



BOARD REPORT

Friday February 23, 2018



Medical Officer of Health Report to the Board

Friday, February 23, 2018

ACCREDITATION

Features

- May be based on a Continuous Quality Improvement (CQI) model in which organizations assess themselves against the accreditation standard to identify their strengths and areas for improvement (Accreditation Canada) or principal-driven, criteria-based (Excellence Canada)
- May involve self-review and site visits
- May be integrated with an organization's existing quality improvement program
- May have a progressive approach (e.g., primer --> full accreditation)
- Example standards: developing policy, delivering public health services, achieving positive public health outcomes

In Ontario, accreditation of Public Health Units is not mandatory

- About one-third were accredited through the Ontario Council of Community Health Accreditation (OCCHA) when it folded
- Also Accreditation Canada, Excellence Canada
- Other external accreditation processes (e.g., Baby-Friendly Initiative)
- LHINs: accreditation is not mandatory, but increasingly recognized as a strategy for strengthening accountability
- Hospitals: must develop & publicly post an annual Quality Improvement Plan (Excellent Care for All Act, 2010)
- CHCs: must be accredited
- CCACs: voluntary process, but all 14 in Ontario are accredited
- 2003: Auditor General recommended that OMHLTC explore use of accreditation results within the accountability framework
- 2006: Capacity Review Committee recommended mandatory accreditation as a key component of the PM framework

Pros and Cons of Accreditation for Public Health	
Pros	Cons
<ul style="list-style-type: none"> • Promotes continuous quality improvement • Standardization of organizational and governance practices in line with best practices • Provides support in meeting the Organizational Standards • Improves public trust in and visibility of public health units • Accountability is measured through a third-party • Consistency with other parts of the health sector 	<ul style="list-style-type: none"> • Limited interest among PHUs, with fluctuating list of participating organizations over time • Process requires significant commitment in terms of time and resources (no direct OMHLTC funding) • May not be necessary for PHUs, given the ministry's requirement that PHUs comply with the Organizational Standards, although there is no mechanism currently to audit compliance on an ongoing basis • Potential alignment challenges between third-party standards and legislated requirements

SUMMARY REPORT OF ACCREDITATION WITHDRAWAL

- On August 16, 2016, Maureen Handley, Director of Accountability and Chief Nursing Officer sent a letter to Julie Langlois of Accreditation Canada to request a "Survey Postponement" from September 2017 to March 2018. The request was made under the survey postponement criteria #6 – "a major local re-organization of health services". The letter explained that the circumstances were related to significant structural changes within the organization that began with a new funding formula.
- On August 25, 2016, Accreditation Canada replied in a letter to Dr. Kennedy that the request for a postponement had been reviewed by the Accreditation Decision Committee and they were unable to grant a postponement of our survey with an extension of our accreditation status. *(It was subsequently explained by email on February 5, 2018, that the reason we did not qualify for a postponement was that "major reorganization" means a merger of organizations.)* In accordance with their re-scheduling of a planned re-survey policy we had two options available:
 1. Continue to prepare and go ahead with survey that was scheduled to take place in September of 2017; or
 2. Cancel our 2017 survey, in which case our accreditation status would expire at the end of September 2017. Our organization would remain in the program as a not accredited client. A new date for an accreditation survey would be determined in consultation with Accreditation Canada and based upon surveyor availability.
- On September 12, 2016, Maureen emailed Accreditation Canada to inform them of our decision to withdraw from the program.

- On September 19, 2016, Accreditation Canada replied to Maureen with a letter acknowledging our withdrawal from the program.
- In an email communication on Monday, February 5, 2018, it was explained by Accreditation Canada that if we choose to re-enter the program we could start where we left off. We would not need to start with the Primer. We would need to apply to be a client again and it should not be difficult since we are in their system. Once we had an on-site visit we would be accredited.

Dr. Hazel Lynn



PROGRAM REPORT FEBRUARY 2018

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Working with the Grey Bruce communities to protect and promote health

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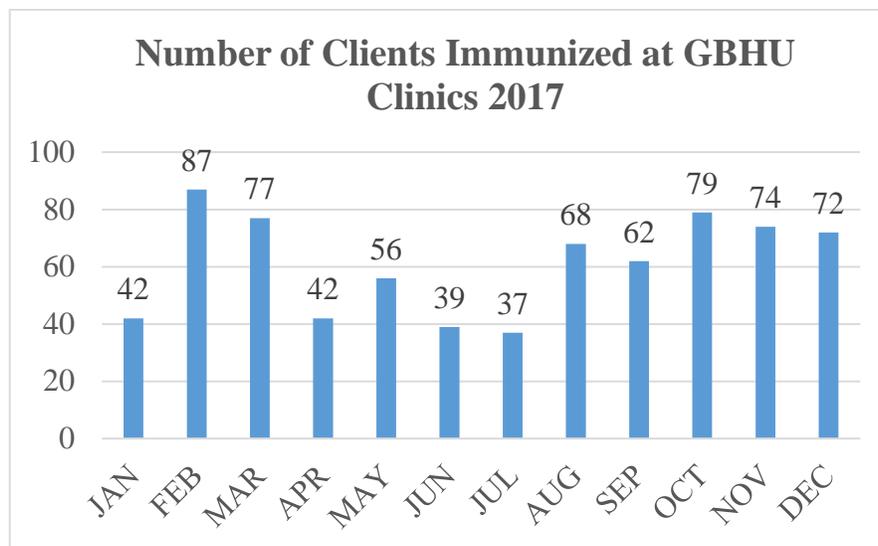
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Immunization Services for Priority Populations

The Grey Bruce Health Unit offers immunization services for priority populations within our region in accordance with the Ontario Public Health Standards. Immunization clinics are held in both Owen Sound and Walkerton for clients without regular access to a health care provider. Clients attending the clinics receive immunizations for a variety of reasons: infants without a health care provider needing to start an immunization series, new Canadians updating their immunizations for employment and students requiring immunizations for school.

In 2017, 725 clients accessed immunization clinics in Owen Sound and Walkerton – see chart for monthly attendance.

In 2018, Public Health will continue to offer these important immunization services to clients, in compliance with the Ontario Public Health Standards and aligning with the Patient’s First direction from the Ministry of Health and Long-Term Care.



Vector-Borne Disease Surveillance

Grey Bruce Health Unit operates a vector-borne disease management strategy in accordance with the requirements of the Ontario Public Health Standards. The strategy is flexible and adapts to changing local vector-borne disease risks (Lyme disease and West Nile virus) and emerging risks such as eastern equine encephalitis virus (EEEV).

Lyme disease

Lyme disease is a bacterial infection transmitted through the bite of an infected tick. Symptoms may include fever, headache, muscle and joint pain, fatigue and an expanding red rash. If untreated, infection can lead to serious chronic adverse health outcomes.

Lyme disease activity is currently tracked through tick surveillance and by monitoring the incidence of reported human cases. GBHU's tick surveillance program is unique in that ticks are recovered from animal patients of sentinel veterinary sites throughout Grey Bruce in addition to those derived from humans. This has greatly increased the number of ticks collected and improved the accuracy of the program. All ticks collected are identified by species (the Black-legged Tick is the carrier of Lyme disease in Ontario). Black-legged ticks from humans are tested by the provincial public health laboratory for *Borrelia burgdorferi*, the bacteria that causes Lyme disease.

Summary of 2017 tick surveillance:

- 73% (n=138) of ticks from Sentinel Veterinary Clinics were Black-legged
- 40% (n=40) of ticks from humans were Black-legged
- One Black-legged tick from a human submission was positive for *Borrelia burgdorferi*, but it was later determined the tick had been found on a dog.

Three human cases of Lyme disease were identified in Grey Bruce in 2017, **but none were the result of local exposure to ticks.**

Passive surveillance activities will continue in 2018. In addition, active surveillance in the form of [tick dragging](#) will be carried out in selected areas. While passive surveillance identifies the presence of Black-legged ticks in a specific locale, it cannot determine whether these ticks are incidentals that have dropped from migratory birds or whether they represent an active breeding population. Tick dragging attempts to establish the ongoing presence of ticks at various times of the year which would confirm the existence of a breeding population.

Consultation was undertaken with PHO with regard to expanding bacterial testing of ticks to include those from sentinel veterinary clinics. As the provincial laboratory does not test ticks from a non-human host, this service would have to be contracted from a private lab, at cost. Noting the current level of bacterial monitoring of human-derived ticks is adequate, it was felt that the cost to expand testing could not be justified. It was agreed that any knowledge gained would not significantly affect the delivery of the program. While there may be academic interest in knowing more about the prevalence of *Borrelia* in the local Black-legged tick population, such knowledge would not alter the key prevention strategy which is public messaging that: *Black-legged ticks are prevalent in Grey Bruce. At any point in time, they may be carriers of Lyme disease bacteria. Therefore, measures to guard against ticks should always be taken.*

West Nile virus

West Nile virus (WNV) is transmitted through the bite of an infected mosquito. Approximately 80% of those infected with WNV show no symptoms. Of the 20% that show symptoms, most experience mild self-resolving flu-like illness. Less than 1% of those infected with WNV experience severe illness involving the central nervous system.

WNV activity in Ontario is tracked via health unit mosquito trapping and by monitoring the incidence of reported human and equine cases. Last year saw a significant upsurge of mosquitos across the province testing positive for WNV as well as a marked increase in the number of human and equine cases. In Grey Bruce, a pilot trapping project was initiated mid-season in response to this resurgence. Trapping identified mosquitos capable of transmitting WNV but no specimens were positive for the virus. However, a trap maintained by Health Canada within Grey Bruce did yield positive mosquitos. Three reported human cases of WNV were locally-acquired with a fourth case possibly locally-acquired. Several locally-acquired equine cases were also identified.

Based on these findings, a comprehensive mosquito trapping program, developed in consultation with Public Health Ontario (PHO), will be undertaken this year. A series of traps will be operated across the south of Grey Bruce with additional “jump over” traps located at sites north of the main series. Trapping results combined with human/equine case reporting will be tracked and will be used to inform public messaging. The province is not recommending large-scale mosquito control measures using larvacides/pesticides at this time. However, consideration of such measures could occur if a significant increase in severe human cases of WNV is identified.

Eastern equine encephalitis virus

Like WNV, eastern equine encephalitis virus (EEEV) is transmitted through the bite of an infected mosquito. However unlike WNV, a significantly larger proportion of people infected with EEEV develop life-threatening symptoms and serious, chronic outcomes. EEEV activity is currently sporadic with only a few equine cases identified each year province-wide. Only one human case, identified in 2016, has been reported in the province. Last year, two equine cases of EEEV were identified in Ontario with one of occurring in Grey Bruce.

In response to the presence of this equine case in Grey Bruce, staff consulted with PHO to determine if the mosquito trapping program should be modified to include EEEV. PHO's recommendation was to focus trapping efforts on WNV, based on the fact that EEEV activity continues to be low-level/sporadic and therefore equine case surveillance is sufficient. It was also noted that mosquito trap placement for EEEV vector species varies from optimal placement for WNV vector species. Therefore, dedicating traps to EEEV surveillance could negatively affect the efficacy of the WNV surveillance.