



**AGENDA**  
**MIDDLESEX-LONDON BOARD OF HEALTH**

Thursday, July 16, 2020, 6:30 p.m.  
Microsoft Teams Conferencing

**MISSION - MIDDLESEX-LONDON HEALTH UNIT**

The mission of the Middlesex-London Health Unit is to promote and protect the health of our community.

**MEMBERS OF THE BOARD OF HEALTH**

Ms. Maureen Cassidy (Chair)  
Ms. Aina DeViet (Vice-Chair)  
Mr. John Brennan  
Ms. Kelly Elliott  
Ms. Tino Kasi  
Ms. Arielle Kayabaga  
Mr. Ian Peer  
Mr. Bob Parker  
Mr. Matt Reid

**SECRETARY-TREASURER**

Dr. Christopher Mackie

**DISCLOSURE OF CONFLICTS OF INTEREST**

**APPROVAL OF AGENDA**

**MINUTES**

Approve: June 18, 2020 Board of Health meeting  
June 25, 2020 Special Meeting of the Board of Health

Receive: July 2, 2020 Finance and Facilities  
June 18, 2020 Governance Committee

Item #	Delegation	Recommendation	Information	Report Name and Number	Link to Additional Information	Overview and Lead
<b>Reports and Agenda Items</b>						
1.		X	X	Finance and facilities Committee Update (Report No. 031-20)		To provide a recap the July 2, 2020 meeting.  Lead: Ms. Kelly Elliott, Chair FFC
2.			X	Governance Committee Verbal Update		To provide a verbal update on the July 16, 2020 meeting. Lead: Ms. Aina DeViet, Chair GC
3.			X	COVID-19 Verbal Update		To provide an update on the the local and provincial response to COVID-19 Leads: Dr. Christopher Mackie, Medical Officer of Health Dr. Alexander Summers, Associate Medical Officer of Health
4.		X	X	Sustained COVID-19 Response and Enhancements (Report No. 032-20)	Appendix A	To present a proposal to develop a sustained COVID Team. Leads: Dr. Alexander Summers, Associate Medical Officer of Health Dr. Christopher Mackie, Medical Officer of Health
5.			X	Summary Information Report (Report No. 033-20)		To provide an update on Clinical Services and Ontario Health Teams. Leads: Ms. Heather Lokko, Director Healthy Start and Chief Nursing Officer Dr. Christopher Mackie, Medical Officer of Health
6.			x	CEO (Interim) Verbal Update		To provide an update on: Public Health Modernization; MLHU COVID Response; Transition into Interim CEO role. Lead: Dr. Michael Clarke, CEO (Interim)

7.			X	Medical Officer of Health Activity Report for July (Report No. 034-20)		To provide an update to activities of the MOH since the last Board of Health meeting.  Lead: Dr. Christopher Mackie, Medical Officer of Health
<b>Correspondence</b>						
8.		X	X	July 2020 Correspondence		To receive correspondence items a) through h) for information and to endorse item a)

## OTHER BUSINESS

- Next Board of Health Meeting: September 17, 2020

## CONFIDENTIAL

The Board of Health will move in-camera to consider matters regarding labour relations, identifiable individuals and advice that is subject to solicitor-client privilege, including communications necessary for that purpose, and to consider matters regarding a trade secret or financial information, supplied in confidence to the local board, which if disclosed, could reasonably be expected to prejudice significantly the competitive position or interfere significantly with contractual or other negotiations of a person, group of persons or organization, and a trade secret or financial information that belongs to the municipality or local board and has monetary value.

## ADJOURNMENT



**PUBLIC SESSION – MINUTES**  
**MIDDLESEX-LONDON BOARD OF HEALTH**

Thursday, June 18, 2020, 6:00 p.m.

Webinar – Microsoft Teams

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**MEMBERS PRESENT:**

Ms. Maureen Cassidy (Chair)  
Ms. Aina DeViet (Vice-Chair)  
Mr. John Brennan  
Ms. Kelly Elliott  
Mr. Bob Parker  
Mr. Ian Peer  
Mr. Matt Reid  
Ms. Tino Kasi  
Ms. Arielle Kayabaga

**OTHERS PRESENT:**

Dr. Christopher Mackie, Medical Officer of Health (Secretary Treasurer)  
Ms. Elizabeth Milne, Executive Assistant to the Board of Health and Communications Coordinator (Recorder)  
Dr. Alexander Summers, Associate Medical Officer of Health  
Ms. Laura Di Cesare, Director, Healthy Organization  
Ms. Heather Lokko, Director, Healthy Start  
Ms. Maureen Rowlands, Director, Healthy Living  
Mr. Stephen Turner, Director, Environmental Health and Infectious Disease  
Dr. Michael Clarke, VP Modernization  
Mr. Dan Flaherty, Manager, Communications

Chair Cassidy called the meeting to order at 7:05 p.m.

**DISCLOSURE OF CONFLICT OF INTEREST**

Chair Cassidy inquired if there were any disclosures of conflicts of interest. None were declared.

**APPROVAL OF AGENDA**

It was moved by Mr. Reid, seconded by Mr. Peer, *that the **AGENDA** for the June 18, 2020 Board of Health meeting be approved.*

Carried

**MINUTES**

It was moved by Mr. Reid, seconded by Ms. Kasi, *that the **MINUTES** of the May 21, 2020 Board of Health meeting be approved.*

Carried

*It was moved by Ms. Elliott, seconded by Mr. Parker, that the **MINUTES** of the May 28, 2020 Special Board of Health be approved.*

Carried

It was moved by Ms. DeViet, seconded by Mr. Reid, *that the MINUTES of the June 4, 2020 Finance and Facilities meeting be received.*

Carried

## **REPORTS AND AGENDA ITEMS**

### **Finance and Facilities Committee Update (Report No. 0026-20)**

Ms. Elliott, Chair of the Finance and Facilities Committee noted that there was a report on the re-location of the Health Unit and that it was to be received for information by the Board of Health.

It was moved by Mr. Peer, seconded by Mr. Reid, *that the Board of Health receive Report No. 026-20 re: "Finance & Facilities Committee Meeting – June 4, 2020" for information.*

Carried

### **Governance Committee (GC) Update (Verbal)**

Ms. DeViet provided this update.

She noted that there were three items on the June 18<sup>th</sup> GC agenda:

Governance By- Law Policy and Review – Whistleblower Policy. She noted that this was the only policy to be reviewed at this time as all other policies have been deferred for the time being.

Occupational Health and Safety Report for 2019 – Review of Health and Safety policies, a physical – policy review, physical demands review,

Ms. DeViet noted that Return to Operations would be addressed later in the agenda by Ms. Lokko

It was moved by Ms. DeViet, seconded by Mr. Brennan, *that the Board of Health receive Governance Committee verbal update for information and approve the amended policy.*

Carried

### **Public Health Inspector Enforcement Actions and Inspections Activities – Q1 of 2020 (Report No. 027-20)**

Mr. Turner introduced this report. He noted that all Public Health inspection activities are available on the website. He also noted that there were fewer inspections due to the COVID-19 response, and that Q2 would have even fewer.

Ms. Kayabaga noted that she has received notice from two private properties downtown who are reporting feces in front of their businesses and wondering what the health unit can do. She advised that the problem is continuing even though it was reported more than once. Mr. Turner asked Ms. Kayabaga to speak to him offline. Reported issues like this are usually dealt with by a Public Health Inspector on a priority basis.

It was moved by Mr. Parker, seconded by Mr. Peer, *that Report No. 027-20 re: "Public Health Inspector Enforcement Actions and Inspection Activities – Q1 of 2020" be received for information*

Carried

### **Collection of Race and Other Social Determinants of Health Data During the COVID-19 Pandemic (Report No. 028-20)**

Dr. Summers noted that this report was developed in order to provide the Board of Health with a picture of the collection and analysis of social determinants of health data, especially around race and income.

Dr. Summers noted that more analysis is to come and will continue to work with the Population Health and Surveillance Team (PHAST) and Health Equity (HE) Team and will continue to collect this data after

COVID. He noted that this is work that has been planned for some time. Dr. Summers advised that in early April, MLHU was one of the first public health agencies to collect this data, specifically for COVID patients. Staff were able to go back retrospectively and collect this data from early COVID patients. Requested data included race, total income, occupation, housing, and indigenous identity.

It was noted that this is great work from both teams to pull this together.

In response to a question, Dr. Summers noted that the Health Unit was already collecting the race related data that the Province recently mandated health units collect. The Health Unit does not currently collect this data for other diseases but will be rolling this out for all clients that staff interact with in the future. It is anticipated that the Province will continue to request this important information.

In response to a question, Dr. Summers advised that in order to encourage people to provide this data, and assist with their reluctance, scripting will be developed to articulate why and how the Health Unit is collect the data. It will be meaningful, significant and dignified. It was noted that 87% of COVID cases reported answers to questions around race and income. Early analysis shows that 27% of confirmed positive COVID cases reported as a visible minority, which is higher than the visible minority at baseline in the Middlesex and London Region.

The COVID pandemic has prompted other health units to start collecting race related data. Dr. Summers will participate in meetings in regards to the collection. This collection supports the work that the Health Unit does.

Dr. Summers noted that the high trust that the community has for the Health Unit will help with the collection of the data. He noted that the data that was presented this evening is an early analysis and that it will continue to develop. The Health Unit is leading the way for others.

The Health Unit will work with the Black and Indigenous communities and organizations to learn more about their perspectives on collecting race-based data. It is important to note that this has been a request from the community.

For data gathering and what to do with it later, it would also be helpful to have conversations with key partners such as the City, Police and School Boards.

It was noted that the Health Equity Team has both indigenous and black members which is important to remind us to get more action and not just another 80 years of recommendations.

It was moved by Mr. Reid, seconded by Mr. Parker, *that Report No. 028-20 re: "Collection of Race and Other Social Determinants of Health Data During the COVID-19 Pandemic" be received for information.*

Carried

### **COVID-19 Update (verbal)**

Dr. Summers provided an update on the current COVID situation.

He advised that the Middlesex-London count of positive cases has exceeded 600, however the number of new cases continues to drop and we are approaching the flattening of the curve. Dr. Summers noted that cases in both Long-Term Care Homes and Retirement Homes are slowing.

He noted that our region has moved into stage 2 of phase 2, and that this reopening has meant a lot of work for Health Unit staff.

There is a current recommendation to wear non-medical masks when physical distancing is not possible. Dr. Summers also noted that there is ongoing evidence that it will not cause harm to use a mask.

Staff are planning for a sustainable ongoing response to COVID-19. As the reopening has begun, so does the need to restart regular baseline work. Clinical services are starting to ramp up again.

Dr. Summers advised the Board that the Health Unit continues to be 100% compliant reporting case and contact investigation data to the Province.

There was discussion in regard to masking and whether or not MLHU will mandate the wearing of masks at all times as some other Health Units have. Both Drs. Mackie and Summers have been looking at the mask issue since the beginning and it was noted that data and evidence continue to evolve each week. Dr. Mackie noted that you need to have a strong case to mandate people to wear masks without stepping on

people's rights. The Health Unit will continue to strongly recommend the wearing of masks in certain circumstances and will revisit this if things turn and cases begin to rise.

Ms. Lokko provided an update on Return to Operations.

Since last BOH meeting, the Team has moved forward with developing a dashboard to engage in decisive decision making. The work that is being done by the recovery team is helping to identify the extent to which gaps related to and implications of COVID-19 will impact other Health Unit operations going forward.

There have been 297 interventions that were identified, and a few interventions have been prioritized for the next few weeks. These include things such as immunizations, inspections of restaurants, pools and personal service settings.

Organizational and individual assessments for wellness have been developed for MLHU staff. This survey will be open for 10 days to allow for all staff to participate.

A plan for second wave and/or new pandemic is being developed and draft recommendations will go to the Senior Leadership Team next week.

The Team is working to identify some things that were implemented for the COVID response that would be beneficial to carry forward post COVID.

It is anticipated that there will be more information to share with the Board in September.

Dr. Mackie noted that as we move to next stages and phases for reopening, it is not clear what will be expected from the Health Unit and whether or not there will be added responsibilities. It is anticipated that within the next few weeks, the Province will have more clarity of what will be expected from the Health Unit. He noted that the Board will receive a report next month highlighting what a Full Service COVID-19 Program would look like.

There is a significant amount of work being done with the Health System Leadership and Assessment Centres. More details will be provided at the next Board meeting.

Chair Cassidy noted her concern for staff going back to what they used to do. When the stress is gone, this is when people start to crash. She asked how people are doing across the organization, is there a plan to identify distress, and how can the Board of Health help. Dr. Mackie noted that vacations have resumed to almost normal vacation policy and the Leadership Team are encouraging staff to take vacation.

Ms. Lokko noted the organizational wide assessment survey will specifically ask what staff need to support themselves. She also noted that a couple of experts in the field will be available to assist. EFAP service provider has provided sessions for staff already and this issue is definitely on the Senior Leaders radar.

The question was asked "Once staff have gone back to their old job, how quickly can we get back to the COVID response"? Dr. Summers noted that over the summer a team of staff will be developing a tiered plan to do sustained baseline work and the development of a redeployment plan.

It was moved by Ms. DeViet, seconded by Ms. Elliott, *that the Board of Health receive "COVID-19 Verbal Update" for information.*

Carried

### **Medical Officer of Health Activity Report for June (Report No. 029-20)**

Dr. Mackie noted that Chair Cassidy had asked him elaborate more on what he's doing day to day other than what is noted in this report. He provided a couple of additional updates, noting the following:

The Health Unit is functioning at a high level of productivity, and he is trying to make sure that that is not disrupted by external changes. He is a representative for COMOH for the Ontario Health West COVID-19 response table. Dr Mackie also serves on the Public Health Measures Table which provides advice to Ontario's Chief Medical Officer of Health. Conversations are open and quite frank. He believes that he CMOH and government are listening.

Ontario Health Team (OHT) Regional Leadership work is very involved and has just moved from meeting 5 days per week to 3 days. Dr. Mackie noted that he has seen health system working as a system and organization helping each other as not seen before. Public Health is now part of the decision making process.

More sub-region work, working within the old LHIN geography. This group implements OHT decisions and focusing on LTC and Retirement homes. Hospitals and primary care and other providers are working together.

He noted that there is still one prolonged outbreak in an LTC Home still to resolve.

Daily City media and weekly County calls. Ensuring partners are receiving up to date information. Many sidebar conversations come out of these meetings.

It was moved by Ms. Elliott, seconded by Mr. Peer, *that the Board of Health receive Report No. 025-20 re: "Medical Officer of Health/CEO Activity Report for June" for information.*

Carried

## CORRESPONDENCE

Chair Cassidy inquired if there were any questions, hearing none she asked for a mover and seconder.

It was moved by Mr. Parker, seconded by Mr. Reid, *that the Board of Health receive items a) through c) for information.*

Carried

## Other Business

Next meeting – July 16, 2020

Update from IT regarding Multi-Factor Authentication (MFA) for Board Members

Mr. Cameron provided the update to the Board. He noted that using this process it is one more step in providing additional security to prevent phishing scams.

It was moved by Ms. DeViet, seconded by Mr. Peer, *that the Board of Health receive this update for information.*

Carried

Update – Motion passed unanimously at City Council that will aide the city in ending racism by not only recognizing the issue, but requesting the police board, the school boards and the health unit respond to the issue as well.

Chair Cassidy introduced this update, providing a brief recap of the meeting at City Hall. Dr. Mackie noted he continues to note in the media that racism is a public health issue. There remains a need to continue this conversation. Coming out of the request from the City, the Health Unit will make certain that we have our own house in order, we are following best practices, voices of colour reflected in our work, and use this opportunity to build a community strategy. SLT will further discuss at next Tuesday's meeting.

It is important to have the Board's perspective and support on this issue.

Ms. Kayabaga noted that she and Dr. Mackie had spoken earlier. Council directed the boards to come up with some things that Board can do to address the Black Lives Matter asks.

Mr. Parker wondered if setting up a sub-committee to work on this would be beneficial.

To answer a question from Ms. Kasi, Dr. Mackie noted that the motion was just received from the City today. He advised the Board that the Health Unit has people of colour on staff to work on this but that it is also important to have the perspective the black community. Staff Leads will be people of colour and will



work with the Health Equity Team to engage in a thoughtful, deliberate and engaging process but not move too slowly.

Ms. Kasi noted that there are many leaders within the black community to consider but to also consider the youth as they have the energy and they know what's going on so shouldn't be overlooked.

It was moved by Ms. Kayabaga, seconded by Ms. DeViet, *that the Board of Health endorse identifying racism as a Public Health crisis.*

Carried

**CONFIDENTIAL**

At 8:37 p.m., it was moved by Mr. Reid, seconded by Mr. Peer, *that the Board of Health move in-camera to consider matters regarding labour relations, identifiable individuals and advice that is subject to solicitor-client privilege, including communications necessary for that purpose, and to consider matters regarding a trade secret or financial information, supplied in confidence to the local board, which if disclosed, could reasonably be expected to prejudice significantly the competitive position or interfere significantly with contractual or other negotiations of a person, group of persons or organization, and a trade secret or financial information that belongs to the municipality or local board and has monetary value.*

Carried

At 9:04 p.m. it was moved by Ms. DeViet, seconded by Mr. Parker, *that the Board of Health return to public session.*

Carried

At 9:04 p.m. it was moved by Ms. DeViet, seconded by Mr. Parker, *that the Board of Health take a recess.*

Carried

At 9:27 p.m. the Board of Health reconvened after a brief recess.

At 9:27 p.m. was moved by Ms. DeViet, seconded by Mr. Reid, *that the Board of Health reconvene their meeting.*

Carried

At 9:27 it was moved by Mr. Brennan, seconded by Mr. Peer, *that the Board of Health move in-camera to consider matters regarding labour relations, identifiable individuals and advice that is subject to solicitor-client privilege, including communications necessary for that purpose.*

Carried

At 11:15 it was moved by Mr. Reid, seconded by Ms. Elliott, *that the Board of Health return to public session.*

**ADJOURNMENT**

At 11:15 p.m., it was moved by Mr. Reid, seconded by Ms. Elliott, *that the meeting be adjourned.*

Carried

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MAUREEN CASSIDY  
Chair

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CHRISTOPHER MACKIE  
Secretary-Treasurer



**PUBLIC SESSION – MINUTES**  
**MIDDLESEX-LONDON BOARD OF HEALTH**  
**SPECIAL MEETING**

Thursday, June 25, 2020 5:30 p.m.

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**MEMBERS PRESENT:**

**Ms. Maureen Cassidy (Chair)**  
Ms. Aina DeViet  
Mr. Ian Peer  
Mr. Matt Reid  
Mr. John Brennan  
Mr. Bob Parker (arrived at 5:45 p.m.)  
Ms. Kelly Elliott  
Ms. Arielle Kayabaga  
Ms. Tino Kasi (via Microsoft Teams/Teleconference)

**OTHERS PRESENT:**

Ms. Elizabeth Milne, Executive Assistant to the Board of Health and Communications Coordinator (Recorder)  
Ms. Jodi Gallagher-Healy, Partner, Hicks Morley

Chair Cassidy called the meeting to order at 5:38 p.m.

**DISCLOSURE OF CONFLICT OF INTEREST**

Chair Cassidy inquired if there were any disclosures of conflicts of interest. None were declared.

**APPROVAL OF AGENDA**

It was moved by Ms. DeViet, seconded by Ms. Elliott, *that the **AGENDA** for the June 25, 2020 Special Meeting of the Board of Health meeting be approved.*

Carried

**MINUTES**

**OTHER BUSINESS**

The next regular meeting of the Board of Health will be on Thursday, July 16, 2020

**CONFIDENTIAL**

At 5:38 p.m., it was moved by Mr. Brennan, seconded by Mr. Peer, *that the Board of Health move in camera to consider matters regarding labour relations, identifiable individuals and advice that is subject to solicitor-client privilege, including communications necessary for that purpose.*

Carried

At 7:11 p.m., it was moved by Mr. Reid, seconded by Ms. Kayabaga, *that the Board of Health rise and return to public session.*

Carried

At 7:11 p.m., the Board of Health returned to public session.

**ADJOURNMENT**

At 7:11 p.m., it was moved by Ms. Elliott, seconded by Ms. Kayabaga, *that the meeting be adjourned.*

Carried

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**MAUREEN CASSIDY**  
Chair

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**AINA DEVIET**  
Vice-Chair



**PUBLIC MINUTES  
MIDDLESEX-LONDON BOARD OF HEALTH  
FINANCE & FACILITIES COMMITTEE**

Microsoft Teams  
Thursday, July 2, 2020 9:00 a.m.

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**MEMBERS PRESENT:** Ms. Maureen Cassidy  
Ms. Aina DeViet  
Ms. Kelly Elliott (**Chair**)  
Mr. Ian Peer

**Regrets:** Ms. Tino Kasi

**OTHERS PRESENT:** Dr. Christopher Mackie, Secretary-Treasurer  
Ms. Lynn Guy, Executive Assistant to the Medical Officer of Health (Recorder)  
Ms. Laura Di Cesare, Director, Corporate Services  
Mr. Brian Glasspoole, Manager Finance  
Dr. Michael Clarke, VP, Modernization  
Mr. Joe Belancic, Manager Procurement and Operations  
Ms. Katie denBok, Lead Audit Engagement Partner, KPMG  
Ms. Dania Nabhani, Audit Manager, KPMG

At 9:06 a.m., Chair Elliott called the meeting to order.

**DISCLOSURES OF CONFLICT(S) OF INTEREST**

Chair Elliott inquired if there were any disclosures of conflicts of interest. None were declared.

**APPROVAL OF AGENDA**

It was moved by Mr. Peer, seconded by Ms. Cassidy, *that the **AGENDA** for the July 2, 2020 Finance and Facilities Committee meeting be approved.*

Carried

**APPROVAL OF MINUTES**

It was moved by Mr. Peer, seconded by Ms. Cassidy, *that the **MINUTES** of the June 4, 2020 Finance and Facilities Committee meeting be approved.*

Carried

**NEW BUSINESS**

**4.1 2019 Draft Financial Statements (Report No. 0015-20FFC)**

Mr. Glasspoole briefly walked through the Committee through the financial statements, noting that they were audited by KPMG, an independent external auditor.

Ms. Katie denBok began the conversation in regard to the audited findings by starting with the Executive Summary. She advised that once conversations with FFC are completed, a management representation letter is signed, and the Board's sign off of the statements are received, the auditor's report will be dated. Ms. Dania Nabhani walked the Committee through the audit risks and results, advising that there were no significant issues to note.

Ms. denBok reviewed the appendices attached to the report:

Appendix 1: Other Required Communications – this is the management representation letter that has been provided to the Finance and Facilities Committee.

Appendix 2: Audit Quality and Risk Management – this highlights the audit quality framework that KPMG uses

Appendix 3: a copy of the management representation letter, to be signed by Dr. Mackie and Mr. Glasspoole

Appendix 4: Preparing for PSAB Standard Changes – Ms. denBok noted that in 2021 there will be new standards implemented for the public sector.

Appendix 5: Audit Response to COVID-19 Pandemic – Ms. denBok noted that the financial impact of this pandemic is noted as unknown at this time.

There was a brief discussion in regard to accrued wages and benefits under liabilities on page 4.

Ms. Elliott advised the Committee that following the Confidential portion of the meeting, FFC would participate in a confidential call with Ms. denBok in regard to the audit. As conference line was provided.

It was moved by Mr. Peer, seconded by Ms. Cassidy *that the Finance and Facilities Committee recommend that the Board of Health review and approve the audited Financial Statements for the Middlesex-London Health Unit, December 31, 2019, as appended to Report No. 015-20FFC.*

Carried

#### **4.2 Single Source Contracts (Report No. 016-20FFC)**

Mr. Belancic spoke to this report. He noted that the HVAC Maintenance contract to Honeywell Building Solutions, and the Elevator and Service maintenance contract to Skyline Elevator are both 1-year contracts. Both of these businesses are the current providers of service and maintenance at Citi Plaza. Once as built drawings of the elevator and HVAC system are completed, both of these services will go out for competitive bid.

The third contract is for an upgrade of security and card access card readers that was awarded to JPW Systems for the Strathroy office.

It was moved by Mr. Peer, seconded by Ms. DeViet *that the Finance and Facilities Committee recommends the Board of Health receive Report No. 016-20FFC, re: "Single Source Contract Awards" for information*

Carried

#### **4.3 Ministry of Health Temporary Pandemic Pay Initiative (Report No. 017-20FFC)**

Dr. Mackie noted that Ms. Di Cesare and Mr. Glasspoole would both assist with this report when required.

Mr. Glasspoole noted the extensive requirements that are in place to be eligible to administer the funds to employees. He noted that the interpretation of the guidelines will need to be worked through.

Ms. Di Cesare noted that while this is welcome pay, there is a lot of administrative work that will need to be done to determine how to administer the \$4.00 per hour to eligible employees.

It was noted that clarity from the Ministry in regard to additional funds spent to support pandemic work will be forthcoming.

It was moved by Ms. Cassidy, seconded by Ms. DeViet *that the Finance and Facilities Committee:*  
*1. Receive Report No. 017-20FFC re: "Ministry of Health Temporary Pandemic Pay Initiative"; and*  
*2. Direct staff to receive this funding,*

Carried

#### **4.4 Cash Flow Analysis (Report No. 018-20FFC)**

Dr. Mackie noted that this morning the Committee were given a revised version of the report, advising that he changed some wording back to what was originally drafted.

Mr. Glasspoole noted the different situation with cash flow this year. Because reserve funds were used for expenses related to the move, they are not available to act as a funding buffer. Therefore, the operating cash flow is being closely monitored.

Mr. Glasspoole noted that in June the line of credit was drawn on in the amount of \$400,000, to ensure an adequate cash flow to pay payroll overtime and an additional pay in the spring. The Finance Team will continue to assess the overtime salaries. They will be looking to the Ministry for additional funds.

It was moved by Ms. Cassidy, seconded by Mr. Peer, *that the Finance and Facilities Committee receive Report No. 018-20FFC "Cash Flow Analysis" for information.*

Carried

#### **OTHER BUSINESS**

Next meeting: September 10, 2020 – 9:00am

#### **CONFIDENTIAL**

At 9:59 a.m., it was moved by Ms. Cassidy , seconded by Mr. Peer, *that the Finance and Facilities Committee move in-camera to consider matters regarding a trade secret or financial information, supplied in confidence to the local board, which if disclosed, could reasonably be expected to prejudice significantly the competitive position or interfere significantly with contractual or other negotiations of a person, group of persons or organization, and a trade secret or financial information that belongs to the municipality or local board and has monetary value.*

Carried

At 10:21 a.m., it was moved by Mr. Peer, seconded by Ms. Cassidy, *that the Finance and Facilities Committee return to public session.*

Carried

At 10:21 a.m. the Finance and Facilities Committee returned to public session.

#### **ADJOURNMENT**

At 10:22 a.m., it was moved by Ms. DeViet, seconded by Mr. Peer, *that the meeting be adjourned.*

Carried

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

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**KELLY ELLIOTT**  
Chair

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**CHRISTOPHER MACKIE**  
Secretary-Treasurer



**PUBLIC SESSION – MINUTES**  
**MIDDLESEX-LONDON BOARD OF HEALTH**  
**GOVERNANCE COMMITTEE**

Thursday, June 18, 2020, 5:30 p.m.  
Microsoft Teams

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**MEMBERS PRESENT:** Ms. Aina DeViet (Committee Chair)  
Ms. Arielle Kayabaga (arrived at 5:40 due to technical difficulties)  
Mr. Ian Peer  
Mr. Bob Parker

**REGRETS:** Ms. Maureen Cassidy

**OTHERS PRESENT:** Mr. John Brennan, Board of Health  
Ms. Lynn Guy, Executive Assistant to the Medical Officer of Health and Associate Medical Officer of Health (Recorder)  
Dr. Chris Mackie, Medical Officer of Health/CEO  
Dr. Alex Summers, Associate Medical Officer of Health  
Ms. Laura Di Cesare, Director, Healthy Organization  
Lilka Young, HR Coordinator  
Mr. Brian Glasspoole, Manager, Finance  
Ms. Nicole Gauthier, Manager, Privacy, Risk and Governance  
Ms. Cynthia Bos, Manager, Human Resources  
Ms. Heather Lokko, Director, Healthy Start  
Dr. Michael Clarke, Director, Modernization  
Ms. Elizabeth Milne, Executive Assistant to the Board of Health and Communications Coordinator

Ms. DeViet called the meeting to order at 5:32 p.m.

**DISCLOSURE OF CONFLICT OF INTEREST**

Chair DeViet inquired if there were disclosures of conflicts of interest to be declared. None were declared.

**APPROVAL OF AGENDA**

It was moved by Mr. Peer, seconded by Mr. Parker, *that the AGENDA for the June 18, 2020 Governance Committee meeting be approved.*

Carried

**APPROVAL OF MINUTES**

It was moved by Mr. Parker, seconded by Mr. Peer, *that the MINUTES of the February 27, 2020 Governance Committee meeting be approved.*

Carried

**NEW BUSINESS**

**Governance By-law and Policy Review (Report No. 006-20GC)**

Dr. Mackie introduced this report, and noted that during COVID, staff will only be focusing on policies that urgently need to come to Governance. He also advised that if there were any questions that Ms. Nicole Gauthier is the lead and is available to answer any questions.

It was moved by Mr. Peer, seconded by Mr. Parker, *that the Governance Committee recommend to the Board of Health to:*

- 1) *Receive Report No. 006-20GC re: "Governance By-law and Policy Review" for information; and*
- 2) *Approve the governance policy appended to this report.*

Carried

### **2019 Occupational Health and Safety Report (Report No. 007-20GC)**

Dr. Mackie noted that Ms. Lilka Young, Human Resources Coordinator, Ms. Cynthia Bos, Manager Human Resources as well as Ms. Di Cesare were on the line for extra details if needed.

It was noted that there was nothing in particular that staff thought should be red flagged for the Board.

Ms. Di Cesare noted that the report highlights the incredible amount of work that was accomplished last year. She also indicated that the move to Citi Plaza resolved some issues.

Ms. Young noted a slight increase in WSIB submissions and that is partly due to more appropriate follow-up with staff and in a timely fashion.

It was moved by Mr. Peer, seconded by Mr. Parker, *that the Governance Committee receive Report No. 007-20GC re: "2019 Occupational Health and Safety Report" for information.*

Carried

### **COVID-19 Recovery Planning: Return to Operations (Report No. 008-20GC)**

Dr. Mackie noted that this written report was a follow-up to the verbal update that Ms. Lokko provided at the last Board of Health meeting.

Ms. Lokko noted that interventions have been identified by Senior Leaders for this first phase.

Mr. Peer noted that he has seen some other organizations who were finding it easier to cope with the initial response but harder to get back to normal. Ms. Lokko agreed that there is a great deal to consider. Moving out of COVID will be just as challenging as things continue to change.

Dr. Mackie also agreed that it's difficult to come out of a crisis. Keeping motivated, easing anxiety, prioritizing what needs to happen now and what can be focused on for the next year or two will be key.

Ms. DeViet commented on the work that has gone into this process to date.

It was moved by Mr. Peer, seconded by Mr. Parker, *that the Governance Committee receive Report No. 008-20GC for information.*

Carried

### **OTHER BUSINESS**

The next meeting of the Governance Committee will be on Thursday, October 15, 2020 at 6:00 p.m.

### **CONFIDENTIAL**

At 5:48 p.m. it was moved by Mr. Peer, seconded by Ms. Kayabaga, *that the Governance Committee move in-camera to consider matters regarding labour relations, identifiable individuals and advice that is subject to solicitor-client privilege, including communications necessary for that purpose.*

Carried



**ADJOURNMENT**

At 7:00 p.m., it was moved by Ms. Kayabaga, seconded by Mr. Parker, *that the meeting be adjourned.*

Carried

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**AINA DEVIET**  
Committee Chair

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**CHRISTOPHER MACKIE**  
Secretary-Treasurer

DRAFT



## MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 031-20

TO: Chair and Members of the Board of Health  
FROM: Christopher Mackie, Medical Officer of Health  
DATE: 2020 July 16

### FINANCE & FACILITIES COMMITTEE MEETING – July 2, 2020

The Finance & Facilities Committee (FFC) met at 9:00 a.m. on Thursday, July 2, 2020. A summary of the Committee's discussions can be found in the [draft minutes](#).

Reports	Recommendations for Information and Board of Health Consideration
<b>2019 Draft Financial Statements</b> ( <a href="#">Report No. 015-20FFC</a> )	It was moved by Mr. Peer, seconded by Ms. Cassidy, <i>that the Finance &amp; Facilities Committee recommend that the Board of Health review and approve the audited Financial Statements for the Middlesex-London Health Unit, December 31, 2019, as appended to Report No. 013-20FFC.</i> Carried
<b>Single Source Contract Awards</b> ( <a href="#">Report No. 016-20FFC</a> )	It was moved by Mr. Peer, seconded by Ms. DeViet, <i>that the Finance &amp; Facilities recommends the Board of Health receive Report No. 016-20FFC, re: "Single Source Contract Awards" for information.</i> Carried
<b>Ministry of Health Temporary Pandemic Pay Initiative</b> ( <a href="#">Report No. 017-20FFC</a> )	It was moved by Mr. Cassidy, seconded by Ms. DeViet, <i>that the Finance &amp; Facilities Committee recommend that the Board of Health:</i> <ol style="list-style-type: none"><li>1. Receive Report No. 017-20FFC re: "Ministry of Health Temporary Pandemic Pay Initiative": and</li><li>2. Direct staff to receive this funding.</li></ol> Carried
<b>Cash Flow Analysis</b> ( <a href="#">Report No. 018-20FFC</a> )	It was moved by Ms. Cassidy, seconded by Mr. Peer, <i>that the Finance &amp; Facilities Committee receive Report No. 018-20FFC, "Cash Flow Analysis" for information.</i> Carried

This report was prepared by the Office of the Medical Officer of Health.

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

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health  
Michael Clarke, CEO (Interim)

DATE: 2020 July 16

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## **SUSTAINED COVID-19 RESPONSE AND ENHANCEMENTS**

### ***Recommendation***

***It is recommended that the Board of Health receive Report No. 032-20 re: “Sustained COVID-19 Response and Enhancements”.***

### **Key Points**

- The COVID-19 pandemic has required extraordinary efforts of MLHU staff and redeployment of 70% of the organization to respond to this public health emergency.
- This report details the proposed program and its structure that would allow staff to be redeployed back to existing public health programming.

### **Background**

The first laboratory-confirmed COVID-19 case in the Middlesex-London region was reported to the Middlesex-London Health Unit (MLHU) on January 24, 2020. Since then, and up to July 8, 2020, a total of 631 confirmed COVID-19 cases were reported to and followed up by the MLHU. The MLHU conducts surveillance and reports regularly on the status of COVID-19 through internal and [external](#) portals. COVID-19 infections have been reported from among residents of both Middlesex County and the City of London, although most cases (93%, 586/631) reside in London. The number of cases alone represents a substantial follow-up burden. In addition, each case’s close contacts also require follow-up and monitoring, multiplying the programmatic need associated with this new reportable disease of public health significance.

Community control of the COVID-19 pandemic in the Middlesex-London region has been achieved through unprecedented and intensive physical distancing and aggressive case and contact management. Operationally, the robust response of MLHU to the first wave of the COVID-19 pandemic was achieved through the significant redeployment of MLHU staff. This redeployment significantly limited and constrained other MLHU operations.

As physical distancing restrictions are relaxed and in the absence of a vaccination, COVID-19 remains a significant risk to the population. The experience of other jurisdictions globally suggests the potential of recurrent waves of infection.

### **Key Assumptions**

The following key assumptions have been considered in development of this program:

- Non-COVID-19 work remains essential for MLHU to achieve its mission;
- The COVID-19 response is an expansion of the mandate of MLHU;

- Additional resources will be required to support a sustained response to COVID-19;
- MLHU must be prepared to respond to a COVID-19 pandemic for a minimum of 12-18 months;
- The COVID-19 program must be readily scalable; and
- Rapidly escalating COVID-19 prevalence will once again require redeployment of MLHU staff.

## **The COVID-19 Program**

The COVID-19 program will consist of the following interventions noted below that are intended to reduce the burden of illness associated with the pandemic in our community. The fulsome MLHU Plan for Sustained COVID-19 Response is attached as [Appendix A](#).

### ***Case and Contact Management***

Case and contact management are specialized skills that public health staff use in an investigation of any confirmed COVID-19 case. Case investigation is the identification of any person with confirmed and probable diagnoses of COVID-19 (cases). The management of the case begins with a thorough interview to determine and identify close contacts (contact tracing) using a series of questions and data collecting methods so that information can be documented in a case and contact management tool. Contract investigation or contact tracing is the identification, monitoring and support of the individuals or contacts, who have been exposed to the case and possibly infected themselves. This process prevents further transmission of disease by separating people who have or may have an infectious disease from people who do not.

### ***Outbreak Management***

The COVID-19 Program would support all COVID-19 outbreak investigations and management. Ongoing support of facilities such as long-term care homes or child care facilities would be responsibility of the Infectious Disease Control (IDC) team. However, upon identification of a COVID-19 case in a facility, a case investigator from the COVID-19 program would partner with the IDC investigator to support the management of an outbreak.

### ***Screening, Assessment and Testing***

The COVID-19 Program will be required to support screening initiatives, assessment centres, and testing policy. The program will also oversee and update all relevant medical directives related to testing.

### ***Planning and System Coordination***

The COVID-19 Program will participate in internal and external planning for a COVID-19 resurgence, including the possibility of mass immunization. Internally, the COVID-19 Program would be responsible for developing an escalation plan and surge protocols in the instance of increased COVID-19 prevalence. The program would also develop and support the training of other MLHU staff in anticipation of potential redeployment. Externally, the COVID-19 Program would work with partners in the health sector to assist in system coordination and planning.

### ***Liaison and Community Support***

The COVID-19 program will be responsible for liaison and consultation with non-health sector partners regarding COVID-19. The program will also act as a resource for others in the Health Unit who have pre-existing relationship with external partners and are called on to provide COVID-19 guidance. The COVID-19 program will also provide Tier Two telephone support for general inquiries from the public. The Client Service Representatives (CSR) will be the first line of contact for the public calling about COVID-19. Following a screening by the CSR, the caller will either be provided with the information or transferred to the Tier Two level support.

***Scientific and Technical Support***

The COVID-19 Program will collate, review, interpret, and translate all relevant research, policy, and guidelines. The program will be responsible for providing scientific and technical support internally and externally. This will inform the implementation of public health measures locally.

**Next Steps**

The Middlesex-London Health Unit will continue to prioritize its resources to respond to existing public health priorities and the demands of COVID-19.

This report was prepared by the Associate Medical Officer of Health, the COVID-19 Incident Management Team, and the Return to Operations Team.



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



Michael Clarke, PhD  
CEO (Interim)

## **MLHU Plan for Sustained COVID-19 Response**

**July 2020**



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## 0.0 PREAMBLE

The **MLHU Plan for Sustained COVID-19 Response** articulates the strategic vision and operational plan to guide Middlesex-London Health Unit's (MLHU) ongoing response, readiness, and resilience in the management of the COVID-19 pandemic over the next 12 – 18 months. It positions MLHU to respond in a tiered manner to escalating levels of COVID-19 prevalence in the community.

This plan is a working document informed by actions taken and lessons learned to date in MLHU's response to COVID-19. It will require revisions as new learnings are realized at the agency and local level; as international, national and provincial guidance and directives related to COVID-19 are modified; and as further scientific information related to COVID-19 becomes available.

## 1.0 COVID-19 BACKGROUND

In January 2020, a novel coronavirus was identified as the cause of an outbreak of pneumonia originating in Wuhan, China. On March 11, 2020, the World Health Organization (WHO) declared novel coronavirus (COVID-19) a global pandemic.

On January 25, 2020, Canada confirmed its first presumptive case of the novel coronavirus related to travel to Wuhan, China. By mid-June 2020 Canada had over 100 000 confirmed cases of COVID-19 and over 8 000 attributable deaths (Government of Canada, June 19, 2020) while Ontario had experienced over 33 000 cases and over 2 500 deaths, with over half of these deaths being attributed to Long Term Care homes (Government of Ontario, June 19, 2020).

The first laboratory-confirmed case of COVID-19 in Middlesex-London was reported to Middlesex-London Health Unit (MLHU) on January 24, 2020, well before the WHO's declaration of a global pandemic. The MLHU subsequently activated its Incident Management System (IMS) on January 27, 2020. Before the end of March, the majority of MLHU staff were redeployed to various roles to support COVID-19 related work, with non-urgent public health programs placed on hold. Critical public health services that have continued to ensure urgent public health needs of our community are met have done so with modifications, prioritizing need, maintaining client and staff safety and conserving personal protective equipment for when and where it is needed most.

### 1.1 MLHU's Response to COVID-19

The first laboratory-confirmed case of COVID-19 in Middlesex-London was reported to the MLHU on January 24, 2020. The MLHU activated its Incident Management System (IMS) on January 27, 2020 in response to the expected steep trajectory of the epidemic. Not long after, MLHU began implementing passive surveillance at all MLHU entrances and active surveillance in MLHU clinics and staff interactions with the public.

In mid-February, the situation continued to evolve and the IMS remained activated. The IMS met regularly to organize a response, anticipate challenges, and ensure mechanisms for the provision of accurate information to the public and community partners.

A significant proportion of staff were redeployed to various roles to support COVID-19 related work by March 27, 2020, and non-urgent public health programs were placed on hold. Operational hours

increased and COVID-19 related work was occurring seven days a week. To support physical distancing, staff and managers were encouraged to work from home. At the same time, London's first COVID-19 Assessment Centre opened at Oakridge Arena, and three days later, London's second Assessment Centre opened at Carling Heights Optimist Community Centre. By March 25, 2020, the presence of community transmission in the Middlesex-London region was confirmed. MLHU began hosting briefing webinars twice weekly to provide timely updates to healthcare providers and community stakeholders.

As the pandemic evolved, staff were redeployed to different areas within the Operational system of the COVID response, shifting to meet needed capacity (i.e. from COVID Hotline to Case and Contact Management and Assessment Centre). By mid-March, 127 MLHU staff were redeployed to Case and Contact Management. Soon after, on April 13, 2020, 60 Western University Medical Student Investigator volunteers were recruited to support MLHU's COVID response. As an additional source of support for people diagnosed with COVID-19 and their families, the "COVID Support Line" was implemented, providing telephone-based support and general information about stress and coping related to COVID-19. Students in the clinical stream in Western University's Graduate Psychology Program served as support line agents. Mobile testing was implemented through a partnership with community paramedics operating under an MLHU Medical Directive. This measure enhanced testing accessibility for person's living in congregate living settings, or who otherwise had significant challenges accessing an Assessment Centre. At the beginning of May, the Outbreak and Facilities Management team was created to work with all local congregate living settings and provide enhanced support with Infection Control Measures.

Throughout the response, change has continued to occur at a swift pace with guidance and directives from the province evolving as new information and evidence related to the virus became available.

While many health unit programs and interventions were put on hold to enable the response to the COVID-19 pandemic, critical public health programs and interventions continued, many in a modified state. No program has been unimpacted by this pandemic. Necessary program modifications have included but are not limited to: changes in program hours, reduced staff to deliver programs, change in the format of intervention from in-person to remote phone or video call support, active screening, staff use of PPE for in-person interventions, and embedding of a COVID-19 lens in all program work.

Further details of the MLHU response can be found in [Appendix A](#).

## 2.0 PURPOSE AND SCOPE

The *MLHU Plan for Sustained COVID-19 Response* is intended to guide MLHU's continued response to COVID-19 and preparedness for an anticipated second-wave of the virus. This plan is designed to be flexible and scalable, supporting appropriate and timely interventions. It also guides the allocation and coordination of resources to support MLHU's ongoing mandate to meet COVID-19 related demands in the community.

This plan:

- Describes key assumptions and pandemic response principles;
- Outlines MLHU's approach to escalating a public health response to COVID-19; and
- Proposes needed skills, expertise and training to support baseline programming, surge capacity and a state of readiness for the various areas of the response.

The plan describes MLHU's response around three tiers of escalating levels of COVID-19 prevalence in the community, including the description of a base COVID-19 program, as well as modules and protocols to respond to escalating COVID-19 prevalence.

It is important to note that there are significant interdependencies between COVID-19 work and critical continuing MLHU programs and services. Factors such as seasonality (e.g. Spring public health inspection support for migrant farms); the demands of provincial re-opening (e.g. community pool facilities and restaurants requiring inspections prior to re-opening); and the steady ongoing needs of programs and services (e.g. Healthy Babies Healthy Children, Clinic Services, continued surveillance of other infectious diseases) have an impact on human resources and capacity. While some of these demands can be anticipated, others cannot. This plan provides a framework for COVID-19 related work, but the need to be continuously nimble will be ever-present.

### 3.0 LEGISLATIVE AUTHORITY

(adapted from SMDHU IDERP, 2019)

The *MLHU Plan for Sustained COVID-19 Response* is underpinned by the following legislation and supporting documents:

- a) Health Protection and Promotion Act, R.S.O. 1990 H.7
- b) Personal Health Information Protection Act, 2004, S.O. 2004, c.3 Sched. A (PHIPA)
- c) Quarantine Act, S.C. 2005, c. 20
- d) Coroners Act, R.S.O. 1990, c. C.37
- e) Occupational Health and Safety Act, R.S.O. 1990, c.O.1
- f) Public Hospitals Act, R.S.O. 1990, c. P.40
- g) Emergency Management and Civil Protection Act, R.S.O. 1990, c. E.9
- h) Designation of Diseases O. Reg. 135/18
- i) Communicable Diseases – General R.R.O. 1990, Reg. 557

#### **Related Documents**

- Ontario Public Health Standards, 2018 or as current
- Emergency Management Guideline, 2018 or as current
- Infectious Diseases Protocol, 2018 or as current
- Infectious Diseases Protocol, Appendix A: Disease-Specific Chapters, Chapter: Diseases caused by a novel coronavirus, including Severe Acute Respiratory Syndrome (SARS) and Middle East Respiratory Syndrome (MERS) Effective: January 2020
- Institutional/Facility Outbreak Management Protocol, 2018 (or as current)
- Vaccine Storage and Handling Protocol, 2018 or as current
- Population Health Assessment and Surveillance Protocol, 2018 (or as current)
- Control of Respiratory Outbreaks in Long-Term Care Homes, 2018
- Planning Guide for Respiratory Pathogen Season, 2018
- Pandemic Influenza Plan for Middlesex-London, January 2006
- *Ministry Guidance documents and Directives related to COVID-19, as current*

#### **Internal Documents & Tools**

- MLHU Emergency Response Plan, 2018
- MLHU Return to Operations Dashboard Decision Tool

## 4.0 PLANNING ASSUMPTIONS and ETHICAL DECISION MAKING

(adapted from SMDHU IDERP, 2019; SMDHU PIP, 2010, and other plans)

### 4.1 COVID-19 Related Assumptions

- COVID-19 cases and outbreaks will continue with expected second or subsequent wave(s);
- Most of the population remains susceptible and will have had limited exposure to the virus;
- Severe illness and mortality is expected for a portion of the population; evidence to date has demonstrated that older adults and those with pre-existing medical conditions are most at risk;
- If a strong second wave occurs, acute care and hospital capacity could be challenged;
- Congregate settings, including Long-Term Care Homes, will continue to be higher risk environments for infection transmission and outbreaks;
- There will continue to be disproportionate health impacts on segments of the population who are already affected by reduced access to social determinants of health;
- Sub-clinical infections will occur;
- Scientific evidence related to COVID-19 will continue to emerge;
- Treatment for COVID-19 may continue to be unachievable;
- A vaccine will not be available for a number of months;
- Once available, vaccine will be limited and in high demand;
- The most effective means of control will continue to be disruption of transmission through public health measures; and
- It is expected that the public's sustained adherence to public health measures will require continued public health focus and encouragement.

### 4.2 Planning Assumptions

- Sustained public health response to COVID-19 will be needed and will be guided by directives at the national and provincial level;
- The COVID-19 response is an expansion of the mandate of MLHU:
- Additional resources will be required to support a sustained response to COVID-19;
- As the work of responding to COVID-19 continues, MLHU structures and processes must be readily scalable to need;
- One individual may fulfill more than one key function or role depending on the scale of response;
- The AMOH or designate will continue to direct the COVID-19 response;
- Staff cohorting as a means of protecting and maintaining capacity will continue to be important;

- A rapid increase of COVID-19 prevalence will require the redeployment of MLHU staff.
- During redeployment, non-critical public health programs and services will continue to be impacted, requiring modification and/or suspension;
- The MLHU Return to Operations Dashboard Decision Tool will be used to support redeployment decision-making and to ensure the provision of critical services;
- In a second wave, the availability of public health workers could be reduced by up to one-third due to illness, concern about disease transmission in the workplace, or care-giving responsibilities; and
- Processes will be required to ensure coverage of critical COVID-19 response functions while building in allowances for staff absences, including illness and necessary staff time off.

### 4.3 Ethical Decision Making

MLHU's response to any infectious disease emergency shall be grounded in a framework for **ethical decision-making**. This includes (Canadian Pandemic Influenza Plan, & SMDHU IDERP, 2019, Ontario Plan):

**Openness and transparency** - The process is open for scrutiny, and information about the basis for decisions and when and by whom they were made is publicly accessible;

**Accountability** - Being answerable for decisions; with a mechanism in place to ensure that ethical decision making is sustained;

**Inclusiveness** - Stakeholders are consulted, views are taken into account, and any disproportionate impact on particular groups is considered;

**Reasonableness** - Decisions should not be arbitrary but rather be rational, proportional to the threat, evidence-informed and practical; and

**Responsiveness** - Decisions should be revisited and revised as new information emerges, and stakeholders should have opportunities and a mechanism to voice any concerns they have about the decisions.

Further, there are **core ethical values** (Ontario Health Plan for an Influenza Pandemic 2008, SMDHU IDERP, 2019) that MLHUs response to an infectious disease emergency will be based on. More than one value may be relevant in any given situation and tension between values will occur. These core ethical values include:

**Individual liberty** - May be restricted in order to protect the public from serious harm;

**Protection of the public from harm** - Public health measures may be implemented to protect the public from harm;

**Proportionality** - Restrictions on individual liberty and measures taken should not exceed the minimum required;

**Privacy** - Individuals have a right to privacy, including the privacy of their health information. Confidential information regarding individual cases will not be shared outside of those who need to know in order to fulfill legally mandated public health functions;

**Equity** - All people have an equal claim to receive the health care they need, and health care institutions are obligated to ensure a sufficient supply of health services and materials. During an infectious disease emergency, tough decisions may have to be made about who will receive antiviral medication and vaccinations, and which health services will be temporarily suspended;

**Duty to provide care** - Health care providers (HCPs) have an ethical duty to provide care and respond to suffering. During an emergency, demands for care may overwhelm health care workers and their institutions, creating challenges related to resources, practice, liability and workplace safety. Health care workers may have to weigh their duty to provide care against competing obligations (i.e. to their own health, family and friends);

**Reciprocity**- Society has an ethical responsibility to support those who face a disproportionate burden in protecting the public good;

**Trust** - Trust is an essential part of the relationship between the government, health system partners and the public. During an infectious disease emergency, some people may perceive measures to protect the public from harm (e.g. limiting access to certain health services) as a betrayal of trust;

**Solidarity** - An infectious disease emergency will require solidarity among community, health system partners, and government;

**Stewardship** - In our society, both institutions and individuals will be entrusted with governance over scarce resources, such as vaccines, ventilators, hospital beds and even health workers. Those entrusted with governance should be guided by the notion of stewardship, which includes protecting and developing one's resources, and being accountable for public well-being;

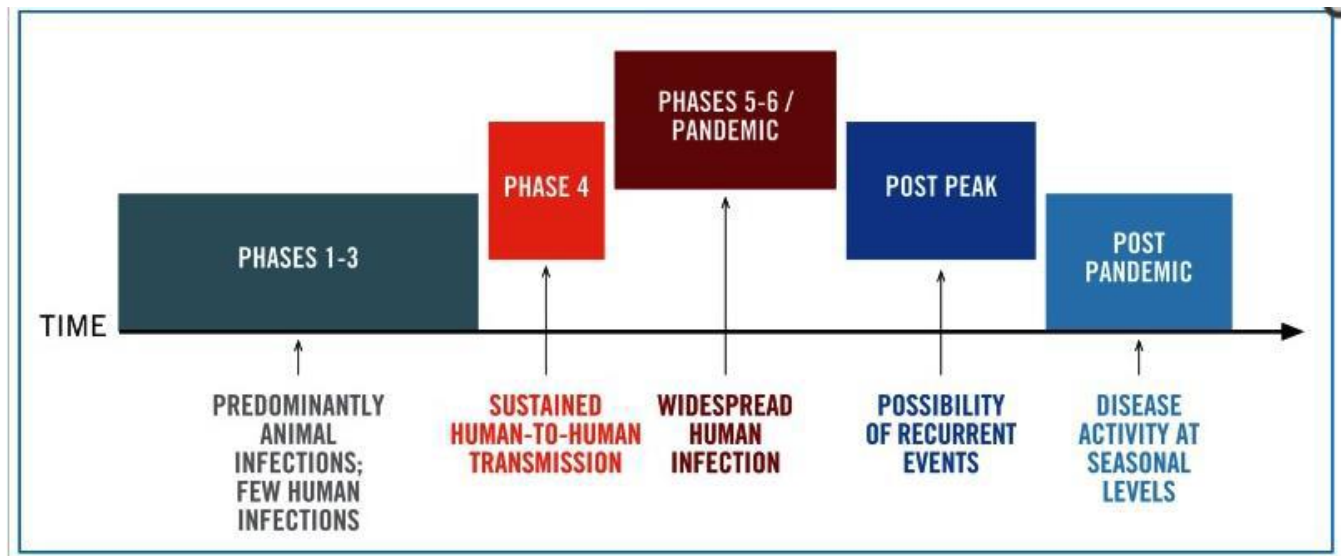
**Family-centered care** - A family's right to make decisions on behalf of a child, consistent with the capacity of the child will be respected; and

**Respect for emerging autonomy** - When providing care for young people, their emerging autonomy will be respected.

## 5.0 PRINCIPLES OF PANDEMIC RESPONSE

### 5.1 Theoretical Phases of a Pandemic Response

To provide a framework to support countries in pandemic preparedness and response, the WHO has categorized the phases of a pandemic (Figure 1). Phases 1-3 correlate with preparedness, including capacity development and planning the response, while Phases 4-6 signal initiation of response and mitigation efforts.



**Figure 1: World Health Organization, Pandemic Influenza Preparedness and Response, 2009**

For more information: visit the [WHO Pandemic Phases](#).

These global pandemic phases can be a useful reference to inform and visualize pandemic planning and response at a local level. It is important to note that as pandemic viruses emerge, different countries will face different risks and viral activity. Canada's response thus far to a novel virus is based on the presence of the virus and activity levels within Canada. Ontario and Health Unit level responses to a pandemic will be in line with Canada's response, with variations dependent on the provincial and local situations. While activation triggers and activities may parallel some of the global WHO phases, they will not align exactly (Pan-Canadian Public Health Network, 2015).

### 5.2 Overview of Public Health Measures

Public health measures are non-pharmaceutical countermeasures used by countries to delay the introduction of a virus into a community, slow the spread of disease, flatten the epidemiological curve, and reduce the total number of severe cases or deaths (WHO, 2019; Government of Canada, May 30, 2020). Public health measures are typically implemented in a combined or layered approach, and they include personal practices taken by individuals as well as community-based measures (Government of Canada, May 30, 2020).



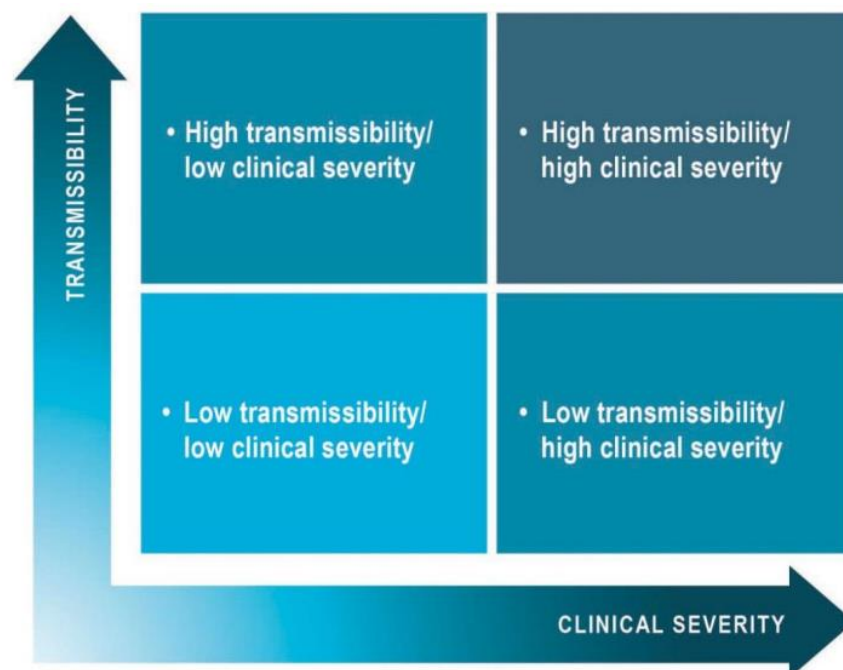
Typical public health measures are communicated and encouraged during regular, non-pandemic states of operation, including performing regular hand hygiene, covering coughs and sneezes, staying home if ill, receiving annual influenza vaccinations, environmental cleaning etc. COVID-19 has necessitated the implementation of more intensive and restrictive measures. Triggers for more restrictive measures have been based on transmission rates and evolving scientific evidence, and have been initiated at the federal, provincial and local public health levels. These measures evolve as new evidence comes forward.

Currently, there is no effective therapeutic treatment or vaccine available for COVID-19. Until such time when a vaccine becomes available and enough people have received the vaccine to establish herd immunity, it is critical that the public health measures that have been so integral in the control of this virus continue. National, provincial, and local governments must continue public health efforts to limit the number of severe cases and deaths and reduce the burden on health care resources, while minimizing societal disruption (Government of Canada, June 10, 2020).

### 5.3 Scaling of Public Health Measures

In any infectious disease outbreak, public health measures utilized are scaled to the severity of the situation, where a mild situation would warrant mild response activities and situations of higher severity would mandate more extreme public health measures. The Ontario Health Plan for an Influenza Pandemic (OHPIP) depicts a severity model, with severity measured along two dimensions: transmissibility of the virus and clinical severity of illness (Ministry of Health, 2013). Using the OHPIP as a guide, pandemic response strategies can be appropriately determined based on one of four severity scenarios (Figure 6). In relation to this model, the public health measures taken for COVID-19 have fallen in the upper right quadrant based on evidence of high transmissibility, and the potential for high clinical severity, notably in older adults and populations with pre-existing chronic health conditions.

**Figure 6: Scaling of Public Health Measures**



Source: Ontario Ministry of Health and Long-Term Care. (2013). *Ontario Health Plan for an Influenza Pandemic*. Retrieved from:

[http://www.health.gov.on.ca/en/pro/programs/emb/pan\\_flu/docs/ch\\_01.pdf](http://www.health.gov.on.ca/en/pro/programs/emb/pan_flu/docs/ch_01.pdf)

As the level of transmissibility or clinical severity changes, the demand for control measures will change. For example, if an effective treatment for COVID-19 becomes available, this will lessen the burden on critical care services. A similar inference can be made with transmissibility. Once a vaccine for COVID-19 becomes available and enough people have been vaccinated, transmissibility within a community will decrease, and public health measures beyond standard practices can then be lifted.

Public health measures can be implemented at the individual, community and institutional levels. As evidence evolves and the prevalence of virus in the community changes, so do the public health measures implemented.

## 5.4 Individual Public Health Measures

Individual public health measures are activities that people can practice to reduce the risk of becoming infected with and transmitting the virus. The individual public health measures that have been taken and advised thus far during the COVID-19 pandemic have included (Government of Canada, June 10, 2020):

- Regularly performing hand hygiene (i.e. washing hands with soap and water and using an alcohol-based hand sanitizer);
- Covering coughs and sneezes (either with a tissue or in the bend of the arm);
- Avoiding face-touching with unwashed hands;
- Disposing of used tissues in lined waste containers;
- Physical distancing (i.e. 2-metre separation from others);
- Avoiding crowded places;
- Wearing a face-covering in public places;
- Limiting non-essential travel outside of the home; and
- Avoiding physical contact such as handshakes.

All individuals will continue to be advised to self-monitor for symptoms of COVID-19 and if symptoms developed, to self-isolate for 14 days, including away from family members of the same household. If an individual had an exposure to COVID-19 (from international travel or a COVID-19 positive person), they will be required to quarantine for 14 days (Government of Canada, June 10, 2020 & Government of Canada, May 30, 2020).

## 5.5 Broader Community-Based Public Health Measures

In addition to the personal infection control practices mentioned previously, additional recommended and mandated community-based public health measures are critical for decreasing community transmission of COVID-19. Community-based public health measures apply to settings where members

of the public gather, including business and workplaces, child and youth settings, community gathering spaces or settings, outdoor spaces and public transportation (Government of Canada, May 30, 2020).

Community-based public health measures can be implemented at the Federal, Provincial and Local levels to reduce transmission of the virus and protect the public. Public health measures can evolve rapidly and become more restrictive as cases increase.

Public health measures change based on the impact of a virus across communities which is monitored through surveillance activities. The type of public health measures used depends on several factors such as (SMDHU, PIP, 2010):

- The epidemiology of the virus;
- The pandemic phase and virus activity in the region;
- Characteristics of the community;
- Resources required to implement the measure;
- Public acceptance of the measure; and
- The amount of social disruption the measure will cause.

As the prevalence of the virus increases, more strict public health measures must be communicated and encouraged. As the number of cases decreases, less restrictive measures can be utilized. With direction from the federal and provincial governments, public health will continuously monitor the effectiveness of current public health measures, assess the harms and benefits, and adjust less effective measures as needed (Government of Canada, June 10, 2020).

## 5.6 Considerations for Congregate Settings

There are specific directives and guidelines for congregate settings. The risk of individuals transmitting COVID-19 within congregate living settings such as long-term care facilities, residential care facilities, correctional facilities, group homes, shelters, and agricultural worker housing is heightened. This is due to a number of reasons, including (Government of Canada, May 30, 2020).

- Crowded accommodations;
- Shared sleeping quarters;
- Shared washrooms;
- Communal kitchens/cafeterias;
- Shared use of items such as utensils and toiletries; and
- Lack of adequate facilities to isolate persons who become ill.

Several public health measures have been used to prevent the introduction of COVID-19 into congregate living settings and to limit the possibility of an outbreak; these measures are tailored to each setting. Public health measures for most congregate settings are directed and recommended by the Ministry of Health; however certain congregate living settings additionally have sector-specific directives from

different Ministries. MLHU will continue to provide support to the congregate living settings in Middlesex-London and assist with implementing these measures.

## 6.0 INTEGRATED RESPONSE AND REGIONAL COORDINATION

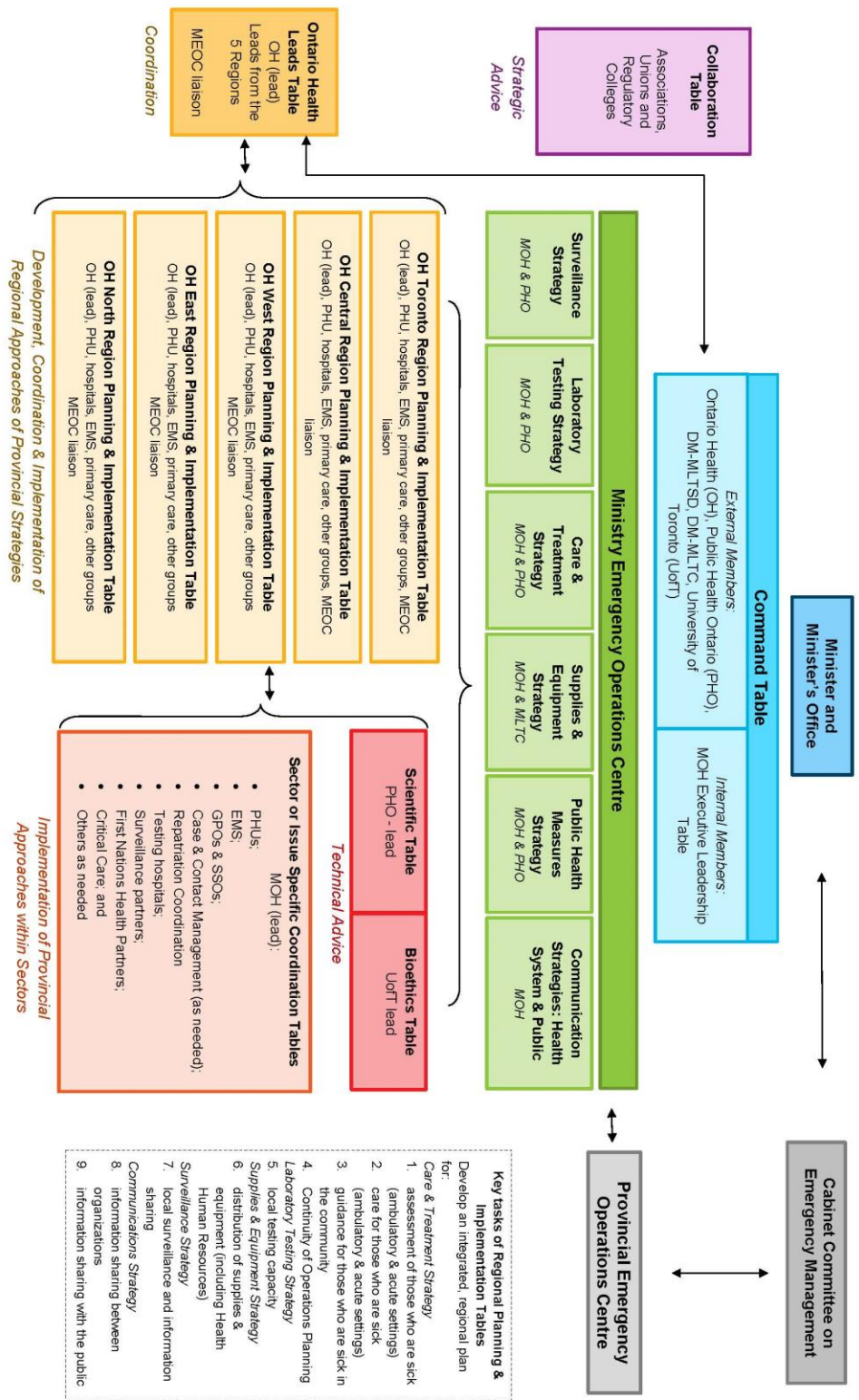
Local public health authorities are the primary responsible body for planning and coordinating local level response to an infectious disease event, with direction from both the provincial and federal governments and in collaboration with health and non-health system partners. The Medical Officer of Health leads the response to an infectious disease incident/emergency within London and Middlesex County.

### 6.1 Federal, Provincial and Municipal Coordination

The Health Unit works closely with the Ministry of Health who provides provincial leadership to the health sector through the Ministry Emergency Operations Centre (EOC). See Figure 2 below: Provincial Governance Model. The Ministry EOC may issue directives to health system partners including health units, hospitals, long-term care facilities and physicians. The Health Unit liaises with health and non-health system partners locally, ensuring that the response in Middlesex-London is coordinated with the provincial response and is in line with the directives issued by the Ministry (MLHU, 2006 & SMDHU IDERP, 2019). The response infrastructure for health emergencies and relationships in the broader emergency response system are outlined in Figure 3 Inter-Relationship Roles below.

Locally, the Head of Council of a municipality may declare a state of emergency in that municipality and may implement the municipality's emergency response plan, authorizing the Head of Council to do what they consider necessary to protect the health, safety and welfare of residents and draw from any resource or service within the community (SMDHU IDERP, 2019). See Figure 4 below: Inter-Agency Emergency Management Structure.

Figure 2: Provincial Governance Model

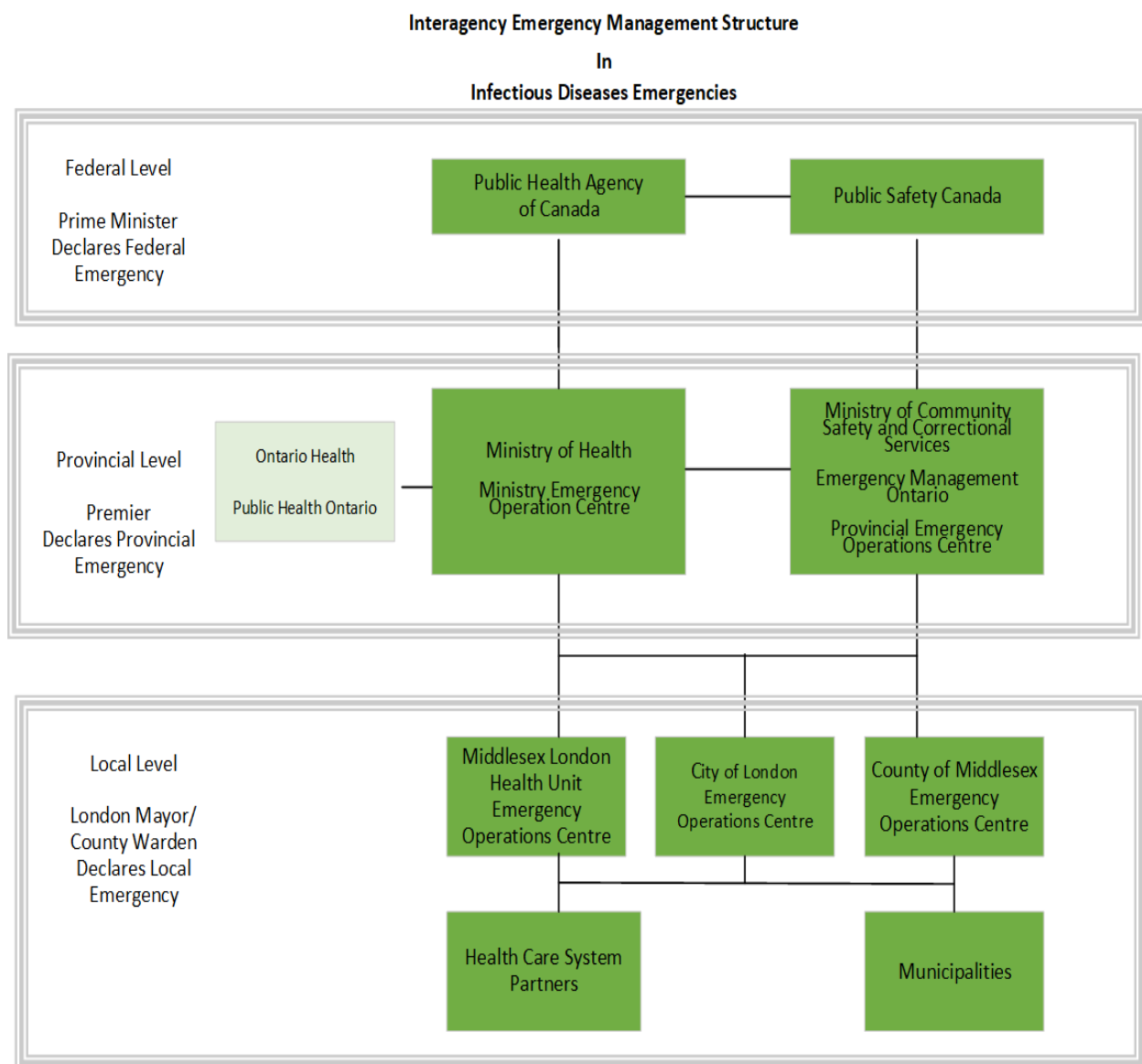


**Figure 3: Inter-Relationship Roles**



Adapted from the Infectious Disease Emergency Response Plan with permission of the Simcoe Muskoka District Health Unit

**Figure 4: Inter-Agency Emergency Management Structure**



Adapted from the Infectious Disease Emergency Response Plan with permission of the Simcoe Muskoka District Health Unit

The Medical Officer of Health maintains regular communication with the province and broader planning systems including, but not limited to, the Public Health Measures Table advising the CMOH on public health measures to be implemented; work with health systems partners to identify and coordinate efforts to address local issues and participate in meetings with PHO, OH, hospital and non-hospital leaders, City of London and County Officials to determine and address community needs and keep key

stakeholders appraised of local developments. The MLHU will ensure that the COVID-19 response in Middlesex-London is coordinated and aligned with Ministry of Health directives.



## 7.0 Proposed MLHU COVID-19 Program and Operational Response

### 7.1 Phases of Pandemic Response at MLHU

During the initial wave of the COVID-19 pandemic, MLHU implemented and utilized a full IMS structure to plan and respond to this public health crisis. To respond to ongoing COVID-19 demands, sustain other critical public health interventions, and prepare for a probable second wave, MLHU proposes the development of a new COVID-19 program, as well as enhance other existing public health programs.

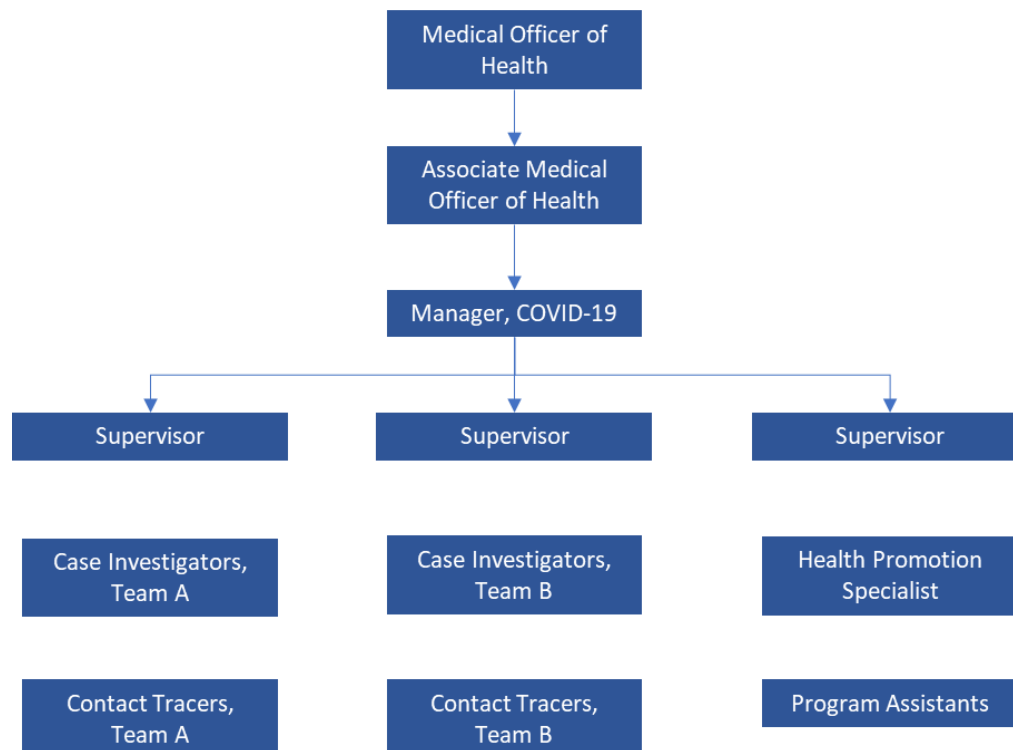
In anticipation of dynamic and variable COVID-19 community transmission, MLHU has structured its response around three tiers of escalating levels of COVID-19 prevalence in the community.

- Level One – Baseline
  - At Level One, the following parameters apply:
    - Maximum 2 new cases/day
    - Total of 30 active cases
    - Minimal institutional outbreaks
    - Hours of Operation
      - Monday to Friday
      - 9am to 5pm
    - 24-hour on-call with weekend on-call from Friday at 5pm to Monday at 9am
- Level Two – Program Surge
  - At Level Two, the following parameters apply:
    - Maximum 5 new cases/day
    - Total of 70 active cases
    - A small number of institutional outbreaks
    - Hours of Operation
      - Seven days per week
      - 9am to 8pm
- Level Three – Redeployment Surge
  - At Level Three, the following parameters apply:
    - Greater than 5 new cases/day
    - A substantial number of institutional outbreaks
    - Hours of Operation
      - Seven days per week
      - 9am to 8pm
    - Redeployment of MLHU staff required

## 7.2 Base COVID-19 Program

COVID-19 and the health risks associated with this virus are expected to continue for many months. In order to respond to the ongoing demands of COVID-19 while sustaining other critical public health interventions and re-instate vital public health programs that have been put on hold, a reorganization of structure and augmentation of resources to establish a COVID-19 Program (Figure 5) has been proposed. The core program will be structured and resourced to respond to the initial two tiers of escalation. At the third tier, redeployment of staff from across the organization will once again be required.

**Figure 5: Proposed COVID Program Structure**



The core components and intervention of the COVID-19 Program are as follows:

- Case and Contact Management
- Outbreak Management
- Screening, Assessment and Testing
- Planning and System Coordination
- Liaison and Community Support
- Scientific and Technical Support

Details on the proposed staff and resources required for the base COVID-19 program can be found in [Appendix B](#).

### 7.3 Required Enhancements for other MLHU Programs

Some of the work that has been previously operationalized within the first wave COVID-19 IMS response is best described as base programming for other MLHU programs. To enhance coordination and deal specifically with COVID-19, these resources were redeployed to the IMS response. As the COVID-19 situation continues, it is recommended that components of this work be repatriated and adequately resourced to appropriately manage both COVID-19 and other public health needs in the community.

The work that is proposed to be repatriated includes:

- Facility Liaison;
- Infection prevention capacity building in facilities and congregate settings;
- Communications;
- Emergency Preparedness;
- Vulnerable Population Liaison and support;
- Population Health Assessment and Surveillance;
- Human Resources;
- Information Technology; and
- Operations and Procurement.

The core COVID-19 program would collaborate closely with many programs across the Health Unit, providing technical and scientific advice for COVID-19 specific issues. Processes will need to be developed to ensure robust collaboration, clear communication and role clarity. At high levels of COVID-19 prevalence, redeployment would result in a redistribution of work and the redeployment of MLHU staff.

Details on the proposed enhancements to other MLHU programs can be found in [Appendix C](#).

## 8.0 ESCALATION MODULES AND PROTOCOLS

Based on the experience and learnings of MLHU's response to the first wave of COVID-19, template modules and protocols have been developed for utilization in a potential second wave. They will be optimized and refined by the COVID-19 Program in anticipation of a tiered response to escalating levels of COVID-19 prevalence in the community.

These modules and protocols describe the roles and responsibilities, required skill sets, staffing considerations, training, coverage, and core functions. These modules were developed based on documentation that has been generated to date by the COVID-19 IMS response team, focus groups with COVID-19 staff and check-in sessions to ensure clarity of information.

The modules include protocols for the following functions:

- Surveillance and Reporting
- Case and Contact Management
- Outbreak and Facility Management
- Hotline
- Communications
- Data Support
- Assessment Centre and Testing Support
- Priority Populations Support and Liaison
- Mass Immunization
- Internal health and safety

## 9.0 MENTAL HEALTH AND WELLBEING

Focused discussion of mental health and wellbeing has not historically been included as part of a pandemic plan. A search of the literature, including grey literature, evidence from global analysis and themes in current event coverage has shown that the unprecedented COVID-19 pandemic has had a significant impact on population mental health and wellbeing. Including considerations for mental health in MLHU's emergency and infectious disease pandemic planning can ensure that the appropriate resources and interventions are in place to mitigate the impact that pandemics have on mental health for individuals and communities.

The potential morbidity and mortality of the COVID-19 virus has necessitated restrictive public health measures in an effort to control spread, including physical distancing, quarantine, self-isolation, institutional no visitor policies, closure of schools and public gathering spaces, cancelling of events, etc. which has significantly disrupted opportunities for social connection. Additionally, financial implications of closing non-essential businesses and workplaces, coupled with ever-present global news and information regarding the pandemic has been shown to increase feelings of stress, fear and anxiety, creating an increased risk for adverse mental health outcomes.

Considering mental health explicitly in the pandemic planning aligns with the requirements of the 2018 OPHS Mental Health Promotion Guideline, which directs Boards of Health to consider:

- Embedding mental health promotion strategies and approaches across public health programs and services;
- Seeking opportunities to offer mental health promotion programs and services across the life course; and
- Seeking opportunities to implement whole-population and community-based interventions, particularly for cross-cutting issues.

*Ministry of Health and Long-Term Care. (2018). Mental Health Promotion Guideline, 2018*

The COVID-19 pandemic has presented a need and opportunity to ensure that, as the COVID-19 pandemic evolves, with the potential for second wave and continuation and re-tightening of restrictions, that MLHU further enhance focus on mental health and well-being, with additional attention paid to specific groups most vulnerable to adverse mental health outcomes.

## 10.0 REDEPLOYMENT STRATEGY AND PREPARATION

As previously stated, the core program will be structured and resourced to respond to the initial two tiers of escalation. At the third tier, redeployment of staff from across the organization will once again be required.

Escalation to the third tier will require utilization of business continuity plans to ensure that the appropriate level of agency response and time-critical public health services can continue during an escalated COVID-19 response.

Considerations in business continuity and return to operations planning include (adapted from SMDHU Business Continuity Plan, Public Version, 2019):

- Staffing complement (FTE) necessary to carry out roles and functions (for redeployment to COVID-19 response and for prioritized public health services that remain in place during the pandemic);
- Certification and skill set necessary to carry out roles and functions (for redeployment to COVID-19 response and for prioritized public health services that remain in place during the pandemic);
- COVID-19 related training/refresher training and skill development for redeployed staff and for staff that continue to provide prioritized public health services;
- Potential recruitment of contract staff (for COVID-19 response and for prioritized public health services that remain in place during the pandemic);
- Surge capacity and seasonal demand for time-critical public health services that continue to be offered during the pandemic;
- Technology, tools and equipment needed to carry out services/functions;
- Service delivery modifications;
- Priority ratings (based on community need, impact, health equity, community capacity, implementation challenges, etc.) for public health interventions to return to operations
- Multiple dependencies that influence ability to maintain public health services and/or return to operations;
- Anticipated demand for public health services;
- Interdependencies between COVID-19 response functions and continuing time-critical public health services, and other public health programs and mandates; and
- Physical and psychosocial health and safety impacts on staff.

If a secondary incident or public health emergency were to arise requiring public health resources that are already being utilized, then the MOH, Senior Leadership Team and relevant IMS Committee will reassess the impacts of both incidents on all time-critical public health services and reassign and deploy staff as appropriate in order to manage both situations (SMDHU Business continuity plan).

## 11.0 COVID-19 RESOURCES

11.1 MLHU Website ([www.healthunit.com/novel-coronavirus](http://www.healthunit.com/novel-coronavirus))

### COVID-19 Guidance and Resources

Please click on the links below to find COVID-19 guidance and resources for the general public, health care providers and institutions, long-term care and retirement homes and workplaces and community settings.



### 11.2 Provincial, Federal and International COVID-19 Websites

- [Ontario Ministry of Health](#)
- [Public Health Ontario](#)
- [Public Health Agency of Canada](#)
- [U.S. Centers for Disease Control](#)
- [World Health Organization](#)

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## 13.0 APPENDICES

### Appendix A – COVID-19 and Initial MLHU Response

#### COVID-19 - Global Context

In January 2020, a novel coronavirus was identified as the cause of an outbreak of pneumonia originating in Wuhan, China. By January 23rd, cases had been identified in Thailand, Japan, South Korea, other cities in China, and the United States of America, all having a travel history to Wuhan China (WHO, January 23, 2020). On January 31, 2020, the World Health Organization (WHO) declared the outbreak to be a public health emergency of international concern and the day prior, the Emergency Committee on the novel coronavirus was convened (WHO, January 31, 2020).

On January 25, 2020, Canada confirmed its first presumptive case of the novel coronavirus related to travel to Wuhan, China. On February 20, 2020, Canada's first case related to travel outside of mainland China was confirmed, and on March 9, 2020, Canada confirmed its first novel coronavirus related death. The World Health Organization (WHO) declared novel corona virus (COVID-19) a global pandemic on March 11, 2020. With the WHO declaration of a pandemic, broad based public health measures were triggered. On March 13, 2020, the Canadian Government advised Canadians to avoid all non-essential travel outside of Canada and by March 16<sup>th</sup> any travelers entering Canada were advised to self-isolate for 14 days. On March 18<sup>th</sup> an announcement was made that the Canada-US border was closed to all non-essential visitors and the Canadian Government implemented a ban on all foreign nationals from all countries except the United States from entering Canada (Government of Canada, June 19, 2020).

The number of cases in Canada has increased rapidly: by April 28, 2020, Canada confirmed more than 50 000 COVID positive cases, and more than 2 000 deaths, and by mid-June there were over 100 000 cases in Canada with over 8 000 deaths (Government of Canada, June 19, 2020).

#### COVID-19 - Ontario Context

Novel Coronavirus was added as a reportable disease under Ontario's public health legislation on January 22, 2020 enabling prompt public health investigation, lab testing and case and contact management to prevent and control the spread of the virus (Ontario Newsroom, January 22, 2020).

Provincially mandated public health measures ensued: On March 12, 2020 the Ontario Government announced the closure of all public schools for the two weeks following March Break (Ontario Newsroom, March 12, 2020). The closure was later (May 19, 2020) extended for the remainder of the school year (Ontario Newsroom, May 19, 2020).

On March 17, 2020 a declaration of emergency under 7.0.1 (1) the *Emergency Management and Civil Protection Act* was made by the Government of Ontario legally requiring the closure of indoor recreational programs, public libraries, private schools, licensed child care centres, bars and restaurants excepting takeout and delivery, theatres, cinemas, concert venues, and placing a restriction on organized public events over 50 people (Ontario Newsroom, March 17 2020). The limit on social gatherings was later reduced to 5 people (March 28, 2020) and all non-essential businesses were required to close (Ontario Newsroom, March 28 2020). The state of emergency has subsequently been extended several times, with variation in the type and extent of mandated restrictions corresponding to changing trends in provincial COVID-19 case prevalence and transmission.

The number of cases in Ontario has changed quickly: by April 28, 2020, Ontario confirmed more than 15 000 COVID-19 positive cases, and more than 900 deaths, and by mid-June 2020 there were more than 33 000 cases in Ontario with over 2 500 deaths, with over half of these deaths being attributed to Long Term Care homes (Government of Ontario, June 19, 2020).

Although Ontario experienced an increase in cases over several months, modeling in mid-April showed signs the weekly average of new cases was decreasing due to enhanced public health measures. This prompted the Ontario Government to begin re-opening businesses using a three phased process and outlining parameters in place for businesses permitted to open (Government of Ontario, May 19, 2020). On June 8, 2020, the Ontario Government announced they will be moving forward with Stage 2 of re-opening Ontario based on promising indicators such as lower rates of transmission, increased capacity in hospitals, and progress made in testing. Stage 2 of re-opening Ontario permitted additional businesses to open with public health measures in place and increased the limit on social gatherings to 10 (Ontario Newsroom, June 8 2020). The Ontario Government continues to monitor regional and provincial situations and will either continue to reopen businesses or reapply certain public health measures to manage the spread of COVID-19.

#### Activation of IMS Structure and Operational Response

MLHU activated the IMS system under the premise that Canada had its second case of the novel coronavirus, human-to-human transmission had been confirmed in multiple countries, and the trajectory of the epidemic was steep. Although the risk level in the community was low at that point, the purpose of activating the IMS was to clarify roles, create meeting cycles and structure, and to allow for clear decision making and tracking of operational objectives.

MLHU conducted surveillance activities to monitor the situation locally and began frequent communications with federal and provincial stakeholders to keep informed on the developments of the virus. The Infectious Disease Control Team at MLHU was preparing for probable and confirmed cases to come to Middlesex-London.

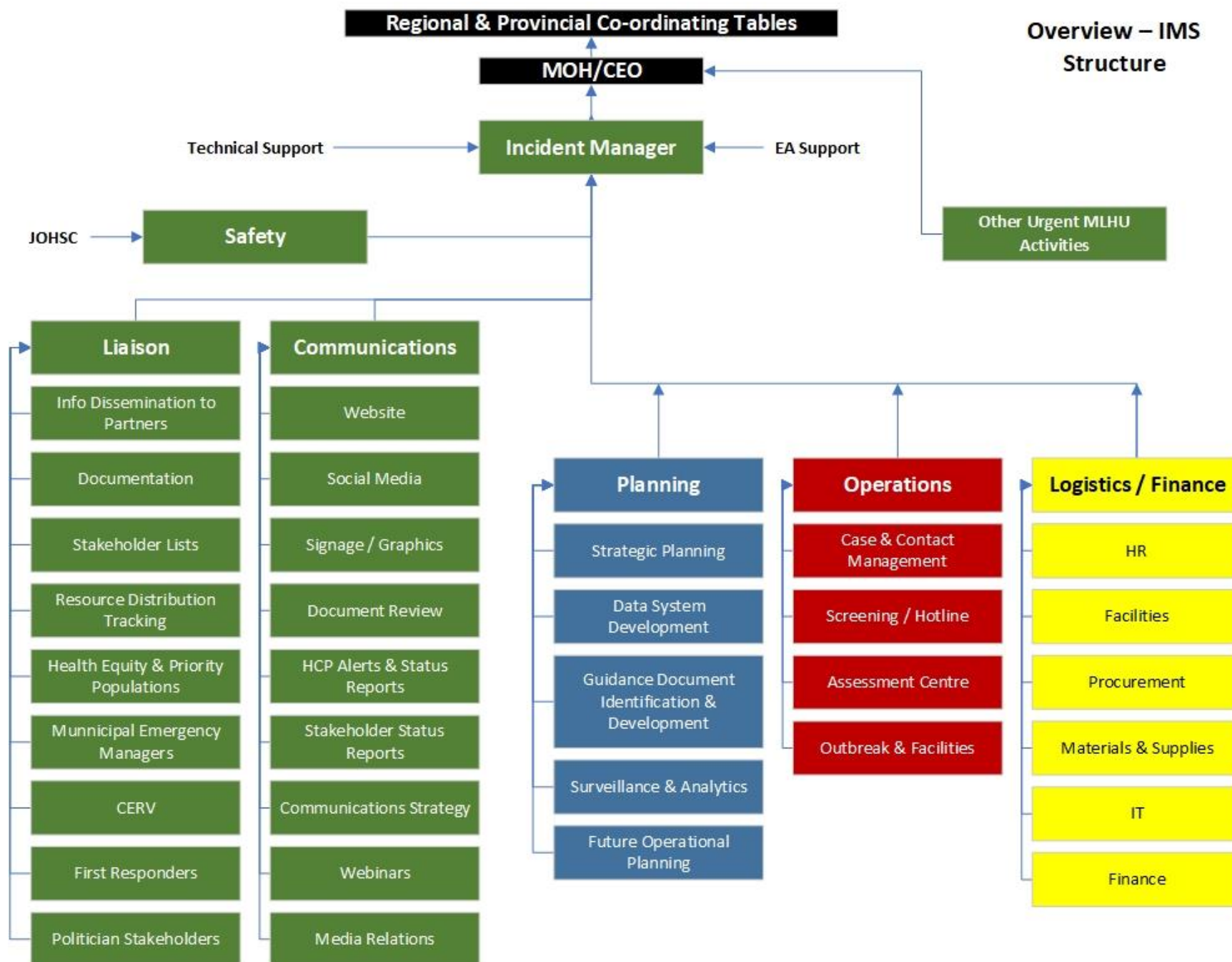
Once cases were increasing in Canada and locally, MLHU moved into the next phase of the Health Unit's local response and began ramping up IMS activities including deploying a small number of staff to help with the response. MLHU hosted a large meeting that drew together local stakeholders and decision makers, local hospitals, post-secondary education, the English and French language school boards, as well as police, fire and emergency services. Sentinel surveillance was conducted to determine the presence of the virus within Middlesex-London and if community transmission was occurring. This data identifies trends, outbreaks and monitors the burden of disease.

On March 16, 2020, shortly after the WHO declared COVID-19 as a pandemic (Phase 6), MLHU moved into full IMS mode. All non-urgent work ceased and most MLHU staff were seconded to support COVID related work. Staff were placed in positions within the IMS structure to help with the COVID response. As we move into post peak in Ontario and locally, surveillance activities continue to track virus activity and provide insight on actions and resources needed for the COVID response, including planning and preparation for the second wave.

The incident management system (IMS) is an international practice that encourages organizations to

work together effectively to manage multi-jurisdictional incidents while improving communication, coordination and optimization of resources to facilitate cooperation and coordination between agencies.

The Ministry requires Boards of Health to incorporate concepts consistent with IMS into emergency response plans in accordance with the Emergency Management Guideline (2018). As such, MLHU adopted the IMS model at the outset of the COVID-19 Pandemic once response demands exceeded capacity of existing infectious disease management structures.



Brief descriptions of the roles within the IMS structure are described below.

<b>Table 1: COVID-19 First Wave IMS Structure</b>	
Incident Commander (AMOH)	<ul style="list-style-type: none"> <li>• Operationalized MLHU's response to escalating COVID-19 prevalence in the community;</li> <li>• Determined local pandemic strategy, and in consultation and approval from the MOH, implement said strategy;</li> <li>• Determined planning cycle timelines and objectives for the response</li> <li>• Provided technical advice and guidance to case and outbreak management;</li> <li>• Approved major and significant decisions relevant to overall redeployment response, in consultation with Senior Leadership Team and the MOH;</li> <li>• Appropriately delegated other decisions within the redeployment response;</li> <li>• In conjunction with the MOH, provided timely situational awareness for the organization and community; and</li> <li>• In conjunction with the MOH, liaised with the Ministry of Health, health care sector, and public health sector.</li> </ul>
Liaison	<ul style="list-style-type: none"> <li>• Maintained situational awareness with COVID-19 stakeholders in accordance with the level of interest and influence to support community adaptation of COVID-19 prevention measures;</li> <li>• Assessed the COVID-19 risks for priority populations and ensured plans were in place to address health inequities; and</li> <li>• Informed Incident Commander of actions taken in conjunction with other agencies.</li> </ul>
Health and Safety	<ul style="list-style-type: none"> <li>• Ensured COVID-19 operations comply with the Occupational Health and Safety Act and the applicable regulations:</li> <li>• Ensured the wellbeing and health and safety of MLHU employees, volunteers, students and visitors by assessing risks and implementing protection measures through hazard identification and control (i.e. Engineering (physical barriers) and administrative controls (active screening, policies and training) and Personal Protective Equipment) that supported MLHU operations in a COVID-19 pandemic environment;</li> <li>• Engaged the Be Well Committee in applicable wellness programming and communications to enhance employee wellness; and</li> <li>• Engaged the Joint Occupational Health and Safety Committee in the assessment and mitigation of COVID-19, pandemic risks.</li> </ul>
EOC Documentation	<ul style="list-style-type: none"> <li>• Documentation and storage/filing of all COVID-19, Pandemic outbreak activities within the EOC folder S:MLHU/EOC and assisted with EOC setup.</li> </ul>

<b>Table 1: COVID-19 First Wave IMS Structure</b>	
Planning (Surveillance & Reporting)	<ul style="list-style-type: none"> <li>• Coordinated, managed and analyzed the collection of COVID surveillance data and information;</li> <li>• Developed epidemiological reports to inform Incident Command and other internal stakeholders;</li> <li>• Monitored trends in the incidence and prevalence of COVID to identify new or unrecognized exposures or risk factors;</li> <li>• Completed consolidated summary reports and Incident Action Plan and maintained incident documentation; and</li> <li>• Provided guidance to Incident Commander on activities to prevent or slow the spread of COVID-19.</li> </ul>
Operations	<ul style="list-style-type: none"> <li>• Coordinated and oversaw the COVID-19 Hot Line activities;</li> <li>• Coordinated and oversaw the activities of the COVID-19 Case and Contact Management;</li> <li>• Coordinated and oversaw the Outbreak and Facilities activities and</li> <li>• Initiated strike teams to address the needs of priority populations to address public health inequities.</li> </ul>
Logistics/Finance	<ul style="list-style-type: none"> <li>• Prepared and maintained facilities for expanded hours and implemented COVID-19 prevention measures;</li> <li>• Procured, distributed and maintained supply chain to support COVID-19 operations including: <ul style="list-style-type: none"> <li>○ PPE</li> <li>○ Testing Swabs</li> <li>○ Technical Hardware</li> </ul> </li> <li>• Developed staffing plans to support COVID-19 operations;</li> <li>• Developed, implemented, and supported technology infrastructure for COVID-19 operations; and</li> <li>• Monitored the cost of COVID-19 operations and number of hours worked by employees for each operational period.</li> </ul>
Communication	<ul style="list-style-type: none"> <li>• Ensured accurate and timely communication of COVID-19 to staff, community stakeholders and to the public;</li> <li>• Developed public and stakeholder information and maintained and supported media relations related to COVID-19; and</li> <li>• Ensured staff are using accurate and consistent messaging with their stakeholders, partners and specific audiences.</li> </ul>

### Activation of Business Continuity Plan

At the beginning of the COVID-19 emergency, MLHU's plans for deployment and business continuity were activated by the MOH and IMS Committee. Non-critical public health programs were stopped or reduced, new functional structures, teams and processes were developed, and many staff were redeployed to the COVID-19 response.



Throughout the response constant assessment of response needs has occurred with staffing assignments and structures evolving to meet shifting demands.

While a significant number of staff were deployed directly to the operational COVID response, and components of many public health programs and interventions were put on hold, several critical public health services have continued, recognizing that ensuring urgent public health services remain available is critical for the health of our community. All programs, however have needed to implement adjustments in services and processes within the COVID-19 pandemic to prioritize need, maintain client and staff safety and conserve personal protective equipment for when and where it is needed most.

Clinical services that remain in place during the pandemic include: TB clinics and direct observed therapy; vaccine distribution and Immunization Clinic; Family Planning and STI Clinics, dispensary, and needle exchange; Outreach; breastfeeding home visits; Healthy Babies, Health Children and Nurse Family Partnership Family Home Visits; Healthy Smiles Ontario Emergency and Essential Services (HSO-EESS) Clinic, and the smoking cessation Quit Clinic. Modification included adjustments in frequency of and hours of service, use of phone OTN as default with in-person care when needed. Each of these services engages in active screening, point-of-care risk assessment, and the appropriate use of personal protective equipment (MLHU BOH report, April 16, 2020).

Urgent tobacco enforcement, public health inspections and consultations, and other prioritized environmental health services continue, with processes adjusted as needed to ensure employee and community member safety. Processes in receiving have also been altered to ensure staff and courier safety, and staff and clients interacting at reception are protected by a physical barrier. All continuing programs and services, while not officially deployed to COVID-19 work, have occurred through a COVID-19 lens (MLHU BOH report, April 16, 2020).

## Appendix B - Proposed COVID-19 Program Staffing and Budget

The proposed COVID-19 program will be structured for a tiered response to escalating levels of COVID-19 prevalence in the community. The core program will be structured and resourced to respond to the initial two tiers of escalation. At the third tier, redeployment of staff from across the organization will once again be required. The staffing scenarios below outline the assumptions that were used to propose the number of staff required. The variables include workday length, case complexity, new cases per day, total active cases, contacts per case, call frequency and time to complete each task.

### Core Program Components and Interventions

#### Case and Contact Management

Case and contact management are specialized skills that public health staff use in an investigation of any confirmed COVID-19 case. Case investigation is the identification of any person with confirmed and probable diagnoses of COVID-19 (cases). The management of the case begins with a thorough interview to determine and identify close contacts (contact tracing) using a series of questions and data collecting methods so that information can be documented in a case and contact management tool. Contract investigation or contact tracing is the identification, monitoring and support of the individuals or contacts, who have been exposed to the case and possibly infected themselves. This process prevents further transmission of disease by separating people who have or may have an infectious disease from people who do not.

#### Outbreak Management

The COVID-19 Program would support all COVID-19 outbreak investigations and management. Ongoing support of facilities such as long-term care homes or child care facilities would be responsibility of the Infectious Disease Control (IDC) team. However, upon identification of a COVID-19 case in a facility, a case investigator from the COVID-19 program would partner with the IDC investigator to support the management of an outbreak.

#### Screening, Assessment and Testing

The COVID-19 Program will be required to support screening initiatives, assessment centres, and testing policy. The program will also oversee and update all relevant medical directives related to testing.

#### Planning and System Coordination

The COVID-19 Program will participate in internal and external planning for a COVID-19 resurgence, including the possibility of mass immunization.

Internally, the COVID-19 Program would be responsible for developing an escalation plan and surge protocols in the instance of increased COVID-19 prevalence. The program would also develop and support the training of other MLHU staff in anticipation of potential redeployment.

Externally, the COVID-19 Program would work with partners in the health sector to assist in system coordination and planning.

### Liaison and Community Support

The COVID-19 program will be responsible for liaison and consultation with non-health sector partners regarding COVID-19. The program will also act as a resource for others in the Health Unit who have pre-existing relationship with external partners and are called on to provide COVID-19 guidance.

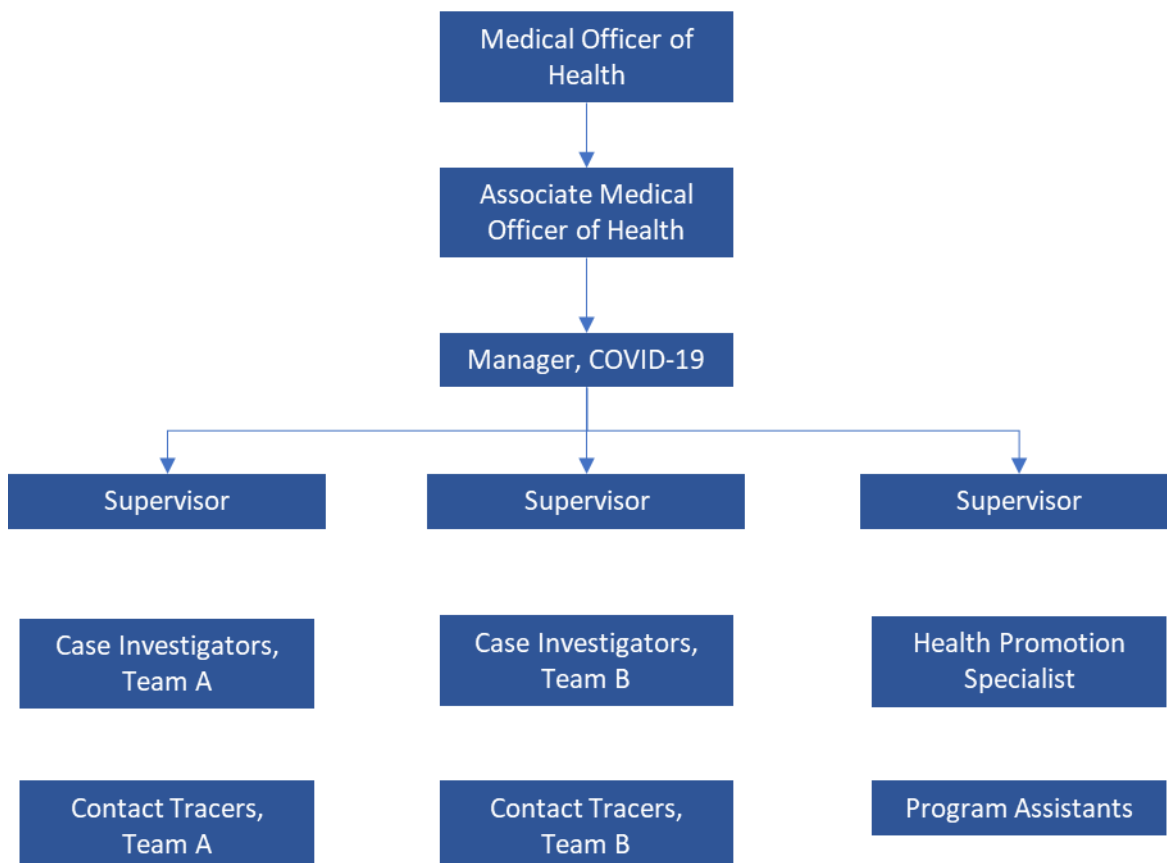
The COVID-19 program will also provide Tier Two telephone support for general inquiries from the public. The Client Service Representatives (CSR) will be the first line of contact for the public calling about COVID-19. Following a screening by the CSR, the caller will either be provided with the information or transferred to the Tier Two level support.

### Scientific and Technical Support

The COVID-19 Program will collate, review, interpret, and translate all relevant research, policy, and guidelines. The program will be responsible for providing scientific and technical support internally and externally. This will inform the implementation of public health measures locally.

## Program Staffing Model

### Organizational Structure



## Position Descriptions

Position	Description
Medical Officer of Health	The Medical Officer of Health will continue to act as the primary external liaison with senior government and health sector leaders and will provide strategic direction to the COVID-19 program. These responsibilities may be delegated to the AMOH.
Associate Medical Officer of Health	The Associate Medical Officer of Health will provide strategic and operational direction for the COVID-19 program, in addition to medical, technical, and scientific advice. The AMOH will also oversee surveillance activities.
Manager, COVID-19	<p>The COVID-19 Manager will provide leadership of the COVID-19 Program by setting operational goals and objective, monitoring performance, and providing constant oversight of operational objectives. In collaboration with Supervisors, the Manager will identify and address issues, challenges, and opportunities.</p> <p>The Manager provides overarching performance management of all members of the COVID-19 team using constant feedback from the Supervisors. The Manager will also be responsible for ensuring that each intervention is appropriately staffed to reflect changing priorities.</p>
Supervisor, COVID-19	<p>The COVID-19 Supervisors are responsible for the delivery of assigned interventions within the COVID-19 Program. The interventions are assigned at the discretion of the Manager and the Supervisor is responsible for the effective delivery of assigned interventions. This includes regular and robust oversight and reporting on the performance of the intervention and of staff, including participation in necessary performance management and discipline.</p> <p>Supervisors will be responsible for ensuring that program staff are following required documentation and data collection practices through the regular review of case documentation and running reports from case management databases and tools.</p> <p>The Supervisors are also responsible for providing consultative support and guidance to Case Investigators and Contact Tracers who encounter difficult or complex cases and contacts. They will also mentor, coach and provide feedback on performance.</p> <p>The Supervisors are also responsible for the day-to-day scheduling and attendance management of the staff assigned to their interventions.</p>
Case Investigator	The Case Investigator is responsible for all aspects of Case and Contact Management. They will work collaborative with Contact Tracers to ensure that follow-up targets are met. This includes that complete and accurate use of COVID-19 tools. This role also acts to support cases and contacts with other social supports that may be required.

Contact Tracer	<p>The Contact Tracers will provide follow-up phone calls to contacts of cases and, in the event of a Level Three – Redeployment Surge, will participate in case follow-up.</p> <p>Contact Tracer are to be used upon activation of Level Two – Program Surge. Contact tracers would be drawn from a pool of casual staff. Consideration will need to be given for initial training, ongoing communication and support at Level One – Baseline.</p> <p>Strong consideration should be given to having a pool of Contact Tracers with a wide range of fluent languages.</p>
Program Assistant	<p>The Program Assistant supports all administrative needs of the COVID-19 Program which include but are not limited to monitoring of lab results being received by fax, reconciling data and preparing lists for case investigators, and ensuring that reporting to provincial reporting systems are complete.</p>
Health Promotion Specialist	<p>The Health Promotion Specialist provides direct support to the Supervisors and Manager. This includes the identification, review and implementation of new guidance documents and evidence. This role will work closely with other Foundational Standards supports to ensure that the best practices for COVID-19 are being implemented in Middlesex-London.</p>

## Program Parameters

- Level One – Baseline
  - At Level One, the following parameters apply:
    - Maximum 2 new cases/day
    - Total of 30 active cases
    - Minimal institutional outbreaks
    - Hours of Operation
      - Monday to Friday
      - 9am to 5pm
    - 24 hour on-call with weekend on call from Friday at 5pm to Monday at 9am

	Length of Workday (in minutes)	Meetings / Handoffs	Case and Contact Follow-up	Documentatio n and Review	Consultation with Team	Other
% of Day	--->	15%	55%	20%	5%	5%
Case Investigators	390	58.5	214.5	78	19.5	19.5
Contact Tracer	390	58.5	214.5	78	19.5	19.5
<b>Assumptions</b>						
2	New Cases Per Day		Hr / Day			7
30	Total Active Cases		Days / Week			5
20	Contacts Per Case		Staffing Factor			1
600	Total Active Contacts		% of Cases that are high risk			50%
			% of Contacts that are high risk			50%
Case Investigation First Call	60					
Case Follow-up - High Risk	45		Minimum viable staff per day			Total FTE
Case Follow-up - Low Risk	30		Case Investigator		19.6	19.6
Case Discharge	30		Contact Tracer		0.0	0
Contact Follow-up - High Risk	15					
Contact Follow-up - Low Risk	15					
Type of Call	Who Calls	Proportion of Calls	Calls in 14 day period	# per day	Minutes per day	
Case Investigation First Call	Case Investigator	100%	1	2.0	120.0	
Case Follow-up - High Risk	Case Investigator	50%	12	12.9	578.6	
Case Follow-up - Low Risk	Case Investigator	50%	7	7.5	225.0	
Case Discharge	Case Investigator	100%	1	2.0	60.0	
Contact Follow-up - High Risk	Case Investigator	50%	7	150.0	2250.0	
Contact Follow-up - Low Risk	Case Investigator	50%	3	64.3	964.3	

## Level Two – Program Surge

- At Level Two, the following parameters apply:
  - Maximum 5 new cases/day
  - Total of 70 active cases
  - A small number of institutional outbreaks
  - Hours of Operation
    - Seven days per week
    - 9am to 8pm
- Case Investigator capacity would be maximized before mobilization of contact tracers

	Length of Workday (in minutes)	Meetings / Handoffs	Case and Contact Follow-up	Documentatio n and Review	Consultation with Team	Other
	--->	15%	55%	20%	5%	5%
Case Investigators	570	85.5	313.5	114	28.5	28.5
Contact Tracer	570	85.5	313.5	114	28.5	28.5
<b>Assumptions</b>						
5	New Cases Per Day		Hr / Day			10
70	Total Active Cases		Days / Week			7
10	Contacts Per Case		Staffing Factor			2
700	Total Active Contacts		% of Cases that are high risk			50%
			% of Contacts that are high risk			50%
Case Investigation First Call	60					
Case Follow-up - High Risk	45		Minimum viable staff per day			Total FTE
Case Follow-up - Low Risk	30		Case Investigator		7.4	14.8
Case Discharge	30		Contact Tracer		12.0	23.9
Contact Follow-up - High Risk	15					
Contact Follow-up - Low Risk	15					
Type of Call	Who Calls	Proportion of Calls	Calls in 14 day period	# per day	Minutes per day	
Case Investigation First Call	Case Investigator	100%	1	5.0	300.0	
Case Follow-up - High Risk	Case Investigator	50%	12	30.0	1350.0	
Case Follow-up - Low Risk	Case Investigator	50%	7	17.5	525.0	
Case Discharge	Case Investigator	100%	1	5.0	150.0	
Contact Follow-up - High Risk	Contact Tracer	50%	7	175.0	2625.0	
Contact Follow-up - Low Risk	Contact Tracer	50%	3	75.0	1125.0	

- Level Three – Redeployment Surge
  - At Level Three, the following parameters apply:
    - > 5 new cases/day
    - A substantial number of institutional outbreaks
    - Hours of Operation
      - Seven days per week
      - 9am to 8pm
    - Redeployment of MLHU staff required

	Length of Workday (in minutes)	Meetings / Handoffs	Case and Contact Follow-up	Documentatio n and Review	Consultation with Team	Other
	--->	15%	55%	20%	5%	5%
Case Investigators	570	85.5	313.5	114	28.5	28.5
Contact Tracer	570	85.5	313.5	114	28.5	28.5
<b>Assumptions</b>						
<b>10</b>	<b>New Cases Per Day</b>		Hr / Day			10
<b>140</b>	<b>Total Active Cases</b>		Days / Week			7
<b>5</b>	<b>Contacts Per Case</b>		Staffing Factor			2
<b>700</b>	<b>Total Active Contacts</b>		% of Cases that are high risk			50%
			% of Contacts that are high risk			50%
Case Investigation First Call	60					
Case Follow-up - High Risk	45		<b>Minimum viable staff per day</b>			<b>Total FTE</b>
Case Follow-up - Low Risk	30		<b>Case Investigator</b>			<b>14.8</b>
Case Discharge	30		<b>Contact Tracer</b>			<b>23.9</b>
Contact Follow-up - High Risk	15					
Contact Follow-up - Low Risk	15					
<b>Type of Call</b>	<b>Who Calls</b>	<b>Proportion of Calls</b>	<b>Calls in 14 day period</b>	<b># per day</b>	<b>Minutes per day</b>	
Case Investigation First Call	Case Investigator	100%	1	10.0	600.0	
Case Follow-up - High Risk	Case Investigator	50%	12	60.0	2700.0	
Case Follow-up - Low Risk	Case Investigator	50%	7	35.0	1050.0	
Case Discharge	Case Investigator	100%	1	10.0	300.0	
Contact Follow-up - High Risk	Contact Tracer	50%	7	175.0	2625.0	
Contact Follow-up - Low Risk	Contact Tracer	50%	3	75.0	1125.0	



## Appendix C – Proposed Enhancements to Existing Programs

The programs highlighted below are those which require additional staffing enhancements and augmentation to support a sustained COVID-19 response. Other programs requiring enhancement may be determined through further discussions.

### Public Health Programs

#### *Infection Prevention and Control*

Role	Proposed FTE	Rationale for Enhancement
Public Health Inspector / Public Health Nurse	5.0	To support increase infection prevention and control in regulated facilities, additional staffing is required.
Program Assistant	1.0	To support increased administrative work.

#### *Community Outreach*

Role	Proposed FTE	Rationale for Enhancement
Public Health Nurse	1.0	To support liaison and infection prevention and control capacity building in shelters and amongst people experiencing homelessness.

#### *Environmental Health*

Role	Proposed FTE	Rationale for Enhancement
Public Health Inspector	2.0	To support liaison and infection prevention and control capacity building among vulnerable occupancies, such as migrant farm communities and rooming homes.

### Foundational Standards

#### *Communications*

Role	Proposed FTE	Rationale for Enhancement
Communications Coordinator	1.0	To support increase communication demands relevant to COVID-19

#### *Population Health Assessment and Surveillance*

Role	Proposed FTE	Rationale for Enhancement
Epidemiologist	1.0	To support ongoing surveillance and data analytic requirements for COVID-19

#### *Program Planning and Evaluation*

Role	Proposed FTE	Rationale for Enhancement
Program Evaluator	0.5	To support enhanced COVID-19 program planning, implementation, and evaluation, in addition to tool development and deployment

## Healthy Organization

### *Human Resources*

Role	Proposed FTE	Rationale for Enhancement
Human Resources Coordinator	1.0	To provide continued support for the HR hotline and increased recruitment
Occupational Health and Safety Specialist	1.0	To respond to heightened COVID-19 occupational health and safety measures

### *Finance*

Role	Proposed FTE	Rationale for Enhancement
Payroll and Benefits Coordinators	0.5	To support increased finance demands for non-traditional payroll

### *Clinic Support Services*

Role	Proposed FTE	Rationale for Enhancement
Client Service Representative	2.0	To support active screening and Level One COVID-19 telephone support

### *Procurement and Operation*

Role	Proposed FTE	Rationale for Enhancement
Shipping and Receiving Coordinator	1.0	To support centralized PPE inventory management, swab management, and PPE procurement and ordering

TO: Chair and Members of the Board of Health

FROM: Dr. Christopher Mackie, Medical Officer of Health  
Dr. Michael Clarke, CEO (Interim)

DATE: 2020 July 16

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## SUMMARY INFORMATION REPORT - JULY 2020

### **Recommendation**

*It is recommended that the Board of Health receive Report No. 033-20 re: “Summary Information Report - July 2020” for information.*

#### **Key Point**

- Early in the COVID-19 response, MLHU services were prioritized and adjusted. Many of these adjustments remain in place, however, further changes have been made in response to increased demand for service and the impacts of the extended duration of the pandemic.
- Ontario Health Teams (OHT) are groups of health care providers and organizations that are clinically and fiscally accountable for delivering a full and coordinated continuum of care to a defined geographic population. In the past, the Health Unit has been involved in discussions related to the development of the Western Ontario Health Team, and has now been asked to become more involved in leadership of this OHT.

### **Update on Clinical Services During Pandemic**

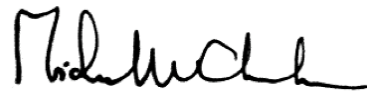
In April 2020, the Board of Health received a report outlining [Further Adjustments to Health Unit Services During Pandemic](#). Recently, changes have been made in response to increased demand for service and the impacts of the extended duration of the pandemic. As of July 3<sup>rd</sup>, the Friday morning Sexually Transmitted Infections (STI) clinic has been reinstated. Appointment slots in the Monday and Wednesday STI clinics have increased from 50 to 84 clients, with the return to having three physicians in the clinic. For Family Planning Clinic (FPC), two new physicians have been hired and will start this month. As of July 14<sup>th</sup>, the FPC will be adding one more physician to Tuesday afternoon clinic (14 additional appointment slots) and one physician to the evening clinic (12 additional appointment slots), with additional schedule changes to be confirmed for the second physician joining the team. Although phone and virtual OTN appointments are still offered and utilized in the FPC, an increasing number of clients are indicating preference for in-person appointments. For vaccine-preventable disease services, additional immunization clinics will be added on Tuesday and Thursday mornings for Grade 7 “catch-up” clinics, until the end of August. In Healthy Start, nurses are continuing essential home visits (e.g., when virtual breastfeeding support is inadequate; when more in-depth mental health and well-being assessment and support is required; when in-person assessment and support related to intimate partner violence is required; when sustained telepractice intervention is negatively impacting client engagement and program attrition). As restrictions are easing and enhanced masking practices are being introduced, the provision of in-person support has increased based on client request and nursing assessment. Family Home Visitors have also returned primarily to program work and are providing phone and virtual OTN support to families.

**Western Ontario Health Team**

Ontario Health Teams (OHT's) are groups of health care providers and organizations that are clinically and fiscally accountable for delivering a full and coordinated continuum of care to a defined geographic population. Currently, the Western Ontario Health Team is functioning as an effective healthcare sector collaboration and integration table focused on London and Middlesex. This OHT has chosen a target population of patients with chronic health impacts of COVID-19. The Health Unit has been involved in the past in discussions related to the development of the Western Ontario Health Team, and more recently has been asked to become more involved in leadership of this OHT. Reorienting the healthcare system is a key component of health promotion work, as defined in the Ottawa Charter for Health Promotion. Although local public health is not currently resourced to do this work, there is an opportunity for the Health Unit to be involved in this important work. Next steps include advancing the model of partnership, and identifying in-kind and financial budget contributions from partner organizations. A further report on this, including any financial implications, will come forward at a future Board of Health meeting.



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



Dr. Michael Clarke, PhD  
CEO (Interim)

TO: Chair and Members of the Board of Health  
FROM: Christopher Mackie, Medical Officer of Health  
DATE: 2020 July 16

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## MEDICAL OFFICER OF HEALTH ACTIVITY REPORT FOR JULY

### **Recommendation**

*It is recommended that the Board of Health receive Report No. 034-20 re: “Medical Officer of Health Activity Report for July” for information.*

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The following report presents activities of the Medical Officer of Health (MOH) for the period June 6, 2020 to July 3, 2020.

The COVID-19 Pandemic continues to occupy the majority of the MOH’s time. During the last week of June, Dr. Alex Summers, AMOH was seconded to Windsor Public Health to assist with the pandemic response there. The MOH stepped into some of the roles that were temporarily left vacant with this move.

The MOH continues to participate in many external pandemic related meetings each week. These include calls daily, every other day, or weekly with Middlesex County, the City of London, local health partners, the Association of Local Public Health Agencies (alPHA), the Ministry of Health, Ontario Health West, the Southwest LHIN, the Office of the Chief Medical Officer of Health, and Public Health Ontario, to name a few. The MOH and London Mayor Ed Holder continue to provide daily media briefings on the COVID-19 pandemic.

The MOH and the Associate Medical Officer of Health (AMOH) will continue to host a weekly all staff Town Hall throughout the summer weeks to present on many topics, including COVID-19.

The following events were also attended by the MOH.

June 8	Meeting with Mayor Holder and staff to discuss Stage 2 reopening Interview with Mr. Chris dela Torre, CBC Radio in regard to Stage 2 reopening
June 9	Participated on the Council of Medical Officers of Health (COMOH) Section teleconference Met with Mr. Jonathan Sher, previously with the London Free Press
June 10	Met with Board of Health Chair to review the June 18 <sup>th</sup> Board of Health agenda
June 11	Attended a meeting of the Ontario Health Team Coordinating Council
June 18	Live interview on the AM980 CFPL, Craig Needles Show in regard to masking and the local COVID-19 picture Met with Councillor Arielle Kayabaga to discuss the community response to systemic racism and Health Unit involvement Interview with Mr. Matthew Trevithick, AM980 CFPL in regard to the recommendation to use a mask or face covering in public places. Attended the Board of Health Governance Committee meeting and the Board of Health’s regular meeting

June 23 Met with Ms. Karen McKibbin to discuss Case and Contact Tracing Software.

June 25 Spoke about COVID-19 at a Constituent Town Hall hosted by Peggy Sattler, MPP  
London West

June 29 Participated on a call of the Western Ontario Health (WOH) Governance Task Team

June 30 Hosted both the Healthcare Provider and Stakeholder webinars

July 2 Attended the Board of Health Finance and Facilities Committee meeting

This report was submitted by the Office of the Medical Officer of Health.

A handwritten signature in black ink, appearing to read 'Chris Mackie', with a stylized flourish at the end.

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

## **CORRESPONDENCE – July 2020**

- a) Date: 2020 May 20  
Topic: Basic Income for Income Security during COVID-19 Pandemic and Beyond  
From: Simcoe Muskoka District Health Unit  
To: Prime Minister Justin Trudeau, Deputy Prime Minister Chrystia Freeland, Minister of Finance Bill Morneau

### ***Background:***

On May 20, 2020, the Board of Health for the Simcoe Muskoka District Health Unit wrote to Prime Minister Trudeau as well as Minister Freeland and Minister Morneau to convey their strong support for the evolution of the Canada Emergency Response Benefit (CERB) into a basic income for all Canadians, during the COVID-19 Pandemic and beyond.

***Recommendation:*** Endorse.

- b) Date: 2020 June 9  
Topic: Basic Income for Income Security during COVID-19 Pandemic and Beyond  
From: Timiskaming Health Unit  
To: Prime Minister Justin Trudeau, Deputy Prime Minister Chrystia Freeland, Minister of Finance Bill Morneau

### ***Background:***

On June 3, 2020, the Board of Health for the Timiskaming Health Unit wrote to Prime Minister Trudeau as well as Minister Freeland and Minister Morneau to endorse the Simcoe Muskoka District Health Unit's call for the federal government to "take swift and immediate action on the evolution of the CERB Benefit into legislation for a basic income as an effective long-term response to the problems of income insecurity, persistent poverty and household food insecurity, as well as a response to the economic impact of the COVID-19 pandemic.

***Recommendation:*** Receive.

- c) Date: 2020 June 29  
Topic: Basic Income for Income Security during COVID-19 Pandemic and Beyond  
From: Porcupine Health Unit  
To: Prime Minister Justin Trudeau, Deputy Prime Minister Chrystia Freeland, Minister of Finance Bill Morneau

### ***Background:***

On June 3, 2020, the Board of Health for Porcupine Health wrote to Prime Minister Trudeau as well as Minister Freeland and Minister Morneau to endorse the Simcoe Muskoka District Health Unit's call for the federal government to "take swift and immediate action on the evolution of the CERB Benefit into legislation for a basic income as an effective long-term response to the problems of income insecurity, persistent poverty and household food insecurity, as well as a response to the economic impact of the COVID-19 pandemic.

***Recommendation:*** Receive.

- d) Date: 2020 June 25  
Topic: Basic Income for Income Security during COVID-19 Pandemic and Beyond  
From: Peterborough Public Health  
To: Prime Minister Justin Trudeau, Deputy Prime Minister Chrystia Freeland, Minister of Finance Bill Morneau

***Background:***

On June 3, 2020, the Board of Health for Peterborough Public Health wrote to Prime Minister Trudeau as well as Minister Freeland and Minister Morneau to endorse the Simcoe Muskoka District Health Unit's call for the federal government to "take swift and immediate action on the evolution of the CERB Benefit into legislation for a basic income as an effective long-term response to the problems of income insecurity, persistent poverty and household food insecurity, as well as a response to the economic impact of the COVID-19 pandemic.

***Recommendation:*** Receive.

- e) Date: 2020 June 19  
Topic: Basic Income for Income Security during COVID-19 Pandemic and Beyond  
From: Haliburton, Kawartha, Pine Ridge District Health Unit  
To: Prime Minister Justin Trudeau, Deputy Prime Minister Chrystia Freeland, Minister of Finance Bill Morneau

***Background:***

On June 18, 2020, the Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit wrote to Prime Minister Trudeau as well as Minister Freeland and Minister Morneau to endorse the Simcoe Muskoka District Health Unit's call for the federal government to "take swift and immediate action on the evolution of the CERB Benefit into legislation for a basic income as an effective long-term response to the problems of income insecurity, persistent poverty and household food insecurity, as well as a response to the economic impact of the COVID-19 pandemic.

***Recommendation:*** Receive.

- f) Date: 2020 June 19  
Topic: Endorsement of the Association of Local Public Health Agencies' Response to the Public Health Modernization Discussion Paper  
From: Haliburton, Kawartha, Pine Ridge District Health Unit  
To: The Honourable Christine Elliott, Minister of Health

***Background:***

At its June 18, 2020 meeting, the Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit endorsed the Association of Local Public Health Agencies' response to the Public Health Modernization Discussion Paper. On February 4, 2020, the Association of Local Public Health Agencies (alPHA) published a response to the Public Health Modernization Discussion Paper. alPHA's response is intended to be complementary to the individual responses of its members. Feedback was synthesized and presented with the framework of themes and questions laid out in the consultation survey. The Statement of Principles for Public Health Modernization released by alPHA in November 2019 formed the foundation of the response to the Discussion Paper.



**Recommendation:** Receive.

- g)      Date:    2020 June 19  
          Topic: Clarification on Ministry's Criteria to Move to Stage 3 in the - Framework for Reopening Our Province  
          From:    Board of Health for Lambton County  
          To:      The Honourable Christine Elliott, Deputy Premier Minister of Health

**Background:**

At its recent meeting on June 17, 2020, Lambton County Councillors (Board of Health) expressed concern about the lack of publicly available criteria that the province will use to advance public health unit jurisdictions from Stage 2 to Stage 3 of the Ministry's document A Framework for Reopening our Province. In follow-up, they are requesting that the Ministry share the criteria that the Ministry of Health will rely upon to move into Stage 3 and ensure that this information is communicated early so that it is clearly defined and understood.

**Recommendation:** Receive.

- h)      Date:    2020 June 18  
          Topic: Endorsement of correspondence regarding the 2020 Municipal Cost Share of Public Health Funding from Eastern Ontario Health Unit; and  
                  Correspondence regarding COVID-19 and Reconsiderations Related to Public Health Modernization from the Association of Local Public Health Agencies  
          From:    Haliburton, Kawartha, Pine Ridge District Health Unit  
          To:      The Honourable Christine Elliott, Minister of Health

**Background:**

At its meeting on June 18, 2020, the Board of Health for the Haliburton, Kawartha, Pine Ridge District endorsed the following letters of correspondence:  
February 12, 2020 letter from Eastern Ontario Health Unit re: 2020 Municipal Cost Share of Public Health Funding asking that the provincial Ministry to Health reverse the 305 COST-Share formula and return to previous years' municipal share of 25% applicable only to previously shared mandatory programs.  
alPHa's March 6, 2020 letter to Minister Elliott asking that the Public Health Modernization Initiative be paused until the COVID-19 emergency is declared over in order to ensure that the response can be analyzed, evaluated and incorporated into the consultations.

**Recommendation:** Receive.