DRAFT AGENDA
MIDDLESEX-LONDON BOARD OF HEALTH

399 RIDOUT STREET NORTH — Thursday, 7:00 p.m.
SIDE ENTRANCE, (RECESSED DOOR) — 2014 January 16
Board of Health Boardroom

MISSION - MIDDLESEX-LONDON BOARD OF HEALTH

The mission of the Middlesex-London Health Unit is to promote wellness, prevent disease and injury, and protect the public's health through the delivery of public health programs, services and research.

MEMBERS OF THE BOARD OF HEALTH

Mr. David Bolton
Ms. Denise Brown (Vice Chair)
Mr. Al Edmondson
Ms. Patricia Fulton
Mr. Marcel Meyer (Chair)
Mr. Stephen Orser
Mr. Ian Peer
Ms. Viola Poletes Montgomery
Ms. Nancy Poole
Mr. Mark Studenny
Ms. Sandy White

SECRETARY-TREASURER

Dr. Christopher Mackie

DISCLOSURE OF CONFLICTS OF INTEREST

APPROVAL OF AGENDA

ELECTION OF OFFICERS
Item #1 – Report No. 001-14

APPROVAL OF MINUTES
Public Session December 12, 2013

BUSINESS ARISING FROM THE MINUTES

SCHEDULE OF APPOINTMENTS

7:05 - 7:20 p.m. — Ms. Trish Fulton, Chair, Finance and Facilities Committee re Item # 2
Report No. 002-14 re Finance and Facilities Committee – January 9, 2014

Please Note: The Board of Health will consider Items #3 and #4 before resuming the Schedule of Appointments

7:45 – 8:00 p.m. — Dr. Maria VanHarten, Dental Consultant re Item #5
Report No. 005-14 re Access to Dental Care for Adults

Item #	Report Name and Number	Link to Additional Information	Delegation	Recommendation	Information	Brief Overview
1	Election of Officers Report 001-14	Appendix A		x		To fulfill the requirements of the first Board of Health meeting of each year, e.g., election of Chair/Vice Chair for 2014
Committee Reports						
2	Finance and Facilities Committee (FFC) Report – January 9, 2014 Report 002-14	Appendix A	x	x		For the Board of Health to receive information and consider recommendations from the January 9th FFC meeting
Other Delegation and Recommendation Reports						
3	Governance Committee – Draft Terms of Reference Report 003-14	Appendix A		x		To request Board of Health approval of the draft Terms of Reference for the proposed Governance Committee
4	Current Accreditation Status and Relevant Developments Report 004-14	Appendix A Appendix B Appendix C Appendix D		x		To update the Board of Health on the Health Unit's accreditation status and seek direction for future decisions
5	Access to Dental Care Report 005-14	Appendix A Appendix B Appendix C	x		x	To seek Board of Health approval for advocacy for provincial dental treatment and prevention programs for low-income adults
Information Reports						
6	Oral Health Report 2013 Report 006-14	Appendix A			x	To inform the Board of Health about the Health Unit's oral health surveillance findings from the school based dental screening program during the 2012-2013 school year
7	Changes to Oral Health Programs Report 007-14	Appendix A			x	To report that the Health Unit is assessing implications of the MOHLTC proposal to integrate all publicly-funded oral health programs
8	Middlesex-London Health Unit Supports Continued Funding for Bike Lanes Report 008-14				x	To inform the Board of Health that the capital budget reductions contained in the City of London's 2014 Budget Report include reductions to the City's Bike Lane Program
9	Revised Public Health Funding and Accountability Agreement Report 009-14	Appendix A Appendix B Appendix C			x	To report that the three year Accountability Agreement between the MOHLTC and the Board of Health has expired and MOHLTC is proposing revisions for future agreements
10	Annual Performance Report on the Strategic Directions Report 010-14	Appendix A			x	To report on the progress made in the Health Unit's current strategic plan and next steps

11	Meat Processing Inspections: New Responsibility Report 011-14				x	To report that due to recent amendments to the Ontario Meat Regulation 31/05, public health inspectors at Ontario health units now have responsibility for inspecting lower risk and lower volume free standing meat plants
12	Medical Officer of Health Activity Report – January Report No. 012-14				x	To provide an update on the activities of the MOH for January

CONFIDENTIAL

The Board of Health will move in camera to consider personal matters about an identifiable individual.

OTHER BUSINESS

Next proposed Finance and Facilities Committee Meeting: Thursday, January 29, 9:00 a.m.
Next proposed Board of Health Meeting: To Be Determined

CORRESPONDENCE

a) Date: 2013 December 13 (Received 2013 December 13)
Topic: Support to Prohibiting All Commercial Advertising Targeted to Children Under 13 Years of Age
From: Dr. Hazel Lynn, Medical Officer of Health, Grey Bruce Health Unit
To: The Honourable Deb Matthews, Minister of Health and Long-Term Care

b) Date: 2013 December 16 (Received 2013 December 19)
Topic: Response to Letter re MLHU's Resolution Regarding Menu Labelling
From: The Honourable Kathleen Wynne, Premier of Ontario
To: Mr. Marcel Meyer, Chair, Board of Health

c) Date: 2013 December 19 (Received 2013 December 20)
Topic: 2013n Nutritious Food Basket Results in Sudbury and District Health Unit Area
From: Dr. Penny Sutcliffe, MOH, Sudbury and District Health Unit
To: The Honourable Kathleen Wynne, Premier of Ontario

d) Date: 2013 December 24 (Received 2014 January 02)
Topic: MOHLTC will provide the Middlesex-London Board of Health with one-time funding for Healthy Communities Fund – Partnership Stream Program
From: The Honourable Deb Matthews, Minister of Health and Long-Term Care
To: Mr. Marcel Meyer, Chair, Board of Health

e) Date: 2014 January 9 (Received 2014 January 9)
Topic: Public Health Funding and Accountability Agreement Webinars
From: Sylvia Shedden, Director, Public Health Standards, Practice & Accountability Branch Health Promotion Division, and Laura Pisko, Director, Health Promotion Implementation Branch, Public Health Division
To: Board of Health Chairs, Medical Officers of Health and Chief Executive Officers

ADJOURNMENT

DRAFT PUBLIC SESSION - MINUTES

MIDDLESEX-LONDON BOARD OF HEALTH

2013 December 12

MEMBERS PRESENT:	Mr. David Bolton Ms. Denise Brown (Vice-Chair) Mr. Al Edmondson Ms. Trish Fulton Mr. Marcel Meyer (Chair) Mr. Stephen Orser Mr. Ian Peer Ms. Viola Poletes Montgomery Ms. Nancy Poole Mr. Mark Studenny Ms. Sandy White
REGRETS:	None
OTHERS PRESENT:	Mr. Wally Adams, Director, Environmental Health and Chronic Disease Prevention Services Ms. Laura DiCesare, Director, Human Resources and Corporate Strategy Mr. Dan Flaherty, Manager, Communications Mr. Ross Graham, Manager, Strategic Projects Dr. Christopher Mackie, Medical Officer of Health & CEO Mr. John Millson, Director, Finance and Operations Ms. Sherri Sanders, Executive Assistant to the Board of Health (Recorder) Mr. Alex Tyml, Online Communications Coordinator Dr. Bryna Warshawsky, Associate Medical Officer of Health and Director, Oral Health, Communicable Disease & Sexual Health Services
MEDIA OUTLETS:	None

Board of Health Chair, Mr. Marcel Meyer, called the meeting to order at 6:00 p.m.

DISCLOSURES OF CONFLICT(S) OF INTEREST

Chair Meyer inquired if there were any disclosures of conflict of interest to be declared. None were declared at this time.

APPROVAL OF AGENDA

It was moved by Mr. Bolton, seconded by Mr. Studenny *that the **AGENDA** for the December 12, 2013 Board of Health meeting be approved.*

Carried

APPROVAL OF MINUTES

It was moved by Mr. Orser, seconded by Mr. Peer *that the **MINUTES** for the November 21, 2013 Board of Health meeting be approved.*

Carried

COMMITTEE REPORTS

1) Finance and Facilities Committee (FFC) Report, November 28th Meeting (Report No. **130-13**)

Ms. Trish Fulton, Chair of the Finance and Facilities Committee (FFC), introduced Report No. 130-13 re the November 28 Finance and Facilities Committee meeting.

Business Arising from the November 28, 2013 FFC meeting

Dr. Mackie presented a draft completed 2014 Planning & Budget Template that was prepared by Environmental Health staff to demonstrate the process staff will use to determine a draft budget for programs.

It was moved by Ms. Fulton, seconded by Mr. Edmondson *that the Board of Health approve the draft Planning & Budgeting Template as attached as Appendix A to Report No. 020-13C.*

Carried

It was moved by Ms. Fulton, seconded by Ms. Brown *that Report No. 130-13, including the draft public minutes of the November 28, 2013 Finance and Facilities Committee meeting, be received for information.*

Carried

ACTION REPORTS

2) Proposed Dates for 2014 Board of Health and Finance & Facilities Committee Meetings (Report No. 131-13)

Concern was expressed that the meeting date of February 20th would be a potential conflict with those planning to attend the alPHa Symposium February 20-21, 2014. The date February 27 was suggested as an alternative. It was agreed that the February Board of Health meeting date will be discussed at the January 16th meeting.

It was moved by Mr. Orser, seconded by Mr. Peer *that the proposed meeting dates be approved, noting that the February meeting date is still to be decided.*

Carried

3) Building The Best Board: A Governance Committee (Report No. 132-13)

Dr. Mackie presented this report, recommending that at its January meeting, the Board create a Standing Committee to review Board member recruitment, Board education objectives, code of conduct, Board evaluation and other governance issues. The Governance Committee, which would most likely meet quarterly, would replace the ad hoc committee that was struck to review the Board Self-Assessment tool.

It was suggested that the Board consider a two-year appointment of Board of Health Chair to ensure more continuity. This suggestion will be discussed at the January Board of Health meeting.

It was moved by Ms. Fulton, seconded by Mr. Studenny *that the Board of Health support the development of a draft Terms of Reference for a Governance Committee to be reviewed at a future meeting*.

Carried

Ms. Poletes Montgomery arrived at 6:30 p.m.

INFORMATION REPORTS

4) A Review of the 2003 Mandatory Health Programs and Services Guidelines Gap Analysis
(Report No. 133-13)

Dr. Mackie assisted Board members with their understanding of this report using Appendix A.

Discussion ensued about encouraging the Province to provide more funding to the Health Unit in order to bring the cost-shared arrangement up to 75% provincial / 25% municipalities. Dr. Mackie reported that alPHa is looking for a more rational way to allocate increases, e.g., population based or social determinants of health based.

Mr. John Millson, Director of Finance and Operations, reported that based on a survey this Health Unit conducted in 2012, 19 out of the 36 health units were not at the 75%/25% cost-sharing arrangement.

In reference to a question about per capita spending of health units, Dr. Bryan Warshawsky referred Board members to **Report No. 131-12** that explained per capita spending using the most recent data (2007).

Mr. Millson reported that the Ministry of Health and Long-Term Care has provided $8 million to the Middlesex-London community to improve public health. He also reminded Board of Health members that the Health Protection and Promotion Act states that the government may provide a grant.

It was moved by Ms. Brown, seconded by Ms. Poletes Montgomery *that the Board of Health advocate to the Provincial government to provide an appropriate level of funding to reach the 75% provincial / 25% municipal cost-shared arrangement to bring the Middlesex-London Health Unit back into alignment with other Health Units in Ontario.*

Carried

Dr. Mackie reported that staff will collect current information about per capita funding across comparable Ontario health units and present the findings at a future Board of Health meeting.

It was moved by Ms. Brown, seconded by Mr. Orser *that the Board of Health receive Report No.133-13 re A Review of the 2003 Mandatory Health Programs and Services Guidelines Gap Analysis for information.*

Carried

5) Medical Officer Of Health Activity Report – December (Report No. 134-13)

It was moved by Mr. Bolton, seconded by Ms. White *that the Board of Health receive Report No. 134-13 re Medical Officer of Health Activity Report – December for information.*

Carried

Dr. Mackie introduced Ms. Laura Di Cesare, the incoming Director of Human Resources and Corporate Strategy, who has been working part time with Ms. Louise Tyler, Director of Human Resources and Labour Relations, until Ms. Tyler's retirement at the end of 2013. Ms. Di Cesare will begin full time at the Health Unit in January 2014.

CONFIDENTIAL

At 6:50 p.m., it was moved by Mr. Studenny, seconded by Mr. Peer *that the Board of Health go in camera:*

1) *To discuss personal matters about an identifiable individual, and*
2) *To discuss a proposed or pending acquisition of land by the Middlesex-London Board of Health*

Carried

At 7:15 p.m., it was moved by Mr. Bolton, seconded by Mr. Studenny that *the Board of Health return to a public forum and report that progress was made in personal matters about an identifiable individual and matters concerning a proposed or pending acquisition of land by the Middlesex-London Board of Health.*

Carried

REPORT FROM IN CAMERA SESSION

It was moved by Mr. Bolton, seconded by Ms. White:

1) *That the Board of Health endorse the reappointment of provincial appointee, Ms. Viola Poletes Montgomery, whose current appointment expires February 28, 2014, for an additional 2 years; and further*

2) *That a letter endorsing this reappointment be sent to the Minister of Health and Long-Term Care.*

Carried

It was moved by Mr. Edmondson, seconded by Ms. Poletes Montgomery:

1) *That the Board of Health endorse the reappointment of provincial appointee, Mr. Mark Studenny, whose current appointment expires April 10, 2014, for an additional 2 years; and further*

2) *That a letter endorsing this reappointment be sent to the Minister of Health and Long-Term Care.*

Carried

It was moved by Ms. Fulton, seconded by Ms. White *that the Board of Health congratulates everyone at the Health Unit who was part of initiating the Program Budgeting and Marginal Analysis process (PBMA) on producing a comprehensive document that will definitely assist the Board of Health in making decision that make the most efficient use of Health Unit funds.*

Carried

CORRESPONDENCE

Chair Meyer reported that Ms. Trish Fulton has been reappointed for a three year term that runs until January 28, 2017.

There were no questions about the correspondence.

OTHER BUSINESS

Next scheduled Board of Health Meeting: **Thursday, January 16, 2014 at 7:00 p.m.**

ADJOURNMENT

At 7:30 p.m., it was moved by Mr. Orser, seconded by Ms. Poole *that the meeting be adjourned.*

Carried

________________________________ ________________________________

MARCEL MEYER
Chair

CHRISTOPHER MACKIE
Secretary-Treasurer

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 001-14

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2014 January 16

ELECTION OF 2014 BOARD OF HEALTH EXECUTIVE AND OTHER PROCEDURES

Recommendations

It is recommended:

1) ***That the Board of Health amend Bylaw # 3 to change the term of the Chair to two years, with the second year being confirmed by a vote of the Board at the relevant January meeting.***

2) ***That _________________________ be elected Chair of the Middlesex-London Board of Health for the year 2014; and further***

3) ***That _________________________ be elected Vice-Chair of the Middlesex-London Board of Health for the year 2014; and further***

4) ***That Dr. Christopher Mackie be elected Secretary-Treasurer of the Middlesex-London Board of Health; and further***

5) ***That the Board of Health recognize the Finance and Facilities Standing Committee, created in 2013.***

Board Membership Update

The current Board of Health consists of:

1. **Five (5) Provincial Appointees:** Ms. Trish Fulton, Mr. Ian Peer, Ms. Viola Poletes Montgomery; Ms. Nancy Poole and Mr. Mark Studenny. In 2013, three provincial appointees were reappointed by the Minister of Health and Long-Term Care as follows: Ms. Nancy Poole (term now expires July 2016, Mr. Ian Peer (term now expires November 2016) and Ms. Trish Fulton (term now expires January 2017). Ms. Viola Poletes Montgomery and Mr. Mark Studenny have requested reappointment.
2. **Three (3) City of London Appointed Members:** Ms. Denise Brown, Mr. Stephen Orser and Ms. Sandy White.
3. **Three (3) Middlesex County Appointed Members:** Mr. David Bolton, Mr. Al Edmondson and Mr. Mayor Marcel Meyer.

The terms of the current municipal appointees expire November 30, 2014 (City of London) and December 31, 2014 (County of Middlesex). The municipalities will make appointments to the Board of Health for the 2014 to 2018 term following the October 2014 municipal election.

The terms of Board of Health Members can be found in Appendix A.

Procedures for the First Meeting of the Year

Bylaw No. 3 of the Board of Health regulates the proceedings of the Board. Section 18.0 of this Bylaw addresses Elections and Appointment of Committees. It reads as follows:

18.1	*At the first meeting of each calendar year, the Board shall elect by a majority vote a Chair and a Vice-Chair for that year.*
18.2	*The Chair of the Board shall rotate on an annual basis to one of the representatives of the City of London, the County of Middlesex and the Province of Ontario.*
18.3	*At the first meeting of each calendar year, the Board shall appoint the representative or representatives required to be appointed annually at the first meeting by the Board to other boards, bodies or commissions where appropriate.*
18.4	*The Board may appoint committees from time to time to consider such matters as specified by the Board. (e.g., Human Resources, Planning, etc.).*

Election of Executive Officers

Chair: As per the current Bylaw No. 3 Section 18, as stated above, the position of Chair rotates annually among the three representative bodies. The 2013 Chair, Mr. Marcel Meyer, is a Middlesex County appointee. It has been proposed that the Bylaw be amended as follows: *The Chair of the Board shall rotate among one of the representatives of the City of London, the County of Middlesex and the Province of Ontario. The term of the Chair shall be to two years, with the second year being confirmed by a vote of the Board at the relevant January meeting.*

Alternatives for the Board to consider would include: a) maintaining the one-year term; b) moving to a renewable term with a maximum of two or more years; and c) setting a fixed term of two or more years

Vice-Chair: Bylaw No. 3 Section 18 stipulates that the Vice-Chair is elected for a one year term, but does not further stipulate how this position is selected. Ms. Denise Brown, a City of London appointee, was the 2013 Vice-Chair.

Secretary-Treasurer: Traditionally the Secretary-Treasurer functions have been served by the Medical Officer of Health and CEO.

Establishment of Standing Committees

In Section 1.3 (ii) of Board of Health Policy No. 1-010 Structure and Responsibilities of the Board of Health, the Board determines whether it wishes to establish one or more Standing Committees at its inaugural meeting of the year. In 2013, the Board of Health created the Finance and Facilities Standing Committee which meets the first Thursday of the month, starting in August 2013. At the December 2013 meeting, the Board supported Report No. 132-13 re Building the Best Board: A Governance Committee which gave staff direction to develop a draft Terms of Reference for a Governance Committee. This proposed Standing Committee is the subject of Report No. 003-14 in this agenda.

Meeting Schedule for 2014

At the December 2013 Board of Health meeting, Board members approved Report No. 131-13 re Proposed Dates for 2014 Board of Health and Finance & Facilities Committee Meetings. Board members moved that the proposed meeting dates be approved, noting that the February 2014 meeting date will be decided at the January 2014 Board meeting.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health and CEO

This report addresses Bylaw #3 as outlined in the MLHU Administration Policy Manual.

MIDDLESEX-LONDON HEALTH UNIT

2014 Middlesex-London Board of Health

Title	First Name	Last Name	Appointed By	First Appointed	Term Expires on
Mr.	David	Bolton	County of Middlesex	December 21, 2011	December 31, 2014
Ms.	Denise	Brown	City of London	December 1, 2010	November 30, 2014
Mr.	Al	Edmondson	County of Middlesex	December 1, 2002	December 31, 2014
Ms.	Patricia	Fulton	Province of Ontario	January 9, 2013	January 8, 2017
Mr.	Marcel	Meyer	County of Middlesex	January 12, 2011	December 31, 2014
Mr.	Stephen	Orser	City of London	October 4, 2011	November 30, 2014
Mr.	Ian	Peer	Province of Ontario	November 14, 2012	November 13, 2016
Ms.	Viola	Poletes Montgomery	Province of Ontario	March 1, 2006	February 28, 2014
Ms.	Nancy	Poole	Province of Ontario	July 28, 2010	July 27, 2016
Mr.	Mark	Studenny	Province of Ontario	April 11, 2006	April 10, 2014
Ms.	Sandy	White	City of London	December 15, 2012	November 30, 2014

Appendix A

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 002-14

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2014 January 16

FINANCE AND FACILITIES COMMITTEE REPORT – JANUARY 9, 2014

The Finance and Facilities Committee (FFC) met at 9:00 a.m. on Thursday, January 9, 2014 (**AGENDA**). The draft minutes of the public portion of the meeting are attached as Appendix A. The following reports were discussed at the January 9th public meeting and recommendations made:

Report	Summary of Discussion	Recommendations for Board of Health's Consideration
50 King St. Generator – verbal report	Dr. Mackie provided a verbal update on the Generator project for the 50 King Street premise. To accommodate the municipal budgeting timeline, it was decided that the Generator Ad Hoc Advisory Group will meet on January 29, 2014, at 8:30 a.m., prior to the scheduled FFC meeting.	
2014 Budget Process (**Report No 02-14C**)	Dr. Mackie provided an overview of the process to review the Planning and Budget Templates from the six Service Areas. Mr. Wally Adams reviewed the Environmental Health and Chronic Disease Prevention 2014 Planning and Budget Templates (Appendix B to Report No 02-14C). After discussion, it was moved by Mr. Meyer, seconded by Mr. Peer *that the FFC Committee receive Appendix B of Report 02-14C (Environmental Health and Chronic Disease Prevention Planning and Budget Template) for information.* Mr. John Millson reviewed the Finance & Operations and Information Technology 2014 Planning and Budget Templates (Appendix A to Report No 02-14C).	It was moved by Mr. Meyer, seconded by Mr. Peer *that the FFC Committee recommend to the Board of Health that approval for the Planning and Budget templates be deferred until the Templates from all six Service Areas have been received.*

	After discussion, it was moved by Mr. Peer, seconded by Mr. Bolton *that the FFC Committee receive Appendix A of Report 02-14C (Finance and Operations 2014 & Information Technology 2014 Planning and Budget Templates) for information.*	

CONFIDENTIAL

The FFC made a motion to move in camera to discuss a proposed or pending acquisition of land by the Middlesex-London Board of Health.

After discussion, the FFC made a motion to return to public forum and report that information was discussed related to a proposed or pending acquisition of land by the Middlesex-London Board of Health.

OTHER BUSINESS

The next scheduled Finance and Facilities Committee Meeting is Wednesday, January 29 at 9:00 a.m. Room 3A, 50 King Street, London.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

This report addresses the Ontario Public Health Organizational Standards

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 003-14

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2014 January 16

GOVERNANCE COMMITTEE - DRAFT TERMS OF REFERENCE

Recommendation

It is recommended:

1) ***That the Board of Health review and approve the draft terms of reference for the Governance Committee attached as Appendix A; and further,***

2) ***That the Board of Health appoint members of the committee as per the terms of reference; and further,***

3) ***That the Board of Health select a meeting date for the first meeting of the committee.***

Key Points

- A Board of Health Governance Committee is proposed to support effective Board governance and compliance with the Organizational Standards.
- The draft Terms of Reference for this committee is attached as Appendix A.

At the December 2013 meeting, the Board reviewed Report No. 132-13 in regards to implementing a new committee with the purpose of providing an advisory and monitoring role to the Board related to board membership and recruitment, board self-evaluation and governance policy.

Attached for the Board's consideration as Appendix A is the draft terms of reference for the proposed Governance Committee.

This report was prepared by Mr. Ross Graham, Manager of Strategic Projects.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

GOVERNANCE COMMITTEE

PURPOSE

The committee serves to provide an advisory and monitoring role. The committee's role is to assist and advise the Board of Health, the Medical Officer of Health /Chief Executive Officer (MOH/CEO), and the Director of Human Resources & Corporate Strategy in the administration and risk management of matters related to board membership and recruitment, board self-evaluation and governance policy.

REPORTING RELATIONSHIP

The Governance Committee is a committee reporting to the Board of Health of the Middlesex-London Health Unit. The Chair of the Governance Committee, with the assistance of the Director, Human Resources & Corporate Strategy and the MOH/CEO, will make reports to the Board of Health as a whole following each of the meetings of the Governance Committee.

MEMBERSHIP

The membership of the Committee will consist of a total of five (5) voting members. The members will include the Chair and Vice-Chair of the Board of Health and in total, the membership will contain at least one Middlesex County Board Member, one City of London Board Member and two provincial Board Members.

The Secretary-Treasurer will be an ex-officio member

Staff support:
- Director, Human Resources & Corporate Strategy
- Executive Assistant to the Board of Health or the Executive Assistant to the Medical Officer of Health, depending on availability

Other Board of Health members are able to attend the Governance Committee but are not able to vote.

CHAIR

The Committee will elect a Chair at the first meeting of the year to serve at least one year, and optimally two years.

TERM OF OFFICE

At the first Board of Health meeting of the year the Board will review the committee membership. At this time, if any new appointments are required, the position(s) will be filled by majority vote. The appointment will be for at least one year, and where possible, staggered terms will be maintained to ensure a balance of new and continuing members. A member may serve on the committee as long as he or she remains a Board of Health member.

DUTIES

The Committee will seek the assistance of and consult with the MOH/CEO and the Director of Human Resources & Corporate Strategy for the purposes of making recommendations to the Board of Health on the following matters:

1. Recruitment and nomination of suitable Board members.
2. Orientation and training of Board members.
3. Performance evaluation of individual members, the Board as a whole, and committees of the Board.
4. Compliance with the Board of Health Code of Conduct.
5. Performance evaluation of the MOH/CEO.
6. Governance policy and bylaw review and development.
7. Compliance with the Organizational Standards.

FREQUENCY OF MEETINGS

The Committee will meet quarterly or at the call of the Chair of the Committee.

AGENDA & MINUTES

1. The Chair of the committee, with input from the Director of Human Resources & Corporate Strategy and the MOH/CEO, will prepare agendas for regular meetings of the committee.
2. Additional items may be added at the meeting if necessary.
3. The recorder is the Executive Assistant to the Board of Health.
4. Agenda & minutes will be made available at least 5 days prior to meetings.
5. Agenda & meeting minutes are provided to all Board of Health members.

BYLAWS:

As per Section 19.1 of Board of Health By-Law No. 3, the rules governing the proceedings of the Board shall be observed in the Committees insofar as applicable.
This will include rules related to conducting of meetings; decision making; quorum and self-evaluation.

REVIEW

The terms of reference will be reviewed every 2 (two) years.

Implementation Date: January 16th, 2013

Revision Dates:

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 004-14

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 Month Day

CURRENT ACCREDITATION STATUS AND RELEVANT DEVELOPMENTS

Recommendations

It is recommended:

1. ***That the Board of Health receive Report No. 004-14 re Current Accreditation Status and Relevant Developments for information, and***
2. ***That the Board of Health Request an additional report in 2014 to identify expected costs and benefits of pursuing accreditation with an external body.***

Key Points

- Due to the recent closure of its accrediting body, the Ontario Council on Community Health Accreditation, MLHU is not accredited for the first time in roughly15 years.
- While accreditation is voluntary and requires an investment of human and financial resources, research has demonstrated that there are benefits for local public health organizations that dedicate resources toward accreditation.
- The Ministry of Health & Long Term Care has encouraged Boards of Health to pursue accreditation with one of two national accreditation bodies.

Background

The Middlesex-London Health Unit (MLHU) has achieved the highest level of accreditation for roughly 15 years (most recently, see Report No. 009-13). However, in March 2013, the Ministry of Health & Long Term Care (MOHLTC) ended a 32 year funding arrangement with the Ontario Council on Community Health Accreditation (OCCHA). This caused OCCHA to cease operations, and annulled the accreditation status for 12 health units, including MLHU. Since then, the MOHLTC has released a discussion paper on accreditation (see Appendix A) and recently organized webinars on two national accreditation bodies: Accreditation Canada and Excellence Canada.

The Value of Accreditation in Public Health

While accreditation is a common practice in many sectors including education and healthcare, some have questioned the value and efficiency of accreditation in local public health. This question has been the subject of intense study, and the general consensus from practitioners, scientists and policy-makers is that accreditation yields not only expected and obvious benefits, but also multiple, unanticipated benefits for local public health agencies that can dedicate resources to the process. This is true to the extent that a national Public Health Accreditation Board (PHAB) was recently formed in the United States (US) following a multi-year, multi-study initiative called the *Exploring Accreditation Project*. See Appendix B for the costs and benefits of accreditation in public health, as well as the reference material for this report.

Impact on Health

Accreditation is a strategy that can improve agency administration and service delivery, when agencies commit to engage in the process. In theory, these benefits should then translate into improved community health. However, as with all administrative interventions, it is difficult to establish a causal link between an administrative change and improvement in health status. This being said, a model has been established to graphical depict the relationships between resources, activities, outputs and health outcomes of accreditation in public health (see Appendix C).

Canadian Evidence & Additional Considerations

Given the benefits of accreditation, some have called accreditation "one of the most important initiatives in public health today." However, there is limited Canadian research, meaning the reported benefits from US public health agencies may not translate to the Canadian context. The exception is a 2007 survey which surveyed Canadian public health practitioners about the value of accreditation. They found that the majority were in favour of accreditation in public health, and that those opposed cited the lack of capacity currently in the system. Yet, proponents argued that accreditation could actually be used as a capacity-building tool and assist "to fight the tyranny of the urgent." Research has also produced some key recommendations for successful accreditation adoption in public health. First, is that accreditation must be thought of as an investment in the future of public health rather than an added cost, and furthermore that the greater the investment in thoughtful self-analysis, the greater the benefits. It has also been stressed that agencies benefit most from accreditation when it is used as a tool for improvement, not simply compliance.

Accreditation Canada and Excellence Canada

While the MOHLTC has encouraged health units to pursue accreditation with Accreditation Canada or Excellence Canada, it is still voluntary, and up the discretion of each Board of Health. Accreditation Canada and Excellence Canada offer different approaches and fee structures, each with strengths and weaknesses (see Appendix D). So far, two health units have pursued accreditation with Accreditation Canada, and two with Excellence Canada.

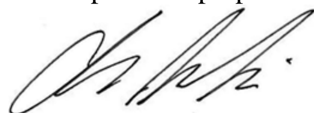
The Organizational Standards: A Complicating Factor

The Ontario Public Health Organizational Standards (OS) provide an administrative framework for public health service delivery. The mandatory nature of the OS has caused some to view them as a replacement for accreditation. This is misguided. The OS establish minimum requirements for Boards of Health. They do not facilitate ongoing improvement. An involved, funded, internal 'accreditation-like' process could perhaps use the OS as a starting place for facilitating improvement. However, this would likely be done at a similar cost to pursuing accreditation with an external agency. An internal process would also (a) not be guided by process experts (which external accreditation bodies possess), and (b) would be insulated from many of the sector- and public-oriented benefits listed above.

Next Steps

MLHU is currently not accredited. The Board of Health is being asked to chart a course for the future of accreditation at MLHU. Given the importance of this decision, staff recommend that the Board of Health request an additional detailed report in 2014 to identify expected costs and benefits of pursuing accreditation with an external body.

This report was prepared by Mr. Ross Graham, Manager of Strategic Projects.



Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

Accreditation and Continuous Quality Improvement for Public Health Discussion Paper

I. PURPOSE

The purpose of this paper is to describe the history and current context of accreditation in public health and to outline options to inform the ministry's position regarding accreditation requirements for public health units (PHUs).

By describing the purpose, function and considerations for accreditation in public health and the broader health sector, this paper outlines future options regarding accreditation.

II. BACKGROUND

Accreditation in Public Health

- Accreditation of PHUs is not mandatory; approximately 1/3 of the 36 PHUs were accredited through Ontario Council of Community Health Accreditation (OCCHA) at the time when it ceased operations. The number of PHUs being accredited by OCCHA appears to have decreased slightly over the past few years.
- The OCCHA accreditation requirements provided a structure to assess whether key process and practices were in place related to governance, management and program/service delivery. One recognized limitation of this system of review was the lack of availability of online tools and supports compared to industry competitors.

Table 1: Organizations Most Recently Accredited by OCCHA	
1. Algoma Public Health	7. Kingston, Frontenac and Lennox & Addington Public Health
2. Northwestern Health Unit	8. Leeds, Grenville and Lanark District Health Unit
3. Sudbury and District Health Unit	9. Middlesex-London Health Unit
4. Brant County Health Unit	10. Niagara Region Public Health Department
5. Durham Region Health Department	11. Simcoe Muskoka District Health Unit
6. City of Hamilton, Public Health Services	12. Wellington-Dufferin-Guelph Public Health

- Two PHUs have been accredited through Accreditation Canada, an organization that does not receive ministry funding. Accreditation Canada accredits over 1000 organizations across the country, including approximately 50 public health organizations. Three PHUs have associated with Excellence Canada; one health unit, within its broader regional municipality, has also achieved certification through this organization (see Appendix 1 for details).
- Different components of public health involve separate accreditation processes, including the Baby-Friendly Initiative, as well as individual processes for public health managers and nurses.
- Table 2 provides an overview of the pros and cons of accreditation for public health.

Table 2: Pros and Cons of Accreditation for Public Health	
Pros	**Cons**
• Promotes continuous quality improvement; • Standardization of organizational and governance practices in line with best practices; • Provides support in meeting the Organizational Standards; and, • Improves public trust in and visibility of public health units.	• Limited interest among PHUs, with fluctuating list of participating organizations over time; • Process requires significant commitment in terms of time and resources; and, • May not be necessary for PHUs, given the ministry's requirement that PHUs comply with the Organizational Standards, although there is no mechanism currently to audit compliance on an ongoing basis.

Accreditation in the Health Sector

- While not mandatory, almost all of Ontario's hospitals and many of the community-based health care provider organizations in the province (such as nursing homes) undertake accreditation through a formalized, recognized and respected accreditation body. The Ontario government does not provide direct funding to accreditation bodies within the health sector; however ministry funding may be utilized for accreditation costs at the organization's discretion.

Local Health Integration Networks (LHINs)

- Accreditation of Ontario's LHINs is not mandatory. However, accreditation by an external accrediting body is becoming increasingly recognized in the health system as a strategy for strengthening agency accountability and ensuring compliance with best practice standards (for both clinical and governance practices).
- LHINs commonly insert accreditation into their Multi-Sector Service Accountability Agreements (M-SAAs) as a performance obligation for their community sector health service providers. In 2009, a number of LHINs participated in a pilot survey to look at performance measures relative to governance issues.
- In 2011, the South East LHIN became the first LHIN to be accredited through Accreditation Canada. Working with Accreditation Canada, the LHIN Board will develop a standard of health system governance that could form the basis of accreditation requirements that are tailored for the LHIN sector in Ontario.

Hospitals

- In June 2010, the Ontario Government passed the Excellent Care for All Act, 2010 (the Act), legislation and associated policy aimed at improving quality and value in the healthcare system.
- As part of the Act, all health care providers develop and publicly post an annual Quality Improvement Plan (QIP), a requirement that has become a significant transformational lever to engage the system in improving performance and demonstrating their commitment to quality.
- Many hospitals have incorporated participation in an accreditation process as part of their QIPs. There is an interface between some of the requirements of Accreditation Canada and the Act, particularly around surveys, and government continues to work with organizations to develop the most efficient and effective process to ensure that duplication is avoided.

Community Health Centres (CHCs)

- It is mandatory that all CHCs commit to participation in an accreditation process through a formalized, recognized and respected accreditation body. The Canadian Centre for Accreditation (CCA), which receives no ministry or LHIN funding, is most commonly used by CHCs.
- CCA was formed through the partnership of five Canadian associations with a combined 100 years of accreditation experience. CHCs accredited through CCA are required to meet the requirements in two modules (see Table 3). The Community-Based Primary Health Care Module was developed using the Building Healthier Organizations (BHO) accreditation program as a foundation and transformed through broad review and consultation with the health sector.
- BHO began as an initiative of the Association of Ontario Health Centres (AOHC) and the Ontario Ministry of Health in the early 1990's with centres being asked to go through the accreditation process every three years.
- Table 3 outlines the components of the CCA accreditation program for Community-Based Primary Health Care, for which CHCs are expected to meet minimum standards of excellence:

Table 3: Components of the CCA Accreditation Program

CCA Organizational Standards Module	CCA Community-Based Primary Health Care Module
Governance	Using a Community-Based Approach
Stewardship	Planning Programs and Services
Organizational Planning and Performance	Delivering Quality Programs and Services
Learning Culture	Ensuring Safety
Human Resources	Evaluating Program and Services
Human Resources – Volunteers	
Systems and Structure	
Community	

Community Care Access Centres (CCACs)

- The CCACs within Ontario are committed to providing quality care. Many quality initiatives, including accreditation, are coordinated among the 14 CCACs at a provincial level.
- By December 2012, all 14 Ontario CCACs were accredited through a recognized accrediting organization. Twelve CCACs are with Accreditation Canada and two CCACs are affiliated with the Commission on Accreditation of Rehabilitation Facilities (CARF).
- Accreditation for CCACs remains a voluntary process, independent of government, and organized and administered by these third-party accrediting bodies.

III. POTENTIAL OPTIONS FOR PUBLIC HEALTH UNITS

Position to Date

- The ministry has historically supported voluntary accreditation for PHUs, acknowledging that the process can provide assurance and accountability for board of health compliance with best practices related to organizational and governance practices, promote a culture of

continuous quality improvement and ensure that performance management is relevant, effective and sustained within each board of health.

- The ministry's positioning of accreditation as voluntary respects the diversity and complexity of existing governance models within the sector. Some health units are part of larger municipal or regional governments, which have their own CQI/quality improvement strategies.

See Appendix I for an overview of accreditation bodies available to Ontario's PHUs.

Mandatory Accreditation

- Whether and how to mandate accreditation has been the source of policy debate for many years. In 2003, the Auditor General recommended that the ministry explore the use of accreditation results within the accountability framework. The Auditor General specifically recommended that the ministry obtain any resulting reports and analysis completed through accreditation and assess whether these tools should be used by all PHUs. Obtaining accreditation results from individual health units or OCCHA was not pursued given the voluntary and confidential nature of accreditation.

- The Capacity Review Committee (CRC) recommended in its final report 'Revitalizing Ontario's Public Health Capacity' (2006) that mandatory accreditation form a key component of the Performance Management Framework for Public Health.

- Table 4 provides an overview of the pros and cons of mandating accreditation for public health.

Table 4. Pros and Cons of Mandating Accreditation for Public Health Units

Pros	Cons
• Promotes continuous quality improvement; • Standardization of organizational and governance practices in line with best practices; • Improves public trust in and visibility of PHUs; • Accountability is measured through a through a third-party; and, • Consistency with other parts of the health sector (i.e., requirement for CHCs to participate in accreditation process).	• No alternative PHU for public to access/choose where a PHU is not accredited as there is only one PHU per area; • Potential alignment challenges between third party standards and legislated requirements; • Government liability issues arising from a health unit(s) that fails to meet accreditation standards; • Time and money needed to apply for and achieve accreditation with limited public health resources.

Peer Review Option

- A possible alternative to accreditation within the public health sector would be a system of peer review among health units. Peer review helps create and sustain a culture of continuous quality improvement in ways that other auditing processes cannot.
- Boards of health that are already accredited may decide to retain that relationship; may choose to participate in both accreditation and a peer review process; or may choose to discontinue their relationship and become involved in a peer review process alone.

- The process could be voluntary or could involve all health units and be incorporated into the accountability agreement process as a requirement.

IV. CONSIDERATIONS

- The ministry's positioning of accreditation as voluntary respects the diversity and complexity of the existing governance models within the sector. Some PHUs are part of larger municipal or regional governments, which have their own CQI/quality improvement strategies.
- Accreditation remains a viable and valuable opportunity for any board of health that wants to pursue continuous quality improvement with other organizations (see Appendix I for description of Accreditation Canada and Excellence Canada).
- The ministry continues to build and implement its support for quality improvement through initiatives such as the following:
  - The implementation of the Excellent Care for All Act, 2010 provides expectations for quality in health care settings, and could be considered for the public health sector in the future.
  - The implementation of the Performance Management Framework for Public Health in Ontario is built on a philosophy of continuous quality improvement (CQI). The components that provide the most direct impact on quality improvement expectations include:
    - The *Organizational Standards for Public Health in Ontario* (2011). During the planning for implementation, consideration was given to how the role of OCCHA and accreditation in general could be aligned with the Organizational Standards. The ministry views accreditation as a form of operational support to an organization's ability to meet the Organizational Standards. Accreditation provides a process and framework for organizational CQI, but all organizations have a responsibility to do this, whether they are accredited or not.
    - An Organizational Standards Risk Monitoring Tool has been drafted, based upon a template used by the Ministry for its Agencies, Boards and Commissions. It has been designed for the purpose of individual board of health disclosure to government of its organizational risks on an annual basis, the identification of mitigation strategies, and the scoring of the likelihood and impact of the risks. This tool will be piloted shortly.
    - The CQI tools in the Accountability Agreements provide a mechanism for the proactive identification and follow-up on variances in public health performance. The intent is to use this information to identify appropriate actions on the part of both PHUs and the ministry to achieve improved results.
    - The opportunity to report on positive performance achievements through the Positive Performance Variance Reports is an example of encouraging the sharing of experience and success within the sector to promote quality improvements.

See Appendix II for current Operationalization of the CRC Performance Management Framework.

APPENDIX I – ACCREDITATION BODIES FOR PUBLIC HEALTH IN ONTARIO

Accreditation Canada[1, 2, 3]

Cost: The accreditation cost is structured in three elements:

1. **Application Fee:** an initial one-time administration fee of $1,175.
2. **Annual Fee:** The annual fee is the annual component of the accreditation cost and is calculated based on the client's total revenue figure most recently reported on audited financial statements, by applying a percentage of .0129%. There is no minimum annual fee.
3. **Survey Fee:** The survey fee is $2,065 per surveyor per day for all programs. Participating organizations undergo a full accreditation survey every four years.

Description:

- Their accreditation process is based on a CQI model in which organizations assess themselves against the accreditation standard to identify their strengths and areas for improvement. Their process is designed to integrate with an organization's existing quality improvement program.
- For new clients, there is a progressive approach to becoming accredited, which provides for a preparatory "primer" step to moving into the full accreditation program within a 2 year timeframe. The ongoing process is a three year process of self-review, data collection on core indicators, action planning and a site visit by trained assessors.

Knowledge of Public Health:

- In 2006, the organization began to offer accreditation to public health organizations.
- Along with the core accreditation standards on governance, effective administration, and service excellence, new standards were developed which addressed five functions of public health: health surveillance, health assessment, health protection, health promotion, and disease and injury prevention.
- These standards contain the following subsections:
    - Building knowledge and understanding needs
    - Creating networks and mobilizing partners
    - Developing policy and designing services
    - Engaging prepared and proactive staff
    - Delivering public health services
    - Achieving positive public health outcomes
- These standards incorporate priorities identified in the Ottawa Charter and Health Goals for Canada: A Federal, Provincial and Territorial Commitment to Canadians.

Accredited Organizations:

About 50 public health organizations across Canada, including:

- Eastern Ontario Health Unit
- Grey Bruce Health Unit

Excellence Canada (formerly National Quality Institute)[4, 5]

Cost: Fees for the Canada Awards for Excellence (CAE) program Order of Excellence are as follows:

	Small Organization	Medium Organization	Large Organization
# of Employees	<50	51 - 250	+251
Assessment prior to application	quote	quote	quote
Submission Evaluation Fee	$350.00	$750.00	$1500.00
Verification Site Visit	$1000.00	$3750.00	$5000.00
Total Cost - one site	$1350.00	$4500.00	$6500.00
If Multiple Sites: (Per extra site)	$500.00	$1000.00	$1500.00

Description:

Excellence Canada's Progressive Excellence Program® (PEP) is the implementation model for the Framework for Organizational Excellence, which is a principle-driven, criteria-based way to improve performance. The Framework is a comprehensive and practical framework for improvement. The Principles for Excellence permeate the six drivers to form the foundation for long-term improvement, and to achieve sustained organizational performance and results. It also serves as the basis for adjudication of the Canada Awards for Excellence program.

Application to Public Health:

The Leeds, Grenville and Lanark District Health Unit has adapted Excellence Canada's Framework for Organizational Excellence and structured its 2013-2018 internal strategic direction around six quality drivers outlined here:[6]

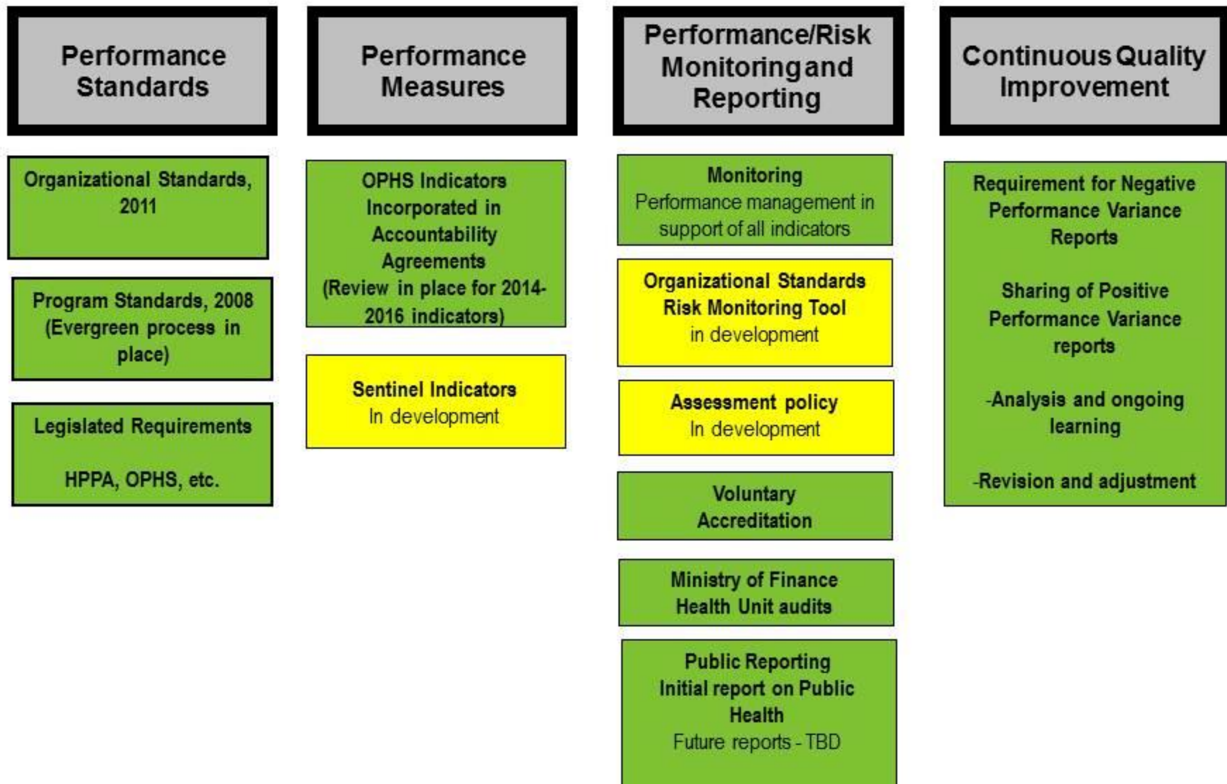
1. Leadership Driver - Effective, responsive leadership team.
2. Planning Driver - Public health planning and practice that responds efficiently and effectively to current and evolving conditions.
3. Client Driver - Clients and community satisfied with and engaged in programs and services.
4. People Driver - Workplace that supports wellness and strengthens the capacity of the workforce.
5. Process Driver - Consistent, effective management of key organizational processes.
6. Partner Driver - Strategically aligned collaborative partnerships.

Participating Organizations:

- Region of Peel (2009 Canada Order of Excellence award recipient; Bronze Partner Status*)
- The Leeds, Grenville and Lanark District Health Unit (Bronze Partner Status*)
- Toronto Public Health (Bronze Partner Status*)

*At an annual cost of $995, Bronze Partnership represents benefits valued at over $5,000 for an organization, including valuable networking opportunities and access to an international database of best practices and performance management tools, as well as discounts off of available services and training. Partnership and PEP involvement are considered independent but complementary processes. PEP certification is valid for two years (for levels 1 to 3) and three years for level 4 certification; site verification must be completed prior to certification for levels 2 to 4.

APPENDIX II



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Public Health Division
Revised on May 22, 2013

Costs and Benefits

The *Exploring Accreditation Project* research, including a survey of 10 local health units undergoing accreditation found the following **costs** associated with accreditation:

- Staff time spent preparing for accreditation, completing the agency self-assessment instrument, preparing for the site visit, coordinating the site visit, and on tasks after the site visit
- Fees to the accreditation body

The *Exploring Accreditation Project* research, and subsequent studies, has found the following **benefits** from accreditation in public health:

- Improves service delivery and quality, including:
  - Improved environmental health services
  - Improved emergency preparedness
  - Improved ability to address health inequities
- Improves administrative policies and processes
- Establishes benchmark for consistent, evidence-based “excellence” in service delivery across communities
- Creates a platform for further quality improvement (QI) projects and for implementing innovations
- Helps agencies understand their own capacity
- Documents accountability to the public and policy makers; helps justify investments in public health
- Supports culture of ongoing agency self-study and improvement
- Improves staff morale, team building, awareness of other team’s activities
- Promotes staff understanding of how their job contributes to the agency’s mission
- Is an effective mechanism for sharing information and resources within the sector
- Promotes regionalization across the public health jurisdictions
- Increases visibility, reduces ambiguity, improves community understanding and support of public health
- Highlights health department strengths and areas for improvement (i.e., motivates and values staff, engages Boards of Health)
- Facilitates organizational goal-setting
- Peer surveyors can apply learnings in home agency
- Improves clarity and relationship between local public health and provincial public health personnel

A notable study was that of 48 accredited health units in North Carolina, which reported the following benefits as a result of accreditation: Updated polices (indicated by 94%), acted on suggestions for QI (50%), conducted a QI project (67%). They also reported improved relationships as a result of accreditation with community partners (32%), local hospitals (23%) and their Board of Health (56%).

DRAFT

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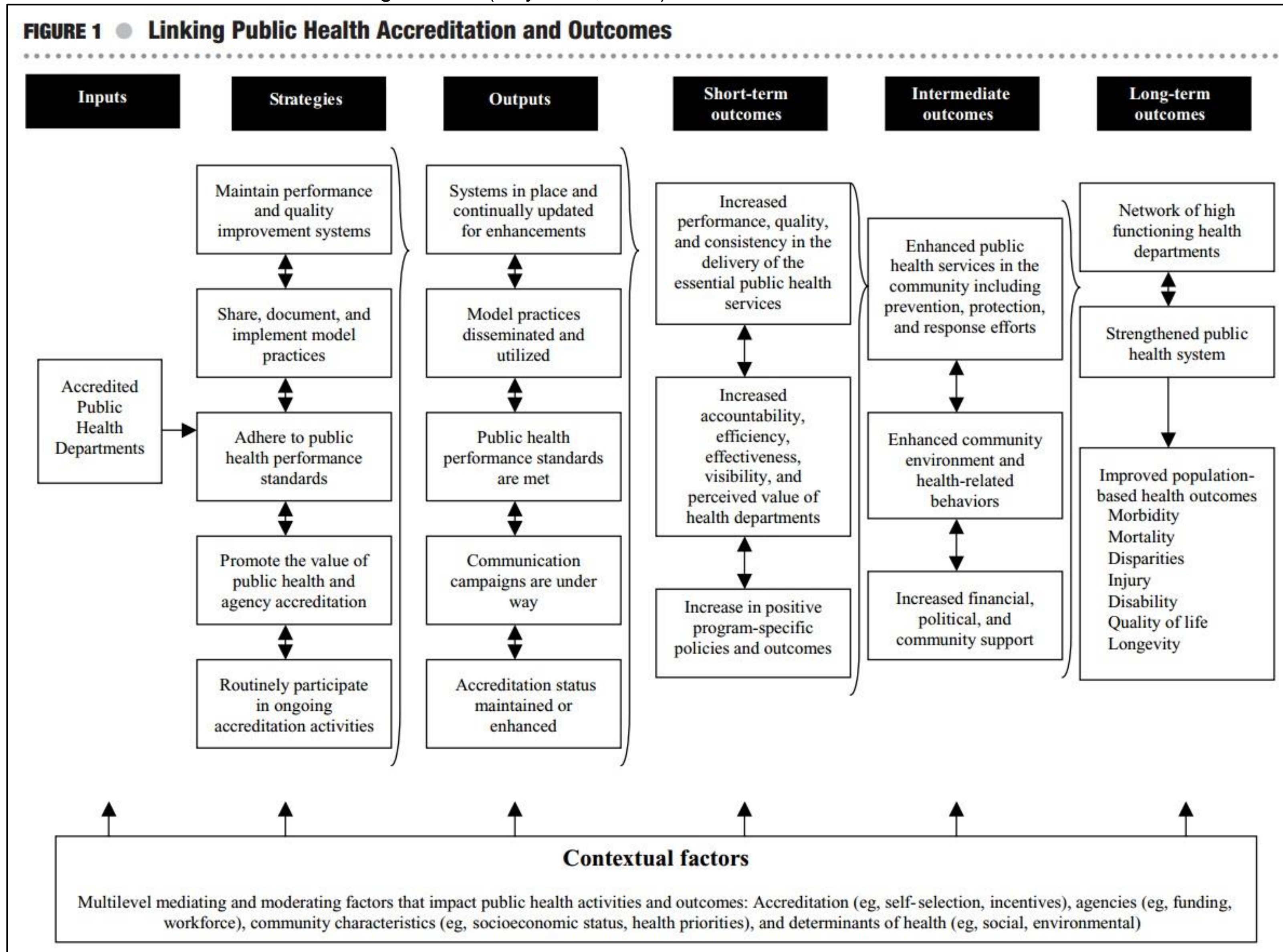
Appendix C – Public Health Accreditation Logic Model (Joly et al., 2007)



Accreditation Canada and Excellence Canada Processes & Costs

<table>
<tr><th colspan="2">Accreditation Canada</th></tr>
<tr><td>Process</td><td>
<u>Step 1: Primer</u>
Every new organization is encouraged to undergo a Primer which allows the organization to be issued an Accreditation Primer Award within 6 months of joining the program. The Primer assesses your organization based on the fundamental elements of quality and safety. The Primer allows organizations to identify areas of improvement and familiarize themselves with the process before the full accreditation program (Qmentum). Once achieved, Primer Accreditation status is valid for two years. During those two years organizations prepare for a full Qmentum accreditation on-site review.

<u>Step 2: Qmentum</u>
Qmentum involves assessing organizations against national standards of excellence. As an organization providing public health services, we would be evaluated based on the following sets of standards:

<u>Core standards:</u>
1. Effective Organization
2. Infection Prevention and Control
3. Managing Medication

<u>Service area standards:</u>
1. Public Health Services

</td></tr>
<tr><td>Public Health Uptake</td><td>
• Eastern Ontario Health Unit
• Grey Bruce Health Unit
</td></tr>
<tr><td>Fees</td><td>
1. Initial registration fee ($1,150)
2. Annual fee (annual budget x 0.01304% - minimum of $585).
3. Survey fees - $2,020 per surveyor, per day (typically 3 days)
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Accreditation Canada Quote

Price Quote

1150 Cyrville Rd., Ottawa, ON, K1Z 7G6
Tel.: 1-800-814-7769

Date:	**07/11/2013**
Valid Until:	**07/12/2013**

Presented to: Ross Graham, Manager, Strategic Projects

Program	Survey Requirement	Billing
Primer	$12,828	Annually 2013-2015*
Qmentum	$12,828	Annually 2016-2019

* Includes 1 year of preparation

Description of Service
Accreditation Canada agrees to provide the organization with accreditation services as outlined below.

Name of Organization	Number of sites	Services offered	Program	Total Cost of Program	Billing Cycle	Annual Fee
MLHU	2	Public Health	Primer	$26,264	2013-2015	$8,755
MLHU	2	Public Health	Qmentum	$30,841	2013-2016	$7,710

This price quote is subject to the following conditions:
Prices quoted are conditional on the number of sites and services detailed above. Any changes in the number of sites and/or services must be communicated to the Accreditation Specialist and may lead to a revision in costs. Accreditation Canada reserves the right to adjust costs based on the parameters outlined in the Accreditation Program Service Agreement. Organizations will be consulted prior to any adjustment in fees.

Fees Breakdown

	# Surveyor Days	Surveyor Fee (2013)	2012 Total Survey Cost	Application Fee	Year 1 Maintenance Fee (Prep Year)	Year 2 Maintenance Fee (+ COLA of 2.0%)	Year 3 Maintenance Fee (+ COLA of 2.0%)	Total Maintenance Fees, Survey Fees & Application Fee	Primer cost per year over 3 years
Primer	6	$2,138	$12,828	$1,195	$4,000	$4,080	$4,162	$26,264	**$8,755**
Qmentum	6	$2,224	$13,346	$4,245	$4,330	$4,416	$4,505	$30,841	**$7,710**

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Excellence Canada		
Process	*Excellence, Innovation and Wellness (EIW) Standard* • Prepare a Charter, Implementation Path and communications strategy (they can help) • Appoint a Champion and Steering Committee • Utilize the benefits of being a partner of Excellence Canada • Review Excellence, Innovation and Wellness Standard and conduct a self-assessment with a cross-functional Excellence Council • Close any gaps identified during **self-assessment** • Prepare Submission and apply for EIW Bronze Level • Provide education/highlights for staff • EIW submission verification • Celebrate achievement and continue with EIW PEP Silver and a Canada Award for Excellence *Excellence Essentials* • Designed for Small to Medium-sized organizations • One-year journey • Reflects some of the requirements in the larger Excellence, Innovation and Wellness Standard, which is implemented progressively (4 levels) • Prepares organizations for the larger Standard if so desired	
Public Health Uptake	• Toronto Public Health (just training) • Region of Peel • Leeds Grenville Lanark	
Fees	• Platinum Partner in Excellence ($25,000 per year) • Gold Partner in Excellence ($15,000 per year) • Silver Partner in Excellence ($10,000 per year) • Bronze Partner in Excellence ($995 per year)	

+ Typical Costs (for Platinum Partner)	*Excellence, Innovation and Wellness*
	• **$5,000 - $10,000** per organization
	• Time required from existing staff:
	  o Sponsor/s: 1 day per quarter
	  o Lead: 3–5 days per month
	  o Committee (~10) 1 day per month
	  o Plus functional support
		Excellence Essentials
		• **$6,000** per organization for a group of 2 organizations or more
		• Time required from existing staff:
		  o Sponsor/s: 1 day per quarter
		  o Lead: 2-3 days per month
		  o Plus functional support

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Excellence Canada Fee Structure

Progressive Excellence Program® - Excellence, Innovation and Wellness Category
Certification Fee Schedule

	Non-Partner Fees	Bronze Partner (Non-Partner less 25%)	Silver Partner (Non-Partner less 32.5%)	Gold Partner (Non-Partner less 36.25%)	Platinum Partner (Non-Partner less 40%)
Progressive Excellence Program® Package *(Standard, Guide, Templates)*	**$ 595**	**$ 446**	**$ 401**	**$ 379**	**$ 357**
Small Organization (< 50 staff)					
PEP Level 1	$ 4,000	$ 3,000	$ 2,700	$ 2,550	$ 2,400
PEP Level 2, 3 or 4	$ 8,000	$ 6,000	$ 5,400	$ 5,100	$ 4,800
Medium Organization (51 to 250 staff)					
PEP Level 1	$ 6,000	$ 4,500	$ 4,050	$ 3,825	$ 3,600
PEP Level 2, 3 or 4	$ 12,000	$ 9,000	$ 8,100	$ 7,650	$ 7,200
Large Organization (251 > staff)					
PEP Level 1	$ 8,000	$ 6,000	$ 5,400	$ 5,100	$ 4,800
PEP Level 2, 3 or 4	$ 16,000	$ 12,000	$ 10,800	$ 10,200	$ 9,600

Progressive Excellence Program® and Linkage to the *Canada Awards for Excellence*		
Organizations that are applying for *CAE* recognition at PEP Levels 2, 3 or 4 also pay the following *CAE* application fee:		
Small Organizations $ 500	Medium Organizations $ 1,000	Large Organizations $ 2,000

1. Verifier's travel time, travel expenses and accommodation costs are charged at cost only in addition to the above fees.
2. A letter with a high level overview feedback will be prepared following the site verification exercise and mailed to applicant within two weeks (approx.)
3. If the applicant requires a comprehensive assessment, presentation, detailed feedback, or other services, we would be pleased to provide them. This must be arranged in advance and additional per diem rates will apply.
4. All levels require an application, i.e. applicants wishing to apply to Level 4 directly must first be assessed and certified at Levels 1, 2 and 3.
5. If the applicant has more than one location (and only one application), a sampling process may be required. We would be pleased to discuss the requirements and prepare a detailed proposal in advance of any work performed.
6. The Certificate will be mailed to the applicant. We would be pleased to participate in formal presentations. Please inquire as to availability and related costs.
7. Re-certification at the same level (every 2 years) and 3 years after level 4 will be charged at 75% of the current rates applicable at the time of re-certification.
8. Membership discounts apply.
9. All prices are subject to applicable taxes.
10. All fees are subject to change without notice.

For more information about our PEP Certification services and the related Journey to Excellence (including baseline reviews, training, assessments, membership, and the Canada Awards for Excellence), please contact us at: T: 416-251-7600 ext. 233 (Toll Free: 800-263-9648) or visit our web site at www.excellence.ca

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 005-14

TO: Chair and Members of the Board of Health

FROM: Dr. Christopher Mackie, Medical Officer of Health and CEO

DATE: 2014 January 16

ACCESS TO DENTAL CARE FOR ADULTS

Recommendation

It is recommended that the Board of Health direct staff to advocate that the Ministry of Health and Long-Term Care develop a program that provides both publicly-funded dental treatment and prevention to low-income adults, including seniors.

Key Points

- Ontario's universal health care system does not include dental care for adults.
- Low-income adults are far less likely to have access to any form of dental care.
- Poor oral health has health and financial costs to the individual as well as costs to the health care system, the economy, and society.
- The provincial government has previously committed to fund a dental program which includes low-income adults, although no adult program has yet been developed.

Background

Oral health affects overall health. Dental disease can cause pain and infection. Gum disease has been linked to respiratory infections, cardiovascular disease, diabetes, poor nutrition, and low birth weight babies. When people suffer from poor oral health, the impact can extend beyond medical concerns. It can affect learning potential, employability, school and work attendance and performance, self-esteem, and social relationships.

Cavities and gum disease are largely preventable and can be effectively treated. However, Ontario's universal health care coverage does not include dental care despite the teeth and mouth being important parts of the human body. Publicly-funded dental programs and services are primarily limited to children and recipients of Ontario Works and the Ontario Disability Support Program. Other adults must pay for their own dental care, sometimes with the assistance of employer-sponsored dental benefits.

For low-income adults, who are less likely to have employer-sponsored dental benefits and are more likely to report poor oral health, the cost of dental care is prohibitive. Thousands of adults avoid seeking care from dentists for pain and infection in their mouths. Instead, they turn to medical doctors and emergency departments for antibiotics and painkillers which cannot address the true cause of the problem. In 2012, Ontario hospital Emergency Rooms had almost 58,000 visits for oral health problems. The South West Local Health Integration Network (LHIN), to which Middlesex-London belongs, had more visits than any other LHIN in Ontario at 6,822.

Political Context

When former Premier Dalton McGuinty announced his Poverty Reduction Strategy in 2008, he committed $45 million annually to dental care for low-income Ontarians. Some money was directed to

expanding the Children in Need of Treatment Program (CINOT) to include older youth up to age 18, and to creating the Healthy Smiles Ontario (HSO) program which is also for low-income children and youth.

Dr. Arlene King, in her 2012 report entitled ***More than Just Cavities***, recognized the health inequities created by income, education, and private dental insurance, and exacerbated by the lack of public funding for adult dental care. She called upon the Province to "explore opportunities for better integration and/or alignment of low-income oral health services in Ontario, including integration and/or alignment with the rest of the health care system".

The Association of Local Public Health Agencies (alPHa), the Ontario Oral Health Alliance, and the Association of Ontario Health Centres, along with Boards of Health across Ontario including Hamilton; Simcoe Muskoka; and Haliburton, Kawartha, Pine Ridge have since called upon the Province to expand publicly-funded care to include low-income adults. The alPHa resolution on this subject and examples of efforts from other Boards are included in Appendix A, Appendix B and Appendix C.

Local Advocacy

Current programs and services that help the children of low-income adults bring many of these people and their stories into the Health Unit. The Health Unit is able to deliver affordable teeth cleaning services to Ontario Works recipients and parents of Healthy Smiles Ontario (HSO) children through the SmileClean program. This program provides cleaning at the low cost of $30.00. However, the Health Unit and Province provide little else in terms of dental treatment or prevention to the more than 40,000 low-income adults in London and Middlesex County if they are not receiving Ontario Works. Dental treatment is often not available for those with acute dental needs. Those in pain often end up in emergency rooms where they may receive prescriptions for opioid drugs.

Staff members at the Health Unit and the Board of Health are well-positioned to advocate to the Province to include low-income adults, including seniors, among those eligible to receive publicly-funded dental care.

Conclusion

It is recommended that the Board of Health advocate that the Ministry of Health and Long-Term Care develop a program that provides both publicly-funded dental treatment and prevention (e.g. cleaning) to low-income adults, including seniors.

This report was prepared by Dr. Maria van Harten, Dental Consultant.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health and CEO

This report addresses the Ontario Public Health Standards: Foundational Standard

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 006-14

TO: Chair and Members of the Board of Health

FROM: Dr. Christopher Mackie, Medical Officer of Health and CEO

DATE: 2014 January 16

ORAL HEALTH REPORT 2013

Recommendation

It is recommended that Report No. 006-14 re Oral Health Report 2013 be received for information.

Key Points

- During the 2012-2013 school year, the Health Unit screened 15,751 students through the school-based dental screening program.
- The percentage of students screened in Junior Kindergarten who were caries-free, (i.e. have never had tooth decay or the removal or filling of a tooth because of caries) was 81%. The percentage of caries-free students in Grade 2 decreased to 60%.
- Six hundred and fifteen (615) students were found to have urgent dental needs which make them clinically eligible to receive Children in Need of Treatment (CINOT) funding for their dental care.

Purpose

The purpose of this Board of Health Report is to inform the Board of the Health Unit's oral health surveillance findings from the school-based dental screening program during the 2012-2013 school year. This information provides an overview of the oral health status of elementary schools students in Middlesex-London. These finding are outlined in the "Annual Oral Health Report" found in Appendix A with some key points summarized below. The findings will be shared with local dental and healthcare providers, partner agencies, and the general public.

Background on Oral Health Screening

One hundred and twenty-nine (129) elementary schools participated in the school-based oral health screening program in the 2012-2013 school year. Students in Junior Kindergarten, Senior Kindergarten, and Grade 2 at elementary schools were screened in accordance with the Oral Health Assessment and Surveillance Protocol of the Ontario Public Health Standards. This screening involves a Registered Dental Hygienist looking in each child's mouth to assess their past history of dental caries and if any teeth need urgent attention. The need for and urgency of dental care is recorded and the parents advised of the required follow-up. Based on the screening results of the Grade 2 students at each school, the school is categorized into the following levels of screening intensity: "Low", "Medium", or "High", as per the Protocol. Increased screening intensity level requires that additional grades be screened.

Results of the 2012-2013 School Year Screening

Participation: Of the 19,423 students who were offered dental screening at the schools that participated in the school-based dental screening program, 15,751 or 81% were screened. For the 2012-2013 school year, the Health Unit did not have parental consent to screen 2,389 (12%) students and 1,283 (7%) were absent on the day(s) that staff were screening at their schools.

Screening Intensity: Among the 126 elementary schools with Grade 2 in the Health Unit's jurisdiction, 103 were categorized as "Low" intensity, 10 as "Medium" intensity, and 13 as "High" intensity as per the Oral Health Assessment and Surveillance Protocol.

Dental Caries: The percentages of Junior Kindergarten, Senior Kindergarten, and Grade 2 students screened who were caries-free, (i.e. have never had tooth decay or the removal or filling of a tooth because of caries) were 81%, 72%, and 60%, respectively. Almost 5% of Grade 2 students screened had two or more teeth with tooth decay. The geographic distribution of school caries-free rates is summarized in Appendix A.

Urgent Dental Needs: Six hundred and fifteen (615) students or 4% of screened students have "Urgent" dental needs which make them clinically eligible to receive Children in Need of Treatment (CINOT) funding for their dental care. This percentage is lower than the recently estimated provincial average of 5-7%. However, comparisons with other jurisdictions and the provincial average should be made with caution as this figure is not routinely reported by Boards of Health or the Ministry of Health and Long-Term Care. The geographic distribution of school "Urgent" rates is summarized in the report in Appendix A.

CONCLUSION

Efforts and strategies have been developed to improve the percentage of eligible students screened. These include developing new resources that clearly explain the benefits of dental screening to parents and educators, and initiating discussions with school administrators and parent groups to investigate ways to improve consent rates. Additionally, staff members will now seek out children who were absent on the day their class was screened, and screen them on a subsequent day if staff is still scheduled to attend that school.

A pilot project to prevent the increase in caries rate as students move from Junior Kindergarten to Grade 2 is under development for two "High" screening intensity schools. Additionally, follow-up initiatives to the 2013 Oral Health Month Activities are in the planning stages to support parents seeking dental care for their young children prior to school entry. These are outlined in Board of Health Report No**.** **083-13**. Early dental care helps to prevent caries by promoting healthy oral behaviours and delivering preventive services such as cleanings and application of fluoride varnish. This work is being done in consultation with local dental providers.

This report was prepared by Dr. Maria van Harten, Dental Consultant; Chimere Okoronkwo, Manager, Oral Health Team; and Hilary Caldarelli, Contract Epidemiologist, Oral Health, Communicable Disease and Sexual Health Services.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health and CEO

This report addresses the requirements of the Child Health, Ontario Public Health Standards.

Purpose

To provide information about the findings of the Health Unit's school-based screening program from the last school year: September 2012 to June 2013.

Methodology

Publicly-funded elementary schools and three private schools participated in the school-based screening program. Students in Junior Kindergarten, Senior Kindergarten, and Grade 2 at these schools were screened in accordance with the Oral Health Assessment and Surveillance Protocol of the Ontario Public Health Standards.

Based on the screening results of the Grade 2 students at each school, the school was categorized into the following levels of screening intensity: "Low"," Medium", or "High", as per the Protocol. Increased screening intensity level requires that additional grades be screened.

The parents of the students in these grades who decline to have their children screened advise their school administrators who then pass this information on to Health Unit staff. Children whose parents have consented to screening but who are absent on the day of screening may be screened on a subsequent screening day.

Student level data was collected by five Registered Dental Hygienists employed by the Health Unit. The need for and urgency of dental care was recorded and the parents advised of the required follow-up. As well, indicators of previous dental caries were recorded. Data was collected and stored in accordance with the Oral Health Assessment and Surveillance Protocol, the Health Protection and Promotion Act, the Municipal Freedom of Information and Protection of Privacy Act, and the Personal Health Information Protection Act.

The Ministry of Health and Long-Term Care's Oral Health Information Support System was used to generate summary statistics from the student level data. Historical aggregate data was accessed from archived Health Unit spreadsheets. These data were further analysed using Microsoft Excel. For the geographic information systems (GIS) mapping of schools' percentages of caries-free and "Urgent" students, their locations and screening data for the 2012 to 2013 school year was used. Maps were developed using ArcGIS v10.

ANNUAL ORAL HEALTH REPORT December 2013

Key Findings

Participation. Of the 19,423 students who were offered dental screening at the schools that participated in the school-based dental screening program, 15,751 or 81% were screened (Figure 1). For the 2012-2013 school year, the Health Unit did not have parental consent to screen 2,389 (12%) students and 1,283 (7%) were absent on the day(s) that staff were screening at their schools. The percentage of absent students is lower than the previous year's percentage which was 11%.

Screening intensity. Among the 126 elementary schools with Grade 2 in the Health Units jurisdiction, 103 were categorized as "Low" intensity, 10 as "Medium" intensity, and 13 as "High" intensity as per the Oral Health Assessment and Surveillance Protocol which is described in the sidebar (Figure 2).

Dental caries. The percentages of Junior Kindergarten, Senior Kindergarten, and Grade 2 students screened who were caries-free, (i.e. have never had tooth decay or the removal or filling of a tooth because of caries) were 81%, 72%, and 60%, respectively (Figure 3). The schools with the lowest caries-free rates were concentrated in the counties to the west of London and the City of London Planning Neighbourhoods of Argyle, Carling, East London, Glen Cairn, Hamilton Road, Huron Heights, and White Oaks (Figures 6, 7). Almost 5% of Grade 2 students screened had two or more teeth with tooth decay (Figure 4).

Urgent dental needs. Six hundred and fifteen (615) students or 4% of those screened were found to have Urgent dental needs which makes them clinically eligible to receive Children in Need of Treatment (CINOT) funding for their dental care; (CINOT provides publicly-funded dental treatment for children with urgent needs who cannot afford this treatment) (Figure 5). Schools located in Southwest Middlesex had greater percentages of students found to have urgent needs compared to other areas of Middlesex County (Figure 8). Within London, schools with greater percentages of children with urgent needs were concentrated in the City of London Planning Neighbourhoods of Argyle, Carling, East London, Glen Cairn, Hamilton Road, Huron Heights, and White Oaks (Figure 9).

Next Steps

- Efforts and strategies have been developed to improve the percentage of eligible students screened.
- Further initiatives are in the planning stages to encourage parents to seek dental care for their young children prior to school entry. (These initiatives began as part the 2013 Oral Health Month Activities.) Early dental care helps to prevent caries by promoting healthy oral behaviours and delivering preventive services.
- A pilot project to prevent the increasing caries rate as students move from Junior Kindergarten to Grade 2 is under development for two "High" screening intensity schools.

Results

Figure 1. Percentages of students screened, absent and refused for the 2011-2012 and 2012-2013 school years

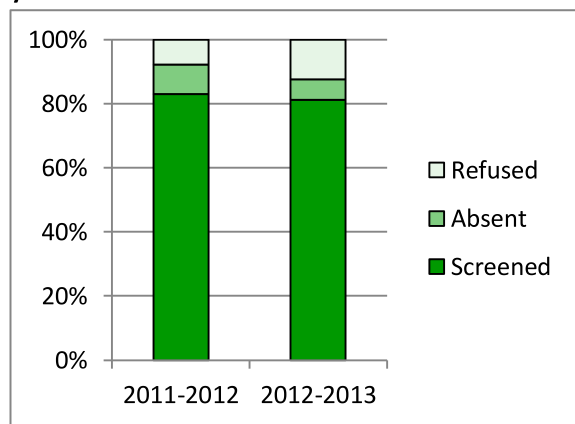


Figure 2. Screening intensity of schools by school year

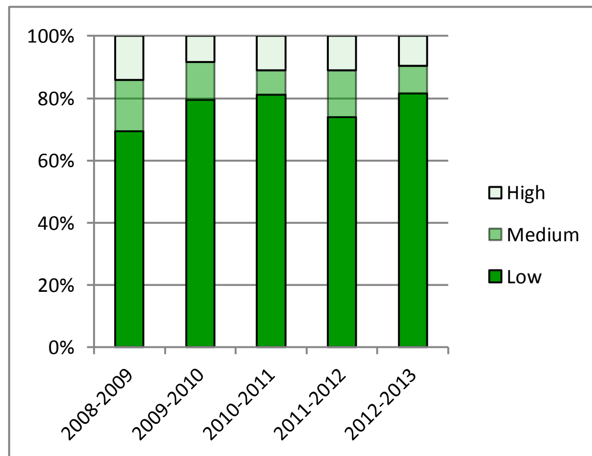


Figure 3. Percentage of students screened who were caries-free by grade for the 2011-2012 and 2012-2013 school years

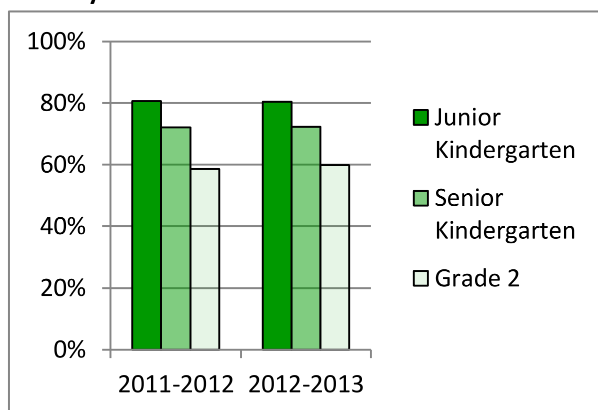


Figure 4. Percentage of Grade 2 students screened with two or more teeth affected by caries (decay, removals, or filling) by school year

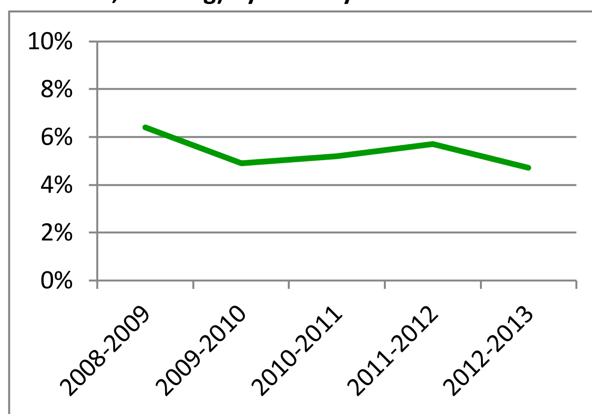


Figure 5. Percentage of students screened with Urgent dental needs by school year

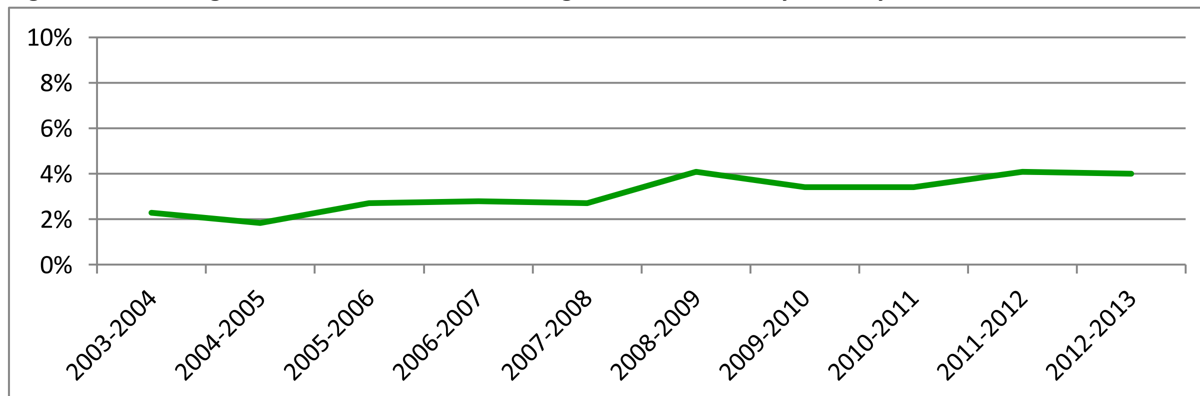


Figure 6. Geographic distribution of Middlesex County schools by percentage of caries-free students for the 2012-2013 school year

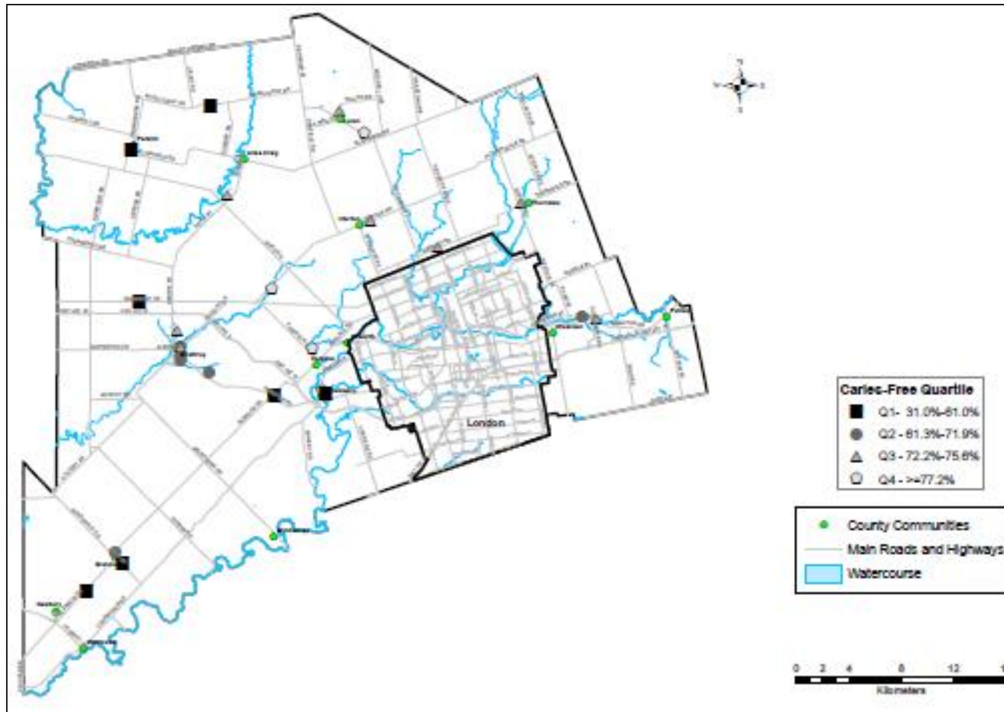


Figure 7. Geographic distribution of London schools by percentage of caries-free students for the 2012-2013 school year

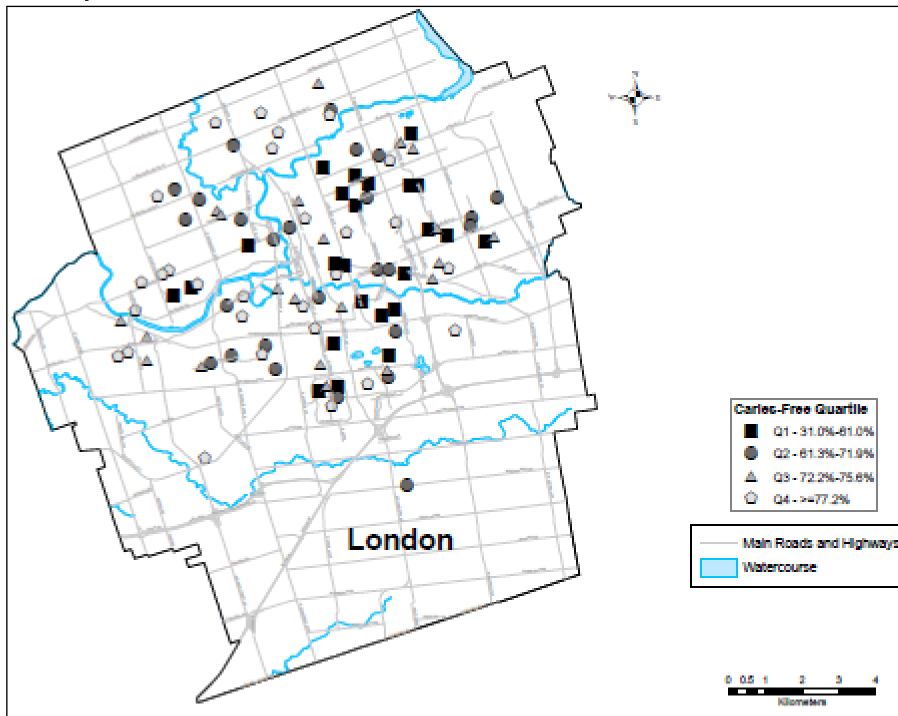


Figure 8. Geographic distribution of Middlesex County schools by percentage of students with "Urgent" needs for the 2012-2013 school year

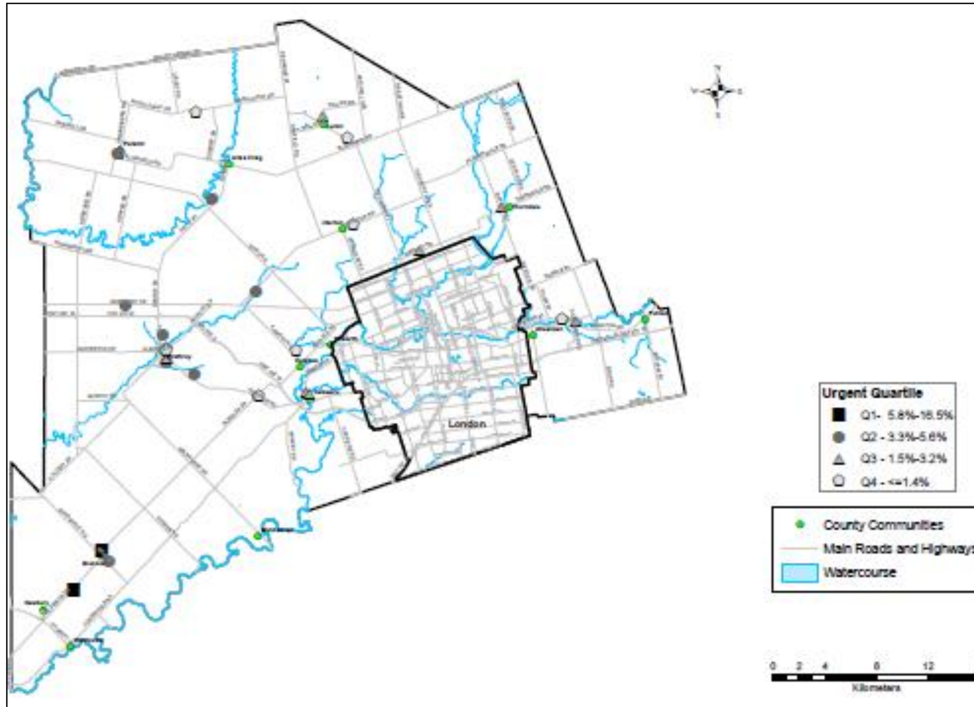
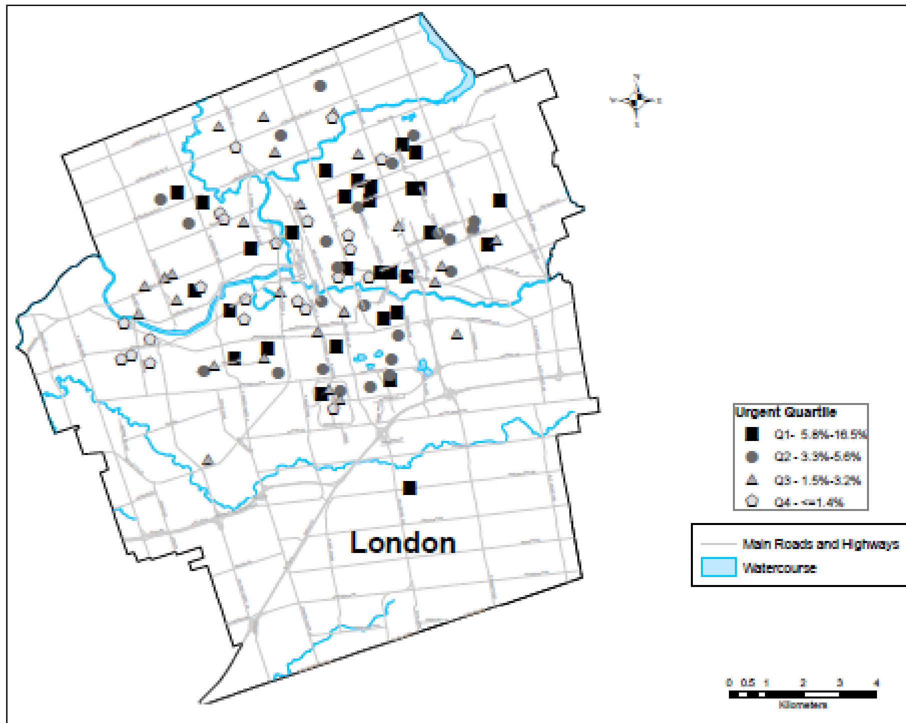


Figure 9. Geographic distribution of London schools by percentage of children with "Urgent" needs for the 2012-2013 school year



MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 007-14

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2014 January 16

CHANGES TO ORAL HEALTH PROGRAMS

Recommendation

It is recommended that Report No. 007-14 re Changes to Oral Health Programs be received for information.

Key Points

- The Ministry of Health and Long-Term Care is proposing the integration of all publicly-funded oral health programs under one program which is similar to the current Healthy Smiles Ontario program.
- The new program will have less restrictive financial requirements and will compensate providers using more consistent fee schedules with claims paid by a third-party who will be determined via a request for proposal process.
- The implications of the announced changes for health units is currently being assessed and clarified.

Introduction

On December 16, 2013, the Ministry of Health and Long-Term Care (MOHLTC) announced several changes to Oral Health Programs. The communication from the MOHLTC is provided in Appendix A. A summary of the proposed changes and their implications are outlined in this Board of Health report.

Proposed Changes

1) **Integration of Programs:** Six publicly-funded children's dental programs will be integrated into one under the name "Healthy Smiles Ontario". The six programs are the current Healthy Smiles Ontario (HSO) program, Children in Need of Treatment (CINOT), Ontario Works, the Ontario Disability Support Program, Assistance for Children with Severe Disabilities, and preventive services within the Ontario Public Health Standards. The integrated programs will be administered jointly with a common fee schedule and entitlements which would include both preventive (e.g. cleanings, sealants, fluoride) and treatment (e.g. fillings, extractions etc.) services.

   The income cut-off for eligible families to participate in the new integrated "Healthy Smiles Ontario" program will be raised from the current net family income of $20,000, to an amount that is indexed to family size. For a family with one child the adjusted family net income cut-off level will be $21,513. It is estimated that the raised cut-off level will allow approximately an additional 70,000 children less than 18 years of age across the province to participate in the program. This change will take effect in April 2014.

2) **Claims Management:** Management of claims from dentists who see clients under the new "Healthy Smiles Ontario" program will be processed by a central claims management process. The provider of this service will be determined by a request for proposal process and is expected to be in place by August 2015. Currently claims are managed by a variety of sources including by local health units.

3) **Coverage for Children Whose Family Income Exceed Cut-off levels:** Provision of services for children who have urgent dental needs, but whose family income exceeds the cut-off level and still cannot afford care, is under consideration. Currently these children would be covered under the Children in Need of Treatment Program. The provision of preventive services for children whose family income level exceeds the cut-off level but cannot afford this service has yet to be determined. Currently this service is provided at no cost at the Health Unit's 50 King Street office.

Implications for the Middlesex-London Health Unit

The implications of these proposed changes to the Oral Health Programs are not totally clear but possible implications include the following:

1) **Changes to Claims Management:** Currently the Health Unit assesses and pays claims from local dentists for services they provide under the Children in Need of Treatment program, Healthy Smiles Ontario program, and Ontario Works for Middlesex County. The centralized claims management process would eliminate the need for the Health Unit to perform these claims management functions.

2) **Preventive Services:** Currently the Health Unit provides preventive services (cleanings, sealants and fluoride) for children who are not eligible for other programs but cannot afford dental care. The provision of this service under the new system is currently unclear.

Next Steps

The province has indicated that they intend to work closely with health units as they sort through the implementation and implications of the proposed changes. Health Unit staff member will be actively engaged in this process to ensure that oral health needs of local residents will continue to be met.

This report was prepared by Dr. Bryna Warshawsky, Associate Medical Officer of Health; Dr. Chimere Okoronkwo, Manager, Oral Health; and Dr. Maria VanHarten, Dental Consultant.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health and CEO

This report addresses the following requirement(s) of the Ontario Public Health Standards: Child Health

Ontario

Ministry of Health and Long-Term Care

Chief Medical Officer of Health

Public Health Division
11th Floor, Hepburn Block
Queen's Park
Toronto ON M7A 1R3

Telephone: (416) 212-3831
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Ministère de la Santé et des Soins de longue durée

Médecin hygiéniste en chef

Division de la santé publique
Édifice Hepburn, 11e étage
Queen's Park
Toronto ON M7A 1R3

Téléphone: (416) 212-3831
Télécopieur: (416) 325-8412

DEC 16 2013

MEMORANDUM

To: **Medical Officers of Health, Board Chairs and CEOs**

Re: **Ontario to Expand Eligibility and Improve Access to Dental Programs for Low-Income Children and Youth**

Dear Colleagues,

As part of Ontario's Action Plan for Health Care to provide the right care, at the right time, in the right place and in support of Ontario's Poverty Reduction Strategy, I'm pleased to inform you of today's government announcement to expand eligibility and improve access to dental programs, making it easier for more children and youth to receive timely dental care.

The province will integrate six publicly-funded dental programs currently provided through Healthy Smiles Ontario, the Children In Need Of Treatment program, Ontario Works, the Ontario Disability Support Program, Assistance for Children with Severe Disabilities and preventive services within the *Ontario Public Health Standards, 2008*, into one seamless program for children and youth aged 17 and under from low-income families, beginning August 2015.

The new program will provide eligible children with:

- a simplified enrolment and renewal process;
- access to the full range of dental services, from preventive care such as cleanings and fluoride treatments to basic care such as fillings, extractions and X-rays;
- dental coverage for a full year.

The new program will also streamline administration and delivery of services, reducing confusion for families looking to access care. Children of social assistance recipients will be automatically enrolled into the new dental program, while all other low-income families will be able to apply through a simplified and more streamlined application process.

The province will also increase access to oral health services such as cleanings, diagnostic services and basic treatment by expanding eligibility for the Healthy Smiles Ontario program, starting in April 2014. The current financial eligibility threshold will be increased, and will vary according to the number of children in the family.

For municipal social assistance delivery agents and boards of health, the new program will result in a reduced administrative burden, allowing more time to be spent with clients on direct service delivery. We plan to actively engage with you to better understand the impact of the new program

on your day-to-day business and to ensure that this program is designed in a way that best meets the needs of clients and their families.

To assist the Ministry with this work, we'll be engaging you more extensively in the coming months to help shape the program's implementation and ongoing operation. We will also be establishing an ongoing program advisory group comprised of delivery partners to help ensure that this engagement is continuous and that your input is included every step of the way. I will also provide additional details on this initiative at the CMOH/MOH teleconference on December 19, 2013.

The new integrated program demonstrates the commitment of the Ontario government to reduce poverty, reduce inequities and increase access to oral health care in Ontario. We all recognize and agree that good oral health is important to overall health including playing a role in preventing chronic disease. I truly believe this program will go a long way to improve the oral health and overall health of Ontario's most vulnerable children and youth.

Thank you for your continuous partnership and collaboration to improve the oral health of Ontario's children.

Sincerely,

Dr. Arlene King
Chief Medical Officer of Health

cc. Kate Manson-Smith, Assistant Deputy Minister, Health Promotion Division, Ministry of Health and Long-Term Care
Roselle Martino, Executive Director, Public Health Division, Ministry of Health and Long-Term Care
Elizabeth Walker, Director, Public Health Planning and Liaison Branch, Public Health Division, Ministry of Health and Long-Term Care

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 008-14

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2014 January 16

MIDDLESESEX LONDON HEALTH UNIT SUPPORTS CONTINUED FUNDING FOR BIKE LANES

Recommendation

It is recommended that Report 008-14 re Middlesex-London Health Unit Supports Continued Funding for Bike Lanes be received for information.

Key Points

- The City of London recognizes that bicycling is a mode of active transportation which plays a critical role in the development of an environmentally stable, economically viable and healthy and active city.
- The Bike Lane Program capital project funding was reduced in 2013 and the City of London's 2014 budget report includes further reductions, putting the future of the program in jeopardy.
- The reductions to the Bike Lane Program funding are inconsistent with a commitment to developing active transportation options for the promotion of healthy and active lifestyles

Background

Active transportation such as cycling should be the preferred mode of transportation for the City of London. A rapidly growing body of research indicates that increased rates of active transportation provide numerous environmental, economic, and health benefits to society at large. Middlesex-London Health Unit has been advocating for several years for infrastructure changes that would support an increase in active transportation. In September 2012, the Board of Health reviewed Report No. 103-12 re BeCause Injuries Are Predictable and Preventable Campaign and accompanying Healthy City/Active London Video to the Rethink London process for amending the City's Official Plan.

The City of London has acknowledged the benefits of active transportation by introducing a Bicycle Master Plan (2005) and a Transportation Master Plan (2004) that recognize active transportation "…should be aggressively promoted." This is further reinforced in the London 2030 Transportation Master Plan. As well, on June 27th, 2012, City Council endorsed the international Toronto Charter for Physical Activity, demonstrating a commitment to policies, services and action that prioritize physical activity such as cycling.

City of London Budget Reductions

Capital budget reductions contained in the City of London's 2014 Budget Report include reductions to the City's Bike Lane Program. The future of the Bike Lane Program will depend upon one-time year-end operating surpluses and future property tax increases to restore capital funding to the original plan. This is described in Civic Administration's recommended solution to redress capital funding cuts contained in the Business Cases appended to the City of London 2014 Budget Report. The recommendation states:

"In the short term, Civic Administration recommends that available 2013 year end operational savings be used to reduce or eliminate the capital funding reduction in the 2014 budget, up to $3.6 million. In the

long term, Civic Administration recommends increasing the tax levy by 0.8% to generate $3.6 million of capital funding to permanently restore the original capital plan that was reduced during 2013 budget deliberations."

Should the Board wish to urge City Council to make no 2014 reductions to the capital funding of the Bike Lane Program, there is an opportunity to make a written submission to the public participation meeting of the City of London's budget process to be held on February 10, 2014 (written submissions due February 3, 2014).

Conclusion

Bike lanes in the City of London have been identified as a key factor in promoting a more active lifestyle as they provide active transportation options for all citizens. The development of a successful bike lane infrastructure in the City is still in the early stages and a continued commitment of financial support is needed. Maintaining that commitment will achieve a sustainable transportation system as identified in the Transportation Master Plan and will help Londoners to develop and maintain healthy and active lifestyles.

This report was prepared by Ms. Marylou Albanese, Manager of the Healthy Communities Injury Prevention Team and Mr. Wally Adams, Director of Environmental Health and Chronic Disease Prevention Services.

Christopher Mackie, MDCM, MHSc, CCFP, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards:
Chronic Diseases and Injuries Program Standards - Chronic Disease Prevention; Prevention of Injury.
And the 2012 – 2014 MLHU Strategic Direction: Healthy Eating and Physical Activity for all.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 009-14

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2014 January 16

REVISED PUBLIC HEALTH FUNDING AND ACCOUNTABILITY AGREEMENT

Recommendation

It is recommended that the Board of Health receive Report No. 009-14 re Revised Public Health Funding and Accountability Agreement for information.

Key Points

- The three year accountability agreement between the Ministry of Health & Long Term Care (MOHLTC) and Middlesex-London Board of Health has expired.
- The MOHLTC is now proposing revisions for future agreements.

Background

In 2011, each Board of Health entered into a three-year funding and accountability agreement with the MOHLTC (see Report No. 080-11). Known as the Public Health Accountability Agreement (PHAA), this agreement sets out funding and accountability obligations for Boards of Health and the MOHLTC. The PHAA also launched a performance monitoring process where Board of Health performance is measured using 14 indicators. The PHAA's three year term ended December 31, 2013.

In preparation for the conclusion of PHAA, the MOHLTC has proposed revisions to the agreement, as well as the performance monitoring process. Boards of Health will be given the opportunity to comment on these revisions via two webinars that will be held in early 2014.

Proposed Agreement Revisions

There are six significant revisions to the agreement (see Appendix A for the entire proposed agreement, provided by the MOHLTC, revisions marked using track-changes):

1. **Name:** The agreement will now be known as the Public Health Funding and Accountability Agreement (PHFAA).
2. **Term:** The PHFAA will no longer use a three year term. Instead it will commence once signed by both parties and will continue until it is terminated by the MOHLTC. However, the agreement must be reviewed at least every five years.
3. **Financial Controls:** The PHFAA will require Boards of Health to comply with a list of required financial controls. See Appendix B for the list of financial controls.
4. **Right to Request Information**: A new item has been added allowing "the Province [to] request additional information, or …meetings with the Board of Health to support compliance with any aspect of this Agreement" (item 8.6).

5. **User Fees and Revenue Reporting:** While the PHFAA no longer requires Boards of Health to share net revenue generated by fees, there is now specific language requiring revenue reporting.

6. **Asset Management:** The PHFAA no longer requires Boards of Health to maintain an inventory of Tangible Capital Assets with a value exceeding $5,000.

Proposed Indicators for the PHFAA

There are also four significant proposed changes to the performance monitoring process (See Appendix C for a detailed overview of these changes):

1. **Indicator Categories:** There are now three indicator categories: performance, monitoring and developmental.

2. **Number of Indicators:** There are now 28 indicators (up from 14).

3. **New Indicator Development:** The PHFAA now requires Boards of Health to “collaborate on the development of developmental indicators for areas of mutual interest.”

4. **Reporting:** The PHFAA has revised the process for Boards of Health to report issues with compliance with the agreement’s conditions (i.e., compliance variance) and issues with achieving performance targets (i.e., performance variance). See article five of the PHFAA for more details.

Feedback and Risk Tool

In January or February 2014, the MOHLTC will be holding webinars for Board of Health members (as well as senior Health Unit staff) to provide comment on the PHFAA. Webinar dates and time have not yet been released.

Board of Health members should also be aware that the MOHLTC is also preparing to launch an Organizational Risk Monitoring Tool (i.e., the “Risk Tool”) that is designed to “identify risks related to not meeting the requirements in the Organizational Standards and the PHFAA” and “provide the ministry with an opportunity to assess boards’ risk management approaches, and identifies areas in need of supports or interventions.” While a release date has not been announced, the MOHLTC has reported that the Risk Tool will be operationalized under the PHFAA.

This report was prepared by Mr. Ross Graham, Manager of Strategic Projects.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

THIS ~~Public Health~~PUBLIC HEALTH FUNDING AND ACCOUNTABILITY AGREEMENT effective as of the first day of January, 2014~~1~~

B E T W E E N :

HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO
as represented by the Minister of Health and Long-Term Care ~~and the Minister of Health Promotion and Sport~~

(the "**Province**")

- and -

[Legal Name of Board of Health]

(the "**Board of Health**")

Background:

The Province provides grants to boards of health under the *Health Protection and Promotion Act* (Act) pursuant to section 76 of that Act.

By receiving the grant provided to boards of health under section 76 of the Act, each board of health is expected to deliver programs and services that meet the Ontario Public Health Standards and other requirements of the Act.

It is acknowledged that boards of health may provide additional programs and services in response to local needs as indicated in the Ontario Public Health Standards published under section 7 of the Act and in section 9 of the Act. Provincial funding, however, is intended to support those programs that all boards of health are required to provide under the Act (and other programs only if specifically authorized by the Ontario Government) and is not intended to cover the potential total scope of public health programming.

Under section 81.2 of the Act, the Minister of Health and Long-Term Care may enter into an agreement with the board of health of any health unit for the purpose of setting out requirements for the accountability of the board of health and the management of the health unit.

Consideration:

In consideration of the mutual covenants and agreements contained herein and for other good and valuable consideration, the receipt and sufficiency of which are expressly acknowledged, the Parties agree as follows:

ARTICLE 1
INTERPRETATION AND DEFINITIONS

1.1 **Interpretation.** For the purposes of interpretation:

(a) words in the singular include the plural and vice-versa;

(b) words in one gender include all genders;

(c) the background and the headings do not form part of the Agreement; they are for reference only and shall not affect the interpretation of the Agreement;

(d) any reference to dollars or currency shall be to Canadian dollars and currency; and,

(e) “include”,~~;~~ “includes” and “including” shall not denote an exhaustive list.

1.2 **Definitions.** In this Agreement, the following terms shall have the following meanings:

“Act” means the *Health Protection and Promotion Act*.

“Admissible Expenditures” are those considered by the Ministry~~ies~~ to be reasonable and necessary for boards of health to achieve and/or maintain compliance with the Ontario Public Health Standards, the Organizational Standards, this Agreement, and other requirements of the Act and, as such, are eligible for reimbursement by the Ministry~~ies~~. These expenditures must be authorized in accordance with the policies of the Board of Health, consistent with government policies, and related to the ~~implementation of Organizational Standards and the~~ delivery of mandatory and related programs.

“Agreement” means this agreement entered into between the Province and the Board of Health and includes all of the schedules to the agreement listed in section 25.1 and any amending agreement entered into pursuant to section 3.4.

“Compliance Variance” means any of: a) non-compliance with any aspect of the Act, the regulations, the Ontario Public Health Standards, or the Organizational Standards; or, b) any other matter that could significantly affect the Board of Health’s ability to perform its obligations under this Agreement.

“Effective Date” means the date set out at the top of the Agreement.

“Event of Default” has the meaning ascribed to it in section 14.1.

“Funding Year” means:

(a) in the case of the first Funding Year, the period commencing on the Effective Date and ending on the following December 31st; and,

(b) in the case of Funding Years subsequent to the first Funding Year, the

period commencing on January 1st following the end of the previous Funding Year and ending on the following December 31st.

"Grant" means the grant provided to the Board of Health by the Province pursuant to section 76 of the Act and this ~~Accountability~~ Agreement.

"Indemnified Parties" means her Majesty the Queen in right of Ontario, her ministers, agents, appointees and employees.

"Minister~~s~~" means Her Majesty the Queen in Right of Ontario as represented by the Minister of Health and Long-Term Care, and **"Ministry"** shall refer to the Ministry of Health and Long-Term Care~~and the Minister of Health Promotion and Sport, and **"Ministries"** shall refer to both ministries Where necessary in the Schedules to this Agreement to differentiate Programs under the responsibility of each Ministry, MOHLTC is used to describe the Ministry of Health and Long-Term Care, and MHPS is used to describe the Ministry of Health Promotion and Sport~~.

"~~**"Negative Performance Variant"** means any of: a) the inability to achieve a result within the range of results for a Performance Indicator as set out in Schedule D; b) any matter that could significantly affect the Board of Health's ability to achieve a Performance Target as set out in Schedule D; c) non-compliance with any other aspect of the Act, the regulations, the Ontario Public Health Standards, or the Organizational Standards; d) non-compliance with the budget approval and financial reporting processes; or, e) any other matter that could significantly affect the Board of Health's ability to perform its obligations under this Agreement.~~**Non-Admissible Expenditures"** are those considered by the Ministry~~ies~~ to be unrelated to the provision of mandatory and related programs, the Ontario Public Health Standards, the Organizational Standards, the requirements of this Agreement, and other requirements of the Act or that are not compatible with applicable government directives. Examples of expenditures that are not admissible include, but are not limited to: sick time and vacation accruals, donations to individuals or organizations, capital fund reserves, ~~and~~ depreciation on capital assets/amortization, gym membership fees, alcoholic beverages, and providing administrative services on behalf of third parties.

"Notice" means any communication given or required to be given under this Agreement, as described in Article 16.

"Notice Period" means the period of time within which the Board of Health is required to remedy an Event of Default, and includes any such period or periods of time by which the Province considers it reasonable to extend that time.

"Ontario Public Health Standards" means the Ontario Public Health Standards published by the Minister of Health and Long-Term Care pursuant to section 7 of the Act.

"Organizational Standards" means the Ontario Public Health Organizational Standards as released by the Ministry~~ies~~ and former Ministry of Health Promotion and Sport on February 18, 2011 or as updated and as provided to the Board of Health.

“Parties” means the Province and the Board of Health.

“Party” means either the Province or the Board of Health.

~~**“Performance Corridor”** means the calculated range of results respecting a Performance Target for a Performance Indicator based on the technical variance of the data and other contextual factors.~~**“Performance Indicator”** means a measure of board of health performance for which a Performance Target is set, and to which the Board of Health will be held accountable for achieving results under the terms of this Agreement.

“Performance Target” means a planned result for a Performance Indicator against which actual results can be compared (as further specified in Table A of Schedule D).

“Performance Variance” means a) the inability to achieve a Performance Target as set out in Schedule D, as identified by the Province.~~**“Positive Performance Variant”** means a successful achievement beyond the range of results for a Performance Indicator as set out in Schedule D.~~

“Program(s)” means:

(a) Mandatory Program(s): the health programs and services boards of health must provide to their local communities in accordance with section 5 of the Act and the Ontario Public Health Standards.

(b) Related Program(s): the programs described in Schedule “B”.

(c) The Organizational Standards.

“Reports” means the reports described in Schedule “C”.

~~**“Tangible Capital Asset”** is a physical asset (e.g., building and land, information technology and telecommunications equipment, vehicles, furniture and other equipment) that has a useful life of more than one year and is used on a continuing basis for the delivery of mandatory and related programs.~~

“Wind-Down Amount” means the amount the Province sets if the Agreement is terminated under sections 12.3(c) or 13.2(c).

ARTICLE 2
REPRESENTATIONS, WARRANTIES AND COVENANTS

2.1 **General.** The Board of Health represents, warrants and covenants that:

(a) it is, and shall continue to be for the term of the Agreement, a validly existing legal entity with full power to fulfill its obligations under the Agreement; and,

(b) unless otherwise provided for in this Agreement, any information the Board of Health provided to the Province in support of its requests for a Grant (including information relating to any eligibility requirements) was true and complete at the time the Board of Health provided it and shall continue to be true and complete for the term of this Agreement, unless otherwise reported in writing by the Board of Health to the Province.

2.2 **Execution of Agreement.** The Board of Health represents and warrants that:

(a) it has the full power and authority to enter into the Agreement;

(b) it will fulfill the obligations set out in the sSchedules to this Agreement in accordance with their terms;

(c) it will deliver Programs and services that meet the Ontario Public Health Standards published under section 7 of the Act, and will comply with the Organizational Standards; and,

(d) it has taken all necessary actions to authorize the execution of the Agreement including, where required, passing a board resolution or municipal by-law authorizing the Board of Health to enter into the Agreement with the Province.

2.3 **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:

(a) procedures to ensure compliance with the Organizational Standards;

(b) a code of conduct and ethical responsibilities for all persons at all levels of the Board of Health's organization;

(c) procedures to ensure the ongoing effective functioning of the Board of Health;

(d) decision-making mechanisms;

(e) procedures to provide for the prudent and effective management of the Grant;

(f) procedures to enable the successful completion of the obligations set out in the sSchedules to this Agreement;

(g) procedures to enable the timely identification of risks to the Board of Health's ability to perform its obligations under this Agreement and strategies to address the identified risks;

(h) procedures to enable the preparation and delivery of all Reports required pursuant to Article 8; and,

(i) procedures to deal with such other matters as the Board of Health considers necessary to ensure that the Board of Health carries out its obligations under the Agreement.

2.4 **Supporting Documentation.** Upon request, the Board of Health shall provide the Province with proof of the matters referred to in this Article 2.

ARTICLE 3
TERM OF THE AGREEMENT

3.1 **Term.** The term of the Agreement shall commence on the Effective Date and ~~shall, subject to section 3.2, expire on **December 31st, 2013**~~shall continue unless terminated ~~earlier~~ pursuant to Article 12, Article 13 or Article 14.

~~3.2 Agreement to Continue. The Parties shall negotiate a new, successor agreement to this Agreement to be effective January 1, 2014. Despite section 3.1, this Agreement shall continue according to its terms until such time as a new agreement is agreed to between the Parties, unless terminated earlier pursuant to Article 12, Article 13, or Article 14.~~]

~~3.3~~3.2 ~~3.3~~ **Application of Schedules during Term.** A schedule, or parts of a schedule, may apply for only part of the Term of this Agreement. Where a schedule, or part of a schedule, applies for only part of the Term of this Agreement, it shall be so indicated in the schedule.

3.3~~4~~ **Amendments to Schedules during Term**. The Parties agree that amendments to the ~~S~~schedules may be made, on the written consent of both parties, during the Term of this Agreement. Without limiting the generality of the foregoing, the ~~S~~schedules may be amended to reflect:

(a) updated allocations in Schedule A;

(b) new polices and guidelines in Schedule B;

(c) new reporting requirements in Schedule C;

(d) updated Performance indicators, baselines and targets in Schedule D; and,

(e) updated financial controls in Schedule E.

3.4~~5~~ **Annual Review of Schedules**. The Parties agree to review the schedules to this Agreement on an annual basis, at the end of each Funding Year, to determine if amendments are appropriate.

3.5~~6~~ **Additional Schedules during Term.** The Parties agree that additional ~~S~~schedules may be added to this Agreement on the written consent of both parties during the Term of this Agreement.

3.6 **Review of Agreement.** The Parties agree to review this Agreement every five (5) years to determine if amendments are necessary and/or appropriate.

ARTICLE 4
GRANT

4.1 **Grant Provided.** The Province shall:

(a) provide the Board of Health a Grant for the purpose of carrying out the obligations set out in the Act, the regulations under the Act, the Ontario Public Health Standards, the Organizational Standards, and this Agreement including the ~~S~~schedules to this Agreement; and,

(b) deposit the Grant into an account designated by the Board of Health provided that the account resides at a Canadian financial institution.

4.2 **Limitation on Payment of the Grant.** Despite section 4.1, the Province:

(a) is not obligated to provide any Grant to the Board of Health until the Board of Health provides a valid certificate of insurance or other proof as provided for in section 11.2;

(b) is not obligated to provide instalments of the Grant until it is satisfied with the progress of the obligations set out in this Agreement and the ~~S~~schedules;

(c) may adjust the amount of the Grant it provides to the Board of Health in any Funding Year based upon the Province's assessment of the information provided by the Board of Health pursuant to section 8.1;

(d) if, pursuant to the provisions of the *Financial Administration Act* (Ontario), the Province does not receive the necessary appropriation from the Ontario Legislature for payment under the Agreement, the Province shall not be obligated to make any such payment, and, as a consequence, the Province may:

(i) reduce the amount of the Grant; or

(ii) terminate the Agreement pursuant to section 13.1 and cease providing Grant funding for a period or periods specified by the Province; and,

(e) may withhold 1% of the bi-weekly Grant payments from the Board of Health which are specified in Schedule A if the Board of Health's complete quarterly financial reports and settlement reports (consisting of Audited Financial Statements, Auditor's Questionnaire with Auditor's Report, and a Certificate of Settlement) are not submitted by the deadline ~~of June 30th~~ specified in~~of~~ any Funding Year~~, or such other deadline as~~

~~the Province specifies in writing,~~ until such time as all the ~~settlement~~ financial reports are provided.

4.3 **Use of Grant Funding.** The Board of Health shall:

(a) use the Grant only for the purposes of the Act and to provide or to ensure the provision of the health programs and services in accordance with sections 4, 5, 6, and 7 of the Act and for the purposes of carrying out the obligations in the s~~S~~chedules;~~.~~

(b) use the Grant only for the provision of the Programs described in this Agreement and the schedules;~~.~~

(c) carry out the obligations in the ~~S~~schedules:

(i) in accordance with the terms and conditions of the Agreement; and

(ii) in compliance with all federal and provincial laws and regulations, all municipal by-laws, and any other orders, rules and by-laws related to any aspect of the Programs; and,

(d) s~~S~~pend the Grant only on Admissible Expenditures.

~~4.4 **User Fees.** As the Province provides Grants for the delivery of public health programs and services, the Board of Health agrees that the Province is eligible to receive its current cost-share percentage of the net revenue from any user fees charged by the Board of Health.~~

4.4~~5~~ **No Changes.** The Board of Health shall not make any changes to ~~S~~schedules, the timelines and/or the use of the Grant without the prior written consent of the Province.

4.5~~6~~ **Interest Bearing Account.** If the Province provides the Grant to the Board of Health prior to the Board of Health's immediate need for the Grant, the Board of Health shall place the Grant in an interest bearing account in the name of the Board of Health at a Canadian financial institution.

4.6~~7~~ **Interest.** If the Board of Health earns any interest on the Grant, it must be reported. If interest income is not reported in the manner specified by the Province, 1% of the Board of Health's cash flow may be withheld through future payments.

4.7~~8~~ **No Interest Payable by Province.** The Board of Health agrees that the Province shall not pay interest on any amount to which the Board of Health may otherwise be entitled under this Agreement.

4.8~~9~~ **Rebates, Credits and the Grant.** The Board of Health shall not use the Grant for any costs, including taxes, for which it has received, will receive, or is eligible to receive, a rebate, credit or refund.

4.9 **Revenues.** All revenues collected by the Board of Health for programs or services provided under the terms of this Agreement must be reported in accordance with the direction provided in writing by the Province.

ARTICLE 5
PERFORMANCE IMPROVEMENT

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

(a) a commitment to continuous quality improvement;

(b) a culture of information sharing and understanding; and,

(c) a focus on risk-management.

5.2 **Performance Obligations.** The Board of Health shall use best efforts to achieve agreed upon Performance Targetswithin the established Performance Corridors for the Performance Indicators specified in Schedule "D".

5.3 **Elements of Performance Improvement Process.** The Board of Health's Performance Improvement Process shall include, but is not limited to:

(a) mMeasuring the Board of Health's performance according to Performance Indicators set out in Schedule D; and and,

(b) tThe use of continuous quality improvement tools including, but not limited to those specified in sections 5.4, 5.5, and 5.6..**Negative Performance Variant Reports.** If a Negative Performance Variant is identified by either the Province or Board of Health, the Board of Health shall immediately submit in writing a Negative Performance Variant Report to the Province which shall include:

5.4 **Compliance Reports.** If a Compliance Variance is identified by either the Province or Board of Health, the Board of Health shall immediately submit in writing a Compliance Report to the Province which shall include:

(a) a description of the Negative PerformanceCompliance Variance Variant;

(b) the cause of the Compliance Variance Negative Performance Variant;

(c) an assessment of the impact of the Compliance Variance Negative Performance Variant on achieving the obligations set out in this Agreement; and,

(d) a description of how the Board of Health plans to resolve the Compliance Variance Negative Performance Variant and the timeline within which the Board of Health expects to resolve it.

5.5 **Performance Reports** If a Performance Variance is identified by the Province, the Board of Health shall submit in writing a Performance Report upon request by the Province. The Performance Report to the Province shall include:

(a) the cause of the Performance Variance;

(b) an assessment of the impact of the Performance Variance on program and service delivery;

(c) a description of how the Board of Health plans to resolve the Performance Variance and the timeline within which the Board of Health expects to resolve it; and

a description of how the Board of Health plans to resolve any impacts on program and service delivery and the timeline within which the Board of Health expects to resolve them.

~~(a) **Positive Performance Variant Reports**. If a Positive Performance Variant is identified by either the Province or Board of Health, the Board of Health may be asked to submit in writing a Positive Performance Variant Report to the Province which shall include:~~

~~a description of the Positive Performance Variant and contributing success factor(s);~~

~~an assessment of the lessons learned; and~~

~~(b)~~(d) ~~a description of how the Board of Health plans to maintain or enhance success~~

~~5.5~~5.6 **Action Plan.** The Province may request in writing, either before or after a ~~Negative Performance Variant~~Compliance Report(s) specified in section 5.4, or Performance Report(s) specified in section 5.5, that the Board of Health submit an Action Plan to address the ~~Negative Performance~~ Compliance Variance(s) or Performance Variance(s)~~t~~. The Action Plan shall describe:

(a) the remedial actions undertaken (or planned to be undertaken) by the Board of Health; and,

(b) the timeframe when the remedial action is~~are~~ expected to be completed.~~;~~

5.7 **Approval of Action Plan**. The Action Plan must be approved by both the Province and the Board of Health prior to its implementation. Any revisions to the Action Plan also require the approval of both the Province and the Board of Health.~~Province Right to Request Information. The Province may request additional data or information, or may request meetings with the Board of Health to support performance improvement as specified in this Article.~~

ARTICLE 6
ACQUISITION OF GOODS AND SERVICES, AND DISPOSAL OF ASSETS

6.1 **Acquisition.** If the Board of Health acquires supplies, equipment or services with the Grant, it shall do so through a process that promotes the best value for money. All procurement of goods and services should be consistent with the Organizational Standards, good procurement practices~~,~~ and applicable government directives.

~~6.2 **Asset Management.** The Board of Health shall maintain an inventory of all Tangible Capital Assets developed or acquired with a value exceeding $5,000 or a value determined locally that is appropriate under the circumstances.~~

~~6.3~~6.2 **Disposal.** The Board of Health shall not, without the Province's prior written consent, sell, lease or otherwise dispose of any asset purchased with the Grant or for which the Grant was provided, the cost of which exceeded $100,000 at the time of purchase.

ARTICLE 7
CONFLICT OF INTEREST

7.1 **No Conflict of Interest with U~~u~~se of the Grant.** The Board of Health shall carry out the obligations set out in this Agreement and use the Grant without an actual, potential or perceived conflict of interest. Note: nothing in this agreement applies to any other local or municipal conflict of interest not dealing with the use of the Grant.

7.2 **Conflict of Interest Includes.** For the purposes of this Article, a conflict of interest includes any circumstances where:

(a) the Board of Health; or,

(b) any person who has the capacity to influence the Board of Health's decisions,

has outside commitments, relationships or financial interests that could, or could be seen to, interfere with the Board of Health's objective, unbiased and impartial judgment relating to its obligations under this Agreement and the use of the Grant.

7.3 **Disclosure to Province.** The Board of Health shall:

(a) disclose to the Province, without delay, any situation that a reasonable person would interpret as either an actual, potential or perceived conflict of interest; and,

(b) comply with any terms and conditions that the Province may prescribe as a result of the disclosure. Note that the Province may determine that no further action is required if it determines that the conflict has been

adequately addressed in accordance with the Board of Health conflict of interest policies.

ARTICLE 8
REPORTING, ACCOUNTING AND REVIEW

8.1 **Preparation and Submission.** The Board of Health shall:

(a) submit to the Province at the address provided in section 16.1 or at any other address specified by the Province, all Reports in accordance with the timelines and content requirements set out in Schedule “C”;

(b) submit to the Province at the address provided in section 16.1, or at any other address specified by the Province, any other reports requested by the Province in accordance with the timelines and content requirements specified by the Province;

(c) ensure that all Reports and other reports are completed to the satisfaction of the Province; and,

(d) ensure that all Reports and other reports are signed on behalf of the Board of Health by an authorized signing officer.

8.2 **Record Maintenance.** The Board of Health shall keep and maintain:

(a) all financial records (including invoices) relating to the Grant in a manner consistent with generally accepted accounting principles for a period of not less than seven (7) years; and,

(b) all non-financial documents and records relating to the Grant or otherwise in connection with Article 5 (Performance Improvement) and the ~~S~~schedules in accordance with applicable law and Board of Health policies.

8.3 **Inspection, Audit or Investigation.** The Province, its authorized representatives or an independent auditor identified by the Province may, at its own expense, upon twenty-four hours’ Notice to the Board of Health and during normal business hours, enter upon the Board of Health’s premises to review the Board of Health’s expenditure of the Grant and/or assess compliance with Article 5 (Performance Improvement), for these purposes, the Province, its authorized representatives or an independent auditor identified by the Province may:

(a) inspect and copy the records and documents referred to in section 8.2; and/or;~~,~~

(b) conduct an audit or investigation of the Board of Health in respect of the expenditure of the Grant, and/or compliance with Article 5 (Performance Improvement).

8.4 **Assessment.** The Province may carry out an assessment of the Board of Health under section 82 of the Act if the legal requirements for an assessment under that section have been met. An assessment may be conducted under the terms of that section irrespective of whether or not an inspection is conducted under section 8.3 of this Agreement.

8.5 **Disclosure.** To assist in respect of the rights set out in section 8.3, the Board of Health shall disclose any information requested by the Province, its authorized representatives or an independent auditor identified by the Province, and shall do so in a form requested by the Province, its authorized representatives or an independent auditor identified by the Province, as the case may be, subject to applicable law.

8.6 **Province Right to Request Information.** The Province may request additional information, or may request meetings with the Board of Health to support compliance with any aspect of this Agreement, subject to applicable law.

8.7 **No Control of Records.** No provision of the Agreement shall be construed so as to give the Province any control whatsoever over the Board of Health's records.

8.8 **Auditor General.** For greater certainty, the Province's rights under this Article are in addition to any rights provided to the Auditor General pursuant to section 9.1 of the *Auditor General Act* (Ontario) and under the *Audit Statute Law Amendment Act*.

ARTICLE 9
FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY

9.1 **FIPPA.** The Board of Health acknowledges that the Province is bound by the *Freedom of Information and Protection of Privacy Act* (Ontario) (FIPPA) and that any information provided to the Province in connection with the Agreement may be subject to disclosure in accordance with FIPPA.

9.2 **MFIPPA.** The Province acknowledges that the Board of Health is bound by the *Municipal Freedom of Information and Protection of Privacy Act* (Ontario) (MFIPPA) and that any information provided to the Board of Health in connection with the Agreement may be subject to disclosure in accordance with MFIPPA.

9.3 **Confidentiality of records.** The Board of Health shall ensure that all personal information or personal health information in its custody or under its control is managed in accordance with the provisions of the Act and its regulations, the MFIPPA ~~*Municipal Freedom of Information and Protection of Privacy Act*~~ and its regulations, the *Personal Health Information Protection Act* (PHIPA) and any other applicable legislation.

ARTICLE 10
INDEMNITY

10.1 **Indemnification.** The Board of Health hereby agrees to indemnify and hold harmless the Indemnified Parties from and against any and all liability, loss, costs, damages and expenses (including legal, expert and consultant fees), causes of action, actions, claims, demands, lawsuits or other proceedings, by whomever made, sustained, incurred, brought or prosecuted, in any way arising out of or in connection with the Programs or otherwise in connection with the Agreement, unless solely caused by the negligence or wilful misconduct of the Province.

ARTICLE 11
INSURANCE

11.1 **Board of Health's Insurance.** The Board of Health represents and warrants that it has, and shall maintain for the term of the Agreement, at its own cost and expense, with insurers having a secure A.M. Best rating of B+ or greater, or the equivalent, all the necessary and appropriate insurance that a prudent person carrying out programs and services similar to the programs and services covered by this Agreement would maintain, including commercial general liability insurance on an occurrence basis for third party bodily injury, personal injury and property damage, to an inclusive limit of not less than two million dollars ($2,000,000) per occurrence. The policy shall include the following:

(a) the Indemnified Parties as additional insureds with respect to liability arising in the course of performance of the Board of Health's obligations under, or otherwise in connection with, the Agreement;

(b) a cross-liability clause;

(c) contractual liability coverage; and,

(d) a 30-day written notice of cancellation, termination or material change.

11.2 **Proof of Insurance.** The Board of Health shall provide the Province with proof of insurance in the form of a valid certificate of insurance that confirms the insurance coverage as required in section 11.1. The Board of Health shall provide a copy of the certificate of insurance to the Province prior to the receipt of Grant funding under this Agreement.

ARTICLE 12
TERMINATION ON NOTICE

12.1 **Termination on Notice.** The Province may terminate the Agreement at any time upon giving at least 120 days' Notice to the Board of Health.

12.2 **Termination of Specific Program**. Despite section 12.1, the Province may terminate any Program that is funded by a Grant under this Agreement with 120 days' Notice. If a Program funded by a Grant under this Agreement terminates for any reason, the parties agree to amend the Agreement and Schedules to incorporate any necessary changes to the Agreement.

12.3 **Consequences of Termination on Notice by the Province.** If the Province terminates the Agreement or a specific Program pursuant to sections 12.1 or 12.2, the Province may:

(a) cancel all further instalments of the Grant;

(b) demand the repayment of any Grant remaining in the possession or under the control of the Board of Health; and/or,

(c) assist the Board of Health to wind-down the Program, project, or other initiative purchased with the Grant, set the Wind-Down Amount; and

(i) permit the Board of Health to offset the Wind-Down Amount against any Grant amount remaining in the possession or under the control of the Board of Health; and/or

(ii) subject to section 4.7, provide ~~the~~ a Grant to the Board of Health to cover the Wind-Down Amount.

ARTICLE 13
TERMINATION WHERE NO APPROPRIATION

13.1 **Termination Where No Appropriation.** If, as provided for in section 4.2(d), the Province does not receive the necessary appropriation from the Ontario Legislature for any payment the Province is to make under the Agreement, the Province may terminate the Agreement immediately by giving Notice to the Board of Health.

13.2 **Consequences of Termination Where No Appropriation.** If the Province terminates the Agreement pursuant to section 13.1, the Province may:

(a) cancel all further instalments of the Grant;

(b) demand the repayment of any Grant funds remaining in the possession or under the control of the Board of Health; and/or,

(c) ~~to~~ to assist the Board of Health to wind-~~-~~down a Program, project or other initiative purchased with the Grant, set the Wind-Down Amount, and permit the Board of Health to offset such Wind-Down Amount against the amount owing pursuant to section 13.2(b).

13.3 **No Additional Grant Funding.** For purposes of clarity, if the Wind-Down Amount exceeds the Grant remaining in the possession or under the control of the Board of Health, the Province shall not be required to provide additional Grant funding to the Board of Health.

ARTICLE 14
EVENT OF DEFAULT, CORRECTIVE ACTION AND TERMINATION FOR DEFAULT

14.1 **Events of Default.** Each of the following events may constitute at the sole option of the Province an Event of Default:

(a) the Board of Health breaches any representation, warranty, covenant or other material term of the Agreement, including failing to do any of the following in accordance with the terms and conditions of the Agreement:

(i) carry out its obligations in the ~~S~~schedules;

(ii) use or spend the Grant; and/or,

(iii) provide, in accordance with section 8.1, Reports or such other reports as may have been requested pursuant to section 8.1(b);

(b) the Board of Health's operations, or its organizational structure, changes so that it no longer meets one or more of the applicable eligibility requirements of the Program under which the Province provides the Grant; and/or,~~and~~,

(c) the Board of Health ceases to operate, is merged or otherwise dissolved.

14.2 **Consequences of Events of Default and Corrective Action.** If an Event of Default occurs, the Province may, at any time, take one or more of the following actions:

(a) initiate any action the Province considers necessary in order to facilitate the successful continuation or completion of the Board of Health's obligations under this Agreement;

(b) provide the Board of Health with an opportunity to remedy the Event of Default;

(c) suspend the payment of the Grant for such period as the Province determines appropriate;

(d) reduce the amount of the Grant;

(e) cancel all further installments of the Grant;

(f) demand the repayment of any amounts of the Grant remaining in the possession or under the control of the Board of Health that is not already promised by legal agreement that the Board of Health has with another person;

(g) demand the repayment of an amount equal to any Grant the Board of Health used for purposes not agreed upon by the Province;

(h) demand the repayment of an amount equal to any Grant the Province provided to the Board of Health; and/or,

(i) terminate the Agreement at any time, including immediately, upon giving Notice to the Board of Health.

14.3 **Opportunity to Remedy.** If, in accordance with section 14.2(b), the Province provides the Board of Health an opportunity to remedy the Event of Default, it shall provide Notice to the Board of Health of:

(a) the particulars of the Event of Default; and,

(b) the Notice Period.

14.4 **Board of Health not Remedying.** If the Province has provided the Board of Health with an opportunity to remedy the Event of Default pursuant to section 14.2(b), and:

(a) the Board of Health does not remedy the Event of Default within the Notice Period;

(b) it becomes apparent to the Province that the Board of Health cannot completely remedy the Event of Default within the Notice Period; and/or

(c) the Board of Health is not proceeding to remedy the Event of Default in a way that is satisfactory to the Province,

the Province may extend the Notice Period, or initiate any one or more of the actions provided for in sections 14.2 (a), (c), (d), (e), (f), (g), (h) and (i).

14.5 **When Termination Effective.** Termination under this Article shall take effect as set out in the Notice.

14.6 **Ministry's Rights under the Act maintained.** Nothing in this Agreement shall limit the Province's or the Chief Medical Officer of Health's rights under section 82 of the Act to conduct an assessment of the Board of Health if the conditions under that section are met.

ARTICLE 15
RETURN OF THE GRANT

15.1 **Return of The Grant*.*** If the Province requests in writing the repayment of the

whole or any part of the Grant; due, for example, to an Event of Default; the amount requested shall be deemed to be a debt due and owing to the Province and the Board of Health shall pay the amount immediately.

15.2 **Method of Return.** The Province may recover the Grant requested in section 15.1 through a cash-flow adjustment. If a cash-flow adjustment is not possible, the Board of Health shall repay the amount payable by cheque payable to the Minister of Finance and mailed to the Province at the address set out in the Province's request for repayment.

15.3 **Interest on the Grant Payable.** The Province reserves the right to demand interest on any amount owing by the Board of Health at the then current rate charged by the Province on accounts receivable. Interest shall accrue 30 days after Notice has been provided under section 15.1 for repayment of the Grant.

15.4 **Unused Grant.** The Board of Health agrees that it shall report to the Province in writing any part of the Grant that has not been used or accounted for by the Board of Health, either 30 days prior to the end of the Funding Year, in the quarterly financial reports, or in a report provided as soon thereafter as possible, and when the amount of the unused Grant is known.

15.5 **Carry Over of Grant Not Permitted.** The Board of Health is not permitted to carry over the Grant from one calendar year to the next, unless pre-authorized in writing by the Province.

15.6 **Return of Unused Grant.** Without limiting any rights of the Province under Article 13, or sections 15.1 or 15.2, if the Board of Health has not spent all of the Grant allocated for the Funding Year as provided for in the ~~S~~schedules, the Province may:

(a) demand the return of the unspent Grant; or,

(b) adjust the amount of any further instalments of the Grant accordingly.

ARTICLE 16
NOTICE

16.1 **Notice in Writing and Addressed.** Notice shall be in writing and shall be delivered by e-mail, postage-prepaid mail, personal delivery or facsimile, and shall be addressed to the Province and the Board of Health respectively as set out below or as either Party later designates to the other by Notice:

To the Province:	**To the Board of Health:**
Ministry of Health and Long-Term Care	[Legal Name of Board of Health]
393 University Ave., Suite 2100 Toronto ON M7A 2S1	[Board of Health address]

Attention:
Sylvia Shedden
Director, Public Health Standards, Practice and Accountability Branch

Fax: 416-314-7078
E-mail: sylvia.shedden@ontario.ca

Attention:
[Medical Officer of Health/ Chief Executive Officer]

Fax: [insert]
E-mail: [insert]

16.2 **Notice Given.** Notice shall be deemed to have been received:

(a) in the case of postage-prepaid mail, seven (7) days after a Party mails the Notice; or,

(b) in the case of e-mail, personal delivery or facsimile, at the time the other Party receives the Notice.

16.3 **Postal Disruption.** Despite section 16.2(a), in the event of a postal disruption:

(a) nNotice by postage-prepaid mail shall not be deemed to be received; and,

(b) the Party giving Notice shall provide Notice by personal delivery, by facsimile, or by e-mail.

ARTICLE 17
CONSENT BY PROVINCE

17.1 **Consent.** The Province may impose any terms and conditions on any consent the Province may grant pursuant to the Agreement.

ARTICLE 18
SEVERABILITY OF PROVISIONS

18.1 **Invalidity or Unenforceability of Any Provision.** The invalidity or unenforceability of any provision of the Agreement shall not affect the validity or enforceability of any other provision of the Agreement. Any invalid or unenforceable provision shall be deemed to be severed.

ARTICLE 19
WAIVER

19.1 **Waivers in Writing.** If a Party fails to comply with any term of the Agreement, that Party may only rely on a waiver of the other Party if the other Party has provided a written waiver in accordance with the Notice provisions in Article 16. Any waiver must refer to a specific failure to comply and shall not have the effect of waiving any subsequent failures to comply.

ARTICLE 20
INDEPENDENT PARTIES

20.1 **Parties Independent.** The Board of Health acknowledges that it is not an agent, joint venturer, partner or employee of the Province, and the Board of Health shall not take any actions that could establish or imply such a relationship.

ARTICLE 21
ASSIGNMENT OF AGREEMENT OR THE GRANT

21.1 **No Assignment.** The Board of Health shall not assign any part of the Agreement or the Grant without the prior written consent of the Province.

21.2 **Agreement to Extend.** All rights and obligations contained in the Agreement shall extend to and be binding on the Parties' respective heirs, executors, administrators, successors and permitted assigns.

ARTICLE 22
GOVERNING LAW

22.1 **Governing Law.** The Agreement and the rights, obligations and relations of the Parties shall be governed by and construed in accordance with the laws of the Province of Ontario and the applicable federal laws of Canada. Any actions or proceedings arising in connection with the Agreement shall be conducted in Ontario.

22.2 **Conflicts - Ontario**. In the event of a conflict between this Agreement and the Ontario Public Health Standards, the Organizational Standards or the Act or its regulations, the Ontario Public Health Standards, Organizational Standards or the Act or its regulations prevail.

22.3 **Conflicts – Municipal**. In the event of a conflict between any requirement of this Agreement and any municipal or local requirement at law to which the Board of Health is subject, the Board of Health shall comply with the stricter requirement.

ARTICLE 23
FURTHER ASSURANCES

23.1 **Agreement into Effect.** The Parties shall do or cause to be done all acts or things necessary to implement and carry into effect the terms and conditions of the Agreement to its full extent.

ARTICLE 24
SURVIVAL

24.1 **Survival.** The provisions in Article 1, Article 4, Article 5, sections 8.1 (to the extent that the Board of Health has not provided the Reports or other reports to the satisfaction of the Province), 8.2, 8.3, 8.4, 8.5, 8.6, 8.7, 8.8, Articles 9, 10 and 11, sections 13.2, 14.2, 14.3, 14.4, Articles 15,18, 19, 21, 26, 27, 28, and all applicable Definitions, cross-referenced provisions and schedules shall continue in full force and effect for a period of seven years from the date of expiry or termination of the Agreement**.**

ARTICLE 25
SCHEDULES

25.1 **Schedules.** The Agreement includes the following schedules:

(a) Schedule "A" – Program-Based Grants;

(b) Schedule "B" – Related Program Policies and Guidelines;

(c) Schedule "C" – Reporting Requirements; ,~~s.~~

(d) Schedule "D" – Board of Health Performance; and

~~(d)~~(e) Schedule "E" – Board of Health Financial Controls.

25.2 **Purpose of Schedules.** The purpose of the schedules under the Agreement is to:

(a) s~~S~~pecify the Grant to be allocated from the Province to the Board of Health to deliver public health p~~P~~rograms and services that meet the Ontario Public Health Standards, the Organizational Standards, and other requirements of the Act~~, and the Organizational Standards~~;

(b) p~~P~~rovide the Board of Health with further information on expectations related to the Grant;

(c) i~~I~~mprove and strengthen the Province's ability to effectively analyze the Board of Health's expenditures and ensure accountability for the use of the Grant; and,~~;~~

(d) c~~C~~ontribute to a public health sector with a greater focus on performance improvement, accountability and sustainability.

ARTICLE 26
COUNTERPARTS

26.1 **Counterparts.** The Agreement may be executed in any number of counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

ARTICLE 27
JOINT AND SEVERAL LIABILITY

27.1 **Joint and Several Liability**. Where the Board of Health is comprised of more than one entity, all such entities shall be jointly and severally liable to the Province for the fulfillment of the obligations of the Board of Health under the Agreement.

ARTICLE 28
ENTIRE AGREEMENT

28.1 **Entire Agreement.** The Agreement constitutes the entire agreement between the Parties with respect to the subject matter contained in the Agreement and supersedes all prior oral or written representations and agreements.

28.2 **Modification of Agreement.** The Agreement may only be amended by a written agreement duly executed by the Parties.

The Parties have executed the Agreement on the dates set out below.

HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO
as represented by the Minister of **Health and Long-Term Care**

____________________________ _______________
Name: Roselle Martino Date
Title: Executive Director
Public Health Division and
Office of the Chief Medical Officer of Health

____________________________ _______________
Name: Kate Manson-Smith Date
Title: Assistant Deputy Minister
Health Promotion Division

[Legal Name of Board of Health]

I/We have authority to bind the Board of Health.

______________________ ________________
Name: Date
Position:

______________________ ________________
Name: Date
Position:

SCHEDULE E

BOARD OF HEALTH FINANCIAL CONTROLS

Financial controls support the integrity of the Board of Health's financial statements and support the safeguarding of assets and prevent and/or detect significant errors including possible fraud. The following control criteria ensure financial transactions include the following attributes:

- **Completeness** – all financial records are captured and included in the Board of Health's financial reports;
- **Accuracy** – the correct amounts are posted in the correct accounts;
- **Authorization** – the correct levels of authority (i.e. delegation of authority) are in place to approve payments and corrections including data entry and computer access;
- **Validity** – invoices received and paid are for work performed or products received and the transactions properly recorded;
- **Existence** – of assets and liabilities and adequate documentation exists to support the item;
- **Error Handling** – errors are identified and corrected by those who have proper authority;
- **Segregation of Duties** – to ensure certain functions are kept separate to support the integrity of transactions and the financial statements; and,
- **Presentation and Disclosure** – timely preparation of financial reports in line with the approved accounting method (e.g., Generally Accepted Accounting Principles (GAAP).

The Board of Health is required to have the following financial controls in place:

1. Controls that support the collection of accurate and complete financial information.

Controls include, but are not limited to:

- Numbered documents such as sequentially numbered cheques to avoid duplication.
- All accounts reconciled on a regular and timely basis.
- Automated controls such as valid date ranges, dollar value limits.
- Regular comparison of budgeted versus actual dollar spending and variance analysis.
- Documented policies and procedures and clearly defined lines of authority for approving payments (e.g., documented Delegation of Authority).
- Exception reports and the timeliness to clear transactions.
- Segregation of duties (e.g., ensure the same person is not responsible for ordering, recording and paying for purchases).
- System batch totals.

2. **Chart of accounts that are used to correctly record financial transactions.**

   Controls include, but are not limited to:
   - An authorized chart of accounts.
   - Use of a capital asset ledger.
   - Dedicated staff with authority to approve journal entries and credits.
   - Access to accounts is appropriately restricted.
   - Budget to actual comparisons (variance analysis) including cash flow analysis.
   - Trial balances including all asset accounts that are prepared and reviewed by supervisors on a monthly basis.

3. **Receivable balances are collected on a timely basis.**

   Controls include, but are not limited to:
   - Independent review of an aging accounts receivable report to ensure timely clearance of accounts receivable balances.
   - Separate accounts receivable function from the cash receipts function.
   - Reconcile trial balances with general ledger control accounts on a regular and timely basis.
   - Original source documents are maintained and secured to support all receipts and expenditures.

4. **Goods are purchased, received and accounted for and paid by someone with proper authority.**

   Controls include, but are not limited to:
   - Segregation of duties is used to apply the three way matching process (i.e. Supplier invoices are 1) matched with the applicable authorized purchase order, 2) matched with applicable validated packing slips, 3) reviewed for accuracy).
   - Duties are segregated with respect to those who set up a vendor versus those approving payment to the vendor, and those receiving goods.
   - Any discounts are accounted for (and recorded in accounts receivable); processes in place to take advantage of offered discounts.
   - Trial balance of accounts payable is reconciled to the general ledger control account on a regular and timely basis.
   - Evidence is on file to support the proper reimbursement of expenses (i.e. they've been submitted properly along with receipts with approval for payment and fall within internal policies and procedures).
   - Original source documents are maintained and secured to support all receipts and expenditures.
   - Regular monitoring to ensure compliance with applicable directives (e.g., Ontario Public Sector Travel, Meal and Hospitality Expenses Directive).
   - Monitoring for duplicate payments (i.e. invoice stamped as paid and matched with cheque copy).
   - Credit card expenses are monitored and authorized before payment is made.
   - Monitoring of breaking down large dollar purchases into smaller invoices in an attempt to bypass approval limits.

5. **Policy and procedures that prevent the event of potential errors, omissions or fraud through disbursement of funds including payroll.**

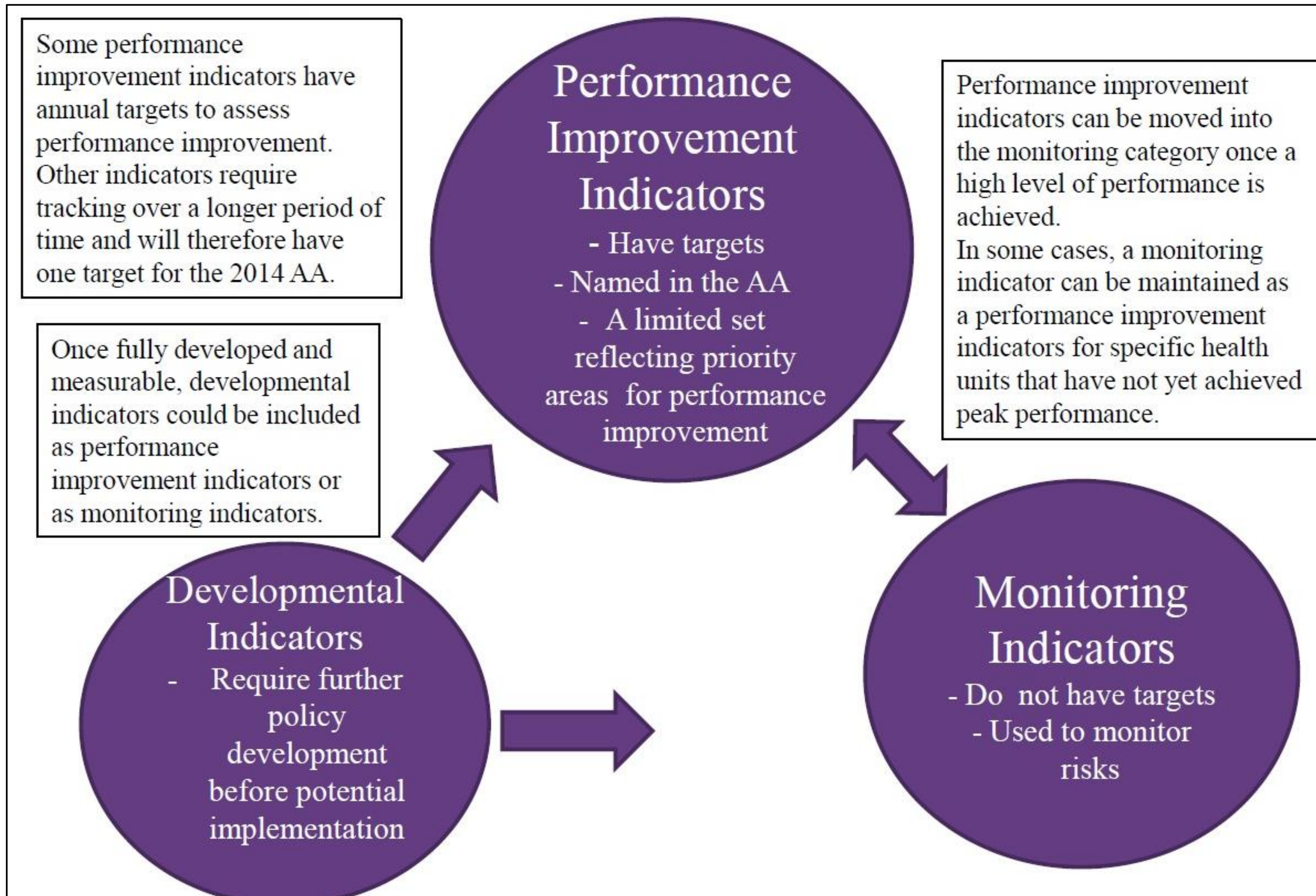
   Controls include, but are not limited to:
   - General policies defining dollar limit for paying cash versus cheque.
   - Separate roles to approve purchases versus paying for purchases along with authorized dollar limits.
   - Cheques are sequentially numbered and access is restricted to those with authorization to issue payments.
   - All cancelled or void cheques are accounted for along with explanation for the cancellation.
   - A process is in place for accruing liabilities.
   - Stale-dated cheques are followed up on and cleared on a timely basis.
   - Bank statements and cancelled cheques are reviewed on a regular and timely basis by a person other than the person processing the cheques / payments.
   - Bank reconciliations occur monthly for all accounts and are independently reviewed by someone other than the person authorized to sign cheques.
   - Separate payroll preparation, disbursement and distribution functions.

6. **Accounting functions including authorizing and processing a financial transaction, recording and holding assets are segregated to substantially reduce the risk of misappropriation of funds.**

   Controls include, but are not limited to:
   - Separating responsibilities of:
     - The person who records transactions and the person who is responsible for purchasing;
     - The person who handles accounts payable and the individual(s) who signs cheques;
     - The person who records invoices and accounts receivable and the person who opens the mail and makes bank deposits;
     - Record keeping is separate from operations and/or the handling and custody of assets; and,
     - Bookkeeper’s duties exclude receiving cash or cheques, preparing bank deposits, signing cheques, and opening incoming mail.
   - Audit trails support the monitoring of transactions including those with override capabilities and the opportunity to spot-check for unauthorized activity.
   - Audit trails of recorded overrides are monitored by individuals who do not hold override capability and are responsible for overseeing the financial activities of the Board of Health.

Public Health Funding and Accountability Agreement (PHFAA): Proposed Indicators

The Ministry (MOHLTC) has created three types of indicators for the next PHFAA: Performance, Monitoring and Developmental. The figure below demonstrates the nature and relationships between the 3 indicator types. The proposed indicators of each type are reported on subsequent pages. However, it is important to note that these indicators are still "proposed" and may change. The MOHLTC reported on December 5, 2013 that "final decisions on indicators for inclusion in the PHFAA will be made by ministry senior management within the next few weeks."



(Used in various *Joint Ministry/Boards of Health Committee* presentations - December 5, 2013)

PERFORMANCE IMPROVEMENT INDICATORS *(require reporting)*

Health Protection	**Current**	**New**
1. % of high risk food premises inspected once every 4 months while in operation	●	
2. % of year-round moderate-risk food premises inspected once every 6 months while in operation		●
3. % of Class A pools inspected while in operation	●	
4. % of high risk Small Drinking Water Systems (SDWS) inspections completed for those that are due for re-inspection^	●	
5. % of known high risk personal service settings inspected annually *	●	
6. % of suspected rabies exposures reported that have the investigation initiated within 24 hours from time of PHU notification		●
7. % of confirmed gonorrhea cases where initiation of follow-up occurred within 2 business days^	●	
8. % of confirmed iGAS cases where initiation of follow-up occurred on the same day as receipt of lab confirmation of a positive case^	●	
9. % of vaccine wasted by vaccine type (HPV) that are stored/ administered by the PHU	●	
10. % of vaccine wasted by vaccine type (influenza) that are stored/ administered by the PHU **	●	
11. % of refrigerators storing publicly funded vaccines that have received a completed routine annual cold chain inspection		●
Health Promotion	**Current**	**New**
12. % of youth who never smoked a whole cigarette ***	●	
13. % of tobacco vendors in compliance with youth access legislation at the time of last inspection	●	
14. Fall-related emergency visits in older adults aged 65+***	●	
15. % of population (19+) that exceeds the Low-Risk Alcohol Drinking Guidelines***	●	
16. Baby-Friendly Initiative (BFI) Status	●	
17. Oral Health Assessment and Surveillance: % of all JK, SK and Grade 2 students screened in publicly funded schools		●
18. % of secondary schools inspected once per year for compliance with the Smoke-Free Ontario Act (SFOA)		●
19. % of completion of youth access inspections for compliance with the Smoke-Free Ontario Act (SFOA)		●
20. % completion of tobacco vendor display, handling and promotion inspections for compliance with the Smoke-Free Ontario Act (SFOA)		●
21. Implementation status of NutriStep®		●

Performance Improvement Indicator Notes

*The Personal Service Settings indicator is expected to be redefined in order to be implementable. A working group has been involved in considering options and making recommendations to the ministry. The revised indicator is being developed using the same indicator criteria that have been used throughout this process.

^These indicators may be used as monitoring indicators (see below) for high performing health units

**A change to the time period for measurement and reporting on the Vaccine Wastage (influenza) indicator is being considered: from the current calendar year to using the flu season (Fall to Spring), as this aligns with field ordering, tracking, and return practices.

***Only one long-term target set for 2016

MONITORING INDICATORS *(require reporting)*

“The following current indicators will be used as monitoring indicators for **those health units that are sustaining high levels of performance**:”

Health Protection	Current	New
1. % of high risk Small Drinking Water Systems (SDWS) inspections completed for those that are due for re-inspection	●	
2. % of confirmed gonorrhea cases where initiation of follow-up occurred within 2 business days	●	
3. % of confirmed iGAS cases where initiation of follow-up occurred on the same day…	●	

“Monitoring indicators for **all health units** will include:”

Health Protection	Current	New
4. % of public spas inspected		●
5. % of school-aged children who have completed immunizations for Hepatitis B	●	
6. % of school-aged children who have completed immunizations for HPV	●	
7. % of school-aged children who have completed immunizations for meningococcus	●	

DEVELOPMENTAL INDICATORS *(do not require reporting)*

Under Schedule D of the PHFAA, the Province agrees to “collaborate on the development of Developmental Indicators for areas of mutual interest including, but not limited to” the following developmental indicators. In other words, the following indicators still require refinement before a decision regarding inclusion/exclusion in the PHFAA.

Health Protection	Current	New
1. Presence of a certified food handler (CFH) in high-risk food service premises;		●
2. N. gonorrhea cases treated according to recommended Ontario treatment guidelines;		●
3. Implementation of infection control measures to address long-term care facility outbreaks;		●

Health Promotion	Current	New
4. Assess the effectiveness of public health unit partnerships regarding falls prevention: using a partnership evaluation tool;		●
5. Track progression on local alcohol policy development: policies that create or enhance safe and supportive environments;		●
6. Tobacco Prevention: Level of Achievement of Tobacco Use Prevention in Secondary School: progress towards implementation of tobacco-free living initiatives within secondary schools;		●
7. Obesity Prevention: Policy & Environmental Support Status: healthy eating and physical activity policy development and the creation of supportive environments that will help to reduce childhood obesity; and		●
8. Growth and Development – Parent access to the Nipissing District Developmental Screen™: promotion and implementation of healthy growth and development screen.		●

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 010-14

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2014 January 16

ANNUAL PERFORMANCE REPORT ON THE STRATEGIC DIRECTIONS

Recommendation

It is recommended that the Board of Health receive Report No. 010-14 re Annual Performance Report on the Strategic Directions for information.

Key Points

- 2014 is the final year of MLHU's current strategic plan.
- Significant progress has been made on nearly all of the strategic directions. Work continues, including preparing for the next strategic plan.

Background

In 2011, the Middlesex-London Health Unit (MLHU) conducted a community consultation and strategic planning process that resulted in a new vision and three year strategic plan for 2012-2014 (see Report No. **008-13**). 2014 is the final year of this strategic plan. This report provides an overview of the progress that has been made in 2013 and the activities that are planned for 2014.

Progress

Significant progress has been made to date on nearly all of the strategic directions (see Appendix A for a detailed overview). Key accomplishments include:

- Launch of new Health Unit website.
- Increased social media use and social media training for staff.
- Launch of a new intranet platform, to improve internal communication and coordination, as well as facilitate process improvements (e.g., mileage submission and reimbursement).
- Completed pilot of the provincial Health Equity Impact Assessment (HEIA) tool, to ensure our programs are accessible to those who need them most (the HEIA will be used more broadly in 2014).
- Numerous health eating/physical activity programs launched (e.g., Middlesex-London *in motion* campaign; Harvest Bucks program).
- Use of provincial social determinants of health (SDOH) nursing funds to support enhanced advocacy and services for marginalized individuals, families and priority populations.

Work continues in a number of areas. Significant events during 2013 (e.g., hiring of a new Medical Officer of Health, the Shared Services Review, the PBMA process) occupied resources that can now be redirected toward the strategic directions.

Sustaining Momentum in 2014

Key initiatives for 2014 include: (a) finalizing a facilities plan that will support Board of Health discussions and decision-making on Health Unit facility locations and renovations; (b) staff education on the impact of social inequities on health status; (c) broader application of the HEIA tool; and (d) sustained advocacy for policy and environments that support healthy eating and physical activity.

The Health Unit will also need to respond to a provincial strategy designed to advance Electronic Medical Records (EMRs) in public health, which is scheduled for release in 2014. Similar to the impact of implementing EMRs in hospitals and primary care, this strategy will likely have a significant impact on Health Unit resources and future priorities.

Preparing for 2015

The final year of a strategic plan also signals the need to prepare for a successive plan. In fact, Boards of Health are required to maintain a 3-5 year strategic plan via Organizational Standard 3.2. Development the next strategic plan will be a key initiative for the Senior Leadership Team, facilitated by the recently hired Director of Human Resource and Corporate Strategy.

This report was prepared by Mr. Ross Graham, Manager of Strategic Projects.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

Area	Desired Outcome	Progress	Notes
Physical Activity Healthy Eating	• Increase opportunities for physical activity in the community		• Numerous programs launched (e.g., Middlesex-London *in motion* campaign) • Extensive internal review of related activities and programs to ensure
	• Increase opportunities for youth and vulnerable families to improve healthy cooking skills		• Increase opportunities for healthy cooking skills targeting vulnerable youth
	• Advocate for policies that make it easier for families to purchase and consume fruits and vegetables, and engage in physical activity		• Numerous advocacy initiatives launched in collaboration with community partnership and the Child & Youth Network (CYN) • Sustained effort needed for 2014
Health Inequities	• Ensure our services are as accessible as possible to all members of the community		• Two internal health equity reviews completed, more scheduled for 2014
	• Dedicate extra staff to support disadvantaged individuals and families		• Numerous initiatives strengthened/launched using provincial social determinants of health nursing funds
	• Support and educate our staff to focus their work on priority populations		• Launch of extensive staff education initiative planned for Feb. 13, 2014
Organizational Health, Vitality	• Enhance leadership and organizational culture		• Cultural assessment completed by SLT and culture visioning session held with all management • Major changes to budget process has enhanced accountability and transparency • Further cultural development planned in 2014, including in financial policies and internal communications
	• Improve communication and coordination		• Numerous new strategies to enhance internal communications and coordination
Communications	• Redevelop MLHU website		• New website launched in spring 2013
	• Increase use of social media tools		• Increase use of Facebook and Twitter and increase staff social media training
Information Technologies	• Upgrade electronic recordkeeping systems		• Review of electronic health record systems conducted • Progress halted given MOHLTC announcement of pending release of provincial EMR strategy
	• Launch new intranet platform		• New intranet platform launched in fall 2013
Facilities	• Develop a long-term Facilities Plan		• Facilities plan still under development

Delayed In-Progress Achieved/On-Track

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 011-14

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2014 January 16

MEAT PROCESSING INSPECTIONS: NEW RESPONSIBILITY

Recommendation

It is recommended that Report No. 011-14 re Meat Processing Inspections: New Responsibility be received for information.

Key Points

- Amendments to *Ontario Meat Regulation 31/05* came into effect on January 1, 2014
- The three amendments result in OMAF inspectors concentrating on slaughter plants and high risk free standing meat plants
- Public Health Inspectors at Ontario health units now have responsibility for inspecting lower risk and lower volume free standing meat plants

Background

Meat processing plants in the province of Ontario are considered either Slaughter Plants or Free Standing Meat Plants (FSMP). The processing at FSMP may include aging, cutting, slicing, tenderizing, packaging, canning, curing, fermenting or smoking. Prior to 2005, Public Health Inspectors (PHI) from health units inspected Free Standing Meat Plants (FSMP) as they are, by definition, "food premises" falling under the authority of the *Health Protection and Promotion Act*. The Canadian Food Inspection Agency (CFIA) or the Ontario Ministry of Agriculture and Food (OMAF), were responsible for licensing and inspecting Slaughter Plants.

In 2004, Justice Haines recommended in his *Report of the Meat Regulatory and Inspection Review* having all FSMPs fall under the jurisdiction of OMAF and the newly created *Ontario Meat Regulation 31/05*. This new regulation replaced the *Meat Inspection Act* and OMAF became responsible for licensing and inspecting all FSMPs in the province of Ontario. This regulatory structure was recently brought into question as it relates to the Ontario government's Open for Business initiative, particularly as it contributed to inefficiencies with inspection processes, and unnecessary challenges for industry.

In 2013, amendments to *Ontario Meat Regulation 31/05* were proposed by OMAF to allow for a more efficient and effective provincial meat inspection program. Under the proposed amendments, OMAF would be able to concentrate their licensing and inspection duties in Slaughter Plants and high risk meat processing plants. On June 7th, 2013, a multi-agency workshop was hosted by OMAF in Guelph ON, to discuss the proposed amendments and to garner feedback from the Ministry of Health and Long-Term Care (MOHLTC), public health units and various industry representatives.

As of January 1, 2014, 3 amendments to the Ontario Meat Regulation 31/05 have come into effect.

Amendments to Ontario Meat Regulation 31/05

The 3 amendments are as follows:

Food product exemption: OMAF will no longer license or inspect businesses that prepare products with less than 25% meat (by weight). Examples of such products may include pizza, sandwiches or lasagnas.

Volume distribution exemption: OMAF will no longer license or inspect businesses if the business only performs low risk processing activities (cutting, slicing and packaging) and most of the product is sold directly to the customer from a retail store. To be exempt from the regulation, businesses must either sell less than 25 per cent or less than 20,000 kg of their products annually, wholesale.

Food service exemption: OMAF will no longer license or inspect food processing activities at premises where the main business is preparing and serving meals to customers (restaurants, caterers etc.).

Conclusion/Next Steps

In an effort to address the food safety gap resulting from the above-noted exemptions to the *Ontario Meat Regulation*, the MOHLTC has advised health units to again take on the food premises inspection responsibility for those exempted FSMPs. The monitoring and inspection of meat processing activities conducted at restaurants, caterers, butcher shops etc. (formerly licensed and inspected by OMAF) are again the responsibility of local health units. The MOHLTC has committed to provide PHI refresher-training sessions early in 2014 regarding high risk meat processing activities (curing, smoking, fermenting etc.). The additional workload for the Food Safety Team, created by these changes, has yet to be determined; however there has been no commitment from the MOHLTC to provide additional PHI resources to complete the added inspection responsibilities. Staff will monitor the impact of the additional workload on their ability to complete their mandated inspection frequencies and report back to the Board at a later date.

This report was prepared by Mr. David Pavletic, Manager of Food Safety.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards: Food Safety Standard – Requirements 1 and 3; Food Safety Protocol – Requirements 1 and 2(d)

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 012-14

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2014 January 16

MEDICAL OFFICER OF HEALTH ACTIVITY REPORT – JANUARY

Recommendation

It is recommended that Report No.012-14 re Medical Officer of Health Activity Report – January be received for information.

The following report highlights activities of the Medical Officer of Health (MOH) from the December Medical Officer of Health Activity Report to January 7, 2014.

The MOH was asked to speak about the social determinants of health at the London Health Sciences Centre Board meeting on December 3, 2013. He was joined by other health officials including Sandra Coleman, Chief Executive Officer of the South West Community Care Access Centre. The MOH spoke about the relative impacts of determinants of health, collaboration between health agencies and ideas for LHSC to improve health in the community both within and outside of hospital walls.

As Chair of the Connecting the Dots (CtD) Forum Planning Committee, the MOH hosted the December 4th event held at St. Michael's College in Toronto. This event brought together leaders at senior levels in local and provincial agencies from across Ontario and across provincial ministries to discuss mental health. In July of 2013, Public Health Ontario (PHO), Centre for Addiction and Mental Health (CAMH) and Toronto Public Health released *Connecting the Dots*, a document that highlights many public health unit activities that address child and youth mental health. A key finding was that the role of public health in mental health for children and youth lack clarity. This event was the result of a year of planning and collaboration with several staff from the Ministry of Health and Long term Care, Ministry of Children and Youth Services, Ministry of Education, Region of Halton Health Department, McMaster University, CAMH and PHO. Invitations to attend the event were sent to key public health and mental health leaders in Ontario. The day was spent discussing strategies to prevent mental illness in children, public health's role in child mental health and opportunities for collaboration between public health and other sectors.

On December 5th, the MOH joined MLHU Staff and Board members at the Annual Staff Day Celebration at the Western Fair District. After a delicious breakfast, the MOH reviewed Service Area activities and events that occurred in 2013. Long Term Service Awards were presented to 46 staff. Louise Tyler, Director, Human Resources and Labour Relations, was acknowledged as she retired at the end of 2013. The guest speaker for the event was Dan Trommatter, a magician who used his craft to identify how important perception is to our experience of reality, and how to foster creative and innovative thinking.

The MOH attended and presented at the Minimum Wage Advisory Panel held at the Delta London Armouries on December 5th. The purpose of this event was for London stakeholders to provide advice on how to adjust Ontario's minimum wage. The MOH provided the Health Unit's position, established at recent Board of Health meetings. The Chair of the Panel will report to the provincial government with recommendations.

On December 13th, the MOH presented to McMaster University Public Health Residents on how to work with external stakeholders to identify and support their interests while also advancing public health goals.

The Senior Leadership Team met with some Senior Leaders from LHSC to learn more about what services each organization offers, and to discuss various options/ideas for collaboration between organizations.

The Medical Officer of Health and CEO also attended the following teleconferences and events:

December 4 - Big Picture Thinking for Boards at London Public Library – hosted by Pillar Non Profit
December 5 - Inaugural Session of Middlesex County Council
December 18 – Visit to 528 Dundas St. Methadone Clinic to meet with John Craven, Associate Director
December 18 – Introductory meeting with Peggy Sattler, MPP
December 19 – Attended a Step 3 Grievance meeting with ONA representatives

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

This report addresses Ontario Public Health Organizational Standard 2.9 Reporting relationship of the medical officer of health to the board of health