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YEAR END ACTIVITY REPORT (JANUARY 1–DECEMBER 31, 2005)

The Health and Emergency Medical Services Committee recommends the adoption of the recommendation contained in the following report, May 11, 2006, from the Commissioner of Community Services, Housing and Health Services:

1. RECOMMENDATIONS

It is recommended that:
1. This report be received for information.

2. PURPOSE

The purpose of this report is:
- To provide Council with data regarding the programs and services provided by the Health Services Department for the year 2005.
- To compare overall service levels between the years 2004 and 2005.

3. BACKGROUND

The Health Services Department has reported program activities on a semi-annual basis since 2004 and prior to that on a quarterly basis. Health Information and Planning collects and analyzes data regarding the programs and services provided by its three operational branches: Emergency Medical Services (EMS), Long Term Care and Seniors (LTCSB) and Public Health. This report presents the year end results for 2005.

4. ANALYSIS AND OPTIONS

4.1 Activity Report Data and Rationale

Indicators are reviewed on an annual basis for applicability and utility purposes and refined as required. Therefore, differences exist between some of the indicators reported in 2004 as compared to 2005. The following section gives a breakdown by Branch comparing the year end activities in 2005 to 2004 and showing the percentage change for each indicator. Highlights of the data are also discussed for various program areas.

4.1.1 Emergency Medical Services Branch

The overall call volumes for 2005 have increased by 16% from 2004 (see Table 1). The 39% increase in emergency coverage redeployment (priority 8) calls can be attributed to the movement of ambulances to provide balanced emergency coverage due to off-load delays and decreased resource availability. Priority 8 calls represent the mobilization of resources from one geographic response area to another.

Table 1 ◆ ✦
Call Volumes

CALL VOLUMES BY DISPATCH PRIORITY	Year 2005		Total		% Difference
	January - June	**July - December**	**2005**	2004	**(2005-2004)**
1) Deferrable/non-urgent transfer (Patient condition not dependant on timely treatment or transport)	1,770	**1,887**	**3,751**	3,852	**-3%**
2) Scheduled transfer (Patient scheduled to arrive at a health care facility or medical appointment)	512	**648**	**1,209**	1,150	**5%**
3) Prompt/non life threatening (Non-life threatening requiring a timely response)	4,755	**4,735**	**9,686**	9,561	**1%**
4) Urgent/life threatening (Patient conditions requires emergency response)	22,264	**23,992**	**47,388**	45,072	**5%**
8) Emergency Coverage Redeployments (Relocation of an ambulance to facilitate balanced emergency coverage)	22,418	**21,562**	**45,050**	32,295	**39%**
Totals	51,719	**52,824**	**107,084**	91,930	**16%**

◆ Data subject to change: The accuracy of the call volume and response time data cannot be validated by York Region EMS. There are approximately 3,000 call records missing for the first half of 2005 from the MOHLTC Addas database for download into the York Region EMS ARIS reporting link. Semi-annual totals do not add up to yearly total due to ongoing data updates.
✦ Data Source: Tables 1, 2a & 2b, MOHLTC, ARIS link as of January 31, 2006

The 90th percentile response time for York Region increased by 2.1%, or 15 seconds (see Table 2a). Markham had the largest increase (7.1%) in 90th percentile response time. The only municipality that had a decrease (-1.6%) in 90th percentile response time was Vaughan (see Table 2b).

Table 2a ✦
Response Times

EMERGENCY RESPONSE TIME York Region EMS resources in York Region Time crew notified to crew arriving at scene	Year 2005		Total		% Difference
	January - June	**July - December**	**2005**	2004	**(2005-2004)**
90th Percentile Response Time maximum response time for 9 out of 10 calls	12:11	**11:49**	**12:01**	11:46	**2.1**
Percent Compliance to 11:39 Responses (arrive on scene) within 11min 39sec	87.9%	**89.5%**	**88.7%**	89.6%	**-0.9** †
Average Emergency Response Time	7:54	**7:42**	**7:48**	7:38	**2.2**

✦ Data Source: Tables 1, 2a & 2b, MOHLTC, ARIS link as of January 31, 2006
† Percent difference for these indicators is calculated by the following equation (2005 – 2004). All other indicators are calculated by the following equation (2005 - 2004)/2004 x 100.

Similarly, there was an overall increase of 2.2% or 10 seconds average response time for York Region, with the largest increase of 7.9% in Markham. However, there was also a decrease in average response time in some areas; Georgina had the largest decrease of 2.8%. (see Tables 2a and 2b).

Overall, there was a small decrease of 0.9% in the percent compliance to 11 minutes 39 seconds for York Region (see Table 2a).

Table 2b ✦
Response Times by Municipality

LOWER TIER MUNICIPALITY	Year 2005				Year End		Year End		% Difference	
	January-June		July -December		2005		2004		(2005-2004)	
	90TH	Avg	90TH	Avg	90TH	Avg	90TH	Avg	90TH	Avg
Whitchurch-Stouffville	14:01	8:42	**13:48**	**8:40**	**13:51**	**8:40**	13:06	8:07	5.7	6.8
Vaughan	12:54	8:26	**11:56**	**8:00**	**12:28**	**8:13**	12:40	8:22	-1.6	-1.8
Richmond Hill	10:31	6:57	**10:10**	**6:49**	**10:22**	**6:54**	9:58	6:38	4.0	4.0
Newmarket	9:42	6:33	**9:36**	**6:26**	**9:40**	**6:29**	9:18	6:19	3.9	2.6
Markham	11:50	7:59	**11:43**	**7:55**	**11:47**	**7:57**	11:00	7:22	7.1	7.9
King	16:10	10:11	**16:30**	**10:15**	**16:21**	**10:14**	16:07	10:03	1.4	1.8
Georgina	13:32	8:15	**13:09**	**7:51**	**13:16**	**8:01**	13:06	8:15	1.3	-2.8
East Gwillimbury	14:19	9:22	**14:28**	**9:08**	**14:19**	**9:13**	14:00	9:28	2.3	-2.6
Aurora	9:42	6:33	**9:44**	**6:22**	**9:41**	**6:26**	9:27	6:20	2.5	1.6

✦ Data Source: Tables 1, 2a & 2b, MOHLTC, ARIS link as of January 31, 2006

It should be noted that there are ongoing EMS data quality issues due to missing call records from the Ministry of Health and Long Term Care's (MOHLTC) Addas EMS database, and this affects the validity of the data presented.

Table 3 ✦
Customer Service

CUSTOMER SERVICE RECOGNITIONS & COMPLAINTS (number per 1000 times units arrive on scene)	Year 2005		Total	
	January - June	**July - December**	**2005**	2004
Recognitions	0.53 ◆	**0.72**	**0.63**	0.57
Complaints	1.30 ◆	**0.99**	**1.14**	0.55

✦ Data Source: York Region Emergency Medical Services as of March 14, 2006
◆ Data subject to change due to ongoing data updates.

4.1.2 Long Term Care and Seniors Branch

For the Long Term Care (LTC) facilities, percent occupancy is as expected (see Table 4). Attrition rate comparisons between periods often reflect significant variations, and are unpredictable and fluctuate over the short term. The 72% increase in the wait list for the Newmarket Health Centre is due to the Newmarket area reaching maximum bed capacity. The 22% decrease in the wait list number for the Maple Health Centre is due to new facilities opening in the Maple area during this period.

One partner school no longer offers the personal support worker (PSW) program, which caused a 26% decrease in volunteer hours between the years 2004 and 2005.

Table 4
LTC Facility Programs

	Year 2005		Total		% Difference
	January - June	**July - December**	**2005**	2004	**(2005-2004)**
Percent Occupancy					
- Newmarket Health Centre	97.7%	**96.7%**	**97.2%**	97.1%	**0.1** †
- Maple Health Centre	97.9%	**98.8%**	**98.4%**	98.7%	**-0.3** †
Attrition Rate	16.3	**10.6**	**26.9**	20.7	**30**
LTC Facility Wait List					
- Newmarket Health Centre	77	**115**	**115**	67	**72**
- Maple Health Centre	67	**69**	**69**	88	**-22**
Percent of Municipal Beds to Total Beds in York Region	6.8%	**6.8%**	**6.8%**	6.8%	**0** †
Total Volunteer Hours	13,436	**10,521**	**23,957**	32,251	**-26**

† Percent difference for these indicators is calculated by the following equation (2005 – 2004). All other indicators are calculated by the following equation (2005 - 2004)/2004 x 100.

The LTC Day Programs are consumer driven programs, which result in statistical fluctuations according to service demands and requirements in the community (see Table 5).

Table 5
LTC Day Programs

	Year 2005		Total		% Difference
	January - June	**July - December**	**2005**	2004	**(2005-2004)**
Cognitive Disorders	3,206	**3,322**	**6,528**	5,574	**17**
Acquired Brain Injury	689	**625**	**1,314**	1,193	**10**
Communicative Disorders	260	**201**	**461**	505	**-9**
Physically Disabled	663	**552**	**1,215**	1,162	**5**

The 24% increase in ACL respite days is reflective of increased community need/demand for this service due to a lack of seniors' housing in the Region (see Table 6). The 22% increase in LTC facility respite days is primarily due to the addition of one respite bed at the Newmarket Health Centre. The 36% decrease in Day Centre respite units is simply reflective of decreased consumer requirements at the present time.

Table 6
Respite Programs

	Year 2005		Total		% Difference
	January - June	**July - December**	**2005**	2004	**(2005-2004)**
ACL Program Respite Days (1 unit of service=24 hours)	575	**494**	**1,069**	863	**24**
LTC Facility Respite Days	598	**639**	**1,237**	1,010	**22**
Day Centre Respite Units (1 unit of service=5.5-7.5 hours)	136	**136**	**272**	421	**-36**

In 2005, there was a change in reporting requirements from the MOHLTC. The difference in how consultations are reported resulted in a 42% decrease in Psychogeriatric and Mental Health Consulting Services consultations compared to 2004 (see Table 7). The change was implemented to standardize the data collection across the Province for this program.

The 6% increase in ACL client days is due to the program's ability to offer service to more tenants (outreach clients) not residing in designated ACL units. Armitage Gardens and its unique partnership with the LTC facility has created an increased demand, thus increasing the ACL wait list by 36% over 2004.

Table 7
Community Outreach Programs

	Year 2005		Total		% Difference
	January - June	**July - December**	**2005**	2004	**(2005-2004)**
Regional Psychogeriatric & Mental Health Consulting Services					
- Consultations	244	**227**	**471**	816	**-42**
- Number of participants	3,137	**1,265**	**4,402**	4,404	**0**
Alternative Community Living (ACL Program)					
- ACL Supportive Housing Client Days	169	**168**	**168**	158	**6**
- ACL Supportive Housing Wait List	407	**461**	**461**	340	**36**

The LTCSB remains above the established 85% minimum acceptable standard for client satisfaction in the combined A (excellent) and B (good) categories, although a 2.4% decrease since 2004 has occurred. Appropriate continuous quality improvement (CQI) taskforces have been implemented to identify areas for further improvement.

Table 8
Client Satisfaction

	Year 2005		Total		% Difference
	January - June	**July - December**	**2005**	2004	**(2005-2004)**
LTC Client Satisfaction – Overall facility rating in the good or excellent categories	95%	**95%**	**95%**	100%	**-5%** †
ACL Client Satisfaction – Percent of clients rating the services as either good or excellent ‡ ◆◆	NA	NA	**86.5%**	85%	**1.76%**
Day Centre Program Client Satisfaction – Percent of clients rating the services as either good or excellent ‡ ◆◆	NA	NA	**100%**	NA	**NA**

† Percent difference for these indicators is calculated by the following equation (2005 – 2004). All other indicators are calculated by the following equation (2005 - 2004)/2004 x 100.
‡ New indicator as of July 2005
◆◆ Indicator reported on an annual basis only

4.1.3 Public Health Branch

The Public Health Branch activities are grouped into three major categories:

- Infectious Diseases Prevention and Control
- Health Information Lines
- Health Promotion

4.1.3.1 Infectious Diseases Prevention and Control

The data for the following indicators have been greatly impacted by data quality and reporting issues from the implementation of the Integrated Public Health Information System (iPHIS) in 2005:

- Number of new infectious disease reports
- Number of people on medical surveillance
- Number of contacts screened for tuberculosis

While it is difficult to estimate the magnitude and direction of the effect of the current data issues, it is most likely that these indicators are underestimated for the second half of 2005, which is why these three indicators demonstrated decreases (see Table 9). The Infectious Diseases Control Division is working with the MOHLTC to address reporting issues with the data, and will resolve them as soon as possible.

There was a 21% increase in the number of infectious disease outbreaks in 2005 as compared to 2004. This increase can mainly be attributed to a marked increase in influenza and vaccine preventable disease outbreaks in 2005.

The reason for the 26% increase in vaccines distributed and the 32% increase in number of shots given can be explained by two vaccination campaigns that took place in 2005. The Meningitis C community campaign occurred from May–August 2005 for high school students. In addition, influenza vaccinations took place in the fall of 2005, and drew a greater number of people than in previous years, likely due to coverage of pandemic influenza by the media.

The 7% decrease in client revisits to the Sexual Health Clinics is likely related to limited physician capacity to accommodate follow-up requirements of clients. (Clients were referred back to their family physician.)

Table 9
Infectious Diseases Control

	Year 2005		Total		% Difference
	January - June	**July - December**	**2005**	2004	**(2005-2004)**
Number of in-services provided ‡	125	**72**	**197**	239*	**-18**
Number of new infectious disease reports	2,711*	**3,133**	**5,844**	5,967*	**-2**
- Rate of new infectious disease reports per 100,000 population	330.5*	**382.0**	**712.5**	746.6*	**-4.6**
Number of infectious disease outbreaks	120	**67**	**187**	154	**21**

Tuberculosis					
- Number of people on medical surveillance	196	**176**	**372**	498	**-25**
- Number of contacts screened for Tuberculosis ‡	508	**863**	**1,371**	1,828	**-25**
Immunization					
- Number of vaccines distributed	161,778	**451,459**	**613,237**	485,041	**26**
- Number of shots given through York Region Health Services Public Clinics	11,171	**32,294**	**43,465**	33,001*	**32**
- Number of records reviewed ‡ **	156,776	**NA**	**NA**	152,556	**NA**
- Percent of total enrolment records ‡ **	100%	**NA**	**NA**	100%	**NA**
Sexual Health					
- Number of new clients to clinics	543	**495**	**1,038**	1,047	**-1**
- Number of client revisits to clinics	2,107	**1,720**	**3,827**	4,107	**-7**

* Revised 2004 and 2005 figures as of January 2006
‡ New indicator as of July 2005
** Review period follows the school year September to June. Indicators are reported in June for the entire preceding school year.

The total number of food establishment inspections increased by 7% overall (see Table 10). The 20% decrease in re-inspections is a positive result and may be a reflection of the effectiveness in enforcement strategies. An increase in inspections and the ongoing enforcement strategy has resulted in a 13% increase in charges laid. The 14% increase in food handlers certified through the Proton Program is likely due to an increased awareness of the program in the food services industry and an increase in new food establishments.

Table 10
Food Safety

	Year 2005		Total		% Difference
	January – June	**July - December**	**2005**	2004	**(2005-2004)**
Units as of July 28, 2005*					
- Inspections High Risk [1729 Units] x (3/year)	2,314*	**2,898**	**5,212**	5,058	**3**
- Inspections Medium Risk [1961 Units] x (2/year)	2,030*	**1,926**	**3,956**	3,688	**7**
- Inspections Low Risk [2841 Units] x (1/year)	1,840*	**1,155**	**2,995**	2,643	**13**
Total number of inspections	6,184*	**5,979**	**12,163**	11,389	**7**
- Total number of re-inspections	740	**791**	**1,541**	1,928	**-20**
Infractions/Charges*					
- Total number of charges laid	59	**58**	**117**	104	**13**
- Number of restaurant closures	5*	**15**	**20**	19	**5**
Certifications					
- Number of food handlers certified	848	**631**	**1,479**	1,300	**14**

* Revised 2005 figures as of January 2006

The total number of daycare inspections has also increased by 15% due to the opening of new daycare establishments (see Table 11). The 13% decrease in audit inspections for LTC facilities is due to a decrease in LTC facilities. It should be noted that food

premises in LTC facilities are not included in this indicator, as food units are inspected under the Food Safety Program.

Table 11
Infection Control

Infection Control Audits and Inspections (totals do not include Food Safety Inspections)	**Year 2005**		**Total**		**% Difference**
	January - June	**July - December**	**2005**	2004	**(2005-2004)**
Day Nurseries as of as of Dec. 31, 2005– [247 Units] (2 inspections per year)					
- Total number of daycare infection control inspections	244*	**253**	**497**	433	**15**
- Percent of daycare infection control inspections	50%*	**51%**	**101%**	93%	**8 †**
LTC Facilities as of Dec. 31, 2005– [61 Units] (1 audit per year)					
- Total number of LTC Facility infection control audits	21*	**46**	**67**	77	**-13**
- Percent of LTC Facility infection control audits	27%*	**75%**	**109%**	103%	**6 †**

* Revised 2005 figures as of January 2006
† Percent difference for these indicators is calculated by the following equation (2005 – 2004). All other indicators are calculated by the following equation (2005 – 2004)/2004 x 100.

As shown in Table 12, there was a 10% decrease in the number of children screened for Dental Services from birth to grade 8 in 2005 as compared to 2004. The decrease is explained by understaffing during that time period. Despite the apparent decrease, all students will be screened before the end of the school year in June 2006. The number of screenings in the second half of the school year will be reflected in the early parts of 2006.

Table 12
Dental Services

	Year 2005		**Total**		**% Difference**
	January - June	**July - December**	**2005**	2004	**(2005-2004)**
Number of children screened from birth to grade 8	33,774	**26,028**	**59,802**	66,590	**-10**
Number of cases with urgent dental needs	1,516	**1,566**	**3,082**	3,202	**-4**
Number of urgent cases resolved ◆◆	1,889*	**1,173**	**3,062**	3,079	**-1**

* Revised 2005 figures as of January 2006
◆◆ The number of urgent cases resolved can only be reported on an annual basis due to the MOHLTC follow-up criteria which allows parents a certain time period to ensure their child receives care.

4.1.3.2 Health Information Lines

Health Connection provides confidential counselling and education on a variety of health related topics. While the number of calls has decreased by 13% (see Table 13), the length and the complexity of calls have increased. In addition, many callers are repeat callers with several questions on multiple topics.

Responsibility for the Sexual Health line shifted from the Sexual Health team in the Infectious Diseases Control Division to Health Connection as of September 1, 2005. The Sexual Health line experienced a 22% decrease in calls, due to two factors: an increase in

call complexity; and, a shift from booking clinic appointments to focusing on counselling and education of callers.

The 14% decrease in the number of calls relating to safe water may be due to greater awareness of the public, as a result of the Health Services Department Well Awareness – Education and Outreach Program, and because residents can access information on water treatment and safety from the Region's website.

Table 13
Call Volumes to Health Information Lines

CALL VOLUMES TO HEALTH INFORMATION LINES	Year 2005		Total		% Difference
	January - June	**July - December**	**2005**	2004	**(2005-2004)**
Nursing and Dietitian Line (Health Connection) (Initial and Follow-up Calls)	19,807	**19,125**	**38,932**	44,732	**-13**
Sexual Health Line (integrated into Health Connection as of September 1, 2005)	3,906	**2,454**	**6,360**	8,165	**-22**
Health Protection Information Disclosure Line (HPIDL) (Initial and Follow-up Calls)	4,025	**4,081**	**8,106**	8,465*	**-4**
Total number of calls	27,738	**25,660**	**53,398**	61,362	**-13**
Number of calls from HPIDL relating to Safe Water (Incoming calls only)	704	**784**	**1,488**	1,738	**-14**

* Revised 2004 figures as of July 2005

4.1.3.3 Health Promotion

In 2005, there was 4% increase in the number of births York Region Health Services Department received notice of, and 5% more families were contacted after discharge (see Table 14). There was greater emphasis placed on telephone nursing assessments as current staffing levels do not allow for visits to all clients, as reflected by the 31% decrease in postpartum home visits. The 32% decrease in visits to high risk clients can be attributed to a decrease in the average number of home visits per family from eight to six. However, families also received support through the Breastfeeding/Baby Place Clinics (see Table 15). Lastly, the transition of all staff to online documentation using the provincial Integrated Services for Children Information System (ISCIS) database required a significant amount of training, with a resulting impact on available service delivery time.

In 2005, one car seat clinic was cancelled due to low registration. Three percent fewer parents had seats with the instruction manuals and installed the car seat with no mistake compared to 2004.

Table 14 ◆
Children (ages 0-6)

	Year 2005		Total		% Difference
	January - June	**July - December**	**2005**	2004	**(2005-2004)**
Healthy Babies Healthy Children (HBHC)					
- Number of births York Region Health Services received notice of	4,578	**4,626**	**9,192**	8,865	**4**
- Number of families contacted after discharge from hospital	4,321	**4,398**	**8,728**	8,295	**5**

- Number of families who received a postpartum home visit	1,029	**933**	**1,962**	2,829	**-31**
- Number of families identified as "high risk" who received home visiting	288	**279**	**419**	430	**-3**
- Number of visits to "high risk" families	1,841	**1,739**	**3,608**	5,277	**-32**
- Number of referrals to HBHC from Health Connection	562	**477**	**1,039**	1,175	**-12**
Injury Prevention					
- Percent of car seats used incorrectly checked through car seat clinics	93	**88**	**91**	88	**3** †

◆ Data subject to change: Semi-annual totals may not add up to yearly totals due to ongoing data updates from the ISCIS database.

† Percent difference for these indicators is calculated by the following equation (2005 – 2004). All other indicators are calculated by the following equation (2005 - 2004)/2004 x 100.

The number of Breastfeeding clinic units increased 11% when a second clinic was opened on Mondays in Richmond Hill in response to client demand, and limited space to accommodate clients in the Markham office (see Table 15). There was a 17% increase in the number of clients seen at the clinics and a 27% increase in the number of clinic visits. The number of clinic visits increased in response to client demand and increased number of staff assigned per clinic. There was also a move from drop-in to booking appointments, which enabled a more effective distribution of client visits.

In 2005, the Ontario Tobacco Strategy was announced with additional funds allocated to health units to enhance tobacco enforcement. The major focus of enforcement was on the prevention of sales to minors by tobacco vendors. Compliance inspections were required of all tobacco vendors quarterly, rather than a 10% random survey yearly. These inspections began in the second half of the year. There was a 228% increase in visits to vendors, resulting in an 852% increase in number of compliance surveys, in turn resulting in an 11% decrease in non-compliance (see Table 15).

Table 15
Adults

	Year 2005		Total		% Difference
	January - June	**July - December**	**2005**	2004	**(2005-2004)**
Breastfeeding					
- Number of breastfeeding clinic units	96	**121**	**217**	196	**11**
- Number of breastfeeding clinic visits	1,081	**1,032**	**2,113**	1,668	**27**
- Number of clients seen	433	**405**	**838**	715	**17**
Tobacco Control Act					
- Number of visits to vendor establishments	1,076	**1,835**	**2,911**	887	**228**
- Number of compliance survey visits	100	**1,462**	**1,562**	164	**852**
- Percent of non-compliance identified during compliance survey visits	32%	**9%**	**10%**	21%	**-11**
No-Smoking By-law					
- Total number of visits (workplaces and public places)	1,491	**546**	**2,037**	2,583	**-21**
- Total number of charges laid (workplaces and public places)	184	**105**	**289**	402	**-28**
Injury Prevention (pool, spa, waterslide) [314 Units] (718 inspections required as of July 28, 2005)					

- Number of inspections	385*	**366**	**751**	657	**14**
- Number of closures	9	**5**	**14**	11	**27**
Falls Clinics					
- Number of clinics ‡	3	**0**	**3**	3	**0**
- Number of clients screened ‡	29	**0**	**29**	27	**7**
- Percent of high risk clients ‡	12%	**0%**	**12%**	9%	**3** †
Workplace Wellness [27,000 businesses in York Region]✦✦					
- Number of worksites subscribing to newsletter or other promotional material	879	**52**	**931**	890	**5**
- Number of companies receiving direct services	206	**36**	**242**	198	**22**
Chronic Diseases‡‡					
- Number of presentations/workshops (Chronic Disease Prevention Program and Early Detection of Cancer Program)	171	**127**	**298**	NA	**NA**

* Revised 2005 figures as of January 2006
‡ New indicator as of July 2005
† Percent difference for these indicators is calculated by the following equation (2005 – 2004). All other indicators are calculated by the following equation (2005 - 2004)/2004 x 100.
✦✦ The number of businesses in York Region is approximate. Source: York Region Economic & Development Review, 2004.
‡‡ New reporting format, therefore data is not available for 2004.

In 2004, the final phase of the York Region No-Smoking By-Law was implemented. There was a large focus of staff time in By-Law education and enforcement while maintaining mandatory program requirements for the *Tobacco Control Act* and Tobacco Education. The 28% decrease in charges laid can be attributed to a greater acceptance to the smoking legislation and a higher compliance rate (see Table 15).

There was a 27% increase in pool, spa and waterslide facility closures as a result of the 14% increase in inspections. Both have likely increased due to the increase in new condominiums with pools in the Region.

Falls Prevention did not hold any clinics in the second half of 2005, as resources have been devoted to the Falls Prevention Pilot Project, which provides in-home support and education to seniors with mobility difficulties.

The number of companies receiving direct services from the Workplace Wellness team increased by 22% (see Table 15). This was a result of two main factors: the modification of services to address client needs, such as the use of more electronic resources and an extensive stress workshop series, and the use of multiple marketing strategies to promote these new services to the workplaces that already receive the wellness newsletter.

Table 16
Nutrition and School Services

	Year 2005		Total		% Difference
	January - June	July - December	**2005**	2004	**(2005-2004)**
Nutrition					
- Number of workshops/presentations provided to professionals (e.g. child care staff, school staff, community agency staff)	19	**10**	**29**	49	**-41**
- Number of workshops/presentations provided for the public (e.g. parents, workplace employees, community members)	95	**67**	**162**	153	**6**
- Total number of workshops/presentations	114	**77**	**191**	202	**-5**
Schools					
- Number of comprehensive school activities	10	**47**	**47**	10	**370**
- Number of schools involved	10	**47**	**47**	10	**370**

The 41% decrease in the number of Nutrition workshops and presentations provided to professionals can be attributed to the high level of attention given to the March 2004 release of the Call to Action: Creating a Healthy School Nutrition Environment report (see Table 16).

Service delivery to elementary schools was changed in 2005 based on the Comprehensive School Health (CSH) best practice model. Forty-seven schools were recruited for the 2005/2006 school year, resulting in a 370% increase. This number includes the 10 schools that were part of the CSH pilot and the comprehensive nutrition strategy in 2004.

5. FINANCIAL IMPLICATIONS

Costs associated with the delivery of Health Services programs and services and the reporting of these data are included in the Health Services Department's annual budget.

6. LOCAL MUNICIPAL IMPACT

York Region Health Services Department continues to provide mandatory and integrated programs and services in order to meet the health needs of the residents of York Region. As of the end of the year in 2005, activity levels for programs and services remain at expected levels.

7. CONCLUSION

This report reflects activity level changes in the programs and services provided to York Region residents by the Health Services Department in the year 2005 as compared to 2004.

Mid year and year end activity reports are prepared and used to improve resource allocation by the Health Services Department and the delivery of programs and services.

Population growth in York Region and an increased awareness of the programs and services offered by the Health Services Department are the major reasons for many of the increases in program activity detailed in this report.

Health Information and Planning will continue to monitor and analyze the activities of the Health Services Department and subsequently report to Committee and Council on a semi-annual basis. Ongoing comparison of service levels and an examination of trends will assist with the efficient use of resources, ensuring compliance to mandatory programs, and planning for the future.

The Senior Management Group has reviewed this report.