CITY OF HAMILTON

PUBLIC HEALTH SERVICES
Office of the Medical Officer of Health

TO: Mayor and Members Board of Health	**WARD(S) AFFECTED:** CITY WIDE
COMMITTEE DATE: February 6, 2012	
SUBJECT/REPORT NO: Public Health Accountability Agreement – Response to Ministry Draft OPHS Performance Targets for 2012 & 2013 BOH11038(a) (City Wide)	
SUBMITTED BY: Elizabeth Richardson, MD, MHSc, FRCPC Medical Officer of Health Public Health Services Department	**PREPARED BY:** Dr. Elizabeth Richardson 905-546-2424 ext. 3502
SIGNATURE:	

RECOMMENDATION

a) That report BOH 11038(a) - Public Health Accountability Agreement – Response to Ministry Draft OPHS Performance Targets for 2012 & 2013 be received; and

b) That the Medical Officer of Health be authorized and directed to send the response outlined in Appendix B to this report, regarding BOH recommendations for the 2012 and 2013 Performance Targets for the Ontario Public Health Standards for Hamilton to the Ministry of Health & Long Term Care.

EXECUTIVE SUMMARY

In October of 2011, the Board of Health authorized and directed the Medical Officer of Health to sign the Accountability Agreement (AA) between the City of Hamilton and the Ministry of Health & Long Term Care for the Ontario Public Health Standards (OPHS) and related programs. Accountability agreements between local boards of health and the Province replaced the Program-Based Grants Terms and Conditions which had been the legal framework under which boards of health received provincial funding to

carry out the OPHS and related programs. The AA executed in October was retroactive to January 1, 2011 and covers a three year period to December 31, 2013.

Schedule D (Appendix A) of the agreement outlines Board of Health Performance Requirements, and sets out performance indicators to both improve board of health performance and support the achievement of improved health outcomes for Ontarians. It is not clear if these are performance targets/goals that local public health should work toward, or minimum standards. At this time, funding is not tied to board of health performance on the indicators outlined in the AA, but it is envisioned that this will be the case in the future. Baseline information for these indicators was collected from all health units during the final quarter of 2011, and the Ministry subsequently provided draft targets for improvement for consideration by local boards of health.

Staff recommend the acceptance of many of the targets, as outlined in Appendix B. The appropriateness of some of the indicators themselves as performance measures for local boards of health continues to be questioned, however, these indicators and targets are recommended to be accepted with the understanding that they should be monitored as health status indicators.

In the case of some of the inspection programs, the targets suggested by the Ministry can be accepted as targets, but a slightly lower number is recommended if it is to be interpreted as a minimum standard. In the case of some of the immunization targets, the targets are not reasonable at all. For these programs, staff recommend that the Board of Health propose alternate targets and request that the Ministry convene a province-wide discussion regarding possible program changes to improve program reach and the establishment of realistic targets.

Alternatives for Consideration – See page 5

FINANCIAL / STAFFING / LEGAL IMPLICATIONS (for Recommendation(s) only)

Financial: There are no specific funding implications associated with the setting of these targets at this time. Staff recommendations outlined in Appendix B are based on maintenance of current budget allocations to the programs and services covered by the these indicators.

In the future, funding may become contingent upon attainment of these performance targets.

Staffing: There are no specific staffing implications associated with the setting of these targets at this time. Staff recommendations outlined in Appendix B are based on

maintenance of current staffing allocations to the programs and services covered by the indicators. No new staffing is being proposed at this time.

Legal: There are no new legal implications associated with these targets.

HISTORICAL BACKGROUND (Chronology of events)

The evolution of the Ontario Public Health System has been further detailed in report BOH09004 and summarized in the April 26, 2010 presentation to the Board of Health on the Ontario Public Health Performance Management System and Organizational Standards. Further background on the Public Health Accountability Agreement can be found in report BOH11038.

POLICY IMPLICATIONS

Setting of Performance Targets for the programs and services that Hamilton Public Health Services carries out under the Ontario Public Health Standards is an important component of continuous quality improvement, and is aligned with the Public Health Services Strategic Business Plan goal of developing a performance monitoring system for the OPHS.

RELEVANT CONSULTATION

N/A

ANALYSIS / RATIONALE FOR RECOMMENDATION

(include Performance Measurement/Benchmarking Data, if applicable)

Accountability Agreements are one component of a system for ensuring public health programs are designed, managed and governed in a progressive and effective manner. The Agreement builds upon the Terms and Conditions of funding which have been in place between the City and the Province for a number of years and introduces program metrics about the effectiveness of local public health programs and services. This agreement aligns with the Public Health Services plan to develop an OPHS monitoring system that provides performance measurement data. Setting of targets for these indicators is an important component of continuously improving local and provincial

public health system performance and thereby, contributing to the improved health of Hamiltonians and Ontarians in general.

The performance targets addressed in this report represent the completion of the first stage in setting performance targets for public health programs. The current performance indicators and targets do not comprehensively address the range of programs and services mandated under the Ontario Public Health Standards. In 2012 and 2013, local public health agencies are also required to work with the province on "Developmental Indicators" for areas of mutual interest including, but not limited to:

(i) physical activity;
(ii) healthy eating and nutrition;
(iii) child and reproductive health;
(iv) comprehensive tobacco control; and
(v) equity.

Staff recommend the acceptance of many of the targets, as outlined in Appendix B, but not all. The appropriateness of some of the indicators themselves as performance measures for local boards of health continues to be questioned, such as fall-related emergency visits in seniors. The indicators are not appropriate as performance standards as boards of health are just one of many agencies and factors that influence these rates. The indicators are important and appropriate as health status indicators to monitor and set targets for each community. However if the indicator declines, it may indicate a need for additional resources to address local need, action by another influencer, greater collaboration across all local influencers, or advocacy for system or policy change. The board of health could accept these indicators with that understanding.

In the case of some of the inspection programs, the targets suggested by the Ministry can be accepted as targets, but a slightly lower number is recommended if it is to be interpreted as a minimum standard. For example, the goal of 100% inspection of high risk food premises every four months is a good target, and one that PHS is close to achieving already. However, due to turnover in businesses, or urgent needs in a related inspection program, for example due to a large food recall or outbreak, it may not be possible to meet the 100% goal every four months. For these indicators it is recommended that the proposed target be accepted as a goal, but an alternate target of >95% be recommended as a minimum standard.

Finally, some of the immunization targets are not reasonable as minimum standards or near-term goals. In the case of the HPV program, no program in Ontario has been able to reach the proposed target of 90%. The highest coverage reached to date is 65%. This is because provincial-level policies and public attitudes do not support greater uptake of the vaccine. Even with substantial changes to how Hamilton PHS carries out the program, the proposed targets could not be achieved, and resources would have been directed away from other effective programs that impact the health of our

community. For these programs, staff recommend that the Board of Health propose alternate targets, and request that the Ministry convene a province-wide discussion regarding realistic targets, and possible program changes to improve program reach so that the laudable goals set out in the province's proposal might be reached in time.

Staff will continue to keep the Board of Health informed about the Ministry's response regarding these performance targets, as well as work on the Developmental Indicators.

ALTERNATIVES FOR CONSIDERATION

(include Financial, Staffing, Legal and Policy Implications and pros and cons for each alternative)

The Board of Health could elect to accept the Performance Targets as originally proposed by the province. However, this is not recommended as some of the targets, as outlined above and in Appendix B, are not reasonably achievable. If resources were realigned from other program areas to strive to achieve these unreasonable targets without greater system change, it would result in both inefficient use of resources and declines in program performance in other effective program areas that improve the health of Hamiltonians.

CORPORATE STRATEGIC PLAN (Linkage to Desired End Results)

The OPHS and Accountability Agreement are designed to create an accountable, continuously improving organization with excellence in both program delivery and governance. Continued implementation of the components of the AA, including setting of the performance targets, is consistent with many of the Corporate Strategic Plan goals, including:

Skilled, Innovative & Respectful Organization – the standards help establish a culture of excellence, develop a skilled, adaptive and diverse workforce, promote more innovation, greater teamwork, better client focus, a respectful culture, and effective communication

Financial Sustainability – the AA aims to set out a framework for financially sustainable, cost-effective public health programs and services, and effective management of capital assets

Effective Inter-governmental Relations – the agreement, once funding is linked to indicators and performance may allow Hamilton to acquire a greater share of Provincial and Federal grants (including those that meet specific needs). The AA also sets out standards for Service Level Agreements for any portion of the OPHS the Board contracts with other public agencies

Healthy Community - the AA is implemented in part to ensure that all Ontarians have equitable access to public health programs and services without barriers or stigma

APPENDICES / SCHEDULES

Appendix A: Schedule D to Accountability Agreement
Appendix B: Recommended Response to Ministry draft Performance Targets

SCHEDULE D

BOARD OF HEALTH PERFORMANCE

PART A. PURPOSE OF SCHEDULE

To set out Performance Indicators to improve board of health performance and support the achievement of improved health outcomes in Ontario.

PART B. PERFORMANCE OBLIGATIONS

Definitions

1. In this Schedule, the following terms have the following meanings:

"**BOH Baseline**" means the result at a given time for a performance indicator that provides a starting point for establishing targets for future board of health performance and measuring changes in such performance.

"**Developmental Indicator**" means a measure of performance or an area of common interest for creating a measure of performance that requires development due to factors such as the need for new data collection, methodological refinement, testing, consultation, or analysis of reliability, feasibility or data quality before being considered to be added as a Performance Indicator.

FUNDING YEAR 2011 - OBLIGATIONS

1. The Province will:

(a) Provide to the Board of Health technical documentation on the Performance Indicators set out in Table A including methodology, inclusions and exclusions for the Performance Indicators and their corresponding Performance Corridors; and,

(b) Provide the Board of Health with the values for the Performance Indicators set out in Table A.

2. **Both Parties** will,

(a) By December 2011 (or by such later date as mutually agreed to by the Parties), establish appropriate BOH Baselines for all Performance Indicators;

(b) Once BOH Baselines are established, develop Performance Targets for 2012 and 2013 for the Performance Indicators outlined in Table A;

(c) Collaborate on the development of Developmental Indicators for areas of mutual interest including, but not limited to:

(i) physical activity;
(ii) healthy eating and nutrition;
(iii) child and reproductive health;
(iv) comprehensive tobacco control; and
(v) equity.

FUNDING YEARS 2012-13 - OBLIGATIONS

1. The Province will:

(a) Provide the Board of Health with values for the Performance Indicators set out in Table A.

2. **Both Parties** will,

(a) Establish appropriate BOH Baselines for Performance Indicators where required;

(b) Once remaining BOH Baselines are established, develop Performance Targets for 2012 and 2013 for the Performance Indicators outlined in Table A;

(c) By December 31, 2012 (or by such later date as mutually agreed to by the Parties), refresh Performance Targets for 2013 for the Performance Indicators outlined in Table A; and

(d) Collaborate on the development of Developmental Indicators for areas of mutual interest including, but not limited to:

(i) physical activity;
(ii) healthy eating and nutrition;
(iii) child and reproductive health;
(iv) comprehensive tobacco control; and
(v) equity.

Table A: Performance Indicators Based on Program Standards[3]				
INDICATOR	**Baseline**	**Performance Target[1]**		
		2011[2]	**2012**	**2013**
% of high risk food premises inspected once every 4 months while in operation	TBD	Establish Baseline		
Proportion of pools and public spas by class inspected while in operation	TBD	Establish Baseline		
% of completed SDWS inspections, of those that are high risk, that are due for re-inspection	TBD	Establish Baseline		
Time between health unit notification of Gonorrhea and initiation of follow up	TBD	Establish Baseline		
Time between health unit notification of an i-GAS case and initiation of follow up	TBD	Establish Baseline		
% of known high risk personal services settings inspected annually	TBD	Establish Baseline		
% of vaccine wasted by vaccine type (HPV, influenza, pneumococcal, and DPT) that are stored/ administered by the PHU	TBD	Establish Baseline		
% completion of reports related to vaccine wastage by vaccine type (HPV, influenza, pneumococcal, and DPT)	TBD	Establish Baseline		

Table A: Performance Indicators Based on Program Standards[3]				
INDICATOR	BOH Baseline	Performance Target[1]		
		2011[2]	2012	2013
% of school-aged children who have completed immunizations for Hepatitis B, HPV and meningococcus	TBD	Establish Baseline		
% of youth (ages 12 - 19) who have never smoked a whole cigarette	TBD	Establish Baseline		
% tobacco vendor compliance with legislation by infraction type	TBD	Establish Baseline		
Fall-related emergency department visits by age group (age groups TBD)	TBD	Establish Baseline		
% of population that exceeds Low-Risk Drinking Guidelines	TBD	Establish Baseline		
Baby Friendly Initiative Status	TBD	Establish Baseline		

Notes:

1) Performance Corridors for each Performance Target are identified below the Performance Target in brackets.
2) BOH Baselines will be established for each Performance Indicator during Funding Year 2011, where possible. Reporting on Performance Targets will begin in Funding Year 2012.
3) Reporting on Organizational Standards and other items will begin in Funding Year 2012.

City of Hamilton - Public Health Services Accountability Agreement Performance Indicator Targets		Baseline Period	Ontario Median	Ontario Range	Your Baseline	MOHLTC Health Promotion Division Identified Targets Date: January 2012				2011 actual if known	Board of Health Proposed Targets Date:					
						2012 Target	Rationale for 2012 Target	2013 Target	Rationale for 2013 Target		1 Board of Health Accepts (Y/N)		2	3	4	5
Indicator											2012	2013	2012 Target	Board of Health Rationale for 2012 Target	2013 Target	Board of Health Rationale for 2013 Target
10	% of youth (ages 12-18) who have never smoked a whole cigarette	2009+2010	84.2%	67.3%-92.5%	86.6%	N/A	MHPS will monitor 2012 results but due to data quality, will only set a 2013 target using combined 2012-2013 data.	88.3%	Achievement of targets will result in continued improvement at the provincial level. Your health unit is in quartile 2 which has been assigned a target of +2% relative to your baseline based on current performance and room for further improvement.	N/A	Y	Y	N/A	Agree with no target for 2012	88.3%	This indicator is not appropriate as a performance indicator as PHS is only one of many influencers over these rates. These are important and appropriate as health status indicators to monitor and set targets for. If status declines, it may indicate a need for additional resources to address local need, action by another influencer, greater collaboration across all local influencers, or advocacy for system or policy change. The Board of Health could accept this indicator with that understanding.
11	% of tobacco vendors in compliance with youth access legislation at the time of last inspection	2011	94%	79%-100%	79%	≥90%	Achievement of targets will result in maintaining the current provincial tobacco vendor compliance rates. Your health unit has been assigned a tobacco vendor compliance rate target of ≥90% based on current performance and room for further improvement. A minimum of a 90% tobacco vendor compliance rate has been documented as the level that effectively limits youth access to tobacco products and takes into consideration other confounding factors.	≥90%	Achievement of targets will result in maintaining the current provincial tobacco vendor compliance rates. Your health unit has been assigned a tobacco vendor compliance rate target of ≥90% based on current performance and room for further improvement. A minimum of a 90% tobacco vendor compliance rate has been documented as the level that effectively limits youth access to tobacco products and takes into consideration other confounding factors.		Y	Y	≥90%	Note the Ministry-established baseline (79%) for Hamilton did not take into account a full year of data, nor a negotiated reduced # of Test Shop inspections in order that PHS could participate in the MHPS/OTRU taxi pilot study. Based on our own data inventory/analysis the baseline compliance rate is approximately 87-92%. Reaching a 2013 target of <90% should not be a problem.	≥90%	Note the Ministry-established baseline (79%) for Hamilton did not take into account a full year of data, nor a negotiated reduced # of Test Shop inspections in order that PHS could participate in the MHPS/OTRU taxi pilot study. Based on our own data inventory/analysis the baseline compliance rate is approximately 87-92%. Reaching a 2013 target of <90% should not be a problem.

City of Hamilton - Public Health Services Accountability Agreement Performance Indicator Targets		Baseline Period	Ontario Median	Ontario Range	Your Baseline	MOHLTC Health Promotion Division Identified Targets Date: January 2012				2011 actual if known	Board of Health Proposed Targets Date:					
						2012 Target	Rationale for 2012 Target	2013 Target	Rationale for 2013 Target		1 Board of Health Accepts (Y/N)		2	3	4	5
Indicator											2012	2013	2012 Target	Board of Health Rationale for 2012 Target	2013 Target	Board of Health Rationale for 2013 Target
12	Fall-related emergency visits in older adults aged 65+ (rate per 100,000 per year)	2009	6,020	3817-8365	5,639	N/A	MHPS will continue to monitor 2012 results but due to data lag, will only set a 2013 target.	5,470	Achievement of targets will result in a reversal of the current provincial trend of increasing falls rates among those aged 65 years+. Note that 2013 target reflects 2012 achievements. Your health unit is in quartile 2 which has been assigned a target of -3% relative to your baseline, based on current performance and room for further improvement.		Y	Y	N/A	Agree with no target for 2012	5,470	This indicator is not appropriate as a performance indicator as PHS is only one of many influencers over these rates. These are important and appropriate as health status indicators to monitor and set targets for. If status declines, it may indicate a need for additional resources to address local need, action by another influencer, greater collaboration across all local influencers, or advocacy for system or policy change. The Board of Health could accept this indicator with that understanding.
13	% of population (19+) that exceeds the Low-Risk Drinking Guidelines	2009+ 2010	32.2%	20.2%-36.5%	28.3%*	N/A	MHPS will monitor 2012 results but due to data quality, will only set a 2013 target using combined 2012-2013 data.	27.1%	Achievement of targets will result in improvement at the provincial level. Your health unit is in quartile 2 which has been assigned a target of -4% relative to your baseline based on current performance and room for further improvement.		Y	Y	N/A	Agree with no target for 2012	27.1%	This indicator is not appropriate as a performance indicator as PHS is only one of many influencers over these rates. These are important and appropriate as health status indicators to monitor and set targets for. If status declines, it may indicate a need for additional resources to address local need, action by another influencer, greater collaboration across all local influencers, or advocacy for system or policy change. The Board of Health could accept this indicator with that understanding.

City of Hamilton - Public Health Services Accountability Agreement Performance Indicator Targets		Baseline Period	Ontario Median	Ontario Range	Your Baseline	MOHLTC Health Promotion Division Identified Targets				2011 actual if known	Board of Health Proposed Targets					
						Date: January 2012					Date:					
						2012 Target	Rationale for 2012 Target	2013 Target	Rationale for 2013 Target		1 Board of Health Accepts (Y/N)		2	3	4	5
Indicator											2012	2013	2012 Target	Board of Health Rationale for 2012 Target	2013 Target	Board of Health Rationale for 2013 Target
14	Baby Friendly Initiative Status (category)	2011	N/A	Preliminary - Designated	Intermediate	Advanced	MHPS' goal is to have all public health units BFI Designated to support breastfeeding in Ontario. Currently your health unit is in the Intermediate category with an assigned target of Advanced.	Designated	MHPS' goal is to have all public health units BFI Designated to support breastfeeding in Ontario. Your health unit will be in the Advanced category with the assigned target of BFI Designation.	Inter-mediate	No	No	Intermediate	Plan is to complete remaining BFI Status Report requirements of the "Intermediate" level (staff education, written information materials for women and their families, finalize plan for future data collection/ analysis including beginnning a 2nd breastfeeding survey the recruitment method of which may be influenced by Healthy Babies Healthy Children policy changes and thus more time-consuming) and the following "Advanced" requirements-identify priorities for year 2013, complete present survey data anaylsis & report, continue to collect and analyze 2nd breastfeeding survey data, documentation review in progress.	Advanced in preparation for 2014 designation	Plan for completion of all staff education, completion of 2nd Breastfeeeding Survey data analysis; the collection and analysis of the 3rd Breastfeeding Survey data (its completion will occur in 2014) plus the Advanced BFI Status Report requirements which include submission of Pre-Assessment contract/fee, pre-assessment site visit. Remaining "Advanced" requirements -external site visit and submission of External Assessment Contract and fee to BCC will take place in 2014.

***95% Confidence Interval (24.9%, 31.7%)**

CITY OF HAMILTON Accountability Agreement Performance Indicator Targets		Ontario Median	Ontario Range	Your Baseline	MOHLTC Identified Targets				2011 actual if known	Board of Health Proposed Targets						
					Date: 23/12/2011					Date:						
					2012 Target	Rationale for 2012 Target	2013 Target	Rationale for 2013 Target		1 Board of Health Accepts (Y/N)		2	3	4	5	
	Indicator									2012	2013	2012 Target	Board of Health Rationale for 2012 Target	2013 Target	Board of Health Rationale for 2013 Target	
1	% of high risk food premises inspected once every 4 months while in operation Baseline Year: 2010	82%	15% - 100%	71%	100%	It is anticipated that with improvements to business practices and data quality, the board of health will be able to make signficant improvements in 2012.	100%	All boards of health are expected to meet the requirements as stated in the Ontario Public Health Standards.	97%	yes	yes	as performance target 100% as minimum standard >95%	This target is currently in the OPHS standsrds and is consistent with our policies and procedures.	as performance target 100% as minimum standard >95%	This target is currently in the OPHS standsrds and is consistent with our policies and procedures.	
2	% of pools and public spas by class inspected while in operation Baseline Year: 2010	73%	0% - 100%	17%	≥ 75%	It is acknowledged that baseline results may be reflective of issues with data retrieval. It is anticipated that with improvements to business practices and data quality, the board of health will be able to make signficant improvements in 2012.	100%	All boards of health are expected to meet the requirements as stated in the Ontario Public Health Standards.	100%	yes	yes	as performance target 100% as minimum standard >95%	This target is currently in the OPHS standsrds and is consistent with our policies and procedures.	as performance target 100% as minimum standard >95%	This target is currently in the OPHS standsrds and is consistent with our policies and procedures.	
3	% of high-risk Small Drinking Water Systems (SDWS) inspections completed for those that are due for re-inspection Baseline Year: unavailable	cannot be established	cannot be established	cannot be established	100%	The target for this indicator is not negotiable. Baseline data is not available for this indicator. All boards of health are expected to complete the required inspections of high-risk SDWS as stated in the Ontario Public Health Standards.	100%	The target for this indicator is not negotiable. All boards of health are expected to complete the required inspections of high-risk SDWS as stated in the Ontario Public Health Standards.	100%	yes	yes	as performance target 100% as minimum standard >95%	This target is currently in the OPHS standsrds and is consistent with our policies and procedures.	as performance target 100% as minimum standard >95%	This target is currently in the OPHS standsrds and is consistent with our policies and procedures.	
4	Time between health unit notification of a case of gonorrhoea and initiation of follow-up *This indicator measures the percentage of confirmed gonorrhoea cases where initiation of follow-up occurred within 0-2 business days* Baseline Year: 2010	80%	0% - 100%	Cannot be established	100%	As a baseline cannot be established, a target has been established based on the requirements as stated in the Ontario Public Health Standards.	100%	All boards of health are expected to meet the requirements as stated in the Ontario Public Health Standards.	N/A	yes	yes	100	This target is currently in the OPHS standsrds and is consistent with our policies and procedures.	100	This target is currently in the OPHS standsrds and is consistent with our policies and procedures.	
5	Time between health unit notification of an Invasive Group A Streptococcal Disease (iGAS) case and initiation of follow-up *This indicator measures the percentage of confirmed iGAS cases where initiation of follow-up occurred on the same day as receipt of lab confirmation of a positive case* Baseline Year: 2010	94%	3% - 100%	Cannot be established	100%	iGAS is a serious disease that requires immediate follow-up. Historical data has also shown relatively low case counts for all boards of health. With improvements in business practices, it is anticipated that all boards of health will be able to initiate follow-up of all cases on the same day.	100%	iGAS is a serious disease that requires immediate follow-up. Historical data has also shown relatively low case counts for all boards of health. With improvements in business practices, it is anticipated that all boards of health will be able to initiate follow-up of all cases on the same day.	N/A	yes	yes	100%	This target is currently in the OPHS standsrds and is consistent with our policies and procedures.	100	This target is currently in the OPHS standsrds and is consistent with our policies and procedures.	

CITY OF HAMILTON Accountability Agreement Performance Indicator Targets		Ontario Median	Ontario Range	Your Baseline	MOHLTC Identified Targets				2011 actual if known	Board of Health Proposed Targets					
					Date: 23/12/2011					Date:					
					2012 Target	Rationale for 2012 Target	2013 Target	Rationale for 2013 Target		1 Board of Health Accepts (Y/N)		2	3	4	5
	Indicator									2012	2013	2012 Target	Board of Health Rationale for 2012 Target	2013 Target	Board of Health Rationale for 2013 Target
6	DEFERRED: % of known high risk personal services settings inspected annually	n/a	n/a	n/a											
7a	% of vaccine wasted by vaccine type that is stored/administered by the public health unit (HPV) Baseline Year: 2010	0.1%	0.0% - 16.6%	0.5%	Maintain or improve current wastage rates	Boards of health that are successful in meeting the requirements as stated in the Ontario Public Health Standards are required to maintain their results or improve.	Maintain or improve current wastage rates	Boards of health that are successful in meeting the requirements as stated in the Ontario Public Health Standards are required to maintain their results or improve.	0.19%	yes	yes	≤0.5%	Currently have strict policies regarding vaccine storage and use and closely monitor the vaccine supply to ensure as little wastage as possible	≤0.5%	Currently have strict policies regarding vaccine storage and use and closely monitor the vaccine supply to ensure as little wastage as possible
7b	% of vaccine wasted by vaccine type that is stored/administered by the public health unit (influenza) Baseline Year: 2010	2.7%	0.0% - 33.3%	2.3%	Maintain or improve current wastage rates	Boards of health that are successful in meeting the requirements as stated in the Ontario Public Health Standards are required to maintain their results or improve.	Maintain or improve current wastage rates	Boards of health that are successful in meeting the requirements as stated in the Ontario Public Health Standards are required to maintain their results or improve.	0.22%	yes	yes	≤2.3%	Currently have strict policies regarding vaccine storage and use and closely monitor the vaccine supply to ensure as little wastage as possible	≤2.3%	Currently have strict policies regarding vaccine storage and use and closely monitor the vaccine supply to ensure as little wastage as possible
8	DEFERRED: % completion of reports related to vaccine wastage by vaccine type that is stored/ administered by other health care providers	n/a	n/a	n/a											
9a	% of school-aged children who have completed immunizations for Hepatitis B Baseline Year: 2009/10	80.3%	29.0% - 89.8%	74.7%	Maintain or improve current coverage rates	Due to the timing of the target negotiation process, it is acknowledged that significant performance improvement of school-based immunization programs in the 2011/2012 school year may not be achievable. As such, boards of health are required to maintain coverage rates or improve where possible.	95.0%	Boards of health are required to improve immunization coverage and work towards achievement of National immunization coverage targets.	72%	Yes	No	≥74.7%	The VPD School Program currently undergoing a program review specifically aimed at increasing our rates of immunization. The review findings are expected to implemented in the fall of 2012.	80%	This target will be difficult to achieve because so many of the factors influencing why an individual may or may not be vaccinated at outside of the direct control of public health.
9b	% of school-aged children who have completed immunizations for HPV Baseline Year: 2009/10	52.0%	1.7% - 65.0%	55.2%	Maintain or improve current coverage rates	Due to the timing of the target negotiation process, it is acknowledged that significant performance improvement of school-based immunization programs in the 2011/2012 school year may not be achievable. As such, boards of health are required to maintain coverage rates or improve where possible.	90.0%	The target has been established to move all boards of health towards achievement of National coverage targets.	61%	Yes	No	≥55.2%	The VPD School Program currently undergoing a program review specifically aimed at increasing our rates of immunization. The review findings are expected to implemented in the fall of 2012.	65%	This target will be difficult to achieve because so many of the factors influencing why an individual may or may not be vaccinated at outside of the direct control of public health.

CITY OF HAMILTON Accountability Agreement Performance Indicator Targets		Ontario Median	Ontario Range	Your Baseline	MOHLTC Identified Targets				2011 actual if known	Board of Health Proposed Targets					
					Date: 23/12/2011					Date:					
					2012 Target	Rationale for 2012 Target	2013 Target	Rationale for 2013 Target		1 Board of Health Accepts (Y/N)		2	3	4	5
	Indicator									2012	2013	2012 Target	Board of Health Rationale for 2012 Target	2013 Target	Board of Health Rationale for 2013 Target
9c	% of school-aged children who have completed immunizations for meningococcus Baseline Year: 2009/10	86.7%	52.5% - 93.8%	88.1%	Maintain or improve current coverage rates	Due to the timing of the target negotiation process, it is acknowledged that significant performance improvement of school-based immunization programs in the 2011/2012 school year may not be achievable. As such, boards of health are required to maintain coverage rates or improve where possible.	90.0%	Boards of health are required to improve immunization coverage and work towards achievement of National immunization coverage targets.	85%	Yes	Yes	≥88.1%	The VPD School Program currently undergoing a program review specifically aimed at increasing our rates of immunization. The review findings are expected to implemented in the fall of 2012.	90%	The VPD School Program currently undergoing a program review specifically aimed at increasing our rates of immunization. The review findings are expected to implemented in the fall of 2012.