Advisory Committee Meeting – Presented at

Haldimand Council – October 06, 2020

Board of Health Meeting – October 06, 2020

Subject:	COVID-19 Update and Sustainability Plan
Report Number:	H.S.S. 20-18
Division:	Health and Social Services
Department:	Haldimand Norfolk Health Unit
Purpose:	For Decision

Executive Summary:

The response to the COVID-19 pandemic has been unprecedented and is expected to remain as the major focus for public heath for the next 18-24 months. The province has recently recognized the beginning of the second wave and we anticipate that the HNHU will see an increase in cases.

For the past six months the Haldimand Norfolk Health Unit (HNHU) has managed this pandemic utilizing redeployed county and public health staff. The emergency response to the pandemic has taken a considerable toll on the staff, especially public health staff; such as increased working hours, and difficulty maintaining an appropriate work-life balance. This is not sustainable in the long term.

As the province reopens, the health unit must address COVID-19 proactively while resuming mandatory public health services geared towards protecting and improving the population health of the communities. To achieve these objectives additional staffing is required as county and public health staff can no longer be redeployed to solely focus on COVID-19 tasks. To further mitigate the human impact of the response to the pandemic, the implementation of an Electronic Medical Records (EMR) solution will improve efficiencies, and reduce the risk of a catastrophic failure if the HNHU has a COVID-19 outbreak in the workplace.

In this context, additional staff and resources are required to continue the efforts to contain COVID-19. Therefore, the HNHU is requesting a COVID-19 response team of 30 temporary FTEs as well as an electronic medical records (EMR) solution. Grants for extraordinary costs have been submitted to the Ministry of Health (MOH), inclusive of the above request.

In summary, this ask of resources has been made to reduce risks to both counties from

the COVID-19 threat; while maintaining our required health services. This ask has been undertaken with due regard to financial positions of the two counties and the taxpayers.

Discussion:

On March 11, 2020 the World Health Organization (WHO) declared COVID-19 a global pandemic. Norfolk County and Haldimand County declared a state of emergency on March 24, 2020. On March 26, 2020 the Haldimand Norfolk Health Unit (HNHU) announced its first confirmed case of COVID-19. The HNHU has since experienced two of the largest outbreaks in the province, the first in March at a Long Term Care and Retirement Home and the second in June on a farm enterprise. As of September 28, 2020, the HNHU has had 491 confirmed COVID -19 cases and 32 COVID-19 related deaths.

The HNHU provides provincially mandated services to approximately 110,000 residents in the counties of Haldimand and Norfolk. A high proportion of these residents are over 65 years of age (Norfolk County 22.5% and Haldimand County 18.1%). This proportion is higher than Ontario's 16.7%. The counties are home to 18 Long Term Care and Retirement homes. This population group is considered highly vulnerable to the illness and death.

The counties of Haldimand and Norfolk also welcome approximately 4,000 migrant farm workers annually. These migrant farm workers reside in over 600 bunkhouses on local farms. The living arrangements at the bunkhouses creates an environment that facilitates the rapid and sustained transmission of the virus to susceptible migrant farm workers. There are approximately 5,000 Low-German Speaking residents living within the jurisdiction of the HNHU. This population travels between Ontario and Mexico; international travel is a high risk activity for COVID-19 transmission.

Haldimand County and Norfolk County have limited acute medical resources. In total, there are less than 10 intensive care unit beds across our jurisdiction. As well, there are less than 100 physicians practicing in both counties. In this context, a large number of COVID-19 cases is likely to strain the healthcare system.

COVID-19 Response Requirements

Since March 2020, the public health focus has been on COVID-19 response**.** Substantive resources have been redeployed to carry out critical operations over the past 6 months. Staffing complement includes over 80 public health staff 17 redeployed county staff, 10 additional new staff, and the support of both counties' Emergency Operating Centres (EOC). The total compensation costs to manage COVID-19 response for this period is $ 4,205,373, as illustrated in Table 2 below. We anticipate that the COVID-19 response will continue or increase for at least the next 18-24 months. The following tables and figures illustrate the points being made.

- Table 1 provides a snapshot of some of the activities carried out between March 7 and September 4, 2020 as part of COVID-19 response.
- Figure 1 shows the trend of the activities count over the same time period.
- Figure 2 shows the trend of FTEs utilized for COVID-19 response over the same time period

- Figure 3 shows the relationship between FTE utilization and the activities count over the same time period
- Table 2 provides the breakdown of compensation costs associated with managing the COVID-19 response over the same time period

Table 1: COVID-19 Response Tasks from March 7 to September 4

Tasks	**Count of Tasks Performed**
Person Under Investigation (PUI) managed	5956
Hotline calls	9333
Environmental Health Team (EHT) calls	4405
Positive cases managed	483
COVID-19 Test Booking	3947
Isolation Plan Approvals	456
Number of arrival groups	679
Virtual Inspections	172
Migrant Farm Workers (MFWs) Illness Reports	32
Inspection Audits	369

Table 1 shows that during period under review 9333 hotline calls were received and responded to for COVID related inquiries. During the same period the team was able to successfully manage 5956 PUIs. The team was able to book 3947 COVID 19 tests for community members. The tasks are those tracked and quantified. Time spent in meetings, trainings, huddles, case conferences are not captured.

Figure 1: COVID 19 Response Tasks from March 7-September

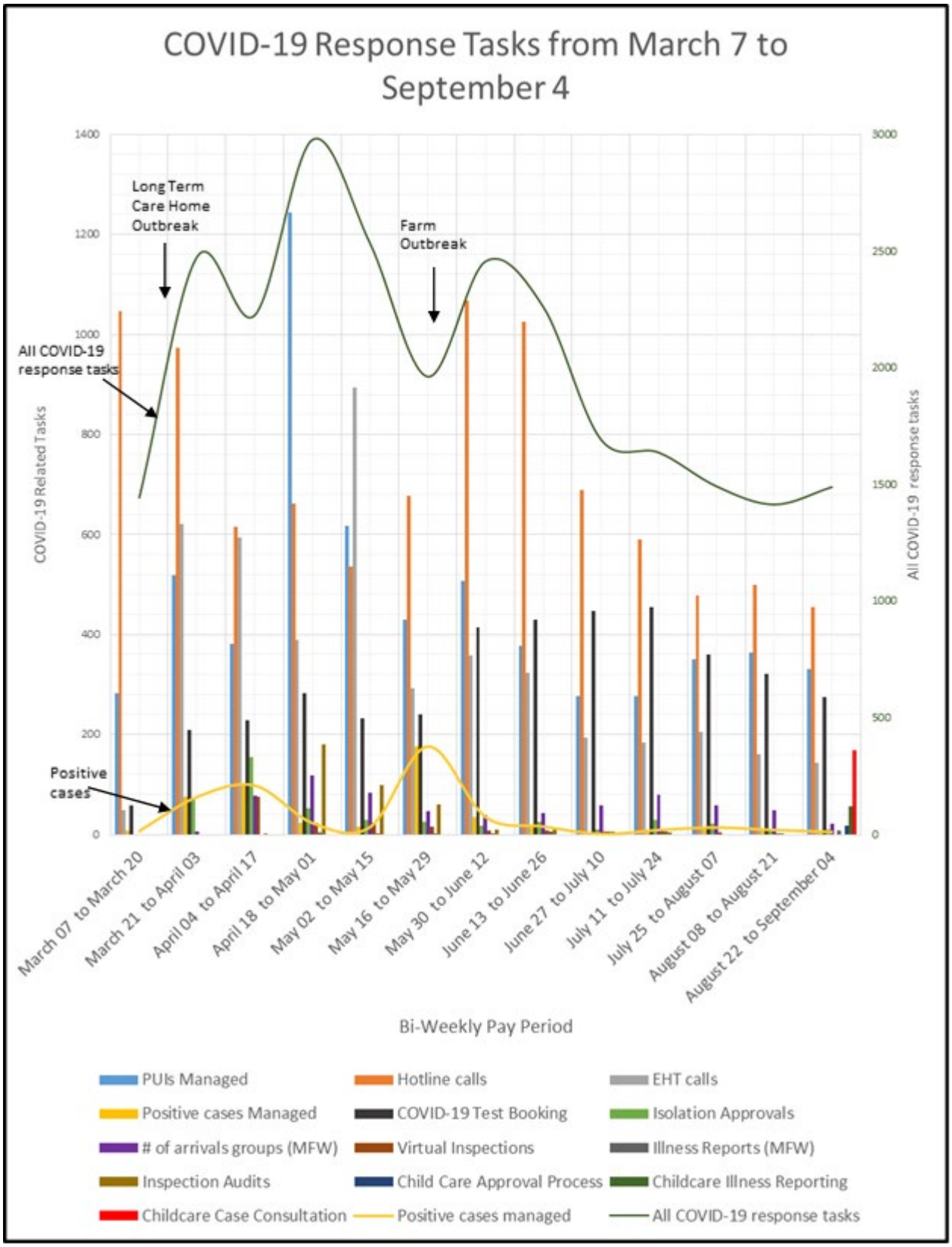


Figure 1 shows the number of times all COVID-19 related tasks were performed within a pay period. As would be expected, at the onset of the pandemic the health unit witnessed a high influx of hotline calls from community members inquiring about the virus. The figure also shows the periods when the health unit managed two significant outbreaks and the impact these outbreaks had on the COVID-19 related activities.

The peak of the COVID-19 related tasks is noted in late April and early May. A sudden increase in the number of hotline calls are also observed in May, 2020 which can be attributed to a farm outbreak within the health unit's jurisdiction. Since then, the number of calls have shown a steady decline. The Environmental Health Team (EHT) calls are observed to follow a similar pattern to the hotline calls. The trend of the COVID-19 related activities are also responsive to new events such as new provincial COVID-19 announcements. For example, the number of test booking requests managed by the health unit is observed to spike shortly after the May 14, 2020 provincial announcement to open COVID-19 testing to asymptomatic individuals.

It is also important to mention that the number of positive cases peaked in the bi-weekly period of May 16 – May 29, and the trend demonstrates a decline in the number of positive cases since that period. It is important to note that although positive cases are low, COVID -19 related tasks and associated work continues to remain high from June 27 – September 4.

The number of cases does not reflect the amount of work completed by the HNHU staff. In essence, low cases are a result of high work load in the efforts of COVID-19 containment.

The trend of the graph demonstrates some stability in the COVID-19 related tasks from July 25 – Sep 4. The bi-weekly data from this period of relative stability was used to project the COVID-19 task related functions going forward. Appendix-A shows the proposed FTE required to meet COVID-19 related tasks which is 30 FTEs.

Figure 2: COVID 19 FTEs Utilized Vs Public Health Budgeted FTEs

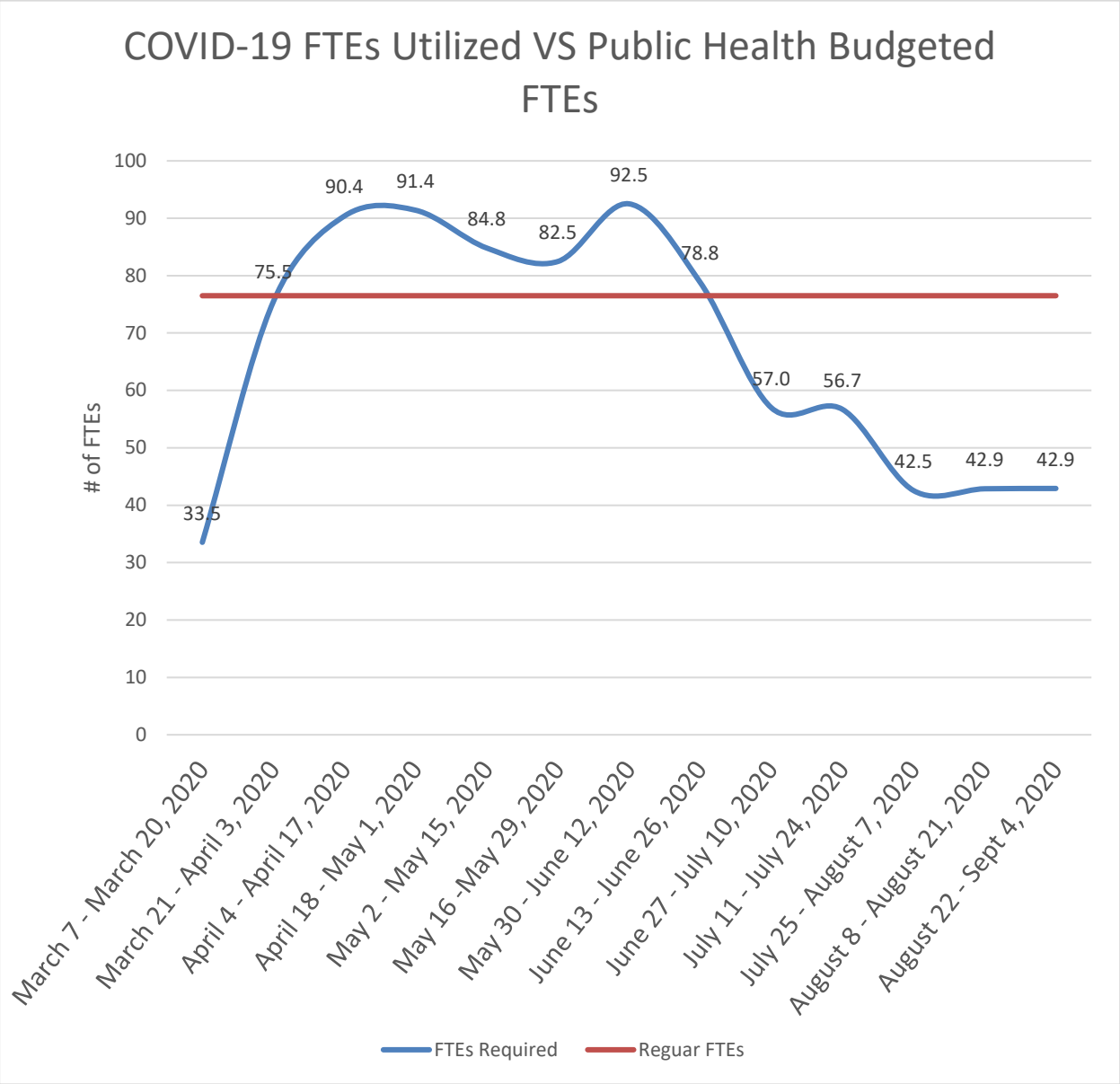


Figure 2 shows the number of FTEs deployed by the health unit in response to COVID-19. It can be observed that the peak level of FTEs (92.51) was deployed during the bi-weekly period of May 30 – June 12. This bi-weekly period corresponds to the period after a major COVID-19 outbreak was declared at a farm. The other peak (April 4 – April 17), corresponds to the period after an outbreak was declared at a Long Term Care Home. This graph reinforces the message that outbreak management processes require a significant mobilization of resources to manage. Resources well above our staffing complement, even assuming no other tasks are being implemented.

The graph also demonstrates that upon declaration of the emergency within the counties, the health unit was overwhelmed in managing the COVID-19 response with its' staffing

complement. Starting from the March 21 – April 3 bi-weekly pay period, the health unit had to mobilize additional resources from other sources to support its' COVID-19 response. Since the second outbreak, the health unit has not experienced any other major outbreaks and this is reflected in the decline in number of FTEs being deployed for the COVID-19 response. At the last bi-weekly period of August 22 – September 4, the current FTEs deployed for COVID response stood at 42.92, without an outbreak

Figure 3: COVID 19 Response Tasks from March 7 to September 4

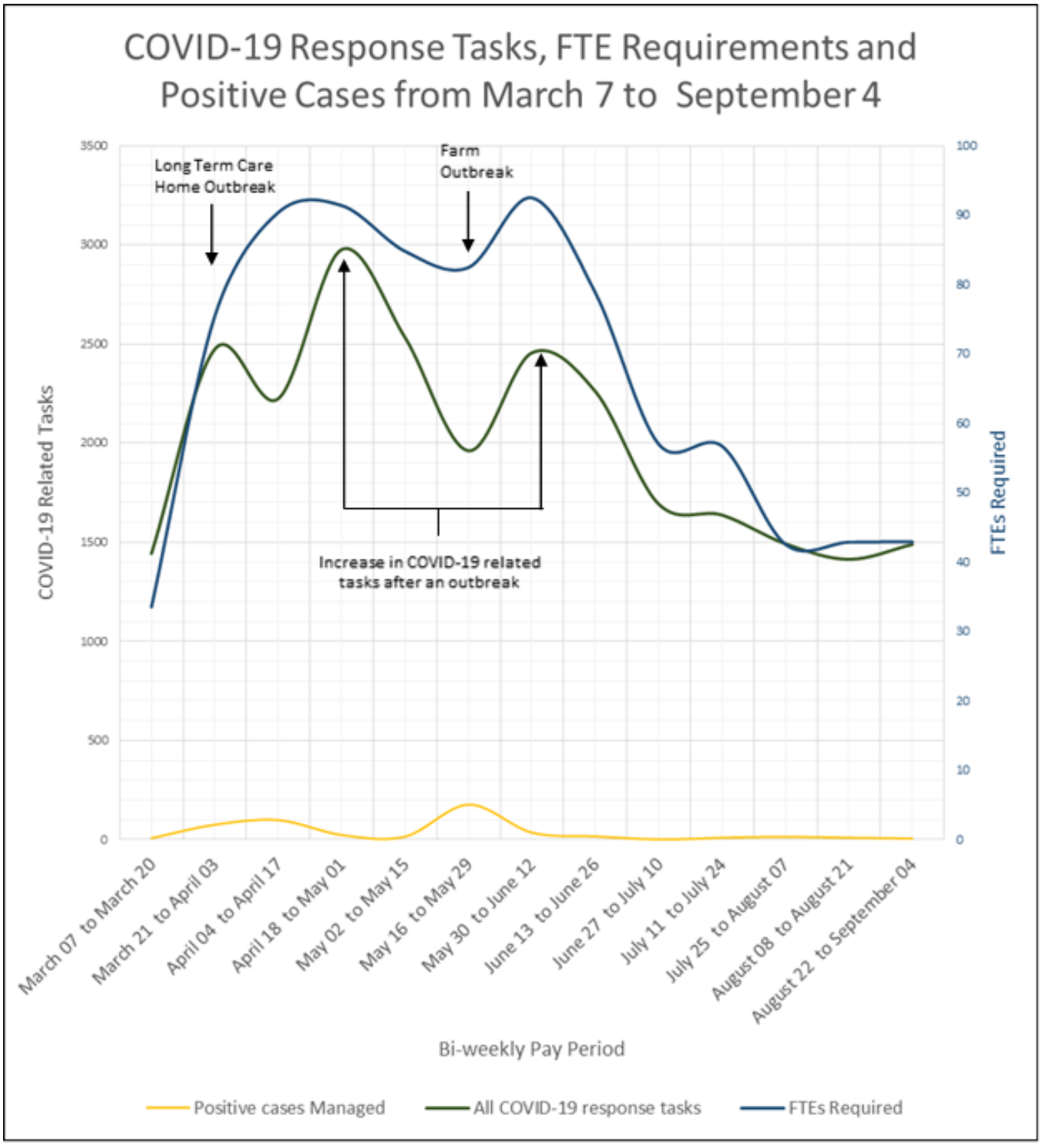


Figure 3 further shows the relationship between the COVID-19 related tasks and the number of FTEs deployed. The figure demonstrates a steady increase in both the number of COVID-19 related tasks and the number of FTEs deployed to respond to COVID-19. This graph also clearly shows an increase in tasks and FTE numbers after every outbreak declared by the health unit. As the province and the health unit were able to institute successful strategies to slow down the pandemic, the COVID-19 related tasks and FTEs tasked with the COVID-19 response fell. This decline appears to have stabilized.

Table 2: Total Compensation Costs related to COVID-19 - March to September 4, 2020

Cost Type	**Cost $**
Public health staff utilized from mandatory programs	2,807,372
Redeployed Staff*	289,926
Additional New Hired Staff*	165,539
Paid Overtime*	322,567
Actual Accrued Unpaid Overtime for Non-Union Staff*	427,227
Additional Part Time and Casual Staffing Costs*	192,742
Total HNHU Compensation Costs related to COVID-19	**4,205,373**

Note:*Additional costs

Table 2 provides the cost breakdown of the resources mobilized to manage the COVID-19 pandemic from March-Sept; from a health unit perspective only. Please note that as the activity levels for the COVID-19 response reduced, the redeployed staff have transitioned back to their home positions.

It is pertinent to note that as a result of the Ministry of Health (MOH) funding formula implemented in 2015, the current HNHU staffing compliment is very lean with limited to no base increases in FTEs over the previous years. Additionally, the recent 2020 budget shift in cost sharing formula resulted in a restructure and reduction of several FTEs.

In addition, with the reopening of the province, the health unit will need to restart the provision of mandatory programs and services to address all the drivers of population health. Therefore, with the current staffing resources the health unit is unable to concurrently manage COVID-19 pandemic activities while also providing mandatory program and services.

Mandated Public Health Programs and Services

The Board of Health is legislated to deliver programs and services as outlined in the Ontario Public Health Standards (OPHS) pursuant to the *Health Protection and Promotion Act (HPPA)*. During the pandemic response following mandated programs and services were halted;

- School based immunization (restarted in August off site)
- Oral health programming
- Health promotion programming and planning

- Vaccine fridge inspections
- Breastfeeding support
- Food safety and other environmental health programs
- Tobacco Enforcement
- Continuous Quality Improvement
- Comprehensive substance use strategy
- Strategic and operational planning

While, the following mandated programs and services were reduced;

- Healthy Babies, Health Children programming
- Harm Reduction initiatives
- Vector Borne Disease activities

Please note that HNHU continued to deliver programs and services that required 24/7 response time. For example adverse water reports, rabies investigations, complaints etc.

For the health unit mandated programs and services there are approximately 45 Accountability Indicators which are reported to ministry and are linked to our funding agreements.

Table 3 is a snapshot of a few key accountability indicators for 2020 that demonstrates the reduction in public health programs and services and the need to resume these legislated programs and services.

Table 3 – Accountability Indicators Performance

Accountability Indicators	2019 (up to Q3)	2020 (up to Q3)	% Variance
2.5. # of re-inspections for year-round food premises	137	40	**-71%**
2.6. # of food safety complaints received that triggered an investigation/inspection	12	7	**-42%**
4.1. # of school immunization clinics held by the BOH for the grade 7 school-based program including HBV, meningococcal, and HPV vaccines.*	82	21	**-74%**
4.3. # of HPV, meningococcal, and HPV vaccine doses administered to students.*	2130	997	**-53%**
4.4. # and percentage of premises that stored publicly funded vaccine that received their routine annual inspection	89%	47%	**-47%**
7.2. Number and percentage of elementary schools (offering JK, SK, and Grade 2) screened (dental)	100%	80%	**-20%**
7.3. Number and percentage of JK, SK, and Grade 2 students screened (dental)	89%	70%	**-21%**

The public health unit will be restarting programs this fall and is anticipating having to more normalize its performance indicators in 2021. Without additional staff this will not be possible.

The Unspoken Effects of COVID-19

Preliminary research indicates Canadians are already experiencing the adverse effects of COVID-19. Increased risk of alcohol and cannabis use are occurring and cannabis sales have spiked. One in five (20.5%) who drink alcohol and are staying at home more report drinking alcohol more often than before the onset of the pandemic [1].

During April and May 2020, Toronto experienced its highest number of fatal suspected opioid overdose calls each month to Toronto Paramedic Services since September 2017.[2] As well in May 2020, the British Columbia (BC) Coroners Service reported a 44% increase in the number of illicit drug toxicity deaths seen in May 2020 compared with April 2020, and 93% increase compared with May 2019.[3]

COVID-19 had increased the risk of mental health concerns among Canadians especially among vulnerable populations. According to the Canadian National Health Association, people in Canada are feeling the effects on their mental health resulting from COVID-19 effects include 38% say their mental health has declind,46% feel anxious and worried,14% are having trouble coping, 6% had suicidal thoughts and 2% have tried to harm themselves.[4]

We are entering unchartered territory. If a second wave occurs, we don't know the impact of mental health, substance use and other matters. If income supports are removed the impact on those using substances, priority populations and our vulnerable residents could have significant ramifications within our communities. If this occurs the HNHU will need to address these outcomes.

HNHU Human Impact

Haldimand Norfolk Health Unit (HNHU) staff are experiencing adverse consequences of COVID-19.The shift to a 7 day work week, extended hours, additional on call response and cancelling of vacation has been challenging. This is not sustainable in the long term.

The human impact over the past six months is palpable. Staff must balance competing priorities at home; which may include child care concerns, and care giving concerns for aging parents. These challenges lead to extra stressors which significantly impact staff overall health, wellbeing, and resilience.

The utilization for Employee Assistance Program (EAP) services has also accelerated especially through the summer months in 2020, and in terms of pure case volumes we are higher than last year for the months of June, July and August across all departments and divisions in the County. When looking at 2019 in comparison to 2020 through the summer

months, June 2020 was up 10% over June 2019, July 2020 was up 13% over July 2019, and August was up 18.6% over August 2019. Month over month, August was 7.4% higher in volumes than June. The current trends as reported by Homewood Health are: anxiety remains the top issue for Norfolk County staff; there was an increase in stress related calls; and an increase in counselling for marital status and depression related calls.

Vacation banks remain high as vacations were cancelled, and time off approval has been limited to meet operational demands. Year to date, public health staff have taken less time off by approximately 2,400 hours when compared to the same period in 2019.

Sick time taken has increased from 2,495 hours in 2019, to 2,873 hours in 2020 over the same time period.

Reopening and Sustainability Plans

As the fall arrives, the HNHU anticipates a continued COVID-19 response and management of a second wave. Schools and day care centers have reopened and activities will be moving inside as the weather becomes colder.

In order to comply with the Ontario Public Health Standards (OPHS) and Accountability Agreements the health unit is implementing recovery plans. As part of this planning we have begun to redeploy staff to their regular positions and work.

The reintroduction of public health programs and services will require enhanced COVID-19 protocols and activities for all areas of programming including screening, personal protective equipment, logistics, schedule changes, staggered appointments, off site provision of programming, COVID-19 education and training, enhanced cleaning requirements, case and contact management (24 hours response and data entry),and additional data collection and reporting.

Additional activities include, a potential addition of 300 bunkhouse inspections, ongoing seasonal housing isolation plan approvals and an increased number of off site vaccination clinics. As well, influenza vaccinations are a component of the mandated programs. This year the HNHU will be exploring strategies to increase immunizations within the community aligning with provincial strategies in the management of COVID-19. In the event a COVID-19 vaccine is available, large community clinics will be held to immunize residents in a number of locations. Planning is under way to prepare for these mass immunization clinics.

As the province reopens and the case numbers continue to rise, it is unlikely that other health units will be available to assist with outbreak management from an outbreak in Haldimand and Norfolk. In these instances the HNHU team will be redeployed to focus on COVID-19 activities.

This redeployment comes with risk of over extending staff who are already fatigued. Additionally, the health unit will be unable to meet mandated programs, services and accountability agreements, which will affect the population health of our communities.

Electric Medical Record (EMR)

An EMR is an electronic system that allows for the storage of a medical record. It offers many benefits when compared to the current methods used by program staff. Some of the benefits, though not limited to these, include: working remotely (allows program staff to work from multiple locations, alignment with the County's direction to promote work from home and limits the number of staff in the workplace), better service with improved communication between program staff and with clients (such as charting improvements to meet professional body standards, and other quality improvement objectives), and better data management.

Before the advent of the COVID-19 pandemic, the majority of our programs utilized clinical charts in paper format in the clinical management of clients. With our current COVID-19 response this practice has been shown to be inefficient for case and contact management. This is because this practice does not lend itself an ability to work from multiple locations. In the event that there is a COVID-19 exposure or outbreak in the workplace there is a high risk that our COVID-19 response would be crippled. Should this happen the health and safety of Haldimand and Norfolk residents will be at risk. To mitigate this risk and align with county work from home policies, an EMR should be purchased and implemented as soon as possible.

An EMR is robust enough to mitigate and/or eliminate the current challenges and limitations experienced by program staff.

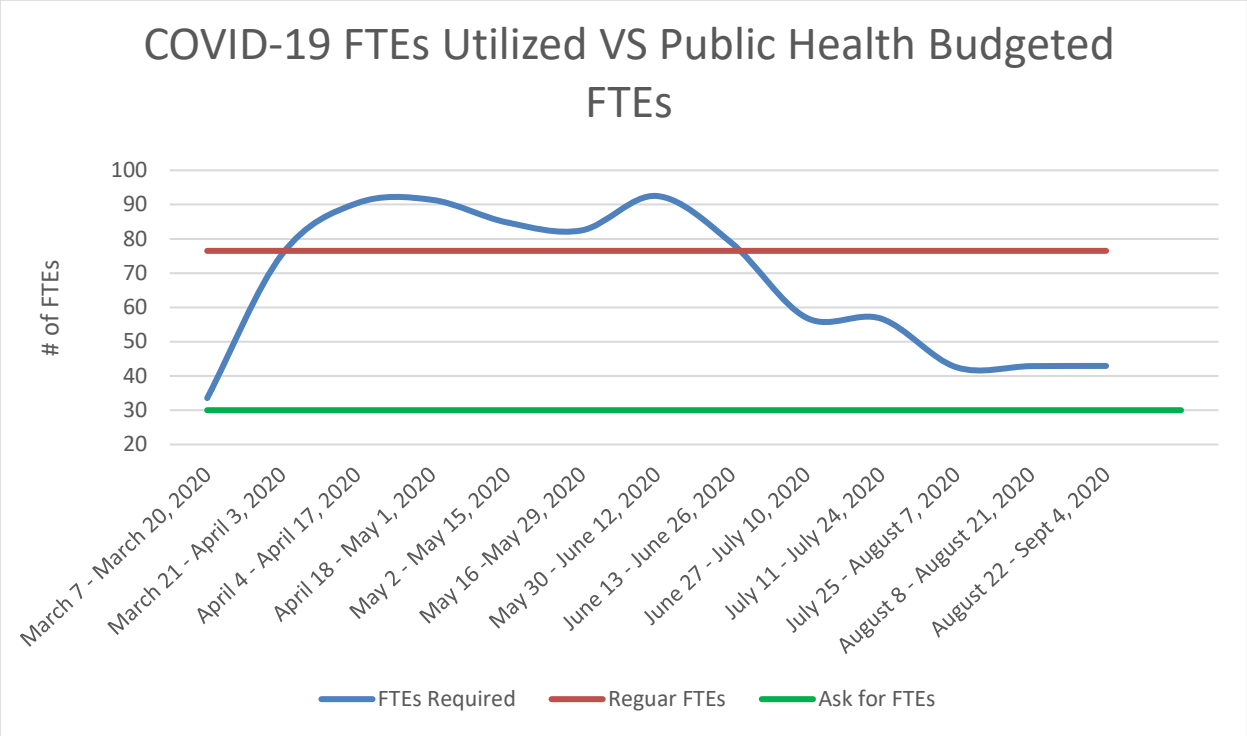
Years ago the HNHU should have implemented an EMR. This pandemic has highlighted another reason to move to an EMR. There will be longer term efficiencies and cost reductions that the EMR can lead to (such as reduced physical space), but these are not the driving reason for this adoption however these benefits will be realized in the future. Currently, the need is to allow us to effectively operate in this crisis.

Proposal to Meet COVID-19 Challenges

The province has directed Boards of Health (BOH) to take necessary measures to respond to COVID-19 within their jurisdictions while continuing to maintain other critical public health programs and services. Staff have submitted extraordinary costs to the Ministry of Health to offset the cost outlined in this report. An updated report outlining the financial impacts of COVID-19 will be provided in a future report to the Board of Health.

It is important to note that other health units have added additional resources and substantive FTEs to support the COVID-19 response. The province has also made significant investment announcements over the past months and continues to invest billions of dollars in COVID-19 response including announcements as recent as last week.

Figure 4 – COVID-19 FTEs Utilized vs Public Health Budgeted FTEs



Management of COVID-19 is a new functional unit which must be resourced as any other program. Given the ministry direction and the information provided earlier about this program in this report, the HNHU is requesting to hire a COVID-19 response team of 30.2 temporary FTEs until June 2022 to manage ongoing operational requirements. Figure 4 demonstrates the 30.2 FTEs request is below the 42.9 FTEs from Figure 2 to manage COVID-19 in the absence of any significant outbreak.

Table 4–Proposed COVID-19 Team

Positions	**FTE**
Registered Practical Nurse	7.0
Epidemiologist	1.0
Public Health Inspector	10.0
Public Health Nurse	5.0
Health Promoter	1.0
Admin Assistant	1.0
Program Assistant	1.0
Program Manager	1.0
MOH	0.2
Junior Human Resources Generalist	1.0
Financial Analyst	1.0
IT Support Technician	1.0
Total FTEs	**30.2**

As noted in Table 4 the health unit is proposing a COVID -19 response team of 26.2 FTEs, 1.0 FTE program manager and 3.0 FTEs support staff (1.0 IT, 1.0 Finance and 1.0 HR). The program manager is necessary as this is a new team which will be tasked exclusively in responding to COVID-19. As noted in Table 2 non-union unpaid overtime amounted to $427,227 which is equivalent to 4.5 FTEs. This we believe is more than sufficient to cover the cost of the additional program manager.

The requirements to support the COVID-19 pandemic has significantly increased for the corporate departments of Human Resources (HR), Financial Services and Information Technology (IT), with no increase in staffing resources. These internal departments work to support the Operational Divisions of the Corporation. As a result of the increase workload related to COVID-19, the corporate departments which are already lean, continue to experience difficulties in meeting the demands of the Corporation. From mid-March to mid-September 2020, the Human Resources department staff allocated 1645 hours, the Financial Services department has allocated 2027 hours and the IT department has allocated 1475 hours towards COVID-19. To put this into perspective, 1820 hours per year is considered a Full time equivalent based on a 35 hours per week employee. Additional details are provided in Appendix B of the report.

Hiring the COVID-19 response team ensures the BOH can manage COVID-19 activities and meet mandated obligations under new enhanced COVID-19 protocols.
It also enables the HNHU to respond to increased bunkhouse inspections, offsite vaccination clinics, and healthy babies, healthy children program screening etc. Staff can return to providing regular programs and services, and yet be available to be redeployed to support COVID-19 outbreak management. Having a COVID-19 team will support current HNHU staff, and maintain a safe and healthy workforce.

Risks of Inability to Hire

The second wave is currently upon us and the modelling shows an upward trajectory with cases doubling in 10 to 12 days. The unique feature of this second wave is that the increase in cases is seen in all age groups.

The inability to hire the COVID-19 response team will pose a challenge to the HNHU's ability to contain the virus and potentially lead to increase in confirmed cases, clusters, and outbreaks within the communities; including death. Outbreak management requires a timely response and a trained team ready to mobilize at a moment's notice. This was demonstrated during management of our two significant outbreaks. In both situations over 30 FTEs were mobilized immediately to contain and manage those outbreaks. In addition to the 30 FTEs the HNHU required the support of seven staff from the Brant County Health Unit (BCHU).

The inability to hire will continue to compromise the HNHU's abilities to provide mandatory programs and services as the reopening of the province puts the communities' health and safety at risk. The prolonged impacts of COVID-19 on society are still largely unknown, however, public health resources will be critical in the management of the long term impact of COVID-19 on population health.

Like any emergency response the costs are higher as the response is reactive to address the immediate and urgent needs, as demonstrated with the costs to date. A planned,

controlled and structured approach with the new team will enable the HNHU to deploy staff appropriately. It is understood that even with the new team and the focus on COVID-19 not all accountability indicators will be met.

The impact on staff will be cumulative over time, and without the additional support could lead to battle fatigue with the attendant negative effects on overall health, wellbeing, and resilience.

It is important to note that recruiting and on boarding of new hires takes between six to eight weeks, thus presenting a challenge to mobilize staff quickly when needed. To further complicate the recruitment process, health care skilled staff are in high demand as all health units and health partners are currently hiring.

Funding

Staff have submitted extraordinary costs for the above expenditures, and will apprise the BOH of any additional funding opportunities and will continue to leverage these grants for cost recovery.

Financial Services Comments:

Norfolk

Budgetary Impact

The Approved 2020 Operating Budget does not include a budgetary allocation for the COVID-19 Team or the EMR System as requested within this report. Specific funding allocations have not been confirmed at this time from the Ministry of Health for these initiatives, however an application has been made under the extraordinary costs related to COVID-19. Staff will continue to apply to funding opportunities, as they are made available to reduce the additional financial burden of these requests on Haldimand and Norfolk Counties.

The estimated financial implications of this report for 2020 and 2021 are provided in Table 5 below:

Table 5: Estimated Additional Budgetary Requirements in 2020 and 2021 for COVID-19 Team (in thousands):

	2020 Nov 1 – Dec 31	2021 Jan 1 – Dec 31
COVID-19 Team Compensation	507,500	3,045,200
COVID-19 Team IT Equipment*	100,000	-
COVID-19 Team Materials & Supplies Costs**	17,000	105,000
EMR***	420,000	130,000
Total Budgetary Requirements	$1,044,500	$3,280,200
Funding Allocation:		
Haldimand Est. Funding Share (40.9%)	427,200	1,341,600
Norfolk Est. Funding Share (59.1%)	617,300	1,938,600

*Includes purchase of all required IT equipment (including cellphones, laptops, monitors, etc.)

**Includes other ongoing operating supplies such as mileage, training, monthly cellphone plans, etc.

***The EMR Capital project budget estimate is based on executing a cooperative purchasing process through “piggybacking” on an existing agreement between the City of Toronto and IntraHealth, which allows other Ontario municipalities to negotiate an agreement with the vendor based on comparable terms. The ongoing costs for this system is estimated to be $130,000 annually.

If this report is approved by the Board, the 2020 budget will be amended to include an additional $1,044,500 expenditures, with offsetting funding to be provided by Norfolk and Haldimand counties. Additionally, the 2021 budget will include a Board Approved Initiative in the amount of $3,280,200

EMR Return on Investment (ROI)

As identified within the body of the report, if the EMR request is not approved, an additional 4.0 FTEs, or $272,000 annually, would be required to support the COVID-19 Team. The net annual operating savings anticipated for the EMR is approximately $142,000 ($272,000 staffing savings less $130,000 annual EMR maintenance costs).

Based on the initial investment of $400,000, the payback period for this investment is approximately 3.1 years. These savings are anticipated due to the significant efficiencies related to file and data management anticipated. This payback period does not reflect one time transition costs.

Haldimand

Interdepartmental Implications:

Norfolk

Haldimand: Haldimand county comments will be provided in a memo.

Consultation(s):

BOH Strategic Plan Linkage:

Communication, Healthy, Supportive Environment, Organizational Strength and Quality and Performance: The sustainability plan supports the response to COVID-19 while reopening mandatory programs and services of the Ontario Pubic Health Standards (OPHS) and the HNHU strategic goals.

Strategic Plan Linkage:

Financial Sustainability and Fiscal Responsibility:

Conclusion:

The HNHU and BOH must continue to be responsive to COVID-19, adapting to response requirements, as well as provincial direction and guidance to manage the pandemic. At the same time, it is imperative that programs and services reopen to continue to protect the population health, not just COVID-19. The added FTEs and EMR resources will enable the HNHU to continue to respond to COVID-19 and safely reopen the mandated programs and services outlined in the OPHS.

Recommendation(s) of Health and Social Services Advisory Committee: Presented directly to Haldimand County

Recommendation(s):

THAT Staff Report HSS 20-18, COVID-19 Update and Sustainability Plan be received as information;

AND THAT the Board of Health authorize an increase of up to 30.2 Temporary FTE until June 2022, to continue in the response of COVID-19 while reopening mandated public health programs and services;

AND THAT the Approved 2020 Board of Health Operating Budget be amended to include $1,044,500 for the COVID-19 Team and the purchase of the EMR;

AND THAT the Board of Health approve a Cooperative Purchasing Initiative with the City of Toronto Request for Proposal No. 3405-18-0353, in accordance with the Norfolk County Purchasing Policy ECS-02 Section 4.1, for the implementation of an Electronic Medical Record (EMR) solution to support staff in clinical documentation;

AND THAT the General Manager, Health and Social Services be authorized to execute a contract with IntraHealth Canada Limited for the Electronic Medical Records (EMR) solution in the amount up to $400,000 (excluding HST) for a term ending August 31, 2021 with the option to extend for three (3) consecutive one (1) year periods;

AND THAT a letter be sent to the Minister of Health to request 100% funding of the costs of COVID-19 response that exceed the 2020 Annual Service Plan and Budget;

AND FURTHER THAT the Board of Health send a letter to the Ministry of Health and the Ontario Ministry of Agriculture Food and Rural Affairs and Service Canada to advocate for funding and policy changes to support the Agricultural Community during the self-isolation period and to provide policy for post isolation to manage COVID-19.

Attachment(s)
Appendix A: FTEs Requirement for Bi-Weekly COVID-19 Related Tasks
Appendix B: COVID 19 Response – Human Resources, Financial Services, and Information Technology Department FTE Justification

References:

1. https://www.ccsa.ca/more-1-5-canadians-who-drink-alcohol-and-have-been-staying-home-more-have-been-drinking-once-day
2. https://public.tableau.com/profile/tphseu#!/vizhome/TOISDashboard_Final/ParamedicResponse
3. https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/statistical/illicit-drug.pdf
4. https://cmha.ca/wp-content/uploads/2020/06/EN_UBC-CMHA-COVID19-Report-FINAL.pdf

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Appendix A: FTEs Requirement for BI-Weekly COVID-19 Related Tasks

Lowest Activity payperiod Task	Total Time Spent by Knowledge area				Total Time spent (Minutes)	Total Time spent (Hours)
	Program Assistant	Public Health Nurse	Public Health Inspector	Logistics/Data Management		
File Management				5250	5250	88
Hotline ID COVID	1433	8596			10028	167
Hotline EHT			5083		5083	85
Hotline daily tasks	5040	2940			7980	133
Test Booking	4251				4251	71
PUI Daily Tasks				2240	2240	37
PUI Monitoring		32071			32071	535
Case and Contact Management		6056			6056	101
Test Results	8820	140		1680	10640	177
Outbreak Management		2210		600	2810	47
Outbreak Assessment		120			120	2
COVID Enforcement			16125		16125	269
Migrant Farm Worker Approval Process	351		6489	351	7191	120
Migrant Farm Worker Inspection Audits			3459	507	3967	66
Migrant Farm Worker Virtual Inspections			938		938	16
Migrant Farm Worker Illness Reporting and Monitoring			284		284	5
Migrant Farm Worker Arrivals	70		351	1087	1508	25
Child Care Approval Process	72		810		882	15
Childcare Illness Reporting	456		1710		2166	36
Childcare Case Consultation			5070		5070	85
Total Hours spent by knowledge area (Minutes)	19060	52133	40320	11716		
Total Hours spent by knowledge area (Hours)	318	869	672	195		
FTE Count	**5**	**12**	**10**	**3**		

Appendix A was presented as an additional analysis undertaken to further support our suggested requirements.

Appendix B: COVID 19 Response – Human Resources, Financial Services, and Information Technology Department FTE Justification

The internal corporate departments of Human Resources, Finance and Information Technology provide a myriad of resources to Public Health as follows:

Human Resources:

- Recruitment and Selection, which includes the creation of job descriptions, job postings, interviews, offer letters etc.)
- Onboarding – collection of vital personal information, criminal record checks.
- Benefits coordination.
- Increase in payroll related functions which includes, questions related to timesheets, processing bi-weekly pay, vacation entitlements, sick leave entitlements etc.
- Training and Development – orientation, health and safety and other ongoing training related to the Corporation.
- Occupational Health, Safety and Wellness, which includes supporting physical, mental health, return to work and accommodations under the *Ontario Human Rights Code.*
- Ongoing Employee and Labour Relations items.
- Providing advice on employee development and performance management.

Information Technology:
The department provides development, installation, support and maintenance of:

- IT Helpdesk and associated work orders
- Telephone, cellular devices and voicemail systems
- IT infrastructure equipment
- Installation, maintenance and support of workstations and peripherals
- Corporate software applications and training
- Networks, data backup, and security
- Electronic mail systems (email)
- Internal and External Websites
- Video, Teleconferencing, Surveillance Camera Equipment
- Building Access Control Card System
- Fibre, wireless and DSL municipal area network (MAN) connections
- Security and Permission Changes
- Promotion of effective and appropriate use of information technology

Along with the items noted above, the following list highlights some of the additional IT project work requirements to assist Public Health in support of COVID-19:

- Infrastructure
    - Remote Desktop Services Upgrade and Expansion
    - Windows Server Update Services Update
    - Deployment, installation, maintenance and support of workstations, peripherals and telephone communications and multiple Permission Change Requests
- Applications
    - Configuration and assistance for remote access to software applications
    - Test Centre Scheduler
    - COVID Dashboards

    - Sharepoint Development
        - COVID Call Log
        - COVID EHT Call Log
        - COVID Trackers
        - Childcare and School Tracker (In progress)
        - COVID SWAB Inventory
        - Test Centre Scheduler
        - COVID On-call Manual
        - Seasonal Worker Monitoring and Inspection Trackers
        - Active Surveillance Tracker
        - Community Surveillance Tracker
        - Employee Additional Skills Sheet
        - Volunteer Database Modification
- External Websites
    - Staff Screening Checklist
    - COVID Inquiry Form for Business Owners
    - Modifications to HNHU website content

Further, the implementation of an Electric Medical Record (EMR) system will be a substantial project with the need for dedicated FTE resources to the project and ongoing support from Public Health as subject matter experts and the IT department.

Financial Services:

- PPE costing and projections to support HNHU operations as well as emergency supplies maintained to assist in event of scarcity.
- Financial reporting analysis and projections to provide updates to the Advisory Board and Board of Health on COVID-19 Expenditures.
- Ministry reporting requirements for both COVID-19 specific and HNHU regular program reporting.
- Financial forecasting analysis related to COVID-19 for grant applications related to COVID-19
- Ad-hoc analysis for decision support.

Additionally, there are currently 17 Ministry reporting requirements for regular base and one-time grants. Some of these reports also require co-ordination with our auditor. At present, there are 6 additional COVID-19 specific reporting requirements some of which also require auditing.

The risk of not approving the additional FTEs in the Human Resources, Financial Services, and Information Technology staffing complement includes but is not limited to:

Human Resources:

- Delayed hiring processes.
- Delayed response to Managers/Supervisors for employee type inquiries.
- Further delay of overall department and corporate projects and initiatives that have been identified by SLT.
- Less support and resources will be available to other H&SS areas and corporate departments/divisions.
- Increased workload pressures on the current Human Resources staff.

- Increase in overtime costs for the department.
- Decrease in the ability for current staff to utilize vacation, OT banks which will be carried over to the next year increasing the financial liability to the Corporation.
- Negative impact in employee and labour relations.
- Delays in responding and addressing return to work and accommodation obligations which can lead to grievances or complaints to WSIB or the Ontario Human Rights Tribunal.

Information Technology:

- Delayed response time for IT Helpdesk and associated work orders
- Delayed installation, deployment and maintenance of technology requirements
- Further delay of department and corporate projects and initiatives identified as part of the IT workplan.
- Less support and resources will be available to other H&SS areas and Corporate departments/divisions
- IT system downtime could be longer than normal and expected
- Higher overtime costs will continue and human impacts noted in the report is not sustainable.

Financial Services:

- Inaccurate and untimely financial reporting, as well as little to no review of supporting financial documentation prior to report submissions. This could lead to suboptimal decisions by management and the Board.
- Incomplete financial forecasting and analysis may result in under-reporting on funding applications, which could result in lower funding. As all Public Health Units are competing for limited funds available, it is important to put forward thorough applications to ensure maximum funding allocations.
- Late reporting submissions to Ministries, for both regular base and one-time grants and COVID specific grants.
- Late the submission of year-end financial results to the auditors.
- Less support provided to other H&SS areas (Norview, Social Services & Housing, Child Care) by Financial Services for their deliverables such as variance reporting, budgeting, etc.
- Higher overtime costs for Financial Services will continue; many of the activities described are unavoidable (internal audit of actuals, ministry reporting, etc.).