AGENDA
MIDDLESEX-LONDON BOARD OF HEALTH
Finance & Facilities Committee

Microsoft Teams
Thursday, February 11, 2021 9:00 a.m.

1. DISCLOSURE OF CONFLICTS OF INTEREST

2. APPROVAL OF AGENDA – February 11, 2021

3. APPROVAL OF MINUTES – February 4, 2021

4. NEW BUSINESS

4.1. 2021 Proposed Budget (Report No. 04-21FFC)
4.2. 2021 Financial Situation (Report No. 05-21FFC)

5. OTHER BUSINESS

5.1. Next meeting: Thursday, March 4, 2021 at 9:00 a.m.

6. CONFIDENTIAL

The Finance and Facilities Committee will move in camera to consider matters regarding a proposed or pending acquisition or disposition of land by the municipality or local board, and a trade secret or scientific, technical, commercial, financial or labour relations information, supplied in confidence to the municipality or local board, which, if disclosed, could reasonably be expected to prejudice significantly the competitive position or interfere significantly with the contractual or other negotiations of a person, group of persons, or organization.

7. ADJOURNMENT

PUBLIC MINUTES
FINANCE & FACILITIES COMMITTEE
Microsoft Teams
Thursday, February 4, 2021 9:00 a.m.

MEMBERS PRESENT: Mr. Matt Reid (Chair)
Ms. Aina DeViet
Ms. Tino Kasi
Mr. Aaron O'Donnell
Ms. Maureen Cassidy

OTHERS PRESENT: Dr. Christopher Mackie, Secretary-Treasurer
Ms. Kelly Elliott, Board Member
Ms. Arielle Kayabaga, Board Member
Ms. Stephanie Egelton, Executive Assistant to the Board of Health and Communications Coordinator (Recorder)
Ms. Emily Williams, Director, Healthy Organization
Mr. Mirek Pawelec, Manager, Finance
Mr. Joe Belancic, Manager, Procurement and Operations
Dr. Michael Clarke, Interim CEO
Mr. Stephen Turner, Director, Environmental Health and Infectious Disease

At **9:06 a.m.,** Dr. Christopher Mackie called the meeting to order and opened the floor to nominations for Chair of the Finance & Facilities Committee for 2021.

It was moved by **Ms. Aina DeViet, seconded by Ms. Maureen Cassidy,** ***that Mr. Matt Reid*** *be nominated for Chair of the Finance & Facilities Committee for 2021.*

Carried

Mr. Reid accepted the nomination.

Dr. Mackie called three times for further nominations. None were forthcoming.

It was moved by **Ms. Tino Kasi, seconded by Ms. Cassidy,** ***that Mr. Matt Reid*** *be acclaimed as Chair of the Finance & Facilities Committee for 2021.*

Carried

Mr. Aaron O'Donnell joined the meeting at **9:10 a.m.**

DISCLOSURES OF CONFLICT OF INTEREST

Chair Reid inquired if there were any disclosures of conflict of interest. None were declared.

APPROVAL OF AGENDA

It was moved by **Ms. Cassidy, seconded by Ms. DeViet,** *that the **AGENDA** for the February 4, 2021 Finance & Facilities Committee meeting be approved.*

Carried

APPROVAL OF MINUTES

It was moved by **Ms. Tino Kasi, seconded by Ms. Cassidy,** *that the **MINUTES** of the December 3, 2020 Finance & Facilities Committee meeting be approved.*

Carried

NEW BUSINESS

2021 Terms of Reference and Annual Reporting Calendar (Report No. 01-21FFC)

Dr. Michael Clarke, Interim CEO stated that these are standard and have not been changed from last year. Ms. Emily Williams, Director, Healthy Organization explained that this outlined by quarter what reports were required on certain dates to the committee.

It was moved by **Ms. DeViet, seconded by Ms. Kasi,** *that the Finance & Facilities Committee approve Report No. 01-21FFC re: "Finance & Facilities Committee – Terms of Reference and 2021 Reporting Calendar."*

Carried

EFAP Contract Renewal (Report No. 02-21FFC)

Dr. Clarke noted that this was an extension of the Homewood Health EFAP program, with no further changes to the contract.

It was moved by **Ms. Kasi, seconded by Ms. Cassidy**, *that the Finance & Facilities Committee make a recommendation to the Board of Health to receive Report No. 02-21FFC: "Employee and Family Assistance Program (EFAP) Services Contract Extension" for information*.

Carried

FoodNet Canada Ontario Sentinel Site Update and Memorandum of Agreement (Report No. 03-21FFC)

Mr. Stephen Turner, Director, Environmental Health and Infectious Disease noted that this is the 7th year involved with FoodNet Canada. FoodNet has assisted in retail food testing and is helpful in testing pathogens in breaded chicken products. This contract is to extend another year (London chosen as a sentinel site) and anticipated to be a perpetual program unless there are changes at the federal level. The health unit has always looked at two out of four surveillance items and is decided by geographic region from Public Health Ontario.

It was moved by **Ms. Cassidy, seconded by Ms. DeViet,** *that the Finance & Facilities Committee make a recommendation to the Board of Health to:*

1) *Receive Report No.03-21FFC re: "FoodNet Canada Ontario Sentinel Site Update and Memorandum of Agreement"; and*
2) *Direct staff to renew the contract with FoodNet Canada for an additional one-year term.*

Carried

CORRESPONDENCE

The City of London provided correspondence of the entire budget motion passed at a recent meeting. The relevant correspondence was provided to the committee.

It was moved by **Ms. Cassidy, seconded by Ms. Kasi,** *to receive City of London Budget Resolution Correspondence from January 12, 2021 for information.*

Carried

OTHER BUSINESS

The next meeting is February 11, 2021.

ADJOURNMENT

At **9:35 a.m.,** it was moved by **Ms. Cassidy, seconded by Ms. Kasi**, *that the meeting be adjourned.*

Carried

At **9:36 a.m.,** Chair Reid *adjourned the meeting*.

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MATTHEW REID
Chair

CHRISTOPHER MACKIE
Secretary-Treasurer

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 04-21FFC

TO: Chair and Members of the Finance & Facilities Committee

FROM: Chris Mackie, Medical Officer of Health and Michael Clarke, Interim CEO

DATE: 2021 February 11

2021 PROPOSED BUDGET

Recommendation

It is recommended that the Finance & Facilities Committee make a recommendation to the Board of Health to:

1) ***Approve the 2021 Proposed Budget in the gross amount of $42,657,163 as appended to Report No. 04-21FFC re: "2021 Proposed Budget";***
2) ***Forward Report No. 04-21FFC to the City of London and the County of Middlesex for information; and***
3) ***Direct staff to submit the 2021 Proposed Budget in the various formats required by the different funding agencies.***

Key Points

- The 2021 Budget was developed according to the approved allocation from the Ministry of Health (MoH) on the Mandatory Program funding.
- The budget also includes other known or potential funding sources from the Public Health Agency of Canada (PHAC), Ministry of Children, Community & Social Services (MCCSS – 100%), and other sources of revenue.
- The overall 2021 Proposed Budget as presented in Appendix A is increasing by $7,348,148 or 20.81%.
- Data presented in this report and appendices is limited compared to previous years due to pandemic response. Additional data will be provided prior to or at the FFC meeting on February 11.

Background

The 2021 Proposed Budget provides an overview of the work of the Middlesex-London Health Unit and outlines the programs and services that are delivered to the community. The Proposed Budget is designed to enhance the Board's understanding of how funding supports the programs and interventions that are delivered to meet the Ontario Public Health Standards: Requirements for Programs, Services and Accountability, 2018. Typically, the Budget is presented as part of a fulsome Annual Service Plan (ASP); however, due to COVID-19, to date, the full ASP reporting requirements have not been provided by the Ministry of Health (MoH) to Health Units, including MLHU. In the absence of that direction, a high-level summary ASP report has been prepared for the 2021 budget. The 2020 ASP, which may serve as a useful reference as a baseline for incremental changes, is available here.

2021 Proposed Board of Health Budget

Included in the proposed budget are COVID-19 projected costs for 2021, specific to the ongoing work of the Case and Contact Management and Outbreak and Facilities Management teams. The MoH is requesting that Health Units continue to take all necessary measures to respond to COVID-19, giving assurances that there will be a process to request reimbursement of COVID-19 extraordinary costs incurred in 2021. This request from the MoH includes the roll-out of the COVID-19 Vaccine Program of which projected costs are currently unknown and are therefore not included in this budget. The COVID-19 Vaccine Program costs will be reported separately at a later date.

To accommodate inflationary pressures on salaries and wages and to address cost increases in connection with the relocation to new facilities at Citi Plaza, the 2021 proposed budget includes PBMA proposed disinvestments as well as investments that were approved by the Finance & Facilities Committee at the November 5, 2020 meeting (Report No. 027-20FFC). A summary of the proposed 2021 Board of Health Budget, including the PBMA proposals, is contained in Appendix A.

The overall 2021 Proposed Budget as presented in Appendix A is increasing by $7,348,148 or 20.81%. Components of this increase are as follows:

Source of Funding	Amount
Ministry of Health & Long-Term Care (Cost-Shared)	$ (549,898)
The City of London	30,727
The County of Middlesex	5,853
Ministry of Health & Long-Term Care - mitigation funding	1,361,300
Ministry of Health & Long-Term Care (100%) - COVID-19	7,274,786
Ministry of Health & Long-Term Care (100%- Senior Dental)	(700,000)
City of London - CLIF Tobacco Enforcement	136,714
Public Health Agency of Canada	(5,898)
Public Health - Ontario	(3,564)
User Fees	(138,520)
Other Offset Revenue	(63,352)
Net Change to Funding	**$ 7,348,148**

MoH base funding is projected to be lower by $ 549,898 than budgeted in 2020 as the ministry has provided a reduced allocation amount for 2020 and has signaled that these levels will continue into 2021.

The City of London contribution is expected to be higher by $ 30,727 than was budgeted in 2020, however, despite the $ 6,704,565 that was budgeted from the City for 2020, the actual funding required was at the reduced 2019 levels of $ 6,095,059 due to a one-time provincial grant. City staff have indicated to the Health Unit that thus far, City Council has approved $ 6,095,059 for the Health Unit.

The County of Middlesex contribution is expected to be higher by $ 5,853 than was budgeted in 2020, however, despite the $ 1,277,057 that was budgeted from the County for 2020, the actual funding required was at the 2019 levels of $ 1,160,961 due to a one-time provincial grant.

MoH is providing mitigation funding for 2021 in the amount $ 1,361,300 included in Schedule “A” in attached Appendix B.

COVID-19 funding requirement from the MoH is projected at $7,274,786 to continue efforts to contain the pandemic. As noted above, this does not include vaccine-related costs.

Funding for the Senior Dental mobile clinic is being reduced from the 2021 budget as the mobile clinic is not being pursued by MLHU.

The City of London is providing temporary funding of $303,560 to support local cannabis enforcement and education from the Cannabis Legalization Implementation Fund, an increase of $136,714 from prior year's budget.

Expected funding from both, the Public Health Agency of Canada and Public Health Ontario are slightly lower for 2021 in relation to the 2020 budget.

User Fees and Other Offset Revenues are expected to be lower compared to prior year's budget due to ongoing pandemic efforts.

2021 Annual Service Plan

The 2021 Annual Service Plan (ASP) summary provides planning & budgeting information for the programs delivered by MLHU. The ASP allows the Board to make informed resource allocation decisions and ensure that programs address local public health issues, the Ontario Public Health Standards and other relevant program mandates.

Planning and budget information is organized by program, which are a grouping of public health interventions related to a disease, topic, population/age, or other relevant characteristics. The associated interventions are intended to achieve the desired short, intermediate and long-term program outcomes.

To develop the 2021 ASP summary, all MLHU staff [Full Time Equivalent (FTE), salary, wages, and benefits] were allocated from teams to the programs that they deliver. While redeployments continue across the organization to support COVID-19 work, program budgets were created based on PBMA decisions and assumptions that typical programmatic activity will resume and need to be supported accordingly. Careful tracking of redeployed employees is conducted by MLHU to ensure COVID-19-related costs are captured and submitted to the MoH for reimbursement. All other program expenses were allocated from team budgets to the relevant program budgets based on FTE allocations.

Conclusion

The 2021 proposed budget is $42,657,163 which represents an increase of $7,348,148 or 20.81% from the 2020 budget, exclusive of vaccine campaign costs.

This report was prepared by the Healthy Organization Division.

Dr. Chris Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

Dr. Michael Clarke
Interim CEO

2021 PBMA Disinvestment

Dept.	No.	Proposal	Value	FTE	Score
EHID	1-0008	Staff Immunization Services	- $ 6,988	- 0.08	-67
EHID	1-0018	Travel Clinic	- $ 23,203	-0.40	-90
EHID	1-0019	MOH On Call Stipend	- $ 8,400	0.00	-63
HL	1-0002	Discontinuation of UVR Health Promotion	- $ 54,798	-0.50	-181
HO	1-0014	Refund - ASO Overcontribution	- $ 150,000	0.00	0
HO	1-0015	Eliminate Conferencing Tool	- $ 3,600	0.00	0
HS	1-0005	Operational Budget Reduction	- $ 20,000	0.00	0
HS	1-0006	Eliminate Casual PHN Budget	- $ 24,135	0.20	-121
HS	1-0009	Deprioritize Preconception Health	- $ 48,960	0.50	-181
OCNO	1-0016	Health Equity Professional Services	- $ 45,900	0.00	
		Total	**-$ 385,984**	**-1.68**	**-703**

Disinvestment Descriptions

#1-0008 – Staff Immunization Services

The staff immunization PHN on the vaccine preventable disease team would continue to review and assess immunization status of new and current employees including students and volunteers and recommend vaccines according to staff immunization polices.

Instead of offering appointments and organizing flu clinics, the staff immunization PHN would recommend that these services be accessed in the community and an updated record be submitted for input into the Ontario Immunization database Panorama.

Currently this Program requires a .15 FTE. This proposed initiative would reduce FTE requirement by half.

#1-0018 – Travel Clinic Closure
Elimination of the MLHU support for the Travel Clinic. Includes disinvestment of MLHU's contributions to PA support, Materials and Supplies and staff development.

#1-0019 – MOH On Call Stipend
Elimination of stipend for 3rd MOH on-call due to resignation.

#1-0002 – Discontinuation of UVR Health Promotion
This proposal is the disinvestment of a 0.5 FTE Public Health Nurse who is the agency and content lead for the ultraviolet radiation and sun safety program, and the person responsible for Healthcare Provider Outreach and website content pertaining to cancer screening (0.4 FTE). The position also supports the Tobacco Quit Clinic and the Tobacco Cessation program (0.1 FTE).

#1-0014 – Refund - ASO Overcontribution
In reviewing MLHU's experience in funding Administrative Services Only (ASO) personal insurance claims for employees, the monthly contribution to the Health Unit's insurer, Canada Life, has consistently exceeded the ASO experience paid out for insurance claims submitted. Monthly premiums were reduced commencing in January 2020 by approximately $8,500 or $102,000 per annum. In addition, $250,000 was also withdrawn from the ASO balance in Q3, 2020 due to continued lower experience of claims. Notwithstanding these adjustments to the ASO pool, the plan consultant, AON has confirmed that MLHU can safely withdraw between 133,000 and $185,000 in 2021 if the account remains at current surplus levels. Accordingly, a withdrawal of up to $150,000 to occur in Q4, 2021 is proposed.

#1-0015 – Eliminate Conferencing Tool
Pragmatic has supplied conference calling to MLHU for many years. The implementation of MS Teams has reduced the need for conference calling as it was replaced with video conferencing. Audio conference calling can be maintained through the 3CX phone system at no additional charge to the organization. As a result, Pragmatic conference calling could be eliminated without any disruption to existing services. Instructions will be provided to MLT on how to use 3CX conference calling prior to the elimination of Pragmatic.

#1-0005 – Operational Budget Reduction
To disinvest $15,000.00 from the Early Years Program Supplies budget, in addition to $5,000 from the HS Office of the Director. There is no change in program implementation with this disinvestment as many health promotion activities are currently being implemented through social media.

#1-0006 – Eliminate Casual PHN Budget
Disinvest public health nurse casual wage budget from the Early Years Team budget. This would result in the casual wage funding to no longer be available to support the program work of the Early Years Team. This represents approximately 0.20 FTE of a PHN (1 day/week). This would impact the capacity of the team to conduct its work (e.g., community partnerships, breastfeeding visits, phone line support) .

#1-0009 – Deprioritize Preconception Health

Preconception health is identified as a topic area for consideration in the OPHS. At this point, there are not sufficient resources to address preconception health using a comprehensive population health approach, and the impact of existing efforts is unknown. As a result of COVID-19 the program planning and review process has not been completed. If this disinvestment proposal is accepted, the program planning process will not continue and all preconception health interventions, other than providing information on the MLHU website, will be discontinued indefinitely.

#1-0016 – Health Equity Professional Services

Funds allocated to the Health Equity Team to pay an external consultant for the Diversity and Inclusion Assessment will not be needed in full again in 2021, or at all in 2022. This proposal considers the divestment of these funds from the Health Equity budget.

2021 PBMA Investment

Dept.	No.	Proposal	Value	FTE	Score
HL	1-0025	Investment, 1.0 FTE PHN Substance Use Prevention & Drug Strategy Prevention Focused Support	$ 108,399	1.00	252
HS	1-0027	Nurse-Family Partnership Expansion	$ 108,399	1.00	288
HS	1-0028	Introduction of iHEAL Program	$ 108,399	1.00	212
OMOH	1-0023	Community Outreach Team, Client Travel	$ 12,000	0.00	175
		Total	**$ 337,197**	**3.00**	**927**

Investment Descriptions

#1-0025 – Investment PHN Substance Use Prevention & Drug Strategy Prevention Focused Support

This proposal is for a 1.0 FTE PHN to increase MLHU capacity in meeting its public health mandate for substance misuse prevention under the OPHS Substance use and Injury Prevention program standard, and to provide MLHU resources to support the Middlesex-London Community Drug and Alcohol Strategy in implementing recommendations related to prevention

This proposal is for a 1.0 FTE PHN to increase MLHU capacity in meeting its public health mandate for substance misuse prevention under the OPHS Substance use and Injury Prevention program standard, and to provide MLHU resources to support the Middlesex-London Community Drug and Alcohol Strategy in implementing recommendations related to prevention. This position would be focused on substance prevention using a comprehensive *Public Health approach; ensure interconnection between prevention and harm reduction focused work; facilitate enhanced cross divisional coordination for substance related programming with the intent of greater impact; and strengthen collective community action related to upstream prevention.

Impact of COVID-19 on substance use and harms:
Substance use and related harms have been a concern in the Middlesex-London Community for some time, with significant evidence and surveillance data demonstrating community need. There is growing and broad Canadian evidence, and emerging local evidence that that the COVID-19 pandemic and associated public health measures aimed at controlling viral spread have led to increased substance use and substance related harms, including increased opioid poisonings and deaths and increased rates of alcohol and cannabis use. Notably, there has been impact on substance related risk and protective factors (income, employment, mental wellbeing, social connection etc.) that are expected to have lasting implications. With future waves of COVID-19 in our communities and the unknowns about life post-pandemic, it is important for MLHU to continue to monitor the negative impacts associated with substance use, deliver related health promotion strategies, engage in policy development work, and leverage supports of community partners in order to reduce the negative impacts on substance use.

1-0027 – Nurse-Family Partnership
This PBMA enhancement proposal seeks the funds necessary to increase the PHN staffing complement of the NFP Team by one FTE. This enhancement will allow program caseload capacity to increase from 100 to 120 women and their children, and would ensure the NFP program is available for first-time mothers up to at least 24 years of age. The NFP program serves as an effective strategy to meet the recovery planning priorities identified by MLHU: domestic violence, mental health promotion, substance use, food insecurity and racism.

#1-0028 – Introduction of iHEAL Program
This proposal seeks funds to hire 1 FTE PHN in order to introduce the iHEAL program to the Middlesex-London Health Unit. iHEAL is a comprehensive, health promotion intervention for women who are in the transition of separating from an abusive partner. Public health nurses work in partnership with women for ~ 6 months to address a range of issues that affect women's safety, health and well-being. This intervention aligns with the Substance Use and Injury Prevention Program, supports our mandate for mental health promotion, and aligns with the priorities proposed by Recovery Planning focused on emerging and priority public health issues (domestic violence, mental health, and possibly substance use).. It is essential to note that this individual-level intervention targeting women experiencing violence and at significant risk for exposure to increased violence must be part of a comprehensive population public health approach to addressing violence in our community.

#1-0023 – Community Outreach Team, Client Travel
Due to clients being significantly marginalized people with many immediate needs, travel by taxi continues to be the most efficient way to get clients to appointments and other supports in a timely manner. Taxi is an ideal mode of transport as they can be called to the client's location and drop them off at the door of a facility or hospital to assist with an immediate escort to their appointment location. This helps decrease "no show" rates for appointments and helps the team to work in a more efficient manner by seeing more clients each day. Bus tickets are also considered for clients experiencing more stability in their recovery journey.

Impacts of investment:
• With a budget of $1,000 per month the team can prioritize travel for medical appointments and work with community partners to share travel responsibilities for shared clients where appropriate
• This budget will allow the Community Outreach Team to transport clients to HIV and other medical appointments
• Increase efficiencies to seek, find and link to care as clients can reliably make it to appointments
• Better engagement in the health system and connecting to care when travel is not a barrier to getting well

Middlesex - London Health Unit

2021 Annual Budget

February 2021

MIDDLESEX-LONDON HEALTH UNIT
2021 BOARD OF HEALTH DRAFT BUDGET SUMMARY

	2019 Budget	2020 Budget	2021 Budget	$ increase/ ($ decrease) over 2020	% increase (% decrease) over 2020	Notes	2020 FTE	2021 FTE	increase/ decrease
Healthy Organization									
Office of the Director	$ 354,699	$ 366,239	$ 363,368	$ (2,871)	-0.8%	A	1.50	1.50	0.00
Finance	455,506	376,539	378,369	1,830	0.5%	A	4.00	4.00	0.00
Human Resources	701,599	718,985	753,498	34,513	4.8%	B	7.50	7.50	0.00
Information Technology	1,069,292	1,208,932	1,314,725	105,793	8.8%	1.	3.00	3.00	0.00
Privacy Risk & Governance	153,110	159,272	157,039	(2,233)	-1.4%	A	1.50	1.50	0.00
Procurement & Operations	283,638	187,821	193,968	6,147	3.3%	B	2.00	2.00	0.00
Program Planning & Evaluation	873,039	889,028	888,157	(871)	-0.1%	C	9.00	9.00	0.00
Strategic Projects	263,202	276,792	283,660	6,868	2.5%	B	2.50	2.50	0.00
Total Healthy Organization	**$ 4,154,085**	**$ 4,183,608**	**$ 4,332,785**	**$ 149,177**	**3.6%**		**31.00**	**31.00**	**0.00**
Healthy Living Division									
Office of the Director	$ 379,454	$ 264,565	$ 266,814	$ 2,249	0.9%	B	2.00	2.00	0.00
Child Health	1,685,760	1,666,881	1,676,101	9,220	0.6%	B	15.00	15.00	0.00
Chronic Disease and Tobacco Control	1,407,541	1,595,629	1,642,694	47,065	2.9%	2.	15.10	15.40	0.30
Healthy Communities and Injury Prevention	1,168,241	1,142,960	1,244,496	101,536	8.9%	3.	10.20	11.20	1.00
Oral Health	1,116,045	986,797	993,196	6,399	0.6%	B	12.00	12.00	0.00
Senior Dental Health	-	2,455,451	1,755,451	(700,000)	-28.5%	4.	7.50	7.50	0.00
Southwest Tobacco Control Area Network	436,500	441,345	442,300	955	0.2%	B	2.40	2.40	0.00
Young Adult Health	1,137,457	1,108,234	1,123,044	14,810	1.3%	B	10.00	10.00	0.00
Total Healthy Living Division	**$ 7,330,998**	**$ 9,661,862**	**$ 9,144,096**	**$ (517,765)**	**-5.4%**		**74.20**	**75.50**	**1.30**
Officer of the Medical Officer of Health									
Office of the Medical Officer of Health	$ 576,556	$ 484,130	$ 508,590	$ 24,460	5.1%	D	2.30	2.30	0.00
Communications	531,685	585,917	593,067	7,150	1.2%	B	5.70	5.70	0.00
Associate Medical Officer of Health	295,831	332,008	357,413	25,405	7.7%	D	1.50	1.50	0.00
Population Health Assessment & Surveillance	593,835	549,380	603,071	53,691	9.8%	5.	5.00	5.50	0.50
Clinical Support Team	-	952,414	983,638	31,224	3.3%	6.	11.25	11.25	0.00
Total Officer of the Medical Officer of Health	**$ 1,997,907**	**$ 2,903,849**	**$ 3,045,779**	**$ 141,930**	**4.9%**		**25.75**	**26.25**	**0.50**
Environmental Health & Infectious Disease Division									
Office of the Director	$ 302,938	$ 308,774	$ 270,673	$ (38,101)	-12.3%	7.	2.60	2.00	-0.60
Emergency Management	180,848	133,818	135,530	1,712	1.3%	B	1.00	1.00	0.00
Food Safety & Healthy Environments	1,727,958	1,459,602	1,494,969	35,366	2.4%	B	14.00	14.00	0.00
Infectious Disease Control	1,814,317	1,834,640	1,869,014	34,374	1.9%	B	16.90	16.90	0.00
Safe Water, Rabies & Vector-Borne Disease	1,382,228	1,682,618	1,685,177	2,559	0.2%	B	16.02	16.02	0.00
Sexual Health	3,279,751	2,853,039	2,862,156	9,117	0.3%	B	16.87	16.87	0.00
Vaccine Preventable Disease	1,638,371	1,662,785	1,642,828	(19,957)	-1.2%	8.	17.02	16.54	-0.48
COVID-19			7,274,786	7,274,786		18.		86.10	86.10
Total Environmental Health & Infectious Disease Division	**$ 10,326,411**	**$ 9,935,276**	**$ 17,235,133**	**$ 7,299,857**	**73.5%**		**84.41**	**169.43**	**85.02**
Healthy Start Division									
Office of the Director	$ 208,616	$ 212,473	$ 215,306	$ 2,833	1.3%	B	1.70	1.70	0.00
Best Beginnings	3,105,295	3,106,227	3,310,511	204,284	6.6%	9.	29.80	31.80	2.00

MIDDLESEX-LONDON HEALTH UNIT
2021 BOARD OF HEALTH DRAFT BUDGET SUMMARY

	2019 Budget	2020 Budget	2021 Budget	$ increase/ ($ decrease) over 2020	% increase (% decrease) over 2020	Notes	2020 FTE	2021 FTE	increase/ decrease
Early Years Health	1,648,166	1,586,332	1,535,123	(51,209)	-3.2%	10.	14.23	14.00	-0.23
Reproductive Health	1,368,189	1,395,827	1,377,616	(18,211)	-1.3%	11.	12.50	12.00	-0.50
Screening Assessment and Intervention	2,124,932	-	-	-					
Total Healthy Start Division	**$ 8,455,198**	**$ 6,300,859**	**$ 6,438,557**	**$ 137,698**	**2.2%**		**58.23**	**59.50**	**1.27**
Office of the Chief Nursing Officer	**$ 778,328**	**$ 789,317**	**$ 734,963**	**$ (54,354)**	**-6.9%**	12.	**6.30**	**6.30**	**0.00**
General Expenses & Revenues	**$ 2,683,323**	**$ 2,675,102**	**$ 2,983,322**	**$ 308,220**	**11.5%**	13.			
Expected Agency Gapping Budget	**$ (1,124,269)**	**$ (1,140,858)**	**$ (1,257,473)**	**$ (116,615)**	**10.2%**	14.			
TOTAL MIDDLESEX-LONDON HEALTH UNIT EXPENDITURES	**$ 34,601,981**	**$ 35,309,015**	**$ 42,657,163**	**$ 7,348,148**	**20.8%**		**279.89**	**367.98**	**88.09**
Funding Sources									
Ministry of Health & Long-Term Care (Cost-Shared)	$ 17,101,100	$ 20,442,198	$ 19,892,300	$ (549,898)	-2.7%				
The City of London	6,095,059	6,704,565	6,735,292	$ 30,727	0.5%	18.			
The County of Middlesex	1,160,961	1,277,057	1,282,910	$ 5,853	0.5%	19.			
Ministry of Health & Long-Term Care (100%)	4,066,700			$ -					
Ministry of Health & Long-Term Care - mitigation funding			1,361,300	$ 1,361,300		20.			
Ministry of Health & Long-Term Care (100%) - COVID-19			7,274,786	$ 7,274,786		17.			
Ministry of Health & Long-Term Care (100%- Senior Dental)		2,561,400	1,861,400	$ (700,000)	-27.3%	4.			
Ministry of Children, Community & Social Services (100%)	4,580,072	2,483,313	2,483,313	$ -	0.0%				
City of London - CLIF Tobacco Enforcement	-	166,846	303,560	$ 136,714	81.9%	15.			
Public Health Agency of Canada	428,261	443,714	437,816	$ (5,898)	-1.3%				
Public Health - Ontario	106,526	106,526	102,962	$ (3,564)	-3.3%				
User Fees	678,090	678,090	539,570	$ (138,520)	-20.4%	16.			
Other Offset Revenue	385,212	445,306	381,954	$ (63,352)	-14.2%	16.			
TOTAL MIDDLESEX-LONDON HEALTH UNIT EXPENDITURES	**$ 34,601,981**	**$ 35,309,015**	**$ 42,657,163**	**$ 7,348,148**	**20.8%**				

Notes to Team Budget Summary:

A Change in staffing pay grade for new staff - decreased salary and benefits for new staff - inflationary increases in salaries and benefits for remaining staff

B Inflationary increase in salaries and benefits

C Inflationary increase in salaries and benefits and reduction in benefits for one staff member

D Inflationary increase in salaries and benefits and two year retroactive approved increase to one staff member

1 Includes one-time investment in IT Development in the amount of $ 100,000 in addition to inflationary increases to salary and benefits

2 Reduction of 0.5 FTE for UVR Health Promotion, reduction 0.2 FTE in Tobacco Enforcement and addition of 1 FTE for Cannabis Health Promotion and increase in program supplies and inflationary increase to salaries and benefits to remaining staff

3 Reflects investment of 1.0 FTE in a PHN for Substance Use Prevention & Drug Strategy Prevention Focused Support and inflationary increase to salaries and benefits

4 One-time Ontario Seniors Mobile Dental Clinic in the amount of $ 700,000 not being perused as was anticipated in prior budget year

5 Includes the addition of temporary epidemiologist 0.5 FTE for Substance Use and Opioids and Other Drugs and inflationary salary and benefit increase

6 Reflects addition of $ 12,000 for Client Travel on the Community Outreach Team in addition to inflationary salary and benefit increase

7 Reduction of 0.4 FTE to eliminate Travel Clinic, reduce 0.2 FTE program assistant and $ 8,400 reduction in MOH On-Call Stipend, as well as inflationary salary and benefit increase

8 Reduction of 0.08 FTE to eliminate Staff Immunization Clinic, additional reduction of 0.4 FTE between program assistants and casual nurses, in addition to inflationary salary & benefit increase

MIDDLESEX-LONDON HEALTH UNIT

2021 BOARD OF HEALTH DRAFT BUDGET SUMMARY

9 Addition of 2.0 FTE nurses, for Nurse-Family Partnership and the introduction of iHEAL program as well as inflationary salary and benefit increase

10 Elimination of Casual PHN Budget 0.23FTE and the reduction of $ 20,000 in program supplies and inflationary increase to salaries and benefits

11 Deprioritize preconception Health, reduction of 0.5 FTE as well as inflationary salary and benefit increase

12 One-time reduction in Health Equity Professional Services in the amount of $ 45,900. Staffing change at lower pay grade and inflationary increase in salaries and benefits for remaining staff

13 Increase to occupancy costs and planned financing charges for 2021 partly offset by refund of overcontribution of ASO premiums

14 Changes to Gap reflects cumulative impact of inflationary pressures.

15 Increase in funding for tobacco and cannabis enforcement from City of London

16 Anticipated reduction in user fees and other revenues due to pandemic

17 COVID-19 Extraordinary costs - to be funded by MOHLTC

18 City of London actual funding in 2020 has reverted back to 2019 funding level compared to what was initially budgeted, therefore there is an increase in 2021 of $ 640,233 or 10.5% over 2019 funding level

19 The County of Middlesex actual funding in 2020 has reverted back to 2019 funding level compared to what was initially budgeted, therefore there is an increase in 2021 of $ 121,949 or 10.5% over 2019 funding level

20 One time mitigation funding from the MOHLTC

YOY Continuity of General Expense		
Opening Budget - 2021	**$**	**2,675,102**
Reverse one time Refund of overcontribution of ASO premiums 2020		250,000
Refund of overcontribution of ASO premiums 2021		(150,000)
Incremental occupancy costs - 2021		191,320
Incremental insurance costs		20,500
PBMA proposal		(3,600)
Proposed budget - 2021	**$**	**2,983,322**

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2021 MLHU Programs

		Budget	FTE
Emergency Management			
400	Emergency Management	$ 147,636	1.06
Effective Public Health Practice			
401	Communications	$ 593,067	5.70
403	Quality and Transparency	$ 179,754	1.56
402	Program Planning and Evaluation	$ 633,263	6.10
404	Research and Knowledge Exchange	$ 350,803	3.36
Health Equity			
410	Health Equity and Indigenous Public Health Practice	$ 412,679	3.60
Population Health Assessment			
415	Population Health Assessment and Surveillance	$ 625,605	5.10
	Total Foundational Standards	**$ 2,942,807**	**26.48**
Chronic Disease Prevention Well-Being			
420	Healthy Eating Behaviours	$ 403,631	3.62
421	Oral Health	$ 558,534	6.64
422	Physical Activity and Sedentary Behaviours (Active Living)	$ 268,436	2.37
423	Mental Health Promotion	$ 139,102	1.23
424	Ultraviolet Radiation and Sun Safety	$ 41,102	0.36
479	Seniors Dental Care	$ 1,755,451	7.71
	Total Chronic Disease Prevention Well-Being	**$ 3,166,256**	**21.93**
Food Safety			
425	Food Safety	$ 1,738,161	15.76
	Total Food Safety	**$ 1,738,161**	**15.76**
Healthy Environments			
430	Health Hazard Response	$ 382,963	3.46
431	Healthy Environments and Climate Change	$ 101,226	0.89
	Total Healthy Environments	**$ 484,190**	**4.35**
Healthy Growth and Development			
440	Breastfeeding and Infant Feeding	$ 1,427,225	12.76
441	Growth and Development	$ 2,009,046	20.43
442	Healthy Pregnancies	$ 1,337,515	11.73
443	Healthy Sexuality	$ 220,870	1.42
444	Mental Health Promotion	$ 687,769	6.01

Salaries & Wages	$	28,594,075
Overtime / Shift Premium	$	83,288
Benefits	$	6,779,615
Expected vacancies	$	(1,257,472)
Travel	$	303,684
Program Supplies	$	1,751,992
Board expenses	$	45,500
Staff Development	$	211,322
Occupancy	$	2,455,307
Professional Services	$	2,528,670
Furniture & Equipment	$	615,010
Other Program Costs	$	546,173
Expenses by Program	**$**	**42,657,163**

MOHLTC (Cost Shared)	$	29,272,088
MOHLTC (100%)	$	1,861,400
MOHLTC (100%) - COVID	$	7,274,786
MCCSS	$	2,483,313
CLIF Tobacco Enforcement	$	303,560
PHAC	$	437,816
Public Health Ontario	$	102,962
User Fees	$	539,284
Other Offset Revenue	$	381,954
Revenue by Program	**$**	**42,657,163**

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2021 MLHU Programs

			Budget	FTE
445	Preconception Health	$	422,461	3.67
	Total Healthy Growth and Development	**$**	**6,104,887**	**56.02**
Infectious and Communicable Disease Prevention and Control				
450	Infection Prevention and Control	$	433,096	3.77
451	Rabies and Zoonotic Disease	$	361,534	3.03
452	Respiratory, Enteric, and Other Infectious Disease	$	735,107	6.45
453	Sexually Transmitted and Blood-Borne Disease	$	2,808,446	18.20
454	Tuberculosis	$	451,861	3.79
455	Vector-Borne Disease	$	494,504	5.97
	Total	**$**	**5,284,548**	**41.20**
Immunization				
460	Adverse Vaccine Events and Safety	$	28,544	0.22
461	Vaccine Inventory Management	$	229,496	2.37
462	Vaccine Preventable Disease	$	608,984	5.40
	Total Immunization	**$**	**867,023**	**7.99**
School Health				
465	Comprehensive School Health	$	2,852,630	25.25
466	Immunization - School Health	$	996,021	10.06
467	Oral Health - School Health	$	489,530	5.83
468	Vision	$	36,914	0.28
	Total School Health	**$**	**4,375,095**	**41.42**
Substance Use and Injury Prevention				
470	Alcohol and Cannabis	$	551,090	5.08
471	Childhood Injury Prevention	$	148,575	1.32
472	Falls Prevention and Healthy Aging	$	128,636	1.31
474	Opioids and Other Drugs	$	594,385	4.27
475	Road and Off-Road Safety	$	182,202	1.61
476	Southwest Tobacco Control Area Network	$	458,407	2.49
477	Tobacco Control and Electronic Cigarettes	$	879,022	8.34
478	Violence Prevention	$	459,023	3.91
	Total Substance Use and Injury Prevention	**$**	**3,401,340**	**28.33**

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2021 MLHU Programs

			Budget	FTE
Safe Water				
480	Drinking Water	$	193,225	1.62
481	Recreational Water	$	313,709	2.62
482	Small Drinking Water Systems	$	76,848	0.63
	Total Safe Water	**$**	**583,782**	**4.87**
Required Support				
490	Strategic Projects	$	310,515	2.60
491	Finance	$	405,224	4.10
492	Procurement	$	90,239	0.60
493	Governance	$	81,184	0.60
494	Human Resources	$	780,354	7.60
495	Information Technology	$	1,247,881	3.10
496	Operations	$	542,342	6.70
497	Privacy and Records	$	130,695	1.15
498	Risk Management	$	93,003	0.75
	Total Required Support	**$**	**3,681,436**	**27.20**
COVID-19				
	COVID-19	$	7,274,786	86.10
	COVID-19 - Vaccine - TBD			
	Total COVID -19	**$**	**7,274,786**	**86.10**
Required Support				
498	General Revenues and Expenditures	$	1,819,550	-
498	CNO / MOH / Admin / Secretarial	$	933,303	6.33
	Total Required Support	**$**	**2,752,853**	**6.33**
Total MLHU Programs 2021		**$**	**42,657,163**	**367.98**

SCHEDULE "A"
GRANTS AND BUDGET

Board of Health for the Middlesex-London Health Unit

DETAILED BUDGET - MAXIMUM BASE FUNDS (FOR THE PERIOD OF JANUARY 1, 2020 TO DECEMBER 31, 2020, UNLESS OTHERWISE NOTED)			
Programs/Sources of Funding	**2019 Approved Allocation ($)**	**Increase / (Decrease) ($)**	**2020 Approved Allocation ($)**
Mandatory Programs (70%)	21,167,800	(1,361,300)	19,806,500
MOH / AMOH Compensation Initiative (100%)[1]	114,000	(28,200)	85,800
Ontario Seniors Dental Care Program (100%)	1,861,400	-	1,861,400
Total Maximum Base Funds[2]	**23,143,200**	**(1,389,500)**	**21,753,700**

DETAILED BUDGET - MAXIMUM ONE-TIME FUNDS (FOR THE PERIOD OF APRIL 1, 2020 TO MARCH 31, 2021, UNLESS OTHERWISE NOTED)			
Projects / Initiatives			**2020-21 Approved Allocation ($)**
Mitigation (100%)[3]			1,361,300
Mandatory Programs: Public Health Inspector Practicum Program (100%)			10,000
COVID-19: Extraordinary Costs (100%)[3]			2,988,000
COVID-19: Public Health Case and Contact Management Solution (100%)[4]			74,900
COVID-19: School-Focused Nurses Initiative (100%)[5]	# of FTEs	22.0	1,474,000
MOH / AMOH Compensation Initiative (100%)			21,900
Ontario Seniors Dental Care Program Capital: Aboriginal Health Access Centre Dental Clinic - Muncey (100%)[6]			160,500
Ontario Seniors Dental Care Program Capital: Dental Clinic - Citi Plaza (100%)[6]			229,300
Ontario Seniors Dental Care Program Capital: Mobile Dental Clinic (100%)[6]			700,000
Temporary Pandemic Pay Initiative (100%)[7]			271,900
Total Maximum One-Time Funds[2]			**7,291,800**

MAXIMUM TOTAL FUNDS	2019-20 Approved Allocation ($)	2020-21 Approved Allocation ($)
Base and One-Time Funding	**23,143,200**	**29,045,500**

DETAILED BUDGET - MAXIMUM ONE-TIME FUNDS (FOR THE PERIOD OF APRIL 1, 2021 to MARCH 31, 2022, UNLESS OTHERWISE NOTED)			
Projects / Initiatives			**2021-22 Approved Allocation ($)**
Mitigation (100%)[8]			1,361,300
COVID-19: School-Focused Nurses Initiative (100%)[9]	# of FTEs	22.0	726,000
Total Maximum One-Time Funds[2]			**2,087,300**

NOTES:

(1) Cash flow will be adjusted to reflect the actual status of current MOH and AMOH positions.
(2) Maximum base and one-time funding is flowed on a mid and end of month basis. Cash flow will be adjusted when the Province provides a new Schedule "A".
(3) One-time funding is for the period of January 1, 2020 to December 31, 2020.
(4) One-time funding is approved for the period of June 15, 2020 to March 31, 2021.
(5) One-time funding is approved for the period of August 1, 2020 to March 31, 2021.
(6) One-time funding is approved for the period of April 1, 2020 to March 31, 2021, or such later EXPIRY DATE as agreed to by the parties.
(7) One-time funding is approved for the period of April 24, 2020 to August 13, 2020.
(8) One-time funding is approved for the period of January 1, 2021 to December 31, 2021.
(9) One-time funding is approved for the period of April 1, 2021 to July 31, 2021.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 05-21FFC

TO: Chair and Members of the Finance & Facilities Committee

FROM: Chris Mackie, Medical Officer of Health and Michael Clarke, Interim CEO

DATE: 2021 February 11

JANUARY 2021 FINANCIAL SITUATION

Recommendation

It is recommended that the Finance & Facilities Committee make a recommendation to the Board of Health to:

1. ***Receive Report 05-21FFC, the January 2021 Financial Situation Report; and***
2. ***Direct staff to enter into negotiations to extend the Health Unit's rotating credit facility.***

Key Points

- All possible MLHU staff have been redeployed to COVID-19 work. However, due to the second wave and tremendous surge in cases, significant additional staff were required to support COVID-19 activities.
- Given the current retroactive nature of Ministry funding for COVID-19 expenses, and the timing of the monthly revenue cycle, there has been a shortfall in cash at a number of local public health units.
- MLHU is launching a significant vaccine campaign that will require further investment in facilities (lease costs etc.), infrastructure (security systems, uninterrupted power sources, information technology etc.), supplies, and human resources.
- Several mitigation strategies are underway to ensure the successful implementation of the vaccine campaign is not impeded in any way by associated financial risks.

Background

The Ministry of Health is requesting that Public Health Units continue to take all necessary measures to respond to COVID-19, giving assurances that there will be a process to request reimbursement of COVID-19 extraordinary costs incurred in 2021 (See Appendix A). In 2020, all COVID-19 expenses were tracked separately and up to Q3 2020 were submitted to the Ministry. Q4 2020 costs are to be submitted as part of the Standards Activity Report (SAR) in February 2021 for consideration of additional reimbursement. As of January 29th, 2021 MLHU has received the following in COVID-19 related funding for 2020:

COVID-19 Extraordinary Costs (one time)	$2,988,000
COVID-19: Public Health Case and Contact Management Solution	$59,130
COVID-19: School-Focused Nurses Initiative	$ 1,105,500
Total Funding	**$4,152,630**

In order to ensure the preservation of critical public health programming, an internal Redeployment, Recruitment and Repatriation (R3) committee was struck in 2020 to oversee staff redeployments across the organization. All possible staff have been redeployed to COVID-19 work and MLHU has optimized operations to maintain critical Public Health services with minimum levels of staff. Despite this approach, due to the second wave and tremendous surge in cases, significant additional staff were required to support COVID-19 and the Level Three Redeployment Surge model was implemented, as approved by the board in

July (Report No. 032-20; Appendix A). The additional staff have resulted in an average pay roll cost of $1,050,000.00 every two weeks. This is almost double the salary expenditures from the same time last year, and will increase with the scale up of the vaccine campaign.

Current State

Given the current retroactive nature of Ministry of Health funding for COVID-19 expenses, and the timing of the monthly revenue cycle there has been a shortfall in cash reserves at MLHU to cover payroll for two consecutive pay periods (January 2021) requiring the use of the organizational Line of Credit. A table outlining monthly cashflows is found in Appendix B. Beyond these two instances, the MLHU Line of Credit ($1.5M Limit) had to be extended by $500,000 on January 21 to meet payroll obligations for that date due to overtime requirements during the holiday period. In December of 2020, a short-term variable loan of $ 1,150,000 was taken out by the organization to cover 2020 overtime costs and previous payroll shortfall from April 2020; this was approved by the Board on Nov 26, 2020, with the plan to repay this upon receipt of Ministry of Health funding. The $2.9M in one-time funding referenced above was received on January 29 along with the planned Ministry of Health revenue payment, returning MLHU to a positive operating position of $ 2.3M.

MLHU is launching a significant vaccine campaign for London and Middlesex that will require further investment in facilities (lease costs etc.), infrastructure (security systems, uninterrupted power sources, information technology etc.), supplies, and significant human resources. These expenditures will put additional pressure on the organization's cash flow, and the existing rotating credit facility is unlikely to be inadequate.

On January 25th, 2021, the Association of Local Public Health Agencies (alPHa) wrote a letter to the Honorable Peter Bethlenfalvy, Minister of Finance (Appendix C) urging the Ministry to provide, among other things, "Timely provision of [COVID-19] funds…" as this would be "far preferable than end-of-year reimbursements." It can be assumed that many health units in the province are struggling with the extraordinary financial commitments required for ongoing support of COVID-19 response which will certainly be magnified by the next phase of vaccine planning and distribution.

On February 3rd, 2021 a meeting with the Manager, Funding and Oversight at the Accountability and Liaison Branch of the Office of the Chief Medical Officer of Health was held to provide an overview of the current financial situation at MLHU and highlight concern with the 2020 reimbursement process. Confirmation that other health units are facing the same challenges was received, as was reassurance that a more frequent reimbursement process for COVID-19 related expenses will be undertaken by the Ministry of Health for 2021. Clarity on expectations for tracking costs was also provided and is consistent with MLHU current financial processes, ensuring MLHU is well-positioned to receive the funding required.

Next Steps

Three activities are being undertaken by MLHU to ensure the successful implementation of vaccine campaign and mitigation of the associated financial risk:

1) Submission of Q4 expenses via the SAR in February for reimbursement from Ministry of Health;
2) Completion of Ministry of Health funding templates as they are made available with respect to advanced funding and/or more frequent reimbursement cycles to support case and contact management and vaccine-related costs;
3) Engagement of MLHU financial institution to explore financing options available as a bridge to Ministry of Health funding to ensure the successful implementation of the vaccine campaign.

Conclusion

The COVID-19 response required by MLHU presents a significant challenge to the financial position of the organization. Ongoing efforts are underway to influence revenue timing from the Ministry of Health as well as ensure interim support from the organization's financial institution to ensure the successful implementation of the critical vaccine campaign.

This report was prepared by the Healthy Organization Division.

Dr. Chris Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

Dr. Michael Clarke
Interim CEO

MLHU Plan for Sustained COVID-19 Response

July 2020

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT
www.healthunit.com

Contents

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.

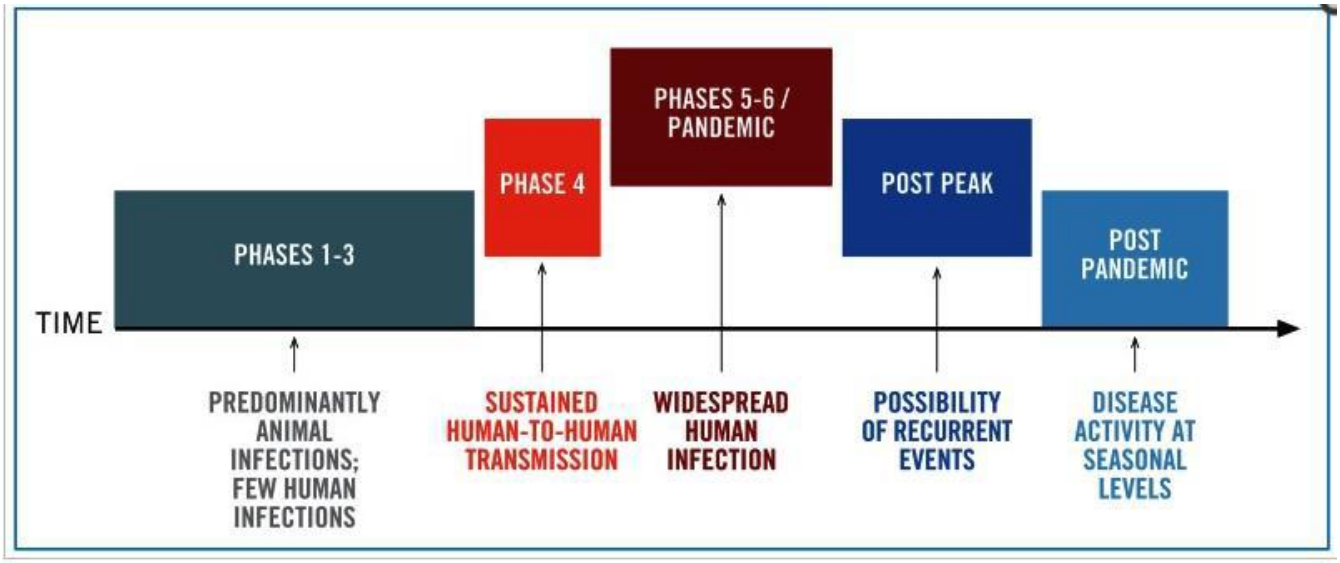


Figure 1: World Health Organization, Pandemic Influenza Preparedness and Response, 2009

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

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 measure 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 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 became 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

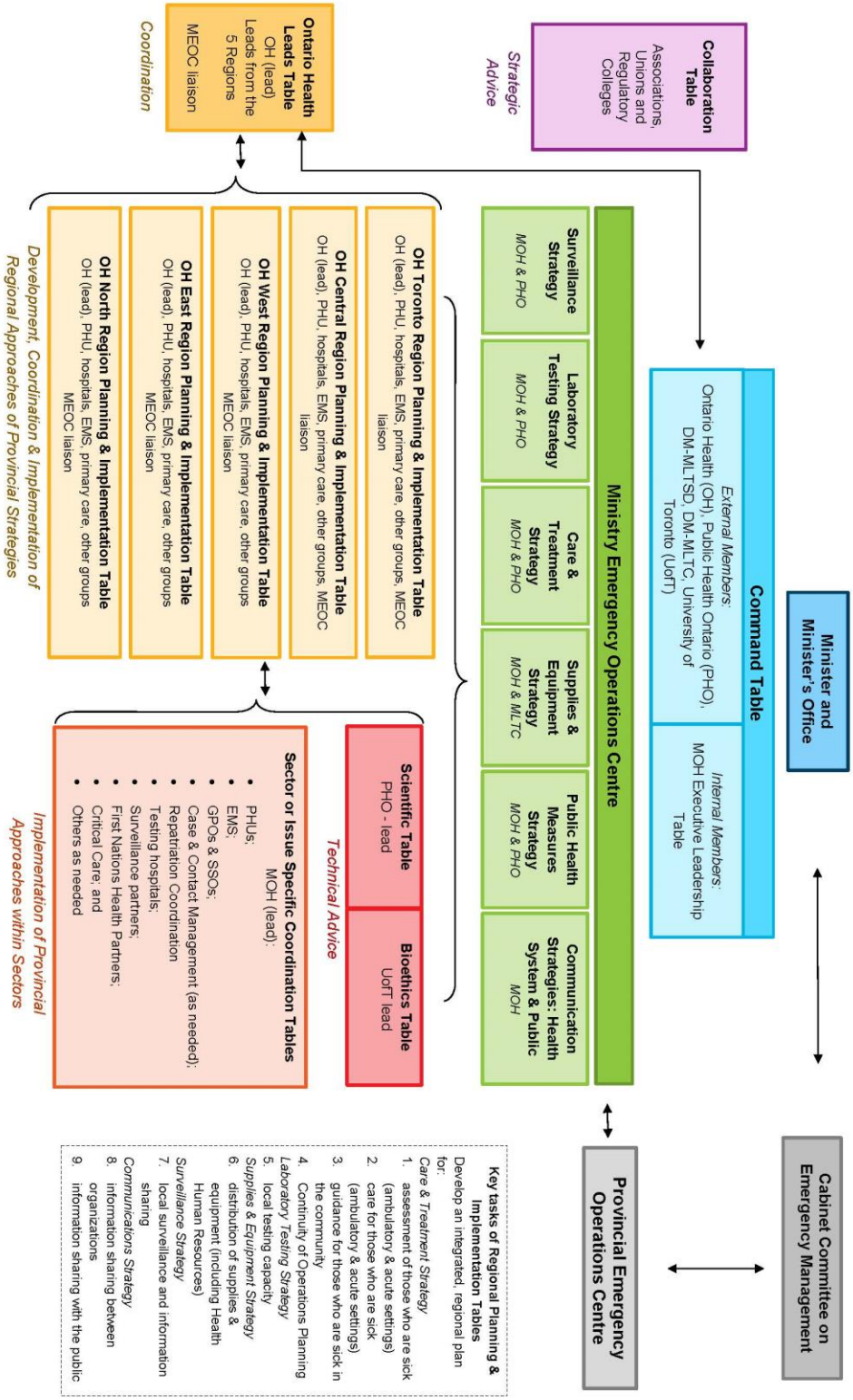
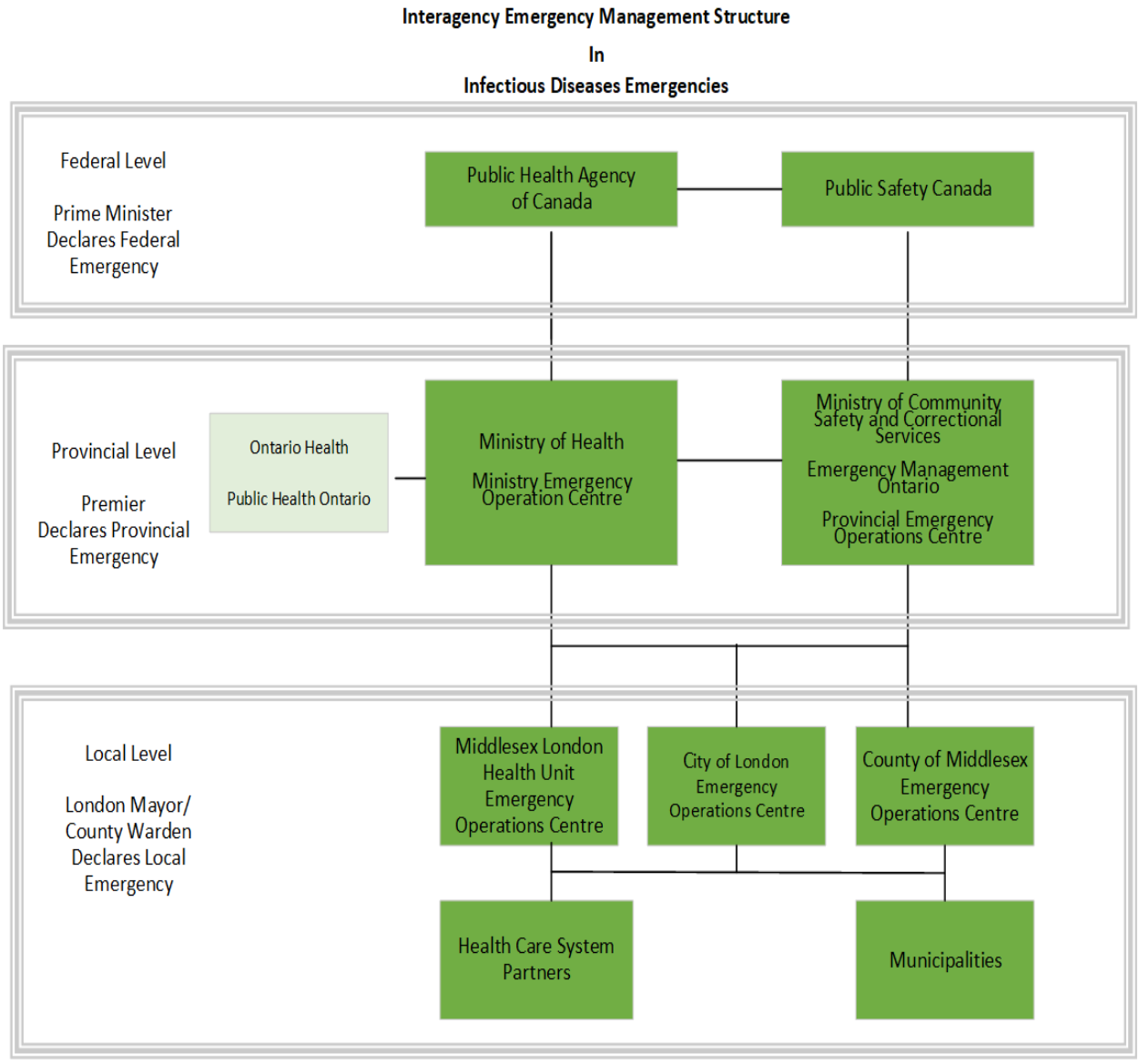


Figure 3: Inter-Relationship Roles

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

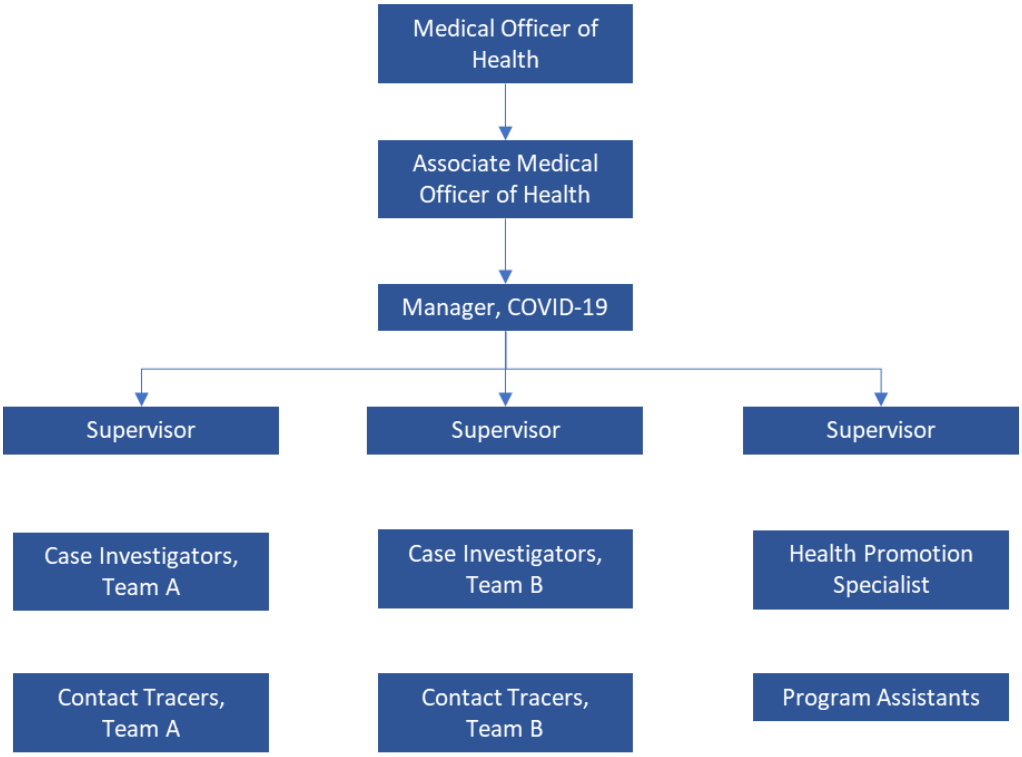
- Level Two – Program Surge
    - At Level Two, the following parameters apply:
        - Maximum 5 new cases/day
        - Total of 70 active cases
        - A small number of institutional outbreaks
        - Hours of Operation
            - Seven days per week
            - 9am to 8pm

- 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)

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 16th any travelers entering Canada were advised to self-isolate for 14 days. On March 18th 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.

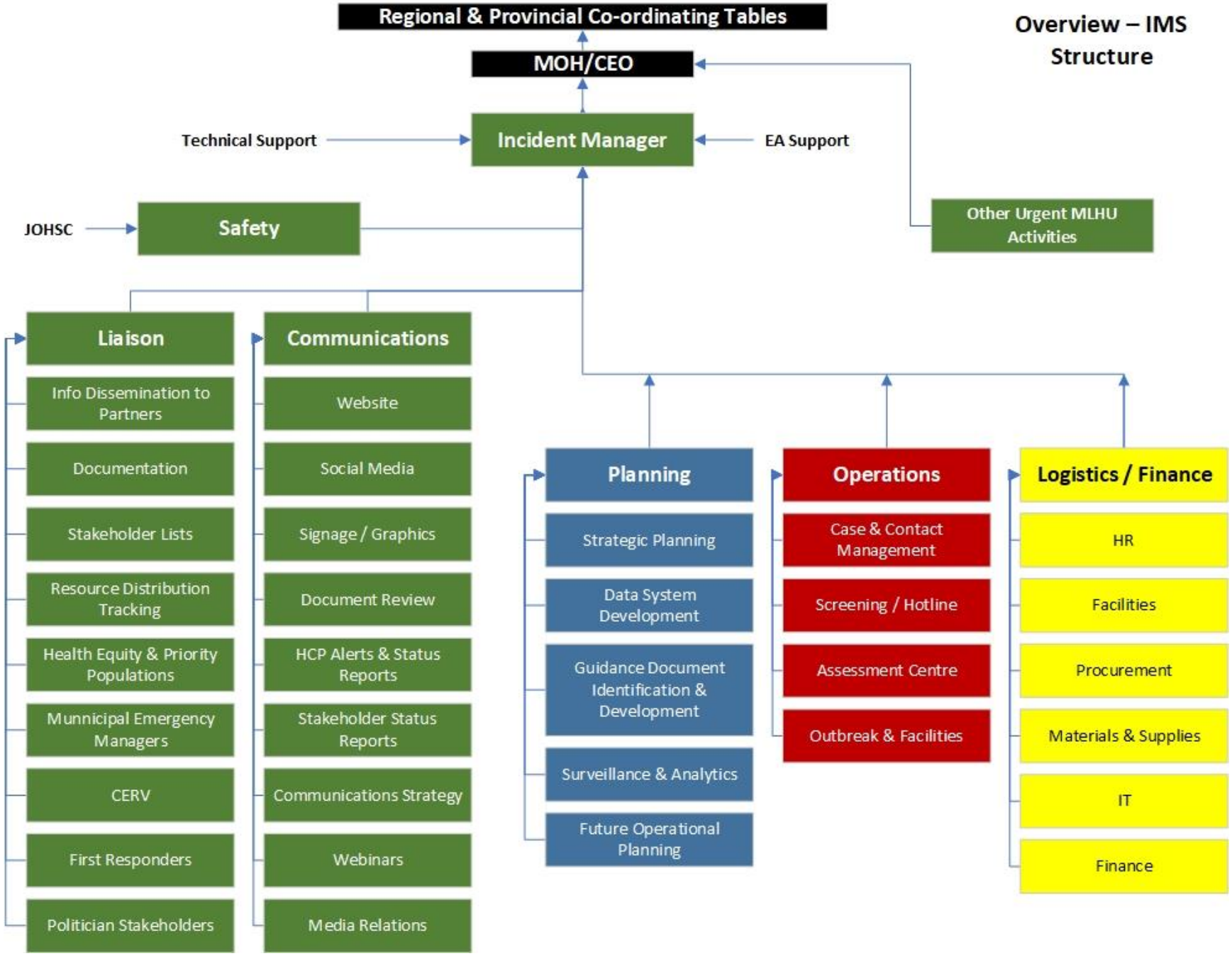
On March 16, 2020, shortly after the WHO declared COVID-19 as a pandemic (Phase 6), MLHU moved into full IMS mode. All non-urgent work ceased and most MLHU staff were seconded to support COVID related work. Staff were placed in positions within the IMS structure to help with the COVID response. As we 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.

Overview – IMS Structure



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

Table 1: COVID-19 First Wave IMS Structure	
Incident Commander (AMOH)	• Operationalized MLHU's response to escalating COVID-19 prevalence in the community; • Determined local pandemic strategy, and in consultation and approval from the MOH, implement said strategy; • Determined planning cycle timelines and objectives for the response • Provided technical advice and guidance to case and outbreak management; • Approved major and significant decisions relevant to overall redeployment response, in consultation with Senior Leadership Team and the MOH; • Appropriately delegated other decisions within the redeployment response; • In conjunction with the MOH, provided timely situational awareness for the organization and community; and • In conjunction with the MOH, liaised with the Ministry of Health, health care sector, and public health sector.
Liaison	• 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; • Assessed the COVID-19 risks for priority populations and ensured plans were in place to address health inequities; and • Informed Incident Commander of actions taken in conjunction with other agencies.
Health and Safety	• Ensured COVID-19 operations comply with the Occupational Health and Safety Act and the applicable regulations: • 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; • Engaged the Be Well Committee in applicable wellness programming and communications to enhance employee wellness; and • Engaged the Joint Occupational Health and Safety Committee in the assessment and mitigation of COVID-19, pandemic risks.
EOC Documentation	• Documentation and storage/filing of all COVID-19, Pandemic outbreak activities within the EOC folder S:MLHU/EOC and assisted with EOC setup.

Table 1: COVID-19 First Wave IMS Structure	
Planning (Surveillance & Reporting)	• Coordinated, managed and analyzed the collection of COVID surveillance data and information; • Developed epidemiological reports to inform Incident Command and other internal stakeholders; • Monitored trends in the incidence and prevalence of COVID to identify new or unrecognized exposures or risk factors; • Completed consolidated summary reports and Incident Action Plan and maintained incident documentation; and • Provided guidance to Incident Commander on activities to prevent or slow the spread of COVID-19.
Operations	• Coordinated and oversaw the COVID-19 Hot Line activities; • Coordinated and oversaw the activities of the COVID-19 Case and Contact Management; • Coordinated and oversaw the Outbreak and Facilities activities and • Initiated strike teams to address the needs of priority populations to address public health inequities.

Logistics/Finance	• Prepared and maintained facilities for expanded hours and implemented COVID-19 prevention measures;
	• Procured, distributed and maintained supply chain to support COVID-19 operations including:
	  ○ PPE
	  ○ Testing Swabs
	  ○ Technical Hardware
	• Developed staffing plans to support COVID-19 operations;
	• Developed, implemented, and supported technology infrastructure for COVID-19 operations; and
	• Monitored the cost of COVID-19 operations and number of hours worked by employees for each operational period.

Communication	• Ensured accurate and timely communication of COVID-19 to staff, community stakeholders and to the public; • Developed public and stakeholder information and maintained and supported media relations related to COVID-19; and • Ensured staff are using accurate and consistent messaging with their stakeholders, partners and specific audiences.

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.

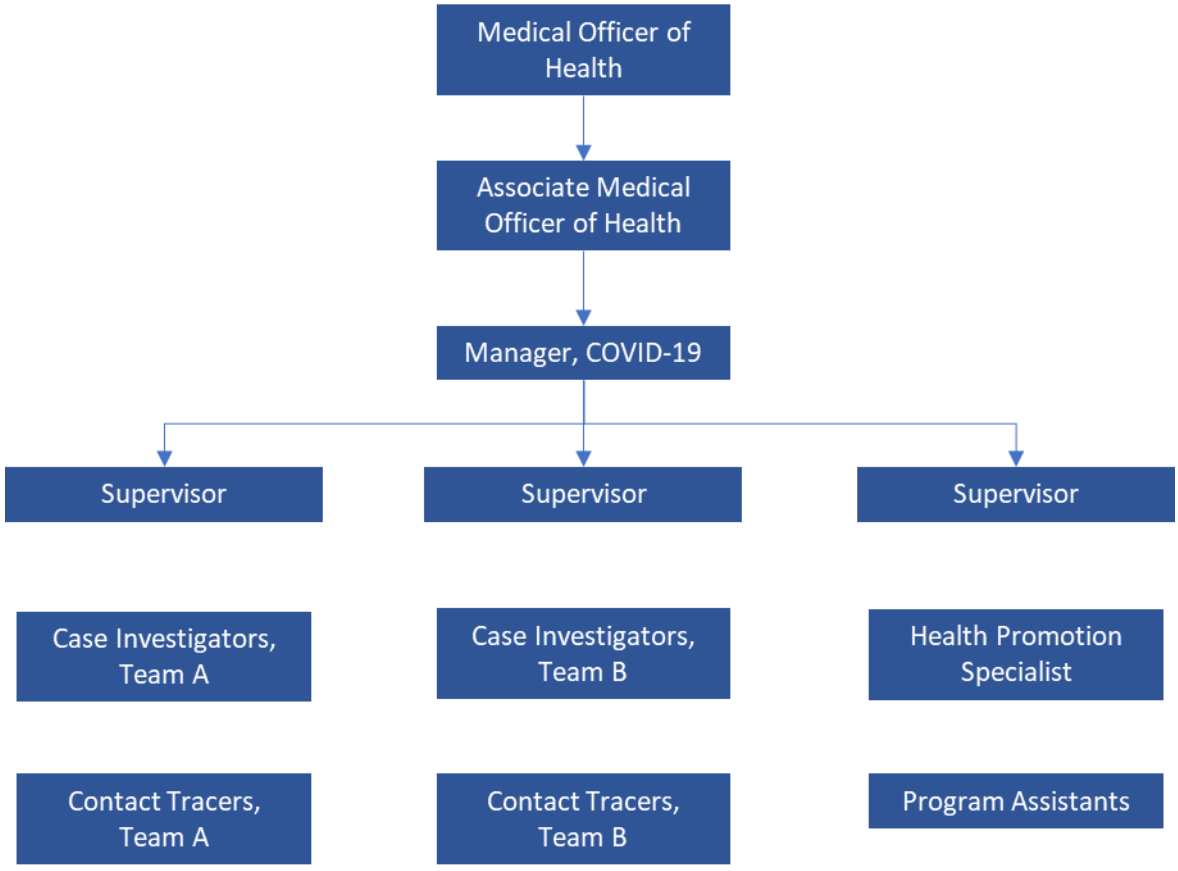
The COVID-19 program will also provide Tier Two telephone support for general inquiries from the public. The Client Service Representatives (CSR) will be the first line of contact for the public calling about COVID-19. Following a screening by the CSR, the caller will either be provided with the information 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	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. 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.
Supervisor, COVID-19	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. 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. 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. The Supervisors are also responsible for the day-to-day scheduling and attendance management of the staff assigned to their interventions.
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	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. 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. Strong consideration should be given to having a pool of Contact Tracers with a wide range of fluent languages.
Program Assistant	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.
Health Promotion Specialist	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.

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	Documentation 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

Assumptions

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	**Minimum viable staff per day**		**Total FTE**
Case Follow-up - High Risk	45	**Case Investigator**	**19.6**	**19.6**
Case Follow-up - Low Risk	30	**Contact Tracer**	**0.0**	**0**
Case Discharge	30			
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	Documentation 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

Assumptions

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
Case Follow-up - Low Risk	30
Case Discharge	30
Contact Follow-up - High Risk	15
Contact Follow-up - Low Risk	15

Minimum viable staff per day		**Total FTE**
Case Investigator	**7.4**	**14.8**
Contact Tracer	**12.0**	**23.9**

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	Documentation 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

Assumptions

10	**New Cases Per Day**	Hr / Day		10
140	**Total Active Cases**	Days / Week		7
5	**Contacts Per Case**	Staffing Factor		2
700	**Total Active Contacts**	% of Cases that are high risk		50%
		% of Contacts that are high risk		50%

		Minimum viable staff per day		**Total FTE**
Case Investigation First Call	60	**Case Investigator**	**14.8**	**29.7**
Case Follow-up - High Risk	45	**Contact Tracer**	**12.0**	**23.9**
Case Follow-up - Low Risk	30			
Case Discharge	30			
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	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

Appendix B

Monthly Cashflow Analysis		
Day of Month	**Description**	**Amount**
1	Municipalities	558,714
15	Municipalities	109,000
15	MOH	1,058,431
15	MCCSS	103,471
29	MOH	1,058,431
29	MCCSS	103,471
	Cash Receipts	**2,991,518**
1 - 7	A/P (incl. rent)	-334,816
10	Payroll	-1,050,000
8 - 14	A/P	-177,259
15 - 21	A/P (incl. Canada Life)	-209,700
25	Payroll	-1,050,000
22 - 30	A/P (incl. OMERS)	-519,337
30	Loan repayments	-21,727
	Disbursements	**-3,362,839**
Net monthly cash flow		**-371,321**

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January 25, 2021

The Honourable Peter Bethlenfalvy
Minister of Finance
c/o Budget Secretariat
Frost Building North, 3rd floor
95 Grosvenor Street
Toronto ON M7A 1Z1

Also submitted via e-mail: submissions@ontario.ca

Dear Minister Bethlenfalvy,

Re: Spring 2021 Budget consultations

On behalf of the Association of Local Public Health Agencies (alPHa) and its member Medical Officers of Health, Boards of Health and Affiliate organizations, I am writing to provide input for your consideration as you prepare the spring 2021 Budget for continuing Ontario's COVID-19 response and recovery.

Every Ontarian continues to be deeply affected by the ongoing COVID-19 pandemic and we understand that this will continue to be the foundation for the decisions you will make about how to invest Ontarians' tax dollars in the coming year. We also understand the importance of striking a balance between protecting people from the direct effects of the coronavirus and protecting Ontario's economy from the secondary ones. A healthy economy and healthy people are interdependent, and Ontario's public health sector is a critical link.

During the first two phases of Ontario's COVID-19 Action Plan, there has been a strong commitment to providing financial certainty and resources to public health units to support a robust response to local incidences and outbreaks of COVID-19, in keeping with our fundamental duty to protect the health of the people in our communities. We reiterate that such a commitment needs to be made permanent and sustainable if our public health system is to carry out its health protection and promotion duties, both routine and extraordinary.

Ontario appears to be near the peak of a dramatic but expected resurgence of cases, which is having devastating effects on elderly Ontarians living in congregate settings and is threatening to overwhelm our health care system. Nearly all our member health units' resources have been redirected to the COVID response, with case & contact management, outbreak response, provision of guidance and direction to municipalities, businesses, and other community organizations, and planning for the vaccine rollout pre-empting virtually all other mandated activities.

These response activities must obviously continue, but with no immediate end in sight for this pandemic, we need to return some focus to our obligations under Ontario Public Health Standards, which are equally important to protecting the health of all Ontarians. A COVID recovery will not be possible without meaningful investments in local public health and the central supports that it relies on.

Immediate Needs:

Immediately reverse the change to the provincial-municipal public health cost-sharing formula

The decision to implement sudden and arbitrary changes to the provincial / municipal cost-sharing formula for public health units has resulted in undue hardship for Ontario's obligated municipalities, as illustrated by the need for provincial mitigation funding to offset the increase. We are therefore urging that the Province immediately restore the previous 75% - 25% split with assurances that no further changes will be made without extensive analysis and consultation.

Harmonize funding announcements and their allocation.

The commitment of $100 million to public health units (PHUs) that was communicated earlier in the pandemic response (*COVID-19 Extraordinary Expenses*) and another $50 million for hiring 500 school-focused public health nurses were examples of welcome announcements, but additional certainty about eligibility, specifics about allocation and timing needs to accompany them. Timely provision of these funds with clear eligibility criteria would be far preferable than end-of-year reimbursements. The latter approach places the onus for extraordinary expenditures on boards of health without any assurances that they will be compensated in full. It also exacerbates the complexities of reallocating already scarce available funds.

We are therefore urging the immediate provision of the previously announced funding allocations to PHUs for *COVID-19 Extraordinary Expenses* and for the *School-Focused Nurses,* and consideration of mechanisms in the Fall Budget to do likewise with any new announcements.

Health Equity Pandemic Planning

We now know that COVID-19 has disproportionately affected communities with lower socioeconomic status. Striking the balance between reducing the transmission of COVID-19 and maintaining the economy in all of Ontario's communities will require a targeted strategy to address the higher rates of infection, hospitalization and death among lower-income people, racialized communities, and essential workers. Collecting, analyzing and acting on data (e.g. case rates and percentage of positive tests) within marginalized / at-risk populations to ensure that these rates are not significantly different from the rest is imperative.

Longer term considerations: Preservation of Public Health Core Functions

Many of Ontario's public health units have diverted up to 90% of their available resources to the pandemic response, even after significant expansions and reallocations at the staff level. This diversion has come at the expense of many of the routine programs and services that are required under the Ontario Public Health Standards, which are also the foundation for their Annual Business Plans and Accountability Agreements.

Recognizing that the COVID-19 emergency is likely to be a public health preoccupation for the foreseeable future, attention needs to be turned to restoring capacity to return to routine health protection and promotion activities within our communities. Examples include the Healthy Babies, Healthy Children program, which provides outreach to vulnerable families; school vaccination programs; smoking cessation supports; food safety inspections; and the wide range of other activities that are aimed at preventing chronic diseases, which remain responsible for the majority of deaths in Ontario and account for over $10B in direct health care costs with total economic burden of over $20B[i].

Restoring this capacity is comparable to ensuring that hospitals have the capacity to provide essential surgeries and diagnostic procedures while maintaining capacity to respond to COVID-19.

This crisis has proven the worth of local public health and demonstrated that a healthy economy is not possible without healthy people. The imperative of sufficient, stable, and predictable investments to ensure that Ontario's boards of health can carry out the comprehensive range of health promotion and protection programs and services that are outlined in the Ontario Public Health Standards is clear, and plans should be made for a comprehensive review of the public health response after the emergency is over.

For your further consideration, the following is an adapted version of the recommendations that we submitted as part of the 2019 and 2020 pre-budget consultations, which speak to the routine but critical public health functions that should be able to continue alongside the extraordinary ones.

Public Health is on the Front Line of Keeping People Well

alPHa's members are the medical officers of health, members of boards of health and managers of the major public health programs. These are the people on the front lines of delivering the programs and services that prevent disease and promote health in every community in Ontario. For more than 180 years, Ontarians have enjoyed a strong, locally based public health system that puts their health and wellbeing at the front and centre. The integrity of Ontario's public health system must be maintained and reinforced with assurances from the Province that it will continue its funding commitment to cost-shared programs and make other strategic investments that address the government's priorities of improving services and ending hallway medicine.

Public Health Contributes to Strong and Healthy Communities

Boards of health in each of Ontario's public health units provide programs and services that are tailored to improve the health of the entire population starting with addressing needs at the local level. In so doing, they form the local foundation of a province-wide system that works "upstream" to address risks to health thereby reducing the demand on and costs to the health care system. These activities are outlined and mandated in the *Ontario Public Health Standards: Requirements for Programs, Services and Accountability* under the Health Protection and Promotion Act and fall under the following categories:

- Chronic Disease Prevention and Well-being
- Food Safety
- Healthy Environments
- Healthy Growth and Development
- Immunization
- Infectious and Communicable Diseases Prevention and Control
- Safe Water
- Substance Use and Injury Prevention

Four "Foundational Standards" ensure that population health assessment, a focus on health equity, effective public health practice through quality assurance and transparency, and emergency management are considerations in each of these categories.

Boards of health tailor the requirements to meet local needs in collaboration with a wide array of community partners (local medical/health care communities, municipalities, school boards, etc.) or develop new programs to address the specific health needs of their communities.

Public Health Delivers an Excellent Return on Investment

Public Health makes a critical contribution to alleviating pressures on our hospitals and doctors' offices, by delivering programs and services that keep people from becoming ill in the first place. While it is difficult to accurately measure the impacts (one cannot count the number of outbreaks that didn't happen because of a vaccine campaign or cases of food poisoning that were prevented through regular inspection of restaurants), studies have nonetheless demonstrated that public health interventions are good value for money and an excellent return on investment.

The following are only a few examples of the return on investment in public health:

- Every $1 spent on immunizing children with the measles-mumps-rubella vaccine saves $16 in health care costs.
- Every $1 invested in community water fluoridation yields an estimated $38 in avoided costs for dental treatment.
- Every $1 spent on mental health and addictions saves $7 in health costs and $30 dollars in lost productivity and social costs.
- Every $1 invested in tobacco prevention programs saves up to $20 in future health care costs,
- Every $1 spent on early childhood development and health care saves up to $9 in future spending on health, social and justice services.

Public Health is an Ounce of Prevention that is Worth a Pound of Cure

The 2017 report of the Auditor General of Ontario (AGO) contained a chapter on the Ministry of Health and Long-Term Care's (MOHLTC) Chronic Disease Prevention program, which concluded that most chronic diseases (e.g., diabetes, cancer, etc.) are preventable, or their onset can be delayed by addressing physical inactivity, smoking, unhealthy eating and excessive alcohol consumption. The Institute for Clinical Evaluative Sciences estimated that 22% of the Province's spending on health care was attributable to those four modifiable risk factors associated with chronic diseases, which totaled $90 billion in health care costs, including hospital care, drugs and community care, between 2004 and 2013.

The Ministry's own estimates conclude that major chronic diseases and injuries accounted for 31% of direct, attributable health care costs in Ontario. Preventing chronic diseases not only helps to reduce the financial burden on the health care system but it also creates a better quality of life that in turn supports individuals' ability to contribute to vibrant communities and a strong economy. Public Health leads in reducing the modifiable risk factors behind chronic disease and injury. The effective execution of this role is limited only by its capacity.

Public Health is Money Well Spent

Boards of health budgets are paid for by their respective obligated municipalities in accordance with the Health Protection and Promotion Act (HPPA) with the Ministry of Health providing offsetting grants of approximately 70 cents on the dollar for mandatory programs.

According to the 2018-19 Ministry Expenditure Estimates, the operating estimate for the entire Population and Public Health Program (which includes internal Ministry expenses, funding for Public Health Ontario and the local grants) was $1.267 billion, or about 2% of the total Ministry operating expenses. We believe that this demonstrates the tremendous value of Ontario's system of local public health given its significant impact on the health of the people of Ontario.

Having applied the lessons learned from several public health crises that emerged in Ontario in the first decade of the new millennium (the Walkerton tragedy (2000), SARS (2003) and pandemic influenza (2009) and now the ongoing COVID-19 emergency, the value of Ontario's public health system is more clearly understood, as is the importance of investing in it to ensure that it remains robust, integrated, cost-effective, and accountable.

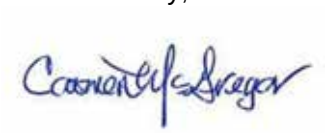
We have demonstrated that modest investments in the public health system can generate significant returns, including better health, lower costs, and a stronger economy. We believe first and foremost that the integrity of Ontario's locally based public health system should remain intact. In addition, we believe that an explicit commitment to the ongoing provision of the 75% provincial share of public health funding along with additional strategic investments in the public health system will address your Government's priorities of improving services, ending hallway medicine, and addressing Ontario's fiscal challenges.

Public Health's broad efforts in the areas of health protection and promotion and disease prevention touch upon where we live, work and play, improving our quality of life and promoting healthy communities across the province. Further investments in these efforts will only strengthen their contributions to your Government's goals of cutting hospital wait times and ending hallway health care, improving the delivery of government programs and services, and even putting money back in people's pockets by keeping them healthy and able to contribute to the prosperity of the Province of Ontario.

As for specific investments in the fight against COVID-19, we expect that you will continue to make the most appropriate decisions to maximize our collective ability to protect the people of Ontario from the virus, prevent harmful indirect consequences, and support the recovery of our economic and educational sectors that have so many positive impacts on other aspects of physical and mental health.

In closing, thank you for the opportunity to present this information as you deliberate on how Ontarians' tax dollars are to be spent. We would be pleased to discuss our submission with you further. To schedule a meeting, please have your staff contact Loretta Ryan, Executive Director, alPHa, at loretta@alphaweb.org or 416-595-0006 ext. 222.

Yours sincerely,



Carmen McGregor,
alPHa President

COPY:
Hon. Doug Ford, Premier of Ontario
Hon. Christine Elliott, MPP, Deputy Premier and Minister of Health
Hon. Todd Smith, Minister of Children, Community and Social Services
Helen Angus, Deputy Minister, Health
Dr. David Williams, Chief Medical Officer of Health
Alison Blair, Associate Deputy Minister, Pandemic Response and Recovery
Matt Anderson, CEO, Ontario Health

Encl: Pre-Budget Deposition Jan. 25, 2021 Speaking Notes

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[i] Public Health Ontario, July 2019: Burden of Chronic Diseases in Ontario. Retrieved from https://www.publichealthontario.ca/en/data-and-analysis/chronic-disease/cdburden#:~:text=The%20total%20annual%20economic%20burden,inadequate%20vegetable%20and%20fruit%20consumption.

Association of Local Public Health Agencies
Speaking Points
Ministry of Finance
Re: 2021 Ontario Budget
Monday, January 25, 2021

- Good afternoon, Minister Bethlenfalvy and team.

- I am Dr. Robert Kyle, Past-President of the Association of Local Public Health Agencies, better known as alPHa, and Durham Region's Medical Officer of Health.

- alPHa represents all of Ontario's 34 boards of health, medical officers of health (MOHs) and senior public health managers in each of the public health disciplines – nursing, inspections, nutrition, dentistry, health promotion, epidemiology and business administration.

- As you may know, in essence, the work of public health is organized in the Ontario Public Health Standards as follows:

    - Chronic Disease Prevention and Well-Being
    - Emergency Management
    - Food Safety
    - Health Equity
    - Healthy Environments
    - Healthy Growth and Development
    - Immunization
    - Infectious and Communicable Diseases Prevention and Control

  - Population Health Assessment
  - Safe Water
  - School Health
  - Substance Use and Injury Prevention

- In January 2019, in the alPHa Pre-Budget Submission, alPHa noted that:

  - Public Health is on the Front Line of Keeping People Well.
  - Public Health Delivers an Excellent Return on Investment.
  - Public Health is an Ounce of Prevention that is Worth a Pound of Cure.
  - Public Health Contributes to Strong and Healthy Communities.
  - Public Health is Money Well Spent.

- Furthermore, alPHa recommended that:

  - The integrity of Ontario's public health system be maintained.
  - The Province continue its funding commitment to cost-shared programs.
  - The Province make other strategic investments, including in the public health system, that address the government's priorities of improving services and ending hallway medicine.

- As regards to this last point, Public Health's contribution to ending hallway medicine is summarized in alPHa's Public Health Resource Paper.

- Despite the above, at a prescient moment of things to come, on January 17, 2020, in its appearance before the Standing Committee on Finance and Economic Affairs, alPHa noted that "the Office of the Chief Medical Officer of Health has recently noted, the Public Health Agency of Canada is tracking a novel coronavirus outbreak in Wuhan, China; as our experience with SARS demonstrated, infectious diseases "know no borders".

- Throughout 2020, alPHa's members have distinguished themselves by leading the pandemic response locally. Of course, our members' workforces have an abundance of "unsung heroes" from a wide variety of backgrounds including associate/medical officers of health, public health inspectors, public health nurses, etc.

- As an example, Durham Region is Ontario's 5th largest Public Health Unit (PHU); its #PublicHealthProtects infographic illustrates the reach of its pandemic response.

- alPHa values and appreciates Ontario's leadership, guidance and support throughout the pandemic response, including financial support for its pandemic-related extraordinary costs.

- Despite the above, a "cloud" still sits over our members' heads and it is one that cannot be ignored.

- In Ontario budget 2019, it was announced that provincial funding to PHUs would be cut by 25% over a three-year period.

- On September 11, 2019, the Ministry of Health confirmed the cost-sharing formula for public health would change to 70% provincial/30% municipal to be applied to almost all mandatory public health programs and services.

- On August 19, 2019, the Premier announced at the AMO Conference, and which alPHa welcomed, municipalities would be receiving one-time transitional funding to limit the increase in costs borne by municipalities in 2020 to no more than 10%.

- Despite this, in 2019, many boards of health reported that they had to draw on their reserves to ease the financial burden that this decision has placed on their obligated municipalities.

- Ontario should ensure public health receives the robust funding necessary to protect public health programs and services whose value was demonstrated previously during SARS and the H1N1 pandemic and is currently being demonstrated during the COVID-19 pandemic. A COVID-19 recovery will not be possible without meaningful investments in local public health and the central supports that it relies on. A healthy economy is not possible without healthy people.

- With all the foregoing in mind, alPHa calls upon Ontario, once again, to do the following:

    - Ontario should restore the previous provincial-municipal cost-sharing (75/25) formula for public health and, at the very least, make no further changes to the current (70/30) formula, permanently.

    - Ontario should continue to invest in public health operations and capital, including 100% funding for priority programs, such as Infectious and Communicable Diseases Prevention and Control, and Immunization.

- The above recommendations are fleshed out and expanded upon in more detail in the accompanying written submission.

    - In closing, as the pandemic continues, alPHa's members are poised to lead local efforts to implement Ontario's COVID-19 Vaccine Distribution Plan, in addition to the ongoing pandemic response.

    - As you know, with respect to so-called "Public Health Modernization", on November 18, 2019, the Ministry of Health launched renewed Public Health consultations and released a Discussion Paper.

    - alPHa is pleased that the consultations were suspended during the pandemic.

- If Ontario plans to resume Public Health Modernization once the pandemic is controlled, alPHa urges that a reasonable period of recovery and reflection ensue before engaging our members in the consultation process. Our members are completely and utterly exhausted.

- Thank you for your attention. I would be pleased to answer any questions.

Check against delivery.

For an online version of these remarks and the corresponding submission, including access to links, please go to: https://www.alphaweb.org/page/alPHa_Letters