



Minutes of the Board of Health Budget Meeting

Thursday, January 14, 2010

Leeds and Grenville Room

458 Laurier Boulevard

1:10 p.m. – 4:37 p.m.

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

Regrets: J. Earle
A. Warren

J. Futch, Department of Clinical Services
S. Gates, Director, Quality Improvement Department
J. Hess, Director, Family Health Department
R. Kavanagh, Health Promotion Department
J. Lyster, Director, Health Protection Department

D. Clark, Recorder and Times

C. Kennedy

1. Overview:

J. Butt called the meeting to order at 1:10 p.m. He welcomed everyone to the first budget meeting of 2010 and stated that he is pleased to see that there are many board members and staff here. J. Butt introduced everyone to 2 new faces. The first new face is Dr. Christine Kennedy who is with us for about 3 months as a resident in Community Medicine. Also Deanna Clark is here from the Recorder and Times, replacing Ron Zajac.

J. Butt introduced the budget process by making a few remarks. A power point presentation was given. (see Appendix #1)

J. Butt stated that the Board is held accountable to the public for the expenditure of the funds that they give us. The expectation of the minister is that we develop and approve a budget.

A year ago during this process when we talked about an increase to the levy, we talked about an absolute number. Depending upon what number we use, total population or census data, the levy municipal share, is either \$17 or \$15. The increase could be in the order of \$1.70 to \$2.00. When you apply the \$2-\$15 it works out to 20% which is a tremendous headline, but in reality the absolute value is less than the price of a coffee. J. Butt reviewed sections of the Act that relate to the budget process.

The ministry has advised that in 2011 we will have a performance management framework. Allison Stuart confirmed that there is no hope for more dollars. In 2011 the ministry is not going to take back from health units that are overfunded. This will be phased in over time.

J. Butt stated that Dr. Carter and J. Pearce are totally transparent in the information they give us. They are not playing games with us. Our lobbying was successful with the ministry because we did argue for a funding formula and they stated that they would develop one.

We don't do a good job of making sure our community knows what we are about. The public health agenda touches people every day and we are about developing safe and healthy communities. Boards are between a rock and a hard place. Public health is not just another service. The value of the services in public health are only noticeable when there is a crisis.

J. Butt stated that we need to ask the right questions and go away from here when the budget is approved knowing that we as a Board have done the best job possible.

2. Principles/Budget History:

Dr. Carter gave a power point presentation (see Appendix #2). She stated that she wants to change our dictionary a bit when it comes to the budget process. We used to use the term enhancements for new positions. We can't use this term anymore because the ministry of health uses the word enhancements to describe things that are not required under the OPHS. The new term we will use is additions needed to meet the OPHS requirements.

The second term we need to change is status quo, which means no changes. There was a problem around this term amongst staff. They felt it implied there were no negative effects at all. We are going to try to call it the budget to support approved operations.

We are going to be as efficient and effective as possible and we need to decide whether to use the retained municipal reserve. When we went through H1N1 we spent a lot of money and the ministry has still not paid us. At one point we were in an overdraft position and we used reserves. There are arguments on both sides.

We do not want to send a penny back to the MOHLTC. One of the ways we get closer to using MOHLTC funds is budgeting for some use of the retained surplus or reserve. We do have a tendency to under spend a budget at yearend because of gapping and other things. If we budget to use the reserve a little bit then it allows us to get closer to that budget line. In the 2 years we have budgeted to go over and use reserves, we have never used it to the extent approved yet. If we can use one time funding to help us reduce our operating budget that is a big step. Our IT lab has saved us a lot of operating dollars. Now we have our own facility and do not have to rent a site and set up and tear down equipment.

We are part way through our program review and have completed the need and impact analysis and have used that in creating our budget. We are honest and we do not pad the budget. We are way behind and everyone knows it.

A lot of health units send people to Toronto to support provincial initiatives but we do as little of that as possible –we prioritize local service.

We have yet to complete the capacity and partnership sections of the program review. We have had to estimate this in the budget. We also don't have the new positions rated in order of priority. Everything we have given you is given with equal priority. We should finish the program review in May and we think we can have this information to the Board in May.

We suggest we pass the budget using our estimates to meet the OPHS. We can't get anything if we don't ask for it, but we don't expect to get more than a 3% increase this year. We will implement the approved operations budget when it is passed and then when we come to the May Board we can decide what of the additions to meet the requirements we will do at that point. The Board should have the full information by May to make that decision. We are all in this together.

The province has recognized the funding problem and are trying to implement a province wide solution. Our short term plan is that we submit a budget to the MOHLTC to the best of our knowledge around how to meet the standards. Long term, beyond 2010, we will continue to plan to move towards meeting these standards so we can sign the accountability agreement when it comes.

We expect the new funding formula to allow a gradual increase in our budget after 2011. Dr. Carter reviewed the budget history with board members. We still need the 12 positions requested previously plus 10 more positions. The bottom line is that we need 22 more positions to meet the new standards. She does not want us to be the weak link that affects the entire province.

Dr. Carter circulated a chart to board members and the press showing the budgets of other health units. We are all very comparable geographically. We have the lowest per capita budget. The big difference is what comes from the province. Dr. Carter stated that if you work out the per capita funding of the 13 rural health units in the initial public health report, we are the second lowest in that group in that report. When the ministry did the funding they took the entire budget, which is not comparing apples to apples as some health units do not have programs such as Land Control and PSL. Dr. Carter turned the meeting over to J. Pearce.

3. Approved Operations Budget Review:

J. Pearce reviewed with board members what was handed out at the meeting. She gave a power point presentation to the group. (see Appendix #3)

J. Pearce reviewed the history of public health funding. The base budget in 1993 supported 109.92 FTE's or \$5,201,248. In 2009, 16 years later the base budget for the same programs is \$8,551,871 with 106.56 FTE's with much bigger requirements for each service. Our total funding loss was about 22% or \$1,054,000 in 1997. That is part of what got us where we are now.

J. Pearce reviewed the funding ratios. Prior to 1998 the funding ratio was 75-25%. In 1998 it was 100% municipally funded and from 2007 onward it has been 75-25%. That is where we are intended to be today. In actual fact in this draft budget for approved operations, the ministry, if we assume a 3% increase will only be funding 70.18% and the remainder falls to the municipalities.

Long Range Planning – In 1999 we embarked on our first long range plan but it was not sustained. We need to consider returning to multi-year budgeting as suggested in the capacity review report published in 2006.

The purpose of this budget is to inform the 2010 Municipal Levy and to assist municipalities with local budgeting and to complete a cost shared budget to the ministry. J. Pearce reviewed a summary of the 2010 budget changes. She advised that salaries and benefits represent 86.7% of our budget. Human Resources are the largest part of this budget. Most service delivery organizations are around 80%. Page 3 is not included in the package because it contains individual salary information. If we need to discuss this further we will need to go incamera.

One of the things downloaded this year was the expanded CINOT program. The increase to the purchase service line is largely due to the downloading of that budget line. The travel line will increase by \$44,000. We were too optimistic in the 2009 budgeting, and did not achieve the savings projected. B. Fletcher asked does that have anything to do with closing Almonte? J. Pearce advised no, we are in the process of finalizing a report on that and there is no significant change in mileage due to Almonte.

Dr. Carter stated that we cut quite a bit out of the travel line in 2009 and it was too much. F. Kinsella questioned what the difference is between the 2009 budget and the 2009 estimate? J. Pearce stated that the budget is what you approve and the estimate is a projection. Under administration/supplies there is an additional \$30,000 expected there. Dr. Carter stated that what actually occurred up until November is more like real life. The estimate is what our actuals would have been without the impact of H1N1. With H1N1 the world changed.

F. Kinsella asked what kind of funding is there for H1N1? J. Pearce advised that we will receive \$10 per shot. If we incurred costs that were extraordinary above the \$10 per shot the ministry would reimburse them. Where we used staff from 100% funded programs we should be reimbursed. We did make some decisions purposefully using those staff when we found this out. Dr. Carter advised that we are expecting a bit of a yearend surplus because of H1N1, but that will be in the 100% funded programs and we will have to send it back. The 2009 estimates will not be what you will see in your audited statements J. Pearce advised.

J. Pearce advised that there was lost revenue in rental income. We do have office space for rent but we have not rented it. We also have meeting rooms to rent. We had to reduce expectations there because the rental income is not materializing. There is a total base increase of \$652,000 and a net increase of \$442,000.

In salaries there is a 4.89% increase over 2009 salaries. \$64,000 is grid increases. There is about \$100,000 for 2 positions for administration and maintenance of the Smiths Falls Office. Part of that is for a caretaker. We need to have a property manager there. The intent is that the property manager position would also be a liaison to Corporate Services and take on some financial responsibilities which is succession planning for when J. Pearce retires. The remainder of the \$149,000 reflects potential contract settlements and salary awards. The CUPE Agreement is expiring at the end of March and there has been no award yet for non union staff.

Benefits increased \$73,000 in total. Because of salary increases and a \$900 increase to maximum pensionable earnings, the cost of OMERS is expected to go up by \$22,000. Green Shield is expected to escalate to \$14,000 due to increased premiums and usage. R. Haley asked do you shop for other carriers other than Green Shield? J. Pearce advised that every year our benefits broker shops for us. Dr. Carter has made recommendations around the 10 highest drugs used and suggested generic substitutes for staff to save funds. R. Haley stated that LTD costs could increase. J. Pearce advised that we pay \$3.09 per \$100 of earnings for LTD. R. Haley asked do we pay 100% of premiums? J. Pearce advised yes. If employees were to pay a share of that, then any income is not taxable.

Dr. Carter commented that we have a union contract signed already requiring us to provide this benefit.

Occupancy Costs – There is a \$61,000 increase due to waste disposal and utility costs. We are budgeting \$44,000 for operating costs for the Smiths Falls building. We have not had to pay operating costs in the past. That was understood when the Board approved the building. We have budgeted for modest increases in Kemptonville and Gananoque.

J. Butt asked is he to understand that the \$11,000 increase for Brockville was due to increases in services that are being provided by the City? J. Pearce stated that we don't get pickup of garbage here so we have to pay Waste Management to pick up our garbage. Dr. Carter advised that part of that fee would be the tipping fee at the Brockville landfill site. J. Butt stated that would be about a 5% increase to that line.

J. Pearce advised that safety engineered syringes cost another \$4,000. We also had to reinstate the marketing line budget. This was given up last year to perform a onetime youth risk factor surveillance. We have reinstated it to market our agency this year. The cost of cell phones is increasing. We added cell phones last year for nurses in isolated rural areas. This is a safety issue. The cost was \$3,000 a year extra.

Increase to courier costs are \$5,000 a year. About \$2,000 of that would be related to Almonte and the vaccine delivery program. There are a lot of things that need to be shipped between offices. Dr. Carter advised that we do save as much courier costs as we can. Anytime staff are driving between offices we give the item to them to take, and don't use courier. K. Graham asked is there an increase in the bulk rate? J. Pearce advised no, it is \$3.75 per package (Ministry of Health rate) and the normal rate would be \$12. There is a tradeoff between postage and courier. We are more confident with courier. Canada Post can be quite expensive.

Board costs are expected to increase by \$8,000. We have enlarged our Board which is a good thing for our agency. Part of that is reinstatement of the Board educational budget. Last year we had reduced it. Because of size and interest the budget line was returned to \$7,000.

We have requested an increase to staff development by \$4,000. This came out of the formula used to come up with staff development. We used to use a formula driven by the type of staff, but decided to make it uniform at \$500 per staff per year. It is \$2,000 for a director, a manager is \$1,000 a year, and \$500 per year for all other staff. That does not mean everyone gets to spend \$500 a year. The directors can use their discretion on how it is allocated. There are systems within departments.

One Time Costs – This budget does not include any Smiths Falls expected onetime costs. The purpose is to inform the municipal levy. The municipal share of any capital costs will come out of the capital reserve. J. Pearce will need to get this together to include in the budget for the ministry.

In 2009 we initiated an HR web based system for implementation in 2010 for a cost of \$12,000. Staff will be able to log on anywhere to complete their timesheet. Right now, if timesheets are not in we have trouble allocating costs.

When staff complete the timesheet it will go to the director for approval. There will be no paper. It will then go to HR. HR will probably save a day a week minimally. The system will allow the directors at any time to bring up their team to see who is off that day and they will know who is here and who is not, as requests for time off will also be in this system. J. Pearce advised that the mileage forms are also attached to this. If they don't submit this they will not get their mileage paid. L. Paine asked is there going to be a policy for this? J. Pearce stated that right now we use an informal system but we do monitor who has submitted and who has not. L. Paine stated that there should be a policy or direction. J. Pearce stated that she agrees, if there is a policy we can enforce it better. By spring we will bring a policy to Board. J. Pearce stated that with us going into negotiations with CUPE now is a good time to propose this. This is an enhancement of our Ceridian system. Dr. Carter advised that our old system was so outdated Ceridian was not going to support it anymore. We had to upgrade. We have also encouraged our staff to subscribe to epost and receive their pay stubs electronically.

Vector borne disease expenses are expected to go down by \$17,000 because mosquito ID testing is done every other week instead of every week. J. Lyster advised that this was a cost saving measure. J. Pearce stated that is everything for the budget for approved operations.

Requests for New Positions

J. Pearce advised that we are requesting 22.07 additional FTE's as a separate budget to implement OPHS. She referred to the directors' justifications stating that these positions represent a 17% increase to our budget for approved operations. The cost is a \$2.73 per capita increase for the municipalities. The purpose is to fully implement the OPHS to meet service needs, to reduce Board's liability, and to enable Board to sign accountability agreements in 2011. L. Paine asked are these in the 100% funded programs? J. Pearce replied no they are not. Dr. Carter stated that we are only talking about the cost shared budget.

J. Butt stated that we should mention what the 2 different packages are. The second package is justification for these positions. The budget we just finished was the one for approved operations and this is for the additional positions to meet the OPHS.

J. Pearce reviewed the budget process. The municipalities have been asked to maintain the 2010 cash flow at 2009 levels pending budget and/or levy approval.

The levy can be approved without a budget. That can be increased when the budget is approved if it requires additional levy. The budget needs to be submitted to the ministry by the end of March and municipalities are obligated under the HPPA to submit their share of the levy as approved by the Board.

J. Pearce reviewed the levy page. The first option is a 3% increase to the levy supplemented by the use of the retained municipal surplus to support the draft budget for approved operations. The levy will increase by 51 cents per capita and \$179,000 is used out of municipal reserves. R. Haley asked how much is the retained surplus? J. Pearce advised that right now it is \$179,000 but she does not know the H1N1 contribution. J. Butt stated that last year there was a perception to keep a little reserve to smooth things out but the notion was that was money that belonged to the municipality. Once we determine what we need in the bank we should spend the rest.

J. Pearce stated that there are 3 options but there is room to pick between them. Option B is an increase of \$1.72 which would be an increase to the levy by the full amount to support the draft budget for approved operations. Option C is an increase to the levy by the full amount to support the draft budget for approved operations and the additions needed to implement the OPHS requirement. Option C is not reasonable to do in its entirety in 2010. These are annualized figures and this is the worst case scenario.

L. Paine asked of these 22 positions what are the 10 that are required to meet the OPHS? J. Pearce advised that there has been no prioritizing, the ones asked for in 2007 are not necessarily more important than the additional 10. We would never expect that in one fell swoop. We do not have the capacity. S. Gates stated that we have not finished our program review process yet but these are our best guesses using our need and impact data. Dr. Carter stated that before any decisions are made we want to put in a budget that would allow us to meet the OPHS. J. Butt referred to the justifications sheets stating that they are supported by the need and impact. This will be reviewed next.

R. Haley stated in terms of the program review we hope to be done by May and you will know what staff you need. J. Pearce stated that every year that we don't submit to the ministry there will be a lost opportunity. If we don't submit now they will think our needs have changed. Dr. Carter stated that we have to at least ask the ministry. We know we won't get it, but we have to ask. We need to move the budget forward every year in order to meet the OPHS. We will know by May and can start hiring in June and July and the Board can make its decision by doing some multiyear planning. We will put this budget up so much this year, so when we come to next year it is not such a big chunk. We can't not move forward every year. We do know what we will need and by May we will have finished our whole program review and we don't want to wait until the next year.

J. Butt stated that the critical piece going forward is that we need to figure out by the end of March, what as a Board will we approve to be the annual operating budget. Then there is the other budget that we submit and in this case it would be using the best information available that reflects our needs to be able to achieve the OPHS. The best we are going to get from the MOHLTC is 3%.

B. Fletcher stated that in years past we made sure the budget we submitted was everything we needed, but we already had a budget set. If we didn't get that money we knew where we were going. We always have to ask but prepare for what we get. We should not debate what we really need. We have to have 2 budgets ready to go.

L. Paine stated that in terms of going forward and asking them to meet requirements, rather than throwing out 20 positions fine turning would be a good step. S. Gates stated that we did not approach it by adding the old 12 and adding new ones. The directors all started by looking at the requirements and looking at what we need. It just so happens that those 12 came back with an added 10. Dr. Carter stated that now we have a new set of requirements and we started over. L. Paine stated that you can't use a budget to correct the past.

J. Butt suggested a short break at 2:46 p.m.
When we return the directors will be presenting the justification on positions requested in their department.

The meeting was called to order at 2:58 p.m.

J. Pearce stated that there is a lot for board members to digest in the package. You have all the documents in front of you and each director will speak to the needs in their department. Board members are asked to go away and digest the documents and we should be able to make decisions around the municipal levy next week at the January 21st meeting. Her expectation is that board members will give her direction to carry forward in the preparation of the budget.

4. Requirements to Implement the Ontario Public Health Standards:

J. Futch gave her report for the Department of Clinical Services. The first positions she requires are for the VPD program. She is asking for 2 RPN positions because the ministry of health in the new OPHS changed the standards and protocols in regards to who is responsible for the vaccine. We are responsible for the vaccine. They changed the follow up as well.

If the temperature goes up in the fridges storing vaccine we need to call pharmaceutical companies to advise if we can or cannot use that vaccine. Some doctor's offices may require us to phone 6-7 pharmaceutical companies. Follow up can take up to 2-3 days. We also have to visit every doctor's office once a year to verify that the fridge can hold vaccine – we do teaching with office staff regarding cold chain. Most of the doctors' offices are on board with this.

S. Dodge asked how often during the year would this happen? J. Futcher advised that all of our hospitals may have 5-6 fridges that hold vaccines, and we probably have at least 2 or 3 of these breaks a week. Dr. Carter advised that a fridge can have \$50,000 of vaccine in it easily. B. Fletcher asked is there no requirement for the doctor to have a good fridge? J. Futcher advised yes, the doctor is required to have a fridge that holds a temperature. In some offices, after they have had significant breaches, we do not give vaccine until they get a proper fridge. The RPN's are also involved in 2 new programs – HPV vaccine given to grade 8 girls and pneumococcal vaccine to grade 7. School clinics have increased to 390 per year.

This year with H1N1 we had every nurse immunizing in the school program. We had to make sure all of the second doses were into children by the end of January. F. Kinsella asked what about record keeping of vaccines? Who inputs the information that the child has been vaccinated? J. Futcher advised that we have not computerized the school program. We will computerize next fall. It will be a download from the H1N1 system which clerical staff will enter. We can't download right now into our immunization system. It has to be entered by hand.

J. Futcher advised that sexual health and teaching programs have suffered the most. If we had 2 additional staff that were vaccine specific we would be able to increase the amount of people we see in our travel clinics. We make \$50,000-\$60,000 per year in these clinics. We could make more money with these clinics if we have these 2 new staff. We could make another \$20,000 per year. We would also be able to increase teaching with our healthcare providers.

L. Paine asked have you seen any increases in STI's? J. Futcher advised yes we have. F. Kinsella commented that the kids consistently say that they trust a nurse far more than any other source regarding sexual health teaching.

J. Futcher would like to see a permanent clerical position for the immunization as well. This person does all data entry for IRIS, attends clinics and supports nursing staff and packs vaccine. Other program assistants in our program do not have time.

The next 2 positions for VPD are data entry positions for daycare and school immunization. It would take at least 2 years for 2 people full time to do this whole process to get us caught up. We also have to add all the children in daycares.

We should know the immunization status of every child in every school for every day. We currently cannot do that. When we have had infectious and VPD disease in the schools it has taken a phenomenal amount of time for nurses to get on the phone, deal with schools, get bus lists and call every single parent of every child to get immunization records. Most children are immunized. Rates are 85% - the only data we have entered is for 35%.

F. Kinsella commented that as soon as you hire someone it is fulltime employment, it is possible to run a summer program for students where they would do the data entry. J. Futcher advised that we might have problems with our unions. Dr. Carter stated that it is not just data entry; these are well trained and highly skilled people. J. Futcher commented that it is looking at an immunization record and knowing whether it is up to date, this is what your children need. It is quite intense. IRIS surveillance is a huge issue and it is not getting done.

Sexual Health STI Program – J. Futcher advised that we cut back on sexual health clinics in our schools. If we open 6 high schools it will take us 24 hours per week. We need to get this service back. Kids and parents want nurses. We want to get back to providing teacher and education resources.

G. Grewal questioned on page 6 under promote sexual health behaviours – parents would like to see same sex classes in grades 5 and 6 ? J. Futcher advised that they want separate sexual health teachings for boys and girls in schools but we do not have the resources to do this.

R. Haley stated going back to page 4 and data entry; we have to be more creative in how we get the work done. There are ways to get it done with savings. Dr. Carter advised that it is not data entry, it starts with sending out letters, then talking to parents, then interpreting records, and dealing with hostile parents. This person also deals with doctors offices and interprets records, which is complicated. R. Haley stated that he heard from that to get a template to use to say what you need. J. Futcher advised that the smallest part of this job is the data entry piece.

J. Futcher spoke about the harm reduction program advising that our pharmacy system is only working in Gananoque. We need to take a look at other models and strategies. We are wanting some time for the team leader in the program to have dedicated time for planning for the program.

J. Butt suggested that we use today's forum to gather the information. Questions are welcome and necessary for clarification, but going forward into our next meeting more questions will be answered. It is not surprising that we did say as a Board that we needed to know an answer to the question are we the most appropriate person to deliver the service. Far be it for him to second guess the staff. Going forward into next week we should be aware that is a fair question.

R. Haley stated that it would have been useful to have this information in advance. J. Butt stated that is what next week is all about. B. Fletcher advised that we need to listen to managers now and write down our questions and think about how we can ask the questions for the next meeting.

Jane Hess gave her report for the Family Health Department.

1.0 FTE manager – There is no middle management and we want to make sure we are following standards and safety. There are increased requirements in the OPHS. Currently there are around 36 staff that report to her. We could do a better job supervising staff in the field.

The next positions are requirements in the OPHS. This includes child and reproductive health. Documents from the ministry have just come out to the health units. This is a good way to look to see if we are on the right track.

Screening tools – 0.5 FTE – This is a comprehensive approach. The ministry put out 2 new tools for child screening and one is NutriStep and the other is a pediatric dental screening tool. There are 2 Best Start networks in LGL. One in Lanark and one in Leeds and Grenville. We need to ensure that these different screening tools are implemented strategically to give kids the best chance.

0.5 FTE – The second half of that job is the enhancement of breastfeeding. The nurse is not just dealing with the mom but all of the supportive environments and all community partners. We have been working unsuccessfully on a comprehensive approach to breastfeeding for the past 16 years. We need to work on community readiness which would be this 0.5 FTE's role.

The PHN position in child health is split in half as well. We are looking at the role of positive parenting. We can influence development of policies for healthy parenting. Roots of Empathy – We got involved in 2001 when we had 100% funding with 1 PHN. We have a contact person in Toronto. The program involves following babies throughout the year. We are still doing it but it has not grown a lot. When funding stopped we kept doing it a bit but it is withering without adequate support.

The other half of that position is parenting Triple P. This is using childcare healthcare reform dollars. \$96,000 buys 1 public health nurse. If that money was put into the position to support Triple P continuing we would do the health promotion population parts of it. We are the organization that is population based and have that mandate.

The second half of that position is healthy family dynamics. There are lots of statistics on family violence. When we look at parenting it is around mal treatment – yelling, screaming, and hitting. Not a positive environment for children to develop well. When the ECD money stopped we had a PHN to support that. We are the only organization with the population based approach.

F. Kinsella stated that we found with high unemployment periods, that is the thing about how fluid these budgets can be, with high unemployment family violence goes up. Are we flexible enough in our budgeting to move resources in and take out resources when we need to?

J. Hess stated that when we talk about a comprehensive health promotion strategy, we would not be intervening directly with individuals but working with our community partners to do that. We are flexible.

Regarding prevention and post partum depression our role is the broader role. We have stopped doing one on one consultation. We do want to work on the comprehensive health approach.

2 PHNs for Reproductive Health – One is with preconception, for men and women, anyone of reproductive age. From 9 to menopause. We would work with the school team. Sexual health is a community wide approach. This has always been in our mandate and we have never gotten to it. We have never had the capacity to have a nurse assigned to this. The other PHN is for reproductive health and preparation for parenting. This is new, not in the previous guidelines. We could make an impact if we get to women earlier. Lots of violence against women happens in the first pregnancy.

Health Promotion Summer Students – This meets the requirements for kids 3-12. This group reaches an audience that PHNs do not have time to do. We expanded it last year to include healthy eating, healthy weights and physical activity. It is a recruitment strategy for future public health professionals and is a joint effort between family health and health promotion. Last year the students also did beach water testing one day per week.

Clerical Support - 0.5 FTE Program Assistant – We have 1 program assistant for 13.75 FTE staff for child and reproductive health. This is the only person in the Smiths Falls office funded by HB/HC.

Rebecca Kavanagh gave her report for the Health Promotion Department. R. Kavanagh stated that we focused on our department structure and how best to organize ourselves to implement the OPHS. A lot of the standards required us to change what we do in health promotion.

Program Manager – This position would alleviate a lot of administrative duties that staff take on.

Program Assistant to support the Dental Program – Currently we have a 0.5 FTE and the new OPHS requires a lot more data entry. Right now dental staff carry a lot of that work which prevents them from doing preventative services.

2 Teams – School Team and Workplace Team – As of December 31 Tri-Health has ceased to exist and as of March 31 FOCUS ceases to exist. This leaves a big gap. She proposes 3 teams by just adding 1.5 PHN's. She will rework these teams.

Summer Students – Currently we have a .46 FTE – 2 summer students for 12 weeks. Last year we went to 16 weeks which allowed them to get established and get into the kindergarten classes before they ended. She is looking for a 0.15 FTE to allow these positions to continue at 16 weeks each.

Team Leader Supplement for 1 additional PHN – We have 2 team leaders one for school and one for workplace. She would like one for community. They don't have a supervisory role but have a coordinating role.

Jane Lyster gave her report for the Health Protection Department She looked at the OPHS and asked what are we not doing? J. Hess talked about a return on investment and in orientation we talked about how small the public health budget is and the problems we have, but the return on investments is so large. For every dollar spent on proper water treatment it saves \$10 on the healthcare system. Our goal is to get common knowledge out there about public health and choices people can make today in their day to day lives.

1.0 FTE Public Health Inspector – This pertains to emergency preparedness and response. Impacts of that program – Regarding the internal component, we need to train our staff and ensure that our plans are revised and relevant. We need to test our plan and maintain a comprehensive resource manual. This externally impacts partner agencies and communities – table top exercises. Dr. Carter advised that this does become primary prevention in many ways – i.e. preventing contamination of water supply with sewage.

1.0 FTE. Public Health Inspector – This relates to food safety. We have approximately 100 day nurseries and 100 schools that require some sort of education program. We do have capacity issues. Educating food handlers – We are doing about 1/3 of what we should be doing.

L. Paine asked with full daycares will that increase your workload? J. Lyster advised that there is infection control in regards to food safety. R. Haley asked about the education piece, is there not duplication? J. Hess advised that it depends on the target audience. We tend to focus to grade 2. Rabies education is later than that. J. Lyster advised that for food safety the prime target age is grade 7. R. Haley asked are multiple people doing the same job? J. Lyster replied no, not at all. R. Kavanagh stated that we work in partnership to get everyone covered when needed.

J. Lyster advised that we have 12,000 plus food premises. They need training every 5 years. Dr. Carter stated that the turnover is high in these establishments. K. Graham asked do we generate revenue? J. Lyster stated yes, we generated \$6,000 last year.

J. Lyster advised that the disclosure program is a specific requirement in the OPHS where we have to make inspection reports available to the public for food premises. We are hoping to have a basic program available April 1. She advised that this might mean someone could call our office and want a copy of a restaurant inspection and we could provide it. J. Butt asked it is not the sticky on the door as I go in? J. Lyster advised no. L. Sowchuk asked are kitchen staff required in nursing homes to take this food handler course? J. Lyster advised yes, and they are inspected.

.5 FTE Public Health Inspector - Safe Water - SDWS is 100% funded and we have been advised it will continue to be funded until the end of 2011. Training and education for SDWS operators and public pool operators is something we have not touched on. This is a requirement under the OPHS. With private water systems they can request private consultation services with us. 19% of water systems are being tested, J. Lyster would like to aim for 50%.

1.0 FTE Public Health Inspector for health hazard prevention and management. There is no capacity to lead this program. Skill development is required. Premises that pose a public health risk we have an obligation to check at least annually. A state of the environment report is a way of having indicators that tell us about the health of our environment and how we can measure that over time. The ministry wants us to get involved in air pollution for example. We could have education to help with monitoring.

.5 FTE Public Health Inspector involved in infectious diseases and vector borne diseases. We have over 260 personal services facilities which have the potential to be a public health problem and we have an obligation to do education.

S. Gates gave her report for the Quality Improvement Department. She is requesting that the Production Artist position be increased from a 0.7 FTE to a full time position. This is not a new request. Upon review of the OPHS the rationale is even stronger as there are enhanced communication requirements within the standards. We need to increase public awareness by national campaigns or local campaigns. If we increase this position by .3 we could complete 48 more jobs in a year. That would be producing educational resources, newsletters, pamphlets, posters, program manuals and ads for the newspaper. It is a low cost.

We have spoken to other health units that contract out design work, and based on that hourly rate we would save money by housing this person on our staff. Our production artist works with our communications coordinator. We learned during H1N1 that talking with the media could affect the quality of our media coverage and it helped our relationship. By increasing the production artist by .3 it would take the remaining graphic design work away from the communications coordinator and she could focus on media and public relations. One of the challenges of living in a rural area is that we have local media and many residents look to local media for information. We do need to adapt provincial/federal campaigns to meet our own local needs.

The second request is for a Staff Development Consultant which is building on a mentorship coordinator. The OPHS requirements go beyond a mentorship program. They involve developing a highly skilled and developed workforce and deal with core competencies. A staff development position could allow us that focus to look at core competencies and integrate them into our services. This person could coordinate staff and board orientation, and help coordinate accreditation. There is always new legislation coming out i.e. The Accessibility for Ontarians Act, which requires additional activities and skills for us. This position will reduce staff turnover and reduce the need for recruitment of staff and reduce need for supervision. It may also reduce Board liability by having a competent and reliable workforce. There is evidence to demonstrate these impacts.

Evidence shows that we need dedicated people to sustain programs which we have experienced with our mentoring program. When we ran out of mentoring funding we tried to give that responsibility to a PHN. We also tried to address these requirements through committees, but the program died. With 1 FTE dedicated to these activities we could achieve these objectives. A person in this position would partner with surrounding health units and educational institutions and arrange in house training opportunities for staff as well as online training opportunities for staff.

F. Kinsella asked how many staff do we have? J. Pearce advised approximately 150.

J. Butt stated that today clearly we were bombarded with a lot of information. We know that the budget planning process will build on this next week.

Next Thursday at noon we are getting together and he would hope that we would have had a chance to review all the materials received and have some questions for the staff so that by the end of that meeting perhaps we can set some direction. We can seek more clarification if needed. We have various funding or budget scenarios and he hopes we can concentrate our effort on this and decide what approach we can take. This leads up to our February meeting where we approve the budgets that go forward to the ministry.

If you look at the information Dr. Carter gave us, and take the lowest and the next lowest and multiply by the population base, the difference to move us to the next level is \$1,000,000. If you took the 20 some position scenario that requests \$1,600,000 more, that difference is \$600,000. That shows us that in the scheme of things being at the bottom of the pile is where we are at.

F. Kinsella thanked staff for doing all of this work and stated that it will enhance our ability to take our case to the province. It took a lot of time and effort and he appreciates the input.

5. Questions and Discussion:

J. Butt stated that if board members have any questions that staff would have to do research on before the next meeting, please contact either J. Pearce or himself.

J. Butt thanked everyone for attending. The meeting adjourned at 4:37 p.m.

J. Butt, Chair

Date

H. Bruce, Recording Secretary

Date

- c: Board members
- HU offices
- Municipalities
- Shared Drive