Chatham-Kent Board of Health

Minutes

Wednesday, March 21, 2018 10:30 a.m.

Call to Order

Present: Councillor Joe Faas, Chair
Councillor Bob Myers, Vice-Chair
Ms. Noreen Blake
Mr. Ron Carnahan
Ms. Sharon Pfaff
Dr. David Colby, Medical Officer of Health
Teresa Bendo, Director, Public Health
Dr. April Rietdyk, General Manager, Community Human Services
Lisa Powers, Executive Assistant, Community Human Services

Regrets: Councillor Brock McGregor
Councillor Carmen McGregor

1. Provision for Declaration of Pecuniary Interest

No member of the Board declared a pecuniary interest on any matter on the open session agenda.

2. Recess To Closed Session

Mr. Carnahan moved, seconded by Ms. Blake:

"That the Board of Health move into a Closed Session Meeting pursuant to Section 239 of the Municipal Act, 2001, as amended, for the following reasons:

- Labour relations or employee negotiations in regard to CUPE 12.3;
- Personal matters about an identifiable individual, including municipal or local board employees.

The Chair put the Motion.

Motion Carried

3. Adjournment Of Closed Session

4. Resumption of Open Board of Health Meeting – 11:10 a.m.

5. Minutes of the Board Meeting February 21, 2018

Councillor Myers moved, seconded by Ms. Blake:

"That the minutes of the February 21, 2018 Board of Health meeting be approved."

The Chair put the Motion.

Motion Carried

6. Business Arising from the Minutes

Healthy Smiles Ontario Dental Fee Guide Remuneration, Prepared by Stacy Rybansky, Program Manager

Background

At the May 17, 2017 Board of Health meeting, a request was made by the Board for additional information and context around the remuneration of private dental practitioners with regard to the Healthy Smiles Ontario (HSO) program.

Healthy Smiles Ontario is a publicly funded dental insurance program for children under the age of 18 from low income families. This public insurance program provides funding for preventative, treatment, restorative and emergency dental services, and is 100% provincially funded.

Comments

Healthy Smiles Ontario delivery service models vary between the 36 provincial health units. In Chatham-Kent, the model is two-pronged and includes the direct provision of preventative services from qualified health unit dental staff, at fixed and mobile health unit clinic areas, as well as a fee-for-service stream in which local dental providers and/or specialists provide preventative and restorative treatment. The dental providers are reimbursed for their treatment and services for children enrolled in HSO by a third party administrator (Accerta). Services are remunerated to the maximum payable fee amount for HSO covered services as determined in the HSO fee guide. This fee guide is provided by the Ministry of Health and Long Term Care.

The HSO fee guide schedule, last updated in January 2017, differs from the Ontario Dental Association's (ODA) fee guide, which is used in private practice for billing purposes.

Presently the HSO fee guide provides the following remuneration for fee-for-service as compared to that of the ODA fee guide:

- Preventative services(scaling, polishing, fluoride application)- 58-70% of the ODA fee guide
- Diagnostic services (exams/assessment)-57% of the ODA fee guide
- Radiology 47-50% of the ODA fee guide

- Restorative services (fillings, root canal, dependent on primary vs permanent tooth)- 28-40% of the ODA fee guide

Frequency of services affects billing rates, in that services used less frequently are compensated at lower rates than those that are used more frequently; this can be seen with preventative services.

In Chatham-Kent, over 92% of private dental practitioners participate in providing HSO services. Each office has its own policies or guidelines regarding the number or percentage of publicly funded clients they serve in their practice; for example one office may accept and maintain new and/or an existing number of HSO clients, while other offices may not accept new HSO clients but will continue to provide service to clients who are in good standing with the office and have been regular clients in the past. The decision is solely that of the practitioner and the practice as a whole. Chatham-Kent program staff do not refer to any one specific practitioner (to avoid over saturating one practice) and clients that already have a dental practitioner are encouraged to continue with their regular practitioner for preventative and restorative needs. Where clients do not have a practitioner, they are enrolled into the Health Unit's preventative services-only program and require a referral for treatment at a private practice.

The ODA has been actively advocating to the ministry on behalf of their members for improved compensation for fee-for-services regarding publicly funded insurance programs, such as HSO. Although remuneration of services is one cited contributor to Canadian dental providers reducing the number of clients they may accept, it is not the sole reason for non-participation in a publicly-funded program. In a national research study, other rationale provided were concerns with the limited services covered under the fee guide, broken appointments by clients, slow payment and the denial of payment.

The Ontario Oral Health Association (OOHA) also advocates to the Ministry on behalf of marginalized populations in Ontario. Recommendations have included the implementation of additional comprehensive community-based strategies that are financially sustainable and which would increase access to oral health care[1].

Consultation

The Ontario Oral Health Association was consulted in producing this information report.

Financial Implications

There are no financial implications resulting from this information report.

[1] Quinonez, Carlos R., Figueirdos, Rafael, Locker, David. (Spring 2009). Canadian Dentists' Opinions on Publicly Financed Dental Care. Journal of Public Health Dentistry, volume 69, issue 2, pages 64-73. Doi:10.1111/j.1752-7325.2008.00102.x

Mr. Carnahan moved, seconded by Councillor Myers:

“That the Healthy Smiles Dental Fee Guide Remuneration Report be received as information”

The Chair put the Motion.

Motion Carried

7. Education/Training

a) New Electronic Fan Out List Demonstration, Kurt Clemens, Public Health Inspector, Chatham-Kent Public Health Unit

Mr. Clemens provided an overview and demonstration of this system which will be implemented soon and will replace the current Health Unit emergency fan-out process. The new system has many advantages, cutting down on staff time to initiate the phone tree and getting important information out to staff and Board members in a timely manner. Mr. Clemens provided a live demonstration of the system so that Board members could hear the type of message they may receive.

The Board thanked Mr. Clemens for his work on this project.

b) Demographic Snapshot, presentation by Stanley Ing, Epidemiologist, and Karen Loney, Health Educator, Chatham-Kent Public Health Unit

Mr. Ing and Ms. Loney showed a PowerPoint presentation regarding the demographics of Chatham-Kent relating to the work of the Health Unit and the CK Plan 2035. Some highlights of this presentation included:

- Overview of high school completion rates
- Percentage of families living in low income in Chatham-Kent
- Population rates and growth
- Environmental sustainability, specifically in term of how citizens get to work (i.e. car, bike, walk)

This information will be used to inform programming decision making and will be used to engage community partners. The goal will be to develop services that meet the needs of all stakeholders.

Councillor Myers Moved, seconded by Mr. Carnahan:

“That the two presentations be received as information.”

The Chair put the motion.

Motion Carried

8. **New Business**

A. Items Requiring Action - None

B. Information Reports to be received

a) Director's Report, Verbal Report by Teresa Bendo, Director, Public Health

Ms. Bendo provided the following verbal update:

Much of the month has been spent preparing for the submission of the Service Plan. The third installment of the new Ontario Public Health Standards was received on March 20, 2018; some standards are still outstanding. Focus for the month of April will be on participating in Harm Reduction, and working with Employment and Social Services around homeless enumeration at the beginning of the month. Team reorganizations will be announced at the beginning of the month.

b) 2017 Strategic Plan Year-End Summary and 2018 Plan, prepared by Teresa Bendo

Background

The Ontario Public Health Organizational Requirements requires that the board of health ensure that the administration establishes a strategic plan and demonstrates the use of a systematic process to plan public health programs and services.

On March 1, 2018 Chatham-Kent Public Health Unit (CKPHU) submitted its 2018 Service Plan to the Ministry of Health and Long Term Care (MOHLTC) that includes a list of all programs and CKPHU's planned interventions for those programs.

CKPHU selects annual priorities to align with:

- Municipality of Chatham-Kent **CK Plan 2035**
- CKPHU Strategic Plan 2017-2021
- Current health system environment, emerging trends and community needs
- Ontario Public Health Standards: Requirements for Programs, Services, and Accountability
- Program reviews and/or evaluations

Priority areas for the health unit receive increased focus for the year.

Throughout 2018 detailed information will be provided to the board regarding priority initiatives in the form of Director's updates, information and recommendation reports as appropriate.

The purpose of this report is to provide the board of health a summary of the accomplishments of the 2017 priority objectives and a summary of the 2018 plan.

Comments

All initiatives from the 2017 plan are in progress or ongoing, and a majority of the initiatives have been completed.

Several situational assessments have been continuing in progress from 2017. As the scope of the project and the nature of the data and information to be collected was clarified, appropriate timelines were set out in order to allow for meaningful stakeholder engagement and high quality data collection methods, while continuing to provide quality programs and services.

Situational assessments and other work related to planning and evaluation take a great deal of time and resources. There needs to be a practical balance between "planning" and "doing". The Foundational Standards team is working to help build capacity (infrastructure, processes, tools, resources) for planning and evaluation, while playing a large role in supporting and reviewing (in terms of ethical conduct and quality) planning and evaluation activities occurring across all program areas in the organization.

With the current high demand from programs for planning and evaluation support, there is a need to prioritize projects and then dedicate the time and resources required to make progress within a realistic timeframe.

A summary of the 2017 plan and progress to date can be found in Appendix A.

Trends and issues in the following four areas continue to influence the work of CKPHU and are reflected in the 2018 plan:

- **Legislation**- examples include: Immunization 2020, ongoing public health transformation, legalization of cannabis;
- **Collaboration-** examples include: the creation of the Community Human Services department, reorganization of CKPHU, Ontario Public Health Organizational Requirements;
- **Evidence informed decision making and accountability**- increased expectation to use population health assessment and data to inform program planning and decision-making both within CKPHU and the broader health system; and
- **Financial sustainability** - ongoing provincial and municipal budget pressures to effectively fund public health program and services

A summary of the 2018 plan can be found in Appendix B.

Consultation

There was no consultation required in producing this information report.

Financial Implications

There are no financial implications as a result of this information report.

c) Demographic Snapshot, Chatham-Kent, Prepared by Laura Zettler, Epidemiologist

Background

As outlined in the Foundational Standards of the Ontario Public Health Standards (OPHS), public health units in Ontario work toward several outcomes related to population health assessment, including, but not limited to the following three items:

- Increased awareness and use of data to influence and inform the development of local healthy public policy, programs and services.
- Increased awareness of relevant and current population health information among the public, Local Health Integration Networks (LHINs), community partners, and health care providers.
- Increased access to population health information, including information on health inequities, among LHINs and other relevant community partners for planning, delivering, and monitoring health services that are responsive to population health needs.

Under the OPHS, boards of health are mandated to assess health status, health behaviours, preventive health practices, risk and protective factors, health care utilization relevant to public health, and demographic indicators. Boards are to use this information to assess the needs of the local population and to tailor programs and services to meet identified needs, as well as provide population health information (including social determinants of health and health inequities) to the public and community partners.

Population demographics, socio-economic status and geography are important categories of population health data, and include indicators related to age; sex; ethnicity/race; family structure; Indigenous identity; immigration; language; population size, distribution and growth; income; education; employment; housing; population density; and urban/rural description of public health unit regions. With the cancellation of the mandatory long-form Census in 2011, regions have gone 10 years without comprehensive and valid population data. The refreshed 2016 Census data, with the reinstated mandatory long-form, was released over the course of 2017, filling important data gaps and providing regions with a better picture of the local communities in which they serve.

The purpose of this report is to provide highlights from the Demographic Snapshot that outlines findings from the 2016 Census. A copy of the Demographic Snapshot is attached as Appendix 1.

Comments

Demographic Snapshot: Chatham-Kent, Highlights from the 2016 Census

Population and dwelling counts

- The population of Chatham-Kent was 102,042 (2% decline since 2011).
- Chatham-Kent's land area was 2,470 km^2 and the population density was 41 people per km^2.
- 70% of the population were living in urban areas while 30% of the population were living in rural areas.
- There were 43,175 occupied private dwellings in Chatham-Kent.

Age and sex

- The average age of the population was 43.3 years (44.5 years for females and 42.3 years for males).
- The 0 to 14 years, 15 to 64 years, and 65 years and over age groups represented 16.4%, 62.6% and 21.0% of the population, respectively.
- Chatham-Kent had a greater percentage of older adults age 50+ compared to Ontario; the 65 years and over group has grown, making up 21% of the total population while the under 65 years group has declined over time.
- The population of Chatham-Kent consisted of 51.2% (52,295) females and 48.8% (49,750 males).

Type of dwelling

- On average, household size was 2.3 people.
- Single-detached houses represented 76.6% of all occupied private dwellings; other attached dwellings represented 19.7%, and apartments in buildings with five or more storeys represented 3.2% of all occupied private dwellings.

Families, households, and marital status

- There were 29,740 census families and 16,340 individuals classified as "persons not in census families" living in private households.
- Over half of all census families were two-person census families; 83.2% of census families were couple families (married/common-law) and 16.8% of census families were lone-parent families (nearly 80% headed by female parent).
- There were 10,955 couple families and 4,995 lone-parent families with children.

- 61.3% of children aged 0 to 14 years were living in an intact two-parent family, 24.5% were living in a lone-parent family, and 12.1% were living in a stepfamily.
- There were 12,875 individuals aged 15 years and over who were living alone, of which, 42.5% were 65 years and over.
- Nearly 60% of the population aged 15 years and over were either married or living with a common-law partner.

Language

- 92.4% of individuals were knowledgeable in only English, 7.0% were knowledgeable in both English and French, and less than 1% did not have knowledge of either English or French.
- 89.2% and 2.9% of individuals identified English and French as their mother tongue, respectively, and 8.9% of individuals reported another language as their mother tongue.
- English was the most common language spoken at home (97.8%); German, Portuguese, Dutch, Spanish, and Italian were the most common languages other than English or French spoken at home.

Income

- The 2015 median after-tax income of private households was $52,667, which was lower compared to Ontario ($65,285) and declined by nearly 4% since 2005.
- 21.3% of private households reported an income of under $30,000 while 23.0% of private households reported an income of $100,000 and over.
- Low-income rates were higher than the province; 17.0% (6,915) of individuals overall, 27.4% of children under 6, and 22.3% of children under 18 were in low-income, with lone-parent families and single individuals experiencing the highest rates of low-income.
- 73.3% of individuals aged 15 years and over received some form of government transfer.
- 58.4% (25,215) of private households contributed to registered savings accounts, with tax-free savings accounts the most common account type contributed to.

Immigration and ethno cultural diversity

- Majority of the population identified with either European origins (75.7%), other North American origins (39.3%), or North American Aboriginal originals (5.7%).

- 8.6% (8,630) of individuals identified as being immigrants (nearly 80% arrived prior to 2001).

- Top places of birth for individuals who identified as immigrants were: Mexico, United Kingdom, Netherlands, United States, and Portugal; for recent immigrants, Mexico, India, United States, Jamaica and Philippines were the most common birth places.

- 705 individuals in Chatham-Kent identified as being a refugee.

- 4.5% identified as a visible minority which is lower in comparison to Ontario (29.3%) and Canada (22.3%); Black (47.1%), South Asian (12.1%), Latin American (8.7%), Southeast Asian (6.6%) and Chinese (5.4%) were the most common visible minority groups.

Aboriginal peoples

- 4,065 (4.1%) individuals identified as having Aboriginal identity (higher compared to Ontario) and 1,240 (1.2%) individuals identified as having Aboriginal ancestry.

- The majority of the Aboriginal population reported a single Aboriginal identity, including First Nations (60.1%), Métis (37.6%) or Inuk (Inuit) (0.5%).

- 1,805 (1.8%) individuals had Registered or Treaty Indian status.

- The Aboriginal population was younger on average compared to the population overall, and this population experienced lower median income and rates of educational attainment, and higher rates of low-income and unemployment compared to Chatham-Kent overall.

Housing

- Of all private households, 72.2% owned and 27.7% rented their dwelling.

- 7.7% of private households reported that their dwelling was in need of major repairs.

- 2.8% of private households reported that their dwelling was not suitable, largely due to a shortfall of one bedroom.

- 21.0% of private households reported they spend 30% or more of their income on shelter costs (12.8% of owner compared to 41.7% of renter households).

- 4,500 (10.4%) private households were in core housing need and 14.9% of renter households were living in subsidized housing.

- Average monthly shelter costs increased from $711.00 to $937.00 for owners and from $574.00 to $744.00 for renters, from 2001 to 2016.

Education

- Rates of educational attainment were lower than the province; of the population aged 25 to 64 years, 16.1% had less than a high school diploma or equivalent, 84.0% had at least a high school diploma or equivalent and 54.1% had a postsecondary certificate, diploma or degree.

- 9.1% of females aged 25 to 64 with a bachelor's degree or higher studied STEM (science, technology, engineering and mathematics) compared with 28.3% of males.

- Most common fields of study:

  - Apprenticeship or trades certificate or diploma: mechanic and repair technologies/technicians; precision production; construction trades; personal and culinary services; and transportation and materials moving.

  - College, CEGEP or other non-university certificate or diploma: health professions and related programs; business, management, marketing and related support services; family and consumer sciences/human sciences; engineering technologies and engineering-related fields; and mechanic and repair technologies/technicians.

  - Bachelor's degree or higher: education; health professions and related programs; business, management, marketing and related support services; social sciences; and psychology.

Labour and journey to work

- The 2015 labour participation rate, employment rate and unemployment rate for the population aged 15 years and over were 60.1%, 55.6%, and 7.6%, respectively.

- 12.7% of the employed labour force were classified as self-employed.

- Of the employed labour force, 32.4% worked full year/full time and 30.7% worked part year and/or part time.

- Most common occupations were: sales and service occupations (24.1%), trades; transport and equipment operators and related occupations (17.5%), business; finance and administration occupations (12.2%) and management occupations (11.0%).

- Most common industry sectors were: manufacturing (13.2%), health care and social assistance (12.6%), retail trade (11.5%), agriculture, forestry, fishing and hunting (7.8%), accommodation and food services (6.9%) and construction (6.7%).

- 81.7% of the employed labour force worked at a usual place, 7.4% worked from home, and 10.5% had no fixed workplace address.
- 84.0% of the employed labour force had commuted within the Municipality of Chatham-Kent and 15.7% commuted outside of the Municipality to get to work; for over 90%, a passenger vehicle was the mode of transportation to work, and nearly a quarter had a commuting duration of 30 minutes or more.

Consultation

Epidemiologists worked together using the Population Health Assessment and Surveillance protocol (2018), the Core Indicator Framework from the Association of Public Health Epidemiologists in Ontario (APHEO), and 2016 Census data products from Statistics Canada in order to finalize the content of the Demographic Update. Health unit staff and community partners will be able to use this information to inform program, service and policy development and decision-making.

Financial Implications

There are no financial implications with this information report. Costs incurred were covered within the current budget.

Mr. Carnahan moved, seconded by Ms. Pfaff:

"That the three information reports be received."

The Chair put the Motion.

Motion Carried

C) Items to be Received and Filed

Councillor Myers moved, seconded by Ms. Blake:

"That items a) through d) be received and filed."

a) Letter from Dr. Eric Hoskins to Mr. Joe Faas, dated February 23, 2018, regarding the response from Chatham-Kent on the Minister's Expert Panel on Public Health

b) Memorandum from Roselle Martino to Medical Officers of Health, CEOs, and Board Chairs, dated February 16, 2018, regarding the Ontario Public Health Standards-Implementation Work Plan Updates

c) Resolution regarding Tobacco and Smoke-Free Campuses from Sudbury and District Health Unit

d) Letter from Haliburton, Kawartha and Pine Ridge District Health Unit to Helena Jaczek regarding 2018 Annual Service Plan

The Chair put the motion.

Motion Carried

9. Non-Agenda Items- None

10. Motions of Closed Session

Information was received by the Board from Administration regarding the new Public Health Service Plan and an update on labour negotiations regarding CUPE 12.3.

Mr. Carnahan moved, seconded by Councillor Myers:

"That the minutes of the Closed Session Meeting of February 21, 2018 be approved."

The Chair put the motion.

Motion Carried

11. Time, Date and Place for the Next Meeting of the Board

The next meeting of the Board will be held Wednesday, April 18, 2018 at the Health and Family Services building, 435 Grand Ave. W., Chatham, with the open portion of the meeting to start at 11:00 a.m.

12. Adjournment

Moved by Ms. Pfaff that the meeting be adjourned at 11:52 am.

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Joe Faas, Chair