implement and evaluate a Comprehensive School Health action plan. School staff, parents and students were empowered to enhance/initiate quality instruction and programs and create healthy physical and supportive social environments with a focus on nutrition and physical activity, in addition to other areas such as hand-washing, bullying and self-esteem.



**Table 36: KEY ACTIVITY:** Providing support to schools in implementing health promotion activities using the Comprehensive School Health model (target: all schools)

TYPE	INDICATORS for 2007	VALUE
Level of Service Delivery Indicators	Total number of resources developed or adapted per year	41
	Total number of health promotion events directed at target population per year	84
	Total number of health promotion events targeted at community partners, including health professionals, per year	19
	Total number of consultations per year	3,184
	Total number of (external) coalitions per year (both membership or initiated by us)	13
Reach Indicators	Total number of individuals from target population that attended health promotion events	2,996
	Total number of resource materials provided to clients and partners per year	11,437
	Total number of partnered health promotion events	57
Effectiveness Indicators	Proportion of health promotion events directed at building partner capacity	38%
	Proportion of consultations (initiatives) focused on policy development	8%
	Proportion of programs that integrate 3 or more components of the Ottawa Charter	60%
	Proportion of health promotion events that are based on theory or evidence	98%

## 2. Promotion of comprehensive workplace wellness programming

The Workplace Wellness program aims to improve the health and well-being of York Region businesses and their employees by promoting, guiding and advocating for comprehensive workplace wellness programming. Program services support capacity building within organizations, creating sustainable practices that are evidence-based and address identified needs from the target population, such as nutrition and physical activity.

**Table 37: KEY ACTIVITY:** Promoting and facilitating comprehensive workplace wellness programming (target: workplaces)

TYPE	INDICATORS for 2007	VALUE
Level of Service Delivery Indicators	Total number of resources developed or adapted per year	12
	Total number of health promotion events directed at target population per year	59
	Total number of health promotion events targeted at community partners, including health professionals, per year	5
	Total number of consultations per year	324
	Total number of (external) coalitions per year (both membership or initiated by us)	2
Reach Indicators	Total number of individuals from target population that attended health promotion events	2,102
	Total number of resource materials provided to clients and partners per year	30,800
	Total number of partnered health promotion events	32
Effectiveness Indicators	Proportion of health promotion events directed at building partner capacity	100%
	Proportion of consultations (initiatives) focused on policy development	100%
	Proportion of programs that integrate 3 or more components of the Ottawa Charter	92%
	Proportion of health promotion events that are based on theory or evidence	100%



### 3. Building a healthy nutrition environment

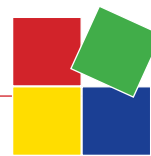
Promoting and building capacity for a healthy nutrition environment in elementary schools and workplaces considers all activities in the school or workplace where food and nutrition are taught, promoted, offered or served. Building a healthy nutrition environment begins with identifying activities related to healthy eating and then provides guidance and support for making healthy eating the easy choice. In this way, individuals will receive the same message about healthy eating wherever food is promoted or served, whether in the classroom, in the school, at work and in the home.

**Table 38: KEY ACTIVITY:** Promoting and building capacity for healthy nutrition environments (target: workplaces and schools)

TYPE	INDICATORS for 2007	VALUE
Level of Service Delivery Indicators	Total number of Healthy Schools with a nutrition focus for the 2006-2007 school year	28
	Total number of elementary schools that have at least one Food for Learning program per year (as at June 2007)	51
	Total number of workplaces that implemented the Healthy Measures (HM) program in 2007	13
Reach Indicators	Proportion of Healthy Schools with a nutrition focus for the 2006-2007 school year	56%
	Proportion of elementary schools that have implemented at least one Food for Learning program (as at June 2007)	21%
	Proportion of workplaces that received service from the Workplace Wellness Team that implemented the Healthy Measures (HM) program in 2007	10%
Effectiveness Indicators	Proportion of Healthy Schools with a nutrition focus that have implemented at least one activity in each of the four components from the Comprehensive School Health model	54%
	Proportion of workplaces that have implemented at least one activity from each nutrition component of the Healthy Measures program (Awareness and education, and supportive environment)	23% of workplaces that have implemented the Healthy Measures program
	Proportion of elementary schools with a Food for Learning program that are sustained from the previous year	92% sustainability

## 3.6 INCLUSIVITY, IMMIGRATION and POPULATION GROWTH

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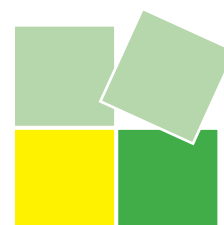


### 3.6 Inclusivity, Immigration and Population Growth

What do the statistics tell us?

What are we doing about it?

1. Inclusivity Action Plan
2. Accessibility Plan
3. Provision of Health Connection telephone line





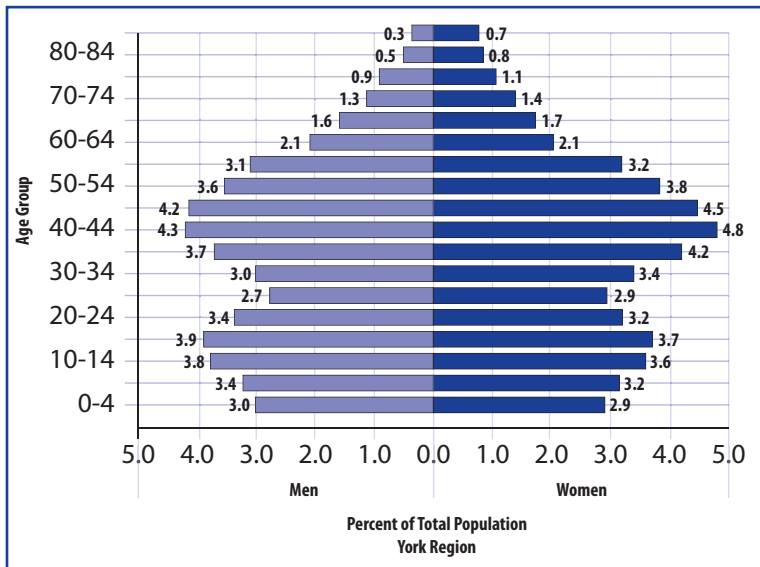
### 3.6 Inclusivity, Immigration and Population Growth

This section includes key activities from the Equal Access standard of the 1997 *Mandatory Health Programs and Services Guidelines*.

#### What do the statistics tell us?

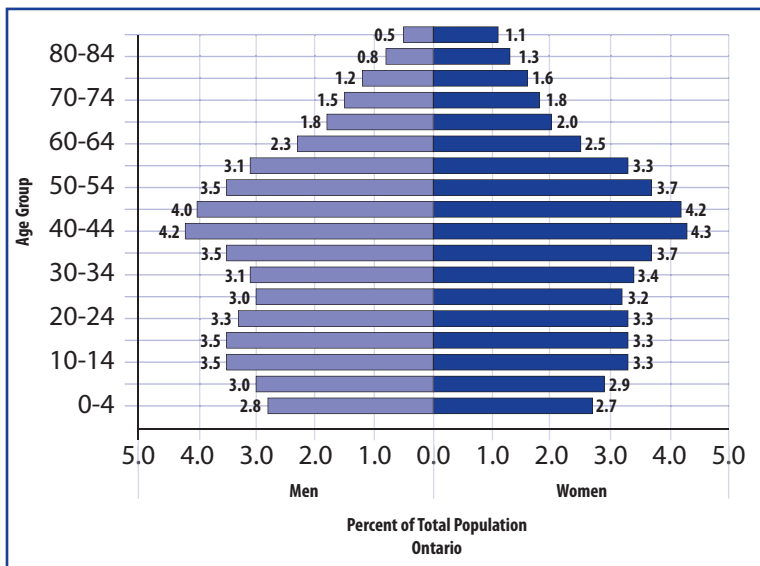
York Region is one of the fastest-growing health units in Ontario (Table 39), with a population growth of 22.4% from 2001 to 2006. While only 10.3% of the population were seniors in 2006, this percentage will increase as the demographic bulge currently between the ages of 40 to 60 continues to age (Figure 3 and 4). Approximately 12% of York Region's population live with a disability that impairs functional ability to some degree (Table 39). The total immigrant population of York Region in 2006 was 42.9% of the population compared to a provincial average of 28.3%. A significant number of residents do not speak English as their first language: after English, the top four home languages spoken in York Region are Chinese, Italian, Russian, and Farsi.

Figure 3: Percentage of People in the Population by Age and Sex, York Region, 2006<sup>e</sup>



<sup>e</sup>Census 2006

Figure 4: Percentage of People in the Population by Age and Sex, Ontario, 2006<sup>e</sup>



<sup>e</sup>Census 2006

**Table 39: DEMOGRAPHICS**

INDICATOR	YORK REGION	ONTARIO
Population growth (2001-2006) <sup>e</sup>	22.4%	6.6%
Total immigrant population (2006) <sup>e</sup>	42.9%	28.3%
Home language, percentage of total population (2006) <sup>e</sup>	<b>Top 5 single responses</b> English - 69.8% Chinese languages - 10.3% Italian - 2.3% Russian - 2.1% Farsi - 1.6%	<b>Top 5 single responses</b> English - 80.3% Chinese languages - 3.2% Punjabi - 1.0% Italian - 0.9% Spanish - 0.8%
Residents with a disability (2001)	12.0%	13.5% <sup>k</sup>

<sup>e</sup>Census 2006, <sup>d</sup>Census 2001, <sup>k</sup>Participation and Activity Limitation Survey 2001

### What are we doing about it?

Rapid population growth, physical disability and cultural barriers can reduce access to public health programs. One of the goals under the *Mandatory Health Programs and Services Guidelines* is to ensure all Ontarians have access to public health programs by reducing educational, social and environmental barriers. The York Region Public Health Branch has undertaken a number of key activities to improve access to public health programs.

### Key activities under the theme of Inclusivity, Immigration and Population Growth include:

#### 1. Inclusivity Action Plan

The Branch was an active member of the York Region Inclusivity Action Plan (IAP). The IAP is a community-inspired and driven planning framework to increase York Region's capacity to welcome and integrate new immigrants, involving six working groups and 88 participants from 47 human service organizations. IAP projects focus on three themes for action: to enhance ethno-cultural awareness in York Region; to promote ethno-cultural representation in human service agencies, and to improve communication between service providers and the newcomer population.

A key IAP accomplishment was the summer 2007 opening of the York Region Welcome Centre, a unique collaborative service delivery model which delivers core settlement services under one roof. Discussions between Public Health and the Welcome Centre have identified opportunities to offer public health programming from the Centre. Initial Public Health programming for 2007 included conducting a community flu clinic at the Centre.

To promote inclusivity, the Public Health Branch strives to tailor educational materials to appropriate educational levels and diverse languages by employing health educators and purchasing translation services.

**Table 40: KEY ACTIVITY: Planning and implementing inclusivity initiatives (target: general public)**

TYPE	INDICATORS for 2007	VALUE
Level of Service Delivery Indicators	Proportion of current written materials (targeted at clients) and translated into three or more languages	7%
	Proportion of current programs that specifically target diverse ethnocultural and societal groups	40%
Effectiveness Indicators	Proportion of current programs that consulted diverse ethnocultural groups in program planning	38%



## 2. Accessibility Plan

Under the *Ontarians with Disabilities Act*, all municipalities in the province have a legal obligation to prepare an annual accessibility plan to improve opportunities for people with disabilities through the identification, removal or prevention of barriers. The Public Health Branch contributed to the development of the annual plan and undertook specific activities such as: inclusion of persons with disabilities into Health Services emergency planning, revising print material to enlarge font size, improving communication through the integration of teletypewriter services with interactive voice response, increasing staff awareness through participation in inclusivity training, applying the accessible meeting checklist when planning meetings to ensure facilities and sites are barrier free and have suitable access for special groups.

**Table 41:** KEY ACTIVITY: Planning and implementing *Ontarians with Disabilities Act* initiatives (target: staff, people with disabilities and general public)

TYPE	INDICATORS for 2007	VALUE
Level of Service Delivery Indicators	Number of projects completed from annual Branch accessibility plan (total of 5 projects related to Public Health for the year)	1
	Number of projects underway from annual Branch accessibility plan (total of 5 projects related to Public Health for the year)	4
Reach Indicator	Proportion of Public Health staff that have attended <i>Ontarians with Disabilities Act</i> Inclusion and Accessibility Course	0.8%

## 3. Provision of Health Connection telephone line\*

The Health Connection line offers education, counselling and referral via telephone as a means of improving access to public health information and programs. Teletypewriter and translation services help ensure that individuals who are hearing impaired and residents who do not speak English as their first language may still benefit from a telephone delivery model.

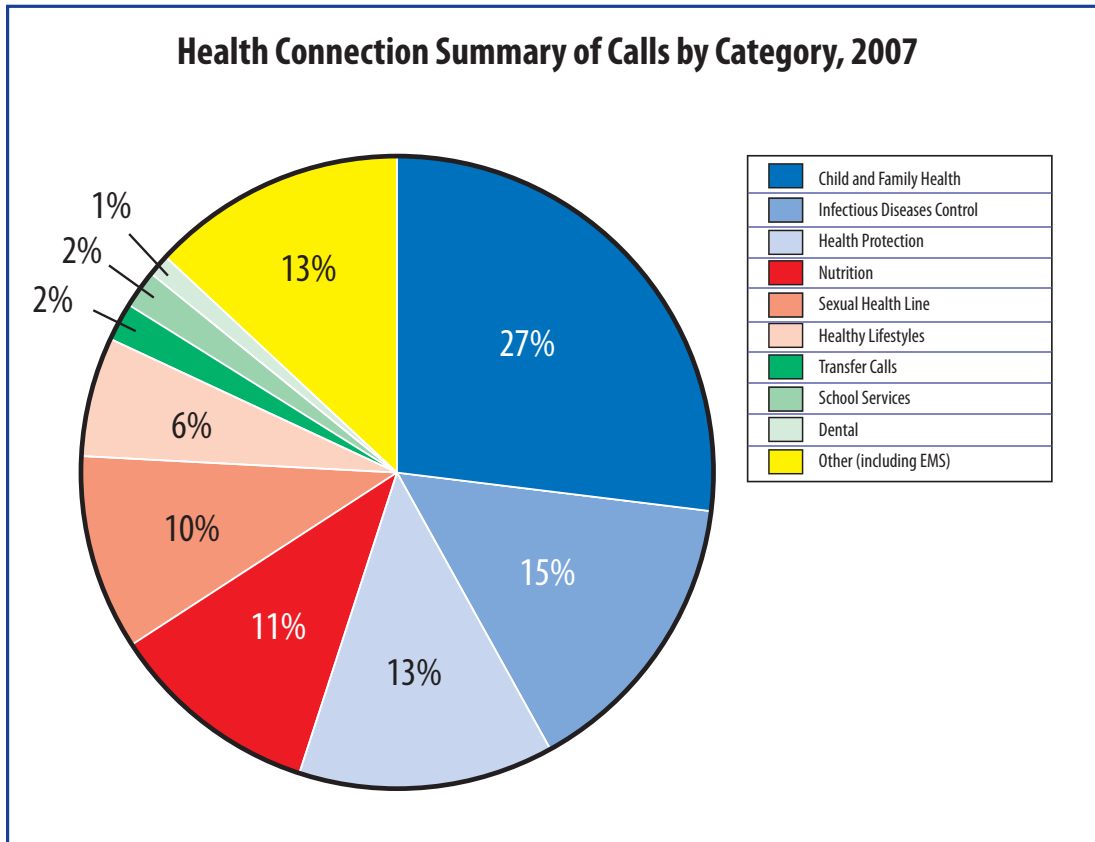
\*Note: Not all telephone calls to the Public Health Branch are received through the Health Connection line.

**Table 42:** KEY ACTIVITY: Providing education, counselling, and referral via telephone (target: York Region residents)<sup>h</sup>

TYPE	INDICATORS for 2007	VALUE
Level of Service Delivery Indicators	Total number of Health Connection calls per year	39,247
	Total number of calls to pre-recorded messages 24/7 per year	3,558
	Total number of hits to York Region Public Health home page	Not Available
	Total number of abandoned calls	7,637
	Total number of calls transferred to voicemail	7,990
Reach Indicators	Proportion of York Region residents that are aware of Health Connection's services	16% - data collection period Jan-May 2006 <sup>m</sup>
	Proportion of answered calls per year	60%
Effectiveness Indicators	Average length of call	15 minutes



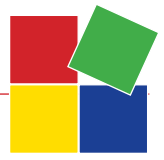
**Figure 5: Health Connection Calls by Topic Area**





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# 4. MEASURE of RESOURCES



## 4. Measure of Resources





## 4. Measure of Resources

According to the Institute for Clinical Evaluative Sciences (ICES) report, *Developing a Balanced Scorecard for Public Health*, “[u]nderstanding the amount of resources and services delivered is a cornerstone of a performance report for all health sectors.”<sup>26</sup> Types of indicators customarily included to measure resources and services include indicators of financial resources, such as per capita costs and number of FTEs.

In 2007, there were a total of 431 FTEs employed in the Public Health Branch of the Community and Health Services Department to deliver the programs mandated by the *1997 Mandatory Programs and Services Guidelines*. This included:

COST-SHARED PROGRAM FTE		COST-SHARED ADMINISTRATIVE FTE		100% FUNDED FTE	
1.0	Commissioner	3.0	Communications Manager/ Media Coordinator	53.5	Healthy Babies Healthy Children Staff
20.0	Dental Hygienist/Assistant	2.0	Director/Business Administrator	11.5	Smoke-Free Ontario Staff
1.0	Dentist/Director	4.0	Financial Staff	7.0	SARS Short-Term Action Plan Staff
4.0	Epidemiologist	2.0	Human Resource Staff/Coordinator		
8.0	Health Promoter	7.0	I & IT Staff		
2.0	Medical Officer of Health/Associate	5.0	Manager/Supervisors		
12.0	Nutritionist/Dietitian	4.0	Other Administrative Staff		
1.0	Other Program Staff (Web Project Coordinator)	14.0	Secretarial/Administrative Staff		
3.0	Program Coordinator				
4.0	Program Director				
24.0	Program Manager/Supervisors				
53.0	Program Support Staff				
62.0	Public Health Inspector				
113.0	Public Health Nurse/ Registered Nurse				
10.0	Registered Practical Nurse				
<b>318</b>	<b>SUB-TOTAL COST-SHARED</b>	<b>41</b>	<b>SUB-TOTAL COST-SHARED</b>	<b>72</b>	<b>SUB-TOTAL 100% FUNDED FTE</b>
<b>431 TOTAL PROGRAM FTE</b>					

The 2007 gross annual budget for the York Region Public Health Branch was \$48,404,289.\* The Ministry of Health and Long-Term Care and The Regional Municipality of York share the responsibility for funding most of the mandated programs. In 2007, the Ministry supplied 75% of the funding for cost-shared programs while the remaining 25% came from the Regional levy. There are also a few dedicated programs where 100% of the funding is provided by the Ministry. These include Smoke-Free Ontario programs and Healthy Babies, Healthy Children, as well as positions funded as part of the Ontario SARS short-term action plan. In addition, costs for the Ontario Works Dental Program for Dependant Children and the Ontario Works Dental Program for Adults are offset by the former Community Services and Housing Department.

At present, we are limited to reporting only approved budget rather than expended budget, and limited by accounting mechanisms to reporting by mandatory program area rather than by key activity.

\* Offset revenues of about \$1,000,000 are received from various sources, including \$400,000 in fees and charges, \$500,000 from reserves offsetting computer lease renewals, \$70,000 from the Ontario Health Insurance Plan to offset sexual health clinic visits, and approximately \$60,000 in sundry revenue (such as fines collected through the Smoke-Free Ontario program).



Figure 6: 2007 Public Health Budget

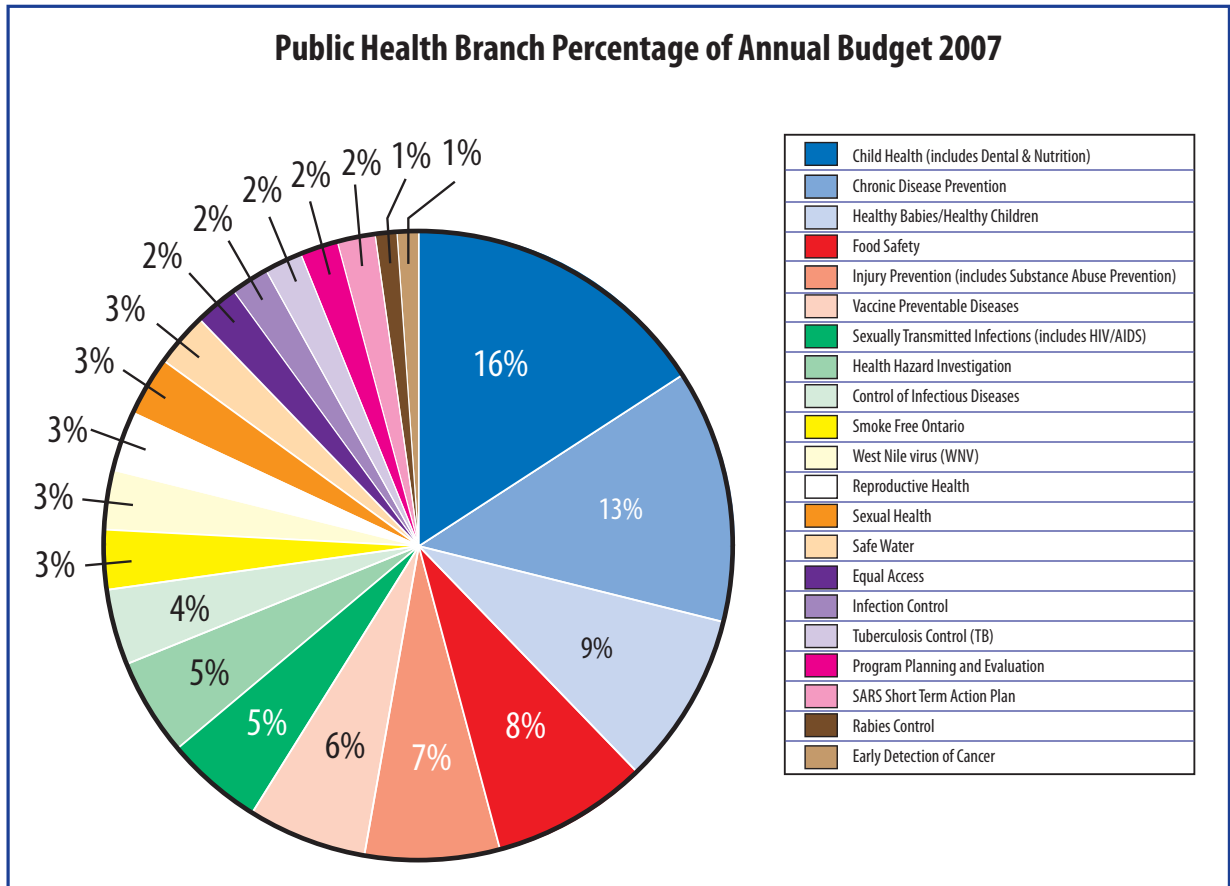
MANDATORY PROGRAMS	BUDGET REQUEST	PER CAPITA SPENDING (983,000)	DEVOTED FTEs	TOTAL FTEs	PERCENTAGE of ANNUAL BUDGET
	2007	2007	2007	2007	2007
Equal Access	\$1,127,985	\$1.15	9.19	10.38	2.33%
Health Hazard Investigation	\$2,431,069	\$2.47	19.03	21.49	5.02%
Program Planning and Evaluation	\$789,339	\$0.80	5.20	5.87	1.62%
Chronic Disease Prevention	\$6,051,324	\$6.16	47.47	53.59	12.50%
Early Detection of Cancer	\$387,681	\$0.39	2.93	3.32	0.80%
Injury Prevention including Substance Abuse Prevention	\$3,191,904	\$3.25	25.04	28.26	6.59%
Sexual Health	\$1,423,065	\$1.45	11.86	13.38	2.94%
Reproductive Health	\$1,455,360	\$1.48	11.51	12.98	3.01%
Child Health	\$7,900,513	\$8.04	58.03	65.49	16.32%
Control of Infectious Diseases	\$1,923,771	\$1.96	15.65	17.68	3.97%
Food Safety	\$4,110,814	\$4.18	33.06	37.34	8.49%
Infection Control	\$1,078,991	\$1.10	8.28	9.33	2.23%
Rabies Control	\$664,474	\$0.68	5.15	5.80	1.37%
Safe Water	\$1,379,217	\$1.40	10.85	12.26	2.85%
Sexually Transmitted Infections (STI) including HIV/AIDS	\$2,534,486	\$2.58	20.19	22.79	5.24%
Tuberculosis Control (TB)	\$906,696	\$0.92	7.52	8.49	1.87%
Vaccine Preventable Diseases	\$2,989,712	\$3.04	27.06	30.55	6.18%
<b>NET SHAREABLE MANDATORY PROGRAM COSTS</b>	<b>\$40,343,401</b>	<b>\$41.04</b>	<b>318.00</b>	<b>359.00</b>	<b>83.35%</b>

RELATED COST SHARED PROGRAMS	BUDGET REQUEST	PER CAPITA SPENDING (983,000)	DEVOTED FTEs	TOTAL FTEs	PERCENTAGE of ANNUAL BUDGET
	2007	2007	2007	2007	2007
West Nile virus (WNV)	\$1,483,579	\$1.51	0	0	3.06%
<b>100% FUNDED PROGRAMS</b>					
Healthy Babies/Healthy Children	\$4,260,015	\$4.33	53.50	53.50	8.80%
Smoke-Free Ontario	\$1,562,166	\$1.59	11.50	11.50	3.23%
SARS Short Term Action Plan	\$755,128	\$0.77	7.00	7.00	1.56%
<b>TOTAL 100% FUNDED PROGRAM COSTS</b>	<b>\$6,577,309</b>	<b>\$6.69</b>	<b>72.00</b>	<b>72.00</b>	<b>13.6%</b>
<b>TOTAL MANDATORY and RELATED BUDGET AND 100% FUNDED</b>	<b>\$48,404,289</b>			<b>431</b>	<b>100%</b>

Note: Devoted FTEs are those assigned to a specific program area. Total FTEs also includes administrative staff who provide support across program areas.



**Figure 7: Public Health Branch Percentage of Annual Budget 2007**



**Figure 8: Public Health Branch Percentage of Annual Budget 2007**  
(Includes Mandatory, Related Cost Shared and 100% Funded Programs)

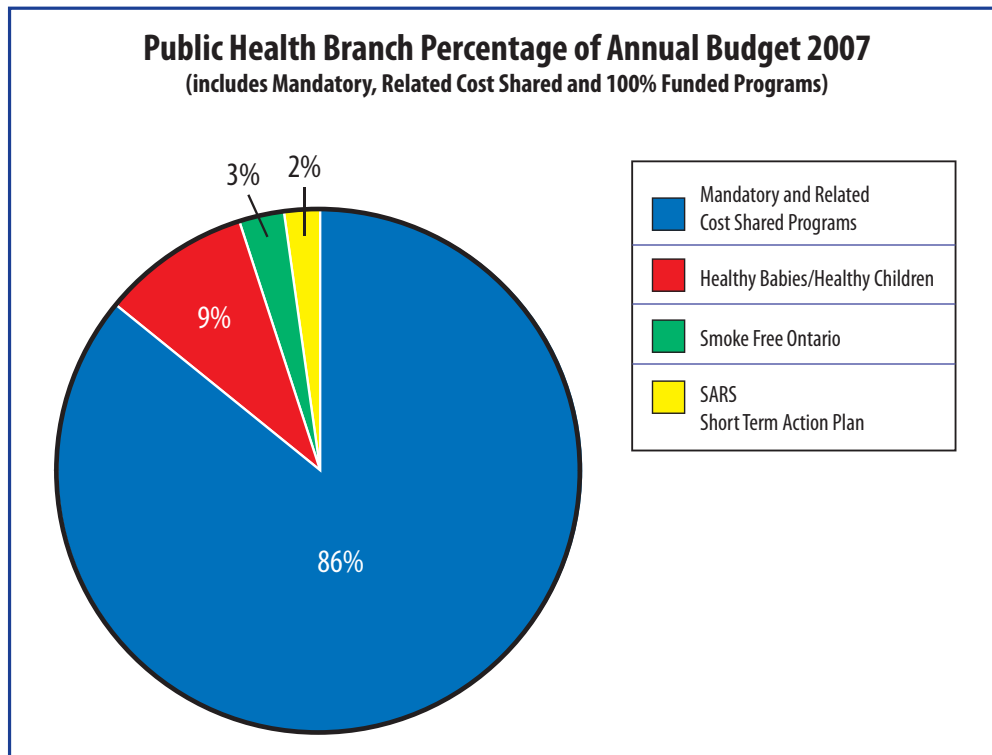




Figure 9: Public Health Branch Per Capita Spending in 2007

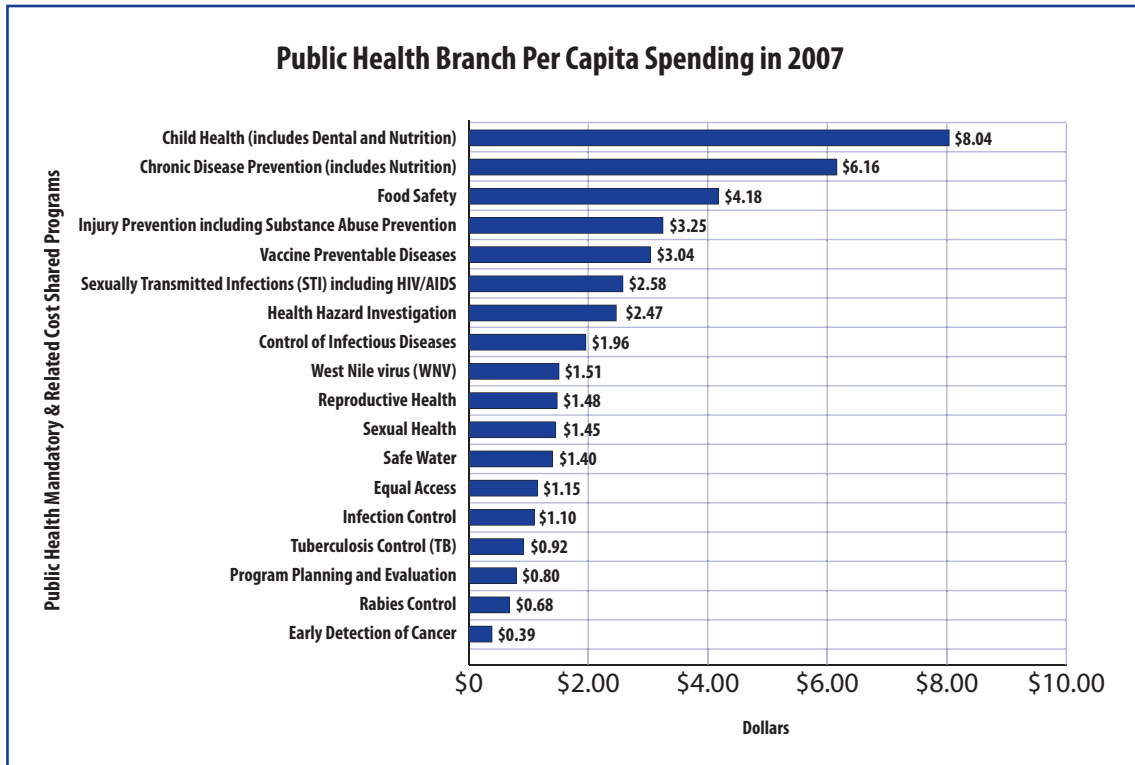
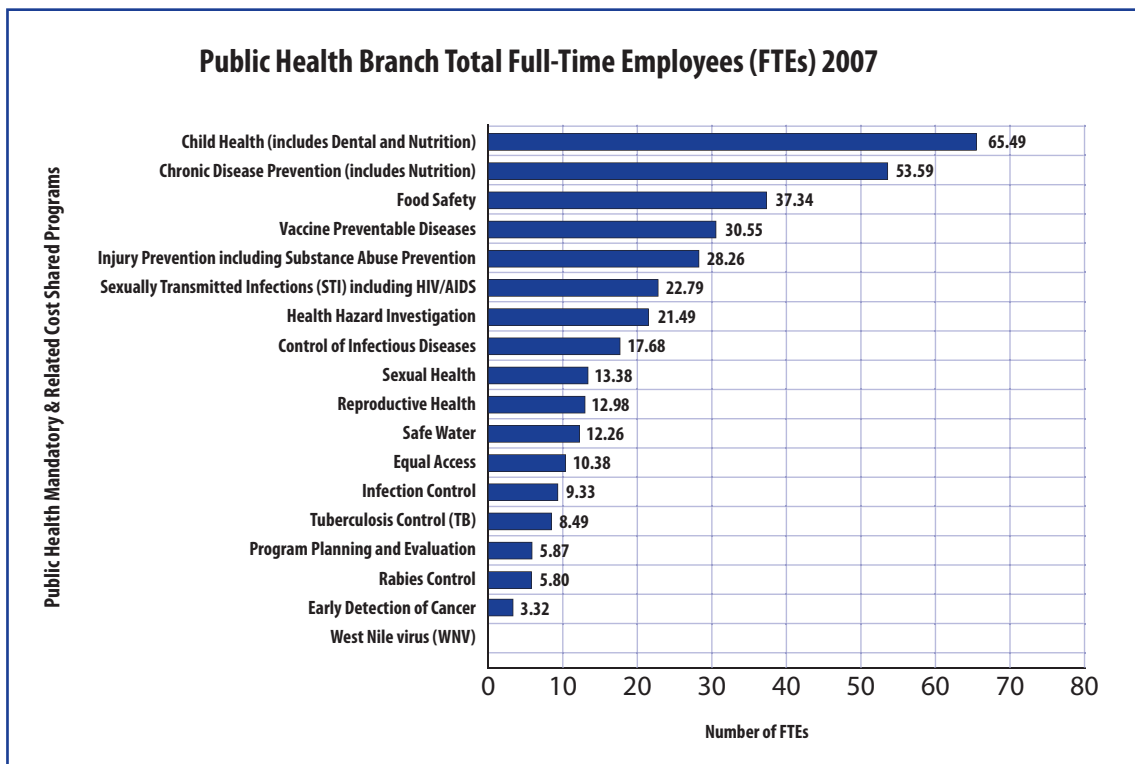


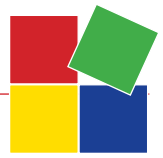
Figure 10: Public Health Branch Total Full-Time Employees (FTEs) 2007



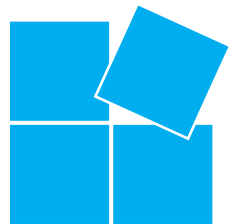


# 5. MEASURE of COMMUNITY ENGAGEMENT

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## 5. Measure of Community Engagement





## 5. Measure of Community Engagement

York Region is one of the fastest-growing health units in Ontario (Table 39), with a population growth of 22.4% from 2001 to 2006. Understanding the views of the people a program serves is a fundamental principle of accountability and can improve the way services are delivered. Public Health can engage the community in a number of ways. Client satisfaction surveys are one of the traditional ways to invite input and feedback. For programs that target populations or the entire community, where it can be difficult to define the clients, focus groups and surveys help assess community needs, awareness and preferences. Media encounters draw attention to public health programs and services, helping to increase community uptake of current public and population health issues.

### What are we doing about it?

#### 1. Collection and distribution of health data

In addition to client satisfaction surveys and focus groups, in 2007 York Region Public Health demonstrated its commitment to more rigorous evaluation by hiring a full time program evaluation specialist, who is undertaking comprehensive evaluations of priority programs as identified by branch staff.

The Rapid Risk Factor Surveillance System (RRFSS), an ongoing telephone survey conducted in various public health units across Ontario, is one tool that is used to collect current, local health data to support program planning and evaluation, to advocate for public policy development, and to improve community awareness. York Region has been participating in RRFSS since 2001. As of June 2007, 21 of 36 health units across Ontario were participating. Using random digit-dialing methods, 100 adults aged 18 years and older are interviewed via telephone on a monthly basis in each RRFSS participating health unit area, for a possible total of 1,200 interviews per year. Interviews are conducted by trained interviewers from the Institute for Social Research at York University. The survey is used to monitor risk factors and behaviours, knowledge and awareness, on topics such as smoking, immunization, obesity and chronic diseases. There is common content asked by all participating health units, and variety of optional content areas, from which health units may choose the content that best fits their needs. Health units receive the data from the Institute for Social Research approximately two months after each data collection month.

The York Region Public Health Branch has 6 complete years of RRFSS data available:

- 45 unique modules were used during 2006-2007, 15 of which were core modules, 7 were core for rotating years and 23 were chosen optional modules
- 6 web fact sheets were produced based on RRFSS data
- 12 work requests used RRFSS data out of a possible 58 requests (20%) for 2006-2007

An additional way of engaging the community is to prepare health status reporting documents for internal and external clients to be used in a variety of manners. Internal clients use this information for program planning and needs assessments. External clients may use it to learn about the health of their community or to compare to other jurisdictions. In 2007, 26 data products were produced that described the health status of York Region residents.

**Table 43: COMMUNITY ENGAGEMENT**

TYPE	INDICATORS for 2007	VALUE
Community Engagement	Proportion of current programs that ever consulted target populations* in needs assessments	47%
	Proportion of current programs that involved client satisfaction component in the past year	56%
	Total number of media encounters (e.g. Rogers daytime segments, media requests, TV interviews, newspaper articles) per year	354
	Proportion of current programs that have undergone formal evaluation (i.e. completed)	22%
	Total number of published products describing health status produced per year	26

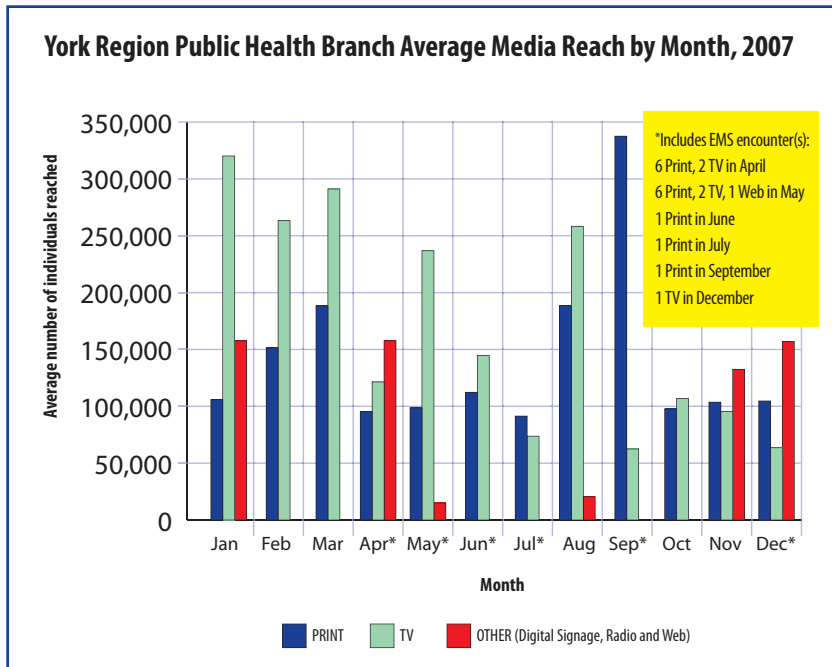
\*population(s) identified in the program logic model.



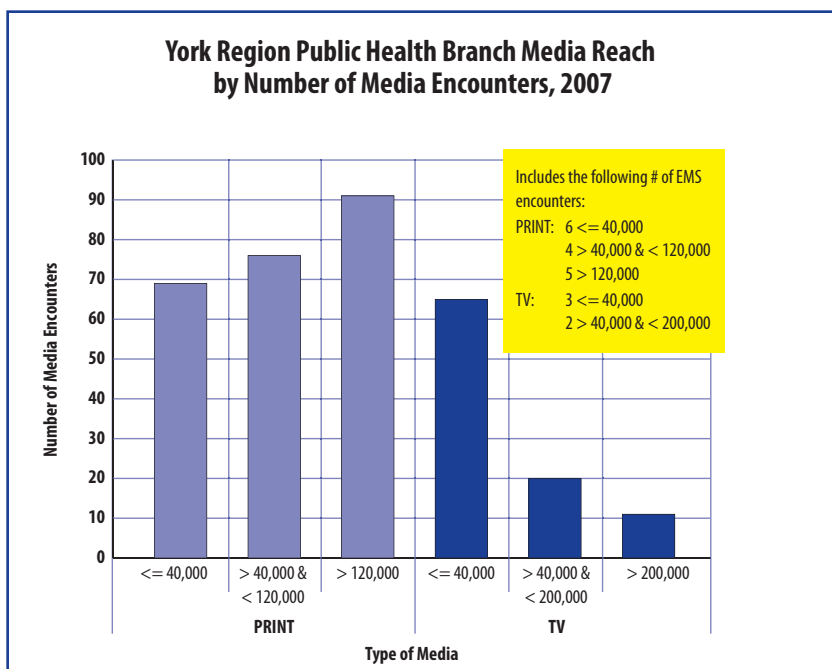
## 2. Communication through media partners

Media can influence attitudes and knowledge about public health strategies. Establishing and fostering mutually respectful relationships with various members of the media provides the York Region Public Health Branch with an ongoing opportunity to disseminate accurate information and respond to issues raised in a timely and credible manner. Messaging occurs via print, television, and other media, which may be categorized by size of audience reached.

**Figure 11:** York Region Public Health Branch Average Media Reach by Month, 2007



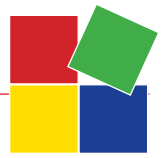
**Figure 12:** York Region Public Health Branch Media Reach by Number of Media Encounters, 2007



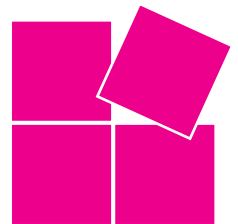


# 6. MEASURE of INTEGRATION and RESPONSIVENESS

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## 6. Measure of Integration and Responsiveness





## 6. Measure of Integration and Responsiveness

Responsiveness implies flexibility and horizon scanning to keep up with emerging issues, evidence and best practice. A key component of responsiveness is continuing professional development.

### 1. Staff engagement

Staff of the Public Health Branch are encouraged to develop their professional skills by participating in external courses and conferences, as well as in York Region corporate programs such as corporate learning courses and the corporate mentorship program.

**Table 44:** INTEGRATION AND RESPONSIVENESS

TYPE	INDICATORS for 2007	VALUE
Integration and Responsiveness	Total number of peer reviewed journal publications, conference presentations and posters	57
	Number of staff who have participated in corporate mentorship program (either as a mentor or protégé) since inception (2005)	16 participants
	Staff turnover rate (not including transfers and promotions within the branch)	12%
	Proportion of branch staff that have completed corporate staff satisfaction survey in the past year	81%

### 2. Emergency preparedness

Integration and responsiveness also entails emergency preparedness. In order to ensure that public health staff responds effectively and efficiently to prevent or minimize the health impact of any community emergency, comprehensive plans and protocols are developed, and staff are oriented to those plans and provided with specific skills and resources to support their roles. Core Competency workshops, compulsory for all staff over a 3-year cycle, form the basis of training. Coordinating plans and participating in emergency response exercises with health care partners ensures an integrated response to emergent issues.

**Table 45:** EMERGENCY PLANNING

KEY ACTIVITY: Developing Public Health Emergency Response Plans based on Hazard Identification Risk Assessment (HIRA) (target: Staff of the former Health Services Department)

TYPE	INDICATORS for 2007	VALUE
Level of Service Delivery Indicators	Total number of plans reviewed and created for different topics	5
	Total number of emergency exercises per year	6
	Total number of core competency training sessions per year	5
	Total number of staff attending core competency training sessions per year	362
	Total number of meetings with internal stakeholders to plan emergency response	11
Reach Indicators	Proportion of PH staff receiving emergency preparedness training per year	100%
	Proportion of PH staff receiving at least 1 training session per year	74%
	Proportion of PH staff receiving 2 or more training sessions per year	26%
Effectiveness Indicators	Proportion of participants whose risk communication knowledge increased as a result of participation in emergency exercises or emergency preparedness training per year	38%
	Proportion of participants whose infection prevention and control knowledge increased as a result of participation in emergency exercises or emergency preparedness training per year	92%
	Proportion of participants whose incident management system knowledge increased as a result of participation in emergency exercises or emergency preparedness training per year	74%

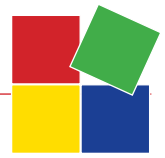
**Table 46:** KEY ACTIVITY: Engaging external partners in emergency planning (target: external planners)

TYPE	INDICATORS for 2007	VALUE
Level of Service Delivery Indicators	Total number of meetings with external partners per year	42
	Total number of collaborative activities with external partners per year	6
Reach Indicators	Proportion of key stakeholders that attended planning sessions	89%
	Proportion of key stakeholders that we have collaborated with	90%
Effectiveness Indicators	Proportion of external stakeholders that have engaged in pandemic planning	85%

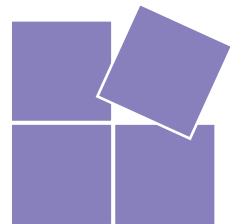


# 7. LIMITATIONS

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## 7. Limitations





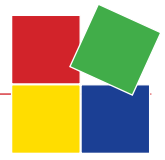
## 7. Limitations

The following limitations were encountered while developing the first balanced scorecard:

- This initial report provides only a snapshot of certain key programs and services conducted by the York Region Public Health Branch. Future reports will be able to identify trends
- It was difficult to develop consistent definitions of indicators across program areas
- Certain data items are not easily or feasibly available
- If 2007 data were not available, the most recent available data were reported
- Provincial comparative data and benchmarks are not available for all indicators
- The effectiveness of certain strategies is not easily measured in quantity. Future reports might look at qualitative measures or case studies
- This first balanced scorecard report includes a large number of indicators. Ongoing review and evaluation may result in the use of fewer indicators
- The parameters for financial reporting have been set at the same level of detail required by the Ministries of Health and Long-Term Care and Health Promotion

# 8. NEXT STEPS

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## 8. Next Steps

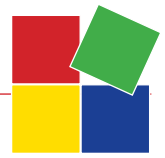




## 8. Next steps

This is a baseline report. After dissemination to York Regional Council, it will be distributed to internal and external stakeholders to evaluate its impact and utility. Lessons learned from this evaluation will assist in the development of the next report and in refining indicators, as will Ministry of Health and Long-Term Care guidance on public health performance measures.

Emerging themes from this process which might guide future reports include the built environment, health inequity, and other priorities as identified by the revised standards for public health in Ontario.



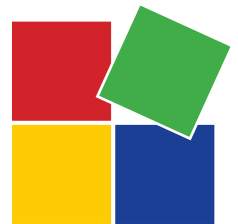
9.1 References

9.2 Data Sources

9.3 Glossary

9.4 Balanced Scorecard Evaluation Form

9.5 List of Tables and Figures





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#### <sup>a</sup>Canadian Community Health Survey (CCHS)

The CCHS, Cycle 3.1, was conducted by Statistics Canada to provide cross-sectional (at one point in time) estimates of the factors that influence the health of the population, health status of the population and use of the health system by the population for 126 health regions across Canada.

The CCHS Cycle 3.1 (2005) Sharing File - Ontario Sample consisted of 39,486 respondents, aged 12 and over. Respondents were randomly selected, one per household. The target population of the CCHS included household residents in all provinces and territories, with the exclusion of populations on Indian Reserves, Canadian Forces Bases and some remote areas.

#### <sup>b</sup>Canadian Vital Statistics Program (PHPDB)

Statistics Canada's Canadian Vital Statistics Program obtains from the provincial and territorial vital statistics registrars personal information on births, deaths, stillbirths and marriages that take place in Canada as well receiving from the federal Department of Justice's Central Registry of Divorce Proceedings personal information on divorces. In addition, some state registries in the United States provide to Statistics Canada personal information on births, deaths and stillbirths of Canadian residents that occur in their jurisdictions. Vital statistics data are used by Statistics Canada in the production of population estimates and projections, demographic and health trend analyses, as well as for methodological studies and survey sampling. The Canadian Vital Statistics Program is a long-standing arrangement between the federal government and provincial/territorial governments and is overseen by the Vital Statistics Council for Canada.

#### <sup>c</sup>Cancer Care Ontario (CCO) – Ontario Cancer Registry

Cancer Care Ontario is an umbrella organization that steers and coordinates Ontario's cancer services and prevention efforts. The agency operates screening and prevention programs; collects, monitors and reports information about cancer system performance; develops evidence-based standards and guidelines; and works with regional providers to plan and improve services for patients. Cancer incidence data collected by Surveillance Epidemiology and End Results (SEER) registries are distributed with SEER\*Stat.

#### <sup>d</sup>Census 2001

The Canadian Census is conducted by Statistics Canada every five years to provide a reliable source for describing the characteristics of Canada's people, dwellings and agricultural operations.

The Census provides the population and dwelling counts not only for Canada but also for each province and territory, and for smaller geographic units such as cities or districts within cities. The Census also provides information about Canada's demographic, social and economic characteristics.

#### <sup>e</sup>Census 2006

The Canadian Census is conducted by Statistics Canada every five years to provide a reliable source for describing the characteristics of Canada's people, dwellings and agricultural operations. (See Census 2001 above). The most recent Census of Canada took place on Tuesday, May 16, 2006. The data from this Census is being released in stages during 2007 and 2008. Where available, 2006 data are used. Information is supplemented with 2001 data.

#### <sup>f</sup>Dental Indices Survey (DIS)

DIS is a survey conducted annually by Ontario public health units on the oral health status of a sample of children ages 5, 7, 9 or 13 years who attend publicly funded schools. The sample is chosen from the population of children who receive dental screening every year in schools. Children who are absent from school on the day of the DIS, schooled at home or who refuse are excluded. Children living on native reserves, military bases, in institutions or attending private schools are also excluded.

#### <sup>g</sup>Dental Screening

Dental health screening is conducted annually by Ontario public health units to identify children with severe dental health problems and those eligible for the Children In Need Of Treatment (CINOT) program or for preventive oral health services (topical fluoride or pit and fissure sealants).

#### <sup>h</sup>Health Connection

Health Connection is a free and confidential public phone response line. The recording of the information occurs as soon as possible and must be complete within 24 hours of the contact. Information about the caller and nature of the call is also recorded, including: gender and age of the caller, age focus of the call, the name of the program the call is most related to and the topic of the call.

#### <sup>i</sup>Health Planning System (HELPS)

Health units receive data from the Ontario Ministry of Health and Long-Term Care and Statistics Canada and Central East Health Information Partnership Population Data Cubes. Information on therapeutic abortions (TAs) is collected by hospitals and clinics and provided to the Ontario Ministry of Health. The information is provided voluntarily by hospitals but is considered to be relatively complete. Since clinics must provide the information as a condition of their license, the data essentially capture all in-clinic TAs.

Data for the number of TAs done in clinic were not available until 1992; data should only be presented for 1992 and later. The number of hospital and clinic TAs from HELPS data cannot be differentiated in 1993. As of 1996, the Canadian Institute for Health Information (CIHI) collected and processed all Ontario TA data.

#### <sup>j</sup>Integrated Public Health Information System (iPHIS)

iPHIS is the database that Ontario public health units are required to use for the collection and analysis of information related to cases and contacts of reportable disease as well as for the purposes of outbreak management. The most common source of case identification is through laboratory notification of confirmed test results (serology, microbiology cultures, etc.). Physicians are required to report cases that fulfill laboratory or clinical case definitions. There may be considerable under-reporting of actual cases for some diseases. For instance, when an infected person has mild clinical symptoms they may not seek medical care and/or laboratory testing may not be performed.



**<sup>k</sup>Participation and Activity Limitation Survey (PALS) 2001**

PALS is a survey conducted every 5 years by Statistics Canada on Canadians (adults and children), whose day-to-day activities may be limited because of a condition or health problem. It is a postcensal survey because it uses the census as a sampling frame to identify its target population. For example: the 2001 Census questionnaire included general questions on activity limitations. The PALS respondents were selected through the use of the census information on age, geography and the responses to these general questions.

**<sup>l</sup>Population Estimates (PHPDB)**

The source data used are population estimates by single year of age (up to 90+) and sex for Ontario's Census Subdivisions (CSD) as of July 1, 1986 – 2006. The population estimates are produced by the Demography Division, Statistics Canada, and are based on the 1986, 1991, 1996 and 2001 census counts adjusted for net undercoverage. The latest update to the population estimates includes revisions to postcensal estimates for 2003 – 2005 and new estimates for 2006, released by Statistics Canada in January 2007.

**<sup>m</sup>Rapid Risk Factor Surveillance System (RRFSS)**

RRFSS is an ongoing monthly telephone survey that occurs in various public health units across Ontario. Every month, a random sample of 100 adults aged 18 years and older in each participating health unit area is interviewed regarding awareness, knowledge, attitudes and behaviours about topics and issues of importance to public health. These can include: smoking, sun safety, use of bike helmets, air quality, etc. The telephone survey is conducted by the Institute for Social Research (ISR) at York University on behalf of the York Region Community and Health Services Department.

**<sup>n</sup>Hospital Inpatient Discharges (PHPDB)**

Data are collected from each patient's chart at the time of discharge from hospital and are recorded on an abstract provided by Canadian Institute for Health Information (CIHI). The abstract collects information on the patient and the nature of their stay. One abstract is completed for each separation (stillbirth, death, discharge) from the hospital. The main diagnostic code gives the primary reason for the hospital stay or "most responsible diagnosis" (MRD). A second set of codes, external cause or "e-codes", are used to classify the environmental events, circumstances and conditions that cause an injury (e.g. motor vehicle traffic injury). While the e-codes are the principal means for classifying injury deaths, they are not used as a MRD for hospitalizations so they need to be examined separately. The data source contains discharge records, not admissions. The data is reported for completed cases only. Hospitals do not report on cases that are still being treated. The data presented in this report includes discharges from January 1, 2006 – December 31, 2006. The data represents the number of discharges, not the number of people.

**Audits:**

An audit monitors infection prevention and control practices of Long-Term Care Homes, Group Homes, and Daycares. Conducted 1/year for LTCH and Group Homes; conducted 2/year for Daycares.

**Adverse water quality investigations:**

When the Medical Officer of Health (MOH) or Public Health Inspector (PHI) receives information about adverse water quality they should perform a risk analysis to assess the potential health impact the adverse water quality may have on users. Where necessary, the MOH or PHI should take appropriate action to protect public health. While it is recognized that the owner/operator of the drinking water system is responsible for the provision of safe drinking water, the MOH under the authority of the HPPA is responsible for the management of health hazards. The MOH or PHI may institute measures that provide the necessary assurances that consumers have been alerted about adverse water quality. The MOH or PHI may also provide instructions to the users or owner/operator on how to mitigate the risk and observe that the owner/operator of the affected drinking water system is taking the necessary corrective action.

**Consultations:**

A consultation is an interaction between public health staff and a client or key stakeholder. This may take place via telephone, email or in-person. Purposes of consultation include:

- to engage in and/or guide through discussion, critical thinking or a decision-making process
- to impart public health and other relevant information, resources and expertise

**Compliance checks:**

Compliance checks refer to ensuring tobacco vendors meet requirements of the SFOA for signs and display and promotion criteria. SFOA was implemented June 06.

**Comprehensive School Health:**

A best practice, integrated approach that promotes opportunities for students to observe and learn positive, lifelong health attitudes and behaviours. Healthy Schools aim to engage staff, parents and students to address an identified health issue using the four foundations of CSH: Quality Instruction & Programs, Healthy Physical Environment, Supportive Social Environment, and Community Partnerships.

**Client satisfaction:**

Client satisfaction measures the extent to which a client's expectations for a good or service are met. Expectations may not be in line with what the program is or should be delivering, as stated in its objectives, or with what it can actually provide, given the resources available. Measures may include:

- verbal feedback given directly to public health staff
- survey (paper or electronic)
- interview
- focus group

**Critical infractions:**

An infraction that is critical to food safety including time/temperature abuse, cross contamination, adulteration and poor personal hygiene.

**Directly Observed Therapy:**

In directly observed therapy, a trained health care worker monitors the patient taking each dose of anti-tuberculosis medication. When TB patients receive all medications as prescribed under a program of DOT, both patients and community benefit.

**Food for Learning program:**

York Region Food for Learning is a diverse community partnership that supports student nourishment programs which enhance learning and health in York Region schools. York Region Food for Learning provides expertise, funding and resources to develop and sustain breakfast and snack programs.

**Health Promotion:**

Health promotion is the process of enabling people to increase control over, and to improve, their health.

**Healthy Schools:**

Schools who have committed to working towards a Comprehensive School Health approach. Schools participating in the York Region Healthy Schools Program receive support and resources from public health staff to assess strengths and needs, link to community partners and develop, implement and evaluate a Comprehensive School Health action plan.

**Healthy Measures program:**

Healthy Measures is a comprehensive nutrition program offered by Nutrition Services. The main goal of this program is to promote and enhance the nutritional well-being of those who live and/or work in York Region and to contribute to the reduction of nutrition-related chronic diseases. The Healthy Measures program is promoted and implemented in workplaces in York Region using a variety of strategies, including awareness raising, skill building, environmental support and nutrition policy initiatives. Workplaces are offered a variety of activities including educational workshops and consultation around improving the food and beverage choices available in the workplace cafeteria, vending machines and at business meetings. For workplaces that have a cafeteria on site, the Eat Smart! Workplace Cafeteria Program is promoted and implemented by nutrition staff in collaboration with the Health Protection Division.

**High risk inspection:**

An inspection conducted at a facility that was assessed as a high risk premise as per the Hazard Analysis Critical Control Point (HACCP Protocol). Examples include full service food premises such as banquet halls.

**High Risk Personal Services Settings:**

Personal Services Settings that have the potential for the transmission of blood-borne diseases. These include such premises as Tattoo Parlours, Ear/Body Piercing Salons, Acupuncture and Electrolysis facilities.

**Hilary:**

Hilary is a mail-out package sent to all families with newborns in York Region who consented to have a postpartum contact from HBHC program. The Hilary mail-out package includes information about the HBHC program, Purple Pages (resource guide of services and support for new families in York Region), a book to read with your baby, Nipissing District Developmental Screen, and a Kids Line Brochure.

**LTCH audits:**

Audits that monitor infection prevention and control practices of Long Term Care Homes, Group Homes, and Daycares. Conducted 1/year for LTCH and Group Homes; conducted 2/year for Daycares.

**Low risk inspection:**

An inspection conducted at a facility that was assessed as a low risk premise as per the Hazard Analysis Critical Control Point (HACCP Protocol). Examples include convenience stores.

**Medical surveillance:**

Individuals newly arrived in Canada may have been referred for medical surveillance for TB by Citizenship and Immigration Canada because of a previous history of TB or an abnormal chest x-ray suggestive of inactive TB. Following their arrival in Canada, these persons are required to report to the local public health authorities to establish whether or not active TB currently exists and to determine the appropriate course of medical care, which may include treatment of latent TB infection (LTBI).



**Medium risk inspection:**

An inspection conducted at a facility that was assessed as a medium risk premise as per the Hazard Analysis Critical Control Point (HACCP Protocol). Examples include submarine shops and pizza shops.

**Red Flags:**

Red Flags is a Quick Reference Guide for Early Years professionals. Red Flags outlines a range of functional indicators or domains commonly used to monitor healthy child development, as well as potential problem areas for child development. It is intended to assist in the determination of when and where to refer for additional advice, formal assessment and/or treatment. It can be used in conjunction with a validated screening tool, such as Nipissing District Developmental Screens or Ages and Stages Questionnaire.

**Re-inspections:**

Includes the number of inspections of public pools, spas and wading pools required for follow-up after an initial compliance inspection but does not include the number of inspections required in response to a complaint or request or after a closure order.

**Resources:**

Resources include items with written or audio-visual content that raise awareness, increase knowledge and/or develop skills related to public-health key messages, programs and services (e.g. bookmarks, flyers, brochures, pens, fact sheets, manuals, CDs, DVDs).

**Surveillance investigations:**

- 1) Enteric surveillance investigations are initiated according to the following criteria:
  - For community outbreak investigations, when two or more individuals develop similar gastro-intestinal symptoms within 7 days from a suspected meal/event within the community
  - For institutional outbreak investigations, when two or more cases of illness with similar gastro-intestinal symptoms occur within a 48-hour period in a facility/institution
- 2) Respiratory surveillance investigations are initiated according to the following criteria:
  - Two cases of acute respiratory tract illness occurring within 48 hours in a geographic area (e.g., unit, floor)

**Urgent cases:**

Urgent dental cases as defined by the Ministry of Health Promotion's Children in Need of Treatment (CINOT) program include cases that involve: infection; haemorrhage; trauma; pathology, present pain or pain frequently in the week preceding CINOT eligibility determination; and dental caries when there are large, open lesions in permanent teeth well into the dentin, or in crucial primary teeth that, if left untreated, the child might be deemed to be in a state of dental neglect and thus eligible for referral to a Children's Aid Society under the *Child and Family Services Act*.

**Vendor compliance:**

Vendor compliance with SFOA (promotion and display) means inspections by Tobacco Control Officers (TCO) of tobacco vendors to ensure they are in compliance with the SFOA legislation regarding signs, display and promotion requirements. Where a tobacco vendor is not in compliance, TCO will take appropriate action, from providing education to prosecution. Ministry of Health Promotion requires a minimum of at least 1 visit per site per year.



The Regional Municipality of York, Community and Health Services Department, Public Health Branch have undertaken a Balanced Scorecard as a means to measure and monitor divisional success and progress. Your honest responses to this evaluation would be greatly appreciated. All responses are anonymous and they will be aggregated to provide an overall picture of feedback of the Balanced Scorecard.

1. In your opinion, was the Balanced Scorecard helpful in providing you with relevant information on the activities of Public Health over the past year?  
 Strongly Agree     Agree     Disagree     Strongly Disagree     Not Applicable
2. In your opinion, was the Balanced Scorecard helpful in providing you with the relevant information on the accomplishments of Public Health achieved over the past year?  
 Strongly Agree     Agree     Disagree     Strongly Disagree     Not Applicable
3. Do you think there was information missing from the Balanced Scorecard that you would have been interested in?  
 Yes     No     Not Applicable

If yes, please elaborate: \_\_\_\_\_

4. What do you think about the level of detail provided in the Balanced Scorecard?  
 Too much detail     Not enough detail     Enough detail to provide a general overview
5. Was the information provided within the Balanced Scorecard communicated in a simple and clear manner?  
 Yes     No    Suggestions for Improvement: \_\_\_\_\_
6. Was the visual presentation of the information in the Balanced Scorecard presented aesthetically?  
 Yes     No    Suggestions for Improvement: \_\_\_\_\_
7. Did the Balanced Scorecard accurately reflect the business function of the Public Health Branch of York Region Community and Health Services?  
 Yes     No    Suggestions for Improvement: \_\_\_\_\_
8. Overall, do you think the Balanced Scorecard is an effective tool to communicate the activities and accomplishments of the Public Health Branch of York Region Community and Health Services Department?  
 Yes     No     Not Applicable
9. Three ways to improve the Balanced Scorecard in the future are:  
 a. \_\_\_\_\_  
 b. \_\_\_\_\_  
 c. \_\_\_\_\_
10. Overall, I was satisfied with the Balanced Scorecard as a whole.  
 Yes     No     Not Applicable

11. Which category best describes you?

- |   |   |
|---|---|
| <input type="checkbox"/> York Region community partner (specify): _____       | <input type="checkbox"/> Local councillor         |
| <input type="checkbox"/> York Region Health Service provider (specify): _____ | <input type="checkbox"/> York Region employee     |
| <input type="checkbox"/> Employee of another health unit                      | <input type="checkbox"/> Member of general public |
|   | <input type="checkbox"/> Other (specify): _____   |

**Thank you for taking the time to provide your feedback and honest opinion!**  
**Please fax your evaluation form back to 905-954-4002**

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