

Technical Document: Public Health Accountability Agreement Indicators 2011 - 13

Ministry of Health and Long-Term Care
Public Health Division
Health Promotion Division

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Table of Contents

Introduction	3
Chapter 1 - Indicator # 1. % of high-risk food premises inspected once every 4 months while in operation	5
Chapter 2 - Indicator # 2. % of Class A pools inspected while in operation.....	9
Chapter 3 - Indicator # 3. % of high-risk Small Drinking Water Systems (SDWS) inspections completed for those that are due for inspection	14
Chapter 4 - Indicator # 4. Time between health unit notification of a case of gonorrhea and initiation of follow-up.....	21
Chapter 5 - Indicator # 5. Time between health unit notification of an Invasive Group A Streptococcal Disease (iGAS) case and initiation of follow-up	33
Chapter 6 - Indicator # 6. DEFFERED: % of known high-risk personal services settings inspected annually .	41
Chapter 7 - Indicator # 7. % of vaccine wasted by vaccine type that are stored/administered by the public health unit.....	44
Chapter 9 - Indicator # 9. % of school-aged children who have completed immunizations for hepatitis B, HPV and meningococcus	50
Chapter 10 - Indicator # 10. % of youth (ages 12 – 18) who have never smoked a whole cigarette	55
Chapter 11 - Indicator # 11. % of tobacco vendors in compliance with youth access legislation at the time of last inspection.....	60
Chapter 12 - Indicator # 12. Fall-related emergency visits in older adults aged 65+	65
Chapter 13 - Indicator # 13. % of population (19+) that exceeds the Low-Risk Drinking Guidelines	72
Chapter 14 - Indicator # 14. Baby-Friendly Initiative (BFI) Status.....	80

Introduction

The government is committed to developing and implementing a comprehensive performance management system that is grounded in clear standards and measures that make it possible to evaluate success in the delivery of public health programs and services. As stated in the Capacity Review Committee's report (2006), the performance management system is intended to capture, report on, and respond to the performance of boards of health and health units, and the public health system.

One key strategy has been the development and implementation of Public Health Accountability Agreements between boards of health and the Ministry of Health and Long-Term Care (MOHLTC). The Accountability Agreements set out obligations for the parties for a 3-year period (January 1, 2011 - December 31, 2013). They articulate the respective roles and responsibilities of the parties, specify performance expectations for boards of health, serve as a performance monitoring tool to support and inform continuous quality improvement strategies, and may assist in demonstrating the role that public health plays in the broader health system. The performance expectations for boards of health include a set of performance indicators which will be measured and monitored for the length of the Accountability Agreement.

This document provides technical information for each of the performance indicators included in the 2011-13 Public Health Accountability Agreement. Each chapter describes one of the performance indicators and includes information about the calculation method, data sources, and other relevant technical considerations. Please note that Indicator 6 and Indicator 8 have been deferred for further policy work. As development of Indicator 6: '% of known high risk personal services settings inspected annually' has been progressing, a descriptive chapter has been included for this indicator. However, the chapter for Indicator 8: '% completion of reports related to vaccine wastage by vaccine type that are stored/ administered by other health care providers' is not included in this document at this time as there is a significant amount of policy work required prior to implementation.

The performance indicators are common across all boards of health. Data to support monitoring of these indicators has been drawn from both existing data sources and reporting directly from public health units.

Implementation of two of the indicators included in the Accountability Agreement has been deferred as additional policy work is required before they can be measured: Indicator 6 - inspection of high-risk personal services settings; and Indicator 8 - completion of vaccine wastage reports. Further information related to these two indicators will be provided when available.

Please note that the titles of some of the indicators have been refined in this document, since the Accountability Agreement was finalized (see Appendix D). The revised titles are a better reflection of the data being measured.

If you have any questions about the information in this document, please contact the MOHLTC at PHUIndicators@ontario.ca.

Glossary

Indicator

A measurement that reflects the status of a system. Indicators reveal the direction of a system (a community, the economy, the environment), whether it is going forward or backward, increasing or decreasing, improving or deteriorating, or staying the same¹.

Personal services settings

Settings in which aesthetic services are delivered, such as but not limited to: hairdressing and barber shops; tattoo and body piercing studios; electrolysis; acupuncture; and various aesthetic services².

References

1. National Public Health Performance Standards Program. Acronyms, glossary, and reference terms. Atlanta, GA: Centers for Disease Control and Prevention; 2007 [cited 2008 May 28]. Available from: <http://www.cdc.gov/od/ocphp/nphpsp/documents/glossary.pdf>
2. Ontario. Ministry of Health and Long-Term Care. Infection prevention and control in personal services settings protocol. Toronto, ON: Queen's Printer for Ontario; 2008 [cited 2012 Nov 21]. Available from: http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/infection_prevention_personal_services.pdf.

Chapter 1

Indicator # 1. % of high-risk food premises inspected once every 4 months while in operation

Overview

The *Technical Document: Public Health Accountability Agreement Indicators 2011-13* provides information for each of the performance indicators included in the 2011-13 Public Health Accountability Agreement. This chapter describes the ‘% of high-risk food premises inspected once every 4 months while in operation’ indicator and includes information about the calculation method, data source, and other relevant technical considerations.

If you have any questions about the information in this document, please contact the MOHLTC at PHUIndicators@ontario.ca.

Description

- Monitors the proportion of fixed high-risk food premises that received a routine inspection at least once in each trimester.

Rationale

- High-risk food premises prepare and handle foods where the risk of food-borne illness is high.
- Frequent inspection of high-risk premises is important to ensure adequate monitoring for possible risks of food-borne illness to the population. This is important as a way of reducing the incidence of food borne illnesses¹.

Required Activity Under the OPHS

- The *Food Safety Protocol, 2008* (or as current), under the *Ontario Public Health Standards, 2008* (OPHS) requires that boards of health conduct inspections of all fixed high-risk food premises “not less than once every four months”².

Board of Health Outcomes

The OPHS identify the following board of health outcomes related to this indicator³:

- The board of health achieves timely and effective detection and identification of: food-borne illnesses; their associated risk factors and emerging trends; and unsafe food in food premises.
- Food handlers in food premises handle and manage food in a safe and sanitary manner.
- The board of health mitigates food-borne illness risk.

Data Source

Public Health Unit Reporting to MOHLTC

Data will be collected directly from Ontario's 36 public health units via a reporting template. There is currently no provincial data system that reports on number of high-risk food premises or

inspection frequency. Public health units will be required to provide data for all the data elements identified below.

Formula

$$\left(\frac{\text{\# of fixed high-risk food premises with completed routine inspections once in each 4-month period (i.e. trimester) while in operation during the specified time period}^i}{\text{\# of fixed high-risk food premises in operation during the specified time period}^i} \right) \times 100$$

Data Elements

Numerator:

of fixed high-risk food premises with completed routine inspections once in each 4-month period while in operation during the specified time period:

This includes the number of fixed high-risk food premises that received a routine inspection at least once, any time in each 4-month trimester within the calendar year. The trimesters are divided up as follows:

Trimester 1: January 1 to April 30

Trimester 2: May 1 to August 31

Trimester 3: September 1 to December 31

Denominator:

of fixed high-risk food premises in operation during the specified time period:

This includes all fixed high-risk food premises that were in operation for the full calendar and high-risk food premises that were in operation or categorized as high-risk for part of the year.

Notes

- Includes only food premises which are under the jurisdiction of public health units for the purposes of inspections.
- The numerator and denominator include premises which are open and high-risk for at least one full trimester after their initial inspection.

ⁱ The 'specified time period' will be a 4-month period for calculation of the indicator at the mid-year point and a 12-month period for calculation of the indicator at year-end.

- For premises that open or become high-risk in the calendar year, the numerator includes only premises which received an inspection in each of the full trimesters following that in which the high-risk categorization was determined. For example, if a premise is newly identified as a high-risk premise in March, then it must have received a routine inspection once in trimester 2 and once in trimester 3 to be included in the numerator.
- For premises that closed within the year or became low or moderate risk, the numerator includes only premises which received an inspection in each of the full trimesters preceding that in which the premises closed or changed risk categorization. For example, if a high-risk food premise closed in August, then it must have received a routine inspection in the first trimester to be included in the numerator.
- Excludes premises which open in the last trimester of the calendar year or premises that are newly identified as high-risk in the last trimester (i.e. any premise that opens or becomes high-risk between September 1st and December 31st).
- Excludes premises which open in one trimester and close in the next trimester.
- Excludes transient, temporary and seasonal food premises.
- Excludes additional inspections which are conducted as necessary to follow-up on non-compliance with the Food Premises Regulation⁴, to investigate food-borne illnesses and outbreaks, to investigate consumer complaints, or for food recall-related activities.

Limitations

- There is currently no standardized risk categorization model and the risk categorization of food premises may vary across boards of health.
- Public health units use different inventory management and scheduling systems. The quality of the data is dependent on the ability of data systems to produce the information required and practices of the public health units related to food premises inventory management, scheduling, and record keeping.

References

1. Ontario. Ministry of Health and Long-Term Care. Ontario public health standards: food safety logic model. Toronto, ON: Queen's Printer for Ontario; 2008 [cited 2012 Nov 21]. Available from: http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/fslv.pdf.
2. Ontario. Ministry of Health and Long-Term Care. Food safety protocol. Toronto, ON: Queen's Printer for Ontario; 2008 [cited 2012 Nov 21]. Available from: http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/food_safety.pdf.
3. Ontario. Ministry of Health and Long-Term Care. Environmental health program standards: food safety. In: Ontario public health standards 2008. Toronto, ON: Queen's Printer for Ontario; 2008 [cited 2012 Nov 21]. Available from: http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/ophs_2008.pdf.
4. *Food Premises*, R.R.O. 1990, Reg. 562. Available from: http://www.e-laws.gov.on.ca/html/regs/english/elaws_regs_900562_e.htm

Chapter 2

Indicator # 2. % of Class A pools inspected while in operation

Overview

The *Technical Document: Public Health Accountability Agreement Indicators 2011-13* provides information for each of the performance indicators included in the 2011-13 Public Health Accountability Agreement. This chapter describes the ‘% of Class A pools inspected while in operation’ indicator and includes information about the calculation method, data source, and other relevant technical considerations. Please note that the title of this indicator has been refined since the Accountability Agreement was finalized.

If you have any questions about the information in this document, please contact the MOHLTC at PHUIndicators@ontario.ca.

Description

- This indicator tracks the proportion of year-round Class A pools (including municipal pools) inspected once in every 3 month quarter and Class A seasonal pools inspected at least twice a year while in operation, in accordance with O. Reg. 565¹ and the *Recreational Water Protocol, 2008* (or as current)².

Rationale

- This indicator addresses the requirement for boards of health to inspect pools while in operation in order to monitor risks related to the safety of recreational water settings.
- Regular inspections play a role in providing an opportunity to educate owners/operators on up-to-date methods of ensuring recreational water safety. Therefore, monitoring inspection rates is a way of assessing the reach of health unit activities to educate pool and spa operators and inspect for infractions, both of which are believed to lead to reduced public exposure to water safety risks³.

Required Activity Under the OPHS

- The *Recreational Water Protocol, 2008* (or as current) of the *Ontario Public Health Standards, 2008* (OPHS) requires that boards of health inspect regulated public pools and public spas at least two times per year and no less than once every three months while operating².

Board of Health Outcomes

The OPHS identify the following board of health outcomes related to this indicator⁴:

- Owners/operators of recreational water facilities operate in a safe and sanitary manner.
- The board of health achieves timely and effective detection and identification of water contaminants and illnesses, their associated risk factors, and emerging trends.

Data Source

Public Health Unit Reporting to MOHLTC

Data will be collected directly from Ontario's 36 public health units in via a reporting template. There is currently no provincial data system that reports on number of Class A pools or inspection frequency. Public health units will be required to provide data for all the data elements identified below.

Formula

$$\left(\frac{\begin{array}{l} \text{(# of year-round Class A pools inspected once in every 3 month} \\ \text{quarter during the specified time period}^{\text{i}}) + \\ \text{(# of seasonal Class A pools inspected at least two times per year)} \end{array}}{\begin{array}{l} \text{(# of year-round Class A pools in operation during} \\ \text{the specified time period}^{\text{i}}) + \\ \text{(# of seasonal Class A pools in operation during the calendar year}^{\text{ii}}) \end{array}} \right) \times 100$$

Data Elements

Numerator:

of year-round Class A pools inspected once in every 3 month quarter during the specified time period:

This includes the number of year-round Class A pools that received a routine inspection at least once, any time, in each 3 month quarter. The quarters are divided up as follows:

Quarter 1: January 1 to March 31

Quarter 2: April 1 to June 30

Quarter 3: July 1 to September 30

Quarter 4: October 1 to December 31

of seasonal Class A pools inspected at least two times per year:

This includes the number of seasonal Class A pools that received a routine inspection at least two times, at any time, while operating during the calendar year.

ⁱ The 'specified time period' will be a 6-month period for calculation of the indicator at the mid-year point and a 12-month period for calculation of the indicator at year-end.

ⁱⁱ Seasonal Class A pools are only included in the calculation at year-end. Thus, at year-end, the denominator will include the total # of seasonal Class A pools in operation during the entire calendar year.

Denominator:

of year-round Class A pools in operation during the specified time period:

Includes only Class A pools as defined in O. Reg 565¹ (Public Pools) under the *Health Protection and Promotion Act*³ that were open at some time during the calendar year.

of seasonal Class A pools in operation during the calendar year:

Includes all seasonal Class A pools that were in operation at some time during the calendar year.

Notes

- For year-round pools:
 - For year-round Class A pools that were open only part of the year, the numerator includes the Class A pools that received an inspection in each full quarter that the pool was open. For example, if a new year-round pool opened in April, then it must have received a routine inspection once in quarter 3 and once in quarter 4 to be included in the numerator.
 - For year-round Class A pools that closed in the year, inspections in each of the full quarters preceding that in which the pool closed will be included in the numerator. For example, if a pool closed in September, then it must have received a routine inspection in both the first and second quarters to be included in the numerator.
 - Excludes year-round pools which opened for the first time in the last quarter of the calendar year since a full quarter of operation was not achieved.
 - Excludes year-round pools which closed in the first quarter of the calendar year.
 - Excludes year-round pools which opened in one quarter and closed in the next quarter.
 - Excludes additional inspections in response to opening or reopening after construction, alteration, or closure of more than four weeks' duration, to address non-compliance with regulation, to investigate complaints, and reports of illness or injury and to monitor the safety of the facilities².
- Includes seasonal facilities.
- For seasonal pools there is no minimum time period for seasonal pool openings. All seasonal pools require two inspections during their annual operating period, with the one exception for pools which have unplanned closures.

Limitations

- Seasonal variations in the number of operating pools are expected due to increases in the number of regulated public pools operating during the summer months.
- Public health units use different inventory management and scheduling systems throughout the province. The quality of the data is dependent on the ability of data systems to produce the information required and practices of the public health units related to pools inventory management, scheduling, and record keeping.

Glossary

Class A pools

A Class A pool is:

- i. a pool to which the general public is admitted,
- ii. a pool operated in conjunction with or as a part of the program of a Young Men's Christian Association or similar institution or an educational, instructional, physical fitness or athletic institution supported in whole or in part by public funds or public subscription, or
- iii. a pool operated on the premises of a recreational camp, for use by campers and their visitors and camp personnel¹.

References

1. *Public Pools*, R.R.O. 1990, Reg. 565. Available from:
http://www.e-laws.gov.on.ca/html/regs/english/elaws_regs_900565_e.htm.
2. Ontario. Ministry of Health and Long-Term Care. Recreational water protocol. Toronto, ON: Queen's Printer for Ontario; 2008 [cited 2012 Nov 21]. Available from:
http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/recreational_water.pdf.
3. Ontario. Ministry of Health and Long-Term Care. Ontario public health standards: safe water logic model. Toronto, ON: Queen's Printer for Ontario; 2008 [cited 2012 Nov 21]. Available from:
http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/swlv.pdf.
4. Ontario. Ministry of Health and Long-Term Care. Environmental health program standards. In: Ontario public health standards 2008. Toronto, ON: Queen's Printer for Ontario; 2008. Available from:
http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/ophs_2008.pdf.

Chapter 3

Indicator # 3. % of high-risk Small Drinking Water Systems (SDWS) inspections completed for those that are due for inspection

Overview

The *Technical Document: Public Health Accountability Agreement Indicators 2011-13* provides information for each of the performance indicators included in the 2011-13 Public Health Accountability Agreement. This chapter describes the ‘% of high-risk Small Drinking Water Systems (SDWS) inspections completed for those that are due for inspection’ indicator and includes information about the calculation method, data source, and other relevant technical considerations.

If you have any questions about the information in this document, please contact the MOHLTC at PHUIndicators@ontario.ca.

Description

- Proportion of SDWS with completed inspections of those that have been identified as high risk and are due for inspection in the identified year.

Rationale

- Oversight of SDWS was transferred from the Ministry of Environment (MOE) to MOHLTC on December 1, 2008.
- SDWS inspections are conducted by public health inspectors (PHI) to determine the level of operator compliance with applicable regulation, to assess the safety of the drinking water supply, and to reduce the incidence of water-borne illness.
- Inspections include a risk assessment that assigns a risk level category of high, moderate or low. This allows the PHI to direct the operator to apply specific requirements for water sampling and operational monitoring.
- Upon the completion of the inspection and initial risk assessment, a directive is issued identifying the specific sampling and operational requirements in accordance with O. Reg. 319/08¹.

Required Activity Under the OPHS

- The *Drinking Water Protocol, 2008* (or as current) under the *Ontario Public Health Standards, 2008* (OPHS) requires high risk drinking water systems to have routine risk assessments not less than once every two years².

Board of Health Outcomes

The OPHS identify the following board of health outcomes related to this indicator³:

- The board of health achieves timely and effective detection and identification of water contaminants and illnesses, their associated risk factors, and emerging trends.
- Owners/operators of drinking-water systems operate in a safe and sanitary manner.

Data Source

The Risk Categorization and Assessment Tool (RCat) is a component of an electronic application – Small Drinking Water Information System (SDWIS) used by public health units to gather information while assessing hazards to assign a risk category to SDWS. The system is designed to ensure a consistent approach to risk assessments to determine operational risk levels among public health units.

RCat is based on a multiple barrier approach to drinking water quality protection. Data are collected based on standardized questions organized into six parts (General Information, Source of Water, Treatment of Water, Distribution and Storage, Flow Diagram, Grading System). RCat analyzes data and produces a report of recommended strategies and initiatives at the end of the assessment that includes a risk category for each system based on various predetermined components.

Each SDWS is assigned a risk level of high, moderate, or low which will determine the type of parameter and testing frequency for the purpose of ongoing monitoring. This risk category also establishes when the system is due for inspection in accordance with the requirements of the *Drinking Water Protocol, 2008* (or as current)². That is, if it is a high-risk system, the PHI will go back to conduct an inspection in two years; whereas, if it is a low or moderate risk system, the PHI may go back in four years. For the purposes of this indicator, the risk assessment finalized date in RCat will be used to assess the # of high-risk SDWS with completed inspections.

Formula

$$\left(\frac{\text{\# of high-risk SDWS with completed inspections in the specified time period}^1}{\text{\# of high-risk SDWS due for an inspection in the calendar year}} \right) \times 100$$

Data Elements

Numerator:

of high-risk SDWS with completed inspections in the specified time period:

The numerator includes the total number of high-risk SDWS identified as due for inspection (see ‘Denominator’ below) that were inspected in the specified time period. These systems are identified in RCat using the ‘Risk Category’ and the ‘Finalized Date’ data fields (see Appendix).

¹ The ‘specified time period’ will be a 6-month period for calculation of the indicator at the mid-year point and a 12-month period for calculation of the indicator at year-end.

Denominator:

of high-risk SDWS due for an inspection in the calendar year:

Boards of health are required to maintain an inventory of all regulated drinking water systems within the health unit².

The denominator includes those small drinking water systems that are due or overdue for an inspection in the calendar year. This includes high-risk systems that received their initial inspection or most recent inspection at least two years earlier as of January 1 of the calendar year. These systems are identified in RCat using the ‘Risk Category’ and the ‘Finalized Date’ data fields (see Appendix).

Notes

- Systems identified as ‘Inactive’ in RCat are excluded from the calculation of this indicator.
- A high-risk SDWS is considered to be eligible for inclusion when it has received an inspection at any time in the calendar year that is two years prior to the year of measurement and has not had an inspection in the interim. For example, a high-risk SDWS that received an inspection in January 2010 would be included in the denominator for 2012 if it did not receive an inspection in 2011.
- The Appendix provides the criteria for inclusions and exclusions of SDWS in the denominator and example scenarios for the 2012 calendar year.
- The specific date (i.e. day and month) that the SDWS had an inspection is not relevant for the calculation of this indicator. For example, a SDWS that had an inspection in January 2010 may have an inspection at any time in 2012 to be included in the numerator.
- Public health units that do not have any SDWS or do not have any ‘Active’ high-risk SDWS will not have a result for this indicator.
- The indicator measures routine inspections and does not include non-routine inspections (owner/operator requested, complaint or incident generated).

Limitations

- RCat does not capture the date a directive is issued. The date the risk category was finalized in RCat is used to determine whether a system will be included in the numerator and/or denominator. In cases where there is a significant lag in the time between the date of the actual risk assessment and the date of the information entry into RCat, a system may be captured as assessed in a different time period than was true for the actual risk assessment. This situation can be mitigated by health units ensuring that record keeping in RCat is kept up to date.
- It is the responsibility of public health unit staff to ensure system optimization and maintenance of records to ensure data accuracy.

Glossary

Inspection

A scheduled on site visit for the purpose of conducting one or all activities that may occur during the visit:

- Observation of system performance for compliance with O.Reg. 319/08;
- Conducting risk assessments and assigning (or re-assigning) a risk category;
- Collecting drinking water samples;
- Identifying upgrades or deficiencies to the SDWS that may affect the risk category; or
- Providing education and supporting information to the SDWS operator.

The inspection may also be referred to as “routine inspection”, “scheduled inspection”, “compliance inspection”, and “mandatory inspection”.

Re-assessment

Any assessment being done for the purposes of follow-up to outstanding items or review of an intervention from a previously conducted risk assessment or re-assessment.

Re-inspection

Means an activity carried out for the purpose of follow-up to outstanding items from a prior inspection or re-inspection.

Risk Assessment

An activity to appraise or investigate the operation and performance of a SDWS system that assigns or changes a risk level category.

Small drinking water system

A small drinking water system as defined in O. Reg. 318/08⁴ (Transitional-Small Drinking Water Systems) and O. Reg. 319/08¹ (Small Drinking Water Systems) under the *Health Protection and Promotion Act*⁵.

References

1. *Small Drinking Water Systems*, O. Reg. 319/08. Available from: http://www.e-laws.gov.on.ca/html/regs/english/elaws_regs_080319_e.htm.
2. Ontario. Ministry of Health and Long-Term Care. Drinking water protocol. Toronto, ON: Queen’s Printer for Ontario; 2008 [cited 2012 Nov 21]. Available from: http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/drinking_water.pdf.
3. Ontario. Ministry of Health and Long-Term Care. Environmental health program standards. In: Ontario public health standards 2008. Toronto, ON: Queen’s Printer for Ontario; 2008 [cited 2012 Nov 21]. Available from: http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/ophs_2008.pdf.
4. *Transitional – Small Drinking Water Systems*, O. Reg. 318/08. Available from: http://www.e-laws.gov.on.ca/html/regs/english/elaws_regs_080318_e.htm.
5. *Health Protection and Promotion Act*, R.S.O. 1990, c. H.7. Available from: http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90h07_e.htm.

Appendix: Derivation of Denominator for 2012 Calendar Year

Criteria for Identifying Systems to be Included in the Denominator:

1. Create a single listing for each SDWS which are identifiable using the ‘SDWS#’ data field. The listing should include the ‘Finalized Date’ and ‘Risk Category’ data fields for each completed inspection.
2. Sort SDWS by year of initial inspection.
3. Exclude all SDWS with initial inspections in 2011 and 2012.
4. Exclude all SDWS with an inspection in 2011.
5. Exclude all SDWS that had an initial or re-inspections in 2009 or 2010 which resulted in a low or medium risk designation.

Table 1: Example Scenarios

	2009	2010	2011	2012	2013	Include in Denominator?
1a	Initial Risk assessment categorizes premise as high-risk (next due in 2011)		Inspected on schedule, still categorized as high-risk (next due in 2013)		Inspection due	Exclude
1b	Initial Risk assessment categorizes premise as high-risk (next due in 2011)		Inspected on schedule, risk category lowered (next due in 2015)			Exclude
1c	Initial Risk assessment categorizes premise as high-risk (next due in 2011)	Inspected a year early, still categorized as high-risk (next due in 2012)		Inspection due		Include
1d	Initial Risk assessment categorizes premise as high-risk (next due in 2011)		Inspection due but none completed	Inspection due		Include

*Technical Document: Public Health Accountability Agreement Indicators 2011-13
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	2009	2010	2011	2012	2013	Include in Denominator?
2a		Initial Risk assessment categorizes premise as high-risk (next due in 2012)		Inspection due		Include
2b		Initial Risk assessment categorizes premise as high-risk (next due in 2012)	Inspected a year early, still categorized as high-risk (next due in 2013)		Inspection due	Exclude
2c		Initial Risk assessment categorizes premise as high-risk (next due in 2012)	Inspected a year early, risk category lowered (next due in 2015)			Exclude
3a			Initial Risk assessment categorizes premise as high-risk (next due in 2013)		Inspection due	Exclude
3b			Initial Risk assessment categorizes premise as high-risk (next due in 2013)	Inspected a year early, still categorized as high-risk (next due in 2014)		Exclude
3c			Initial Risk assessment categorizes premise as high-risk (next due in 2013)	Inspected a year early, risk category lowered (next due in 2016)		Exclude

Chapter 4

Indicator # 4. Time between health unit notification of a case of gonorrhoea and initiation of follow-up

Overview

The *Technical Document: Public Health Accountability Agreement Indicators 2011-13* provides information for each of the performance indicators included in the 2011-13 Public Health Accountability Agreement. This chapter describes the ‘Time between health unit notification of a case of gonorrhoea and initiation of follow-up’ indicator and includes information about the calculation method, data source, and other relevant technical considerations.

If you have any questions about the information in this document, please contact the MOHLTC at PHUIndicators@ontario.ca.

Description

- Proportion of confirmed gonorrhoea cases where initiation of follow-up occurred within 2 business days.

Rationale

- This indicator monitors the timeliness of public health unit follow-up on confirmed cases of gonorrhoea.
- Timeliness is a critical aspect of effective public health case management to ensure cases and contacts receive prompt treatment and to reduce the secondary spread of infections.
- Current best practice recommendations in Ontario specify that initiation of contact with the health care provider or case should occur as soon as possible, ideally within 2 business days, after the public health unit receives laboratory confirmation of *Neisseria gonorrhoeae* (*N.gonorrhoeae*) in an appropriate clinical specimen¹.

Required Activity Under the OPHS

- Appropriate public health case management and timely case management as described in the Infectious Diseases Prevention and Control Standard² and the *Infectious Diseases Protocol, 2008* (or as current)³, including the disease-specific chapter for gonorrhoea of the *Ontario Public Health Standards, 2008* (OPHS)².
- The Sexually Transmitted Infections Case Management and Contact Tracing Best Practice Recommendations from the Provincial Infectious Diseases Advisory Committee states that contact should be initiated within two business days¹.

Board of Health Outcomes

- The OPHS identify two board of health outcomes related to this indicator:
 - The board of health achieves timely and effective detection and identification of cases of sexually transmitted infections and blood-borne infections, and their associated risk factors and emerging trends.
 - The board of health manages reported cases and contacts of sexually transmitted infections and blood-borne infections.

Data Source

Integrated Public Health Information System

In Ontario, the integrated Public Health Information System (iPHIS) is used for reporting information on all reportable diseases as described in Ontario Regulation 569⁴ of the *Health Protection and Promotion Act* (HPPA)⁵. The HPPA requires that each public health unit in Ontario collect information on reportable diseases in their jurisdiction and report it to the Ministry of Health and Long-Term Care or as specified by the Ministry, to the Ontario Agency for Health Protection and Promotion (Public Health Ontario). This information is used for local, provincial and national surveillance.

The most common source of case identification to public health units is through laboratory notification of confirmed test results (e.g. serology, microbiology cultures, etc.). Physicians are required to report cases that fulfill laboratory or clinical case definitions.

Formula

$$\left(\frac{\text{Total number of confirmed gonorrhoea cases with initiation of follow-up within 2 business days in the specified time period}^i}{\text{Total number of confirmed gonorrhoea cases in the specified time period}^i} \right) \times 100$$

Data Elements

Numerator:

Total number of confirmed gonorrhoea cases with initiation of follow-up within 2 business days in the specified time period:

The total number of confirmed gonorrhoea cases with initiation of follow-up within 2 business days is calculated using the “encounter date” field and the “investigation start date” field in iPHIS. This numerator consists of the number of cases that have a difference of less than 2 days between “encounter date” and “investigation start date” after **excluding** weekends and holidays.

However, the calculation currently being applied by Public Health Ontario to exclude weekends cannot exclude statutory holidays. For holidays to be excluded from the numerator, public health units must identify them to the MOHLTC. Please see the Limitations section for further details.

The “encounter date” field is a mandatory iPHIS field and is defined as the date that the diagnosing health unit was first notified of the client’s encounter with the health unit. The “investigation start date” is a required iPHIS field and is defined as the date of first attempt to contact the client or physician for follow-up. If two public health units are involved, the date

ⁱ The ‘specified time period’ will be a 6-month period for calculation of the indicator at the mid-year point and a 12-month period for calculation of the indicator at year-end.

entered is the date the first public health unit started the investigation. Further information on the use of the “encounter date” and “investigation start date” fields can be found in Public Health Ontario’s *Definitions of Encounter Date and Investigation Start Date in iPHIS*⁶ document which was released with iPHIS Notice #319 (see Appendix A and Appendix B).

Cases missing data in one or both fields are excluded from this numerator.

Denominator:

Total number of confirmed gonorrhoea cases in the specified time period:

This denominator is calculated by identifying the total number of confirmed cases of *N. gonorrhoeae* infection in the specified time period in iPHIS. Cases were identified as confirmed if they were classified as “Confirmed” in the “Diagnosis Status” field.

The denominator includes cases missing data in either field.

Notes

- Public health units have been provided with a CRN report via each health unit’s folder in the Custom Environment for CRN 2.0 (iPHIS Notice #312) to extract data for this indicator.
- The provincial case definition for gonorrhoea appears in the appendix of the *Infectious Diseases Protocol, 2009* (or as current)³.
- Initiation of follow up includes an attempt at contact with either the case or a health care provider involved with the case. Initiation of follow up can include a range of activities including leaving messages via phone calls or email messages to clients.
- Cases missing information in the “investigation start date” or “encounter date” fields are treated as a data entry issue and will be included in the denominator but not in the numerator (i.e. included in the formula but not considered followed-up within 0-2 days).
- Cases with negative time to follow-up (e.g. the initiation of follow-up occurred before the encounter date) will be included in the numerator and denominator.

Limitations

- It is possible that cases may be double-counted; however, the duplicate management system in iPHIS should reduce the duplicates both within and among public health units.
- The calculation currently being applied to exclude weekends cannot exclude statutory holidays. If a public health unit identifies a case where the follow-up period fell over a holiday, it may contact PHUIndicators@ontario.ca to adjust the calculation accordingly.

References

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http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90h07_e.htm.
6. Ontario Agency for Health Protection and Promotion (Public Health Ontario). Definitions of encounter date and investigation start date in iPHIS. Toronto, ON; Queen's Printer for Ontario; 2012.

Appendix A: iPHIS Report Information (As provided by Public Health Ontario, November 2012)

Purpose:

The purpose of this document is to provide information on the reports used to generate the data from iPHIS for the Accountability Agreement indicators that are based on iPHIS data. The relevant indicators are as follows:

- Time between health unit notification of a case of gonorrhoea and initiation of follow-up

Table 2: Gonorrhoea Report fields and definitions

CRN Field Name	Required Field?	iPHIS Field Name	Definition
Client ID	N/A	Client ID	Unique client identifier
STD Encounter ID	N/A	Encounter ID	Unique encounter identifier
Encounter Date	Y	Encounter Date	The date that the diagnosing health unit was first notified of the client's encounter. E.g. through phone call, from physician, lab slip.
Created Date	N/A	N/A	System generated date that is set to the date the case created in iPHIS
Investigation Start Date	Y	Investigation Start Date	The date of first attempt to contact the client or physician. If two HUs are involved, this is the date the first HU started the investigation.
Time to initiation of follow-up	N/A	N/A	Calculated based on the Investigation Start Date minus the Encounter Date and expressed in days

CRN Field Name	Required Field?	iPHIS Field Name	Definition
Work Days Between Investigation and Encounter Date	N/A	N/A	Calculates the number of work days between when the case was reported to the health unit and the initiation of follow up. Calculated using the following formula: $((\text{cast}(_days_between([\text{Investigation Start Date}],1900-01-01)/7,\text{integer}) * 5) + \text{if}(_day_of_week([\text{Investigation Start Date}],1) > 5) \text{ then } (4) \text{ else } (\text{mod}(_days_between([\text{Investigation Start Date}],1900-01-01),7) + 1)) - ((\text{cast}(_days_between([\text{Encounter Date}],1900-01-01)/7,\text{integer}) * 5) + \text{if}(_day_of_week([\text{Encounter Date}],1) > 5) \text{ then } (4) \text{ else } (\text{mod}(_days_between([\text{Encounter Date}],1900-01-01),7) + 1)) + (\text{if}(_day_of_week([\text{Encounter Date}],1) > 5) \text{ then } (-1) \text{ else } (0))$
Responsible Health Unit Area Description	Y	HU	The health unit responsible for case management.
Disease	Y	Disease Code	Specifies the disease the case has.
Diagnosis Status	Y	Status	Select “Confirmed” if case meets definition.
Encounter Status	Y	Encounter Status	Set to the value reflecting the status of the investigation (e.g. Open, Closed etc).

Table 3: Filter Logic Applied to the Gonorrhea Report

Filter Name	Purpose of Filter	Predefined Filter?	Filter Logic
Confirmed Case Filter	Restricts report to only confirmed cases	Yes = [STD Encounters Reporting].[Confirmed Case]	[STD Encounters Reporting].[STD Encounter Details].[Encounter Type] = 'CASE' AND [STD Encounters Reporting].[STD Encounter Diagnosis].[Diagnosis Status] = 'CONFIRMED'
Disease Filter	Restricts report to only cases of gonorrhea	No	[STD Encounters Reporting].[STD Encounter Diagnosis].[Disease]= 'GONORRHOEA (ALL TYPES)'
Date Filter	Restricts report to STD encounters that have encounter dates within the specified range	No	[STD Encounters Reporting].[STD Encounter Details].[Encounter Date] in_range ?Encounter Date?
Encounter Status Filter	Removes records that are marked as entered in error or were duplicate records	No	[STD Encounters Reporting].[STD Encounter Details].[Encounter Status] not in ('CLOSED - DUPLICATE - DO NOT USE', 'CLOSED - ENTERED IN ERROR')
Health Unit Filter	Only for particular tabs. Restricts the results to the health unit responsible for case management as appropriate	No	[STD Encounters Reporting].[STD Encounter Details].[Responsible Health Unit Area Description] = <i>'Health Unit Name as appropriate'</i>

Appendix B: Definitions of Encounter Date and Investigation Start Date in iPHIS

DISCLAIMER: THIS DOCUMENT IS NOT PART OF THE TECHNICAL DOCUMENT: PUBLIC HEALTH ACCOUNTABILITY AGREEMENT INDICATORS 2011 – 13 AND IS INCLUDED AS AN APPENDIX. THIS DOCUMENT WAS CREATED BY THE ONTARIO AGENCY FOR HEALTH PROTECTION AND PROMOTION (PUBLIC HEALTH ONTARIO). THE FORMAT HAS BEEN MODIFIED FOR POSTING ON THE GOVERNMENT OF ONTARIO WEBSITE.

REFERENCE: Ontario Agency for Health Protection and Promotion (Public Health Ontario). Definitions of encounter date and investigation start date in iPHIS. Toronto, ON; Queen’s Printer for Ontario; 2012.

Definitions of Encounter Date and Investigation Start Date in iPHIS

Issue

The current definitions for Encounter Date and Investigation Start Date in iPHIS have been found to be used inconsistently through the analysis of data for the Accountability Agreement Indicators. Mostly this has been with respect to gonorrhea and what date to input when a client visits a health unit's STI clinic.

For example:

A case presenting at an STI clinic on April 1 has that date recorded as the Encounter Date, but the investigation start date is recorded as April 9, after receipt of the confirmatory laboratory test results at the health unit and subsequent entry into iPHIS. Cases having an encounter date many days earlier than the Investigation Start Date will be flagged by the Ministry of Health and Long-Term Care during their regular Accountability Agreement Indicator data checks.

Definitions

The Encounter Date and Investigation Start Date have corresponding fields in outbreak and TB modules of iPHIS.

The fields Encounter Date and Investigation Start Date are currently defined as follows and will remain as such:

Table 1: Definitions of Encounter Date and Investigation Start Date Fields

Encounter Date	M	Enter the date that the diagnosing health unit was first notified of the client's encounter.
Investigation Start Date	R	Enter the date of first attempt to contact the client or physician. If two HUs are involved, enter the date the first HU started the investigation.

Interpretation and Scenarios

The Encounter Date will be the date that the health unit first became aware of the case, including cases referred to a health unit from outside of Ontario. While this often coincides with the acquisition of a laboratory report the health unit may become aware of a potential case prior to laboratory confirmation of that case.

The Investigation Start Date does not apply to any specific individual contacting the client. It is the date that a health unit employee first attempted to contact the client or physician, regardless of whether the attempt was successful in reaching the client or not.

To clarify the meaning of these definitions the following scenarios and considerations apply:

Scenario 1: The health unit receives laboratory confirmation of a case or is referred a case from outside of Ontario. The case is not in iPHIS. As part of iPHIS entry the health unit will specify the date that the laboratory confirmation was received at the health unit. The health unit then attempts to contact the individual.

In this scenario Encounter Date would be the date the health unit received the laboratory results. The Investigation Start Date would be when the health unit tried to contact the individual or their physician.

Scenario 2: The health unit receives notification of a case from a physician. The case is not in iPHIS. As part of iPHIS entry the health unit will specify the date that the physician notified the health unit. The health unit then attempts to contact the individual.

In this scenario Encounter Date would be the date the health unit was notified of the case by the physician. The Investigation Start Date would be when the health unit tried to contact the individual or the physician.

Scenario 3: The health unit receives information of a contact of a confirmed case. The contact is in iPHIS. The health unit attempts to contact the contact. Later, the contact tests positive and becomes a confirmed case.

In this scenario Encounter Date would be the date the health unit received information of the contact. The Investigation Start Date would be when the health unit tried to contact the contact. In this case a zero day lead time to investigation start may be generated. This is ok, and is in fact an indication that the contact tracing conducted by the health unit was timely.

Scenario 4: The client visits the health unit's STI clinic; samples are taken and sent for testing. The health unit receives notification that the client has tested positive and is now considered a case.

In this scenario the Encounter Date would be the date that the health unit received the laboratory results. The Investigation Start Date would be when the individual first visited the health unit's STI clinic in relation to this encounter. In this case, a negative time to investigation start would be generated. This is ok, as it reflects accurately the case investigation.

Scenario 5: The diagnosing health unit receives a forwarded laboratory slip from another health unit. The case is not in iPHIS. As part of iPHIS entry the health unit will specify the date that the laboratory confirmation was received at the health unit. The health unit then attempts to contact the individual.

In this scenario Encounter Date would be the date the health unit received the laboratory confirmation. The Investigation Start Date would be when the health unit tried to contact the individual or the physician.

Scenario 6: The diagnosing health unit receives a forwarded laboratory slip from another health unit. The case is in iPHIS.

In this scenario, the Encounter Date does not need to be changed. Verify whether the client or the physician was contacted by the referring health unit.

If yes, the Investigation Start Date is when the attempted contact occurred by the referring health unit.

If no, the Investigation Start Date is when the health unit receiving the referral attempts to contact the client or the physician.

Chapter 5

Indicator # 5. Time between health unit notification of an Invasive Group A Streptococcal Disease (iGAS) case and initiation of follow-up

Overview

The *Technical Document: Public Health Accountability Agreement Indicators 2011-13* provides information for each of the performance indicators included in the 2011-13 Public Health Accountability Agreement. This chapter describes the ‘Time between health unit notification of an Invasive Group A Streptococcal Disease (iGAS) case and initiation of follow-up’ indicator and includes information about the calculation method, data source, and other relevant technical considerations.

If you have any questions about the information in this document, please contact the MOHLTC at PHUIndicators@ontario.ca.

Description

- Proportion of confirmed iGAS cases where initiation of follow-up occurred on the same day as receipt of lab confirmation of a positive case.

Rationale

- Monitoring timeliness of public health response to lab confirmed cases of iGAS is important because iGAS poses a significant burden of disease and timeliness of response is key in efforts to reduce the spread of illness.
- The *Infectious Diseases Protocol, 2008* (or as current) specifies that investigation of reported iGAS cases should begin as soon as possible after receiving a report¹. National guidelines also emphasize the importance of immediate follow-up with cases, contacts and involved health care providers².

Required Activity Under the OPHS

- Appropriate public health case management as described in the *Infectious Diseases Prevention and Control Standard*² and the *Infectious Diseases Protocol, 2008* (or as current), including the disease-specific chapter for iGAS¹.
- Investigation of reported cases should begin as soon as possible after receiving a report.

Board of Health Outcomes

- The *Ontario Public Health Standards, 2008*² identify two board of health outcomes related to this indicator:
 - The board of health achieves timely and effective detection and identification of cases/outbreaks of infectious diseases of public health importance, their associated risk factors and emerging trends.
 - The board of health manages reported cases of infectious diseases of public health importance and their contacts.

Data Source

Integrated Public Health Information System (iPHIS)

In Ontario, the integrated Public Health Information System (iPHIS) is used for reporting information on all reportable diseases as described in Ontario Regulation 569³ of the *Health Protection and Promotion Act* (HPPA)⁴. The HPPA requires that each public health unit in Ontario collect information on reportable diseases in their jurisdiction and report it to the Ministry of Health and Long-Term Care or as specified by the Ministry, to the Ontario Agency for Health Protection and Promotion (Public Health Ontario). This information is used for local, provincial and national surveillance.

The most common source of case identification to public health units is through laboratory notification of confirmed test results (e.g. serology, microbiology cultures, etc.). Physicians are required to report cases that fulfill laboratory or clinical case definitions.

Formula

$$\left(\frac{\text{Total number of confirmed iGAS cases in the specified time period}^1 \text{ with initiation of follow-up on the same day as receipt of lab confirmation of a case}}{\text{Total number of iGAS cases in the specified time period}^i} \right) \times 100$$

Data Elements

Numerator:

Total number of confirmed iGAS cases in the specified time period with initiation of follow-up on the same day as receipt of lab confirmation of a case:

The total number of confirmed iGAS cases with initiation of follow-up on the same day is calculated using the “reported date” field and the “investigation start date” field in iPHIS⁵. This numerator consists of the number of cases that have a difference of 0 days between “reported date” and “investigation start date”.

Please note that the numerator consists of the number of cases with initiation of follow-up on the same date not cases with initiation of follow-up within 24 hours.

The “reported date” field is a mandatory iPHIS field and is defined as the date that the diagnosing health unit was first notified of the client’s episode/encounter/case. The “investigation start date” is a required iPHIS field and is defined as the date of first attempt to contact the client or physician. Further information on the use of the “reported date” and

¹ The ‘specified time period’ will be a 6-month period for calculation of the indicator at the mid-year point and a 12-month period for calculation of the indicator at year-end.

“investigation start date” fields can be found in Public Health Ontario’s *Definitions of Encounter Date and Investigation Start Date in iPHIS*⁶ document which was released with iPHIS Notice #319.

Cases missing data in one or both fields are excluded from this numerator.

Denominator:

Total number of confirmed iGAS cases in the specified time period:

The denominator is calculated by identifying the total number of confirmed cases of iGAS in the specified time period in iPHIS. Cases were identified as confirmed if they were classified as “Confirmed” in the “Classification” field.

The denominator includes cases with missing data in either field.

Notes

- Public health units have been provided with a CRN report via each health unit’s folder in the Custom Environment for CRN 2.0 (iPHIS Notice #312) to extract data for this indicator.
- Note that this calculation **includes** weekends and holidays.
- The provincial case definition for iGAS appears in the appendix of *the Infectious Diseases Protocol, 2008* (or as current)¹.
- Initiation of follow up includes contact with either the client or a health care provider involved with the case.
- Cases missing information in the “investigation start date” or “reported date” fields are treated as a data entry issue and will be included in the denominator but not in the numerator (i.e. included in the formula but not considered followed-up on the same day).
- Cases with negative time to follow-up (e.g. the initiation of follow-up occurred before the encounter date) will be treated as appropriate case management and will be included in the numerator and denominator.

Limitations

- It is possible that cases may be double-counted; however, the duplicate management system in iPHIS should reduce the duplicates both within and among public health units.

References

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http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90h07_e.htm.
5. Ontario. Ministry of Health and Long-Term Care. iPHIS user guide, respiratory user guide - section V -sporadic group A streptococcus disease, invasive cases. Toronto, ON: Queen's Printer for Ontario; 2009.
6. Ontario. Ministry of Health and Long-Term Care. Definitions of encounter date and investigation start date in iPHIS. Toronto, ON: Queen's Printer for Ontario; 2008.

Appendix: iPHIS Report Information (As provided by Public Health Ontario, November 2012)

Purpose:

The purpose of this document is to provide information on the reports used to generate the data from iPHIS for the Accountability Agreement indicators that are based on iPHIS data. The relevant indicators are as follows:

- Time between health unit notification of an iGAS case and the initiation of follow-up.

Table 1: iGAS Report Fields and Definitions

CRN Field Name	Required Field?	iPHIS Field Name	Definition
Case ID	Y	Case ID	Unique case identifier
Case Reported Date	Y	Reported Date	The date that the diagnosing health unit was first notified of the client's case. E.g. through phone call, from physician, lab slip.
Created Date	N/A	N/A	System generated date that is set to the date the case created in iPHIS
Investigation Start Date	Y	Investigation Start Date	The date of first attempt by the health unit to contact the client or physician. If two HUs are involved, this is the date the first HU started the investigation.
Time to initiation of follow-up	N/A	N/A	Calculated based on the Investigation Start Date minus the Encounter Date and expressed in days

CRN Field Name	Required Field?	iPHIS Field Name	Definition
Work Days between Investigation and Case Reported Date	N/A	N/A	<p>Calculates the number of work days between when the case was reported to the health unit and the initiation of follow up. Calculated using the following formula:</p> <pre> ((cast(_days_between([Investigation Start Date],1900-01-01)/7,integer)*5)+if(_day_of_week([Investigation Start Date],1)>5) then (4) else (mod(_days_between([Investigation Start Date],1900-01-01),7))+1) - ((cast(_days_between([Case Reported Date],1900-01-01)/7,integer)*5)+if(_day_of_week([Case Reported Date],1)>5) then (4) else (mod(_days_between([Case Reported Date],1900-01-01),7))+1) + (if(_day_of_week([Case Reported Date],1)>5) then (-1) else (0)) </pre>
Responsible Health Unit Area Description	Y	Health Unit Responsible	Auto-populates the HU responsible for case management.
Disease Description	Y	Disease	Specifies the disease the case has
Classification Description	Y	Classification	CONFIRMED: Select if the case meets the case definition for invasive GAS.
Disposition Description	Y	Disposition	Set to the value reflecting the status of the investigation (e.g. Open, Closed etc).

Table 2: Filter Logic Applied to the iGAS Report

Filter Name	Purpose of Filter	Predefined Filter?	Filter Logic
Confirmed Case Filter	Restricts report to only confirmed cases	Yes = [STD Encounters Reporting].[Confirmed Case]	[STD Encounters Reporting].[STD Encounter Details].[Encounter Type] = 'CASE' AND [STD Encounters Reporting].[STD Encounter Diagnosis].[Diagnosis Status] = 'CONFIRMED'
Disease Filter	Restricts report to only cases of gonorrhea	No	[STD Encounters Reporting].[STD Encounter Diagnosis].[Disease]='GONORRHOEA (ALL TYPES)'
Date Filter	Restricts report to STD encounters that have encounter dates within the specified range	No	[STD Encounters Reporting].[STD Encounter Details].[Encounter Date] in_range ?Encounter Date?
Encounter Status Filter	Removes records that are marked as entered in error or were duplicate records	No	[STD Encounters Reporting].[STD Encounter Details].[Encounter Status] not in ('CLOSED - DUPLICATE - DO NOT USE', 'CLOSED - ENTERED IN ERROR')
Health Unit Filter	Only for particular tabs. Restricts the results to the health unit responsible for case management as appropriate	No	[STD Encounters Reporting].[STD Encounter Details].[Responsible Health Unit Area Description] = <i>'Health Unit Name as appropriate'</i>

Chapter 6

Indicator # 6. DEFFERED: % of known high-risk personal services settings inspected annually

Overview

The *Technical Document: Public Health Accountability Agreement Indicators 2011-13* provides information for each of the performance indicators included in the 2011-13 Public Health Accountability Agreement. This chapter describes the deferred indicator ‘% of known high-risk personal services settings inspected annually’ and includes the rationale for deferring it. Further detail will be provided regarding the calculation of this indicator when it is implemented.

If you have any questions about the information in this document, please contact the MOHLTC at PHUIndicators@ontario.ca.

Description

- Intended to monitor the frequency of required inspections of “high-risk” personal services settings (e.g. hair salons, tattoo parlours, etc.) in order to assess compliance with the *Ontario Public Health Standards, 2008*¹ (OPHS).

Rationale

- Personal services can involve the risk of transmission of blood-borne and other infections for both clients and staff. Frequent monitoring of these premises is important to help reduce the spread of disease.

Required Activity Under the OPHS

- Routine inspections of all personal services settings are required at least once a year.
- Under the OPHS personal services settings are defined as: “settings in which aesthetic services are delivered, such as but not limited to: hairdressing and barber shops; tattoo and body piercing studios; electrolysis; acupuncture; and various aesthetic services”.
- The *Infection Prevention and Control in Personal Services Settings Protocol, 2008* (or as current)² does not define “high risk” personal services settings but does require boards of health to “incorporate risk assessments into the yearly inspection process, and when investigating potential health hazards in personal services settings.”

Board of Health Outcomes

The OPHS identify the following board of health outcomes related to this indicator:

- Settings that are required to be inspected are aware of appropriate infection prevention and control practices.
- There is increased public awareness of infection prevention and control practices.
- The board of health achieves timely and effective detection and identification of cases/outbreaks of infectious diseases of public health importance, their associated risk factors and trends.

Rationale for Deferring this Indicator

- There is no consistent definition of a “high-risk personal services setting” available. Additionally, the following issues have been identified:
 - A setting may be identified as “high risk” not solely based on the types of procedures performed, but also based on infection prevention and control practices; and,
 - Risk of blood borne infections is not the only consideration when trying to identify a high risk setting. Risk of bacterial and other infections may also be considered.
- A definition of a “high-risk personal services setting” for use across the province is currently being developed under the direction of the Infection Risk Assessment for Personal Services Settings Working Group. The Working Group includes representatives from several health units across the province, Public Health Ontario and the ministry.
- The Working Group has been reviewing available evidence in the development of an Infection Risk Assessment for Personal Services Settings (IRA-PSS) tool.
- Indicator derivation can be completed once the IRA-PSS tool is completed.

Glossary

Personal services settings

Settings in which aesthetic services are delivered, such as but not limited to: hairdressing and barber shops; tattoo and body piercing studios; electrolysis; acupuncture; and various aesthetic services².

References

1. Ontario. Ministry of Health and Long-Term Care. Ontario public health standards 2008. Toronto, ON: Queen's Printer for Ontario; 2008 [cited 2012 Nov 21]. Available from: http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/ophs_2008.pdf.
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Chapter 7

Indicator # 7. % of vaccine wasted by vaccine type that are stored/administered by the public health unit

Overview

The *Technical Document: Public Health Accountability Agreement Indicators 2011-13* provides information for each of the performance indicators included in the 2011-13 Public Health Accountability Agreement. This chapter describes the ‘% of vaccine wasted by vaccine type that are stored/administered by the public health unit’ indicator and includes information about the calculation method, data source, and other relevant technical considerations.

If you have any questions about the information in this document, please contact the MOHLTC at PHUIndicators@ontario.ca.

Description

- Monitors the percentage of wastage of publicly funded vaccines that are stored, transported, or administered by public health units for the following vaccines:
 - HPV (Gardasil); and
 - Influenza.

Rationale

- This indicator relates to the effectiveness of local public health unit vaccine storage, handling and management practices.
- It is believed that there are significant opportunities for cost savings by implementing efforts to reduce vaccine wastage, and this is a priority for the MOHLTC.

Required Activity Under the OPHS

- The *Vaccine Storage and Handling Protocol, 2010* (or as current)¹ requires that vaccine wastage should not exceed five percent for any one product.

Board of Health Outcomes

The *Ontario Public Health Standards, 2008* (OPHS)² identify the following board of health outcomes related to this indicator:

- Health care providers adhere to proper vaccine management, including storage and handling practices and inventory management.
- Vaccines are distributed in an equitable and timely manner that adheres to proper vaccine management, including storage and handling practices.

Data Source

For HPV: Public Health Unit reporting to MOHLTC

Data will be collected directly from health units for this indicator. Although the Ontario Government Pharmaceutical and Medical Supply Service (OGPMSS) maintains the Computer

Assisted Material Management System (CAMMS) which includes information on vaccine returned from public health units to OGPMSS, a number of challenges have been identified with using CAMMS data to measure this indicator. CAMMS data may be used by the MOHLTC for verification purposes.

For Influenza: Public Health Unit reporting to MOHLTC

Data will be collected directly from health units for this indicator. There is currently no data system that identifies vaccine wastage by organization or health care provider. In order to get an accurate value for influenza vaccine wasted that is stored/administered by the public health unit, data must be collected from public health units.

Formulas

$$\left(\frac{\text{\# of HPV vaccine doses wasted by PHU for all reasons in the specified time period}^i}{\text{\# of HPV vaccine doses distributed to PHU in the specified time period}^i - \text{\# of HPV vaccine doses successfully distributed to other health care providers by the PHU in the specified time period}^i - \text{\# of useable doses returned in the specified time period}} \right) \times 100$$

$$\left(\frac{\text{\# of influenza vaccine doses wasted by PHU for all reasons in the calendar year}^{ii}}{\text{\# of influenza vaccine doses distributed to PHU in the calendar year}^{ii} - \text{\# of influenza vaccine doses successfully distributed to other health care providers by the PHU in the calendar year}^{ii} - \text{\# of useable doses returned in the calendar year}^{ii}} \right) \times 100$$

ⁱ The ‘specified time period’ will be a 6-month period for calculation of the indicator at the mid-year point and a 12-month period for calculation of the indicator at year-end.

ⁱⁱ Influenza vaccine wastage will only be calculated at year-end. Thus, the numerator and denominator will be calculated based on the entire calendar year.

Data Elements (HPV)

Numerator:

of HPV vaccine doses wasted by PHU for all reasons in the specified time period:

This includes wasted vaccine doses returned to OGPMS and those not returned to OGPMS. This includes only doses that were wasted while in the care and control of the public health unit, meaning doses that were wasted while being:

- stored by the public health unit,
- administered by the public health unit,
- inadvertently shipped to a health care provider or
- transported from the public health unit to another location (e.g., a school clinic or another health care provider).

Wasted vaccine includes any vaccine that cannot be used¹. This includes vaccine wastage in unopened vials and vaccine wastage in opened (stopper has been punctured) vials:

- Vaccine wastage includes:
 - Expired vaccine;
 - Discarded remaining doses as per the vaccine monograph;
 - Vaccine that cannot be used due to exposure to temperatures below +2°C (e.g., frozen vaccine) or above +8°C for a specific period of time (this will depend on the specific vaccine);
 - Vaccine damage caused by the public health unit;
 - Not being able to withdraw all of the vaccine doses from a multi-dose vial;
 - Suspected contamination; and
 - Issues during vaccine administration (e.g., client pulls away before entire dose is administered)³.

Denominator:

of HPV vaccine doses distributed to PHU in the specified time period:

- This includes the **total** number of doses distributed by OGPMS to the public health unit, as reported by the public health unit.

This data will be collected directly from the public health unit.

of HPV vaccine doses successfully distributed to other health care providers by the PHU in the specified time period:

This includes the vaccine doses that were distributed to other health care providers by the public health unit. Vaccine must be received by the health care provider (this does not include vaccine that was wasted during transit) and ordered by the health care provider. This data will be collected directly from the public health unit.

of useable doses returned in the specified time period:

Number of useable doses returned to OGPMS by the public health unit, as reported by the public health unit.

Data Elements (Influenza)

Numerator:

of influenza vaccine doses wasted by PHU for all reasons in the calendar year:

This includes wasted vaccine doses returned to OGPMS and those not returned to OGPMS. This includes only doses that were wasted while in the care and control of the public health unit, meaning doses that were wasted while being:

- stored by the public health unit,
- administered by the public health unit,
- inadvertently shipped to a health care provider, or
- transported from the public health unit to another location (e.g., a school clinic or another health care provider).

Wasted vaccine includes any vaccine that cannot be used. This includes vaccine wastage in unopened vials and vaccine wastage in opened (stopper has been punctured) vials:

- Vaccine wastage includes:
 - Expired vaccine;
 - Discarded remaining doses as per the vaccine monograph;
 - Vaccine that cannot be used due to exposure to temperatures below +2°C (e.g., frozen vaccine) or above +8°C for a specific period of time (this will depend on the specific vaccine);
 - Vaccine damage caused by the public health unit;
 - Not being able to withdraw all of the vaccine doses from a multi-dose vial;
 - Suspected contamination; and
 - Issues during vaccine administration (e.g., client pulls away before entire dose is administered)³.

Denominator:

of influenza vaccine doses distributed to PHU in the calendar year:

- This includes the **total** number of doses distributed by OGPMS to the public health unit, as reported by the public health unit.

of influenza vaccine doses successfully distributed to other health care providers by the PHU in the calendar year:

This includes the vaccine doses that were distributed to other health care providers by the public health unit. Vaccine must be received by the health care provider (this does not include vaccine that was wasted during transit) and ordered by the health care provider. This data will be collected directly from the public health unit.

of useable doses returned in the calendar year:

Number of useable doses returned to OGPMS in the calendar year, as reported by the public health unit.

Notes

- Vaccine wastage for all reasons as noted above are to be included in the numerator as doses wasted.
- All doses wasted, even vaccine that is not returned to OGPMS, is to be reported as wasted vaccine for this indicator.
- Vaccine (HPV and Influenza vaccine) that is wasted while in the care and control of other health care providers and organizations is excluded from the numerator.
- The ministry may use data from CAMMS to assist in verification of the data submitted by public health units.

Limitations

- As there are significant challenges in using CAMMS data to measure this indicator, data quality and accuracy are dependent on the inventory management practices at the public health unit.
- As vaccine wastage is measured on the calendar year, for the influenza vaccine wastage indicator, the indicator measures the wastage and distribution of a portion of two influenza seasons rather than one complete influenza season.

References

1. Ontario. Ministry of Health and Long-Term Care. Vaccine storage and handling protocol. Toronto, ON: Queen's Printer for Ontario; 2010. Available from: http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/vaccine_storage_handling.pdf.
2. Ontario. Ministry of Health and Long-Term Care. Infectious diseases program standards: Vaccine preventable diseases. In: Ontario public health standards 2008. Toronto, ON: Queen's Printer for Ontario; 2008 [cited 2012 Nov 21]. Available from: http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/vpd.aspx.
3. Ontario. Ministry of Health and Long-Term Care. Vaccine storage and handling guidance document. Toronto, ON: Queen's Printer for Ontario; 2010 [cited 2013 Feb 5]. Available from: http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/guidance/gd_vaccine_storage.pdf.

Chapter 9

Indicator # 9. % of school-aged children who have completed immunizations for hepatitis B, HPV and meningococcus

Overview

The *Technical Document: Public Health Accountability Agreement Indicators 2011-13* provides information for each of the performance indicators included in the 2011-13 Public Health Accountability Agreement. This chapter describes the ‘% of school-aged children who have completed immunizations for hepatitis B, HPV and meningococcus’ indicator and includes information about the calculation method, data source, and other relevant technical considerations.

If you have any questions about the information in this document, please contact the MOHLTC at PHUIndicators@ontario.ca.

Description

- Percentage of Grade 7 students who have completed their immunization series with the hepatitis B vaccine by the end of the school year (August 31).
- Percentage of Grade 8 female students who have completed their immunization series with the Human Papillomavirus (HPV) vaccine by the end of the school year (August 31).
- Percentage of Grade 7 students who have completed their immunization series with the meningococcal conjugate C (Men-C-C) or quadrivalent meningococcal conjugate (Men-C-ACYW135) vaccine by the end of the school year (August 31).

Rationale

- This indicator reflects the effectiveness of local school based immunization programs.
- Immunization coverage assessment establishes immunization trends over time, facilitates the identification of sub-populations with inadequate coverage, and contributes to the evaluation of immunization promotion initiatives.

Required Activity Under the OPHS

- The board of health is required to assess, maintain records, and report on, the immunization status of children¹.
- The board of health is required to promote and provide provincially-funded immunization programs to any eligible person in the health unit¹.

Board of Health Outcomes

The *Ontario Public Health Standards, 2008* (OPHS) identify the following board of health outcomes related to this indicator¹:

- Target coverage rates for provincially funded immunizations are achieved.
- The public is aware of the importance of immunization across the lifespan.
- The board of health is aware of and uses epidemiology to influence the development of health public policy and its programs and services to reduce or eliminate the burden of vaccine preventable diseases.

- Children have up-to-date immunizations according to the current *Publicly Funded Immunization Schedules for Ontario*² and in accordance with the *Immunization of School Pupils Act*³ and the *Day Nurseries Act*⁴, (where applicable).

Data Source

Immunization Records Information System (IRIS)

The Immunization Records Information System (IRIS) is a DOS-based system that was developed for public health units in 1993 to maintain immunization and tuberculin testing records for all school-aged children within their jurisdictions.

Immunization coverage is calculated for each of the six designated diseases (diphtheria, tetanus, polio, measles, mumps and rubella) for which immunization is required under the *Immunization of School Pupils Act*³. Under the *Immunization of School Pupils Act*³, parents are directly responsible for the immunization status of their children. Parents are obligated to report any immunizations that their children receive to the public health unit and it is then entered into the IRIS. Currently, measles, mumps, rubella, diphtheria, tetanus, and polio vaccines are the only designated vaccines required under the Act.

The IRIS is also used to support public health units and Medical Officers of Health to manage yearly school pupil immunization assessment and suspension processes.

The IRIS is also used to support public health units and Medical Officers of Health to manage immunizations for school-based programs such as immunizations against hepatitis B, HPV, and meningococcal disease.

Demographic, parent/guardian contact, and school information for school-aged children is provided to boards of health by boards of education and private schools in each health unit and imported into the IRIS. The quality of demographic information in the IRIS is significantly dependent on the quality of this data and the import process.

Formulas

$$\left(\frac{\text{Grade 7 cohort with "complete for age" immunization for the hepatitis B vaccine in the school year}}{\text{Grade 7 cohort in the school year}} \right) \times 100$$

$$\left(\frac{\text{Grade 8 female cohort with “complete for age” immunization for the HPV vaccine in the school year}}{\text{Grade 8 female cohort in the school year}} \right) \times 100$$

$$\left(\frac{\text{Grade 7 cohort with “complete for age” immunization for the MEN-C-C or MEN-C-ACYW_vaccine in the school year}}{\text{Grade 7 cohort in the school year}} \right) \times 100$$

Data Elements

Numerator:

“Complete for age” immunization for the hepatitis B vaccine

Students who received the requisite two doses of hepatitis B vaccine at the appropriate interval between doses as per the *Publicly Funded Immunization Schedules for Ontario*². This numerator is calculated using the “complete for age” logic in the IRIS.

“Complete for age” immunization for the meningococcal conjugate C or quadrivalent meningococcal conjugate vaccines:

Students who received the requisite dose of meningococcal conjugate C or quadrivalent meningococcal conjugate vaccines as per the *Publicly Funded Immunization Schedules for Ontario*². This numerator is calculated using the “complete for age” logic in the IRIS.

“Complete for age” immunization for the HPV vaccine:

Students who received the requisite three doses of HPV vaccine at the appropriate interval between doses as per the *Publicly Funded Immunization Schedules for Ontario*². This numerator is calculated using the “complete for age” logic in the IRIS.

Denominator:

Grade 7 or Grade 8 cohort in the school year:

Student information that is provided by boards of education in each health unit is uploaded into the IRIS which establishes the denominator.

Notes

- In the IRIS, coverage is calculated based on “complete-for-age” logic. A student is considered “complete for age” if the student has started the immunization series and received the requisite number of doses of vaccine with the appropriate interval between doses for his/her age as per the *Publicly Funded Immunization Schedules for Ontario*².
- Students are considered “incomplete for age” if they have started the immunization series and have not completed it.

- Coverage is expressed as the proportion of the Grade 7 cohort or the Grade 8 female cohort who are “complete for age” for the Hep B, Men-C-C or Men-C-ACYW, or HPV vaccine amongst the entire Grade 7 cohort or the Grade 8 female cohort enrolled in school.

Limitations

- Students are also considered “complete for age” until they are overdue according to the IRIS, unless they start the immunization series. For example, if a student has not had any doses of Hep B, the student will be considered “complete for age” until the student reaches the age of 15, which is the age that the IRIS considers the student is “overdue”. When the student turns 15, the student will be considered “incomplete for age”.
- Students that have not received any of the requisite doses of the vaccine will be considered “incomplete for age” at the age of 15 for Hep B, the age of 14 for HPV, and at the age of 13 for Men-C-C or Men-C-ACYW.
- Students that are immunized with one or more doses of a series, and have not completed the series will be captured in the IRIS as “incomplete for age”. There will be a decline in coverage as more students (who are not yet overdue) start their series, since the IRIS will no longer consider them “complete for age”.
- Coverage decreases when students start an immunization series or when students become ‘overdue’ as they are considered “incomplete for age” in the IRIS.
- Students are considered “incomplete for age” if they were exempted (medical, statement of conscience or religious belief), if they did not have a valid exemption, or if information was missing.
- The IRIS is a live system and the student population is changing; therefore coverage reports that are pulled at different times will vary. Due to student updates being made by public health units (students are being transferred out of schools, while new students are entering schools), the student cohort that is assessed will be different every time the coverage report is pulled.

References

1. Ontario. Ministry of Health and Long-Term Care. Infectious diseases program standards. In: Ontario public health standards 2008. Toronto, ON: Queen’s Printer for Ontario; 2008. Available from: http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/ophs_2008.pdf.
2. Ontario. Ministry of Health and Long-Term Care. Publicly funded immunization schedules for Ontario. Toronto, ON: Queen’s Printer for Ontario; 2011. Available from <http://www.health.gov.on.ca/en/public/programs/immunization/docs/schedule.pdf>.
3. *Immunization of School Pupils Act*, R.S.O. 1990, c. I.1. Available from: http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90i01_e.htm.
4. *Day Nurseries Act*, R.S.O. 1990, c. D.2. Available from: http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90d02_e.htm

Chapter 10

Indicator # 10. % of youth (ages 12 – 18) who have never smoked a whole cigarette

Overview

The *Technical Document: Public Health Accountability Agreement Indicators 2011-13* provides information for each of the performance indicators included in the 2011-13 Public Health Accountability Agreement. This chapter describes the ‘% of youth (ages 12-18) who have never smoked a whole cigarette’ indicator and includes information about the calculation method, data source, and other relevant technical considerations.

If you have any questions about the information in this document, please contact the MOHLTC at PHUIndicators@ontario.ca.

Description

- Measures the percent of youth ages 12 – 18ⁱ who report they have never smoked a whole cigarette.

Rationale

- Preventing adolescents from experimenting with smoking during adolescence is a key intervention to prevent them from smoking as adults, and to prevent morbidity and mortality from smoking-related chronic diseases.
- Youth prevention and engagement initiatives are important elements of the Smoke-Free Ontario Strategy and reflect key areas of government priority and investment. As such, this indicator aims to reflect public health youth prevention efforts related to tobacco use as part of the Chronic Disease Prevention Standard¹.
- The age range of 12 – 18 was selected for this indicator instead of 12 – 19 because 19 year olds are able to legally purchase tobacco products. Different prevention strategies would be used to target these two groups.
- This indicator is used at a provincial and national level to monitor tobacco reduction efforts.

Board of Health Outcomes

The *Ontario Public Health Standards, 2008* identify the following board of health outcome related to this indicator¹:

- Priority populations adopt tobacco-free living.

ⁱ The age range has been changed from the original previously released information

Data Source

Numerator:

Canadian Community Health Survey, Statistics Canada, Share File

Denominator:

Canadian Community Health Survey, Statistics Canada, Share File

The Canadian Community Health Survey (CCHS) is conducted by Statistics Canada. The survey provides cross-sectional (at one point in time) estimates of the factors that influence the population's health status and their use of the health system for 126 health regions across Canada.

The target population of the CCHS includes household residents in all provinces and territories, with the exclusion of populations on “Indian Reserves”, Canadian Forces Bases, and some remote areas. The sampling design is multi-stage. A single respondent within a household is randomly selected, and is asked questions on a wide range of health topics, including: physical activity, height and weight, smoking, exposure to second hand smoke, alcohol consumption, general health, chronic health conditions, injuries, use of health care services and related socio-demographic information.

The CCHS is released in an annual micro-data file and a file combining two years of data. The CCHS collection years can also be combined by users to examine populations of rare characteristics. Record-level CCHS data files are shared through data sharing agreements among boards of health, MOHLTC and Statistics Canada. These data files include survey weights that permit analysts to tabulate population-level estimates.

Sampling and non-sampling errors are two of the types of errors related to the CCHS. Because the CCHS is a sample survey, rather than a census of the population under similar conditions, estimates are subject to sampling error. Sampling errors for CCHS estimates are calculated using the “bootstrap” re-sampling technique. Non-response (either item non-response or total non-response) is another potential source of non-sampling error. Total non-response occurs when a respondent either refused to participate in the survey or because the interviewer could not contact the selected respondent. Social desirability and recall bias are potential sources of bias in the CCHS.

Formula

$$\left(\frac{\text{Weighted number of youth age 12 – 18 who never smoked a whole cigarette in their life}}{\text{Weighted total number of youth age 12 – 18}} \right) \times 100$$

Monitoring

Data for this indicator will be monitored at the following time points:

- Year-End Measurement 2012
 - Monitoring progress only
 - Based on 2011 and 2012 data
- Year-End Measurement 2013
 - Assessment of 2013 target
 - Based on 2012 and 2013 data

Notes

- The ministry recognizes that smaller sample sizes and wide confidence intervals make it more challenging to detect statistically significant changes. Therefore, to reduce the width of the confidence intervals, the ministry will combine two years of consecutive data for this indicator.
- The CCHS 2009 and CCHS 2010 (2009-10) combined estimate for each public health unit served as the baseline.
- Assessment of performance will be based on estimates for time periods that do not overlap with the baseline period (i.e., not 2010 + 2011).
- Additional information will be shared about the methodology that will be used to create the shared weights and bootstrap weights for combining two single years of CCHS data to create the two-year file for assessment of the 2013 target.
- Plans for reporting assume that prevalence estimates are reportable based on Statistics Canada's release guidelines^{2, 3}
- The sampling weights (WTS_S) as provided in the Share File have been used for weighted analysis.
- Those respondents who stated “don't know” or “refusal” or “not stated” to the CCHS smoking questionnaire ((SMK_01A = DK, R, NS) or, (SMK_01B = DK, R, NS) or, (SMK_202 = DK, R, NS) or (SMK_05D = DK, R, NS) are excluded from the analysis⁴.
- The removal of those in the “don't know”, “refusal”, ‘not stated’, category for this indicator is consistent with Statistics Canada method. This choice reflects an intention to have an indicator whose values over time and across public health units are not influenced by differences in the number/proportion of not stated respondents in the denominator.

Limitations

- The CCHS is based on self-reported data collected in telephone and in-person interviews³.
- The CCHS excludes individuals living on Indian Reserve communities, institutions, full-time members of the Canadian Armed Forces, and residents of remote regions of the country³.

Syntax

- This indicator is based on data collected from CCHS smoking module (SMK). The derived variable SMKDSTY is based on questions SMK_01A, SMK_01B, SMK_202 and SMK_05D. This variable indicates the type of smoker the respondent is, based on his/her responses to these questions⁴.
- CCHS derives six types of smokers: (1). Daily smoker, (2). Occasional smoker (former daily smoker), (3). Occasional smoker (never a daily smoker or has smoked less than 100 cigarettes in lifetime), (4). Former daily smoker (non-smoker now), (5). Former occasional smoker (at least 1 whole cigarette, non-smoker now) and (6). Never smoked (a whole cigarette)⁴.
- The relevant type of smokers to this indicator is (6). Never smoked (a whole cigarette). A youth aged 12-18 is classified as “never smoked a whole cigarette” if respondents in that age group answered SMK_202 = 3 and, SMK_01A = 2 and SMK_01B = 2⁴.
- For bootstrapping, BOOTVAR, distributed with all CCHS share files, was used³.

Glossary

Prevention

Policies and actions to eliminate a disease or minimize its effect; to reduce the incidence and/or prevalence of disease, disability, and premature death; to reduce the prevalence of disease precursors and risk factors in the population; if none of these is feasible, to retard the progress of incurable diseases⁴.

References

1. Ontario. Ministry of Health and Long-Term Care. Chronic diseases and injuries program standards. In: Ontario public health standards 2008. Toronto, ON: Queen’s Printer for Ontario; 2008 [cited 2012 Nov 21]. Available from: http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/cdai.aspx.
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Chapter 11

Indicator # 11. % of tobacco vendors in compliance with youth access legislation at the time of last inspection

Overview

The *Technical Document: Public Health Accountability Agreement Indicators 2011-13* provides information for each of the performance indicators included in the 2011-13 Public Health Accountability Agreement. This chapter describes the ‘% of tobacco vendors in compliance with youth access legislation at the time of last inspection’ indicator and includes information about the calculation method, data source, and other relevant technical considerations.

If you have any questions about the information in this document, please contact the MOHLTC at PHUIndicators@ontario.ca.

Description

- Measures enforcement of, and compliance with, provisions of the Smoke-Free Ontario Act (SFOA)¹ that relate to vendor compliance with requirements to restrict youth access to tobacco.

Rationale

- This indicator measures compliance with Sections 3(1) and 3(2) of the SFOA¹, which prohibits the sale of tobacco products to persons under the age of 19 years.
 - Section 3(1) states that: “No person shall sell or supply tobacco to a person who is less than 19 years old” 1994, c. 10, s.3 (1).
 - Section 3(2) states that: “No person shall sell or supply tobacco to a person who appears to be less than 25 years old unless he or she has required the person to provide identification and is satisfied that the person is at least 19 years old” 2005, c. 18, s. 4 (1).
- Tobacco vendor behaviour is an important aspect in monitoring youth access to tobacco products. Therefore, tracking vendor compliance rates will allow boards of health to assess the effectiveness of their education and enforcement efforts, which are key components of public health work as reflected in the Chronic Disease Prevention Standard².
- This formula is sensitive to improvement over the reporting period and is the best estimate of current compliance using the latest available data.

Board of Health Outcomes

The *Ontario Public Health Standards, 2008* identify the following board of health outcomes related to this indicator²:

- Tobacco vendors are in compliance with the Smoke-Free Ontario Act¹.
- Youth have reduced access to tobacco products.

Data Source

Numerator:

Tobacco Inspection System

Denominator:

Tobacco Inspection System

The former Ministry of Health Promotion developed the Tobacco Information System (TIS) in May 2006, to support implementation of the Smoke Free Ontario Act. TIS is a mandatory reporting system used by public health units to electronically capture tobacco vendor inspections in real time. TIS includes modules for ticketing, prosecutions, analytics and reporting, scheduling of court dates, workload management, risk-based inspection design, and Geographic Information System (GIS) capacity.

TIS has undergone several enhancements in order to meet the evolving business needs of its users and to ensure that the inspection process is executed efficiently and effectively. In fiscal year 2010-11, several new modules were added including Prosecution Tracking, Risk Assessment Capability, GIS Capability and Workload Management Reporting.

As a result, the tool has evolved into a comprehensive Tobacco Inspection System used by all 36 public health units in Ontario to capture and report on tobacco related inspection and enforcement data.

Formula

$$\left(\frac{\text{Number of vendors in compliance with SFOA}^1}{\text{Total number of vendors inspected at the time of last inspection}} \right) \times 100$$

Monitoring

Data for this indicator will be monitored at the following time points:

- Mid-Year Measurement 2012
 - Assessment of performance at mid year
 - Based on January 1-June 30, 2012 data
- Year-End Measurement 2012
 - Assessment of 2012 target
 - Based on January 1-December 31, 2012 data
- Year-End Measurement 2013
 - Assessment of performance at mid year

- Based on January 1-June 30, 2013 data
- Year-End Measurement 2013
 - Assessment of 2013 target
 - Based on January 1-December 31, 2013 data

Notes

- Compliance is defined as an inspection conducted on a vendor which results in a “no sale”.
- Vendor is defined as premises and is tracked by address in the Tobacco Information System (TIS).
- The most recent inspection in the reporting year was used as the basis of compliance, as this approach was determined to be the most sound in calculating a compliance rate.
- Compliance is defined as an inspection conducted on a vendor which results in a “no sale” and not the subsequent action taken by a tobacco enforcement officer (e.g. education provided, warning issued, charges laid).
- Compliance rate is not calculated as an annual rate of compliance based on the outcome of multiple visits to a vendor (premises) in the reporting period due to the manner in which compliance data are currently collected through TIS. The identifying unit in TIS is premises based on address, and not owner. If a premises changed ownership during the reporting period, compliance data are currently available in TIS for each unique premises and not owner. Therefore, calculating an annual compliance rate based on multiple visits to the same premises may include compliance information for different owners. The annual rate of compliance for the province or a public health unit is based on most recent inspection. An example of this would be: In 2011, 90% of vendors were in compliance with youth access provisions of the SFOA¹ at time of last inspection.
- Compliance rates may be affected by factors such as local test shopping practices and seasonality.

Limitations

- Three public health units were involved in a pilot study involving the inspection of selected tobacco vendors. This will be taken into consideration when monitoring this indicator.

Syntax

- The fields of the Tobacco Vendor Inspection Form that must be selected in order to be identified as a test shop and be included in the calculation of the compliance rate are:
 - 1) “youth access”;
 - 2) inspection type “compliance” or “enforcement”; and
 - 3) “sale completed: yes/no”.
- Public health units will be able to access the data used to calculate their compliance rates through a report named *Tobacco Vendor Compliance Indicator Report* that will be available in TIS at the following URL:
<https://tisuat.moh.gov.on.ca/Conversion/webclient/login.aspx>

- The report is drawn from the following fields from TIS raw data:
 - 1) PHU name
 - 2) Premises ID
 - 3) Operating Name
 - 4) Inspection ID
 - 5) Date of Visit
 - 6) Date Created
 - 7) Date Synchronized
 - 8) Premises Type
 - 9) Inspection Type
 - 10) Youth Access Sale Completed

Glossary

Inspection

An examination or assessment conducted by a person appointed as an inspector pursuant to Section 14 of the Smoke-Free Ontario Act, and also appointed as a Provincial Offences Officer¹.

Prevention

Policies and actions to eliminate a disease or minimize its effect; to reduce the incidence and/or prevalence of disease, disability, and premature death; to reduce the prevalence of disease precursors and risk factors in the population; if none of these if feasible, to retard the progress of incurable diseases³.

References

1. *Smoke Free Ontario Act*, S.O. 1994, c. 10. Available from:
http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_94t10_e.htm
2. Ontario. Ministry of Health and Long-Term Care. Chronic diseases and injuries program standards. In: Ontario public health standards 2008. Toronto, ON: Queen's Printer for Ontario; 2008 [cited 2012 Nov 21] Available from:
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http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/glossary.aspx.

Chapter 12

Indicator # 12. Fall-related emergency visits in older adults aged 65+

Overview

The *Technical Document: Public Health Accountability Agreement Indicators 2011-13* provides information for each of the performance indicators included in the 2011-13 Public Health Accountability Agreement. This chapter describes the ‘Fall-related emergency visits in older adults aged 65+’ indicator and includes information about the calculation method, data source, and other relevant technical considerations.

If you have any questions about the information in this document, please contact the MOHLTC at PHUIndicators@ontario.ca.

Description

- Monitors the rate of injuries related to falls that result in emergency visits, in adults aged 65 years and older.

Rationale

- Most falls are predictable and preventable, yet fall-related injuries are common and reflect a significant burden on the health care system.
- For Ontarians aged 65 years and older, falls are the leading cause of injury-related emergency visits, hospitalizations, and in-hospital deaths¹.
- This indicator provides a better representation of health care system utilization than fall-related hospitalization rate(s) alone. Fall-related hospitalization rates are more reflective of the severity of fall-related injuries whereas emergency visits capture the incidence of injurious falls.
- The risk of serious fall-related injury is nine times greater for those 65 years of age and older than for younger age groups².
- The number of older adults aged 65 and over is projected to more than double from 1.8 million, or 13.9 per cent of the population, in 2010 to 4.1 million, or 23.4 per cent, by 2036. The growth in the share and number of seniors will accelerate over the 2011–2031 period as baby boomers begin to turn age 65; therefore we expect to see an increase in the number of falls among people in this age group³.
- As part of the Prevention of Injury and Substance Misuse Standard, public health injury prevention interventions involve reducing known risk factors associated with falls and increasing the public’s capacity to prevent injury⁴. This indicator reflects public health efforts related to preventing falls by tracking fall-related emergency visits in adults aged 65 years and older.

Board of Health Outcomes

The *Ontario Public Health Standards, 2008* identify the following board of health outcomes related to this indicator⁴:

- The public is aware that the majority of injuries are predicable and preventable.

- The public is aware of the risk, protective, and resiliency factors associated with injury and substance misuse.
- Priority populations have the capacity to prevent injury, substance misuse, and associated harms.

Data Source

Numerator:

National Ambulatory Care Reporting System (NACRS, Canadian Institute for Health Information (CIHI)), Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO

Denominator:

Statistics Canada Population Estimates (Census-based, updated annually), Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO

Census (2006)

Annual population estimates by age and by public health unit are derived from Statistics Canada estimates and are available to registered users of IntelliHEALTH ONTARIO[†].

IntelliHEALTH ONTARIO^{††} reports for population estimates of public health unit populations are based on Census Subdivision (CSD) populations provided by Statistics Canada. Data were collected through the national census.

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 estimates will be the most recent post-censal, inter-censal estimates available annually from Statistics Canada.

National Ambulatory Care Reporting System (NACRS)

The National Ambulatory Care Reporting System (NACRS) contains data for hospital-based, emergency and ambulatory care. NACRS data can be used to support management decision-making at the local and provincial/territorial levels; facilitate provincial and national comparative reporting; support analysis and research; and support the development and use of case-mix and resource utilization grouping methodologies. Data are received directly from participating

[†] Additional information on the methods Statistics Canada uses to derive population estimates is available from Statistics Canada.

^{††} IntelliHealth ONTARIO is a knowledge repository that contains clinical and administrative data collected from various sectors of the Ontario health care system. IntelliHealth enables users to create queries and run reports through easy web-based access to high quality, well organized, integrated data. Some of the kinds of data that can be accessed through IntelliHealth include data related to hospital services, community care, non-hospital medical services, vital statistics and population data. Reports created from this data are used to inform operational planning and decision making processes. Clients of IntelliHealth include MOHLTC staff, LHINs, health service providers and community agencies responsible for analyzing, evaluating and/or planning the delivery of health care services in Ontario.

facilities or their respective health authorities or ministries of health, and data collection methods may vary by facility.

MOHLTC provides most NACRS data elements as a set of information maps (titled Ambulatory Visits) within IntelliHEALTH ONTARIO. Several geographic variables (e.g. public health unit and Local Health Integration Network (LHIN)) are added to each visit record based on the patient's municipality and postal code of residence reported at the ambulatory visit. Note that ambulatory visits (NACRS data) include visits to hospital-based outpatient clinics and same-day surgery units, as well as scheduled and unscheduled visits to emergency departments and urgent care centres. This indicator only uses the unscheduled ED visits (i.e. unscheduled visits to emergency departments and urgent care centres) portion of the NACRS data. MOHLTC has created standard reports for public health that summarize emergency visits (to emergency departments or urgent care centres) for external causes of injury. These reports provide breakdowns of emergency visits by type of external cause of injury, place of occurrence, residence of patient, etc. Standard reports for public health are typically provided by calendar year while similar reports are provided for LHINs by fiscal year.

Formula

$$\left(\frac{\text{Total number of fall-related (W00-W19) emergency visits in older adults aged 65 and older per year}}{\text{Number of people aged 65 and older}} \right) \times 100,000$$

Monitoring

Data for this indicator will be monitored at the following time points:

- Year-End Measurement 2012
 - Monitoring progress only
 - Based on 2011 data
- Year-End Measurement 2013
 - Assessment of 2013 target
 - Based on 2012 data

Notes

- Numerator inclusion criteria: any emergency visit with at least one fall diagnosis (ICD-10 W00-W19).
- Emergency visits include unscheduled visits to emergency departments or urgent care centres (i.e., AM Case Type = emergency in NACRS data).
- Numerator and denominator include Ontario residents only.
- Denominator uses population estimates from IntelliHEALTH ONTARIO for the time period analyzed.

- The emergency visits represent unique visits with at least one fall diagnosis reported. If more than one fall diagnosis is reported for a single visit, the visit is counted only once.
- This is a count of ED visits, not patients, i.e., if a person had more than one fall-rated emergency visit within the same calendar year, each visit is counted.
- This indicator uses the patient's residence (i.e., based on full address) to assign the fall-related injury to the appropriate public health unit. This indicator does not classify injuries based on either the location of the hospital or the location where the injury occurred.
- The number and rate of fall-related emergency visits may be affected by local factors such as residents who frequently leave the public health unit geographic area and are exposed to environments (e.g., built environments/ recreational activities) dissimilar to those present in the public health unit in which they live.

Limitations

- This indicator does not consider the severity of the injury (e.g. using the Injury Severity Score).
- Differences in the rate of emergency visits across various regions may reflect differences in access to care (e.g. emergency visits vs. walk-in clinics). This is less of a concern when only looking at rate changes in a given health unit.

Syntax

- An indicator data report (Fall-related emergency visits in older adults aged 65 +) has been created and is posted on the IntelliHEALTH ONTARIO website, <https://www.intellihealth.moh.gov.on.ca>. The report is available to licensed IntelliHEALTH ONTARIO users and can be accessed from the Standard Reports\Public health, APHEO indicators subfolder in IntelliHEALTH ONTARIO.

Glossary

Environment

The setting and conditions in which events occur. The total of all influences on health apart from genes, including economic, social, behavioural, cultural and physical factors⁵.

Injury

An injury is the physical damage that results when a human body is suddenly subjected to energy in amounts that exceed the threshold of physiological tolerance, or from lack of one or more vital elements (for example, oxygen). The energy could be mechanical, thermal, chemical, or radiant. Injuries are further defined by whether they are intentional or unintentional⁵.

Population health

Population health is the health of the population, measured by health status indicators. Population health is influenced by physical, biological, behavioural, social, cultural, economic, and other factors. The term is also used to refer to the prevailing health level of the population, or a specified subset of the population, or the level to which the population aspires. Population

health describes the state of health, and public health is the range of practices, procedures, methods, institutions and disciplines required to achieve it. The term also is used to describe the academic disciplines involved in studies of determinants and dynamics of health status of the population⁵.

Prevention

Policies and actions to eliminate a disease or minimize its effect; to reduce the incidence and/or prevalence of disease, disability, and premature death; to reduce the prevalence of disease precursors and risk factors in the population; if none of these if feasible, to retard the progress of incurable diseases⁵.

Resiliency

The capability of individuals and systems (families, groups and communities) to cope with significant adversity or stress in ways that are not only effective, but tend to result in an increased ability to constructively respond to future adversity⁵.

Risk factor

A term first used in the 1950s in reports of results from the Framingham Study of heart disease, meaning an aspect of behaviour or way of living, such as habitual patterns of diet, exercise, use of cigarettes and alcohol, etc., or a biological characteristic, genetic trait, or a health-related condition or environmental exposure with predictable effects on the risk of disease due to a specific cause, including, in particular, increased likelihood of an unfavourable outcome. Other meanings have been given to this term, such as determinants of diseases that can be modified by specific actions, behaviours, or treatment regimens. Risk factors may be divided into those directly related to disease outcomes (proximal risk factors), such as non-use of seat belts and risk of injury in automobile crashes, and those with indirect effect on outcomes (distal risk factors). An example of the latter is the influence of ozone-destroying substances, such as Chlorofluorocarbons (CFCs), on the risk of malignant melanoma, mediated by increased exposure to solar ultraviolet radiation because of depletion of protective stratospheric ozone⁵.

Substance misuse

The use of a substance for a purpose that is not consistent with legal or medical guidelines⁵.

References

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Chapter 13

Indicator # 13. % of population (19+) that exceeds the Low-Risk Drinking Guidelines

Overview

The *Technical Document: Public Health Accountability Agreement Indicators 2011-13* provides information for each of the performance indicators included in the 2011-13 Public Health Accountability Agreement. This chapter describes the ‘% of population (19+) that exceeds the Low-Risk Drinking Guidelines’ indicator and includes information about the calculation method, data source, and other relevant technical considerations.

If you have any questions about the information in this document, please contact the MOHLTC at PHUIndicators@ontario.ca.

Description

- Measures the proportion of population (19 years of age and older) who reported consuming alcohol at levels that exceed Canada’s Low-Risk Alcohol Drinking Guidelines (Guidelines 1 and 2).

Rationale

- Canada’s Low-Risk Alcohol Drinking Guidelines (LRADG) were introduced in 2011 to help Canadians moderate their alcohol consumption and reduce their immediate and long-term alcohol-related harm¹. Canada’s LRADG include five guidelines and replace other guidelines for low-risk drinking.
- This indicator addresses guidelines one and two which provide sex-specific daily and weekly limits for alcohol consumption and recommend at least two non-drinking days every week². Not all five guidelines are measurable by current provincial and local data collection tools. As prevention efforts will vary for children, youth, adults, pregnant and breastfeeding women, the indicator is specific for people 19 years of age and older who are neither pregnant nor breastfeeding.
- Alcohol misuse is associated with many chronic diseases and conditions and its consequences are a significant burden on the health care system. As part of the Chronic Disease Prevention and the Prevention of Injury and Substance Misuse Standards, prevention efforts involve increasing public awareness about the importance of reduced alcohol use; increasing public awareness about the risk, protective, and resiliency factors associated with substance misuse; and increasing the public’s capacity to prevent substance misuse and associated harms. This indicator reflects public health efforts to influence the awareness and health behaviour of people who consume alcohol.

Board of Health Outcomes

The *Ontario Public Health Standards, 2008* identify the following board of health outcomes related to this indicator³:

- The public is aware of the importance of reduced alcohol use.
- The public is aware of the risk, protective, and resiliency factors associated with injury and substance misuse.
- Priority populations have the capacity to prevent injury, substance misuse, and associated harms.

Data Source

Numerator:

Canadian Community Health Survey, Statistics Canada, Share File

Denominator:

Canadian Community Health Survey, Statistics Canada, Share File

The Canadian Community Health Survey (CCHS) is conducted by Statistics Canada. The survey provides cross-sectional (at one point in time) estimates of the factors that influence the population's health status and their use of the health system for 126 health regions across Canada.

The target population of the CCHS includes household residents in all provinces and territories, with the exclusion of populations on “Indian Reserves”, Canadian Forces Bases, and some remote areas. The sampling design is multi-stage. A single respondent within a household is randomly selected, and is asked questions on a wide range of health topics, including: physical activity, height and weight, smoking, exposure to second hand smoke, alcohol consumption, general health, chronic health conditions, injuries, use of health care services and related socio-demographic information.

The CCHS is released in an annual micro-data file and a file combining two years of data. The CCHS collection years can also be combined by users to examine populations of rare characteristics. Record-level CCHS data files are shared through data sharing agreements among boards of health, MOHLTC and Statistics Canada. These data files include survey weights that permit analysts to tabulate population-level estimates.

Sampling and non-sampling errors are two of the types of errors related to the CCHS. Because the CCHS is a sample survey, rather than a census of the population under similar conditions, estimates are subject to sampling error. Sampling errors for CCHS estimates are calculated using the “bootstrap” re-sampling technique. Non-response (either item non-response or total non-response) is another potential source of non-sampling error. Total non-response occurs when a respondent either refused to participate in the survey or because the interviewer could not contact the selected respondent. Social desirability and recall bias are potential sources of bias in the CCHS.

Formula

$$\left(\frac{\text{The weighted number of those aged 19 years and older who reported consuming alcohol in excess of the Low-Risk Alcohol Drinking Guidelines}}{\text{The weighted number of those aged 19 years and older}} \right) \times 100$$

Definitions

- The CCHS questionnaire defines a drink as: one bottle or can of beer or a glass of draft; one glass of wine or a wine cooler; one drink or cocktail with 1.5 oz of liquor.
- For this indicator, those who exceed the Low-Risk Alcohol Drinking Guidelines are defined as:
 - Women (≥ 19 years, excluding those pregnant or breastfeeding): more than 10 drinks in the previous week, or more than 2 drinks on a single day in the previous week, or consuming alcohol on 6 or 7 days in the previous week
 - Men (≥ 19 years): more than 15 drinks in the previous week, or more than 3 drinks on a single day in the previous week, or consuming alcohol on 6 or 7 days in the previous week
 - Men and women (≥ 19 years, excluding those pregnant or breastfeeding): 5 or more drinks on one occasion at least once per month for the last 12 months

Monitoring

Data for this indicator will be monitored at the following time points:

- Year-End Measurement 2012
 - Monitoring progress only
 - Based on 2011 and 2012 data
- Year-End Measurement 2013
 - Assessment of 2013 target
 - Based on 2012 and 2013 data

Notes

- The ministry recognizes that smaller sample sizes and wide confidence intervals make it more challenging to detect statistically significant changes. Therefore, to reduce the width of the confidence intervals, the ministry will produce estimates based on two years of consecutive data for this indicator.
- The CCHS 2009 and CCHS 2010 (2009-10) combined estimate for each PHU served as the baseline.

- Assessment of performance will be based on estimates for time periods that do not overlap with the baseline period (i.e., not 2010 + 2011).
- Additional information will be shared about the methodology that will be used to create the shared weights and bootstrap weights for combining two single years of CCHS data to create the two-year file for assessment of the 2013 target.
- Plans for reporting assume that prevalence estimates are reportable based on Statistics Canada’s release guidelines^{4, 5}.
- The sampling weights (WTS_S) as provided in the Share File have been used for weighted analysis.
- Data on the number of alcoholic drinks and the frequency consumed are collected using the CCHS Alcohol Use (ALC) and Alcohol Use During the Past Week (ALW) modules^{6, 7}. Patterns of drinking are summarized and categorized adapting the syntax created by members of the Association of Public Health Epidemiologists in Ontario (APHEO) Core Indicator Work Group, revised in December 2011⁸.
- Numerator and denominator excludes ages 18 and under; pregnant women (mam_037=1); breastfeeding / lactating women (mex_05=1); don’t know; refusals; and not stated.
- The removal of those in the “don’t know”, “refusal”, ‘not stated’, category for this indicator is consistent with Statistics Canada method. This choice reflects an intention to have an indicator whose values over time and across public health units are not influenced by differences in the number/proportion of not stated respondents in the denominator.

Limitations

- The CCHS is based on self-reported data collected in telephone and in-person interviews. The CCHS excludes individuals living on Indian reserve communities, institutions, full-time members of the Canadian Armed Forces, and residents of remote regions of the country.
- This indicator does not assess if individuals are drinking in “safe environments” as per Guideline 2 because the CCHS does not collect this information.
- This indicator does not address Canada’s Low-Risk Alcohol Drinking Guidelines 3 and 4, which recommend that individuals who meet the following criteria do not drink: *mental or chronic health condition; alcohol dependent; breastfeeding, pregnant or planning to be pregnant; responsible for the safety of others; involved in at-risk activities (e.g., driving vehicles, using machinery or tools, taking medications or drugs that interact with alcohol, doing dangerous physical activity); making important decisions*¹.
- This indicator does not address Canada’s Low-Risk Alcohol Drinking Guideline 5 which suggests that child and youth should delay drinking until they reach their late teens¹.

Syntax

LOWRISKDRINK_Canada

RECODE alw_2a1 (0=0) (996=0) (1 thru 60=1) (997 thru Highest=sysmis) INTO Sunday.

RECODE alw_2a2 (0=0) (996=0) (1 thru 60=1) (997 thru Highest=sysmis) INTO Monday.

RECODE alw_2a3 (0=0) (996=0) (1 thru 60=1) (997 thru Highest=sysmis) INTO Tuesday.

```
RECODE alw_2a4 (0=0) (996=0) (1 thru 60=1) (997 thru Highest=sysmis) INTO Wednesday.
RECODE alw_2a5 (0=0) (996=0)(1 thru 60=1) (997 thru Highest=sysmis) INTO Thursday.
RECODE alw_2a6 (0=0) (996=0) (1 thru 60=1) (997 thru Highest=sysmis) INTO Friday.
RECODE alw_2a7 (0=0) (996=0) (1 thru 60=1) (997 thru Highest=sysmis) INTO Saturday.
EXECUTE.
COMPUTE drinkingdays=Sunday+Monday+Tuesday+Wednesday+Thursday+Friday+Saturday.
EXECUTE.
IF (dhh_sex = 1 & alwdwky <= 15 & alw_2a1 <=3 & alw_2a2 <=3 & alw_2a3 <=3 & alw_2a4
<=3 & alw_2a5 <=3 & alw_2a6 <=3 & alw_2a7 <=3 & drinkingdays<=5 & alc_3<=2)
LOWRISKDRINK_Canada = 1.
IF (dhh_sex = 2 & alwdwky <= 10 & alw_2a1 <=2 & alw_2a2 <=2 & alw_2a3 <=2 & alw_2a4
<=2 & alw_2a5 <=2 & alw_2a6 <=2 & alw_2a7 <=2 & drinkingdays<=5 & alc_3<=2)
LOWRISKDRINK_Canada = 1.
IF (dhh_sex = 1 & (alwdwky > 15 | alw_2a1 >3 | alw_2a2 >3 | alw_2a3 >3 | alw_2a4 >3 |
alw_2a5 >3 | alw_2a6 >3 | alw_2a7 >3 | drinkingdays >5 | (alc_3>=3 & alc_3<=6)))
LOWRISKDRINK_Canada = 2.
IF (dhh_sex = 2 & (alwdwky > 10 | alw_2a1 >2 | alw_2a2 >2 | alw_2a3 >2 | alw_2a4 >2 |
alw_2a5 >2 | alw_2a6 >2 | alw_2a7 >2 | drinkingdays >5 | (alc_3>=3 & alc_3<=6)))
LOWRISKDRINK_Canada = 2.
EXECUTE.
IF (alc_1=2) LOWRISKDRINK_Canada =1.
EXECUTE.
IF (alw_1=2 & alc_3<=2) LOWRISKDRINK_Canada=1.
IF (alw_1=2 & (alc_3>=3 & alc_3<=6)) LOWRISKDRINK_Canada=2.
EXECUTE.
IF (mam_037 = 1 | mex_05 = 1 ) LOWRISKDRINK_Canada = 98 .
IF (dhh_age) <19 LOWRISKDRINK_Canada = 98.
EXECUTE.
IF (mam_037 = 7 | mam_037 = 8 | mam_037=9 | mex_05=9 | alc_3=97 | alc_3=98 | alc_3=99 |
alwdwky = 999 ) LOWRISKDRINK_Canada = 99.
EXECUTE.
FORMATS LOWRISKDRINK_Canada (f1.0).
VARIABLE LABELS LOWRISKDRINK_Canada 'Canada Low Risk Alcohol Drinking
Guidelines'.
VALUE LABELS LOWRISKDRINK_Canada
1 "Complies"
2 "Exceeds"
98 "Not Applicable"
99 "Not Stated, Don't Know or Refusal".
EXECUTE.
```

Glossary

Environment

The setting and conditions in which events occur. The total of all influences on health apart from genes, including economic, social, behavioural, cultural and physical factors⁹.

Health behaviour

The actions people undertake that influence their health status. These actions are influenced by the combination of understanding, insight, beliefs, and practices that define the patterns of actions that influence people's health status, and may promote, preserve, and protect good health, or if aspects of behaviour are harmful, such as driving cars at excessive speed, unsafe work practices, or cigarette smoking, may lead to injury, death, or chronic disease⁹.

Injury

An injury is the physical damage that results when a human body is suddenly subjected to energy in amounts that exceed the threshold of physiological tolerance, or from lack of one or more vital elements (for example, oxygen). The energy could be mechanical, thermal, chemical, or radiant. Injuries are further defined by whether they are intentional or unintentional⁹.

Prevention

Policies and actions to eliminate a disease or minimize its effect; to reduce the incidence and/or prevalence of disease, disability, and premature death; to reduce the prevalence of disease precursors and risk factors in the population; if none of these is feasible, to retard the progress of incurable diseases⁹.

Resiliency

The capability of individuals and systems (families, groups and communities) to cope with significant adversity or stress in ways that are not only effective, but tend to result in an increased ability to constructively respond to future adversity⁹.

Risk factor

A term first used in the 1950s in reports of results from the Framingham Study of heart disease, meaning an aspect of behaviour or way of living, such as habitual patterns of diet, exercise, use of cigarettes and alcohol, etc., or a biological characteristic, genetic trait, or a health-related condition or environmental exposure with predictable effects on the risk of disease due to a specific cause, including, in particular, increased likelihood of an unfavourable outcome. Other meanings have been given to this term, such as determinants of diseases that can be modified by specific actions, behaviours, or treatment regimens. Risk factors may be divided into those directly related to disease outcomes (proximal risk factors), such as non-use of seat belts and risk of injury in automobile crashes, and those with indirect effect on outcomes (distal risk factors). An example of the latter is the influence of ozone-destroying substances, such as Chlorofluorocarbons (CFCs), on the risk of malignant melanoma, mediated by increased exposure to solar ultraviolet radiation because of depletion of protective stratospheric ozone⁹.

Substance misuse

The use of a substance for a purpose that is not consistent with legal or medical guidelines⁹.

References

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Chapter 14

Indicator # 14. Baby-Friendly Initiative (BFI) Status

Overview

The *Technical Document: Public Health Accountability Agreement Indicators 2011-13* provides information for each of the performance indicators included in the 2011-13 Public Health Accountability Agreement. This chapter describes the ‘Baby-Friendly Initiative Status’ indicator and includes information about the calculation method, data source, and other relevant technical considerations.

If you have any questions about the information in this document, please contact the MOHLTC at PHUIndicators@ontario.ca.

Description

- This indicator monitors the Baby-Friendly Initiative (BFI) status of all Ontario public health units using the Public Health Unit (PHU) BFI Status Report.
- The BFI indicator monitors public health unit performance related to the implementation of a number of activities that promote, support and protect breastfeeding. These activities are articulated in the Reproductive Health and Child Health Standards of the *Ontario Public Health Standards, 2008*^{Error! Reference source not found.}
- BFI status categories identified include:
 - Preliminary work towards BFI;
 - Intermediate work towards BFI;
 - Advanced work towards BFI;
 - BFI Designated (includes redesignation);
 - BFI Maintenance.
- The Breastfeeding Committee for Canada (BCC)¹ is the official BFI designation authority in Canada.

Rationale

- Promoting, supporting, and protecting breastfeeding is a ministry priority and a key area of public health work as reflected by the *Ontario Public Health Standards, 2008*^{Error! Reference source not found.} specific to Child Health and Reproductive Health.
- The BFI is evidence based and recognized globally as a best practice, designed to improve breastfeeding outcomes for mothers and babies by improving the quality of their care and establishing breastfeeding as the cultural norm³.
- The BFI promotes the optimal feeding of all infants, from birth to age 2 and beyond³.
- The BFI designation requires organizations to implement a number of components that strengthen all the care points for mothers and infants, and is aligned with several requirements and outcomes of the Child Health and Reproductive Health Standards.
- BFI designation will achieve a number of requirements and outcomes within the OPHS Reproductive Health and Child Health Standards, (Reproductive Health Standard: Requirements #1-6; Child Health Standard Requirements #1, 4-8, 11).

Board of Health Outcomes

The *Ontario Public Health Standards, 2008* identify the following board of health outcomes related to this indicator:

- Breastfeeding women have improved knowledge and skills (Child Health).
- Community partners are aware of the importance of creating safe and supportive environments that promote healthy pregnancies, healthy birth outcomes, and preparation for parenthood (Reproductive Health).
- Community partners are aware of the importance of creating safe and supportive environments that promote healthy child development (Child Health).
- Expectant parents are aware of the benefits and mechanics of breastfeeding and where to obtain assistance (Reproductive Health).

Data Source

- Public health units will self report on their current BFI status using the PHU BFI Status Report at the mid and year-end reporting periods.
- Each public health unit’s baseline BFI status has been collected by the ministry, through public health unit self report, using the PHU BFI Status Report 2011.
- Baby-Friendly Initiative Ontario (formerly Ontario Breastfeeding Committee) will confirm public health unit status by forwarding to the ministry confirmation of public health unit certificates with date as appearing on the certificate.
- The ministry may request confirmation from a public health unit at any time using the current parameters and definitions established for each category e.g. request copies of BFI Ontario and BCC certificates, reports, letters etc.
- The PHU BFI Status Report Reference Guide describes the requirements and working definitions within each category.

Formula

BFI status category as self reported by public health units (PHU):

Table 1: BFI Status Category and Definitions

BFI Status	Definition
Preliminary Work	PHU has contacted Baby-Friendly Initiative Ontario (BFI Ontario) ⁴ and received a Certificate of Intent
Intermediate Work	PHU has received a Certificate of Participation from BFI Ontario ⁴
Advanced Work	PHU has engaged with BCC to begin the BFI designation process and is working on the BCC BFI requirements
BFI Designation	PHU has obtained BFI designation or Label
Maintenance of BFI Designation	PHU is maintaining BFI designation and planning for redesignation

Monitoring

Data for this indicator will be monitored at the following time points:

- Mid-Year Measurement 2012
 - Assessment of performance at mid year
 - Based on January 1-June 30, 2012 data
- Year-End Measurement 2012
 - Assessment of 2012 target
 - Based on January 1-December 31, 2012 data
- Mid-Year Measurement 2013
 - Assessment of performance at mid year
 - Based on January 1-June 30, 2013 data
- Year-End Measurement 2013
 - Assessment of 2013 target
 - Based on January 1-December 31, 2013 data

Notes

- To meet BCC requirements for data collection to describe breastfeeding intention, initiation, duration and exclusivity rates, public health units will identify the data source(s) that best suit their public health unit. Public health units may choose to use data from:
 - Better Outcomes Registry and Network (BORN),
 - Rapid Risk Factor Surveillance System,
 - Canadian Community Health Survey,
 - Healthy Babies, Healthy Children: Integrated Services for Children Information System, or
 - A public health unit-specific Infant Feeding Survey.
- The same data source for each data item must be consistently used for reporting. For further information on this requirement and all other requirements please refer to the PHU BFI Status Report Reference Guide.

Limitations

- The ministry has undertaken further work since public health units completed the BFI indicator survey (Summer 2011). While the categories are the same, the requirements and working definitions have been fully developed. Further instructions related to recording dates entered by public health units, has been added to the BFI Status Report Reference Guide 2012.

Glossary

Environment

The setting and conditions in which events occur. The total of all influences on health apart from genes, including economic, social, behavioural, cultural and physical factors⁵.

Network

A grouping of individuals, organizations and agencies organized on a non- hierarchical basis around common issues or concerns, which are pursued proactively and systematically, based on commitment and trust⁵.

Supportive environments

The term supportive environments refers to both the physical and the social aspects of one's surroundings. It encompasses where people live, their local community, their home, and where they work and play. Action to create supportive environments has many dimensions: physical, social, spiritual, economic and political. Each of these dimensions is inextricably linked to the others in a dynamic interaction⁵.

References

1. Ontario. Ministry of Health and Long-Term Care. Ontario public health standards 2008. Toronto, On: Queen's Printer for Ontario; 2008. Available from: http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/ophs_2008.pdf.
2. Breastfeeding Committee for Canada. Homepage. Drayton Valley, AB: Available from: <http://breastfeedingcanada.ca/BFI.aspx>.
3. Breastfeeding Committee for Canada. BFI integrated 10 steps practice outcome indicators for hospital and community health services. Drayton Valley, AB: 2011. Available from: http://breastfeedingcanada.ca/documents/BCC_BFI_20110704_Final_BCC_BFI_Integrated_Indicators_English.pdf.
4. Baby-Friendly Initiative Ontario. Homepage. Toronto, ON. Available from: <http://www.breastfeedingontario.org/>.
5. Ontario. Ministry of Health and Long-Term Care. Glossary for the Ontario public health standards. Toronto, ON: Queen's Printer for Ontario; 2008 [cited 2012 Nov 21]. Available from: http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/glossary.aspx.

Appendix A: Baby-Friendly Initiative (BFI) Status Report 2012 Year-End Reporting Form

Table 1: Year-End Reporting Form

Ministry of Health and Long Term Care (Health Promotion Division) Public Health Unit (PHU) Baby-Friendly Initiative (BFI) Status Report 2012 Year-End Reporting Form	
Health Unit:	Date:
Completed by:	Title:
Contact phone number:	
<p><i>Public health units must check off all requirements completed for the time period from July 1, 2012 to December 31, 2012 according to the BFI Status Report Reference Guide 2012, posted to the Directory of Networks site (DoN) and the Family Health Network Collaborative site. A copy of the BFI Status Report submitted to the ministry for BFI baseline reporting, and 2012 mid-year reporting can be accessed in the PHU folder on the DoN.</i></p>	
<p>Preliminary Work -- Requirements</p> <p><input type="checkbox"/> Certificate of Intent: Date on Certificate:</p> <p><input type="checkbox"/> PHU has a designated BFI primary contact person</p> <p><input type="checkbox"/> PHU has obtained and communicated endorsement of Medical Officer of Health (MOH) Date:</p> <p><input type="checkbox"/> PHU has obtained copy of the <i>BCC BFI Integrated 10 Steps Practice Outcomes Indicators for Hospital and Community Health Services Tool</i> and initiated self-appraisal Date:</p> <p><input type="checkbox"/> PHU has developed a written plan to achieve BFI designation Date:</p> <p><input type="checkbox"/> PHU has developed a plan for staff training Date:</p> <p><input type="checkbox"/> PHU has reviewed their existing data and identified any data needs Date:</p> <p><input type="checkbox"/> PHU has identified priorities for the next reporting period – List:</p>	

Intermediate Work – Requirements

- Certificate of Participation Date on Certificate:**
- PHU has identified a multidisciplinary committee **Date:**
- PHU has performed Self-Appraisal Assessment **Date:**
- PHU has developed a written BFI policy **Date:**
- PHU provided Board of Health (BOH), MOH, staff and volunteers initial orientation to the policy and annual reorientation **Date:**
- PHU provided staff education (both direct and indirect providers) **Date:**
- PHU reviewed and updated Prenatal Curriculum **Date:**
- PHU provided written Information Materials for women and their families
- Endorsement of BOH **Date:**
- PHU developed plan for capturing data **Date:**
- PHU has identified priorities for the next reporting period – **List:**

Advanced Work – Requirements

- Documentation Review Submitted **Date:**
- Documentation Review Process completed **Date:**
- Submitted the Pre-Assessment Contract and fee to OBC **Date:**
- Completed data analysis **Date:**
- Pre-assessment Site Visit planned **Date:**
- Submitted the External Assessment Contract and fee to BCC **Date:**
- External Site Visit planned **Date:**
- PHU has identified priorities for the next reporting period – **List:**

BFI Designation – Requirements

- BCC Certificate of BFI Designation Date: OR**
- Receipt of label to affix to designation Date:**

Maintenance of BFI Designation

- Self Report submitted to BCC **Date:**
- Annual data review and analysis submitted to BCC **Date:**
- Submitted External Assessment Contract and fee to BCC **Date:**
- Site Visit planned for redesignation **Date:**
- PHU has identified priorities for the next reporting period – **List:**

For Exceptional Circumstances as identified by BCC:

- Certificate of Commitment - Date on Certificate:**
- BFI Action Plan **Date:**
- PHU has identified priorities for the next reporting period – **List:**

Appendix B:

Ministry of Health and Long-Term Care Public Health Unit Baby-Friendly Initiative (BFI) Status Report Reference Guide 2012

The Public Health Unit (PHU) BFI Status Report Reference Guide 2012 identifies and describes each BFI status category. Public health units will be required to report their BFI status to the Ministry of Health and Long-Term Care as requested using the Public Health Unit BFI Status Report. The ministry may request validation of any requirement.

Through the former Ministry of Health Promotion and Sport's consultation process with PHUs, the need for a standardized report was identified so PHUs could confidently report their BFI status, establish their targets and meet performance expectations. The ministry consulted several PHUs and the Breastfeeding Committee for Canada (BCC) in the preparation, creation and testing of this document.

The PHU BFI Status Report is comprised of five BFI status categories: Preliminary work, Intermediate work, Advanced work, BFI Designation and BFI maintenance. The reference guide describes each category using two columns: one identifies the requirements and the second provides the working definition.

PHUS provided a baseline self report to the former ministry checking off each requirement achieved or completed on the PHU BFI Status Report: November 2011, according to the instructions and working definitions. The ministry used the baseline data for the purposes of establishing targets. The baseline report has been placed in the public health unit's file folder on the Directory of Networks (DoN) site.

BFI is a capacity building process and is not linear until the Advanced Work category. PHUs may complete the requirements within the Intermediate category in any order.

PHUs who are currently in the Advanced Category, BFI designated (including re-designated) are only required to complete the Advanced Category section or the BFI designation and BFI maintenance sections of the BFI Status Report. PHUs in either the Preliminary or Intermediate Category must check off all requirements completed.

For further assistance or clarification please contact:

Janette Bowie

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Health Promotion Division

Ministry of Health and Long-Term Care

416 326-2012

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Table 1: Preliminary Work

Preliminary Work	PHU has contacted the Baby-Friendly Initiative Ontario (BFI Ontario) and received a Certificate of Intent.
Requirements	Working Definition
<input type="checkbox"/> Certificate of Intent Date on Certificate	<p>This is a BFI Ontario document confirming the PHU has established contact with BFI Ontario. The Date reported by the PHU is the date appearing on the Certificate. BFI Ontario assigns a primary contact person to support the PHU.</p>
<input type="checkbox"/> PHU has a designated BFI primary contact person	<p>A primary PHU contact person must be identified. This person will be responsible for all communications with BFI Ontario and BCC.</p>
<input type="checkbox"/> PHU has obtained and communicated endorsement of Medical Officer of Health (MOH) to proceed with the BFI Designation process - date	<p>The MOH has endorsed implementation of the BFI and has communicated this intent to all PHU staff and the Board of Health (BOH).</p>
<input type="checkbox"/> PHU has obtained copy of the <i>BCC BFI Integrated 10 Steps Practice Outcomes Indicators for Hospital and Community Health Services Tool</i> and initiated self-appraisal	<p>The PHU will complete an initial self appraisal using the <i>BCC BFI Integrated 10 Steps Practice Outcomes Indicators for Hospital and Community Health Services</i> to assess the degree to which PHU practices are in line with the Ten Steps. This assessment enables the PHU to begin to develop its BFI plan.</p>
<input type="checkbox"/> PHU has developed a written plan to achieve BFI designation.	<p>The PHU will review their practices and develop a written plan to ensure that the <i>BCC BFI Integrated 10 Steps Practice Outcomes Indicators for Hospital and Community Health Services</i> are implemented. The plan can be incorporated into the most suitable format(s) for the PHU e.g. Strategic Plan, Operational Plans, Workplans, Logic Model, etc. The plan identifies implementation steps, budget, timelines and staffing allocations.</p>

Preliminary Work	PHU has contacted the Baby-Friendly Initiative Ontario (BFI Ontario) and received a Certificate of Intent.
Requirements	Working Definition
<input type="checkbox"/> PHU has developed a plan for staff training	The PHU has developed a written plan, budget and timeline reflecting the various training needs of staff to achieve BFI designation. There is no single training program that a PHU must utilize. Staff can be trained at different times using different modalities dependant on the PHU resources available and the level of service provided by the staff. BFI Ontario is a consulting resource to PHUs searching for training options.
<input type="checkbox"/> PHU has reviewed their existing data and identified any data needs	The PHU has reviewed Appendix 6.3 pgs 33-34 in the <i>BFI Integrated 10 Steps Practice Outcomes Indicators for Hospital and Community Health Services</i> and identified possible data sources to meet this requirement. As a minimum, PHUs need to know: the intention to breastfeed rates, the exclusive breastfeeding on hospital discharge rate, the duration and exclusivity rates at 6 months and have a consistent approach to data collection that shows change over time.
<input type="checkbox"/> PHU has identified priorities for the next reporting period	The PHU has identified the key BFI priorities for the upcoming calendar year. The PHU will update the key priorities for the next six month period.

Table 2: Intermediate Work

Intermediate Work	PHU has received a Certificate of Participation from the Breastfeeding Committee for Canada (BCC)
Requirements	Working Definition
<input type="checkbox"/> Certificate of Participation – Date on Certificate	This is a BCC document awarded by BFI Ontario. The Date reported by the PHU is the date appearing on the Certificate.

Intermediate Work	PHU has received a Certificate of Participation from the Breastfeeding Committee for Canada (BCC)
Requirements	Working Definition
<input type="checkbox"/> PHU has identified a multidisciplinary committee	<p>The multidisciplinary committee is essential to integrating and supporting BFI organizationally. The committee must reflect the community the PHU serves and include administrators, staff and members of the community. The established multidisciplinary committee could be an existing community committee/coalition addressing maternal and child health with a commitment to BFI</p>
<input type="checkbox"/> PHU has performed Self-Appraisal Assessment	<p>The PHU has completed the <i>BCC BFI Integrated Practice Outcome Indicators (BFI Indicators)</i> including all appendices.</p>
<input type="checkbox"/> PHU has developed a written BFI policy	<p>The PHU has a written and approved breastfeeding policy that is communicated annually to all PHU staff and volunteers. The policy must be: multidisciplinary, support staff members who are breastfeeding, visibly posted in all sites and areas of the organization that serve pregnant women, mothers, infants and children, and provided to new staff as part of their formal orientation process.</p>
<input type="checkbox"/> PHU provided BOH, MOH, staff and volunteers initial orientation to the policy and annual reorientation	<p>All PHU BOH, MOH, staff and volunteers understand that the BFI promotes, supports, and protects optimal infant feeding, understand their role, and have been reoriented to the BFI policy annually.</p>
<input type="checkbox"/> PHU provided staff education (both direct and indirect providers)	<p>In addition the above point, 50% of staff who are involved in direct care of expectant families, new parents and infants and young children (regardless of their program) have received breastfeeding education. The remaining 50% must be aware of when and how they will be trained. Refer to <i>BCC BFI Integrated 10 Steps Practice Outcomes Indicators for Hospital and Community Health Services: Appendix 2.1, Pgs 17-20.</i></p>

Intermediate Work	PHU has received a Certificate of Participation from the Breastfeeding Committee for Canada (BCC)
Requirements	Working Definition
<input type="checkbox"/> PHU reviewed and updated Prenatal Curriculum	<p>The PHU ensures all expectant families and their care providers have access to prenatal information and programming. Key messages include the importance of skin to skin, baby led latching, frequency of feedings, cue based feeding, hand expression and written materials about community resources to support optimal infant feeding to 2 years and beyond.</p>
<input type="checkbox"/> PHU provided written Information Materials for women and their families	<p>The PHU ensures all expectant and new families have access to <i>Breastfeeding Matters</i> and other complimentary materials in various formats. <i>Breastfeeding Matters</i> meets BFI requirements and reflects the continuum of care approach.</p>
<input type="checkbox"/> Endorsement of BOH	<p>The BOH endorses PHU work to achieve BFI Designation.</p>
<input type="checkbox"/> PHU developed plan for capturing data	<p>The PHU developed a plan to report and share breastfeeding data internally and externally with a minimum data set of: intention to breastfeed, breastfeeding initiation, duration and exclusivity rates. The PHU identified: data source, process for data collection and review, and will be able to report on intention to breastfeed, breastfeeding initiation, duration and exclusivity rates and describe any changes over the past three years.</p> <p>The PHU will have reviewed Appendix 6.3 pgs 33-34 in <i>the BFI Integrated 10 Steps Practice Outcomes Indicators for Hospital and Community Health Services</i>, has identified possible data sources.</p>
<input type="checkbox"/> PHU has identified priorities for the next reporting period	<p>The PHU has identified the key BFI priorities for the upcoming calendar year. The PHU will update the key priorities for the next six month period.</p>

Table 3: Advanced Work

Advanced Work	PHU has engaged with BCC to begin BFI designation process and is working on the BFI pre-assessment requirements
Requirements	Working Definition
<input type="checkbox"/> Documentation Review Process Submitted - date	The PHU has received recommendations from BCC. Date reported is the date recommendations received by PHU from BFI Ontario.
<input type="checkbox"/> Documentation Review Process completed - date	The PHU has received recommendations from BCC. Date reported is the date recommendations received by PHU from BFI Ontario.
<input type="checkbox"/> Submit the Pre-Assessment Contract and fee to BFI Ontario - date	Date reported is the date contract and fee are submitted to BFI Ontario
<input type="checkbox"/> Completed data analysis - date	Date reported is date when PHU has completed data analysis
<input type="checkbox"/> Pre-assessment Site Visit planned - date	Date reported is date of planned Site Visit as arranged with BFI Ontario
<input type="checkbox"/> Submit the External Assessment Contract and fee to BCC - date	Date reported is the date contract and fee are submitted to BCC
<input type="checkbox"/> External Site Visit planned - date	Date reported is date of planned Site Visit as arranged with BCC
<input type="checkbox"/> PHU has identified priorities for the next reporting period	The PHU has identified the key BFI priorities for the upcoming calendar year. The PHU will list the key priorities for the next six month period.

Table 4: BFI Designation

BFI Designation	PHU has obtained BFI designation
Requirements	Working Definition
<input type="checkbox"/> BCC Certificate of BFI Designation <p style="text-align: center;">or</p> <input type="checkbox"/> Receipt of label to affix to designation	The PHU has received their BCC certificate or label. Date of designation / re-designation is noted
Maintenance of BFI Designation	PHU is maintaining BFI designation and planning for redesignation
<input type="checkbox"/> Self Report Submitted to BCC – date	Date reported is date PHU sent report to BCC
<input type="checkbox"/> Annual data review and analysis submitted to BCC	Date reported is date PHU submitted analysis to BCC
<input type="checkbox"/> Submit the External Assessment Contract and Fee to BCC	Date reported is the date contract and fee are submitted to BCC
<input type="checkbox"/> Site Visit planned for redesignation	Date reported is date of planned Site Visit as arranged with BCC
<input type="checkbox"/> PHU has identified priorities for the next reporting period	The PHU has identified the key BFI priorities for the upcoming calendar year. The PHU will list the key priorities for the next six month period.

Table 5: For exceptional Circumstances as identified by BCC

<input type="checkbox"/> Certificate of Commitment – date	<p>This BCC certificate identifies that many best practices are in place but PHU has not yet achieved BFI designation. The Date reported by the PHU is the date appearing on the Certificate. As a result the PHU must develop an action plan to address any deficiencies</p>
Requirements	Working Definition
<input type="checkbox"/> BFI Action Plan - date	<p>The PHU has developed a written Action Plan to address deficiencies. The Date reported by the PHU is the date the Action Plan is completed.</p>
<input type="checkbox"/> PHU has identified priorities for the next reporting period	<p>The PHU has identified the key BFI priorities for the upcoming calendar year. The PHU will list the key priorities for the next six month period.</p>

