



Minutes of the Board of Health Budget Meeting

Monday, January 12, 2009
Board Room, Brockville Office
458 Laurier Boulevard
12:35 p.m. – 1:46 p.m.

Present: J. Butt, Chair
S. Dodge
J. Earle
D. Gordon
K. Graham
R. Haley
F. Kinsella
A. Van Schie
A. Warren
A. Carter, Medical Officer of Health
J. Pearce, Treasurer
H. Bruce, Recording Secretary

Absent: B. Fletcher

J. Hess, Director of Family Health
J. Futch, Director of Clinical Services
B. Dalgleish, Director of Health Promotion
J. Lyster, Director of Health Protection

P. Kall, R. Zajac, Recorder and Times

The budget meeting was called to order at 12:35 p.m. Dr. Carter welcomed everyone to the meeting and advised that this is a public meeting.

Dr. Carter advised that the staff objectives for today are to remind board members of the health unit's historical background and where we are today and for the new board members to bring them up to speed. We would like you to understand our current situation and what we are projecting for 2009 and get to some solutions for these problems.

Dr. Carter gave a power point presentation. (See Appendix #1 attached to these minutes). She advised that we design our budgets to meet the Mandatory Health Programs and Services Guidelines and have an obligation to the people of Leeds, Grenville and Lanark to meet these requirements. Our main goal is to protect human resources and service delivery. We also want to do this with the least possible effect on the local levy by being as efficient as possible.

We also can do this by using our reserves and by not sending any money back to the MOHLTC at yearend. We succeeded in doing this in 2008. Also we want to use special funding effectively where we can. (HFO, one time MOHLTC funding) We were successful this year in getting about \$75,000 worth of one time funding from the ministry and are planning for more next year. We have no desire to burden the local tax payers any more than we have to.

Dr. Carter listed the principles used to prioritize requests.

- honesty, no padding
- potential impact on health
- potential to achieve MHPSPG and reduce liability
- evidence based
- degree of compliance
- potential to move upstream
- meeting strategic plan objectives
- we won't do work for the province until caught up locally

We all want to provide the high quality public health services that the people in Leeds, Grenville and Lanark deserve. We all want to reduce liability. We all need to work together.

Solutions to our budgetary problems

- short term – 2009
- use last of reserve funds to tide us over
- use MOHLTC HFO grants for new nursing grads
- shuffle staff to areas where backlogs need catch up

Dr. Carter handed out a document entitled "Budgets for Rural Health Units in Eastern Ontario", see Appendix #2. She stated that in the incamera session she would like to give board members the identity of each health unit on the chart. She referred to the document and stated that this gives you an idea of all of the rural health units in Eastern Ontario. You can see that we have the lowest per capita budget, the lowest per capita grant from the MOHLTC, and the lowest per capita municipal levy. She added in the levy information what we took from reserves. The ministry now over the last 3 years will not give more than 5%.

J. Pearce stated that all of the health units in this survey feel that they are fully compliant.

Dr. Carter referred to Health Unit E stating that their Board a number of years ago made the decision not to build their own buildings and their occupancy costs are currently 12% of their budget and ours are 3%. We need to continue to press the MOHLTC on this. Dr. Carter and J. Butt are going to Toronto on Wednesday to meet with the Chief Medical Officer of Health and the Assistant Deputy Minister. Since the MOHLTC is saying we can only count on a 3% increase in 2009, but it could be as high as 5%, we are hoping that they will agree that we will get the 5%.

Dr. Carter reviewed the new positions that staff feel we need to meet mandatory programs. She thanked the Board for agreeing to provide 5 new positions in 2007 which has helped a lot.

- RPN Clinical Services – 1.0 FTE - The ministry has given us a 100% funded nursing position which is an infection control practitioner. We already have one on staff and we transferred her from the shared budget to the 100% budget. The MOHLTC made it clear that they require us to hire the position to prove to them that we hired a nurse to qualify for the 100% funding. The cheapest nurse we can hire is an RPN. This would be a cost saving to this health unit. It is for the cold chain maintenance and vaccine storage in doctors' offices. This person backs up all of our immunization clinics. This position is not in the 8.26 FTE you will see in J. Pearce's budget. This would be a savings of \$25,000 J. Pearce advised.
- Program Manager for Health Promotion – 1.0 FTE - This position is needed to support the direction and staff in the department. The department is very stretched because of the wide span of control and diversity. Our current compliance is 78-80%.
- Program Assistant Clinical Services – 1.0 FTE – This position will do IRIS data entry once the PHN (also requested) collects the data. Our current compliance is 20%, and we would increase it to 80%. Since we have been asking for this position we have had 2 outbreaks and were are very fortunate that it has been small rural schools. We are very aware how long it takes us to identify (about 10 days) these unimmunized students. Dr. Carter commended the staff for the work they did during the recent Pertussis outbreak.
- Production Artist - 0.3 FTE – This position would allow the transfer of graphic design work from the Communications Coordinator to allow that position to focus on public relations, our communication plan and activities in the strategic plan.
- Program Assistant Corporate Services - 1.0 FTE – Expansion in complexity and staff for new and expanded programs (SFO in 2006, 5 new positions in 2007, SDWS in 2008, CINOT in 2009) has stretched corporate services beyond the limit. Currently there is an increased liability in human resources and finance due to errors when staff are stretched beyond their limits. Dr. Carter advised that J. Pearce works a huge amount of overtime and is unable to take it all off.
- Public Health Inspector - 0.5 FTE – This position would conduct food safety including audits, disclosure and run train the trainer programs in schools and communities. Our current compliance is less than 1% for audits. This could be increased to 80%. Foodborne illness due to poor food handling is a risk factor if this position is not filled.
- PHN Clinical Services - 1.0 FTE – This position would do verification of immunization records and IRIS compliance. Our current compliance is 20%. It is estimated to increase to 80%.
- PHN Family Health - 1.0 FTE – This position would work on the breastfeeding program. Our current compliance is 0% and could increase to 80%. The risk of not hiring this position would be inadequate breastfeeding promotion, protection and support in LGL.

- PHN Health Promotion - 1.0 FTE – This position would plan and implement activities related to the Healthy Eating Active Living strategy of MHP to combat childhood obesity. Our current compliance is 71% and could increase to 90%. The risk of not hiring this position would be greater chronic disease in our region.
- Summer Students Injury Program - .46 FTE – Our current compliance is 100% and will fall to 50% in 2009 if not approved. It is a very successful community program funded 100% by the ECD program and gapping in the past and needs to be continued.
- Dental Hygienist - 1.0 FTE– Through planning and evaluation this position would convert a very downstream program to a more upstream one. Our current compliance is 88% and could be increased to 100%. This could lead to significant savings in treatment costs over time (CINOT and Ontario Works).

These new positions would have an annualized cost of \$587,768. Prorated for 6 months in 2009 the cost would be \$293,884 which is a 3.44% increase over the 2008 base.

2009 Budget Requirements

If we take our current base which is \$8,555,714 and add the new positions \$293,884 and salary/benefits \$216,896 the total increase to our base budget would be 5.95%.

2010 Considerations

- SDWS becomes cost-shared
- CINOT enhancement becomes cost-shared
- OPHS implementation not expected to be revenue neutral
- potential annualization of new positions
- normal salary/benefit cost increases

Dr. Carter advised that we have to think about not only this year but next year as well.

F. Kinsella asked what was the year they established your base for funding? J. Pearce stated 2006, it has been 3 years that they fixed the percentage increases. The increases since then have been through the municipal dollar.

J. Pearce stated that SMC has met and gone through the budget and has gone through where we can cut costs and make adjustments to make the base increase as minimal as we can. We do not want to burden the taxpayers. J. Pearce reviewed the 2009 Budget Requirements slide from Dr. Carter's presentation. Regarding the new positions, it is our obligation as staff to make the Board aware of what the costs are. It is our obligation to tell you what it takes to fulfill the mandate.

J. Pearce reviewed the Cost Shared Public Health Program Funding 2009 handout. (See Appendix #3 attached to the minutes).

J. Pearce advised that staff are making every effort to teleconference rather than travel from other offices to help us decrease travel costs. A. Van Schie stated that we did have a fleet of cars at one time, but we found paying mileage was less costly than maintaining the vehicles.

Dr. Carter advised that we have reduced the amount of refreshments at Board and staff meetings. We also expect a reduction in recruitment costs. Dr. Carter advised we had about 1/5 the amount of job postings in 2008 than we did in 2007. Insurance rates are down by \$8,500 annually as well.

J. Pearce stated that we have lost rental income and we currently have 2 units for rent which is listed with a local real estate agent. We have developed meetings rooms and would like to start renting them out.

The total budget for next year is just over \$9 million dollars J. Pearce advised. If you remove the new positions it would be an increase of \$214,000.

F. Kinsella asked do we need \$15,000 for ONA negotiations? J. Pearce advised yes we do. The contract is up March 31st.

J. Pearce reviewed the 2009 funding slide. We hope Dr. Carter and J. Butt have a successful meeting with the province and come home with a 5% increase. The best we can expect is 5%. This excludes the west Nile virus/vector borne disease funding.

J. Pearce advised that the provincial best case would be \$6,306,676 with an expected municipal reserve of \$135,000. The municipal levy needs to increase minimally by \$287,412 (14% increase) to a maximum of \$700,708. If the Board chose, she could take \$19,000 out of the capital reserve to add to the \$135,000.

J. Pearce referred to the sheet entitled 2009 Public Health Budget and reviewed it with board members. If it refers to full budget, the new positions are included.

Dr. Carter stated that once you get beyond what the province is willing to pay you are paying with 100% municipal dollars. Our full budget is only a 5.95% increase, but you end up with a 28% increase in the levy. J. Pearce advised that the longer we take to correct this the more painful it is going to be.

J. Pearce reviewed the 2010 considerations. They are all substantial items. If we were to build a building we would do it through our capital funds and it would not affect our operating costs. The \$135,000 is the only reserve we have left for operating costs.

A. Van Schie stated that the budget you are presenting right now is the shared funding budget. We know that there are also costs to the health unit for those 100% funded programs. Dr. Carter advised that the costs that go beyond are already included in this. A. Van Schie stated that when you and J. Butt make your presentation on Wednesday bring up that they are not funding the 100% funded programs. Dr. Carter advised that a lot of the programs are not MOHLTC funded programs. They are funded by other ministries.

J. Butt stated that at some point J. Pearce and Dr. Carter have looked at these numbers and have made some choices that they would like us to consider or give them feedback on.

J. Pearce advised that there are some strategies that require an incamera session.

J. Butt stated that they are seeking from us some direction and feedback, but to look at the alternatives that should be discussed incamera. K. Graham asked for some clarification as to why it would be incamera. Dr. Carter advised that property and human resources will be discussed and an individual could be singularly identifiable.

A. Van Schie commented that if someone requests the health inspection of a restaurant you have to give them that information. Why don't we post this on our website? Dr. Carter stated that we would like to do that. The software we are implementing will eventually allow us to do that. Right now with our old methods, it would take too much time.

D. Gordon referred to inspection information and asked why would we not charge for these information services? If a person wants information charge them for it. J. Lyster advised that theoretically we could, but that is not in the spirit of the Ontario Public Health Standards. It is \$10,000 to get set up and there are impacts for IT. J. Butt stated that this will be mentioned again under the service review.

J. Earle stated shouldn't this just be an A,B,C rating. Dr. Carter advised that it is just the technical ability to do the rating and make sure there is no confidential information. Right now we use a manual system. J. Earle recommended a colour coded system or a grade for a simplified system. J. Butt advised that going forward as we implement the system we will simplify the best we can.

J. Butt asked if there were any further questions for J. Pearce or Dr. Carter. Are we ready to look at these potential opportunities? The motion to move incamera was read at 1:46 p.m.

It was moved by: A. Warren

Seconded by: F. Kinsella

That: This Board move into a closed session of the Board of Health as per the requirements of section 239 (2) of the Municipal Act due to the following:

- (a) the security of the property of the municipality or local board;
- x (b) personal matters about an identifiable individual, including municipal or local board employees;
- x (c) a proposed or pending acquisition or disposition of land by the municipality or local board;
- x (d) labour relations or employee negotiations;
- (e) litigation or potential litigation, including matters before administrative tribunals, affecting the municipality or local board;
- (f) advice that is subject to solicitor-client privilege, including communications necessary for that purpose;
- (g) a matter in respect of which a council, board, committee or other body may hold a closed meeting under another act.
2001, c. 25, s. 239 (2).

Motion Carried.

It was moved by: F. Kinsella
Seconded by: A. Warren
That: This closed session rise and report.

Motion Carried.

There was nothing to report at this time. The meeting ended at 1:46 p.m.

J. Butt, Chair

Date

H. Bruce, Recording Secretary

Date