AGENDA
MIDDLESEX-LONDON BOARD OF HEALTH
Finance and Facilities Committee

50 King Street, London
Middlesex-London Health Unit – Room 3A
Tuesday May 3, 2016 10:00 a.m.

1. **DISCLOSURE OF CONFLICTS OF INTEREST**

2. **APPROVAL OF AGENDA**

3. **APPROVAL OF MINUTES –** April 7, 2016

4. **NEW BUSINESS**

   4.1. Great-West Life Benefits – Rate Renewal (Report No. 013-16FFC)
   4.2. 2016 One-time Funding Confirmation (Report No. 014-16FFC)

5. **CONFIDENTIAL**

   5.1. The Finance and Facilities Committee will move in camera to discuss a matter regarding a proposed or pending acquisition of land by the Middlesex-London Board of Health.

6. **OTHER BUSINESS**

   Next meeting: Thursday, June 2, 2016 at 9:00 a.m. in Room 3A

7. **ADJOURNMENT**

PUBLIC MINUTES
Finance and Facilities Committee
50 King Street, Room 3A
MIDDLESEX-LONDON BOARD OF HEALTH
2016 April 7, 9:00 a.m.

COMMITTEE MEMBERS PRESENT:
Ms. Trish Fulton **(Committee Chair)**
Mr. Marcel Meyer
Mr. Ian Peer
Mr. Jesse Helmer
Ms. Joanne Vanderheyden

OTHERS PRESENT:
Dr. Christopher Mackie, Medical Officer of Health and CEO
Ms. Elizabeth Milne, Executive Assistant to the Board of Health & Communications (Recorder)
Mr. Jordan Banninga, Manager, Strategic Projects
Ms. Laura Di Cesare, Director, Corporate Services
Mr. John Millson, Associate Director, Finance

At 9:02 a.m., Chair Fulton called the meeting to order.

1. DISCLOSURES OF CONFLICT(S) OF INTEREST

Chair Fulton inquired if there were any disclosures of conflict of interest to be declared. None were declared.

2. APPROVAL OF AGENDA

It was moved by Mr. Peer, seconded by Ms. Vanderheyden *that the **AGENDA** for the April 7, 2016 Finance and Facilities Committee meeting be approved.*

Carried

3. APPROVAL OF MINUTES

It was moved by Mr. Peer, seconded by Mr. Meyer *that the **MINUTES** from the March 3, 2016 Finance and Facilities Committee meeting be approved.*

Carried

4. NEW BUSINESS

4.1 Physical Assets and Facilities Update (Report No. 010-16FFC)

Mr. Helmer arrived at 9:09 a.m.

Mr. Jordan Banninga, Manager, Strategic Projects presented the MLHU Relocation Project Plan and answered questions.

Discussion ensued about the following items:

- The city's transit plans and how they may relate to the Health Unit's location moving forward.
- The one-time funding request (Appendix B), submitted in March 2016.

- Fees associated with weighing the buy, build, lease options and the importance of public consultations in this process.

Chair Fulton requested that the Committee consider the commitment that may be required at points in the relocation process in order to inform discussion on the Terms of Reference later in the meeting.

It was moved by Ms. Vanderheyden, seconded by Mr. Helmer *that the Finance and Facilities Committee:*

1. *Receive Report No. 010-16FFC Re: Middlesex-London Health Unit Relocation for information*
2. *Receive Appendix B re: one-time funding requests submitted to the Ministry of Health and Long-Term Care and,*
3. *Approve proposed Middlesex-London Health Unit Relocation Project Plan (Appendix A)*

Carried

4.2 2016 Board Member Remuneration (Report No. 011-16FFC)

It was moved by Mr. Peer, seconded by Mr. Helmer, *that the Finance & Facilities Committee make recommendation to the Board of Health to increase the Board of Health member compensation rate for a half day meeting to $149.25 retroactively to January 1st, 2016.*

Carried

4.3 Terms of Reference – Revisions (Report No. 012-16FFC)

Dr. Mackie and Ms. Di Cesare summarized the FFC Terms of Reference revisions and answered questions.

Discussion ensued about separating facilities work from the finance committee, moving forward. The Committee felt they were able to commit the necessary time to support this work and are well equipped with the background knowledge to give the Board advice on facilities going forward.

Additional discussion ensued about the following items:

- Membership timelines and the appointment process.
- Changing wording to reflect that the Committee sits until after the budget cycle.
- The feasibility of bringing the budget to the Board of Health for approval by the end of the calendar year versus the fiscal year.

It was moved by Mr. Meyer, seconded by Mr. Peer, *that the Finance & Facilities Committee:*

1) *Receive Report No. 012-16FFC for information; and*
2) *Recommend that the Governance Committee recommend to the Board of Health approval of the revised Terms of Reference attached as Appendix A.*

Carried

5. CONFIDENTIAL

It was moved by Mr. Meyer, seconded by Mr. Peer *that the Finance and Facilities Committee approve minutes from its March 3, 2016 in-camera session.*

Carried

6. OTHER BUSINESS

6.1 The next meeting date was changed to Tuesday May 3, 2016 at 10:00 a.m. due to quorum.

7. ADJOURNMENT

At 10:22 a.m. Chair Fulton *adjourned the meeting.*

_____ _____

TRISH FULTON
Committee Chair

CHRISTOPHER MACKIE
Secretary-Treasurer

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 013-16FFC

TO: Chair and Members of the Finance & Facilities Committee

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2016 May 3

GREAT-WEST LIFE BENEFITS – RENEWAL RATES

Recommendation

It is recommended that the Finance & Facilities Committee review and make recommendation to the Board of Health to approve the renewal of the group insurance rates administered by Great-West Life as described in Report No. 013-16FFC re: "Great-West Life Benefits – Renewal Rates".

Key Points

- The group benefits contract with Great-West Life (GWL) expires April 30, 2016. Staff reviewed the renewal rates with Aon Hewitt and have been able to reduce the GWL proposed rate increases.
- As part of the renewal life insurance premiums would increase by 23.7%, and long-term disability premiums would increase by 10%.
- Administrative Services Only (ASO) benefits/claims (Health and Dental) are also expected to increase. Health benefit costs are expected to increase by 12%, and dental benefit costs by 7%.
- Overall the impact of the above rate and volume changes on average is 11.2% annually. For the 8 months of 2016 (May - December) that translates to roughly 7.5% (planned was 5.7%).
- Total expenditures for employer paid benefits are expected to match fairly closely to budget projections.

Background

The Health Unit, with the assistance of Aon Hewitt (Aon), went through a Request For Proposal process in 2012 to ensure that group insurance rates were competitive. As a result the Health Unit changed its insurance carrier from Manulife to Great-West Life effective February 1st, 2013. This change resulted in significant savings for both employees and for the Health Unit. All costs related to the insured benefits (Life, Accidental Death & Dismemberment (AD&D), Long-Term Disability (LTD), Pooling and Administrative Services Only (ASO) expenses were reduced effective February 1st, 2013 and remained unchanged due to rate guarantees until April 30th, 2015. On May 1st, 2015, as a result of the end of the rate guarantees, life insurance rates increased 3%, AD&D rates remained unchanged, and LTD rates (employee paid) increased 7%.

New Insured Benefit Rates (Life, AD&D, LTD, Pooling Insurance, ASO Expenses)

As of May 1st, 2016, life insurance rates will increase by 23.7%, AD&D rates will remain unchanged, and LTD rates (employee paid) will increase by 10%. Great-West Life (GWL) had implemented significant discounts within their 2012 proposal (i.e. 23% discount for Life, 25% for LTD). Given the 2015 & 2016 negotiated rate increases (Appendix A), the 2016 rates are still below the pre-marketing rates of February 1, 2012. In addition to these rate changes, GWL will be increasing the pooling charges effective May 1, 2016 by approximately $11,125 for the renewal year. In regards to the increase in pooling insurance charges, Aon has confirmed that pooling charges have been increasing significantly throughout the insurance industry and rates are typically not negotiable. The ASO expense rates (cost to administer the ASO benefits) are remaining unchanged.

ASO Benefits (Health and Dental)

These benefits are funded based on actual claims utilization of benefits paid. The Health Unit sets a monthly deposit rate in advance to fund expected claims and expenses based on actual experience as well as Aon's recommendation of emerging trends. As can be seen by the ASO benefits history attached as Appendix B, the 2015 total claims cost increased by 5.2% over the previous year. It is expected that this increase will continue for 2016 based on the increase in pooling costs, negotiated increase in vision care, and general increases in both health and dental costs.

For the May 1st, 2016 renewal period Aon had initially recommended a 17% increase in health, and 7% in dental premiums. After discussions with Aon, health unit staff plan to take a more aggressive approach and only plan for a 12% increase for health and 7% increase for dental benefits. Staff will monitor monthly claims experience and if required make a mid-renewal period increase if emerging claims and expenses exceed our planned monthly deposits.

2016 Budget Implications

Overall the expected increase over the renewal period is $127,935 or 11.2%. For 2016, the 8-month increase would be $85,290 or 7.5%. Incorporated into the 2016 operating budget was a $70,300 increase or 5.7%. As can be seen in Appendix B, in the first three months of 2016 there has been a favourable variance in the claims costs related to the premiums paid of $24,347. Considering this positive variance and the aggressive position being taken on the ASO premiums we expect the amount budgeted for employer paid benefits will be sufficient for 2016.

Conclusion

The Health Unit's contract with Great-West Life to provide group insurance expires April 30th, 2016. Health Unit staff, with the assistance of Aon, have negotiated renewal rates with GWL. As a result, life insurance premiums are increasing by 23.7% and long-term disability premiums by 10%. Over the past two years, the ASO benefits have experienced high month – to – month variability, however, the data shows a consistent upward pressure year over year. Therefore, it is also recommended that monthly deposits be increased to maintain expected increases in health claims costs of 12%, and dental claims costs of 7%. Overall benefit costs over the renewal period are expected to increase by 11.2% on average.

This report was prepared by Ms. Lisa Ellington, Payroll and Benefits Administrator, and Mr. John Millson, Associate Director of Finance.

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

Overview of Insured Benefits Pre and Post Marketing

Rate History of Insured Benefits

Benefit	Basis	Pre-Marketing Rates February 1, 2012	Post Marketing			May 1, 2016 Negotiated Rates	Negotiated 2016 Rates Compared to Pre-Marketing
			Post-Marketing Rates February 1, 2013	May 1, 2014 Rates	May 1, 2015 Rates		
Insured Rates							
Life	Per $1,000	$0.254	$0.180	$0.180	$0.186	$0.230	-9.4%
Accidental Death & Dismemberment	Per $1,000	$0.035	$0.030	$0.030	$0.030	$0.030	-14.3%
Long Term Disability	Per $100	$2.888	$2.330	$2.330	$2.500	$2.750	-4.8%

Middlesex-London Health Unit
History of Great West Life ASO Premiums vs Cost of Claims

Period	(A) ASO Premiums	(B) Total Claims Cost	(A) - (B) ASO Premiums - Actual Claims
2014			
January	$ 88,198.05	$ 103,744.76	$ (15,546.71)
February	88,079.97	91,995.56	(3,915.59)
March	88,622.85	76,047.56	12,575.29
April	88,953.33	103,872.46	(14,919.13)
May	83,896.08	78,164.85	5,731.23
June	84,560.00	74,044.13	10,515.87
July	81,328.26	97,975.12	(16,646.86)
August	84,758.71	89,852.47	(5,093.76)
September	84,448.57	93,451.37	(9,002.80)
October	80,203.21	88,313.60	(8,110.39)
November	83,498.66	91,155.47	(7,656.81)
December	82,325.89	90,277.75	(7,951.86)
Total	**$ 1,018,873.58**	**$ 1,078,895.10**	**$ (60,021.52)**
2015			
January	$ 82,369.53	$ 96,183.83	$ (13,814.30)
February	83,077.09	79,292.74	3,784.35
March	82,369.53	82,869.48	(499.95)
April	84,249.86	107,219.70	(22,969.84)
May	93,084.27	79,489.85	13,594.42
June	94,440.32	109,665.64	(15,225.32)
July	93,657.36	78,491.01	15,166.35
August	94,048.84	87,766.75	6,282.09
September	93,657.36	116,356.43	(22,699.07)
October	93,926.39	110,476.46	(16,550.07)
November	93,620.26	83,021.06	10,599.20
December	93,320.62	104,174.86	(10,854.24)
Total	**$ 1,081,821.43**	**$ 1,135,007.81**	**$ (53,186.38)**
2016			
January	$ 92,146.18	$ 85,488.97	$ 6,657.21
February	94,837.68	86,418.98	8,418.70
March	93,785.69	84,514.59	9,271.10
Total (3 mths)	**$ 280,769.55**	**$ 256,422.54**	**$ 24,347.01**

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 014-16FFC

TO: Chair and Members of the Finance & Facilities Committee

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2016 May 3

2015 FUNDING CONFIRMATION FOR ADDITIONAL FUNDING REQUESTS

Recommendation

It is recommended that the Finance & Facilities Committee make recommendation to the Board of Health to approve the Board Chair to sign the Amending Agreement No. 4 to the Public Health Funding and Accountability Agreement as appended to Report No. 014-16FFC.

Key Points

- Boards of Health are required to submit applications for MOH /AMOH compensation to bring overall compensation within ranges stipulated under the Ministry and OMA agreement. Applications for 2014 and 2015 were sent to the Ministry of Health & Long-Term Care (MOHLTC) as requested on October 6, 2015.
- As part of the third quarter financial update to the MOHLTC requested on October 30, 2015, health units were asked to submit One-time funding requests. Middlesex London Health Unit submitted two requests for consideration. One for 100% Children In Need of Treatment (CINOT) funding and another for extraordinary costs related to the management of a complex Tuberculosis case.
- On April 20, 2016 the Board of Health received notification of approvals related to additional funding (Appendix B).

Background

In October 2015, on behalf of the Board of Health two submissions were made to the MOHLTC for additional 2015 funding. On April 20, 2016, the Board of Health received notification of additional funding for the MOH/AMOH compensation under the Physician Service Agreement, and for 2015 One-time funding requests. The revised Amending Agreement No. 4 of the Public Health Funding and Accountability Agreement is attached as Appendix A.

2014 – 2015 MOH/AMOH Compensation Application

The 2008 Physician Service Agreement provided the Ministry and the OMA with a mandate to develop a process that would bring the Medical Officer of Health and Associated Medical Officer of Health (MOH/AMOH) compensation to within the ranges stipulated in the agreement. Since 2008, compensation for the MOH and AMOH positions have been funded through a hybrid model whereby the ministry pays 100% funding to bring the Board of Health compensation amounts up to the amounts provided for under the Physician's Service Agreement.

On October 6, 2015, on behalf of the Board of Health, Mr. John Millson, Associate Director of Finance and Mr. Ian Peer, Chair of the Board of Health made an application to the Ministry of Health & Long-Term Care for additional 100% funding to bring the MOH and AMOH compensation to the levels provided for under the revised MOH/AMOH Salary Grid (Appendix B).

On April 20, 2016 the Board of Health received notification of additional funding for 2015. Attached as Appendix C, is the Ministry's overview for the 2015 MOH/AMOH compensation under the Physician's Service Agreement. It provides the maximum amount of 100% funding available to the Middlesex London Health Unit for the compensation of the MOH and AMOH positions. As part of the 2015 application, the Board of Health requested $83,145 in additional funding for the MOH and AMOH positions but is only eligible for $79,577. The $3,568 difference is due to the number of years of service used for calculating the additional compensation for the AMOH position. According to the MOHLTC, the number of years of service is only adjusted on April 1st of each year of the agreement if the physician has completed a full year of service. This reduces the amount that will be paid out to staff; as such, there is no shortfall for the Health Unit.

Now that the funding has been confirmed, retroactive payments will be calculated based on the ministry approved allocations according to the Physician's Service Agreement.

2015 One-time Funding Requests

As part of the Ministry's 2015 third quarter financial update process, boards of health were requested to submit one-time funding requests. Two one-time funding requests were submitted on behalf of the Board of Health. The first request was for $147,375 in 100% funding for CINOT claims paid to dentists for the August 1st to December 31st period. This request was in recognition of the Ministry's commitment to integrate dental claims administration and upload the costs of dental claims under the new Healthy Smiles Ontario program effective August 1, 2015. The Board of Health received confirmation of $147,400 in funding as a result of its request.

The second one-time funding request was for $12,300 which was made for extraordinary costs associated with the management of a complex Tuberculosis case. The ministry approved $7,000 of additional funding which represents nursing overtime as outlined in the request. Other costs such as translation and mileage expenses were not funded 100%.

Conclusion

On April 20, 2016 the Board of Health received confirmation of additional 2015 funding for requests made to the ministry on October 2015. The approved requests as outlined in Report No. 014-16FFC have been incorporated into the Amending Agreement No. 4 as attached as Appendix A.

This report was prepared by Mr. John Millson, Associate Director of Finance.

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

Amending Agreement No. 4

This Amending Agreement No. 4, effective as of January 1, 2015.

Between:

Her Majesty the Queen
in right of Ontario
as represented by
the Minister of Health and Long-Term Care

(the **"Province"**)

- and -

Board of Health for the Middlesex-London Health Unit

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

WHEREAS the Province and the Board of Health entered into a Public Health Funding and Accountability Agreement effective as of the first day of January, 2014 (the **"Accountability Agreement"**); and,

AND WHEREAS the Parties wish to amend the Accountability Agreement;

NOW THEREFORE IN CONSIDERATION of the mutual covenants and agreements contained in this Amending Agreement No. 4, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties hereto agree as follows:

1. This amending agreement ("Amending Agreement No. 4") shall be effective as of the first date written above.

2. Except for the amendments provided for in this Amending Agreement No. 4, all provisions in the Accountability Agreement shall remain in full force and effect.

3. Capitalized terms used but not defined in this Amending Agreement No. 4 have the meanings ascribed to them in the Accountability Agreement.

4. The Accountability Agreement is amended by:

   (a) Deleting Schedule A-4 (Program-Based Grants) and substituting Schedule A-5 (Program-Based Grants), attached to this Amending Agreement No. 4.

   (b) Deleting Schedule B-3 (Related Program Policies and Guidelines) and substituting Schedule B-4 (Related Program Policies and Guidelines), attached to this Amending Agreement No. 4.

(c) Deleting Schedule C-2 (Reporting Requirements) and substituting Schedule C-3 (Reporting Requirements), attached to this Amending Agreement No. 4.

The Parties have executed the Amending Agreement No. 4 as of the date last written below.

Her Majesty the Queen in the right of Ontario as represented by the Minister of Health and Long-Term Care

_____ _____

Name: Roselle Martino Date
Title: Assistant Deputy Minister
Population and Public Health Division

Board of Health for the Middlesex-London Health Unit

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

_____ _____

Name: Date
Title:

_____ _____

Name: Date
Title:

SCHEDULE A-5
PROGRAM-BASED GRANTS

Board of Health for the Middlesex-London Health Unit

Source	Program / Initiative Name			2014 Approved Allocation ($)	Increase / (Decrease) ($)	2015 Approved Allocation ($)
Base Funding (January 1st to December 31st, unless otherwise noted)						
Public Health & Health Promotion	Mandatory Programs (75%)			15,709,206	571,394	16,280,600
Public Health	Chief Nursing Officer Initiative (100%)	# of FTEs	1.00	121,414	86	121,500
	Enhanced Food Safety – Haines Initiative (100%)			80,000	-	80,000
	Enhanced Safe Water Initiative (100%)			35,627	73	35,700
	Healthy Smiles Ontario Program (100%)			783,924	157,676	941,600
	Infection Prevention and Control Nurses Initiative (100%)	# of FTEs	1.00	90,066	34	90,100
	Infectious Diseases Control Initiative (100%)	# of FTEs	10.50	1,166,722	78	1,166,800
	Medical Officer of Health (MOH)/Associate Medical Officer of Health (AMOH) Compensation Initiative (100%)[1]			133,828	(19,828)	114,000
	Needle Exchange Program Initiative (100%)			234,991	128,709	363,700
	Small Drinking Water Systems Program (75%)			23,900	-	23,900
	Social Determinants of Health Nurses Initiative (100%)	# of FTEs	2.00	180,448	52	180,500
	Vector-Borne Diseases Program (75%)			461,967	33	462,000
Health Promotion	Children In Need Of Treatment (CINOT) Expansion Program (75%)[2]			67,500	-	67,500
	Electronic Cigarettes Act - Protection and Enforcement (100%)[3]				39,500	39,500
	Smoke-Free Ontario Strategy: Prosecution (100%)			25,300	-	25,300
	Smoke-Free Ontario Strategy: Protection and Enforcement (100%)			367,500	-	367,500
	Smoke-Free Ontario Strategy: Tobacco Control Area Network - Coordination (100%)			285,800	-	285,800
	Smoke-Free Ontario Strategy: Tobacco Control Area Network - Prevention (100%)			150,700	-	150,700
	Smoke-Free Ontario Strategy: Tobacco Control Coordination (100%)			100,000	-	100,000
	Smoke-Free Ontario Strategy: Youth Tobacco Use Prevention (100%)			80,000	-	80,000
Sub-Total Base Funding				**20,098,893**	**877,807**	**20,976,700**

SCHEDULE A-5
PROGRAM-BASED GRANTS

Board of Health for the Middlesex-London Health Unit

Source	Program / Initiative Name	2015 Approved Allocation ($)
One-Time Funding (April 1, 2015 to March 31, 2016, unless otherwise noted)		
Public Health	New Purpose-Built Vaccine Refrigerators (100%)	22,700
	Outbreaks of Diseases: Tuberculosis Outbreak (100%) (January 1, 2015 to December 31, 2015)	7,000
	Panorama (100%)[4]	203,900
	Public Health Inspector Practicum Program (100%)	10,000
	Sexual Health: Contraceptives - Competitive Purchasing (100%)	10,100
Health Promotion	CINOT and CINOT Expansion Programs (100%) (January 1, 2015 to December 31, 2015)[2]	147,400
	Electronic Cigarettes Act - Protection and Enforcement (100%)	39,500
	Smoke-Free Ontario Strategy: Expanded Smoking Cessation Programming for Priority Populations (100%)	20,300
Sub-Total One-Time Funding		**460,900**

Total	**21,437,600**

(1) Cash flow will be adjusted to reflect the actual status of current MOH and AMOH positions.
(2) Funded by two sources: Public Health and Health Promotion.
(3) Base funding is pro-rated at $29,625 in 2015.
(4) Jointly funded by the Population and Public Health Division and the Health Services I&IT Cluster.

Payment Schedule

Base funding is flowed on a mid and end of month basis. Cash flow will be adjusted when both Parties have signed the Agreement.
One-Time funding is flowed as follows: 50% when both Parties have signed the Agreement; and, 50% upon receipt of the third quarter financial report (fourth quarter for Panorama).
One-Time funding approved in-year (and highlighted in Schedule A) is flowed when both parties have signed the Agreement.

SCHEDULE B-4

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***Base***
Source	***Public Health***

Chief Nursing Officer Initiative (100%)

Under the Organizational Standards, the Board of Health is required to:

- Designate a Chief Nursing Officer; and,
- Implement the Chief Nursing Officer role, at minimum, at a management level (and preferably a senior management level) within the Board of Health reporting directly to the Medical Officer of Health or Chief Executive Officer.

Should the role not be implemented at the senior management level as per the recommendations of the 'Public Health Chief Nursing Officer Report (2011)', the Chief Nursing Officer should nonetheless participate in senior management meetings in the Chief Nursing Officer role as per the intent of the recommendation, and in that context will contribute to organizational effectiveness.

The presence of a Chief Nursing Officer in the Board of Health will enhance the health outcomes of the community at individual, group and population levels:

- Through contributions to organizational strategic planning and decision making;
- By facilitating recruitment and retention of qualified, competent public health nursing staff; and,
- By enabling quality public health nursing practice.

Furthermore, the Chief Nursing Officer articulates, models, and promotes a vision of excellence in public health nursing practice, which facilitates evidence-based services and quality health outcomes in the public health context.

The following qualifications are required for designation as a Chief Nursing Officer:

- Registered Nurse in good standing with the College of Nurses of Ontario;
- Baccalaureate degree in nursing;
- Graduate degree in nursing, community health, public heath, health promotion, health administration, or other relevant equivalent OR be committed to obtaining such qualification within three (3) years of designation;
- Minimum of 10 years nursing experience with progressive leadership responsibilities, including a significant level of experience in public health; and,
- Member of appropriate professional organizations (e.g., Registered Nurses' Association of Ontario, Association of Nursing Directors and Supervisors in Official Health Agencies in Ontario-Public Health Nursing Management, etc.).

Base funding for this initiative must be used to create additional hours of nursing service (1.0 Full-Time Equivalent (FTE) minimum). Funding is for nursing salaries and benefits

SCHEDULE B-4

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***Base***
Source	***Public Health***

only and cannot be used to support operating or education costs. This funding is for the Chief Nursing Officer position and/or for nursing service to support the functions of the Chief Nursing Officer.

The Board of Health must confirm to the Province that a qualified Chief Nursing Officer has been designated and that a new public health nurse FTE has been established. In addition, at the discretion of the Province, the Board of Health may be required to submit an annual activity report related to the initiative confirming the maintenance of the funded 1.0 nursing FTE, and highlighting Chief Nursing Officer activities for the previous funding period. Other reports, as specified from time to time, may also be requested by the Province upon prior written notice.

Enhanced Food Safety – Haines Initiative (100%)

The Enhanced Food Safety – Haines Initiative was established to augment the Board of Health's capacity to deliver the Food Safety Program as a result of the provincial government's response to Justice Haines' recommendations in his report "Farm to Fork: A Strategy for Meat Safety in Ontario".

Base funding for this initiative must be used for the sole purpose of implementing the Food Safety Program under the Ontario Public Health Standards (OPHS). Eligible expenses include such activities as: hiring staff, delivering additional food-handler training courses, providing public education materials, and program evaluation.

Funded projects/activities must be over and above the level of activities underway or planned based on existing mandatory programs base funding.

As part of the annual Program-Based Grants budget submission process, the Board of Health is required to provide an implementation plan which should detail the objectives of the activities proposed, how the funding will be applied to meet requirements of the Food Safety Program, and how the success of the activities will be evaluated.

The Board of Health is also required to submit an annual activity report on the date specified in Schedule C, detailing the results achieved and the allocation of the funding based on the implementation plan.

Enhanced Safe Water Initiative (100%)

Base funding for this initiative must be used for the sole purpose of increasing the Board of Health's capacity to meet the requirements of the Safe Water Program under the OPHS.

SCHEDULE B-4

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***Base***
Source	***Public Health***

Funded projects/activities must be over and above the level of activities underway or planned based on existing mandatory programs base funding.

As part of the annual Program-Based Grants budget submission process, the Board of Health is required to provide an implementation plan which should detail the objectives of the activities proposed, how the funding will be applied to meet requirements of the Safe Water Program, and how the success of the activities will be evaluated.

The Board of Health is also required to submit an annual activity report on the date specified in Schedule C, detailing the results achieved and the allocation of the funding based on the implementation plan.

Healthy Smiles Ontario Program (100%)

The Healthy Smiles Ontario Program provides prevention and basic treatment services for children and youth, from low-income families, who are 17 years of age or under, and who do not have access to any form of dental coverage. The goal of the Healthy Smiles Ontario Program is to improve the oral health of children and youth in low-income families. Healthy Smiles Ontario builds upon and links with existing public health dental infrastructure to expand access to dental services for children and youth.

The core objectives of the Healthy Smiles Ontario Program are: Ontario-wide oral health infrastructure development; preventive and basic treatment services for the target population; and, oral health promotion.

Base funding for this program must be used for the ongoing, day-to-day requirements associated with delivering services (both prevention and basic treatment) under the Healthy Smiles Ontario Program to children and youth in low-income families. Program expense categories include:

- Salaries, wages and benefits
  - Dental care providers – clinical
  - Administration
  - Oral health staff – non-clinical

- Fee-for-service delivery

- Administrative expenses which include: building occupancy, travel, staff training and professional development, material/supplies, office equipment, professional and purchased services, communication costs, other operating, and information and information technology equipment.

- Health Promotion (including Communication Costs for Marketing / Promotional

SCHEDULE B-4

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***Base***
Source	***Public Health***

Activities)

- Funding used to promote oral health (communication costs, include marketing / promotional activities; travel; promotional materials; and, training).
- Funding used for marketing / promotional activities must not compromise front-line service for current and future Healthy Smiles Ontario clients.
- The Board of Health is responsible for ensuring promotional / marketing activities have a direct, positive impact on meeting the objectives of the Healthy Smiles Ontario Program.
- The Board of Health is reminded that Healthy Smiles Ontario promotional / marketing materials approved by the Province and developed provincially are available for use by the Board of Health in promoting the Healthy Smiles Ontario Program.
- The overarching Healthy Smiles Ontario brand and provincial marketing materials were developed by the Province to promote consistency of messaging, and "look and feel" across the province. When promoting the Healthy Smiles Ontario Program locally, the Board of Health is requested to align local promotional products with the provincial Healthy Smiles Ontario brand. When the Board of Health uses the Healthy Smiles Ontario brand, it is required to liaise with the Province's Communications and Marketing Division (CMD) to ensure use of the brand aligns with provincial standards.

Operational expenses not covered within this program include: staff recruitment incentives / billing incentives; and, client transportation. Other expenses not included within this program include oral health activities required under the OPHS.

As part of the annual Program-Based Grants budget submission process, the Board of Health is required to provide an Oral Health Program Report, which should include projected costs for oral health activities, including the Healthy Smiles Ontario Program, to be undertaken by the Board of Health.

Other requirements of the Healthy Smiles Ontario Program include:

- All revenues collected under the Healthy Smiles Ontario Program (including revenues collected for the provision of services to non-Healthy Smiles Ontario clients) must be reported as income (i.e. revenue collected for CINOT, Ontario Works, Ontario Disability Support Program and other non-Healthy Smiles Ontario programs). Revenues must be used to offset expenditures.

- The Board of Health must use Oral Health Information Support System (OHISS) for the Healthy Smiles Ontario Program.

- The Board of Health must enter into Service Level Agreements with any organization it partners with for purposes of delivering the Healthy Smiles Ontario Program. The

SCHEDULE B-4

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***Base***
Source	***Public Health***

Service Level Agreement must set out clear performance expectations and ensure accountability for public funds.

- Any significant changes to the Ministry-approved Healthy Smiles Ontario business model, including changes to plans, partnerships, or processes, or otherwise as outlined in the Board of Health's Ministry-approved business case and supporting documents must be approved by the Province before being implemented.

- Any contract or subcontract entered into by the Board of Health for the purposes of implementing the Healthy Smiles Ontario Program must be conducted according to relevant municipal procurement guidelines.

- The Board of Health is responsible for ensuring value-for-money and accountability for public funds.

- The Board of Health must ensure that funds are used to meet the objectives of the Healthy Smiles Ontario Program with a priority to deliver dental services (both prevention and basic treatment) to Healthy Smiles Ontario clients.

- The Board of Health is required to bill back the relevant programs for services provided to non-Healthy Smiles Ontario clients.

Infection Prevention and Control Nurses Initiative (100%)

The Infection Prevention and Control Nurses Initiative was established to support one (1) additional FTE Infection Prevention and Control Nurse for every board of health in the province.

Base funding for this initiative must be used for the creation of additional hours of nursing service (1.0 FTE) and for nursing salaries/benefits and cannot be used to support operating or education costs. Qualifications required for these positions are:

1. A nursing designation (Registered Nurse, Registered Practical Nurse, or Registered Nurse in the Extended Class); and,
2. Certification in Infection Control (CIC), or a commitment to obtaining CIC within three (3) years of beginning of employment.

The majority of the Infection Prevention and Control Nurse's time must be spent on infection prevention and control activities. The Board of Health is required to maintain this position as part of baseline nursing staffing levels.

At the discretion of the Province, the Board of Health may be required to submit an annual activity report related to the initiative confirming the maintenance of the funded

SCHEDULE B-4

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***Base***
Source	***Public Health***

1.0 nursing FTE, and highlighting infection prevention and control nursing activities for the previous funding period. Other reports, as specified from time to time, may also be requested by the Province upon prior written notice.

Infectious Diseases Control Initiative (180 FTEs) (100%)

In response to the SARS crisis of 2003, the Province announced that it would bolster its infection and communicable disease control and prevention capacity by increasing full-time positions for infection control practitioners in health facilities. This included 180 FTE infectious diseases control positions for local boards of health.

Base funding for this initiative must be used solely for the purpose of hiring and supporting staff (e.g., recruitment, salaries/benefits, accommodations, program management, supplies and equipment, other directly related costs) to monitor and control infectious diseases, and enhance the Board of Health's ability to handle and coordinate increased activities related to outbreak management. Positions eligible for base funding under this initiative include physicians, inspectors, nurses, and epidemiologists.

The Board of Health is required to remain within both the funding levels and the number of FTE positions approved by the Province.

Staff funded through the Infectious Diseases Control Initiative is required to be available for redeployment when requested by the Province, to assist other boards of health with managing outbreaks and to increase the system's surge capacity.

At the discretion of the Province, the Board of Health may be required to submit an annual activity report related to the initiative confirming the maintenance of the funded positions, and highlighting infectious diseases control related activities for the previous funding period. Other reports, as specified from time to time, may also be requested by the Province upon prior written notice.

Medical Officer of Health (MOH)/Associate Medical Officer of Health (AMOH) Compensation Initiative (100%)

The Province committed to provide boards of health with 100% of the additional base funding required to fund eligible Medical Officer of Health (MOH) and Associate Medical Officer of Health (AMOH) positions within salary ranges initially established as part of the 2008 Physician Services Agreement and continued under subsequent agreements.

Base funding must be used for costs associated with top up for salaries and benefits, and for applicable stipends to eligible MOH and AMOH positions at the Board of Health and cannot be used to support other physicians or staffing costs. Base funding includes

Type of Funding	***Base***
Source	***Public Health***

a decrease of 2.65% to the salary grid under this initiative and is aligned with the Province's "Physician Services: Ten-Point Plan for Saving and Improving Service". This decrease has not been applied to stipends available under this initiative or to cost-shared base salaries and benefits budgeted by the Board of Health as part of mandatory programs. Base funding for this initiative continues to be separate from cost-shared base salaries and benefits.

In order to improve the timeliness of future adjustments to cash flow resulting from potential changes to MOH and AMOH positions (e.g., new hires, leave periods, movement on the salary grid, changes in base salary and benefits and/or FTE), a maximum base allocation has been approved for the Board of Health. This maximum base allocation includes criteria such as: additional salary and benefits for 1.0 FTE MOH position and 1.0 FTE or more AMOH position where applicable, placement at the top of the MOH/AMOH Salary Grid, inclusion of the after-hours availability stipend, and FRCPSC-CM/PHPM stipend per position (some exceptions will apply to these criteria).

Please note that the maximum base allocation in Schedule A will not necessarily reflect the cash flow that the Board of Health will receive. Cash flow will be adjusted by the Province on an ongoing basis to reflect the actual amount the MOH and AMOH positions at the Board of Health are eligible for based on data from the most recent application submission. The Board of Health is required to notify the Province if there is any change in the eligible MOH and/or AMOH(s) base salary, benefits, FTE and/or position status as this may impact the eligibility amount for top-up.

The Board of Health is expected to continue to report expenditures and changes to positions related to this approved funding through the quarterly financial reports and annual reconciliation report.

Needle Exchange Program Initiative (100%)

Base funding for this initiative must be used for the purchase of needles and syringes, and their associated disposal costs, for the Board of Health's Needle Exchange Program.

The Board of Health is required to submit an annual activity report on the date specified in Schedule C.

Small Drinking Water Systems Program (75%)

Base funding for this program must be used for salaries, wages and benefits, accommodation costs, transportation and communication costs, and supplies and equipment to support the ongoing assessments and monitoring of small drinking water

systems.

Under this program, public health inspectors are required to conduct new and ongoing site-specific risk assessments of all small drinking water systems within the oversight of the Board of Health; ensure system compliance with the regulation governing the small drinking water systems; and, ensure the provision of education and outreach to the owners/operators of the small drinking water systems.

Social Determinants of Health Nurses Initiative (100%)

The Social Determinants of Health Nurses Initiative was established to support salaries and benefits for two (2) FTE public health nursing positions for each Board of Health.

Public health nurses with specific knowledge and expertise on social determinants of health and health inequities issues will provide enhanced supports internally and externally to the Board of Health to address the needs of priority populations impacted most negatively by the social determinants of health in the Board of Health area.

Projects/activities undertaken by the nurses in these funded positions must be clearly related to social determinants of health, health equity, or priority populations and must be over and above the level of activities underway or planned based on existing mandatory programs base funding.

The Board of Health is required to adhere to the following:

- Base funding for this initiative must be used for the creation of additional hours of nursing service (2.0 FTEs);
- In keeping with the original 9,000 Nurses Initiative recommendations for nursing hires, base funding must be used for no more than two (2) nursing positions per 1.0 FTE;
- The Board of Health must commit to maintaining baseline nurse staffing levels and creating two (2) public health nursing FTEs above this baseline; and,
- Base funding is for public health nursing salaries and benefits only and cannot be used to support operating or education costs.

As these are public health nursing positions, required qualifications for these positions are: (1) to be a registered nurse, and (2) to have or be committed to obtaining the qualifications of a public health nurse as specified in section 71(3) of the *Health Protection and Promotion Act* (HPPA) and section 6 of Ontario Regulation 566 under the HPPA.

At the discretion of the Province, the Board of Health may be required to submit an

Type of Funding	***Base***
Source	***Public Health***

annual activity report. Other reports, as specified from time to time, may also be requested by the Province upon prior written notice.

Vector-Borne Diseases Program (75%)

Base funding for this program must be used for the ongoing surveillance, public education, prevention and control of all reportable and communicable vector-borne diseases and outbreaks of vector-borne diseases, which include, but are not limited to, West Nile virus and Lyme Disease.

The Board of Health is required to submit an annual activity report on the date specified in Schedule C.

SCHEDULE B-4

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***Base***
Source	***Health Promotion***

Children In Need Of Treatment (CINOT) Expansion Program (75%) (Funded by two sources: Public Health and Health Promotion)

The Children In Need Of Treatment (CINOT) Expansion Program provides coverage for basic dental care for children 14 through 17 years of age in addition to general anaesthetic coverage for children five (5) through 13 years of age. The Board of Health must be in compliance with the OPHS and the CINOT Program Protocol, 2008 (or as current).

The Board of Health must use the OHISS application to process all CINOT Expansion claims. Financial report data should align with expenditures as recorded in OHISS and reflected in Age Profile and Procedure Code Profile Reports for the period January 1st through December 31st.

The Board of Health will not be permitted to transfer any projected CINOT Expansion Program surplus to its CINOT 0-13 year old budget.

As part of the annual Program-Based Grants budget submission process, the Board of Health is required to provide an Oral Health Program Report, which should include projected costs for oral health activities, including CINOT Programs, to be undertaken by the Board of Health.

Electronic Cigarettes Act – Protection and Enforcement (100%)

On May 26, 2015 the government passed legislation – *the Making Healthier Choices Act, 2014* (MHCA) to protect youth from the dangers of tobacco and the potential harms of electronic cigarettes, known as e-cigarettes. The MHCA supports the provincial government's commitment to achieve the lowest smoking rate in Canada. The MHCA includes legislation to regulate the sale, display, promotion, and use of e-cigarettes (*Electronic Cigarettes Act, 2014* (ECA)) – Schedule 3. The legislation would:

- Ban the sale and supply of e-cigarettes to anyone under the age of 19.
- Prohibit the use of e-cigarettes in certain places where the smoking of tobacco is prohibited.
- Ban the sale of e-cigarettes in certain places where the sale of tobacco is prohibited.
- Prohibit the display and promotion of e-cigarettes in places where e-cigarettes or tobacco products are sold, or offered for sale.

Base funding for this initiative must be used to prepare for implementation and enforce the legislation (as of January 1, 2016).

The Board of Health must comply and adhere to the *Electronic Cigarettes Act*: Public

SCHEDULE B-4

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***Base***
Source	***Health Promotion***

Health Unit Guidelines and Directives: Enforcement of the *Electronic Cigarettes Act*.

The Board of Health is required to submit an annual work plan and interim and final program activity reports to the Province on dates specified in Schedule C based on the requirements outlined in the Directives. Work plan and reporting templates will be provided by the Province.

Communications

1. The Board of Health shall:

(a) Act as the media focus for the Project;
(b) Respond to public inquiries, complaints and concerns with respect to the Project;
(c) Report any potential or foreseeable issues to CMD;
(d) Prior to issuing any news release or other planned communications, notify CMD as follows:
    i. News Releases – identify 5 business days prior to release;
    ii. Web Designs – 10 business days prior to launch;
    iii. Marketing Communications (e.g. pamphlets and posters) – 10 business days prior to production and 20 business days prior to release;
    iv. Public Relations Plan for Project – 15 business days prior to launch;
    v. Digital Marketing Strategy – 10 business days prior to launch;
    vi. Final advertising creative – 10 business days to final production; and,
    vii. Recommended media buying plan – 15 business days prior to launch and any media expenditures have been undertaken.
(e) Advise CMD prior to embarking on planned public communication strategies, major provider outreach activities and the release of any publications related to the Project;
(f) Ensure that any new products, and where possible, existing products related to the Project use the Ontario Logo or other Ontario identifier in compliance with the Visual Identity Directive, September 2006; and,
(g) Despite the time frames set out above for specific types of communications, all public announcements and media communications related to urgent and/or emerging Project issues shall require the Board of Health to provide the CMD with notice of such announcement or communication as soon as possible prior to release.

2. Despite the Notice provision in Article 18 of the Agreement, the Board of Health shall provide any Notice required to be given under this Schedule to the following address:

    Ministry of Health & Long-Term Care
    Communications & Marketing Division
    9th Floor, Hepburn Block, Toronto, ON M7A 1R3
    Fax: 416-327-8791, Email: Judy.Langille@ontario.ca

SCHEDULE B-4

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***Base***
Source	***Health Promotion***

Smoke-Free Ontario Strategy (100%)

The Ontario government is committed to achieving the lowest smoking prevalence rates in Canada through actions and investments in the Smoke-Free Ontario Strategy. The Smoke-Free Ontario Strategy is a multi-level comprehensive tobacco control strategy aiming to eliminate tobacco-related illness and death by: preventing experimentation and escalation of tobacco use among children, youth and young adults; increasing and supporting cessation by motivating and assisting people to quit tobacco use; and, protecting the health of Ontarians by eliminating involuntary exposure to second-hand smoke. These objectives are supported by crosscutting health promotion approaches, capacity building, collaboration, systemic monitoring and evaluation.

The Province provides funding to the Board of Health to implement tobacco control activities that are based in evidence and best practices, contributing to reductions in tobacco use rates.

Base funding for the Smoke-Free Ontario Strategy must be used in the planning and implementation of comprehensive tobacco control activities across prevention, cessation, prosecution, and protection and enforcement at the local and regional levels. The Board of Health must comply and adhere to the Smoke-Free Ontario Strategy: Public Health Unit Tobacco Control Program Guidelines and the Directives: Enforcement of the *Smoke-Free Ontario Act*. Operational expenses not covered within this program include information and information technology equipment.

The Board of Health is required to submit a Smoke-Free Ontario annual work plan and interim and final program activity reports to the Province on dates specified in Schedule C. Work plan and reporting templates will be provided by the Province.

<u>Communications</u>

1. The Board of Health shall:

(a) Act as the media focus for the Project;
(b) Respond to public inquiries, complaints and concerns with respect to the Project;
(c) Report any potential or foreseeable issues to CMD;
(d) Prior to issuing any news release or other planned communications, notify CMD as follows:
    i. News Releases – identify 5 business days prior to release;
    ii. Web Designs – 10 business days prior to launch;
    iii. Marketing Communications (e.g. pamphlets and posters) – 10 business days prior to production and 20 business days prior to release;
    iv. Public Relations Plan for Project – 15 business days prior to launch;
    v. Digital Marketing Strategy – 10 business days prior to launch;

vi. Final advertising creative – 10 business days to final production; and,
vii. Recommended media buying plan – 15 business days prior to launch and any media expenditures have been undertaken.

(e) Advise CMD prior to embarking on planned public communication strategies, major provider outreach activities and the release of any publications related to the Project;
(f) Ensure that any new products, and where possible, existing products related to the Project use the Ontario Logo or other Ontario identifier in compliance with the Visual Identity Directive, September 2006; and,
(g) Despite the time frames set out above for specific types of communications, all public announcements and media communications related to urgent and/or emerging Project issues shall require the Board of Health to provide the CMD with notice of such announcement or communication as soon as possible prior to release.

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SCHEDULE B-4

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***One-Time***
Source	***Public Health***

New Purpose-Built Vaccine Refrigerators (100%)

One-time funding must be used for the purchase of two (2) new 49.0 cubic foot (approximate) purpose-built vaccine refrigerators used to store publicly funded vaccines. The purpose-built refrigerators must meet the following specifications:

a. Interior
   - Fully adjustable, full extension stainless steel roll-out drawers;
   - Optional fixed stainless steel shelving;
   - Resistant to cleaning solutions;
   - Ongoing positive forced fan air circulation to ensure temperature uniformity at all shelf levels;
   - Fan is either encased or removed from the chamber. Fan auto shut-off when door is opened; and,
   - Walls are smooth, scratch and corrosion resistant painted interior and exterior surfaces.

b. Refrigeration System
   - Heavy duty, hermetically sealed compressors;
   - Refrigerant material should be R400 or equivalent;
   - Advanced defrost sensor(s) to manage the defrost cycle and minimize trace amounts of frost build-up; and,
   - Evaporator operates at +2°C, preventing vaccine from freezing.

c. Doors
   - Full view non-condensing, glass door(s), at least double pane construction;
   - Spring-loaded closures include ≥90º stay open feature and <90º self-closing feature;
   - Door locking provision;
   - Option of left or right hand opening; and,
   - Interior cabinet lights with door activated on/off switch, as well as, an independent external on/off.

d. Tamper Resistant Thermostat
   - The thermostat should be set at the factory to +5^{o}C with a control range between +2ºC to +8ºC but this could be done at the time of delivery/installation at no additional cost.

e. Thermometer
   - A automatic temperature recording and monitoring device with battery backup;
   - An external built-in visual digital display thermometer independent of the temperature recording and monitoring device which has a digital temperature

display in Celsius and temperature increment readings of 0.1ºC;
- The external built-in digital thermometer must also be able to record and display the maximum, minimum and current temperatures and allow the user to easily check and reset these recordings as required; and,
- The automatic temperature recording and monitoring device and digital display thermometer must be calibrated/accurate within +/- 0.5ºC or better.

f. Alarm Condition Indicator
- Audible and visual warnings for over-temperature, under-temperature and power failure;
- Remote alarm contacts;
- Door ajar enunciator; and,
- Alarm testing system.

g. Top or Bottom Mounted Compressors/Condensers
- Compressor mounted at top or bottom but not in rear.

h. Noise Levels
- The noise produced by the operation of the refrigerator shall not exceed 85 decibels at one metre. Specifications of the refrigerator must include the noise level measured in decibels of sound at one metre from the refrigerator.

i. Locking Plug
- Power supply must have a locking plug.

j. Castors
- Heavy duty locking castors either installed at the factory or upon delivery.

k. Voltage Safeguard
- Voltage safeguard device capable of protecting against power surges related to the resumption of power to the refrigerator.

l. Warranty
- The warranty should include, from date of acceptance, a five (5) year comprehensive parts and labour warranty with the stipulation that a qualified service representative shall be on-site no later than twelve (12) hours after the service call was made. Software upgrades provided free of charge during the warranty period.

m. Electrical Equipment
- All electrically operated equipment must be UL, CSA and/or Electrical Safety Authority approved and bear a corresponding label. The equipment should

Type of Funding	***One-Time***
Source	***Public Health***

specify the electrical plug type, voltage and wattage rating, and the recommended breaker size for the circuit connection.

Outbreaks of Diseases: Tuberculosis Outbreak (100%)

One-time funding must be used to offset extraordinary costs related to the Board of Health's response to a local tuberculosis outbreak. Eligible costs include extraordinary staffing costs, translation, transportation, and medical related expenses.

Panorama (100%) (Jointly funded by the Population and Public Health Division and the Health Services I&IT Cluster)

The Panorama System includes:

- Panorama's Immunization and Inventory Modules;
- Student Information Exchange tool (STIX);
- Immunization Reconciliation Tool (IRT);
- Panorama's Operational Reports;
- Panorama's Data Extract Enhanced Reporting;
- Public Health Business Intelligence; and,
- Other applications or tools developed to support the Panorama System such as Disconnected Mobile Mode, Portals, Bar Coding, and Mobile Apps.

One-time funding for this initiative must be used for costs incurred for the ongoing operations and upgrades of the components of the Panorama System already implemented, as well as, to deploy and adopt components of the Panorama System scheduled for implementation and the associated readiness activities and business process transformation.

Conduct Ongoing Operations and Implementation of Upgrades (releases and enhancements) for the implemented components of the Panorama System:

- Engage in continuous review of business processes to seek improvements, efficiencies, and best practices;
- Implement and support identified improvements and best practices;
- Participate in the development of use-case scenarios for enhancements and releases, as required;
- Provide Subject Matter Expert (SME) Functional Testing resources for selected enhancements or releases, as required;
- Participate in the development of operational and enhanced surveillance reports, as required;
- Implement any defined workarounds;

SCHEDULE B-4

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***One-Time***
Source	***Public Health***

- Conduct duplicate record resolution;
- Prepare plans to address the data collection from licensed day nurseries;
- Conduct upload of all school lists using STIX;
- Archive IRIS data in accordance with Ministry guidelines;
- Maintain local training materials and programs;
- Maintain internal Board of Health support model including the Problem Resolution Coordinator (PRC) role and ensuring integration with the Ministry's service model;
- Implement internal Board of Health incident model including the Incident Coordinator (IC) role for privacy incident and auditing practices and ensuring integration with the Ministry's and eHealth Ontario's incident model;
- Review and adjust existing system accounts, roles, and responsibilities to ensure correct authorization and access levels are being provided to account holders;
- Assign required roles, responsibilities, and accounts to staff members and complete all necessary registration processes;
- Implement and adhere to data standards, security, audit, and privacy policies and guidelines;
- Maintain the security and technical infrastructure required for the operation of the Panorama System including the approved level(s) of the supported browser(s) and the use of encrypted drives and files;
- Ensure required security and privacy measures are followed including using Secure File Transmission mechanisms for transferring data, applying password protection, and encrypting devices where personal and personal health information is involved;
- Confirm appropriate privacy, security, and information management related analyses, activities, and training have been executed in accordance with the Board of Health's obligations as a Health Information Custodian under the *Personal Health Information Protection Act* (PHIPA) and other applicable laws and local business practices and processes;
- Sign required agreements with the Ministry and eHealth Ontario prior to production use of Panorama System;
- Participate in surveys, questionnaires, and ad-hoc reviews, as required;
- Maintain communications with both internal staff and external stakeholders; and,
- Provision of human resources to provide support within at least one (1) of the following categories, as required:
  - Business Practices and Change Management,
  - Release Planning and Deployment,
  - Information Governance,
  - Audit Policies and Guidelines,
  - Data Standards and Reporting,
  - Innovations and Alignment,
  - User Experience, and,
  - Technical (IT) Experience.

SCHEDULE B-4

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***One-Time***
Source	***Public Health***

Conduct Deployment and Adoption Activities for components of the Panorama System scheduled for implementation:

- Review of business processes and workflows and implement changes required to support adoption of new components as per specific Board of Health requirements and best practices best practices;
- Participate in the development of use-case scenarios for new components, as required;
- Provide SME Functional Testing resources for new components, as required;
- Develop local training plans, materials, and programs and complete and execute training plans for new components, as required;
- Complete data mapping and dry runs of data migration, validate migration results, and address duplicate record resolution and data cleansing, as required;
- Assign required roles, responsibilities, and accounts to staff members and complete all necessary registration processes, as required;
- Complete deployment checklists as per required activities;
- Establish and implement internal Board of Health support model including providing the PRC and ensuring integration with the Ministry's service model;
- Establish and implement internal Board of Health incident model including providing the IC and ensuring integration with the Ministry's and eHealth Ontario's incident model;
- Implement the security and technical infrastructure required for the operation of the Panorama System including the approved level(s) of the supported browser(s) and the use of encrypted drives and files;
- Confirm appropriate privacy, security, and information management related analyses, activities, and training have been executed in accordance with the Board of Health's obligations as a Health Information Custodian under PHIPA and other applicable laws and local business practices and processes;
- Implement required security and privacy measures including using Secure File Transmission mechanisms for transferring data, applying password protection, and encrypting devices where personal health information is involved;
- Maintain and execute a communication/information plan for both internal staff and external stakeholders;
- Sign required agreements with the Ministry and eHealth Ontario Hosting prior to production use of Panorama System; and,
- Provision of human resources to provide support within at least one (1) of the following categories, as required:
  - Business Practices and Change Management, and,
  - Deployment and Adoption.

SCHEDULE B-4

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***One-Time***
Source	***Public Health***

If the Board of Health has agreed to be a Builder and Early Adopter it must also use the one-time funding toward the following activities for the Panorama System as noted below:

- Provide special field support services to the Ministry for the Panorama System to: assist with resolution of field specific issues; assess and test releases, enhancements and innovations; identify business process improvements and change management strategies; and, conduct pilots, prototyping and proof of concept activity;
- Chair/Co-Chair Working Group(s), as required;
- Provision of human resources to provide support within at least three (3) of the following categories, as required:
  - Release Planning and Deployment,
  - Information Governance,
  - Business Practices and Change Management,
  - Audit Policies and Guidelines,
  - Data Standards and Reporting,
  - Innovations and Alignment,
  - User Experience, and,
  - IT Experience.

Public Health Inspector Practicum Program (100%)

One-time funding must be used to hire one (1) Public Health Inspector Practicum position. Eligible costs include: student salaries, wages and benefits; transportation expenses associated with the practicum position; equipment; and, educational expenses.

The Board of Health must comply with the requirements of the Canadian Institute of Public Health Inspectors (CIPHI) Board of Certification (BOC) for field training for a 12 week period; and, ensure the availability of a qualified supervisor/mentor to oversee the practicum student's term.

Upon completion of the practicum placement, the Board of Health will be required to submit to the ministry an approved financial report detailing the budgeted expenses and the actual expenses incurred; CIPHI BOC form; and, a report back.

Sexual Health: Contraceptives – Competitive Purchasing (100%)

One-time funding must be used to survey all public health units regarding the use of oral contraceptives and to explore the possibility of co-operative purchasing of contraceptives for public health units in Ontario. Costs include wages and benefits.

SCHEDULE B-4

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***One-Time***
Source	***Health Promotion***

CINOT and CINOT Expansion Programs (100%) (Funded by two sources: Public Health and Health Promotion)

One-time funding must be used for extraordinary costs associated with the delivery of the CINOT and CINOT Expansion programs.

Electronic Cigarettes Act – Protection and Enforcement (100%)

One-time funding must be used for additional resources to enforce the e-cigarette legislation in 2015-16.

The Board of Health must comply and adhere to the *Electronic Cigarettes Act*: Public Health Unit Guidelines and Directives: Enforcement of the *Electronic Cigarettes Act*.

The Board of Health is required to submit an annual work plan and program activity reports to the Province on dates specified in Schedule C based on the requirements outlined in the Directives. One-time funding activities and outcomes should be included and reported on as part of the base-funded e-cigarette reporting requirements as specified in Schedules B and C. Work plan and reporting templates will be provided by the Province.

Smoke-Free Ontario Expanded Smoking Cessation Programming for Priority Populations (100%)

One-time funding must be used for the purchase and provision of nicotine replacement therapy (NRT) to complement smoking cessation interventions (counseling and follow-up support) for priority populations.

The one-time funding will expand cessation services offered to priority populations identified at a higher risk of tobacco-use and help reach more Ontario smokers in quitting. One-time funding is for the purchase and provision of NRT and cannot be used to support staffing costs such as salaries and benefits.

The Board of Health is required to submit interim and final program activity reports for this project to the Province on dates specified in Schedule C. Reporting templates will be provided by the Province.

SCHEDULE B-4

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***Other***
Source	***Public Health***

Vaccine Programs

Funding on a per dose basis will be provided to the Board of Health for the administration of the following vaccines:

Influenza
The Province will continue to pay $5.00/dose for the administration of the influenza vaccine.

Meningococcal
The Province will continue to pay $8.50/dose for the administration of the meningococcal vaccine.

Human Papilloma Virus (HPV)
The Province will continue to pay $8.50/dose for the administration of the HPV vaccine.

In order to claim the vaccine administration fees, the Board of Health is required to submit, as part of the quarterly financial reports, the number of doses administered. Reimbursement by the Province will be made on a quarterly basis based on the information. The Board of Health is required to ensure that the vaccine information submitted on the quarterly financial reports accurately reflects the vaccines administered and reported on the Vaccine Utilization database.

SCHEDULE C-3

REPORTING REQUIREMENTS

The Board of Health is required to provide the following reports/information in accordance with direction provided in writing by the Province:

FINANCIAL AND PROGRAM REPORTING REQUIREMENTS	
Name of Report	**Due Date**
1. 2015 Program-Based Grants (PBG) 1st Quarter Financial Report (*for the period of January 1, 2015 to March 31, 2015*)	April 30, 2015
2. 2015 PBG 2nd Quarter Financial Report (*for the period of January 1, 2015 to June 30, 2015*)	July 31, 2015
3. Smoke-Free Ontario Strategy 2nd Quarter (Interim) Program Activity Report (*for the period of January 1, 2015 to June 30, 2015*)	July 31, 2015
4. 2015 PBG 3rd Quarter Financial Report (*for the period of January 1, 2015 to September 30, 2015*)	October 30, 2015
5. Smoke Free Ontario Strategy: Expanded Smoking Cessation Programming for Priority Populations 2nd Quarter (Interim) Program Activity Report *(for the period of April 1, 2015 to September 30, 2015)*	October 30, 2015
6. *Electronic Cigarettes Act* – Protection and Enforcement 2016 Work Plan	November 13, 2015
7. Smoke-Free Ontario Strategy 2016 Work Plan	November 13, 2015
8. 2015 PBG Revised Budget	December 11, 2015
9. 2015 PBG 4th Quarter Financial Report (*for the period of January 1, 2015 to December 31, 2015*)	January 29, 2016
10. Enhanced Food Safety – Haines Initiative Annual Activity Report (*for the period of January 1, 2015 to December 31, 2015*)	January 29, 2016
11. Enhanced Safe Water Initiative Annual Activity Report (*for the period of January 1, 2015 to December 31, 2015*)	January 29, 2016
12. *Electronic Cigarettes Act* – Protection and Enforcement 4th Quarter (Final) Program Activity Report *(for the period of January 1, 2015 to December 31, 2015)*	February 15, 2016

FINANCIAL AND PROGRAM REPORTING REQUIREMENTS	
Name of Report	**Due Date**
13. Smoke-Free Ontario Strategy 4th Quarter (Final) Program Activity Report (*for the period of January 1, 2015 to December 31, 2015*)	February 15, 2016
14. 2016 PBG Budget Request and Support Documentation[1]	March 1, 2016
15. Needle Exchange Program Initiative Annual Activity Report (*for the period of January 1, 2015 to December 31, 2015*)	March 31, 2016
16. Vector-Borne Diseases Program Annual Activity Report (*for the period of January 1, 2015 to December 31, 2015*)	March 31, 2016
17. 2015 PBG Annual Reconciliation Report [2, 3, 4, 5]	April 29, 2016
18. Panorama Plan Annual Activity Report *(for the period of April 1, 2015 to March 31, 2016)*	April 29, 2016
19. Public Health Inspector Practicum Program – Approved Financial Report; CIPHI BOC Form; and, a Report Back *(for the period of April 1, 2015 to March 31, 2016)*	April 29, 2016
20. Smoke-Free Ontario Strategy: Expanded Smoking Cessation Programming for Priority Populations 4th Quarter (Final) Program Activity Report (*for the period of April 1, 2015 to March 31, 2016*)	April 29, 2016
21. Other Base and One-Time Funding Activity Reports	As Requested

PERFORMANCE IMPROVEMENT REPORTING REQUIREMENTS	
Name of Report	**Due Date**
1. Mid-year Reporting on Achievement of Performance Indicators for current year	July 31, 2015 or As Required
2. Year-end Reporting on Achievement of Performance Indicators for Prior Year	January 29, 2016 or As Required
3. Compliance Reporting (as per a Compliance Variance in section 5.4)	As Required
4. Performance Reporting (as per an Performance Variance in section 5.5)	As Requested
5. Monitoring Indicator Reporting[6]	As Required

Notes:

1. Please refer to the PBG User Guide for further details on the supporting documentation required.

2. The re-evaluation of annual reconciliations by the Province is limited to one (1) year after the annual reconciliations have been provided to the Board of Health.

3. The Annual Reconciliation Report must contain: Audited Financial Statements; Auditor's Attestation report in the Province's prescribed format; and, Annual Reconciliation (Certificate of Settlement) Report Forms. The Province also requires copies of any Auditors' Management Letters issued to the Board of Health. Detailed instruction and templates will be provided by the Province.

4. The Audited Financial Statements must include a separate account of the revenues and expenditures of mandatory programs, as a whole, and each "related" program. This must be presented in separate schedules by program or initiative category or by separate disclosure in the notes to the Audited Financial Statements. It is not necessary to identify the revenues and expenditures of the individual programs within mandatory programs, but each of the "related" programs must be identified separately.

5. For a one-time project(s) approved for the period up to March 31, 2016, the Board of Health is required to confirm and report expenditures related to the project(s) as part of the: 2015 PBG Annual Reconciliation Package, for the period up to December 31, 2015; 2016 PBG 1st Quarter Financial Report for the period up to December 31, 2015 and the period of January 1, 2016 to March 31, 2016; and, 2016 PBG Annual Reconciliation Package for the period of January 1, 2016 to March 31, 2016. In addition to the 2016 PBG Annual Reconciliation requirements, the Province requires a certification from a licensed auditor that the expenses were incurred no later than March 31, 2016 through a disclosure in the notes to the 2016 Audited Financial Statements.

6. Monitoring Indicator means a measure of performance used to: (a) ensure that high levels of achievement are sustained; or (b) monitor risks related to program delivery.

2014-16 MOH/AMOH Salary Grid

MOH/AMOH Salary Grid effective April 1, 2013 to May 31, 2015					
# Years of Service:	**0**	**1**	**2**	**3**	**4 and above**
Medical Officers of Health (MOHs):					
MOH with Masters in PH [1]	$244,572	$254,980	$265,387	$275,794	**$286,202**
MOH with FRCPSC-CM/PHPM [2]	$254,980	$265,387	$275,794	**$286,202**	**$286,202**
MOH/CEO [3] with Masters	$254,980	$265,387	$275,794	**$286,202**	**$286,202**
MOH/CEO with FRCPSC-CM/PHPM	$265,387	$275,794	**$286,202**	**$286,202**	**$286,202**
Acting MOH on training track [4]	$244,572	$247,175	$249,776	$252,378	
Acting MOH not on training track [5]	$0	$0	$0	$0	$0
Associate MOHs (AMOHs):					
AMOH with Masters	$208,147	$218,555	$228,962	$239,369	**$249,776**
AMOH with FRCPSC-CM/PHPM	$218,555	$228,962	$239,369	**$249,776**	**$249,776**
AMOH with Masters serving as Acting MOH [6]	$218,147	$228,555	$238,962	$249,369	**$259,776**
AMOH with FRCPSC-CM/PHPM serving as Acting MOH	$228,555	$229,962	$249,369	**$259,776**	**$259,776**

MOH/AMOH Salary Grid effective June 1, 2015 (with 2.65% decrease)					
# Years of Service:	**0**	**1**	**2**	**3**	**4 and above**
Medical Officers of Health (MOHs):					
MOH with Masters in PH [1]	$238,091	$248,223	$258,355	$268,486	**$278,617**
MOH with FRCPSC-CM/PHPM [2]	$248,223	$258,355	$268,486	**$278,617**	**$278,617**
MOH/CEO [3] with Masters	$248,223	$258,355	$268,486	**$278,617**	**$278,617**
MOH/CEO with FRCPSC-CM/PHPM	$258,355	$268,486	**$278,617**	**$278,617**	**$278,617**
Acting MOH on training track [4]	$238,091	$240,625	$243,157	$245,690	
Acting MOH not on training track [5]	$0	$0	$0	$0	$0
Associate MOHs (AMOHs):					
AMOH with Masters	$202,631	$212,763	$222,895	$233,025	**$243,157**
AMOH with FRCPSC-CM/PHPM	$212,763	$222,895	$233,026	**$243,157**	**$243,157**
AMOH with Masters serving as Acting MOH [6]	$212,366	$222,498	$232,630	$242,760	**$252,892**
AMOH with FRCPSC-CM/PHPM serving as Acting MOH	$222,498	$223,868	$242,761	**$252,892**	**$252,892**

ADDITIONAL STIPENDS (on top of grid):	Not considered as part of benefits under the Initiative; not subject to salary grid increases/decreases
FRCPSC-CM/PHPM	**$5,000** in recognition of community medicine/public health and preventive medicine fellowship. Pro rated by FTE; annual rate.
After hours availability (if not currently compensated)	**$12,000** for MOHs practicing without an appointed AMOH; **$6,000** for MOHs practicing with AMOHs; **$5,000** for AMOHs; Pro rated by FTE; annual rate.
CPSO supervision	**$200/month** for 1-2 hours; **$500/month** for >2 and <10 hours; **$1,000/month** for 10 or more hours/month.

[1] Masters Degree in Public Health or Equivalent.

[2] Fellowship from the Royal College of Physicians and Surgeons of Canada in Community Medicine/Public Health and Preventive Medicine – additional $10K added to starting compensation.

[3] MOH/CEO position indicates greater level of responsibility – additional $10K added to starting compensation.

[4] Acknowledges commitment to obtaining qualifications and degree completion in 4 years as well as level of responsibility.

[5] Acting MOHs understood to be temporary replacements and ineligible for additional compensation, unless on training track.

[6] AMOH assumes greater level of responsibility as Acting MOH - additional $10K added to compensation.

Prepared May 28, 2015

OVERVIEW - 2015 BASE ALLOCATION FOR THE MOH/AMOH COMPENSATION INITIATIVE
MINISTRY OF HEALTH AND LONG-TERM CARE

Board of Health for the Middlesex-London Health Unit (the "Board of Health")

Please note: The table below is intended to illustrate how the 2015 base allocation was calculated for the MOH/AMOH Compensation Initiative, as per Schedule A of the Board of Health's Public Health Funding and Accountability Agreement (the "Accountability Agreement"). The positions reflect the total number of potential MOH and AMOH positions (i.e., budgeted FTEs and/or status of filled/vacant positions) at the Board of Health. Cash flow to the Board of Health will be based on the total base allocation approved (and identified in the Board of Health's Accountability Agreement) then adjusted to eligible funding determined based on information provided to the ministry regarding current MOH and/or AMOH physicians at the Board of Health, and any future Salary Grid under this Initiative. Please see Schedule B of the Accountability Agreement for additional details, and review the additional worksheets in this file for information about your cash flow for 2014 and 2015, and go forward funding.

Position(s)	Salary Grid Placement (Adjusted for FTE)	Base Salary (Adjusted for FTE)[1]	Salary Top Up (Rounded $)	Benefits Top Up ($)	FTE	Total Stipends (if eligible)[2]	Total Top Up for Position (Rounded)
MOH	278,617	244,513	34,104	6,139	1.00	11,000	**52,000**
AMOH	243,157	199,723	43,434	7,818	1.00	10,000	**62,000**

TOTAL BASE ALLOCATION FOR THE BOARD OF HEALTH - PER SCHEDULE A	**114,000**

Notes:

(1) Base salary as per data provided in the 2015-16 application forms submitted by the Board of Health in October 2015 and/or based on estimated average base salaries of MOH or AMOH positions.

(2) Total stipends, if eligible, include the after hours availability stipend and FRCPSC-CM.