RENFREW COUNTY AND DISTRICT BOARD OF HEALTH

Regular Board Meeting

Tuesday, January 26, 2016

The regular Board meeting of the Renfrew County and District Board of Health was held in Pembroke at 10:00 a.m. with the following members present.

Present:

Mr. J. Michael du Manoir	Chair
Mayor Janice Visneskie Moore	Chair
Ms. Carolyn Watt	Vice-Chair
Mayor Michael Donohue	Member
Mayor Jane Dumas	Member
Mr. Wilmer Matthews	Member
Councillor Christine Reavie	Member
Mayor John Reinwald	Member
Ms. Marcia Timm	Member

Regrets:

Warden Peter Emon	Member

Staff:

Dr. Kathryn Reducka	Acting Medical Officer of Health/Chief Executive Officer
Ms. Catherine Bloskie	Director, Corporate Services

1. Call to Order

Chair J. Michael du Manoir called the meeting to order at 10:00 a.m and welcomed Dr. Kathryn Reducka, Acting Medical Officer of Health/Chief Executive Officer.

2. Agenda Approval

A motion by Mayor John Reinwald, seconded by Councillor Christine Reavie,

To approve the agenda with the addition under "New Business" of the following items: vi) Report on Health Links; vii) alPHa Risk Management Workshop Attendees; and viii) Striking Committee Report.

Carried

3. Declaration of Conflict of Interest

No conflicts of interest were declared.

4. Board Elections

Chair J. Michael du Manoir appointed Dr. Kathryn Reducka as the presiding officer to conduct the election for the position of Chair of the Board of Health.

Chair

Dr. Reducka presided over the election of the Chair and called for nominations for the position.

A motion by Mayor Michael Donohue, seconded by Mayor Janice Visneskie Moore,

That Mr. J. Michael du Manoir be nominated for election to the position of Chair of the Board of Health. Mr. du Manoir declined the nomination citing time commitment challenges.

A motion by Mayor Michael Donohue, seconded by Ms. Carolyn Watt,

That Mayor Janice Visneskie Moore be nominated for election to the position of Chair of the Board of Health.

Carried

Mayor Visneskie Moore confirmed her interest in being nominated.

Dr. Reducka called for further nominations. No additional names were put forward.

A motion by Mr. J. Michael du Manoir, seconded by Mayor Jane Dumas,

That nominations for the position of Chair of the Board of Health be closed.

Carried

Dr. Reducka declared nominations closed and Mayor Visneskie Moore was elected by acclamation to the position of Chair of the Board of Health.

Vice-Chair

Chair Janice Visneskie Moore presided over the election of Vice-Chair of the Board of Health and called for nominations for the position.

A motion by Councillor Christine Reavie, seconded by Ms. Marcia Timm,

That Ms. Carolyn Watt be nominated for election to the position of Vice-Chair of the Board of Health.

Carried

Ms. Watt confirmed her interest in being nominated.

Chair Visneskie Moore called for further nominations. No additional names were put forward.

A motion by Mr. Wilmer Matthews, seconded by Mr. J. Michael du Manoir,

That nominations for the position of Vice-Chair of the Board of Health be closed.

Carried

Chair Janice Visneskie Moore declared the nominations closed and Ms. Carolyn Watt was elected by acclamation to the position of Vice-Chair of the Board of Health.

Chair Janice Visneskie Moore presided over the remainder of the meeting.

5. Reports

i) Program Based Grants Update

Ms. Catherine Bloskie, Director, Corporate Services provided the Board with a detailed report and presentation from the annual Program Based Grants Update held by the Ministry of Health and Long-Term Care on January 20, 2016. The workshop papers cover various aspects of the programs funded by the Province and mandated for delivery by Boards of Health as well as Managing Uncertainty – Risk Management for Boards of Health, etc.. Presentation material is appended to these minutes.

Due to scheduling requirements, Chair Visneskie Moore moved to agenda item #11 at this time (minutes reflected at #11) and subsequently resumed the remainder of the agenda.

6. Delegations

None

7. Correspondence

i) Letter from Roselle Martino, Assistant Deputy Minister, Ministry of Health and Long-Term Care Re: Renfrew County and District Health Unit Follow-up Audit. ***For Information.***

ii) Letter to the Board of Directors from Scott, Rosien & Dempsey, Chartered Professional Accountants Re: Audit Planning. The Board of Health reviewed a draft response.

A motion by Ms. Carolyn Watt, seconded by Ms. Marcia Timm,

Authorizing Chair Janice Visneskie Moore to amend the draft response to Scott Rosien & Dempsey to include notice that the Board of Health meeting date has been changed from February 23, 2016 to February 19, 2016 and to sign the amended letter.

Carried

iii) Letter from the Ministry of Health and Long-Term Care, Office of the Minister, January 11, 2016 re: Order in Council and Congratulatory letter to Ms. Marcia Timm. ***For Information***

8. Minutes of the Meetings

A motion by Mayor Michael Donohue, seconded by Mayor Jane Dumas,

That the minutes of the meetings of Special Board of Health meeting of November 5, 2015, Regular Board of Health meeting of December 8, 2015, Special Board of Health meeting of December 18, 2015, and Special Board of Health meeting of January 11, 2016 be approved as circulated.

Carried

9. Business Arising

i) RCDHU Proposal for an alPHa Resolution on Timing of Report Submissions to the Annual General Meeting

Deferred.

ii) Pembroke Office Lease Renewal

The existing five (5) year lease for the health unit's main office at 7 International Drive, Pembroke, expires February 28, 2017 with no further option for renewal. Mr. J. Michael du Manoir reported that the Board of Health Ad Hoc Pembroke Office Property Committee has met several times and that preliminary discussions have taken place with the landlord.

iii) MOH/CEO Recruitment Ad-Hoc Committee Report

Mr. J. Michael du Manoir reported that Dr. Kathryn Reducka has been contracted by the Board of Health in the role of Acting Medical Officer of Health/Chief Executive Officer. Four Corners Group have been engaged to assist the Board of Health in the executive search for the position of a full time Medical Officer of Health/Chief Executive Officer.

iv) 2016 Public Health Programs Estimated Funding Requirement

Deferred to February 19, 2016 Board of Health meeting.

10. New Business

i) Accounts Payable

A motion by Mr. Wilmer Matthews, seconded by Ms. Carolyn Watt,

That the schedule of accounts payable for Renfrew County and District Health Unit operations for the period December 15, 2015 – January 18, 2016 be approved for payment in the amount of $1,231,770.99.

Carried

ii) Ministry of Health and Long-Term Care Patients First – A Proposal to Strengthen Patient-Centred Care in Ontario

An in-service regarding this document at Dr. Reducka's convenience was requested by the Board.

iii) Signing Authority

A motion by Mayor Jane Dumas, seconded by Councillor Christine Reavie,

Appointment of Signing Officers:

1. That for the purposes of the payment of accounts on behalf of the Renfrew County and District Health Unit, facsimile signatures of the Chair of the Board, together with the Treasurer of the Health Unit, shall be embossed upon cheques by mechanical means.

2. That the signing officers of the Health Unit for banking activities, other than those which may be carried out by facsimile signatures, shall be those of the Chair of the Board, or in the absence of the Chair, the Vice Chair of the Board, on behalf of the Board

   Together with the Treasurer of the Health Unit, Catherine Bloskie, or in her absence, Dr. Kathryn Reducka, Acting Medical Officer of Health.

This resolution shall come into force and take effect as of January 26, 2016.

Carried

iv) Procedural By-law Update

Referred to the Governance Committee.

v) Risk Management – Board Discussion of Algoma Public Health Assessor's Report

An in-service regarding this document was requested by the Board. It was noted that alPHa is hosting a Risk Management Workshop on February 24, 2016 for Board of Health members, Medical Officers of Health, and Senior Management. Potential Board member attendees to this workshop are canvassed below under item vii) of this agenda.

vi) Report on Health Links

It was reported that several Board of Health members participate on the Health Links committee. It was suggested that Health Links be requested to make a presentation to the Board of Health. This item was referred to the Strategic Planning and Stakeholder Communication Committee for consideration.

vii) alPHa Risk Management Workshop Attendees

Board member interest in attending the alPHa Risk Management workshop on February 24, 2016 was sought. Mayor Michael Donohue expressed interest and was approved to attend. Dr. Reducka will also be attending.

viii) Striking Committee Report

Ms. Carolyn Watt reported that the Striking Committee are recommending the following members be appointed to the respective Board of Health committees.

Resources Committee: Mayor Michael Donohue (Chair), Warden Peter Emon, Mayor John Reinwald, and Mayor Janice Visneskie Moore.

Governance Committee: Mr. Wilmer Matthews (Chair), Mr. J. Michael du Manoir, Mayor Janice Visneskie Moore, and Ms. Carolyn Watt.

Strategic Planning and Stakeholder Communications Committee: Mayor Jane Dumas (Chair), Councillor Christine Reavie, Ms. Marcia Timm, and Mayor Janice Visneskie Moore.

Striking Committee: Ms. Carolyn Watt (Chair), Mayor Janice Visneskie Moore, and Mr. Wilmer Matthews.

The Medical Officer of Health/Chief Executive Officer will be an ex-officio, non-voting member of all committees.

The work of the Ad-Hoc Pembroke Office Lease Property Committee and MOH/CEO Ad-Hoc Recruitment Committee will be carried out by the Resources and Governance Committees respectively.

A motion by Councillor Christine Reavie, seconded by Mr. Wilmer Matthews,

That the Board of Health approve the recommended appointments of the Striking Committee as reported.

Carried

11. Closed Session – Labour Relations

A motion by Councillor Christine Reavie, seconded by Mr. Wilmer Matthews,

That the meeting become a closed meeting for the purposes of labour relations matters.

Carried

A motion by Mr. J. Michael du Manoir, seconded by Mr. Wilmer Matthews,

That the meeting become an open session of the Board of Health.

Carried

12. Date of Next Meeting

The next regular Board of Health meeting is scheduled for Friday, February 19, 2016 at 10:00 a.m. It was agreed that except for the months of February, July, and August, 2016, regular Board of Health meetings will be held on the last Tuesday of the month. Committees chairs will develop work plans including meeting dates. Each committee shall provide a report to the Board of Health under the agenda item of "Committee Reports".

13. Adjournment

A motion by Councillor Christine Reavie, seconded by Ms. Marcia Timm.

That the meeting be adjourned.

Carried

Janice Visneskie Moore

MEDICAL OFFICER OF HEALTH **CHAIR**

01/03/16

Standards, Practice & Accountability Branch Updates

2016 Program-Based Grants Training Session
Population and Public Health Division, MOHLTC
January 20, 2016

Agenda Item #2

Ontario

Purpose

- To provide updates on public health initiatives managed by the Public Health Standards, Practice & Accountability Branch of the Population and Public Health Division, including:

    - Standards Modernization;
    - Performance Management;
    - Medical Officer of Health (MOH) / Associate Medical Officer of Health (AMOH) Compensation Initiative;
    - Provincial Audits; and,
    - Public Health Funding Formula.

Branch Overview

- Provides leadership for:
    - The development and evergreening of provincial public health standards and performance management;
    - Board of health funding and the management of accountability agreements and frameworks; and,
    - The development and maintenance of public health capacity.

Standards Modernization

- The standards modernization will result in a renewed set of program and organizational standards that are responsive to emerging evidence and priority issues in public health and are aligned with the government's strategic vision and priorities for public health within a transformed health system.

- An Executive Steering Committee (ESC) has been established to provide strategic leadership to oversee the modernization. Their first meeting was held in December 2015. They are committed to frequent communication to the sector throughout the modernization process.
  - The Practice and Evidence Program Standards Advisory Committee (PEPSAC) has also been established to provide expert advice and make recommendations on a set of evidence-based standards, reflective of current accepted practice, that will support system accountability, transparency, and demonstrate value for money. They report to ESC and had their first meeting earlier this week.
  - An Organizational Governance Committee will be established shortly.

- The modernization process will include extensive engagement and consultation with the public health community and others.

Performance Management: 2016 Accountability Agreement

- 2016 indicators and supporting technical documents were released to the field in January 2016.
  - For 2016, the suite of indicators is largely unchanged, with the addition of a few new indicators, and all boards of health will have the same suite of indicators.

- The negotiation of performance targets for 2016 will take place in spring 2016 with all boards of health.
  - The process will be the similar to 2015, where boards of health will be asked to propose targets to the ministry based on current performance for most indicators.

Performance Management: 2016 Accountability Agreement

- Two (2) types of indicators will continue to be used by the ministry in 2016 in order to ensure continued progress and improvement in a number of key areas.
  1. Performance Indicators: Have targets if there is an opportunity for performance improvement or if gains achieved are to be maintained.
  2. Monitoring Indicators: Do not have negotiated targets.

- Both types of indicators will be included in Schedule D of each board of health's Public Health Funding and Accountability Agreement (the "Accountability Agreement").

- See **Appendix 1** for a complete list of 2016 health promotion and protection performance indicators.

MOH/AMOH Compensation Initiative: Background

Physician Services Agreement (PSA):

- The 2008 PSA is the foundation of this initiative and included provisions for top-up funding for MOHs and AMOHs from April 1, 2009 to March 31, 2012 to achieve salary ranges established under the PSA, including salary grid increases in 2010 and 2011.

- A salary grid was subsequently developed by the ministry and the Ontario Medical Association (OMA) and ratified by the OMA Public Health Physician Section in August 2009.

- In addition, eligible physicians may also receive stipends for: after-hours availability, specialty certification in public health/preventive medicine, and supervision of Acting MOHs undertaking public health training.

- The initiative continued under the 2012 PSA with provisions that established decreases to physician payment programs (2.59 % decrease to the salary grid effective January 1, 2013 and 0.5% payment decrease effective April 1, 2013).

MOH/AMOH Compensation Initiative: Background (cont'd)

10 Point Plan:

- The 2012 PSA ended March 31, 2014; however, funds have continued at 2013-14 levels for eligible MOHs/AMOHs hired prior to this date.

- In the absence of a new PSA, on January 15, 2015, the ministry announced the implementation of a "Physician Services: Ten-Point Plan for Saving and Improving Service".
  - It includes a 2.65% payment discount to non fee-for-service payment programs such as the MOH/AMOH Compensation Initiative to be applied to the MOH/AMOH salary grid effective June 1, 2015.

MOH/AMOH Compensation Initiative: Current Status

- Application forms for 2014-15 and 2015-16 were sent to boards of health on September 21, 2015.

- Applications have been reviewed and a funding package is currently in the ministry's approvals process.

- In an effort to streamline the process and expedite future payments of MOHs/AMOHs, it is being proposed that maximum base funding allocations be established for each board of health, funding be approved on the calendar year, and funding be fully rolled into the Accountability Agreement.

- The field will be updated on the status of this initiative on an ongoing basis.

Provincial Audits

- The ministry continues to conduct periodic audits of boards of health to ensure compliance with requirements set out in the Accountability Agreement related to financial, operational, and value for money aspects of transfer payment funding.

- These audits, which are in keeping with policies and directives such as the Transfer Payment Accountability Directive, are currently performed by the Health Audit Service Team of the Ontario Internal Audit Division.

- The authority for the ministry to conduct audits of boards of health is set out in Article 8.3 of the Accountability Agreement.

Provincial Audits (cont'd)

- In selecting a board of health to be audited, the ministry considers a number of factors, including whether a board of health has been audited or assessed over the past number of years and/or non-compliance with Accountability Agreement reporting requirements.
  - A notification letter and terms of reference are issued to the selected board of health in advance of the audit.

- Since 2012-13, three (3) audits of boards of health have been conducted, and one (1) audit is currently underway. We anticipate that audits of boards of health will continue in 2016-17.

- To date, the objective of these audits has been to assess compliance with the Accountability Agreement and the Organizational Standards.
  - The scope of these audits has not included an assessment of the provision of health protection, disease prevention, or health promotion programs.

Public Health Funding Formula

- In 2015, growth funding for mandatory programs was allocated based on a funding formula that takes into account population as well as equity measures.

- The ministry's approach to implementation of the funding model followed the implementation principles recommended by the Funding Review Working Group and was intended to support a stable transition to more equitable and transparent funding of public health programs and services.

- Education and other transitional supports pertaining to the public health funding formula and implementation approach were made available to assist boards of health.

- No decisions have been taken at this time regarding public health funding and the funding formula for 2016.

Questions?

Ontario

Appendix 1:
2016 Health Promotion Indicators

#	Indicator
1.	% of tobacco vendors in compliance with youth access legislation at the time of last inspection (performance)
2.	% of secondary schools inspected once per year for compliance with section 10 of the *Smoke-Free Ontario Act* (SFOA) † (performance)
3.	% of tobacco retailers inspected for compliance with section 3 of the SFOA (performance)
4.	% of tobacco retailers inspected once per year for compliance with display, handling and promotion sections of the SFOA (performance)
5.	Oral Health Assessment and Surveillance: % of all JK, SK, and Grade 2 students screened in publicly funded schools (performance)
6.	Implementation status of Nutristep® (performance)
7.	Baby-Friendly Initiative (BFI) Status (performance)
8.	% of population (19+) that exceeds the Low-Risk Drinking Guidelines (monitoring)
9.	Fall-related emergency visits in older adults aged 65+ (monitoring)
10.	% of youth (ages 12-18) who have never smoked a whole cigarette (monitoring)

† Note: As part of 2015 year-end reporting process, 2013 and 2014 combined data will be used to establish the new baseline for this indicator, due to previous changes in the Canadian Community Health Survey Alcohol Module.

Appendix 1:
2016 Health Protection Indicators

#	Indicator
1.	% of high-risk food premises inspected once every four (4) months while in operation (monitoring)
2.	% of moderate-risk food premises inspected once every six (6) months while in operation (monitoring)
3.	% of Class A pools inspected while in operation (monitoring)
4.	% of high-risk Small Drinking Water Systems (SDWS) inspections completed for those that are due for re-inspection (performance)
5.	% of public spas inspected while in operation (monitoring)
6.	% of restaurants with a Certified Food Handler (CFH) on site at time of routine inspection (New monitoring)
7.	% of personal serviced settings inspected annually (monitoring)
8.	% of suspected rabies exposures reported with investigation initiated within one (1) day of public health unit notification (performance)
9.	% of confirmed gonorrhea cases where initiation of follow-up occurred within two (2) business days (monitoring)
10.	% of confirmed iGAS cases where initiation of follow-up occurred on the same day as receipt of lab confirmation of a positive case (monitoring)
11.	% of salmonellosis cases where one (1) or more risk factor(s) other than "Unknown" was entered into iPHIS (performance)

Appendix 1:
2016 Health Protection Indicators (cont'd)

#	Indicator
12.	% of laboratory confirmed N. gonorrhoeae cases treated according to guidelines (monitoring)
13.	% of HPV vaccine wasted that is stored/administered by the public health unit (monitoring)
14.	% of influenza vaccine wasted that is stored/administered by the public health unit (performance)
15.	% of refrigerators storing publicly funded vaccines that have received a completed routine annual cold chain inspection (performance)
16.	% of school-aged children who have completed immunizations for hepatitis B (monitoring)
17.	% of school-aged children who have completed immunizations for HPV (monitoring)
18.	% of school-aged children who have completed immunizations for meningococcus (monitoring)
19.	% of MMR vaccine wasted (New monitoring)
20.	% of 7 or 8 year old students in compliance with ISPA (New performance)
21.	% of 16 or 17 year old students in compliance with ISPA (New performance)

Note: 2016 will be used as the baseline year for the new health protection indicators.

Immunization 2020:

Modernizing Ontario's Publicly Funded Immunization Program

2016 Program-Based Grants Training Session
Population and Public Health Division
Public Health Policy and Programs Branch
Ministry of Health and Long-Term Care
January 20, 2016

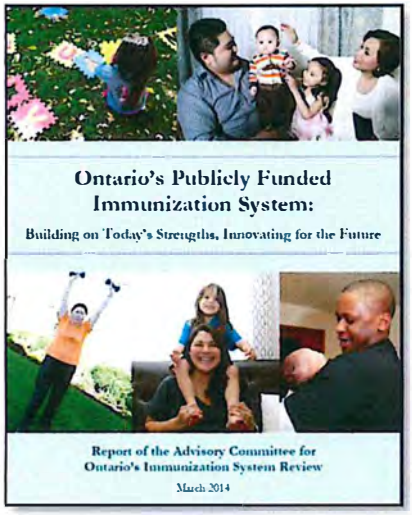
Agenda Item #3

Ontario

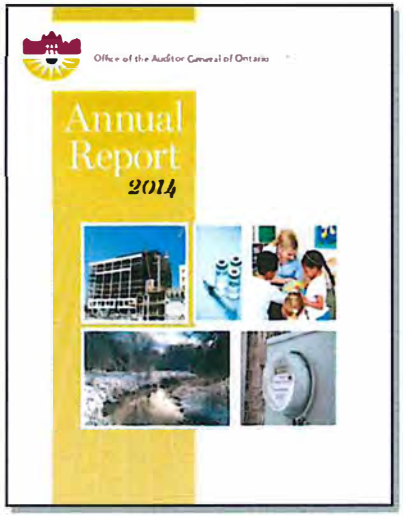
Overview

- Released December 2015
- Strategy for the provincial immunization program over the next five years
- Includes 20 priority actions to be achieved by the year 2020
- Requires collective action and shared commitment among health system partners to implement

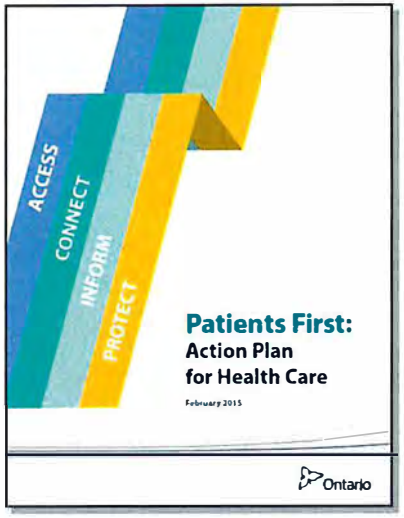
Foundations



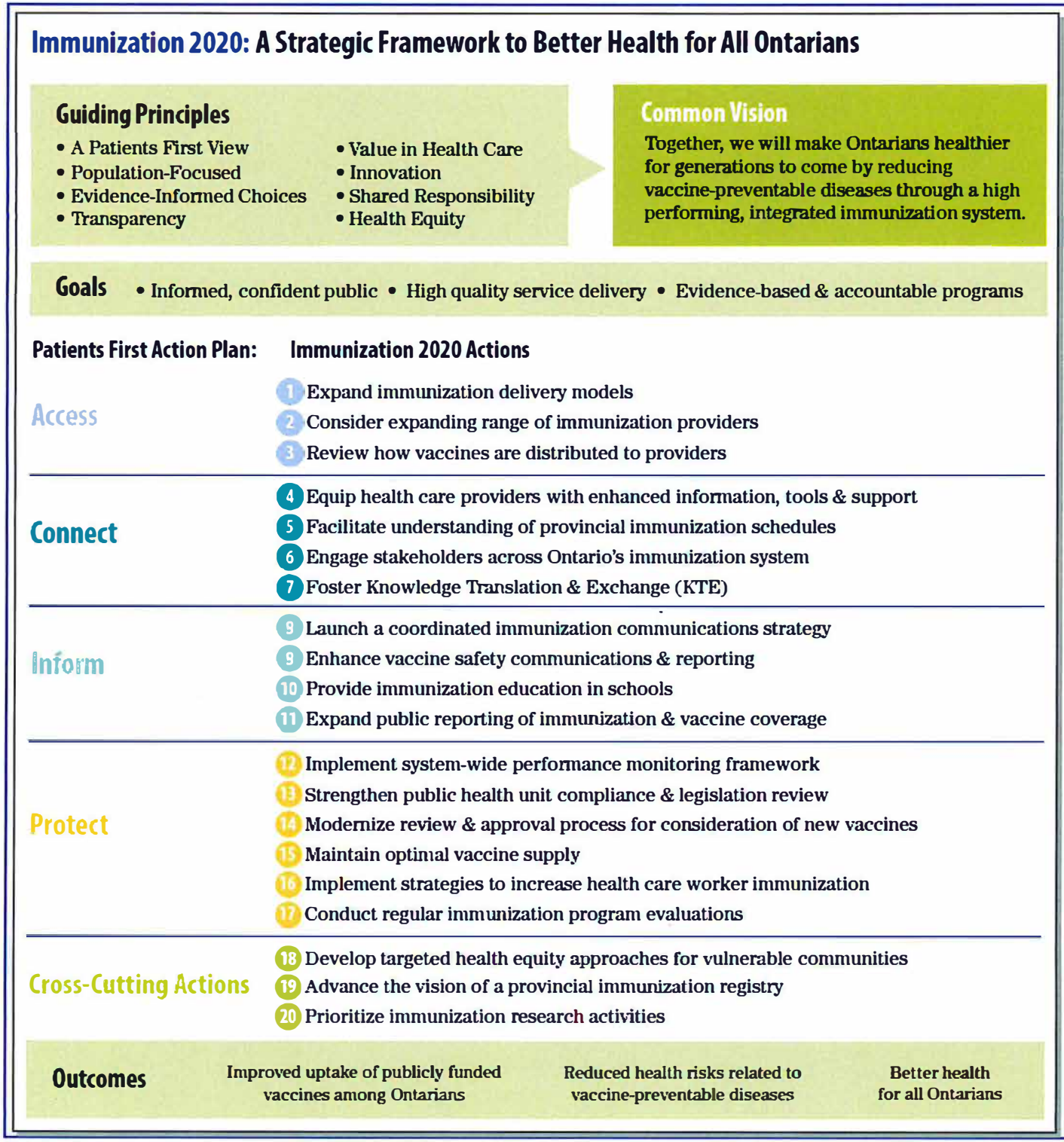
- Immunization System Review conducted by an Expert Advisory Committee, 2012-2014
- Significant stakeholder engagement and input to inform findings
- Final report completed March 2014



- Auditor General of Ontario review of the provincial immunization program completed in 2014
- 11 recommendations made in final report



- Patients First: Action Plan for Health Care released February 2015
- Framework for health system transformation



Goals

- **Informed, Confident Public:** Individuals and communities value publicly funded immunization as both a right and a responsibility
- **High Quality Service Delivery**: Ontarians are at the centre of an integrated and effective immunization system, with all partners contributing toward common goals
- **Evidence-Informed and Accountable Programs:** Immunization program planning and operations are evidence-informed and guided by continuous quality improvement to enhance performance, accountability, and sustainability

Actions: Access

Action #1: Expand Immunization Delivery Models

- E.g., Additional vaccines and catch-up clinics through school-based programs for children and adolescents; additional community-based settings for adults such as before patients are discharged from hospital

Action #2: Consider Expanding Range of Immunization Providers

- E.g., Enabling pharmacists to administer travel vaccines

Action #3: Review How Vaccines are Distributed to Providers

- E.g., Explore opportunities to standardize vaccine delivery methods across the province and improve timeliness of vaccine shipments to providers.

Actions: Connect

Action #4: Equip Health Care Providers with Enhanced Information, Tools and Support

- E.g., Improved online resources with latest scientific evidence about vaccines

Action #5: Facilitate Understanding of Provincial Immunization Schedules

- E.g., Expanded availability of the provincial immunization forecaster tool

Action #6: Engage Stakeholders Across Ontario's Immunization System

- E.g., Proposed Immunization Stakeholder and Citizen Engagement Panel

Action #7: Foster Knowledge Translation and Exchange (KTE)

- E.g., Latest information, tools, and guidelines made available, linked to research priorities (Action #20)

Actions: Inform

Action #8: Launch a Coordinated Immunization Communications Strategy

- E.g., Improve social media presence and resources

Action #9: Enhance Vaccine Safety Communications and Reporting

- E.g., Resources to help patients identify and report potential AEFIs

Action #10: Provide Immunization Education in Schools

- E.g., Develop immunization teaching module that public health units can offer to provide in schools

Action #11: Expand Public Reporting of Immunization and Vaccine Coverage

- E.g., reporting of coverage rates by public health unit, school, or school board

Actions: Protect

Action #12: Implement System-Wide Performance Monitoring Framework

- E.g., Indicators and targets to show progress and support continuous quality improvement

Action #13: Strengthen Public Health Unit Compliance and Legislation Review

- E.g., Strengthen process for obtaining non-medical exemptions from immunization requirements

Action #14: Modernize Review and Approval Process for Consideration of New Vaccines

- E.g., Options for streamlining approval process to incorporate new evidence into existing programs

Action #15: Maintain Optimal Vaccine Supply

- E.g., Review cold chain inspection process and explore opportunities to further reduce vaccine wastage

Action #16: Implement Strategies to Increase Health Care Worker Immunization

- E.g., Continue the work of the Minister's Executive Committee to improve HCW influenza immunization

Action #17: Conduct Regular Immunization Program Evaluations

- E.g., Review and modernization of the Universal Influenza Immunization Program

Actions: Cross-Cutting Actions

Action #18: Develop Targeted Health Equity Approaches for Vulnerable Communities

- E.g., Explore options to improve data collection of socio-economic status and other health equity data

Action #19: Advance the Vision of a Provincial Immunization Registry

- E.g., Explore opportunities to strengthen role of health care providers in reporting immunization information to public health

Action #20: Prioritize Immunization Research Activities

- E.g., Develop provincial immunization research priorities that span all components of the immunization program, in consultation with stakeholders

Immunization 2020

Modernizing Ontario's Publicly Funded Immunization Program

Ontario

Questions & Discussion

Modernization of Safe Food and Water Regulations under the *Health Protection and Promotion Act*

Ministry of Health and Long-Term Care
January 20, 2016

Presented to Public Health Unit Business Administrators

Agenda Item #3

Ontario

ISSUE

The Ministry of Health and Long-Term Care (MOHLTC) is undertaking a comprehensive review to inform the modernization of regulations made under the *Health Protection and Promotion Act* (HPPA) that govern food and water safety in Ontario.

CONTEXT FOR ACTION

- Food and water safety in Ontario is currently governed by six regulations under the *HPPA*:

Regulation	Year Introduced
Ontario Regulation 319/08 – Small Drinking Water Systems[1]	2008
Ontario Regulation 562 – Food Premises	1967
Ontario Regulation 565 – Public Pools	1944
Ontario Regulation 428/05 – Public Spas	2005
Ontario Regulation 568 – Recreational Camps*	1940
Ontario Regulation 554 – Camps in Unorganized Territory*	1944

**Includes requirements for both food safety and water supply*

- Stakeholders have identified issues that can strengthen our current regulatory framework.
- Changes in technology and evidence present an opportunity to modernize our regulations, ensuring they are responsive and adaptive.

[1] The Small Drinking Water Systems transitional and permanent regulations were introduced in 2008 and do not warrant review at this time; however, the transitional regulation, Ontario Regulation 318/08, is due to be repealed.

REGULATORY REVIEW

Overarching Goal:

To modernize Ontario's safe food and water regulations by undertaking a comprehensive review focused on strengthening the overall effectiveness and efficiency of environmental health practice.

Guiding Principles:

A flexible and responsive regulatory framework that is evidence-based and supports innovation

Comprehensive regulations that set clear expectations for regulated parties

Ensure public health benefit is the overarching consideration; streamlined, concise and user-friendly

Optimal use of alternative approaches (i.e., outcomes-based or non-regulatory approaches)

REGULATORY REVIEW CONT'D

Key Questions Guiding the Regulatory Review

1. Are there **redundant** requirements that serve no additional benefit (e.g., duplication of other regulations; out-dated; no evidence)?

2. Are **current science and technological advancements** (and resulting improvements in industry standards) reflected in the regulatory requirements? If not, should they be considered?

3. Where are the **gaps** and what regulatory provisions/policy tools are needed to address the identified gaps?

4. What **clarification** is necessary to avoid and address inconsistency in application across the province?

5. Are there **alternative approaches** that may be better suited (i.e. less prescriptive, outcome based or no regulation)?

6. What are the expected financial or economic impacts of any proposed changes?

KEY ISSUES IDENTIFIED (OVERARCHING)

Operator and Employee Training

Strengthen training and certification requirements across the regulations to protect public health and safety:

- Opportunity to include requirements for mandatory food handler training and certification.
- Identify and streamline minimum training standards for operators of recreational water facilities (i.e. public pools and spas)

Public Disclosure of Inspection Results

- Improve public transparency and inform consumer decision-making by requiring the operator to post inspection status as instructed by the local medical officer of health.

KEY STAKEHOLDERS

- Association of Local Public Health Agencies
- Association of Municipalities of Ontario; Northern Ontario Municipal Association; Rural Ontario Municipal Association; City of Toronto
- Boards of Health (Public Health Units)
- Canadian Council of Pools and Spas
- Canadian Federation of Independent Grocers
- Canadian Food Inspection Agency & Federal/Provincial/Territorial Committee
- Canadian Institute of Public Health Inspectors
- Canadian Red Cross
- Council of Medical Officers of Health
- Lifesaving Society
- Ontario Camps Association
- Ontario Public Health Association
- Ontario Restaurant, Hotel, Motel Association
- Parachute Canada
- World Waterpark Association (Canadian Committee)

STAKEHOLDER ENGAGEMENT SCHEDULE

Communicate plan to Stakeholders

Industry; Public Health Units and Associations; Federal, Provincial and Municipal Stakeholders

Nov-Dec 2015

Stakeholder Consultation

Jan-Jun 2016

3 Working Groups:
Public Health (PH) Associations and Public Health Unit (PHU) representatives

4 Focus Groups:
Industry Perspectives

Posting of Draft Regulations on Regulatory Registry

(minimum 45 days)

Late 2016 / Early 2017

Regulations in force (anticipated):

2017

PH ASSOCIATIONS AND PHU ENGAGEMENT

- Working groups composed of PH Associations and PHUs are scheduled to kick-off in January and February 2016.
- Purpose of the working groups are to seek feedback from PH Associations and PHUs in formulating proposed amendments to the modernization of the identified regulations under the *HPPA*.

Working groups will focus on:

- Validating inventory of longstanding regulatory issues, identifying emerging issues and areas of opportunity
- Providing input on potential impacts of regulatory changes and implementation challenges and opportunities
  - Includes identifying any implementation costs/resources for PHUs, however, the review will result in strengthening environmental health practice so that improvements in efficiency are realized over time.

QUESTIONS?

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Managing Uncertainty

Risk Management for Boards of Health

November 5, 2015 &
January 20 2016

Contact Info

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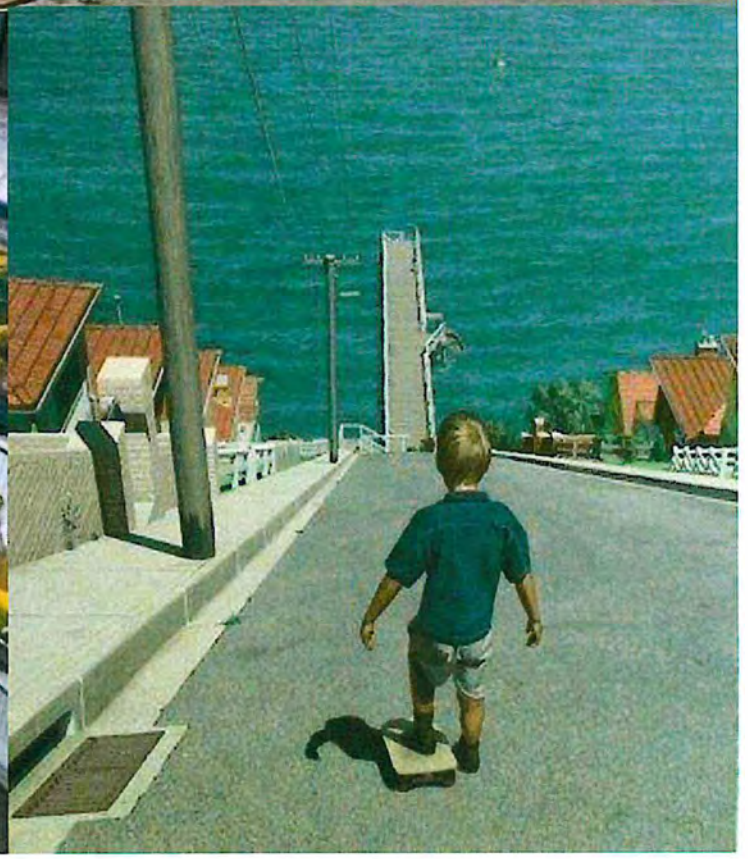


Session Agenda

- **Share the Ontario Public Service (OPS) Risk Management (RM) Framework**
- **Explain the basic concepts of RM**
- **Walk through the steps of RM**
- **BOH responsibilities**
- **Discussion**
- **Q &A's**

Risk Intelligence

"The organizational ability to think holistically about risk and uncertainty, speak a common risk language, and effectively use forward-looking risk concepts and tools in making better decisions, alleviating threats, capitalizing on opportunities, and creating lasting value."

Risk intelligence is essential to survival, success, and relevance of organizations and stakeholders.

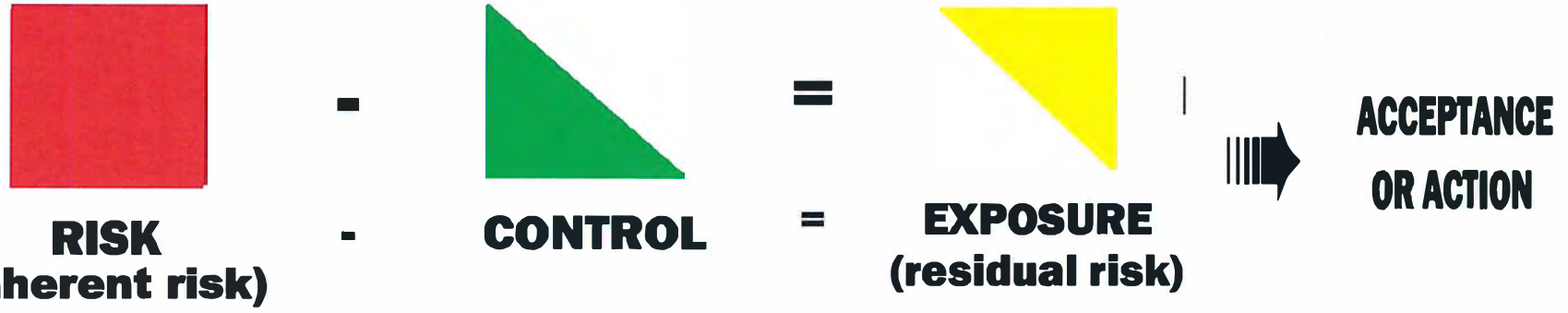
What is Risk?

Risk is the chance of something happening that will have an impact on the achievement of objectives.

Risk can represent an opportunity or a threat to the achievement of objectives.

More Risk Management Basics

- Effective mitigation strategies/controls can reduce negative risks or increase opportunities.
- Residual risk (exposure) is the level of risk after evaluating the effectiveness of controls.
- Acceptance and action should be based on residual risk levels.
  - Can you live with the exposure? If yes, accept it. If no, take more action.



What is Risk Management?

Risk management is a systematic approach to setting the best course of action under uncertainty by identifying, assessing, understanding, acting on, and communicating risk issues.

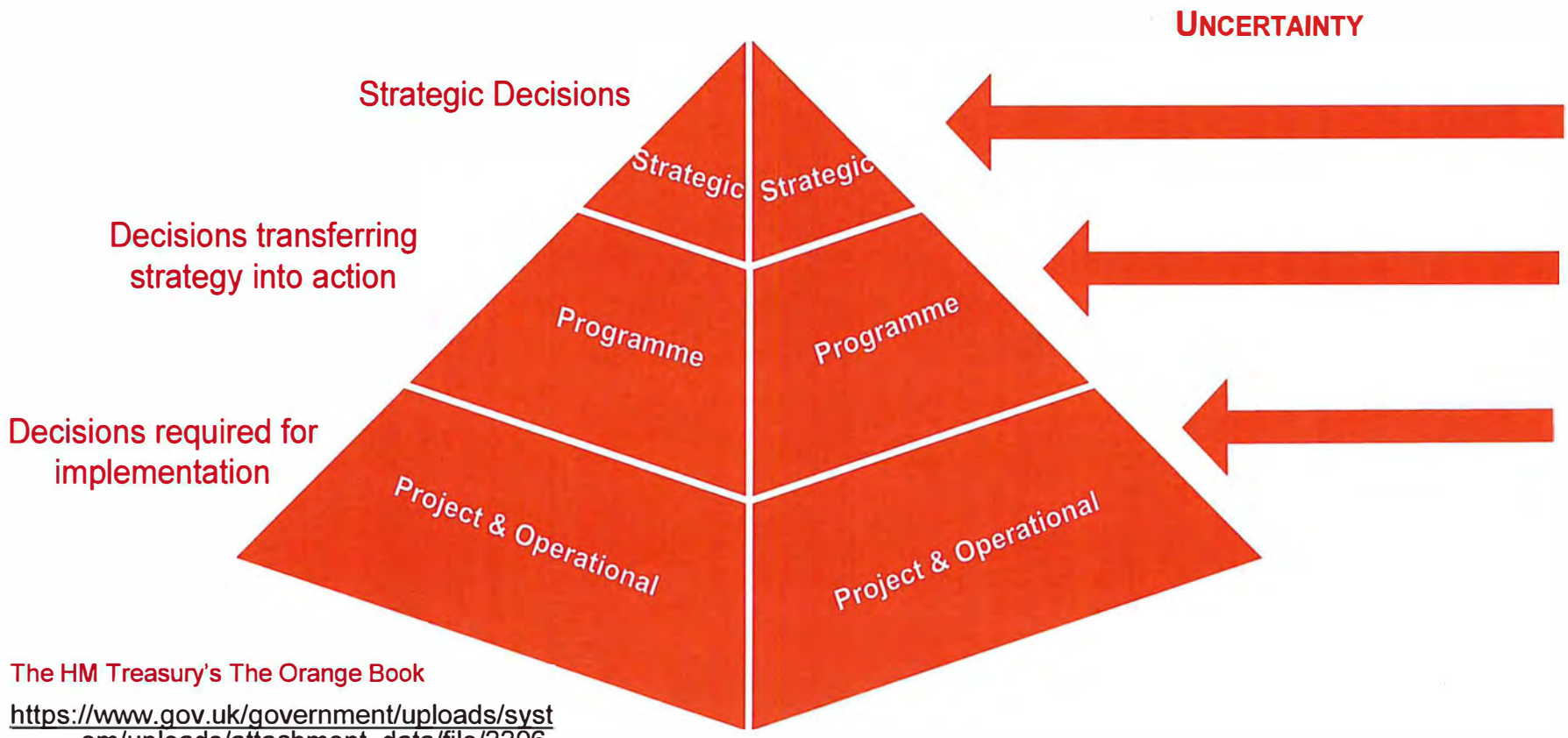
Why do Risk Management?

- Helps the Board of Health (BoH) meet its strategic and operational objectives. **Improves outcomes and the achievement of objectives**.
- Enables decision-makers to **consider and forecast risk and prioritize efforts more effectively**. Allows intelligent "informed" risk management.
- Considers both opportunities and threats as part of your risk assessment and allows you to **mitigate your threats and take advantage of opportunities**.

Why do Risk Management?

- Is proactive…. not reactive. Helps you **prepare for risks before they happen** by developing appropriate risk mitigation and communication strategies.
- Fulfills **"due diligence"** accountability, transparency and responsibility obligations. **……..Really comes down to simple good management**

Risk Management is critical in ALL levels of decisions



The HM Treasury's The Orange Book

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/220647/orange_book.pdf

Decisions can be categorized into three types. The amount of risk varies with the type of decisions. Most decisions are concerned with implementation.

The OPS Risk Management Policy (2002) ...

[In essence, there are] three requirements for ministries and agencies:

- ***Integrate risk management into day-to-day decision-making***
- ***Cultivate a corporate philosophy and culture that encourages everyone to manage and communicate risk***
- ***Support the development of risk management competencies***

The OPS Risk Management Policy

All program managers and staff are responsible for:

- Following the Risk Management Framework
- Applying risk management practices in everyday decision-making
- Documenting risks and strategies to treat risk

Deputy Ministers, CAOs, internal audit and central agencies have special responsibilities

To learn more about the policy and framework, visit
http://intra.mc.fin.gov.on.ca
click on "Guidelines" then "Risk Management"

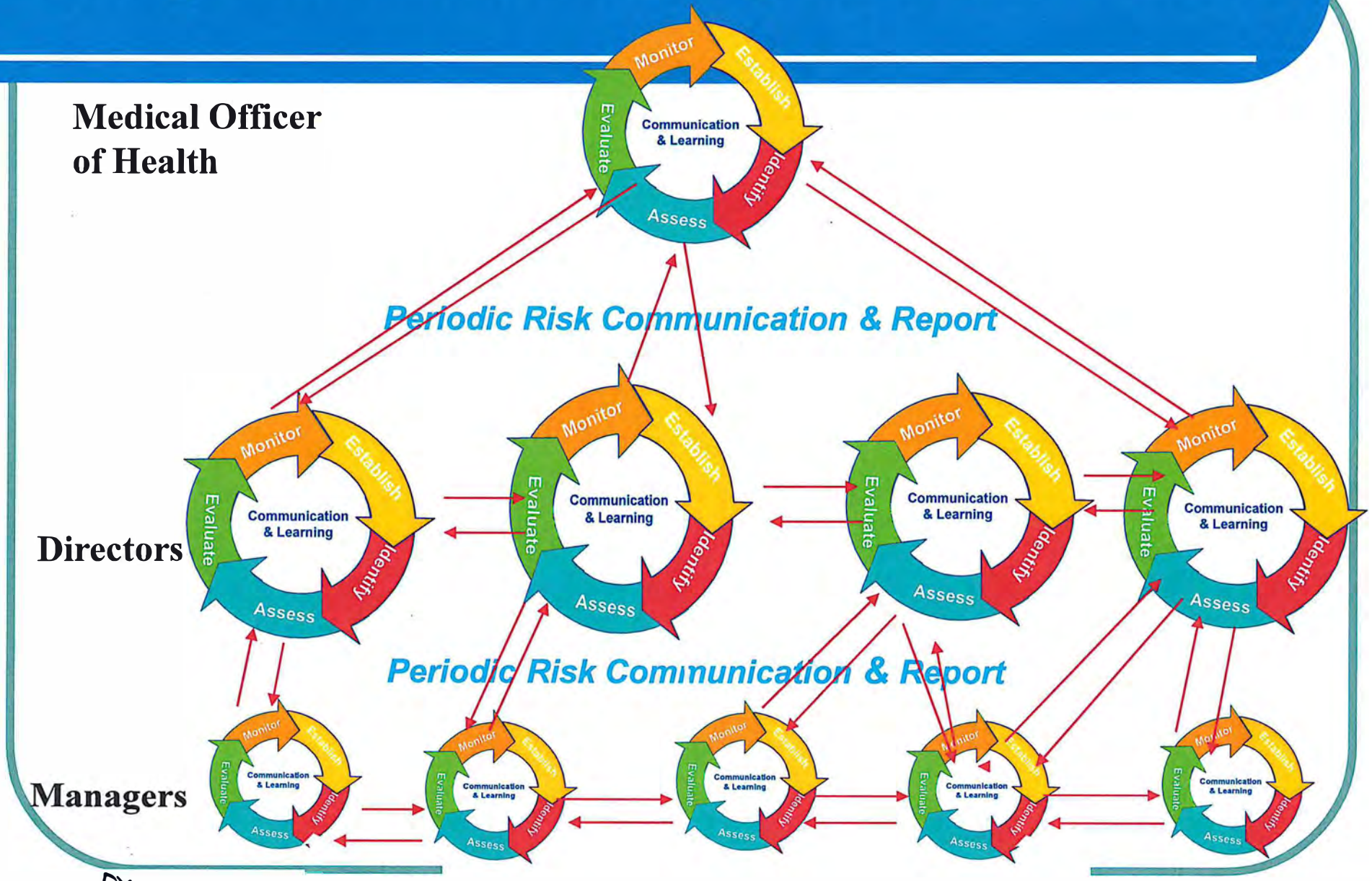
Roles and Responsibilities

- The Public Health Unit – implementing all steps of RM
- The Board of Health – oversight of RM
- The Ministry – sets standards and expectations through OPHS, Organizational Standards and Accountability Agreements

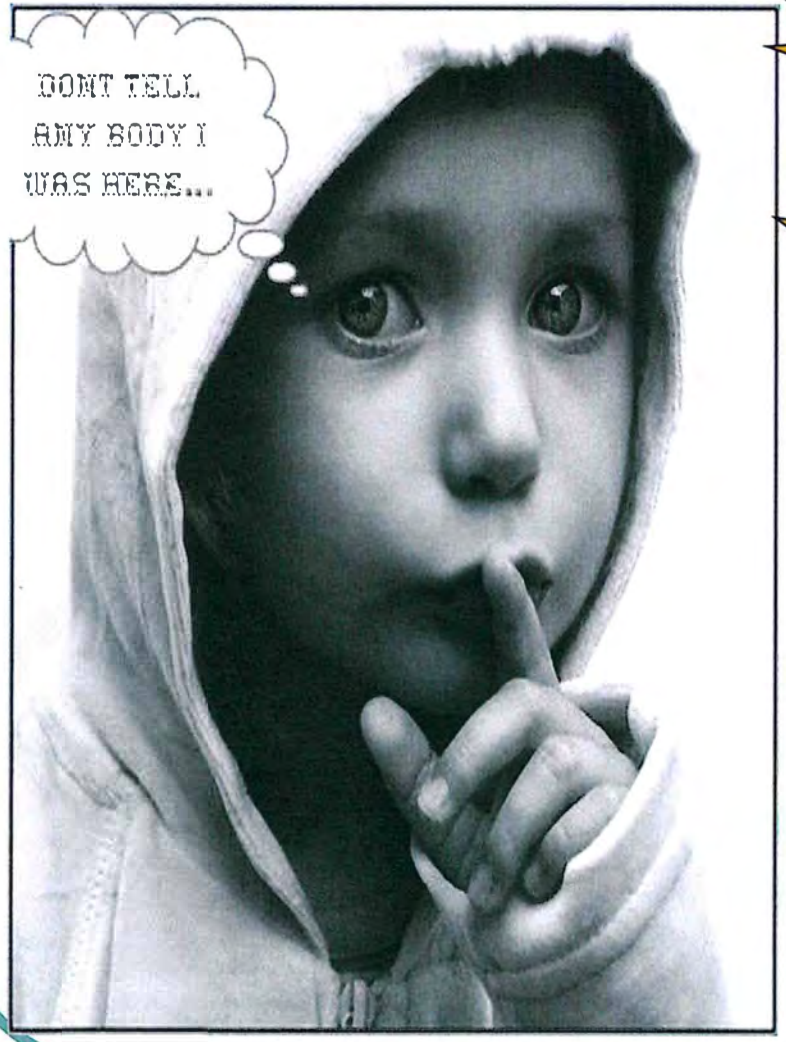
Board responsibilities :

- Approval of RM policy and framework
- Ensure the BOH and staff have the capacity to implement RM
- Ensure that all significant risks facing the PHU are identified and appropriate mitigation strategies are being proposed.
- Ensure that the BOH has adequate input into risk discussions.
- Ensure that BOH has adequate information to monitor progress of implementation and effectiveness of mitigation strategies.

Integrated Risk Management - Divisional



A Healthy Risk Culture is Key



Think globally…act locally

We need to understand and create a healthy risk culture

- What is a healthy risk culture?
- How can we create and nurture it?
- How can we destroy it?
- How do we measure it?

Advice: talk about risk…put it on every agenda!

Risk Management Process

Step 1: State Objectives

What are the objectives?

- Have objectives, functions, mandate and service obligations already been defined?
- Are key objectives, performance measures and targets simple, clear and accurate?
- Where can we find these objectives?

Step 2: Identify Risks

What are the risks to meeting the objectives?

- Use a structured approach to ensure that all risks threatening the objectives are identified and documented prior to the risk assessment. See next slide.
- Consider the current environment within your organization.

Risk Category	Description
Compliance Legal	Uncertainty regarding compliance with laws, regulations, standards, policies, directives, contracts. May expose the ministry to the risk of fines, penalties, litigation.
Equity	Uncertainty that policies, programs, services have an equitable impact on the population.
Financial	Uncertainty of obtaining, using, maintaining economic resources, meeting overall financial budgets/commitments. Includes fraud risk.
Governance/ Organization-al	Uncertainty of having appropriate accountability and control mechanisms such as organizational structures and systems processes. Systemic issues, culture and values, organizational capacity commitment, and learning and management systems, etc.
Information/ Knowledge	Uncertainty regarding the access to or use of accurate, complete, relevant and timely information. Uncertainty regarding the reliability of information systems.
Environment	Uncertainty usually due to external risks facing an organization including air, water, earth, forests. An example of an environmental, ecological risk would be the possible occurrence of a natural disaster and its impact on an organization's operations.

Risk Category	Description
People/ Human resources	Uncertainty as to the ministry's/business unit's ability to attract, develop and retain the talent needed to meet its objectives
Operational Service	Uncertainty regarding the performance of activities designed to carry out any of the functions of the ministry/unit, including design and implementation.
Political	Uncertainty of the events may arise from or impact any level of the government including the Offices of the Premier or Minister, e.g. a change in government political priorities or policy direction.
Privacy	Uncertainty with regards to the safeguarding of personal information or data, including identity theft or unauthorized access.
Security	Uncertainty relating to physical or logical access to data and locations (offices, warehouses, labs, etc.)
Stakeholder	Uncertainty around the expectations of the public, other governments, media or other stakeholders.
Strategic	Uncertainty that strategies and policies will achieve required results or that policies, directives, guidelines, legislation will not be able to adjust necessarily.
Technology	Uncertainty regarding alignment of IT infrastructure with technology and business requirements. Uncertainty of the availability and reliability of technology.

Techniques for identifying risks

- Previous risk assessments
- Brainstorming, mind-mapping
- Past and current performance - evidence
- Prediction and forecasting
- Focus groups and interviews
- Information from other jurisdictions
- Knowledge of the environment, program, clients, providers…
- Professional judgment

Techniques for identifying risks

Communicate, Learn & Improve

Step 3: Assess the Risks

Remember: risk has three elements

- **Likelihood** - For each risk identified in Step 2 – assess risks based on likelihood of occurrence (consider existing and operational controls).

- **Impact** - For each risk identified in Step 2 – assess risks based on potential impact (consider existing and operational controls).

- **Timing** - For each risk identified in Step 2 – assess risks based on potential timing. When would it occur?

Identify potential control gaps / residual risk (i.e. typically, risks that may not be adequately managed).

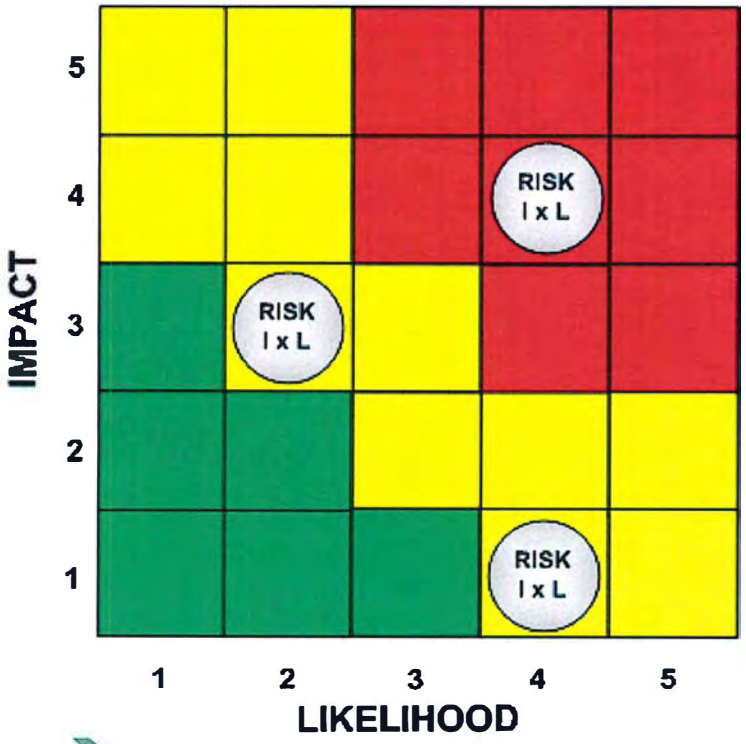
Risk rating

...Combining impact and likelihood

State Objectives → Identify Risks → **Assess Risks** → Plan & Take Action → Monitor & Report

Communicate, Learn & Improve

RISK PRIORITIZATION MATRIX



Value	Likelihood	Impact	Proximity	Scale
1	Unlikely to occur	Negligible impact	More than 36 months	*Very Low*
2	May occur occasionally	Minor impact on time, cost, or quality	12 to 24 months	*Low*
3	Is as likely as not to occur	Notable impact on time, cost, or quality	6 to 12 months	*Medium*
4	Is likely to occur	Substantial impact on time, cost, or quality	Less than 6 months	*High*
5	Is almost certain to occur	Threatens the success of the project	Now	*Very High*

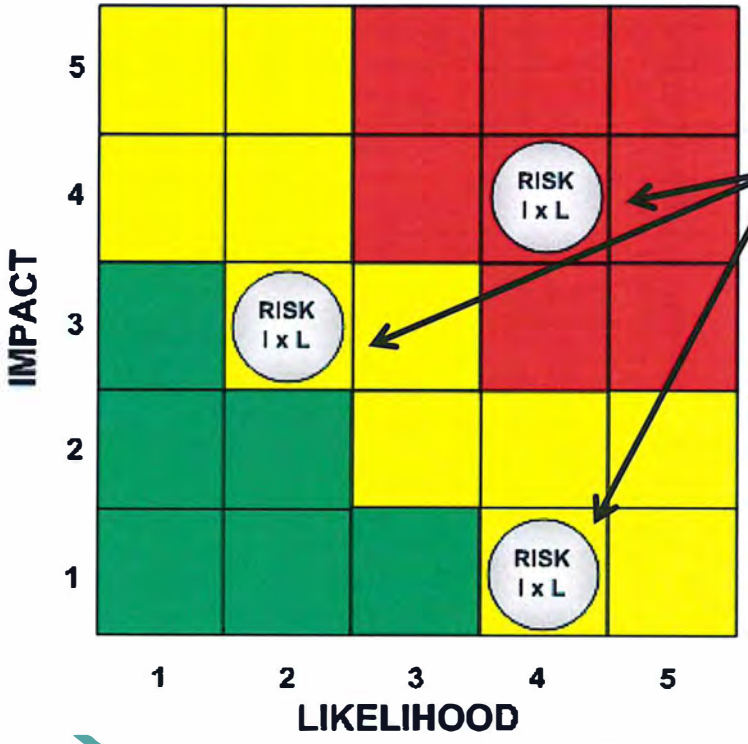
Risk rating

...Combining impact and likelihood

State Objectives → Identify Risks → **Assess Risks** → Plan & Take Action → Monitor & Report

Communicate, Learn & Improve

RISK PRIORITIZATION MATRIX



HOW WE GOT HERE
Placement on matrix = Impact [1 To 5]) **x Likelihood** [1 to 5]
For a Given Risk: Multiply Impact and Likelihood to place it on the matrix
Purpose: Establish relative priority of the risks identified

Risk Level	Action and Level of Involvement Required
High Risk	• Risks that are a significant threat to the achievement of key objectives. Detailed management planning and attention is required.
Medium Risk	• Risks that are a moderate threat to the achievement of objectives. Specify management responsibility and specific procedures are required.
Low Risk	• Risks do not exist or are of minor importance and not likely to significantly affect the achievement of objectives. Risks can be managed by routine procedures.

Step 4: Plan

What actions are required? By whom? When?

- Identify risk exposures (residual risks) and determine whether they are acceptable.
- For ***acceptable*** risk exposures, the rationale should be documented by the person responsible for it.
- For ***unacceptable*** risk exposures, develop, ***document*** and communicate action plans to manage them.

**Note: Decisions as to acceptable risk exposures should be made by senior management.*

… and Take Action

Three categories of mitigating strategies:

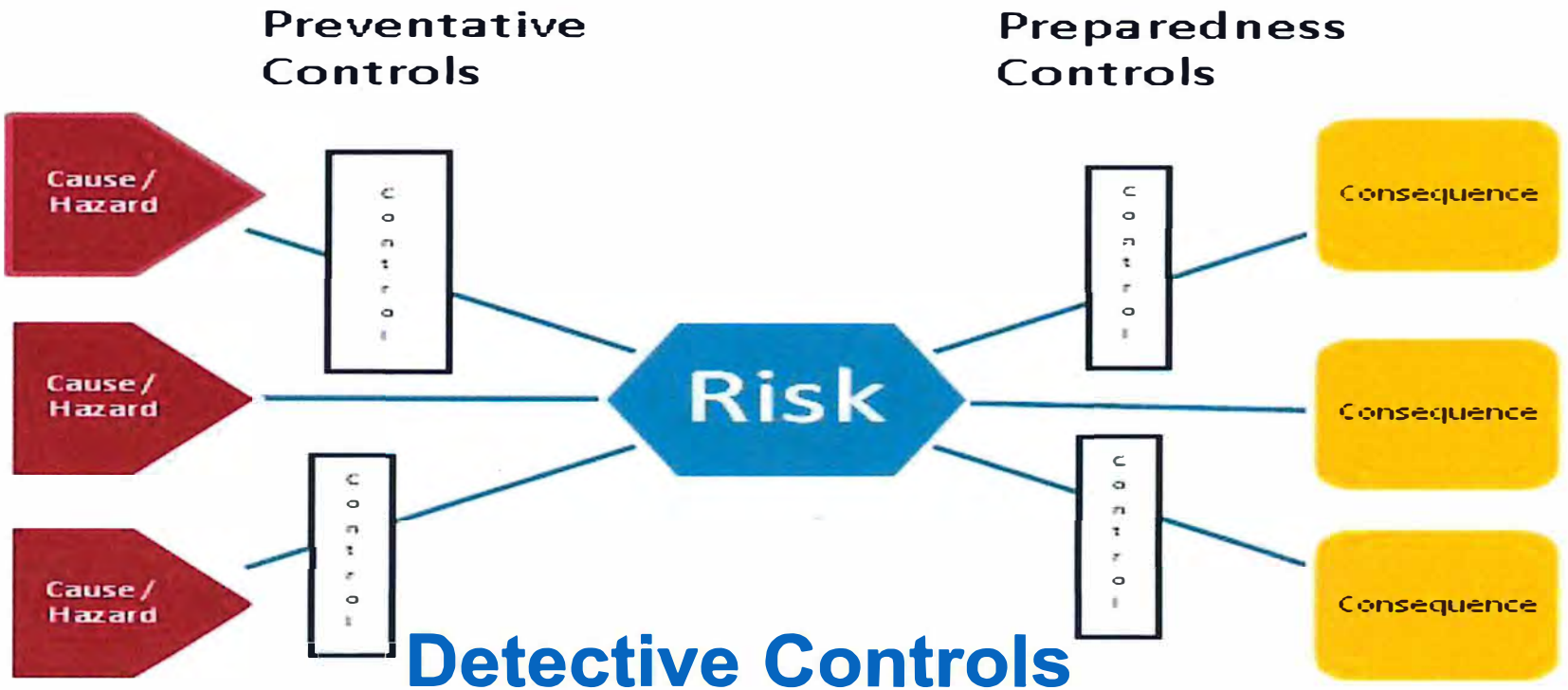
- **Preventive** – strategies that are designed to prevent risk from occurring.
  - Focus on the cause of the risk
  - Reduce likelihood
- **Detective** – strategies that are designed to detect the occurrence of risk early.
  - Focus on either the cause or the consequence of the risk
  - Allows early intervention
  - Reduce impact
- **Recovery/Corrective** – strategies that are designed to respond to the impact if risk occurs.
  - Focus on the impact
  - Reduces impact

For all mitigating strategies identify the following:

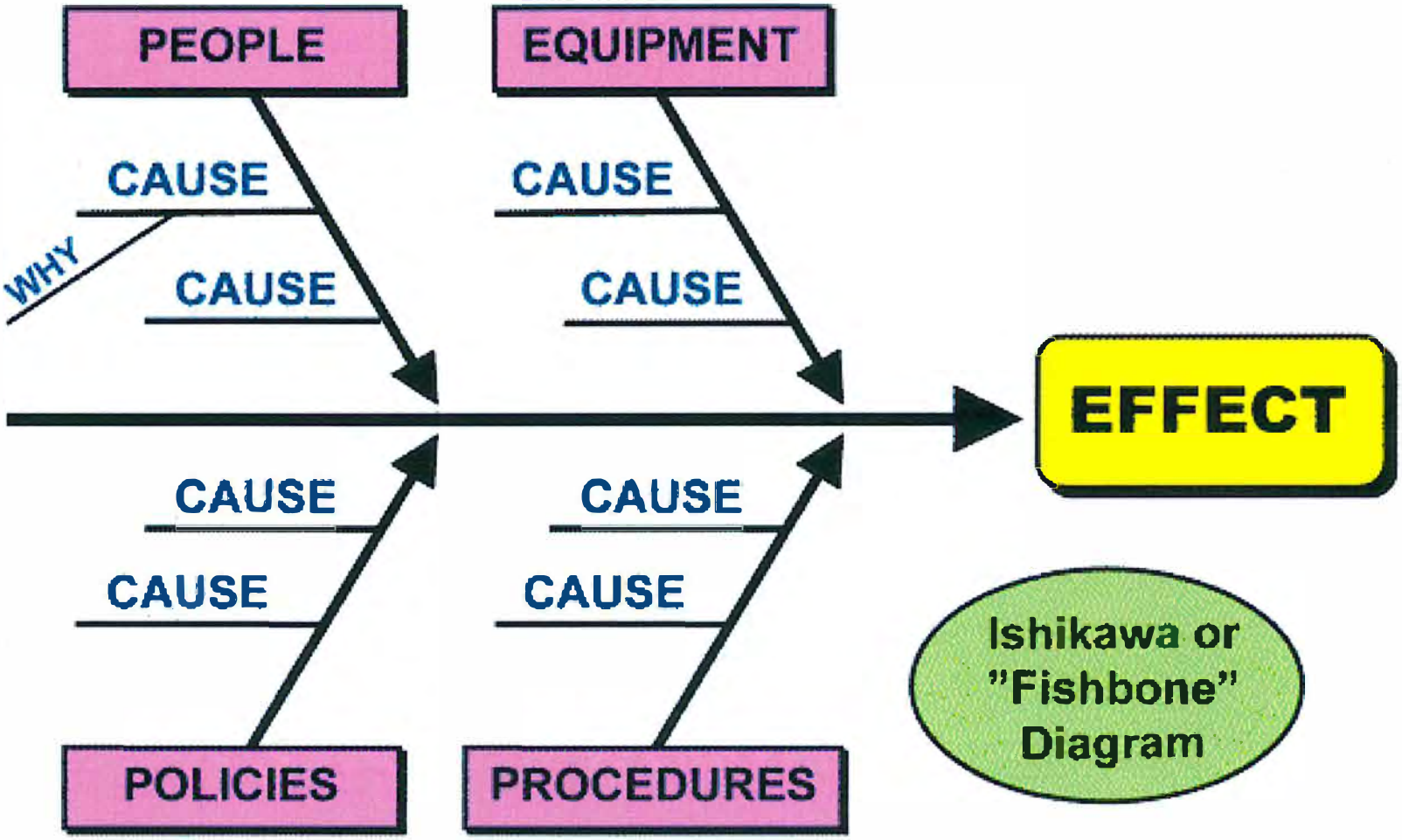
- Risk owner
- Partners involved in the strategy and how
- Timelines established for the desired action

… and Take Action

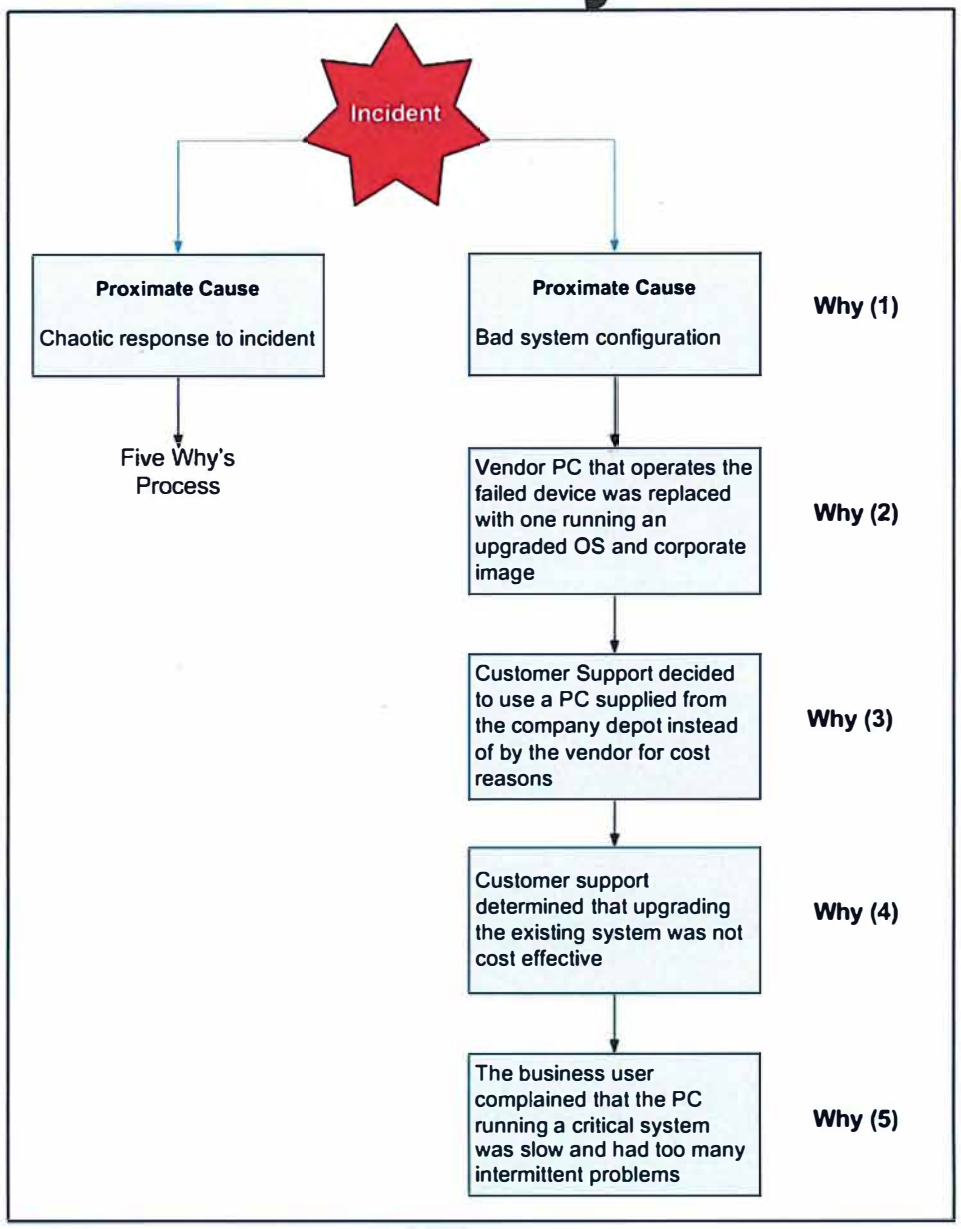
Communicate, Learn & Improve



Root Cause Analysis



Ask 5 Whys


Incident
Proximate Cause
Chaotic response to incident
Five Why's Process
Proximate Cause
Bad system configuration
Why (1)
Vendor PC that operates the failed device was replaced with one running an upgraded OS and corporate image
Why (2)
Customer Support decided to use a PC supplied from the company depot instead of by the vendor for cost reasons
Why (3)
Customer support determined that upgrading the existing system was not cost effective
Why (4)
The business user complained that the PC running a critical system was slow and had too many intermittent problems
Why (5)


CAUTION
THIS SIGN HAS
SHARP EDGES
DO NOT TOUCH THE EDGES OF THIS SIGN
ALSO, THE BRIDGE IS OUT AHEAD
found on UBERPIX.net

Step 5: Monitor & Report the Risks

- Monitor the status of risks and action plans and measure the effectiveness of actions, revising as necessary.
- Share relevant risk-related information on a timely basis via regular reporting to the appropriate parties
- Report risks through the budgeting process and in-year reporting, as required.
- Learn from experience and foster a pro-active risk-responsive approach to decision making.

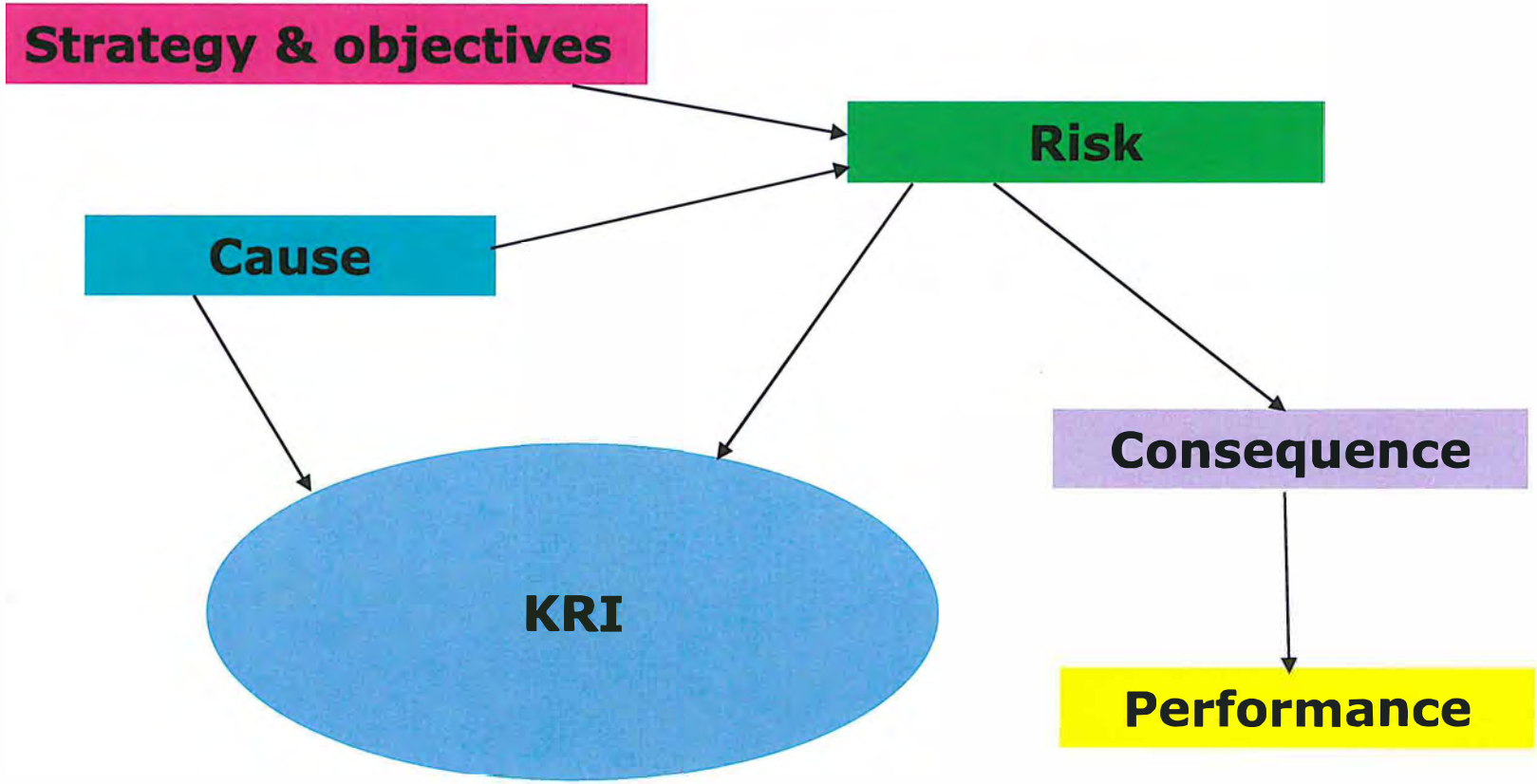
Risk Reporting & Communication

Risk Level – Determine Urgency	Action and Level of Involvement Required		
	Leadership within PHU	**Board**	**MOHLTC and other external parties**
High Risk **(Mitigate, Escalate and Report)**	• Risk mitigation and monitoring required – determine ownership and approve action plan • Assess exposure and likely effectiveness of mitigation (consider timing and impact) • Inform the board and others as per protocol • Develop a communication strategy if appropriate	• Risk mitigation required – determine ownership and approval • Discuss with Chief Executive Officer and Board of Directors • Inform ministry immediately	• To be reported as per agreements between parties.
Medium Risk **(Mitigate, Escalate and Report)**	• Risk mitigation and monitoring MAY be required – determine ownership and approve action plan • Assess exposure and likely effectiveness of mitigation (consider timing) • Inform the board and others as per protocol • Develop a communication strategy if appropriate	• Management mitigation and ongoing monitoring required • Inform ministry in regular reporting	• To be reported as per agreements between parties.
Low Risk	• Accept and monitor • Manage by routine procedures • Inform the board as per protocol	• Accept and monitor • Inform ministry in regular reporting	• To be reported as per agreements between parties.

Monitoring and Reporting Risk

- Show genuine interest
- Go on site
- Request proof/demonstration
- Observe it
- Test / Verify it
- Ask questions
- Share information & discuss with others
- Look for supporting/contradictory evidence
- Learn about the risk
- Document it
- Stay focused on the objectives

Key Risk Indicators (KRIs) are linked to strategy, performance and risk



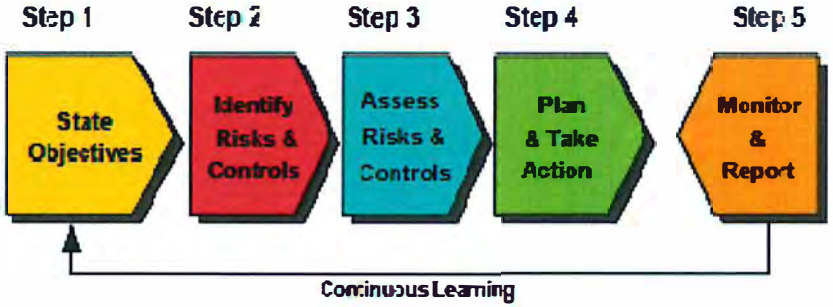
KRIs need to be linked to strategy, objectives and target performance levels, with a good understanding of the drivers to risk.

EXAMPLES OF KRIs

Human resource • Average time to fill vacant positions • Staff absenteeism /sickness rates • Percentage of staff appraisals below "satisfactory" Age demographics of key managers	**Information Technology** • Systems usage versus capacity • Number of system upgrades/ version releases • Number of help desk calls	**Finance** • Daily P&L adjustments (#, amt) • Reporting deadlines missed (#) • Incomplete P&L sign-offs (#, aged)
Legal/compliance • Outstanding litigation cases (#, amt) • Compliance investigations (#) • Customer complaints (#)	**Audit** • Outstanding high risk issues (#, aged) • Audit findings (#, severity) • Revised management action target dates (#)	**Risk management** • Management overrides • Limit breaches (#, amount)

Integrated Risk Management Quick Reference Guide

The OPS risk management process



Step 1: State (or establish) objectives

- Define context and confirm objectives
- Risks must be assessed and prioritized in relation to the objective
- The more specific the objectives (specific goals, key milestones, deliverables and commitments) the easier it is to assess potential risks
- Risks can be assessed at any level; operational, program, initiative, unit, branch, health system

Risk (uncertainty)
The chance that a future event will impact the achievement of established objectives. Risks can be positive or negative.

Control / Mitigation Strategy
Controls/ mitigation strategies put in place by management to minimize negative risks or maximize opportunities.

Consequences

- Identify the specific consequences of each risk, if the risk in fact occurred
- Consider and quantify consequences in relation to cost, quality, time, etc.

Cause/Source of Risk

- Understand the cause/source of each risk
- Use a cause/effect diagram

Step 2: Identify risks & controls

Identify risks - What could go wrong?

- Always use the 13 categories of risk
- Examine trends and consider past risk events
- Obtain information from similar organizations or projects
- Brainstorm with colleagues and/or stakeholders
- Increase awareness of new initiatives/ agendas and regulations, consider interdependencies
- Document short-term and long-term consequences for each risk (consider interdependencies)

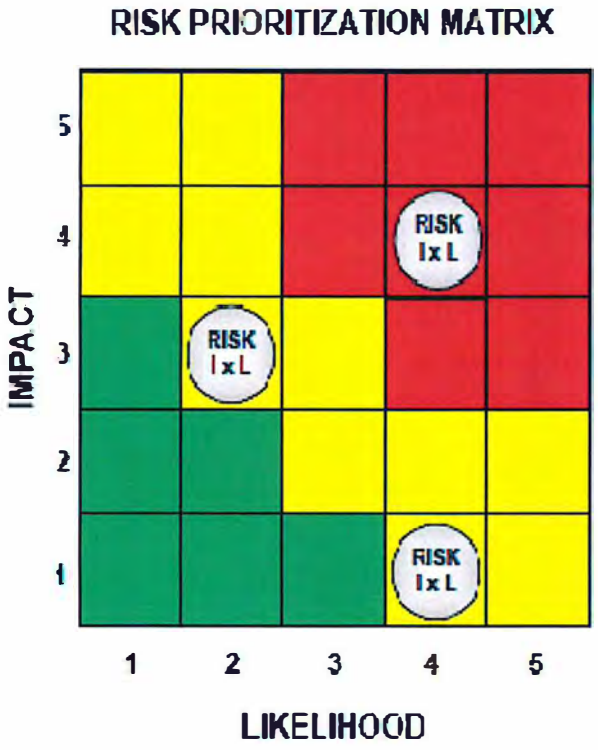
Identify existing controls – What do you already have in place?

- Preventative controls (address causes and source of risk)
- Corrective / Recovery controls (focuses on reducing impact after risk has occurs)

13 categories of risk

RISK	DESCRIPTION
Compliance/ Legal	Uncertainty regarding compliance with laws, regulations, standards, policies, directives, contracts; may expose the ministry to the risk of fines, penalties, litigation.
Equity	Uncertainty that policies, programs, services will have an equitable impact on the population.
Financial	Uncertainty of obtaining, using, maintaining economic resources; meeting overall financial budgets/commitments; preventing, detecting or recovering fraud.
Governance / Organizational	Uncertainty of having appropriate accountability and control mechanisms such as organizational structures and systems processes; systemic issues, culture and values, organizational capacity, commitment, and learning and management systems, etc.
Information / Knowledge	Uncertainty regarding the access to or use of accurate, complete relevant and timely information. Uncertainty regarding the reliability of information systems.
Operational or Service Delivery	Uncertainty regarding the performance of activities designed to carry out any of the functions of the ministry/unit, including design and implementation.
People / Human Resources	Uncertainty as to the ministry's/ business unit's ability to attract, develop and retain the talent needed to meet its objectives.
Political	Uncertainty of the events may arise from or impact any level of the government including the Offices of the Premier or Minister, e.g. a change in government political priorities or policy direction
Privacy	Uncertainty with regards to the safeguarding of personal information or data, including identity theft or unauthorized access.
Security	Uncertainty relating to physical or logical access to data and locations (offices, warehouses, labs, etc).
Stakeholder / Public Perception	Uncertainty around the expectations of the public, other governments, media or other stakeholders; maintaining positive public image; ensuring satisfaction and support of partners.
Strategic / Policy	Uncertainty that strategies and policies will achieve required results or that policies, directives, guidelines, legislation will not be able to adjust as necessary.
Technology	Uncertainty regarding alignment of IT infrastructure with technology and business requirements. Uncertainty of the availability and reliability of technology.

V2



Step 3: Assess Risks & Controls

Assess inherent risks

- *Inherent likelihood* – Without any mitigation, how likely is this risk to occur?
- *Inherent impact* – Without any mitigation, how big will be the impact of the risk on your objective?
- *Inherent Risk Prioritization* - Rate inherent likelihood, impact and proximity of the risk.
- *Risk Owner* - Identify the specific person accountable if the risk occurs. Involve Risk Owner if not already involved.

Assess existing controls

- *Controls* - Evaluate the effectiveness of existing mitigaton strategies.
- *Control Owner* - Identify the person accountable for implementing specific control. Involve Control Owner if not already involved.

Reassess residual risks

- *Residual likelihood* – With existing mitigation strategies in place, how likely is this risk to occur?
- *Residual impact* – With existing mitigation strategies in place, how big an impact will this risk have on your objective?
- *Residual Risk Prioritization* - Re-assess the impact, likelihood and proximity of the risk with mitigation strategies in place.
- Use the 'Risk Assessment Worksheet' available through the Integrated Risk Management Team.

Rating Scale

VALUE	LIKELIHOOD	IMPACT	PROXIMITY	SCALE
1	Unlikely to occur	Negligible impact	More than 36 months	*Very Low*
2	May occur occasionally	Minor impact on time, cost or quality	12 to 24 months	*Low*
3	Is as likely as not to occur	Notable impact on time, cost or quality	8 to 12 months	*Medium*
4	Is likey to occur	Substantial impact on time, cost or quality	Less than 8 months	*High*
5	Is almost certain to occur	Threatens the success of the project	Now	*Very High*

Step 4: Plan & Take Action

- For each of the 13 risk categories establish risk appetite and tolerances with senior management.
- Assess existing mitigaton strategies have reduced the risk rating (Impact x Likelihood) so that the risk is below approved risk tolerance levels.
- Evaluate whether further mitigation strategies are needed.
- Develop SMART (Specific, Measurable, Achievable, Realistic, Time-specific) actions that will either reduce the likelihood of the risks or minimise the impact.
- Develop detailed action plans with timelines, responsibilities and outline deliveries.
- Use the 'Action Plan Worksheet' available through the Integrated Risk Management Team.

Step 5: Monitor & Report

- Ensure processes are in place to review risk levels and the effectiveness of mitigation strategies
- Use risk indicators
- Monitor and report by asking:
  - Have risks changed? How?
  - Are there new risks? Assess them.
  - Do you need to report or escalate risks? To whom? When? How?
- The Integrated Risk Management Team can help you establish monitoring processes.

Key Risk Indicators (KRI)

- *Leading Indicators* - Early or leading indicators that measure sources or causes to help prevent risk occurrences
- *Lagging Indicators* - Detection and performance indicators that help monitor risks as they occur

Risk Tolerance

- The amount of risk that the entity can manage for the area being assessed.

Risk Appetite

- The amount of risk that the entity is willing to manage for the area being assessed.

TAKE SMALL BITES.....

In summary . . .

- **Risk is uncertainty**
- **Risk includes both threats and opportunities to our objectives**
- **Risk is everywhere - and we are already managing risk**
- **Risk can be shaped and transformed, but not totally eliminated**
- **Risk Management is a systematic approach for dealing with uncertainty**
- **Risk Management is useful at home and on the job**
- **Risk Management is a key component in good management**
- **Everyone has a responsibility to manage risk.**

SOME RISK QUESTIONS .....LOOKING FOR ANSWERS

- Do we understand our risks? Do we know what is causing our risks to increase, decrease or stay the same?
- Have we assessed their likelihood and impact of our risks?
- Have we identified the sources and causes of our risks?
- How well are we managing our risks?
- Are we trying to prevent the downside risks from happening? Are we trying to simply recover from them?
- Who is accountable for these risks?
- How do we talk about risk? Do we have a common language across branches, across divisions, across the Ministry, across the OPS?
- Are we taking too much risk? Not enough risk? Are the right people taking the right risks at the right time?
- What's our culture? Are we risk adverse or are we risk-takings? Or somewhere in between?

Where are we and next steps……..

- **Have been working with KFLA Public Health to:**
  - **Develop and start to implement a vision and plan for RM**
  - **Develop a RM policy for Board approval**
  - **Identify an internal working group that identified top risks and recommended mitigation strategies from an agency perspective (program risks not yet integrated). Validated with Board**
- **Presented RM to alPHa session to Board members**
- **Established a small working group from interested PHUs to work on a plan on how to roll out RM across PHU (first meeting January 25 2016). Supported by alPHa.**

Questions and Comments

Appendix

Organizational Standard Requirements

3.1 Board of Health Stewardship Responsibilities: the Board of Health shall provide governance direction to the administration and ensure that the board remains informed about the activities of the organization on the following:

- The delivery of the OPHS and its Protocols;
- Organizational effectiveness through evaluation of the organization and strategic planning;
- Stakeholder relations and partnership building;
- Research and evaluations, including ethical review;
- Compliance with all applicable legislation and regulations;
- Workforce issues, including recruitment of the MOH and any other senior executives (i.e., CEO where applicable);
- Financial management, including procurement policies and practices; and

Organizational Standard Requirements

4.2 Board Of Health Member Orientation And Training: the Board of Health shall ensure that board of health members are aware of their roles and responsibilities and emerging public health issues and trends by ensuring the development and annual implementation of a comprehensive orientation plan for new board members and a continuing education program for continuing board members.

Orientation and continuing education activities shall occur on an on-going basis and shall include information on the following topics:

- board members' fiduciary responsibilities in terms of trusteeship, due diligence, avoiding conflict of interest, maintaining confidentiality, strategic oversight, ethical and compliance oversight, stakeholder engagement, MOH (and executive officers, where applicable) compensation, **risk management oversight** and succession planning;

6.2 Risk Management : the Board of Health shall ensure that the administration monitors and responds to emerging issues and potential threats to the organization, from both internal and external sources, in a timely and effective manner. **Risk management** is expected to include but is not limited to: financial risks, HR succession and surge capacity planning, operational risks, and legal issues

Accountability Agreement states that:

- **Governance.** The Board of Health represents, warrants and covenants that it has, and shall maintain, in writing, for the period during which the Agreement is in effect: strategies, policies, and/or procedures to enable the **timely identification of risks** to the Board of Health's ability to perform its obligations under this Agreement and **mechanisms/strategies to address the identified risks**;

- **Performance Improvement.** The Parties agree to adopt a proactive and responsive approach to performance improvement ("Performance Improvement Process"), based on the following principles: **a focus on risk-management**

- **Emergency Preparedness Program Standard**

- **Public Health Emergency Preparedness**

Board of Health Outcomes

- The board of health has enhanced risk-based emergency planning and programming to guide ongoing board of health preparedness efforts.

- The board of health has effective risk-based emergency response capability and clearly defined public health roles and responsibilities in an emergency.

Agenda Item #5

Ontario

Community Health Capital Programs (CHCP) Policy

Orientation for Public Health Units (PHUs)

Health Capital Investment Branch (HCIB)

Health Capital Division, Ministry of Health and Long-Term Care

January 20, 2016

Context for Change

- Historically, the Ministry has funded capital investments in various sectors using different policies and processes. Challenges for community projects have been created by inconsistencies in funding policies and process across different areas of the Ministry.
- In response to stakeholder feedback expressing a need for an expedited and more flexible process, the ministry drafted a unified policy framework for all community health capital investments and consulted with existing and new stakeholder sectors and associations to obtain feedback.
- The revised policy expands project eligibility criteria, provides consistent capital cost share and space standards, and expedites the capital planning and implementation process.
- We are also ensuring alignment with the Premier's Advisory Committee on Community Hubs and are working closely with CO, who is leading the work to create an implementation framework for proposals with inter-ministerial linkages.

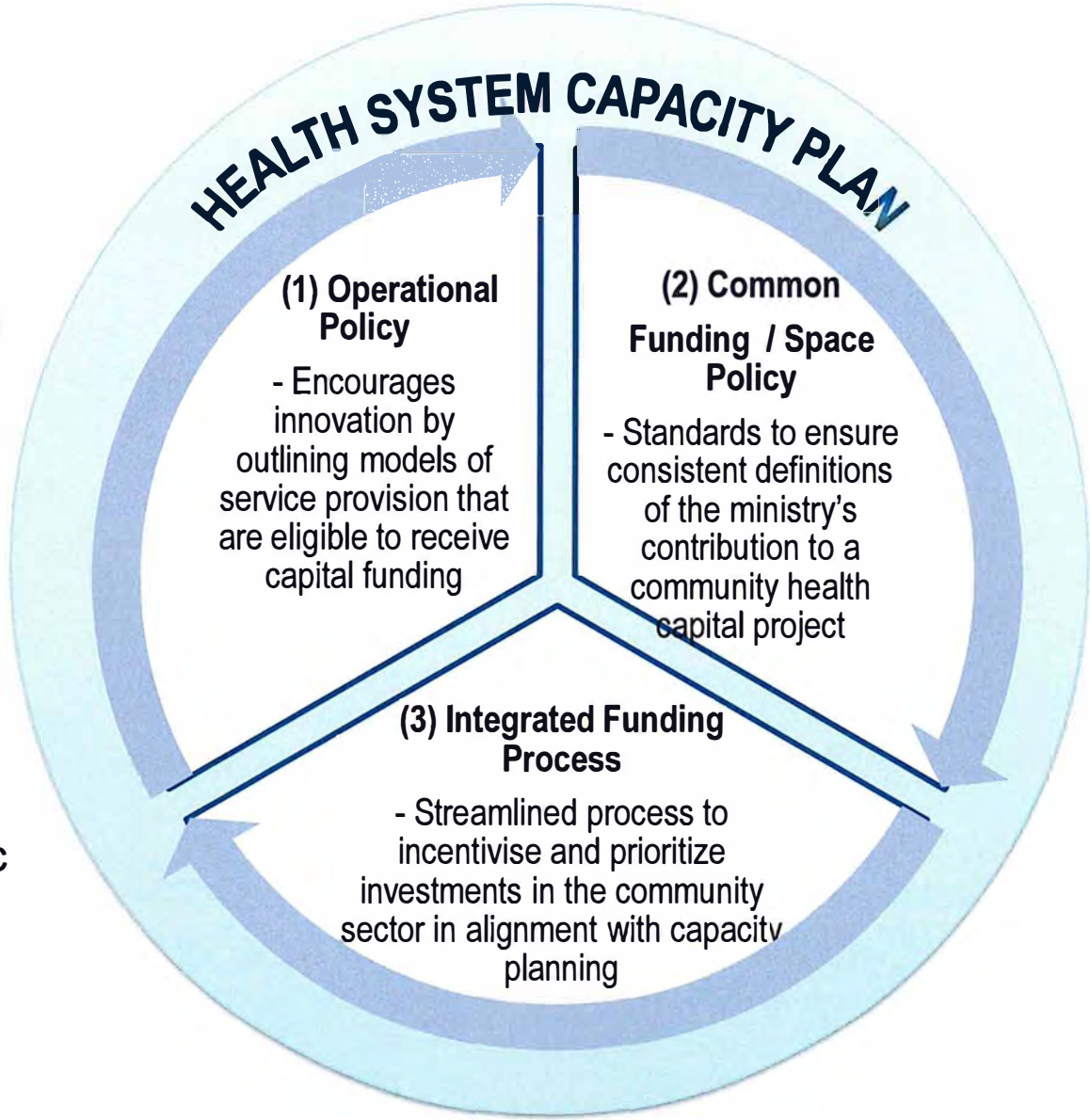
Agenda

- Overview of Community Health Capital Programs (CHCP) Policy
  - Operational Policy
  - Common Funding and Space Policies
  - Integrated Funding Process
- What is the Same and What is Different for PHU?
- Tools and Supportive Documents
- Training and Implementation Timelines
- Questions
- Appendices

Community Health Capital Program (CHCP) Overview

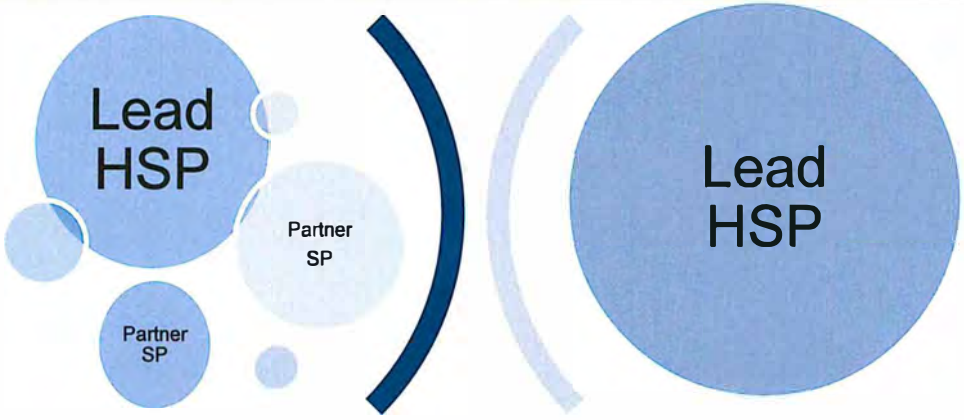
- The CHCP policy contains three key components:
  1. A framework to define appropriate operational models of care;
  2. Consistent capital funding policies and common space standards; and
  3. A streamlined and integrated funding process.

- The CHCP policy outlines overarching principles in these three areas and references more detailed program-specific guidelines and policies as needed.



1. Operational Policy

Integrated Model



Single-Provider

- To facilitate investment, eligibility expressed through criteria, rather than sector:

1. Lead HSP fulfils all Single-Provider Criteria
2. Operational linkages between Lead HSP and Partner SPs such as:
    1. consolidation of back-office functions and/or demonstration of outcomes;
    2. consolidation of patient care pathways;
    3. establishment of a co-located centre to address a specific need
3. Operational costs of service delivery and facility cost have been secured by all Partner SPs

Increasing integration

1. **Organization Type**: provides health services and is not-for-profit;
2. **Operational Funding:** ongoing funding relationship from the ministry/its agencies that accounts for a minimum of 50% of the HSP's operating budget;
3. **Operational Oversight**: clearly defined accountability structure within the Ministry; and
4. **Endorsement:** the LHIN and / or the accountable area within the Ministry have endorsed the operational model / project proposal

2. Common Funding and Space Policies

To ensure consistency in implementation, common, flexible standards have been established in response to concerns from the community sector:

- The draft CHCP space standards provide flexibility through encouragement of multi-purpose space and eligibility for ministry to fund space for non-MOHLTC funded programs that meet specified criteria
- The CHCP cost share guidelines will provide criteria for funding capital investment to support federal/municipal/charitable funded programming; and
- Proposed space allowances will provide for additional 200 sq. ft. for shell and fit out of space for hoteling work stations for other organisations, 200 sq. ft. for shell space for health related retail providers (e.g. dispensing pharmacy) and 50 sq. ft. for retail vending machines where there are contracts for minimal 5 years tenancy

3. Integrated Funding Process

- To streamline implementation of approved projects a common application form is being developed:
  - The common application form will be submitted by the HSP to its accountable area in the ministry, at which point the appropriate implementation path can be determined.
  - All information that is necessary to complete early planning stages will be submitted through the common application form;
  - The accountable area will endorse the proposal, and will oversee approval / implementation. HCIB will oversee budgeting and payment through one of the three potential funding streams.

What is the Same and What is Different For PHU

Item	Same	Different
Applications for Capital Project Funding	PHU continues to send applications to current contacts in Population and Public Health Division	There will be a new standardized Application Form used by all branches in the ministry, beginning in the 2017 fiscal year
Funding for Projects	Approved projects will be ministry funded for eligible costs	Eligible costs will be defined by the standardized "Community Health Service Provider Cost Share Guide" Funding source will be capital funding vs. operating funding Infrastructure projects will be funded through the Community Infrastructure Renewal Fund (CIRF) Program NOTE: For 2016 PHU will use the Program-Based Grants process

What is the Same and What is Different for PHU (con't)

Item	Same	Different
Planning and Implementation of of Capital Projects	PHU continues to manage projects in consultation with Population and Public Health Division	For larger, more complex projects there will be a set of standardized planning tools used across all branches in the ministry Space allocation standards will be standardized through the tools and use of the "Space Planning Guide for Community Health Service Providers" There will be the opportunity for technical review of project plans by HCIB staff on an "as requested" basis
Settlement	Each project will require a Settlement process once completed	Same as current process

CHCP Tools and Supportive Documents

The following are the core Tools and Supportive Documents for the CHCP:

1. CHCP Policy
2. CHCP Toolkit
3. CHCP Toolkit Instruction Guide
4. Community Space Standards for Community Health Care Facilities
5. Community Health Service Provider Cost Share Guide

Training and Implementation Timelines

- The Health Capital Investment Branch will be working with the Public Health Standards, Practice and Accountability Branch to schedule detailed training sessions for PHUs in **February / March 2016**.
- This training will include all information needed to prepare applications for Integrated Model or Single Service Provider model projects.

Questions?

Further inquiries can be sent to
HealthCapitalInvestmentBranch@ontario.ca

Agenda Item #6

Ontario

Integrated Healthy Smiles Ontario 2016 Funding Approach

Program-Based Grants Training Session

January 20, 2016

Purpose

- Review the intent of the integrated Healthy Smiles Ontario (HSO) commitment, including which programs and benefits have been integrated as of January 1, 2016.
- Review the work undertaken to date by the ministry and PHUs to determine costs associated with previous oral health programs that have integrated into HSO.
- Further clarify the ministry's intended approach for 2016 HSO funding.
- Outline next steps and proposed timelines.

Overview of the Integrated HSO Program

- As of January 1st, 2016, the following oral health programs/benefits for children and youth from low income families were integrated into one program, now known as Healthy Smiles Ontario (HSO):

  - Dental benefits provided through Ontario Works (including Temporary Care Assistance but excluding Emergency Assistance);
  - Dental benefits provided through the Ontario Disability Support Program (ODSP);
  - Dental benefits provided through the Assistance for Children with Severe Disabilities (ACSD);
  - Healthy Smiles Ontario (HSO);
  - Children in Need of Treatment (CINOT); and
  - Preventive services within the *Ontario Public Health Standards (OPHS), 2008.*

Overview of the Integrated HSO Program, Cont'd

The HSO program is:

- Live as of January 1, 2016 with the requirements that are expected of PHUs/boards of health outlined in a new *HSO Protocol, OPHS, 2016*.*
  - For public health units, these requirements largely reflect requirements that were previously articulated for the respective oral health programs with the exception of a role in claims processing and payment.

- An amalgamation of existing programs. As such, funding associated with programs that have been integrated is required to support the new integrated HSO program.

- 100% provincially funded.
  - Funding for other oral health requirements within the Child Health Standard of the OPHS that have **not** been integrated, e.g. *Oral Health Assessment and Surveillance Protocol* (school screening), will remain within cost-shared budgets for public health units.

**pending Minister approval*

Ontario

Need for Greater Data on Oral Health Funding

- Prior to the *Oral Health Information Request Tool (Tool)* completed in the Summer of 2015, the ministry had little specific financial data on oral health programming at the local level.
  - HSO and CINOT Expansion programs budgets were allocation based, with other oral programming costing embedded within the mandatory programs' budgets.

- In order to better estimate costs associated with oral health programming and support integration, the ministry and PHUs worked to separate the various costs incurred for delivery of oral health programming.

- For the former HSO, CINOT and CINOT Expansion, OPHS Preventive, Social Assistance (if applicable) programs/benefits, as well as all other oral health protocols/programming, the *Tool* requested the following:
  - Staffing costs incurred for specific staff responsibilities (called service roles in the *Tool*) in both oral health clinic and non-clinic settings; and
  - Overhead costs incurred for supporting various programming elements in both oral health clinic and in non-clinic settings.
  - Bill-back revenues earned by various programs from the loaning of the resources of that program to another.
  - Direct payment to fee-for-service (FFS) providers.

Need for Greater Data on Oral Health Funding, Cont'd

Financial Knowledge Related to Oral Health Programming as Reported by PHUs Through Quarterly Reports and PBG						
Before *Tool*		**After *Tool***				
Mandatory Programs and CINOT Expansion	HSO	OPHS Preventive	CINOT and CINOT Expansion	HSO	Social Assistance (if Applicable)	Other Oral Health Programming
One figure that included all clinic and non-clinic staffing and overhead costs, bill-back revenues, and FFS costs for: • OPHS Preventive. • CINOT • CINOT Expansion. • Social Assistance cohorts (if applicable). • Other oral health programming (e.g. screening and surveillance).	Approximate spend on the following categories: • Salaries and benefits for dental care providers, administration staff, and oral health staff. • All admin or overhead expenses, regardless where incurred. • FFS costs. • Revenue from bill-back.	• Staffing costs incurred in clinics and non-clinic settings for the following : delivery of clinical services, screening and surveillance, oral health promotion and education, referral to services, program promotion, client enrolment, case management, claims administration, program management, reporting and evaluation, and general administration. • Overhead costs incurred in clinics and non-clinic settings for the following: building occupancy, staff travel, equipment, staff training and personal development, materials and supplies for the provision of preventive and treatment services, materials and supplies to support non-clinical activities, professional and purchased services, communication costs, information and information technology equipment and other I/IT costs, and general administration. • Exact FFS costs (i.e. only funds that have been flowed to FFS providers and not other purchased services costs). • Revenue from bill-back for all programs.				

As a result of the *Tool* exercise, the ministry has a better understanding of local level oral health costs that need to be considered as part of integrated HSO at 100%, and oral health costs that will remain within cost-shared mandatory budgets.

Ontario

2016 PBG Budget Instructions for HSO and Oral Health Programming

As previously communicated, using the *Tool* data and relevant information from the validation exercise of the *Tool*, the ministry plans to:

- Reduce cost-shared budgets and HSO budgets to reflect the amount of funding previously associated with direct claims payments;
- Transfer relevant oral health programmatic funding from cost-shared budgets and into a new HSO budget allocation (to be funded at 100%).

Impacts for 2016 cost-shared budgets:

- Claims payment amounts as validated by the ministry and PHUs to be **reduced** in cost-shared budgets for the former CINOT/CINOT Expansion programs and OPHS Preventive (if applicable) at the cost-shared ratio indicated by PHUs during validation discussions.

- Oral health programmatic funding, as reported in the *Tool* for the former OPHS Preventive and CINOT/CINOT Expansion programs will be **reduced** from cost-shared budgets at the cost-shared ratio and **transferred at 100%** into new HSO budget allocations.

2016 PBG Budget Instructions for HSO and Oral Health Programming

- PHUs are not required to submit a budget for the integrated HSO program as part of the 2016 PBG submission process, however **PHUs should continue to budget for oral health activities that have not been integrated, e.g. Oral Health Assessment and Surveillance, etc.)**
  - This may also include costs associated with population based approaches or services to non-eligible HSO clients such as universal fluoride varnish initiatives.

- 2016 will continue to be a transitional year, with robust monitoring, reporting, and dialogue with all delivery partners of the HSO program, including program and financial staff at PHUs.

- An in-year one-time funding request for extraordinary transition-related costs for HSO is anticipated later in 2016.

Next Steps and Timelines

HSO Program

- January - Validation exercise to be completed.

- February - communicate recommended HSO allocations, and reporting requirements to public health units.

- To support the monitoring of the program, data and metrics on various programmatic and financial aspects will be collected from all delivery partners including PHUs throughout 2016 on a quarterly and/or monthly basis. **2016 remains a transitional year.**

Thank you. Questions?

Ontario

2016 Program-Based Grants Process

2016 Program-Based Grants Training Session
Population and Public Health Division, MOHLTC
January 20, 2016

Agenda Item #7

Ontario

Purpose

- To provide an overview of the 2016 Program-Based Grants (PBG) process, including:
    - Background and context on public health funding;
    - 2016 PBG User Guide; and,
    - Next steps.

Background/Context:

Legislative Framework

- It is the duty of a board of health to provide or ensure the provision of public health programs and services as required by the *Health Protection and Promotion Act* (HPPA) and Ontario Public Health Standards (OPHS).
  - Part of the responsibility of a board of health includes establishing the budget for the public health unit.

- Under section 72 of the HPPA, obligated municipalities are required to pay the expenses of boards of health and public health units.

- The ministry may make discretionary grants for the purposes of the HPPA, but is <u>not</u> legally obligated to do so (section 76 of the HPPA).

- Under section 81.2 of the HPPA, the Minister may enter into an agreement with the board of health for the purpose of setting out requirements for the accountability of the board.

Background/Context:
Provincial Policy Framework

- In practice, the ministry has historically provided base and one-time funding to board of health for the provision of public health programs and services.

- Funding for mandatory programs/OPHS has historically been cost-shared between the ministry and obligated municipalities and the cost-sharing arrangement has changed over the years (see **Appendix 1** for timeline).
  - The ministry currently cost-shares the expenses of boards of health with municipalities for the delivery of mandatory programs at 75% of the ministry approved allocation.

- The ministry also provides 75% and 100% funding for a number of other related programs and initiatives delivered by boards of health.

- Ministry funding to boards of health is based on provincial review of budget submissions from boards of health and Minister's approval.
  - If the board of health's approved budget exceeds the ministry's approved funding, then the obligated municipalities are responsible for the additional expenditures.

Background/Context:
Accountability Requirements

- A signed formal, legal agreement is required between a board of health and the ministry as a condition of funding approval.

- Ministry funding for mandatory and related programs is governed by an evergreen Public Health Funding and Accountability Agreement (the "Accountability Agreement"), which came into effect on January 1, 2014 and sets out the obligations of boards of health and the ministry.
  - The Accountability Agreement incorporates financial reporting requirements, performance indicators, and continuous quality improvement tools.

- The Accountability Agreement will remain in effect unless terminated according to the specific articles of the Accountability Agreement.
  - The Accountability Agreement will be reviewed every five (5) years to determine if amendments are required.

- Amendments during the term are made to the Schedules to reflect updated allocations, new policies and guidelines, new reporting requirements, and updated performance indicators, baselines and targets.

Background/Context:
Accountability Requirements (cont'd)

- Key provisions in the Accountability Agreement include:

Provisions	Description
Grant (Article 4)	Provincial grant provided for the purposes of carrying out obligations in the HPPA, OPHS, Ontario Public Health Organizational Standards (the "Organizational Standards"), and Accountability Agreement.
Performance Improvement (Article 5)	Sets out the elements of the performance improvement process and provisions for performance and compliance reporting.
Reporting, Accounting, and Review (Article 8)	Requires boards of health to submit reports to the province and authorizes the ministry to conduct an inspection, audit, or investigation of boards of health.
Schedules (Article 27)	• **Schedule A** specifies the grants allocated by the ministry to boards of health. • **Schedule B** specifies financial policies and guidelines for each of the related programs funded under the Accountability Agreement. • **Schedule C** sets out reporting requirements for both financial and performance. • **Schedule D** requires performance measurement against identified indicators and targets. • **Schedule E** sets out requirements for boards of health regarding internal financial controls.

Background/Context:
Accountability Requirements (cont'd)

Quarterly Financial Reports:

- Required for each of four (4) quarters – due one (1) month after quarter ends.
- Once available, boards of health are required to incorporate actual expenditures as well as the approved ministry funding for mandatory and related programs in their quarterly financial reports.

Annual Reconciliation Report:

- Boards of health are required to submit one (1) Annual Reconciliation Report for funding provided for mandatory and related programs.
- The 2015 and 2016 Annual Reconciliation Reports are currently due to the ministry no later than April 30, 2016 and April 30, 2017, respectively.

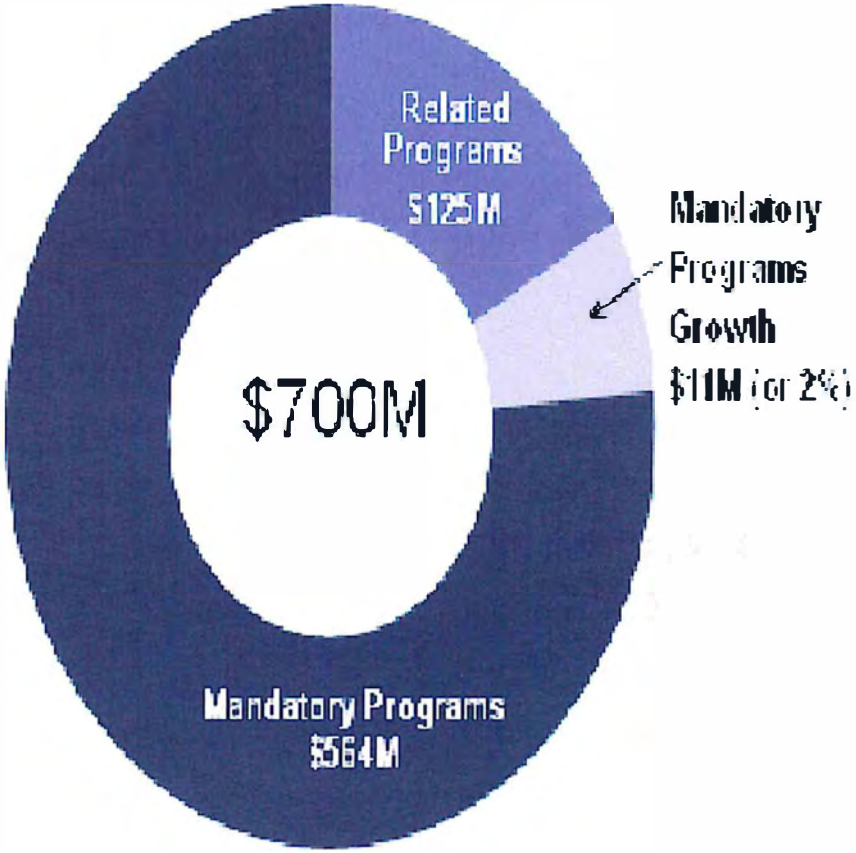
Other Financial Reports:

- Other financial reports include, but are not limited to: Apportionment of Board of Health Costs, Collective Agreement Information, and Board of Health Financial Controls Checklist.

The ministry may withhold 1% of bi-weekly mandatory program payments from boards of health if their Quarterly Financial and Annual Reconciliation Reports are not submitted by the deadline, until such time as they are provided.

Background/Context:
2015 Provincial Investments

- In 2015, the ministry invested a total of $700 million for boards of health for the delivery of mandatory programs ($575 million) and related programs ($125 million). See **Appendix 2** for a detailed breakdown of approvals for each program.
- In 2015, boards of health received up to $34 million in additional funding for the provision of mandatory and related programs.
- Since 2003, provincial funding for boards of health for mandatory and related programs has more than doubled (an increase of approximately $443 million or 170%), including both uploaded costs and increased investments in public health capacity.



Background/Context:

Fiscal Environment and 2016 Funding Direction

- The ministry is continuing to experience tight fiscal constraints, with increased scrutiny and expectations regarding value for public expenditures and investments.

- The Province is now forecasting revised deficits of $7.5 billion in 2015-16 and $4.5 billion in 2016-17.
  - The government remains committed to balancing the budget by 2017-18.

- For 2016, the ministry expects that board of health budgets will continue to recognize and incorporate the identified needs of their communities and will balance local priorities with the government's clear direction for fiscal restraint.
  - Boards of health are being encouraged to look for administrative efficiencies and to prioritize funding requests.

- For 2016 planning purposes, the ministry is continuing to advise all boards of health to plan for no growth funding for mandatory and related programs.

Background/Context:
Grant Review Process

- Key approaches for the 2016 Program-Based Grants (PBG) process:

    1. Need to demonstrate value for money – especially for mandatory and related programs.

    2. Increased emphasis on accountability for public funds.

    3. Minimal changes to the process and forms.

    4. Timely analysis and approvals.

    5. Completeness and data accuracy – increased consistency.

2016 PBG User Guide:

Objectives of the Guide

- Provide information on accountability requirements, including financial reporting requirements.
- Clarify and refine financial policies and eligibility guidelines.
- Incorporate feedback received from the sector on the 2015 process.
- Provide direction on completion of the PBG Request Template.

2016 PBG User Guide:

2016 Financial Cycle for Boards of Health

JANUARY 1 – MARCH 31

- **January 1st**
  - Start of board of health fiscal year
- **January**
  - Release of 2016 PBG budget submission package and supporting documentation
- **January 31st**
  - 2015 4th Quarter Financial Report (to December 31st) due to ministry
- **March 1st**
  - 2016 PBG Request and supporting documentation due to ministry
- **March 31st**
  - End of ministry fiscal year (2015-16)

APRIL 1 – JUNE 30

- **Spring**
  - 2016-17 Ontario Budget approved
- **April 1st**
  - Start of ministry fiscal year
- **April 30th**
  - 2015 Annual Reconciliation Report due to ministry
  - 2016 1st Quarter Financial Report (to March 31st) due to ministry

OCTOBER 1 – DECEMBER 31

- **October 31st**
  - 2016 3rd Quarter Financial Report (to September 30th) due to ministry
  - In-year one-time funding requests due to ministry
- **December 31st**
  - End of board of health fiscal year

JULY 1 – SEPTEMBER 30

- **July 31st**
  - 2016 2nd Quarter Financial Report (to June 30th) due to ministry
- **Summer**
  - 2016 PBG approvals

2016 PBG User Guide:
Key Changes – Accountability

- Key provisions in the Accountability Agreement have been added to the Guide, such as specific requirements of boards of health.

- Boards of health are required to submit a Financial Controls Checklist to the ministry; however, it is not required to be submitted through the 2016 PBG Request process.
  - Information pertaining to this requirement (including timing) will be communicated to boards of health at a later date.

- Boards of health are not required to submit a Building Occupancy Report to the ministry as part of the 2016 PBG Request process.

2016 PBG User Guide:

Key Changes – Mandatory Programs Policies and Guidelines

- Boards of health are not required to submit a Foundational Standard Implementation Plan to the ministry as part of the 2016 PBG Request process.

- The purchase of Electronic Medical Records (EMRs) continues to be a non-admissible expenditure. However, if an EMR was purchased with provincial dollars prior to 2013, the ongoing operating costs associated with the maintenance of that EMR are admissible expenditures.

- The ministry's fundraising policy, which does not permit the use of government funds to compensate staff time for fundraising, is only relevant to fundraising activities that are not directly related to the provision of public health programs and services as per the HPPA and Accountability Agreement.

- Accrual of sick time and vacation credits is not an admissible expense. Funding of these items will be considered only when these amounts are paid out.

2016 PBG User Guide:

Key Changes – Related Programs Policies and Guidelines

- **Chief Nursing Officer Initiative**: The ministry is enhancing the flexibility in the use of base funding for the Chief Nursing Officer Initiative. Base funding requested for this initiative must be used for Chief Nursing Officer related activities of up to or greater than 1.0 full-time equivalent (FTE).

- ***Electronic Cigarettes Act***: In 2016, funding for the implementation of the *Electronic Cigarettes Act* and enforcement activities has been incorporated into the PBG budget submission process.

- **Infection Prevention and Control Nurses Initiative**: The ministry is enhancing the flexibility in the use of base funding for the Infection Prevention and Control Nurses Initiative. Base funding requested for this initiative must be used for nursing activities of up to or greater than 1.0 FTE related to infection prevention and control activities.

2016 PBG User Guide:

Key Changes – Related Programs Policies and Guidelines (cont'd)

- **Infectious Diseases Control Initiative**: Support staff is now included in the list of positions eligible for base funding under the Infectious Diseases Control Initiative.

- **Integrated Healthy Smiles Ontario Program**: Information pertaining to the new Integrated Healthy Smiles Ontario Program has been added to the Guide. Given that 2016 will be treated as a transitional year, a 2016 PBG Request for the Integrated Healthy Smiles Ontario Program is not required at this time.

- **Social Determinants of Health Nurses Initiative**: The ministry is enhancing the flexibility in the use of base funding for the Social Determinants of Health Nurses Initiative. Base funding requested for this initiative must be used solely for the purpose of nursing activities of up to or greater than 2.0 FTE public health nurses.

2016 PBG User Guide:
Key Changes – One-Time Funding

- Boards of health will continue to have the opportunity to request one-time funding through the 2016 PBG Request process for a range of projects and initiatives that support the delivery of mandatory and related programs.

- Specific to information and information technology, in order to be considered for one-time funding, the project cannot include two (2) or more initiatives bundled together (e.g., purchase of two (2) unrelated software packages).

- The ministry will consider one-time funding requests (at 100%) from boards of health for minor capital infrastructure projects/accommodation costs through the 2016 PBG Request process.

- The ministry will consider one-time funding requests (at 100%) from boards of health for the period of January 1, 2016 to August 31, 2016 for extraordinary costs associated with the integration of pharmacists into the Universal Influenza Immunization Program.
    - This will be the final year that the ministry will consider one-time funding requests for this initiative.

2016 PBG User Guide:

Key Changes – PBG Request Template

- Previous year revised budget data is no longer included in the PBG Request Template. As such, the following forms have been removed from the 2016 PBG Request Template:
  - Form 9 – Explanation of Increases/Decreases for Mandatory Programs.
  - Form 10 – Summary by Object of Expense.

- All one-time requests require the completion of the One-Time Funding Request Business Case, which has now been embedded within the 2016 PBG Request Template.

- The 2015 approved base funding allocation (provincial share) for each board of health has been added to the PBG Request Summary by the ministry.

2016 PBG User Guide:

Other Noted Policies – Non-Admissible Expenditures

- Non-admissible expenditures are those considered by the ministry to be unrelated to the requirements of the OPHS, Organizational Standards, Accountability Agreement, and other requirements of the HPPA, and that are not compatible with applicable provincial government directives.

- Examples of non-admissible expenditures include, but are not limited to:
  - Administrative services on behalf of third parties;
  - Alcoholic beverages;
  - Capital fund reserves;
  - Depreciation on capital assets/amortization;
  - Donations to individuals or organizations;
  - EMRs;
  - Gym membership fees;
  - Harmonized sales tax;
  - Staff time for fundraising; and,
  - Sick time and vacation accruals.

2016 PBG User Guide:

Other Noted Policies – Municipal Charges

- Where services are provided by the municipality of which the public health unit is a part, a Memorandum of Understanding or Service Level Agreement is required with the municipality detailing the municipal charges.

- Municipal charges (e.g., accommodations, payroll, etc.) must not exceed those that would have been paid if the transactions were at "arm's length".

- May be subject to provincial audit or assessment.

2016 PBG User Guide:

Other Noted Policies – Procurement

- All procurement of goods and services should normally be through an open and competitive process.
- Section 6.8 of the Organizational Standards states that boards of health must comply with section 270 (2) of the *Municipal Act* which requires that boards of health shall adopt policies with respect to its procurement of goods and services.
- The Management Board of Cabinet's Procurement Directive is available on the Ministry of Government Services website (www.doingbusiness.mgs.gov.on.ca).
- Boards of health are not required to comply with the government's Procurement Directive.
- As boards of health receive substantial funding from the province, best practice and fiscal prudence would align the board of health's procurement policies with the procurement directive and with that of the relevant municipality as appropriate.

2016 PBG User Guide:

Other Noted Policies – Recovery of Surplus Funds

- Carry over of ministry transfer payment funding from one (1) calendar year to the next is not permitted unless pre-authorized by the ministry.
- Requests for extensions to expend one-time funding from December 31st to March 31st will only be considered with valid reasons.
- Given that base funding gets carried over from one (1) calendar year to the next through ongoing payments, the ministry does not consider requests to extend base funding expenditures.
- Funding not expended in-year will be recovered at 100% through adjustments to the board of health's cash flow.
- Recoveries related to prior years (i.e., not recovered in-year) must be returned to the Consolidated Revenue Fund by the ministry.

2016 PBG User Guide:
Other Noted Policies – Revenues

- All revenues collected by boards of health for programs and services provided under the Accountability Agreement must be reported in accordance with the direction provided in writing by the ministry.

- Revenues generated in the delivery of public health services include, but are not limited to:
  - User fees;
  - Revenue for specific programs;
  - OHIP billings;
  - Interest income; and,
  - Donations received.

- If interest income is not reported in the manner requested by the ministry, 1% of the board of health's cash flow may be withheld through future payments.

Next Steps

- Ministry staff will continue to work with boards of health and public health units to ensure that local and provincial priorities are taken into consideration in funding decisions.

- Provincial funding decisions on 2015 additional one-time funding will be made shortly.

- On January 27, 2016, the ministry is hosting the 2016 PBG Request Template training session (via web cast) for public health units.

- 2016 PBG budget submissions and supporting documentation are due to the ministry **no later than March 1, 2016**.

- 2016 funding decisions will be made once the ministry's budget is known and will be based upon available funding.
  - Target release of grants to field: July 2016!

Questions?

Ontario

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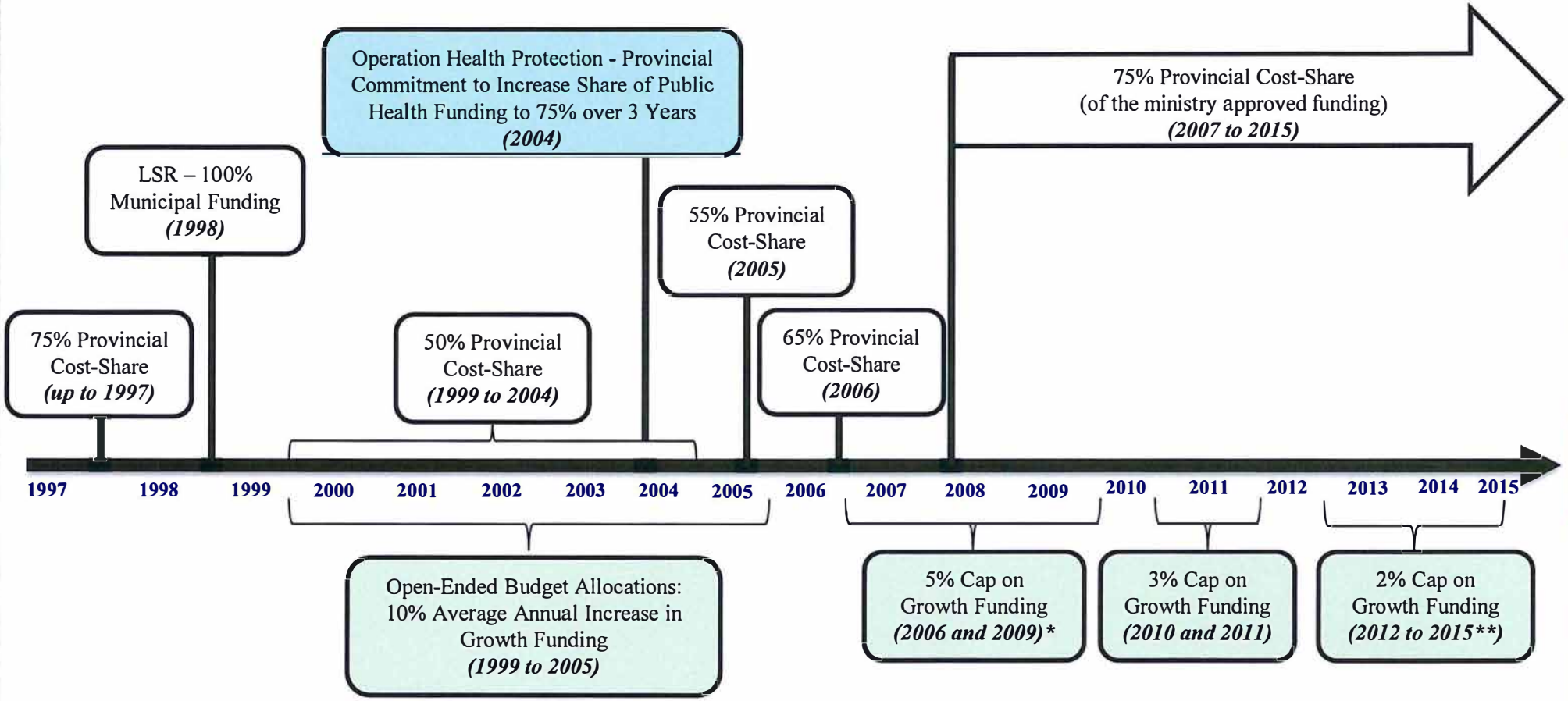
Appendix 1:
Mandatory Programs Funding Timeline



* In an effort to begin to address historical inequities, in 2008 and 2009, the 5% growth funding was divided between a 3% across-the-board increase to all boards of health for common cost drivers, and a 2% increase for population growth and low-income populations.

** In 2015, 2% growth funding was allocated proportionately to eight (8) boards of health based on a funding formula that takes into account population as well as equity measures.

Appendix 2:
Provincially Funded Public Health Programs

Programs / Initiatives	Cost-Sharing Arrangement (Provincial : Municipal)	2015 Approved Grants
Mandatory Programs/OPHS	75:25	**$575 million**
Related Programs		
Chief Nursing Officer Initiative	100:0	$4 million
Children In Need of Treatment Expansion Program	75:25	$3 million
Electronic Cigarettes Act	100:0	$3 million
Enhanced Food Safety – Haines Initiative	100:0	$2 million
Enhanced Safe Water Initiative	100:0	$1 million
Healthy Smiles Ontario Program	100:0	$32 million
Infection Prevention and Control Nurses Initiative	100:0	$3 million
Infectious Diseases Control Initiative (180 FTEs)	100:0	$20 million
Needle Exchange Program Initiative	100:0	$2 million
Panorama	100:0	$5 million
Small Drinking Water Systems Program	75:25	$2 million
Smoke-Free Ontario Strategy	100:0	$23 million
Social Determinants of Health Nursing Initiative	100:0	$7 million
Unorganized Territories	100:0	$6 million
Vector-Borne Diseases Program	75:25	$7 million
Other Grants (e.g., one-time projects)	Varies	$5 million
Related Programs Sub-Total		**$125 million**
GRAND TOTAL		**$700 million**

Notes:

- Includes programs and initiatives governed by the Accountability Agreement.
- Public health units also receive funding for other programs through separate agreements (e.g., Healthy Babies Healthy Children – Ministry of Children & Youth Services).