Board Report

August 26, 2016

Medical Officer of Health

Report to the Board

Friday, August 26, 2016

Building Healthier Communities

On August 15, 2016, I took part in a panel discussion on building healthier communities at the Association of Municipalities of Ontario conference in Windsor. The session presented five approaches to building healthier communities and offered many examples of the successful application of these approaches to healthier outcomes for communities.

Municipal policy can substantially improve health of the population. Examples include smoke-free spaces, built environment, community water fluoridation, housing, and injury prevention initiatives. Applying a health lens to municipal policy-making also means considering health implications when developing policy about non-health issues.

The estimated contribution of modifiable determinants of health leave the majority of room for non-health sectors to influence health outcomes:

- social and economic factors 40%
- health behaviours 30%
- clinical care 20%
- physical environment 10%

Dr. Lisa Simon, Associate Medical Officer of Health from Simcoe Muskoka District Health Unit, presented six ways that a health lens can be applied to municipal policy making:

1) Make use of your local public health unit through collaboration and cooperation, board of health advocacy and specifically designed resources and tools, such as the leadership symposium on October 21, 2016.
2) Incorporate health into councils' strategic and development plans.
3) Encourage and facilitate opportunities for effective cross-sector understanding and feedback (e.g. committees, plans).
4) Explore the judicial use of Health Impact Assessments, where possible.
5) Prioritize policies with the potential for early and multiple wins.
6) Become a 'Healthy Municipality'.

A ‘Health in All Policies’ approach can also be applied across policies, across tiers of government or partners/stakeholders. "Health in All Policies is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts, in order to improve population health and health equity." (WHO, 2008).

This is the main approach applied to practice in Grey Bruce, and has led to several successful initiatives such as the substandard/standard housing work and the election strategy documents produced for the elections in 2014 and 2015.

Many more opportunities for supporting the social determinants of health for the populations of Grey and Bruce exist. Becoming aware of these potentials, and helping to realize them, is an important part of the effective and mandated work of the Grey Bruce Health Unit.

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PROGRAM REPORT AUGUST 2016

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Working with the Grey Bruce communities to protect and promote health

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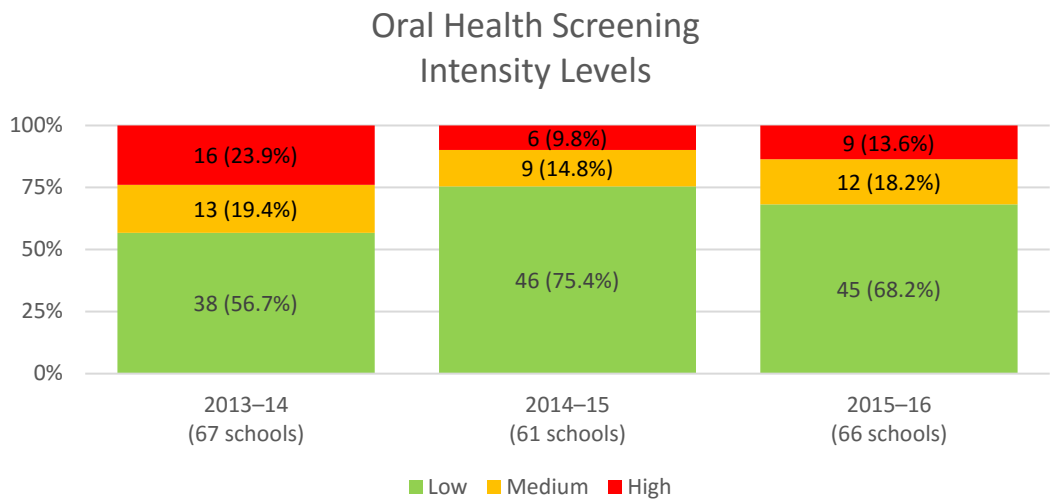
Oral Health Surveillance in Schools

The oral health team conducts surveillance of children in schools as part of the Oral Health Assessment and Surveillance Protocol (May 2016). Public health dental hygienists look for evidence of decay in junior and senior kindergarten and Grade 2 students in all schools including private, Mennonite and Amish schools.

Outcomes of the Grade 2 screening determine additional action. If screening shows a high rate of decay, defined as 14 percent or more of students with decay in two or more teeth, the Grade 4, 6, and 8 students in the school are also screened. For schools with a medium rate of decay, 9.5 to 14 percent of students with decay in two or more teeth, the Grade 8 students are screened. Those with low rates, fewer than 9.5 percent of students with decay in two or more teeth, require no additional screening.

Of the 66 Grey Bruce elementary schools screened in 2015-2016, 9 schools showed high rates of decay, 12 as medium and 45 screened as low. The accompanying chart provides a comparison of screening levels for three school years noting a higher number of low-risk schools and fewer high-risk schools since 2013-2014. This data supports aligning additional public health initiatives for children in areas where there is a high rate of dental decay.

Public health's goal is that each child has optimal oral health, free from decay and pain. We promote early oral health practices, even before the eruption of teeth, as well as first visits to the dentist by the first birthday. We support enrollment in the Healthy Smiles Ontario for eligible children and provide preventive and restorative dental clinics in Owen Sound, Markdale, Wiarton and Walkerton. We work with daycare and parent mutual aid sites to offer dental screening prior to school entry and offer the application of fluoride varnish. We advocate for fluoridated water to optimize oral health for all.



Grey Bruce Tobacco Cessation Community of Practice

Tobacco use remains the number one preventable cause of death and disease in Canada, accounting for approximately 37,000 deaths annually and 100 deaths daily from a smoking related illness. (*Tobacco Use in Canada,* Reid, J.L. et al, 2014*)*

The majority of people who smoke want to quit and are making quit attempts. In order to support quit attempts, it is important to have an integrated approach to tobacco cessation across the region. By working together, we can increase the reach of cessation interventions and address any gaps in local services and programs.

In 2012, Public Health revitalized a distribution list maintained by a community partner to create the Grey Bruce Tobacco Cessation Community of Practice (Cessation CoP). A "Community of Practice" is a group of individuals brought together by a common passion or interest for what they do. The Cessation CoP works to improve access to comprehensive cessation programs for those living within Grey Bruce by:

- Building capacity among members to offer tobacco cessation services
- Working to remove gaps in local cessation services and programs
- Building supportive relationships across member organizations
- Knowledge exchange and training opportunities
- Meeting based on members' needs
- Regular updates to network and share resources through an electronic listserv

Currently, there are 78 members on the Cessation CoP representing a cross-section of disciplines including Public Health, hospitals, family health teams, community health centres, Smokers' Helpline, Aboriginal health centres, addictions agencies, mental health services, community pharmacists, midwives and dental offices.

Reporting Lapses in Infection Prevention and Control

On October 2015, the Minister of Health notified public health units of a new requirement for the public reporting of Infection Prevention and Control (IPAC) lapses identified in health care facilities and personal service settings. The term “health care facilities” in relation to this requirement encompasses physician clinics, dentist offices, diagnostic laboratories and alternative medicine practices. “Personal services settings” refers to tattoo/body piercing facilities, hair care and other esthetic services. “IPAC lapse” refers to an action or condition that could result in the transmission of infectious disease, for example the failure of a facility to sterilize certain instruments.

Public health units are not mandated to inspect health care facilities. Reports of potential IPAC lapses associated with these facilities will arise through client complaint, communicable disease surveillance or referral from another agency. Personal services settings are inspected. Potential IPAC lapses in these settings can be identified through the routine inspection process, as well as complaints and communicable surveillance.

In the event that a complaint of an IPAC lapse against a health care facility or personal service setting, an investigation is undertaken to determine if the complaint is valid. If a complaint is lodged against a regulated facility (e.g. a dentist’s office), we also contact and work in conjunction with the regulatory body for that facility.

Where an investigation reveals a bona fide IPAC lapse, the incident must be posted in a report on the health unit’s website. The posting must be updated regularly as the investigation progresses and closed out when complete.

Complaints regarding potential IPAC lapses are rare in Grey Bruce; staff recall receiving only one such complaint in the past two years. However, the low frequency of reported complaints may not be a true indication of the number of lapses actually occurring since clients may not witness the lapse or understand that one has occurred. Recognizing this possibility, we began working with local facilities to promote IPAC principles.

Family Health Teams and practitioner offices we identified as a priority as these settings see a large number of people and offer a wide variety of services on site. Since June of 2015, we have visited 22 physician office/clinics, with several pending visits scheduled. Visits include sharing infection control resources, best practices recommendations, educational opportunities and answering questions. As a follow-up, the office/clinic were emailed additional resources and links. It was noted that the majority of clinic spaces are in the early stages of implementing IPAC best practice initiatives.

In addition to this work with health care facilities, personal services setting inspections include a strong IPAC educational component designed promote safe practices.

Accountability Indicators and Immunization

Accountability indicators for Vaccine Preventable Disease were reported to the Ministry of Health and Long-Term Care in July. Overall, compliance rates for Grey Bruce are very good.

#	Indicator Description	Monitoring or Performance Indicator	Ministry Target	Grey Bruce Compliance	Comment
4.4	% of school-aged children who have completed immunizations for hepatitis B	Monitoring Indicator	No Target	Compliant: 81.24% Non-Compliant: 18.76%	Hepatitis B vaccine is offered to all Grade 7 male and female students through school based clinics. Hepatitis B is not listed under *Immunization of School Pupils Act* (ISPA) and therefore students are not suspended for non-compliance.
4.5	% of school aged children who have completed immunizations for HPV	Monitoring Indicator	No Target	Compliant: 70.69% Non-Compliant: 29.31%	HPV vaccine is offered to all Grade 8 female students through school based clinics. HPV is not listed under ISPA and therefore students are not suspended for non-compliance NEW 2016/17! Grade 7 male and female students will be offered HPV.
4.6	% of school aged children who have completed immunizations for meningococcus	Monitoring Indicator	No Target	Compliant: 95.62% Non-Compliant: 4.38%	Meningococcal vaccine is offered to all Grade 7 male and female students through school based clinics. Meningococcal vaccine is required for school attendance under ISPA. If a child does not receive meningococcus vaccine, they must provide Public Health with a valid medical or philosophical exemption.
4.8	% of 7 or 8 year old students in compliance with ISPA	Monitoring Indicator	No Target	Compliant: 98.79% Non-Compliant: 1.21%	Grey Bruce Health Unit assesses all immunization records of students attending school in Grey Bruce. Students must provide proof of immunization or a valid exemption in order to avoid school suspension. Required vaccines include: varicella, measles, mumps, diphtheria, polio, rubella and tetanus
4.9	% 16 or 17 year old students in compliance with ISPA	Monitoring Indicator	No Target	Compliant: 95.63% Non-Compliant: 4.37%	Same as above.

Moving Collective Impact Forward

Collective Impact is an emerging framework that engages different sectors to work together to solve complex issues.

Grey Bruce is a leader in creating a culture where organizations work together. This has allowed us to excel in providing client centered care. The challenge now is to move collaboration to a level that will allow system changes to positively impact on population health.

The Grey Bruce Healthy Communities Partnership, under the leadership of co-chair Jan Chamberlain, is moving the Collective Impact conversation forward. Their June 2016

meeting engaged over 30 community leaders in a discussion of the five pillars of Collective Impact: Common Agenda; Backbone Function; Mutually Reinforcing Activities; Continuous Communication; and, Shared Measurement System. The consensus emerging from that discussion was that it takes collaborative leadership to make Collective Impact happen.

On Friday, October 21, community members will come together for the fall Healthy Communities Symposium *Collaborative Leadership for Collective Impact*. This one-day event is a forum to share and celebrate Grey Bruce successes in working together for community change. More information and registration details are available on the Healthy Communities section of our website.