



Minutes of the Board of Health Regular Meeting

Thursday, September 17, 2009

Board Room, Brockville Office

458 Laurier Boulevard

4:00 p.m. – 7:30 p.m.

Present: J. Butt, Chair
S. Dodge
J. Earle
K. Giroux
K. Graham
G. Grewal
R. Haley
F. Kinsella
J. Lousley
L. Sowchuk
A. Warren
A. Carter, Medical Officer of Health
J. Pearce, Treasurer
H. Bruce, Recording Secretary

Regrets: B. Fletcher

J. Futch, Director of Clinical Services
S. Gates, Director of Quality Improvement
J. Hess, Director of Family Health/Health Promotion
J. Lyster, Director of Health Protection
J. Mays, Manager, Health Protection Department

R. Zajac, Recorder and Times
S. Healey

1. Call to Order:

J. Butt called the meeting to order and welcomed everyone to the first meeting of the fall season. He stated that we have some new members and he hopes that the more seasoned board members had an opportunity to introduce themselves. There was a board orientation 2 weeks ago and some newer and more senior board members attended. We had a great day and there was a good interchange of questions.

2. Approval of the Agenda:

R. Haley advised that he would like to move item 6.6 MOH Recruitment up on the agenda as he has to leave the meeting at 5:15 p.m. Board members agreed.

It was moved by: K. Giroux

Seconded by: J. Earle

That: The agenda of the September 17, 2009 Regular Meeting be approved as amended.

Motion Carried.

3. Approval of Minutes:

3.1. Approval of the Minutes from the Board of Health Regular Meeting held on June 18, 2009:

F. Kinsella referred to page 10 of the minutes and asked if there has been a date set regarding the Board orientation to the emergency preparedness plan which includes pandemic? Dr. Carter advised that we have not set a date yet and that J. Lyster is in charge of the plan. This will probably come to the October or November Board of Health Meeting.

F. Kinsella referred to page 15 and asked how do we recoup the cost of \$75,000 for H1N1? Dr. Carter advised that we have asked for compensation from the ministry. F. Kinsella asked what response did you get from the ministry when you and J. Butt visited them in June? Dr. Carter stated that we have not received anything yet. They usually do compensate for special circumstances such as outbreaks after it is over. This is an ongoing situation. J. Butt advised that we have always been compensated for these kinds of issues in the past so why would this be any different?

It was moved by: F. Kinsella

Seconded by: J. Lousley

That: The minutes of the June 18, 2009 Board of Health Regular Meeting be approved as circulated.

Motion Carried.

4. Presentations:

4.1. The Complexity of H1N1:

J. Butt advised that we will do the presentation and then go to item 6.6. Dr. Carter led the presentation and advised that J. Futcher will talk to the Board about planning for the pandemic.

Dr. Carter stated that as a Board it is important for you to know what we know about H1N1 as you may be asked questions by the public as a board member. A crisis may arise and if you have some background it might enable you to better cope in the future.

See Appendix #1 appended to the minutes for the presentation.

Dr. Carter advised that even this last week we have a tiny number of cases which is a problem. When we get into cooler weather and the air dries out and we are indoors that is when it starts to brew. We are used to having no flu right now; this year we are not starting from scratch.

Dr. Carter reviewed the number of confirmed cases. Primarily the young are sick and the older population are not greatly affected. Although the vast majority of people are not very sick there are a very few people that stay sick a very long time and get very ill. The under age 1 had the highest rate of hospitalization of any age group. The rate in adults is very low compared to the children. The children did not die, but the adults did.

We look at the southern hemisphere to see what will happen to us. Australia had less than 5% of influenza that was not H1N1. There are almost identical rates of absenteeism as in previous years. New Zealand is a different story. The deaths per million in the south during winter are about 4 times what we saw in Canada in May/June. Dr. Carter stated that we get on average about 300 deaths per year in Ontario with influenza. Dr. Carter summarized the death rates.

F. Kinsella stated that they used the stats to see who is going to get the vaccine; it is the young and pregnant. Dr. Carter confirmed that is correct. They have put out the sequence who will get it first, the young and pregnant and those with susceptible conditions. Seniors will be last.

Dr. Carter stated that anyone can get the vaccine and that 87% of people hospitalized had underlying conditions. F. Kinsella stated that normally the vaccine covers 3 different types. Because we have been able to identify it, have we studied it more than we have the others? Previously did the doctors identify which flu a person actually had? Dr. Carter advised that if they took a test from the individual, the lab would identify the strain that they had. We cannot predict which strain will appear. Over the last 20 years we have been isolating the same 3 strains year in and year out, this one is new to us.

J. Fitcher explained that a pandemic is a new virus that sweeps the world, and this is what this has done. J. Butt commented that as F. Kinsella stated when the government is announcing a sequencing by each group of who gets the vaccine first, the general public is not aware of how that was determined. We have an opportunity locally for R. Zajac to explain the rationale. Dr. Carter stated that the 6 months and younger age group cannot be immunized so they have to be protected by the mother before the child is born or by immunizing the whole family around them. L. Sowchuk asked have they looked at the long term effects of the vaccine? Dr. Carter commented that seasonal flu vaccine has been used for many years and we are pretty sure we know the effects that it has, however, every single year it changes a little. In this case it is a virus that has changed more than a little bit.

In previous years we have not used an adjuvant in the vaccine, and this year they decided to use it. The vaccine available for pregnant women will be exactly the same as seasonal vaccine with no adjuvant. The vaccine that we will use for everyone else has this adjuvant in it which has been used in Europe with no problems at all.

J. Futchler led the rest of the presentation and outlined the goals of pandemic planning. We started working with our community partners at the very beginning which is very different from other health units. We created a tri-county pandemic plan. Then we created our own internal plan. Our pandemic plan is an appendix to the health unit emergency response plan. It is based on the incident management structure. The pandemic plan is broken down into phases. It has been difficult to plan for immunization because we still do not know the ministry of health's overall immunization plan.

When we did our mass immunization exercise in 2007 every person was involved in some way. We will be using a new data collection system developed by Niagara Public Health. This is done electronically. We have 5 staff going to Niagara on Monday for training and our IT supervisor will take the servers down for special training and the ministry is paying for it. They want to be able to keep track electronically of everyone that has been immunized. As public health staff we are not required to use safety syringes, however, if this is decided upon by the ministry nurses will need to be trained. We have met with all of our partners over the last 5 years regarding pandemic planning. There has been ongoing consultation with physicians, hospitals and long term care facilities. Surveillance was reviewed and public education was discussed.

J. Futchler stated that we are planning for our seasonal flu campaign. It is going to be different than normal. In children over 9 one immunization should be adequate.

J. Lousley asked is there a promotion about cleaning door knobs etc.? J. Futchler replied yes there is. We have all of this information on our website. Staff should be sent home if they are sick. Employers need to ensure that they send sick staff home. J. Butt stated that the hand washing message and cough etiquette is getting out in terms of clubs and organizations.

F. Kinsella spoke about employment continuity, advising that with computers most of us can do our work at home. We don't always need to bring people to work. Have them stay at home to avoid spreading the virus. J. Butt thanked Dr. Carter and J. Futchler for their presentation.

R. Haley stated that education has to be expanded to the workplaces. J. Butt advised that the presentation was great and timely and using our media partners we will get the message out that we are a wonderful resource. The website is the best resource.

J. Butt advised that we will now discuss item 6.6 MOH Recruitment.

4.2. MOH Recruitment:

Dr. Carter stated that she informed the Board in June that she will be leaving hopefully next June to retire. She advised that we put together a proposal for recruitment and she reviewed it with board members. Working with the staff we can do it at a much lower price than the last recruitment when we hired a consultant. We have recommended some relatively inexpensive advertising. We could have a closing date around the middle of November and have interviews around the first week of December. That is a good timeline.

This is our recommendation. We do need a selection committee once we get the applicants to participate in interviews. Dr. Carter recommended that the Board decide who they want on their selection committee. R. Haley asked is it not an opportune time to look at the way we do business? Should we look at dividing some of that workload up and hiring an administrator? At least one health unit has a part time MOH. Could we do that and hire a full time administrator? A. Warren stated that we spoke about this previously. Just before Dr. Carter was recruited Dr. Tolton was here for about 9 months for 3 days per week. All of the directors were given extra responsibilities and hours. It did leave a heavy load on J. Pearce specifically. Maybe Dr. Carter would be a better person to respond to that.

Dr. Carter advised that under the HPPA it is not allowed. Regarding the health units that have part time MOH's it is only a temporary situation that occurs between the departure of one MOH and the hiring of another. She would speak against it. That is why the legislation is set up that way. The CEO has the focus on the medical health of the community.

K. Graham asked what functions of the MOH are mandated by the act and what functions are not? He cannot make a decision until he knows. Dr. Carter responded that it is not specified in the act as CEO. Instead it lists the various parts of the CEO role, but some of the things she does might not be there. For example, because of our internal policies she participates in all of the union negotiations but that is not specified in the act. Some duties are due to internal policies.

J. Butt stated that we have the act and it specifies who does what. Why don't we dig it out and look at it and the worst case is that we are all on the same page regarding the MOH's duties and responsibilities. R. Haley stated that every health unit needs a MOH but what are the required duties and administratively do we need someone to run the administration? J. Pearce stated that the act says that the MOH is the CEO. J. Earle advised that he thinks this is an opportunity to look at ways to improve or do things differently. F. Kinsella stated that when we look at the recruitment of doctors now we are looking at a younger generation and they may think differently. Rather than doing the same thing are there some things we can do. J. Butt stated that he doesn't hear anyone disagreeing. This is a task that our committee can delve into.

L. Sowchuk stated that she wants to make sure that J. Pearce gets none of this work. K. Graham asked where would we be if we have no MOH and can't recruit a replacement? Dr. Carter advised that you would have to have one of the neighbouring MOH's fill in. On a long term basis a health unit needs a fulltime MOH and the province mandates this.

You still need a fulltime MOH by law who must be the CEO. J. Butt stated that the province has negotiated a new contract with the OMA and are taking a more active role, in fact the lead role, in helping classify the incumbent MOH's pay scales. They are reviewing their job descriptions and classifications and so on. We are participating in the process because it is the right thing to do and not by choice.

F. Kinsella asked is there an ideal size for a health unit? Dr. Carter advised that the province feels it is a population of 500,000. With the LHINS is the government moving to form health units of 500,000 and if they are, should we be looking at amalgamating? J. Butt stated that they are not looking at the LHIN model or this size at this time. In the summer we were given a questionnaire to fill out and clearly there were notions of amalgamation. At the end of the day, the economies of scale notwithstanding, in terms of local ownership and the kinds of things Dr. Carter talked about tonight regarding the resource and influence over the services, would be gone.

Dr. Carter advised that with a population of 500,000 every health unit would have one associate MOH as well as a MOH with this size. Minister Smitherman stated he was not interested in amalgamation due to the cost. R. Haley stated that we need to have this report within the next couple of months.

The motion was read. R. Haley suggested that this motion be tabled for a month until we proceed. Dr. Carter advised that the deadline for submitting advertising is tomorrow for the October 27 issue of the CMAJ. We are going to need a MOH regardless. The committee will consist of J. Butt, B. Fletcher, F. Kinsella and A. Warren.

It was moved by: A. Warren

Seconded by: L. Sowchuk

That: The Board of Health approve proceeding with the recruitment of a Medical Officer of Health for the Leeds, Grenville and Lanark District Health Unit. The membership of the selection committee shall be J. Butt, B. Fletcher, F. Kinsella and A. Warren.

Motion Carried.

R. Haley left the meeting at 5:19 p.m.

F. Kinsella asked are we going to put enough time into this? Do we want to call a special meeting and look to the more experienced members to give us some guidance on this? He stated that from his past experience with younger doctor recruitments there has to be a whole new mindset. A. Warren stated that it may be different now because the pay scales have been improved. Dr. Carter advised that there have been more MOH's graduating lately. J. Butt advised that he will get in touch with F. Kinsella, B. Fletcher and A. Warren to set up some meeting dates.

5. Business Arising:

5.1. Program Review Update:

S. Gates gave the program review update at 5:23 p.m. Since she was not able to attend the board orientation she introduced herself as the Director of QI. S. Gates distributed a handout to board members. The first page is background information to reiterate the rationale for the program review. This report speaks to how we are going through the steps on the program review cycle.

We have completed step 1 and will be focusing on the requirements in the new OPHS. Step 2 situational assessment is proving to be a very time consuming step.

Half of the data on morbidity and mortality is collected by the health intelligence team due to the number of standards and the volume of requirements that we need to review.

We have staff assigned to the program review team from each department and they have pretty much completed their research and right now they have to complete the situational assessment questionnaires for need and impact. These questionnaires will go to the prioritization committee to score. As part of the situational assessment we are looking at our capacity and that of our community partners. We have been tracing the time spent on this and there have been 258 days spent on the situational assessments. We have to do a lot of work to get ready for our prioritization team meetings. There are 9 prioritization criteria and once we finalized those we developed a draft scoring system.

We decided to do a pilot of the prioritization process. We have developed our process and are looking at weighting our criteria. We have developed our database to score the situational assessment questionnaires and conducted a training session on September 1 with our prioritization committee. We had hoped to be done the situational assessments by the summer. We had planned 4 months worth of meetings. We tried to estimate the time it would take to review and score 1 situational assessment questionnaire.

We have 130 requirements that need to go through the prioritization assessment process. We are not ready to begin with prioritization. We canceled the September and October meetings, but still have the meetings for November and December booked. We hope to be able to start our prioritization in November. With this delay it is unlikely that we will be able to complete all of the requirements in order to inform our resource allocation for the 2010 budget.

A lot of factors have contributed to this delay. The sheer volume of evidence has turned out to be quite large and is a complex process. We wanted 100% of staff's time to be spent on this review, but this has not happened. Also we had no idea that an H1N1 pandemic was on the horizon. A lot of staff are being called upon to manage the H1N1 situation.

S. Gates stated that our next steps are to try and free up staff's time to work 100% on the program review to get the situational assessments done. There may be some options to scale back the prioritization.

J. Butt advised that S. Gates, Dr. Carter and he have a meeting with the joint services committee next week. We will be explaining the program review and the status of the project and we will post some of the documentation on our website.

F. Kinsella stated that he is surprised with the number of requirements in the questionnaire, 130. Do different departments have different standards? You should prioritize them. S. Gates advised that she thinks it is critical for everyone to look at all the requirements to overcome the bias of their own programs. This would eliminate the bias. F. Kinsella commented that we control time and energy ourselves. S. Gates stated that our review is taking the time to reflect on what we are doing and how it meets this criterion. That is our outcome and purpose for the review.

G. Grewal asked have you taken into account the initial public health report and its weaknesses? S. Gates advised that the public health report was intended to describe what public health is in Ontario and is not meant to be a report on individual health units. It is worth looking at the results of the report and how it corresponds to our review. Dr. Carter advised that many of the indicators in our review are in the public health report. J. Lousley asked will you use the data that is coming from the Statistics Canada survey? S. Gates commented yes if it matches the risk factors that we have identified. It should be finished by the end of September. We have recently received the database from the youth risk factor surveillance system. We need to get that analysis done.

J. Butt thanked S. Gates for her presentation.

5.2. Common Law Language Changes:

5.2.1. Duties and Obligations of Directors:

J. Butt stated that at our June meeting we looked at some common law language around the obligations of Directors and the Board charged A. Warren, F. Kinsella and he to take the information away and try to summarize it in a 1 or 2 page document that would be easily understood and read. Under A. Warren's chairmanship we did so and you see that before you as item 5.2.1. You will also see listed are some duties and responsibilities of Directors as well as those of the Board Chair.

A. Warren commented that she was asked by other members of the Board about the problem of gate keeping and we have tried to address that. One key thing is that we do not want operational interference from board members. To some degree the leadership role of the Board Chair has not been respected at different times. We have included the role and responsibilities of the Board Chair. We need to respect that.

J. Butt stated that the Board Secretary then took the information and amended all of the other procedural and operational items to reflect the documentation. F. Kinsella commented that around this table we should all feel free to discuss the issues and not the personalities.

At the end of the day it is the issues we are debating and discussing here. On page 3 the 5th item down – ruling on procedural matters at board meetings – we are going to use Robert Rules of Order – add this, but if challenged the majority of the Board will decide procedural questions. A. Warren suggested adding Roberts Rules in brackets.

J. Earle referred to the last section on representation. It states to represent the health unit to its various stakeholders in the community; it doesn't say that we represent the public back to the health unit. F. Kinsella advised this is saying that the Chair is responsible to be the official spokesperson.

J. Earle reiterated that still in no case is there anywhere it states that the public gets the representation to the health unit. J. Butt advised that all of us represent in some fashion and are selected by some convention by the community, we are the community. K. Graham stated that in his view, he is appointed by the municipality but also elected. It is important to the Board to have someone to relay the pulse of the community. If the pulse isn't in the best interest of the Board as a whole he has a fiduciary responsibility to respect the Board. A. Warren stated that is precisely why we are appointed the way we are, to bring the public's concern to the Board.

J. Earle stated that nowhere in the documentation does it say that the general public gets a right, it is all downward representation. A. Warren stated that this is the duties and the obligations of the Directors. There may be other places in the manual that we should have these sorts of things but this is not the appropriate place for this. J. Earle advised that he sees top down representation instead of bottom up. This should be reflected somewhere in the documentation. J. Butt commented that he is not sure what exactly we need. If J. Earle could sketch something out we could look at.

Dr. Carter referred to the previous code of conduct saying that it says represent the best interests of public and community health. J. Earle stated this does not say the public. Dr. Carter stated that it says public and community health. J. Earle advised that is not the same thing. J. Butt stated that he would like to get this approved and then maybe A. Warren can add a paragraph.

J. Lousley asked who informs the Board if there is an emergency? There is nothing in here that says that the Chair lets us know. Dr. Carter stated that it depends on how rapidly the emergency moves. Under the Act if it is a health emergency the MOH is legally responsible. We would notify the whole Board. In the actual situation the MOH takes charge. F. Kinsella stated that this is different than the municipalities. As the Mayor he has an emergency measures officer and he is the conductor of the orchestra. J. Butt and Dr. Carter would deal with the emergency.

F. Kinsella talked about police checks for politicians. In any public body these days you have to have a police check. All of the public people have to. What about the elected officials? J. Pearce pointed out that the province does it but they don't provide the information back to the Board. They ask the individual for permission and if the appointment continues they have passed. You can't run for elected office if you have a criminal record S. Dodge advised. A. Warren stated that most municipal representatives have carried other roles where they have had to have criminal record checks. Somewhere in the literature we should have that requirement she advised. J. Butt asked for the motion and he stated that we will then charge the wordsmithing to A. Warren.

G. Grewal stated that under the definition of incamera that is in by-law #4 there is a reference to the municipal act, it says 2001, as it is in 3.9. F. Kinsella commented that he thought we took out any reference to the municipal act. Any meeting that we had by teleconference was validated and the municipal act doesn't allow teleconferences. A. Warren stated that at the last meeting we had requested the reference to the municipal act be taken out simply because a lot of the people here are not appointed by the municipalities.

ACTION: Any reference to the municipal act will be deleted.

J. Earle stated that he wants to register his reluctance. K. Graham stated that we are getting hung up on semantics here. We adopted the principle of the municipal act for going incamera. We took that out in our procedure. G. Grewal stated it is what follows that. Those are the words that are in the municipal act.

It was moved by: F. Kinsella

Seconded by: J. Lousley

That: The Board of Health approve the following as amended:

- Duties and Obligations of Directors
- V-05-0 – Attendances for Meetings and Conferences
- V-215-1 – Board Code of Conduct
- By-Law #4 – To Regulate the Proceedings of the Board of Health
- III-55 – To Regulate the Proceedings of the Board of Health
- III-125 – To Regulate the Proceedings of the Board of Health

Motion carried.

F. Kinsella questioned policy V-05-0 item 1.5.1. which states the daily stipend will not apply for any financial matters, which require the signature of a signing officer. J. Pearce advised that if she asked J. Butt to sign a cheque/document he would be paid mileage but not the stipend.

6. New Business:

6.1. Accounts Payable for May:

J. Pearce advised that in front of you is 3 months of accounts payables. Most programs are in a favourable position. The unfavourable amounts are small in percentage and dollars and are based on the timing of invoices related to payroll/benefits.

It was moved by: F. Kinsella

Seconded by: J. Lousley

That: The Board of Health approve Health Unit Accounts Payable for the month of May 2009 in the amount of \$1,277,403.97.

Motion Carried.

6.2. Accounts Payable for June:

It was moved by: J. Lousley

Seconded by: F. Kinsella

That: The Board of Health approve Health Unit Accounts Payable for the month of June 2009 in the amount of \$1,007,792.52.

Motion Carried.

6.3. Accounts Payable for July:

G. Grewal stated that there is a similar entry on June 12 and June 26 for savings bonds. J. Pearce advised that those are monthly payroll deductions that are remitted on behalf of employees. G. Grewal asked is the date wrong? J. Pearce stated yes, it should read July 10 and July 24.

It was moved by: L. Sowchuk

Seconded by: J. Lousley

That: The Board of Health approve Health Unit Accounts Payable for the month of July 2009 in the amount of \$993,877.12 as amended.

Motion Carried.

6.4. HUAM Manual Changes:

- V-375-1-1 – Transportation Allowance

J. Pearce stated that this is monetary. Non union staff and Board are paid 43 cents per kilometre and ONA are paid 47 cents and will be paid 48 cents effective April 1, 2010. We are recommending an adjustment to 47 cents. If this is approved for January 2010 the Board mileage rate would be this amount.

- V-625-0 – Employee Benefits

J. Pearce advised that the addition of the last paragraph relates to the ONA negotiations finalized in June. We added transitional medical/dental benefits to permanent status employees who retire or go onto LTD to allow them to purchase benefits for 3 months. This allows them to transition at their own cost and there should be a minimal impact on our experience.

- V-1125-0 – Portable Communication Equipment

J. Pearce stated that we removed the cell phones previously left at reception to be booked out. Instead, we have provided nurses a cell phone as a health and safety issue.

- V-1725-0 – Duty to Report Incapacity, Incompetence and Sexual Abuse

J. Pearce stated that this is a new policy which indicates our adherence to Bill 171.

It was moved by: A. Warren

Seconded by: L. Sowchuk

That: The Board of Health approve the following HUAM Manual changes:

V-375-1-1 – Transportation Allowance

V-625-0 – Employee Benefits

V-1125-0 – Portable Communication Equipment

V-1725-0 – Duty to Report Incapacity, Incompetence and Sexual Abuse

Motion Carried.

6.5. Initial Report on Public Health:

Dr. Carter advised that this is for information only. This is an important document but we realize that it is relatively indigestible the way it is written. It often uses raw numbers without denominators. We did the math and looked at all the comparators using denominators and each of the directors did an interpretation. We hope this analysis helps you digest all of this and that you are not too surprised about the results. If board members have further questions or would like further analysis done let Dr. Carter know.

F. Kinsella referred to page 13 of the analysis on adult heavy drinking. He sat on the Board of a woman's abuse centre and one of the early indicators for high unemployment is drinking and violence. He is concerned that the adult heavy drinking rate was 50% and that the Ontario average was 37%. Do we track family abuse? J. Hess stated that we would not track it at the health unit but we could get the results from our partners. We would look at it through family health dynamics.

6.6. MOH Recruitment:

Discussed previously under item 4.2.

6.7. alPHa Conference – October 22 & 23:

Dr. Carter encouraged board members to attend and stated that new board members would find it helpful. It is a good conference. Board members are only allowed to attend 2 conferences per year without permission from the Board and we do have 2 board members who have already attended 2 conferences this year. They are J. Butt and B. Fletcher. K. Giroux would like to attend as well. F. Kinsella asked which conference do you feel would be most beneficial to us? J. Butt stated that the social determinants of health could be interesting, but so much depends on how they put it together. Dr. Carter advised that the alPHa conference gives you a chance to meet other board members from different municipalities so it is the most valuable.

K. Graham moved and A. Warren seconded that B. Fletcher and J. Butt be given permission to attend the additional conference this year. All board members agreed.

6.8. 2009 Funding for the LGLDHU Expansion of the CINOT Program:

J. Pearce advised that these are housekeeping items. We need to approve agreements with the ministry in order to receive funds.

It was moved by: J. Lousley

Seconded by: L. Sowchuk

That: The Board of Health approve the 2009 funding for the Leeds, Grenville and Lanark District Health expansion of the Children In Need Of Treatment (CINOT) program.

Motion Carried.

6.9. 2009 Grant Terms and Conditions for the HB/HC Program:

It was moved by: F. Kinsella

Seconded by: J. Lousley

That: The Board of Health approve the terms and conditions of the 2009 Healthy Babies Healthy Children grant.

Motion Carried.

6.10. Provincial Subsidy of MOH Salaries:

J. Pearce and J. Butt reported that they participated in a webinar to learn about the process used to evaluate and rate the MOH salaries for the subsidy. It is a ministry directed program and they agreed to participate. It is underway.

J. Pearce stated that we just received the package and there is a questionnaire to be completed and it goes to a team to evaluate what the MOH salary should be and hence the subsidy.

7. Advocacy:

Nothing to report.

8. Verbal Report of the Medical Officer of Health:

Business Continuity Plan Implementation in response to pH1N1:

Because of the demands being made on the LGLDHU in response to pH1N1, we have been forced to implement our Incident Management Structure and our Business Continuity Plan under our Emergency Response Plan. Fortunately, this plan was updated recently and we were able to implement it without significant changes. The assumptions under the Business Continuity Plan were that an emergency would interrupt normal business for about 6 weeks so activities were prioritized according to the safety of stopping them for this period of time. It appears that the current pH1N1 situation will last about 4 months or more so some alteration of the plan may be necessary as time goes on.

At present, we have suspended or reduced activities in the lowest 3 priority levels and some activities in the 4th lowest level. This includes school and workplace health promotion activities except those involving pH1N1, community education campaigns, network and some partner meetings, travel health clinics, routine immunization clinics, immunization data entry and Baby Talk. In place of these activities we are accelerating our routine school immunization program so that we will be able to take a number of weeks off from this activity to carry out the expected seasonal and H1N1 influenza immunization activities. We are also carrying out the many activities that Jane Fitcher has outlined in her presentation: training staff to operate the new immunization tracking IT system; developing communication materials for various segments of our community on the pandemic, its prevention, appropriate responses to it and the immunization campaigns that are to come.

We have had a massive number of requests from the community to provide educational sessions to many and varied groups. We have had to say no to most of these requests. It is not possible for us to carry on with even our highest priority activities and our influenza activities and meet these requests. Some of you may receive complaints about this. Some already have. I encourage you to support us in our prioritization activities and accept that we cannot do everything. We have tried to be as efficient as possible with the educational sessions we have decided to do. We have visited every school board, addressed all the school principals and addressed each of our 90 or so schools in a very efficient blitz in the first week of September. With use of our website, which we are promoting, we feel that all teachers will have the resources to keep their students as healthy as possible. Now our next priority is to deal with the preschool and post secondary systems. We know that schools where many young people gather are the most important breeding ground for influenza transmission. Tackling these sites has the potential to blunt the epidemic until we have a vaccine. Everything else must be secondary.

There are two other important activities that we have had to curtail that the Board should be aware of. One is preparing for our accreditation visit which is due at the end of May 2010. Normally we would be in full preparation mode this fall. This is not possible. We have written to the accrediting body, the Ontario Council on Community Health Accreditation, asking for a deferral of this visit until next fall or winter but we are unlikely to be successful as we do not fit their published criteria for extension. Although we will not have time to prepare, we plan to go ahead with the accreditation visit.

We practice all of the requirements of accreditation on a daily basis so feel that, even without special preparation, we will probably do OK, although some deficiencies may be found. In addition, much of the work of previous visits has been reduced because OCCHA has gone to electronic evidence rather than asking for photocopies of evidence required, the production of which was time consuming.

The other activity that we have had to curtail is preparing a new Strategic Plan. Our current plan expires in 2010 and, at this point, we should be starting to prepare for a replacement. This is also not possible given our current state. In early 2009, we put all committees and other activities arising out of our current strategic plan on hold in order to free up resources while we conducted our Program Review. In fact, the Program Review is a massive effort concentrated on one part of our overall strategic plan: the planning driver. Work on all other drivers has stopped in the meantime. A lot of work went into creating our current Strategic Plan and the value in it has only partly been mined. Much work remains to be done. Therefore, I am recommending that the current Strategic Plan be extended until the value in it has been extracted – probably another several years. A resolution to this effect will be brought to the Board in October.

2008 Budget:

As I have informed the Board by email, we have been disappointed again by the MOHLTC allotment for our budget. Three years in a row, this Board has approved a budget that would allow us to meet mandatory requirements. Three years in a row, the MOHLTC has refused to fund its 75% share of that budget, despite the fact that they say quite clearly and frequently that they fund 75% of mandatory requirements. As our experienced board members know, but our new board members are just catching on to, this arises from the fact that the MOHLTC has no funding formula for Boards of Health. Funding is based on the budgets that were approved in the early 2000's when much of funding for public health had been downloaded to local municipalities. Being a relatively poor region, our Board of Health kept the budget low, feeling that the local taxpayers could not afford to fund even the mandatory requirements. Relatively rich regions implemented large budget increases during this time period and the province covered its share of all increases. Then, in about 2005, the MOHLTC set the base budgets in stone by allowing only fixed percent increases in the budget each year while uploading more of the costs to the province. This freeze was a form of reverse socialism where the rich got richer and the poor, like us, stayed poor. This formulaic approach has continued into this year and we received only a 3.98% increase in our budget. Since we had implemented a "status quo" budget that required only 3% increase from MOHLTC, we can survive and carry on with this budget to the end of the year without any need to increase the levy or dip into reserves. However, I want to make it perfectly clear that, although we call it a "status quo" budget, it did in fact involve some significant cuts, including closing an office.

It obtained the name "status quo" because it did not involve any layoffs. The extra 0.98% above our 3% "status quo" budget is entirely and almost exactly consumed by the local proportion of the one-time funding request required to match the 75% of that request that was approved by the MOHLTC to fund the renovations in the Brockville office. This will allow us to avoid dipping into the reserve to match this funding. So financially, we are in good shape but capacity wise and as far as meeting mandatory requirements, we are no further ahead than we were last year.

Brockville Renovations:

This brings me to the Brockville renovations. For our new board members, the Brockville office is 18 years old and the interior of much of it has not undergone any renewal since the building was built. A major tenant moved out in August 2008. Our staff were very cramped at that time and we had a great need for a training lab and more meeting space as we were spending operating dollars renting these items. So it was decided that we would expand into the vacated area (north wing) on the second floor, which was not amenable to rental in any case, and try to rent the vacated space on the first floor. The first phase of this, development of the training lab, more storage and meeting rooms was accomplished in late 2008 with one time funding from the MOHLTC. In our budget submission for 2009, we requested funds to complete the transformation, renew the west wing and purchase new work stations and have received this funding. We have completed much of the work that needs to be done and expect it to be finished well before the end of the year. We hope to arrange a tour for the Board at the time of a future Board meeting. These renovations have improved training efficiency and solved a number of occupational health issues and major storage and meeting space problems. In addition, the money will allow us to update an aging telephone exchange that could not be supported beyond mid 2010. Once we open the Smiths Falls office, we will have 4 digit dialing between the two offices, a major time saver for our reception staff and all staff who make regular telephone calls between the offices.

Unfortunately, given the economic situation, we have been unable to rent the vacant space on the first floor despite a year's efforts and use of real estate agents. We also have meeting rooms for rent now. If any board members know of any group who might like to look at our space, please let us know.

On Call Activities:

The Board is aware that we are required to provide service if needed 24 hours per day, 7 days per week. We provide this through an answering service and managers take turns responding to calls. I am available 24/7 to back them up or help out in urgent situations. The managers keep an On-Call log. This records every "event" that they are required to respond to after working hours and on weekends. Some events are not too time consuming but require specific expertise, such as ensuring that an adverse water result from a laboratory has been responded to appropriately by the owner of the water system. This may take about a ½ hour of work and several telephone calls. Some events are not simple at all. A report of a child bitten by a raccoon in one of our hospitals will require the manager to act as consultant to the doctor caring for the child to determine if the child should be immunized, and if the decision is positive, drive to the health unit office to obtain the required vaccine and drive it to the hospital where that child is located. This may well take several hours.

The on call log indicates that 247 calls were responded to in 2008. This is an average of nearly 5 calls per week. In 2007, there were 222 calls, so the call volume has increased by 9% in one year. The pay for on call, \$35,000, is divided between all managers who take call and amounts to a little under \$700 per week. The pay has not increased since this system was initiated four years ago.

Given that this work is highly skilled, involves sophisticated decision-making, involving the lives and health of people, and that it takes place sometimes in the middle of the night or on Christmas day, the pay is low and a proposal to increase it in the 2010 budget will be brought forward.

Household Survey:

Statistics Canada is conducting a survey for the Health Unit as part of a survey skills development course that they offer as training for their staff. The survey started September 16th and will end on September 21st, 2009. Selected residents in the geographical areas of Augusta, Beckwith, Carleton Place, Drummond/North Elmsley, Elizabethtown-Kitley, Merrickville-Wolford, Montague, North Grenville, Perth, Rideau Lakes, Smiths Falls and Tay Valley are being asked about their awareness of the Health Unit; well-testing practices; knowledge of flu symptoms and transmission; and walking and bicycling activity.

All of the 650 residents being surveyed have been sent a contact letter informing them of the survey in advance. If you receive any calls from concerned citizens about the survey please confirm our participation with Statistics Canada and assure them that the results of this survey are confidential and will be used to aid the Health Unit in the planning and implementation of programs for the community that address their needs and ultimately help them stay healthy. As an aside, for new board members, the RRFSS telephone surveys are ongoing in our community and, if you are asked by a community member about the legitimacy of these telephone calls, your support would be greatly appreciated for these as well.

F. Kinsella stated that there are rumours about Lyme disease being the second pandemic. Do we have a Lyme disease problem? Dr. Carter advised that it is endemic; it has become endemic in parts of our area, particularly along the St. Lawrence River and the islands. If someone goes out hiking, this is a risk activity because they are walking through bush and brush. We have been giving out strong messages. The tick has to be attached for at least 24 hours. If ticks are found and can be pulled off there is no infection. Pants should be tucked into socks and long sleeves should be worn. If clothing is light coloured ticks can be seen. Lyme disease is definitely in the area.

9. Correspondence:

J. Butt reviewed the additional correspondence. F. Kinsella stated that he would like to pass a motion supporting a new appointment from Lanark. J. Butt stated that this will be covered in the incamera session. After his discussions, hopefully there will be some action from the minister's office on this issue.

J. Butt advised that we need a motion to extend the meeting past 7:00 p.m. A. Warren moved that the meeting continue until 7:30 p.m. at the latest. All concurred.

A short recess was taken at 6:53 p.m.

The meeting resumed at 6:59 p.m. Motion to move incamera was read at 6:59 p.m.

10. Incamera Meeting:

It was moved by: S. Dodge

Seconded by: J. Earle

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;
- (b) personal matters about an identifiable individual, including municipal or local board employees;
- (c) a proposed or pending acquisition or disposition of land by the municipality or local board;
- (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, local 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: J. Earle

Seconded by: S. Dodge

That: This closed session rise and report.

Motion Carried.

11. Report from Incamera:

It was moved by: K. Graham

Seconded by: K. Giroux

That: The Board of Health approve the amendments to the non-union staff benefits for vision care, hearing care, and dental care with Green Shield Canada effective October 1, 2009.

Motion Carried.

12. Time, Date and Location of the Next Meeting:

The next meeting will be held on Thursday, October 15th at 4:00 p.m. in the Gananoque office. K. Graham gave his regrets for this meeting.

13. Adjournment:

It was moved by: K. Graham
Seconded by: G. Grewal
That: The meeting adjourn at 7:30 p.m.

Motion Carried.

J. Butt, Chair

Date

H. Bruce, Recording Secretary

Date

c: Board members
HU offices
Municipalities
Shared Drive