THE REGIONAL MUNICIPALITY OF NIAGARA
PUBLIC HEALTH & SOCIAL SERVICES COMMITTEE
FINAL AGENDA

PHSSC 2-2021

Tuesday, February 16, 2021

1:00 p.m.

Meeting will be held by electronic participation only

This electronic meeting can be viewed on Niagara Region's Website at:

https://www.niagararegion.ca/government/council/

Due to efforts to contain the spread of COVID-19 and to protect all individuals, the Council Chamber at Regional Headquarters will not be open to the public to attend Committee meetings until further notice. To view live stream meeting proceedings, visit: niagararegion.ca/government/council

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Pages

1. CALL TO ORDER

2. DISCLOSURES OF PECUNIARY INTEREST

3. PRESENTATIONS

4. DELEGATIONS

4.1. Request for Declaration of State of Emergency for Mental Health, Homelessness and Addiction - Additional Correspondence (COM-C 4-2021 (Agenda Item 6.4))

4.1.1. Steven Soos, Resident, City of Welland and Wayne Campbell, Resident, City of Niagara Falls — 3 - 4
The delegation submission is attached to this agenda item as COM-C 5-2021.

5. ITEMS FOR CONSIDERATION

5.1. *COM-C 8-2021* — *5 - 6*
Motion from Councillor Insinna respecting Homelessness, Mental Health and Addiction in Niagara

5.2. *PHD 1-2021* *7 - 67*
Collaborative Action to Prevent COVID-19 Transmission and Improve Health Equity by Increasing Access to Paid Sick Days

6. CONSENT ITEMS FOR INFORMATION

6.1. PHD-C 3-2021 68 - 83
COVID-19 Response and Business Continuity in Public Health & Emergency Services

6.2. COM-C 3-2021 84 - 90
COVID-19 Response and Business Continuity in Community Services

6.3. COM-C 4-2021 91 - 99
Request for Declaration of State of Emergency for Mental Health, Homelessness and Addiction - Additional Correspondence

6.4. COM-C 6-2021 100 - 131
Improving the Long-Term Care Outbreak Response in Ontario – Association of Municipalities of Ontario's (AMO) Final Submission to the Long-Term Care COVID-19 Commission

6.5. PHD-C 2-2021 132 - 134
Niagara Emergency Medical Services (EMS) Temporary Funded Opportunities

6.6. *COM-C 7-2021* *135 - 140*
Responding to an Information Enquiry Regarding a Community Request for the Region to Declare a State of Emergency on Mental Health, Homelessness, and Addiction

6.7. *PHD-C 4-2021* *141 - 156*
Considerations & Context Regarding Declaration of a State of Emergency

7. OTHER BUSINESS

7.1. *Social Services Relief Funding Phase 2 Holdback Fund Update*
Cathy Cousins, Director, Homelessness and Community Engagement

8. NEXT MEETING

The next meeting will be held on Tuesday, March 9, 2021, at 1:00 p.m.

9. ADJOURNMENT

If you require any accommodations for a disability in order to attend or participate in meetings or

events, please contact the Accessibility Advisor at 905-980-6000 ext. 3252 (office), 289-929-8376 (cellphone) or accessibility@niagararegion.ca (email).

From: PF-Mailbox-01
To: Norio, Ann-Marie; Trennum, Matthew
Subject: FW: Online Form - Request to Speak at a Standing Committee
Date: Thursday, February 04, 2021 12:02:27 PM

From: Niagara Region Website
Sent: Thursday, 04 February 2021 12:02:20 (UTC-05:00) Eastern Time (US & Canada)
To: Clerks
Subject: Online Form - Request to Speak at a Standing Committee

Request to Speak at a Standing Committee

To reply, copy the email address from below and put into 'To'. (if resident entered their email address)

Name
Steven Soos

Address
[redacted]

City
Welland

Postal
[redacted]

Phone
[redacted]

[redacted]

Organization

standing committee
Public Health and Social Services Committee

Presentation Topic
State of Emergency on Mental Health, Homelessness and Addiction

Presentation includes slides
Yes

Previously presented topic
No

Presentation Details
-Would like to include Wayne Campbell, Niagara Falls as part of the delegation: [redacted] -11/12 of Niagara's local area municipalities have unanimously supported the request for Niagara Regional Council to declare a state of emergency on mental health, homelessness and addiction. Public Health and Social Services were copied on all of the resolutions. -Looking to have Niagara Public Health and Social Services committee endorse the resolution to declare a state of emergency on mental health, homelessness and addiction.

Video Consent
Yes

To: Ann-Marie Norio, Clerk, Region of Niagara
From: Councillor Insinna

Motion for consideration at Public Health and Social Services Committee:

HOMELESSNESS, MENTAL HEALTH AND ADDICTION IN NIAGARA

MOVED BY Councillor Insinna

SECONDED BY Councillor Foster

WHEREAS Niagara Region prides itself as being a caring and compassionate community that continually strives to be a place where people want to live, work and play;

WHEREAS providing access to safe, adequate and affordable housing for everyone is fundamental to achieving that goal;

WHEREAS Niagara Region acknowledges that mental health, mental illness, addiction and homelessness, while important issues, are not homogenous, interchangeable or consistently interconnected, and doing so may over simplify exceptionally complex issues that require targeted policy solutions and intervention;

WHEREAS Niagara Region's 10-year Housing and Homelessness Action Plan (HHAP), *A Home For All*, outlines the Region's vision, challenges, and the actions required to achieve its goals;

WHEREAS Niagara Region has embarked on an ambitious effort to end chronic homelessness through participation in the national Built for Zero campaign;

WHEREAS Regional Council formally adopted Mental Health and Wellbeing (2.2) and Addressing Affordable Housing Needs (2.3) as strategic priorities for the current term of our Council;

WHEREAS a recent KPMG report commissioned by Niagara Region indicated that Council invests more levy funding than its peers into homelessness, demonstrating a steadfast commitment to addressing the issue;

WHEREAS Niagara Region acknowledges that people living in shelters are part of the crisis and not the solution;

WHEREAS Niagara Region has two planned housing projects that would directly address those in Niagara who experience chronic homelessness;

WHEREAS the implementation plan for Council's strategic objectives states that staff will identify gaps within the mental health system to increase the functionality and collaboration within it;

WHEREAS the same implementation plan directed staff to partner with Ontario Health (formally the LHIN) to review the local landscape to identify opportunities, including new investment;

WHEREAS the treatment and supports for mental illness, addiction, and homelessness are predominantly funded and directed by the Province;

WHEREAS the success of the Region's Housing and Homelessness Action Plan is dependent on a commitment of sustained and increased funding (both operational and capital) from all levels of government to address the issues of housing insecurity and homelessness in Niagara; and

WHEREAS the needs of the community far outweigh Niagara Region's available resources and funding required to effectively address these issues, and the support of both the Provincial and Federal governments are needed to meet these needs.

THEREFORE BE IT RESOLVED THAT:

1. That Niagara Region Council officially **ACKNOWLEDGE** that a significant crisis exists in Niagara in regard to the prevalence of chronic homelessness and the lack of affordable housing that far surpasses the Region's ability to meet the vision dictated in its 10-year Housing and Homelessness Action Plan (HHAP);

2. That the Regional Chair **BE DIRECTED** to send advocacy letters directly to the appropriate Federal and Provincial ministries outlining Niagara's current situation and requesting additional funding be provided to ensure Niagara can meet the vision outlined in its housing action plan;

3. That the Regional Chair **BE DIRECTED** to advocate to the Minister of Municipal Affairs and Housing and the Minister of Families, Children and Social Development for the required operational funding for the planned supportive and bridge housing initiatives;

4. That Regional staff **BE DIRECTED**, in alignment with the planned review of Council's strategic priorities, to produce a report specifically highlighting the progress being made and critical gaps in regard to services related to mental health, addictions and wellbeing;

5. That Regional staff **BE DIRECTED** to continue providing Regional Council updates on the HHAP and Built for Zero initiatives; and

6. That Regional staff **BE DIRECTED** to request an update from the Overdose Prevention and Education Network of Niagara (OPENN) regarding the current status of the actions being taken to address addiction related issues in Niagara.

Subject: Collaborative Action to Prevent COVID-19 Transmission and Improve Health Equity by Increasing Access to Paid Sick Days

Report to: Public Health and Social Services Committee

Report date: Tuesday, February 16, 2021

Recommendations

1. That Regional Council **ENDORSE** the Decent Work and Health Network's report *Before it's too late: How to close the paid sick days gap during COVID-19 and beyond*[i] attached as Appendix A to Report PHD 1-2021;
2. That Regional Council **BE DIRECTED** to send the letter, attached as Appendix B to Report PHD 1-2021, to the provincial Minister of Health; Minister of Labour, Training and Skills Development; and the Premier, expressing its support for legislated paid sick days through the *Employment Standards Act*; and
3. That a copy of the letter and Report PHD 1-2021 **BE CIRCULATED** to local members of provincial parliament, local members of Parliament, and to the Association of Local Public Health Agencies for dissemination to all Ontario boards of health.

Key Facts

- The purpose of this report is to seek Council's endorsement of the Decent Work and Health Network's report *Before it's too late: How to close the paid sick days gap during COVID-19 and beyond*[i] and to seek Council's support for legislated paid sick days through the Employment Standards Act.
- Currently no requirement for paid sick days exist through provincial employment standards.[ii]
- The gap in access to paid sick days is associated with transmission of infectious illnesses at workplaces[iii] including COVID-19, as many lower paid employees are compelled to work while sick and infectious so as to be able to earn the income they need to live.
- In *From Risk to resilience: An Equity approach to COVID-19*, Chief Public Health Officer of Canada, Dr. Theresa Tam, highlights the need to address the gap of access to paid sick days as an intervention effective in curbing the spread of COVID-19.[iv]

Financial Considerations

There are no immediate financial considerations for Council to consider for this report.

Should the Government of Ontario legislate seven (7) paid sick days to be paid on day one of illness, there would be a financial impact on Niagara Region to pay current employees that do not normally have access to paid sick days on day one of illness – primarily part-time and casual staff. Using January 2021 staffing complement, the cost of providing seven (7) paid sick days to each of these staff is estimated at $1.46 million, excluding other payroll related costs. The bulk of Regional staff working part time or casual are in the following classifications: paramedics, early childhood educators, personal support workers, recreationists, dietary aides, housekeeping & laundry aides, registered practical nurses, registered nurses (in long term care and public health), systems status controllers, students, for example. The local business community who employs staff without access to at least seven (7) paid sick days would have proportionate financial impact as well.

An estimated direct cost of absenteeism to the Canadian economy is $16.6 billion. Universal paid sick leave would likely reduce these costs by keeping infectious illness out of workplaces, balancing out at least part of the increased costs of paid sick leave.

Analysis

Disproportionate Impacts of COVID-19 & Access to Paid Sick Days

The health of Canadians was inequitable prior to COVID-19. Differential access to factors such as housing, income and employment have long resulted in health disparities. [iv] More access to these social determinants of health is linked to better health. In Canada, both the risk of COVID-19 infection and the severity of illness, is disproportionately impacting populations with less access to affordable housing, income and employment. [i] PHD 6-2020 previously described the inequitable impacts of COVID-19 and called upon the federal and provincial government to prioritize measures to reduce poverty and income inequality as a change that should be initiated by this pandemic.

As epidemiological study of COVID-19 has progressed, unpaid sick leave has been identified as key determinant of inequity in this pandemic. [iv] Staying home when sick is one of the most effective containment strategies for infectious disease, yet a benefit more accessible to some workers than others. The Decent Work and Health Network, is

an Ontario based group of health workers and trainees aimed at addressing working and employment conditions in Ontario. Their report, *Before it's Too Late: How to Close the Paid Sick Day Gap During COVID-19 and Beyond* synthesizes evidence that workers without paid sick days are more likely to go to work with contagious illness[v]; and it summarizes data on the number of workers without access to paid sick days and the disproportionate impacts of COVID-19. For instance, in Canada recent data indicates that more than half (58%) of Canadian workers do not have access to paid sick time. Over 70% of workers that make less than $25,000 do not have access to paid sick days.[vi] Low-wage racialized workers, who are more likely to be denied paid sick days, have faced higher rates of COVID-19.[i] In Toronto, reported COVID-19 infection rate is higher for those identifying with racialized groups, 1372.0 cases per 100,000, than it is among those identifying as white, 396.6 cases per 100,000 people. COVID-19 infection rate among people in Toronto is also higher for low-income earning households, 808.0 cases per 100,000 people, compared to individuals not living in low-income households, 355.9 cases per 100,000 people.[vii]

In Ontario, there are no legislated paid sick days through employment standards. [ii] In the absence of legislated paid sick days, workers rely solely on workplace policies for access to paid sick days. Ultimately, workers without paid sick days are faced with a choice between sacrificing their financial security for public health or going to work sick to support themselves and their families. Workplaces with lack of paid sick leave are at greater risk of outbreaks. In Ontario, workplaces with precarious jobs and lack of paid sick leave have become hotspots for COVID-19 infection transmission, including outbreaks in long-term care homes, farms, meat-processing plants, grocery stores, and warehouses. In Niagara, as of January 21, 2021 18% of all COVID-19 cases were staff at a workplace associated with an outbreak. Of the total 1,261 staff associated with an outbreak; 751 were associated with a long-term care or retirement home, 239 with a community location, 207 with a hospital, and 64 with a communal/congregate living setting.

Through Public Health's contact tracing, there have been numerous examples found where the absence of paid sick leave likely contributed to infection spreading:

- Employees who continued to work with infection, thereby spreading illness to others and causing outbreaks
- Employees who are high risk contacts to someone infected with COVID-19; but who continued to work, eventually becoming infectious and harming co-workers

In many cases, these have been low paid employees of settings with vulnerable persons such as long-term care homes. In such settings, continuing to work while sick has likely lead to deaths that could be prevented.

Niagara's large tourism and hospitality industry is particularly at risk from the absence of paid sick leave. Many workers in this industry do not enjoy comprehensive benefits including paid sick leave. Therefore, as tourism resumes, this industry could pose a risk for resurgence of COVID-19 leading to increased infections in Niagara, tourists becoming ill, and Niagara's reputation as a premier tourist destination potentially harmed.

Current Public Policy on Paid Sick Leave

During the COVID-19 pandemic, the Infectious Disease leave within Ontario's *Employment Standards Act* has provided only unpaid, temporary leave that is restricted to COVID-19 related reasons. [viii] Federally, the temporary Canada Sickness Recovery Benefit (CSRB) provides 10 days of income support for COVID-related leave for workers without paid sick days.[vi] However, this program requires workers to have lost at least 50% of their wages, apply for the benefit after that has happened, and endure a waiting period while they wait for their application to be approved and then funds to begin to flow.[viii] Legislated paid sick days would allow workers to receive full and uninterrupted income replacement without delay, which is a primary concern for workers in low-wage and precarious employment.

Canada lags behind other nations globally in guaranteeing workers access to adequate paid sick days for short-term illness. Canada is in the bottom quarter of countries worldwide that do not guarantee paid sick leave on the first day of illness, which is a crucial measure to enable workers to stay home at the first sign of symptoms of an illness. Many other Organisation for Economic Co-operation and Development (OECD) countries legislate employer provided paid sick days for short-term illness, with social insurance programs supplementing for longer term sick leaves. [i]

An Opportunity for Healthy Public Policy Measures through Provincial Legislation

Advocacy efforts have been underway in the United States (US) and Canada to improve public policy related to paid sick days. In Canada, Chief Public Health Officer Dr. Theresa Tam's report, *From risk to resilience: An equity approach to COVID-19* points to paid sick days as an intervention that is essential to protect workers and mitigate the spread of COVID-19. The Decent Work and Health Network's report, *Before it's Too*

Late: How to Close the Paid Sick Day Gap During COVID-19 and Beyond cites research projects that have explored the relationship between paid sick days and infectious disease rates. In the US one study reported that cities with paid sick days saw a 40% reduction in influenza rates during flu waves compared to cities without. [ix] Recent efforts in the US have seen some states expanding employer-provided permanent paid sick days and brought in additional paid sick days for public health emergencies. [x]

Recent calls on the Government of Ontario to take action on paid sick leave include the following:

- November 27 2020, Ontario's Big City Mayors made up of Mayors from 29 cities across Ontario with a population of 100,000 or more, expressed their belief that paid sick leave is needed immediately as a measure to help stop the spread of COVID-19 and to protect workers, urging the Federal and Provincial government to implement paid sick leave
- December 8, Stay Home if You are Sick Act[xi], a Private Member's Bill, was introduced in the Ontario Legislature, calling for permanent paid sick days for Ontario workers during the pandemic and beyond
- January 18, 2021, Toronto City Council requested the Government of Ontario to take immediate action to address rising rates of COVID-19 by requiring paid sick leave
- January 25, 2021 the Greater Toronto and Hamilton Area mayors and regional chairs renewed calls to both the Provincial and Federal Government for all workers to have access to paid sick days
- January 27, 2021 the Kingston, Frontenac, Lennox & Addington (KFL&A) health unit endorsed in principle, the Stay Home if You Are Sick Actxi; called on the Province of Ontario to amend Employment Standards Act to provide paid sick days; and called on the Ontario Government to provide fiscal relief and other supports to employers to provide this sick leave
- February 1, 2021 the city of St. Catharines endorsed legislated sick leave and calls on the government of Ontario to permanently legislate universal paid sick days for all workers in Ontario
- February 9, 2021 the Association of Local Public Health Agencies (alPHa) express that under the Employment Standards Act, the Government of Ontario reinstate guaranteed paid sick leave to protect workers and reduce workplace outbreaks

Based on a jurisdictional scan of best practices and review of medical evidence, the Decent Work and Health Network has developed a criteria of five principles for effective paid sick days policy (further details in Appendix A):

- Universal*:* Available to all workers regardless of workplace size, type of work (including temporary, part time and independent contracts) or immigration status. Legislated, with no exemptions.
- Paid: Fully paid to ensure workers are not financially penalized for following public health advice.
- Adequate*:* At least seven paid sick days provided on a permanent basis, with an additional 14 paid sick days during public health emergencies.
- Permanent: Available during the COVID-19 pandemic and beyond.
- Accessible: No barriers to access. Prohibit employers from requiring sick notes; ensure no disruption of income or unnecessary applications; and provide sufficiently flexible leave that reflects the reality of workers' lives, healthcare needs, and caregiving responsibilities.

Alternatives Reviewed

The alternative of taking no action on paid sick time was considered. However, not taking action will continue to place burden of responsibility on the individual to decide between getting paid and staying home if they are sick. Evidence indicates that this is resulting in the spread of infectious disease, including COVID-19.

Relationship to Council Strategic Priorities

Paid sick days will help to lessen the disproportionate impact COVID-19 is having on workers that do not have access to paid sick leave. Additionally, paid sick leave will help to reduce transmission of COVID-19. This healthy public policy is linked to Council's Healthy and Vibrant Community strategic priority, in particular, the desire to improve health equity.

Other Pertinent Reports

- PHD 6-2020 - Basic Income for Income Security

Recommended by:
Adrienne Jugley, MSW, RSW, CHE
Commissioner, Community Services

Recommended by:
M. Mustafa Hirji, MD, MPH, PCPC
Medical Officer of Health &
Commissioner (Acting)
Public Health and Emergency Services

Submitted by:
Ron Tripp, P.Eng.
Acting Chief Administrative Officer

This report was prepared by Lindsay Garofalo, Manager, Chronic Disease and Injury Prevention in consultation with Pam Abeyskara, Integrated Planning and Policy Advisory, and reviewed by David Lorenzo, Associate Director Chronic Disease & Injury Prevention.

Appendices

Appendix A	Decent Work & Health Network. Before It's Too Late: How to Close the Paid Sick Day Gap During COVID-19 and Beyond
Appendix B	Advocacy Letter

Sources

[i] Decent Work & Health Network. Before it's Too Late: How to Close the Paid Sick Day Gap During COVID-19 and Beyond. Published August 2020. Available from: (https://www.decentworkandhealth.org/beforetoolate)

[ii] Ontario Employment Standards Act. Section 50. Available from: (https://www.ontario.ca/laws/statute/00e41)

[iii] Drago R, Miller K. Sick at Work: infected employees in the workplace during H1N1 pandemic IWPR.org (2010). Available from: (https://iwpr.org/iwpr-general/sick-at-work-infected-employees-in-the-workplace-during-the-h1n1-pandemic/)

[iv] From Risk to Resilience: An Equity Approach to COVID-19. The Chief Public Health Officer of Canada's Report on the State of Public Health in Canada 2020. Published October 2020. Available from: (https://www.canada.ca/content/dam/phac-aspc/documents/corporate/publications/chief-public-health-officer-reports-state-public-health-canada/from-risk-resilience-equity-approach-covid-19/cpho-covid-report-eng.pdf)

[v] Estimates of Foodborne Illness in the United States (2020). Available from: (https://www.cdc.gov/foodborneburden/2011-foodborne-estimates.html)

[vi] Yalnizyan A. After CERB: Paid Sick leave provisions in Canada (2020). Available from: (https://atkinsonfoundation.ca/atkinson-fellows/posts/after-cerb-paid-sick-leave-provisions-in-canada/)

[vii] COVID-19: Status of Cases in Toronto. Available from: (https://www.toronto.ca/home/covid-19/covid-19-latest-city-of-toronto-news/covid-19-status-of-cases-in-toronto/)

[viii] Canada Recovery Sickness Benefit. Government of Canada. Updated November 30, 2020. Available from: (https://www.canada.ca/en/revenue-agency/services/benefits/recovery-sickness-benefit.html)

[ix] Pichler S, Ziebarth N. The pros and cons of sick pay schemes: Contagious presenteeism and concontagious absenteeism behaviour. Voxeu.org. Pichler S, Ziebarth N. (2016) Available from: (https://www.nber.org/papers/w22530)

[x] New York State Passes Permanent Right to Paid Sick Leave. Available from: (https://www.abetterbalance.org/new-york-state-passes-permanent-right-to-paid-sick-leave/)

[xi] Stay Home if You are Sick Act, 2020. Available from: (https://www.ola.org/en/legislative-business/bills/parliament-42/session-1/bill-239)

BEFORE IT'S TOO LATE:

How to close the paid sick days gap during COVID-19 and beyond

TABLE OF CONTENTS

ABOUT THIS REPORT

This report was prepared by the Decent Work and Health Network (DWHN) — a network of health providers based in Ontario who advocate for better health by addressing employment conditions. It is the first report of its kind in Canada. The analysis included in this report draws from best practices in jurisdictions across Canada, the US, and globally. The recommendations apply to Canadian provincial and territorial governments and the federal government.

In addition to a review of the latest evidence from medical and public health research, this report draws on findings from a national survey of physicians and 32 interviews with workers in Ontario who were impacted by inadequate paid sick days or employers requiring sick notes to access paid sick days. Both the survey and interviews were conducted by members of the Decent Work and Health Network (see Appendix B for more information on the methodology). Quotes reflecting key experiences of workers interviewed are included throughout the report. A summary of findings from the interviews with workers is included in Appendix C. The physician survey findings are reflected in the sections on the adequacy of paid sick days and requiring sick notes.

ACKNOWLEDGEMENTS

This report was a collective effort, with many health providers and workers contributing their knowledge, skills, and insights. The report would not have been possible without the workers who participated in the interviews. Support from the Ontario Employment Education and Research Centre (OEERC) and the Atkinson Foundation was crucial in the creation of this report. We respectfully acknowledge that this report was prepared on the traditional lands of the Mississaugas of the Credit, the Anishnabeg, the Chippewa, the Haudenosaunee, the Wendat peoples, and other unrecorded nations. We are committed to active and ongoing solidarity with Indigenous struggles for self-determination. The DWHN is committed to addressing oppression and systemic discrimination within the workplace, healthcare system, and society at large as a significant contribution to improving health outcomes for all.

EXECUTIVE SUMMARY

The COVID-19 pandemic has brought added urgency to the basic public health recommendation to stay home when sick. However, without effective paid sick leave legislation, too many workers are forced to choose between protecting public health by staying home and going to work sick to support themselves and their families. Paid sick days are an essential protection for all workers both during a pandemic and on a permanent basis to protect against other infectious illnesses like influenza.

The pandemic has exposed the urgency of addressing gaps in paid sick days as a matter of racial, gender, disability and economic justice. Low-wage racialized workers, who are more likely to be denied paid sick days, have faced higher rates of COVID-19 and greater negative economic impacts during the crisis. The most recent data available reveals that 58% of workers in Canada — and over 70% of workers making less than $25,000 — have no access to paid sick days. Workplaces with precarious jobs have become hotspots for COVID-19, including long-term care homes, farms, meat-processing plants, nail salons, and grocery stores. The pandemic has clearly established precarious work, including the lack of paid sick days, as a public health hazard. These gaps are especially dangerous for workers with chronic health or immunocompromised conditions, and for persons with disabilities, seniors, children, and patients who rely on workers to provide care and support.

This report will examine public health research and medical evidence to better understand the efficacy of legislatively mandated paid sick days in containing infectious disease, including in curbing the spread of influenza and food-borne illnesses. Lessons are drawn from the SARS and H1N1 outbreaks about the important role of paid sick days during outbreaks in protecting public health and ensuring self-isolation directives are followed. Paid sick days also promote preventive care, create savings in the healthcare system, and reduce presenteeism (going to work while sick) with significant cost savings for businesses.

In Canada, paid sick days are only legislated in Quebec (2 days), PEI (1 day after 5 years of employment), and for federally regulated workers (3 days). Otherwise, workers rely solely on workplace policies for access to paid sick days. Rather than closing the gap in paid sick days during the pandemic, governments across Canada have responded by introducing unpaid, temporary leaves that are restricted to COVID-related reasons. Measures aimed at extending paid sick leave have only been introduced in the Yukon (a rebate accessed at the employer's discretion to provide paid sick days for COVID-related absences) and federally. Federally, a temporary program is set to provide 10 days of income support for COVID-related leave for workers without paid sick days. This program will not address the need for permanent paid sick days and raises concerns about barriers to access that would undermine its effectiveness.

> *The pandemic is still here. We [still] don't have paid sick days. This intensifies the pressure to not miss a day. At my grocery store, we are almost all racialized workers and we take the TTC to work. On the bus there's no way to socially distance. Sometimes I'm literally face-to-face with people and at work I come into contact with over 200 people a day. I'm worried I'm going to get sick. If I get sick I have to stay home without pay and that means losing my financial security. I worry about things like paying rent. We need paid sick days as a security and so we're not expected to come in sick.*
>
> — FELIX, GROCERY STORE WORKER

Canada lags behind other nations globally, in the bottom quarter of countries without guaranteed paid sick leave for workers on the first day of illness — a crucial measure that enables workers to stay home at the first sign of symptoms. Typically, other OECD countries legislate employer-provided paid sick days for short-term illness, with social insurance programs kicking in for longer term sick leave. In the US, which similarly does not guarantee employer-provided paid sick days, many jurisdictions have decided to close the gap. Since 2007, 13 US states and 23 cities or counties have instituted employer-provided paid sick days with positive outcomes for health, equity, business, and the economy.

This report also draws on interviews with workers about their experiences related to paid sick days and a physician survey about prescribing practices for common illnesses and sick notes, both conducted by Decent Work and Health Network members. Based on insights from the interviews and survey, the latest research, and best practices globally, this report advances 5 interrelated principles for effective paid sick day legislation:

- **Universal**: Available to all workers regardless of workplace size, type of work, or immigration status. Legislated, with no exemptions.
- **Paid**: Fully paid to ensure workers are not financially penalized for following public health advice.
- **Adequate**: At least 7 paid sick days provided on a permanent basis, with an additional 14 paid sick days during public health emergencies.
- **Permanent**: Available during the COVID-19 pandemic and beyond.
- **Accessible**: No barriers to access: prohibit employers from requiring sick notes; ensure no disruption of income or unnecessary applications; and provide sufficiently flexible leave that reflects the reality of workers' lives, healthcare needs, and caregiving responsibilities.

We hope these principles will act as a guide for jurisdictions across Canada to move quickly to adopt paid sick leave legislation to protect public health during the COVID-19 pandemic, through the upcoming influenza season, and beyond. The report concludes with recommendations for updating employment standards to provide employer-provided paid sick days — a proven and effective approach.

SUMMARY OF RECOMMENDATIONS:

All provincial, territorial, and federal jurisdictions must update their employment standards to:

- Require employers to provide at least 7 days of paid emergency leave on a permanent basis.
- Require employers to automatically provide an additional 14 days of paid emergency leave during public health emergencies.

Any new paid sick leave legislation must:

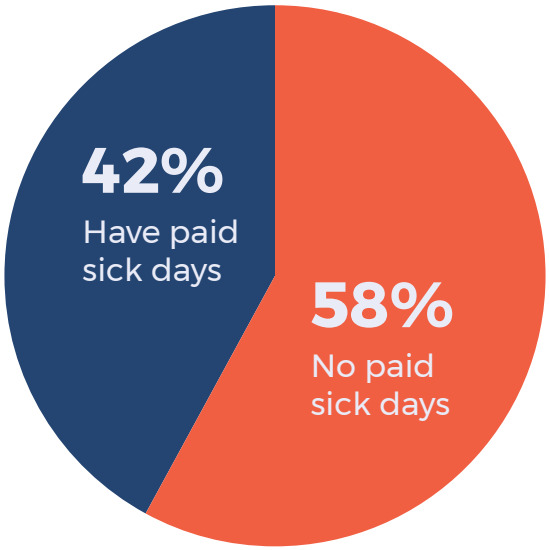
1. Ensure paid sick days are fully paid
2. Ensure paid sick days are adequate
3. Ensure paid sick days are permanent
4. Ensure paid sick days are available to all workers, regardless of employment status, immigration status, or workplace size
5. Prohibit employers from requiring sick notes
6. Prevent the introduction of any new barriers to accessing paid sick days
7. Cover personal sickness, injury, or emergency, as well as family emergencies and responsibilities

INTRODUCTION:
COVID-19 HAS EXPOSED THE GAP IN ACCESS TO PAID SICK DAYS

COVID-19 has highlighted the fundamental public health recommendation, "Stay home when sick." Research demonstrates that staying home when sick is one of the most effective containment strategies for infectious disease.[1,2] The Public Health Agency of Canada (PHAC) recommends that anyone with COVID-19 or influenza symptoms stay home and avoid contact with others.[3,4] Provincial public health agencies in Canada advise self-isolating for up to 14 days after the onset of COVID-19 symptoms. These directives echo global public health agencies: the World Health Organization (WHO) recommends that anyone with COVID-19 symptoms stay home and self-isolate.[5]

Without public policy, however, behavioural recommendations are limited. Despite clear evidence and public health directives to stay home when sick, workers without paid sick days are forced to choose between sacrificing their financial security for public health or going to work sick to support themselves and their families — an untenable choice. The federal government has recently acknowledged that no one should "have to choose between protecting their health, putting food on the table, paying for their medication or caring for a family member."[6] However, a lack of paid sick days persists. In Canada, only 3 jurisdictions have legislated minimal paid sick days: workers in Quebec have 2 paid sick days a year, workers in PEI have 1 paid sick day after 5 years with the same employer, and workers in federally regulated sectors have 3 paid sick days a year.[i] Ontario legislated 2 paid sick days a year in 2018, but the current government repealed them.[7,8]

WHO HAS PAID SICK DAYS IN CANADA?[ii]



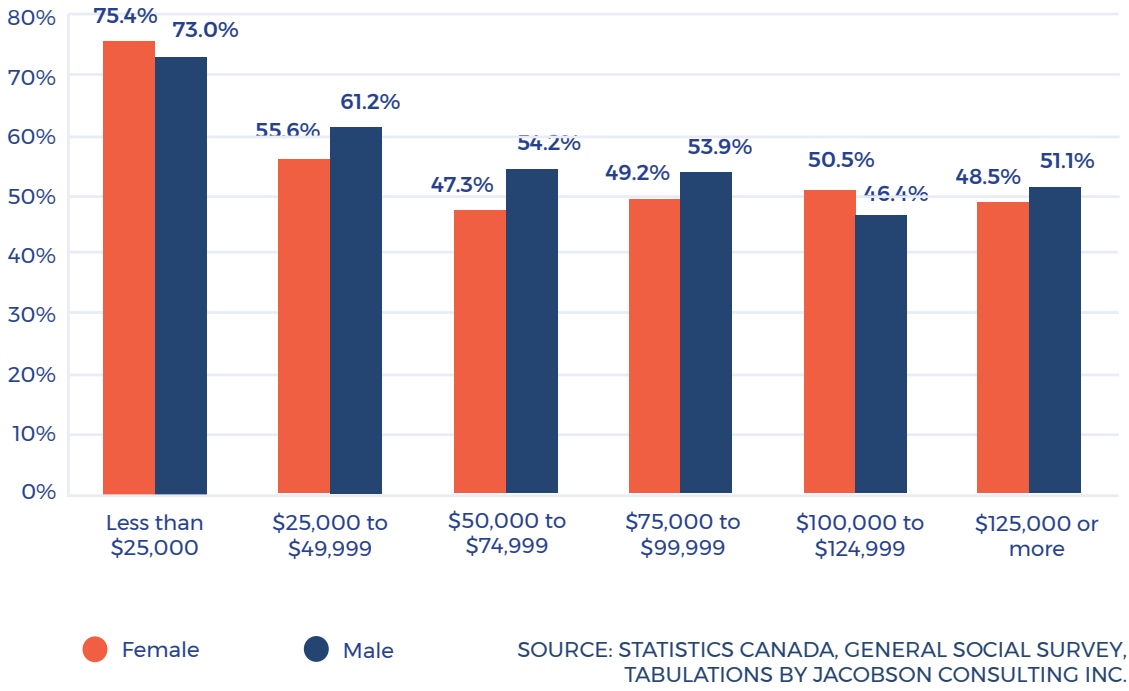
In the absence of legislation, workers rely on workplace policies for access to paid sick days. But a lack of legislative coverage denies paid sick days to over half the Canadian workforce. The most recent data available, from 2016, reveals that 58% of workers in Canada do not have a single paid sick day — ranging from 51% to 61% provincially.[9] Workers without paid sick days are more likely to be in low-wage jobs, which are disproportionately held by women, racialized workers and workers with disabilities. About half of workers making over $50,000 do not have paid sick days, but that number jumps to over 70% for workers making $25,000 or less.[10]

Many low-wage jobs are occupations with a high risk of exposure to COVID-19.[11] In effect, the absence of paid sick leave legislation denies paid sick days to those workers who need them most.[12] This is not only unjust but a threat to public health and the economy. Workers who have been recognized as essential during the pandemic — grocery store workers, care workers, delivery workers, and

i See Appendix A for more information about paid and unpaid sick days across Canada.

ii Yalnizyan A. After CERB: Paid sick leave provisions in Canada. Atkinsonfoundation.ca. https://atkinsonfoundation.ca/atkinson-fellows/posts/after-cerb-paid-sick-leave-provisions-in-canada/. Published June 17, 2020. Accessed August 6, 2020.

LACK OFACCESS TO PAID SICK DAYS BY INCOME AND GENDER[iii]



SOURCE: STATISTICS CANADA, GENERAL SOCIAL SURVEY, TABULATIONS BY JACOBSON CONSULTING INC.

Note: This chart is reproduced with permission from Armine Yalnizyan's brief, "After CERB: Paid sick leave provisions in Canada".

cleaners — are among those denied the essential protection of paid sick days. In the trade and transportation sector, which include grocery store and warehouse workers, 62% of workers lack paid sick days. In the service sector, including food services, the percentage is higher at 75%. Even in the health care and social services sectors, where risk of exposure to infectious disease is highest, 50% of workers do not have paid sick days.[13]

The COVID-19 pandemic has laid bare inequities in the labour market. Income and working conditions are the leading social determinants of health[14] and, predictably, low-wage workers have been hardest hit by the current crisis.[15] Over 80% of COVID-19 cases in Canada have been linked to long-term care,[16] where workers are primarily racialized women earning low wages in precarious jobs.[17] The biggest outbreak in a single workplace was at a Cargill meat-processing plant, where mainly Filipino workers earn low wages and have no access to paid sick days.[18] Outbreaks on farms have led to over 1,000 cases and 3 deaths among migrant farm workers, primarily from the Caribbean and Latin America, who are denied paid sick days and whose temporary immigration status makes it impossible for them to assert their rights.[19] Outbreaks have been reported at grocery stores, nail salons, delivery companies, factories and other workplaces where precarious work is widespread.[20,21,22,23] Public health units have confirmed workplaces are key hotspots for the spread of the virus, especially as economies reopen.[24] The spread of COVID-19 has clearly established precarious work, including the denial of paid sick days, as a public health hazard.

As these outbreaks demonstrate, racialized communities have been most heavily impacted by COVID-19. While Canada does not

iii Yalnizyan A. After CERB: Paid sick leave provisions in Canada. Atkinsonfoundation.ca. https://atkinsonfoundation.ca/atkinson-fellows/posts/after-cerb-paid-sick-leave-provisions-in-canada/. Published June 17, 2020. Accessed August 6, 2020.

collect race-based COVID-19 data (a problem in itself), the disproportionate impact of the pandemic is clear — from the precarious work hotspots to the neighbourhoods most affected. For example, 52% of Toronto's population is racialized, yet racialized people account for 83% of COVID-19 cases in Toronto, and the city's northwest, home to some of the largest Black and Latin American communities, has the highest rate of COVID-19.[25] Racialized workers have also experienced a greater negative economic impact during the COVID-19 pandemic and are more likely to be struggling to pay for food, rent, and bills.[26] The link between systemic racism and health inequity is not unique to COVID-19. It has been well documented that racialized people living on low incomes are at higher risk of acute and chronic illness and death.[27] Increasingly, public health professionals are recognizing anti-Black and anti-Indigenous racism as a public health crisis.[28,29]

> *I have accepted the fact that I'm going to get COVID. I think we all have. We're going to get it because of our working conditions, and we can't stay home when we're sick … If we could take the time off when we had a cough or other symptoms, we could stop this entire process. But because we have no protection, we're forced to come into work. Without exception, all of us are going to get COVID and all of our families are going to get COVID.*
>
> — WYATT, MUNICIPAL WASTE COLLECTOR

Not only a matter of income security and racial justice, access to paid sick days is also central to gender justice. Women not only disproportionately provide care, but they are more likely to report losing wages to care for others, including their children and families when they fall ill.[30] Full-time Canadian women workers took 12.6 days off from work in 2019, in comparison to 8.6 days by men in the same year.[31] Despite requiring more time off due to caregiving responsibilities, women are more likely to have low-wage jobs without access to paid sick days: 2016 data shows that 75% of women earning less than $25,000 have no paid sick days.[32] Recent analysis of paid leave revealed that of the low- to middle-income jobs most likely to be done by women in Canada — caring, clerical, catering, cashiering, and cleaning — only one (clerical work) can be done from home. The others are in-person jobs, often on the front lines of fighting COVID-19, including health care, cleaning, and food preparation.[33] The pandemic and the response, from suggestions to work from home to advice to stay home when sick, have highlighted the gender gap and demonstrated that women's labour is central to the economy but that labour protections for women (especially low-income racialized women) have been marginalized.

Legislating paid sick days is also a matter of disability justice. Statistics Canada data shows that employment for people with disabilities is characterized by precarity. In general, women and men with disabilities were employed most often in retail trade, accommodation, and food services. Men with disabilities also work in construction and transportation, without access to many existing employment standards protections and without paid sick days.[34] Generally speaking, workers with disabilities earn less than their able bodied-counterparts. The absence of paid sick days increases the likelihood of income insecurity among those who already face additional expenses in accommodating disabilities, such as transportation, clothing, and other necessary supports. Three-quarters of people with disabilities require prescription medication, and disabled workers are over-represented in occupations with no supplemental health benefits.[35] A study in San Francisco found that workers with chronic health conditions, alongside single mothers, were the most likely to report needing paid sick days.[36] Persons with disabilities and health conditions who rely on personal attendants and personal support workers are especially vulnerable when workers have no other choice than to work when sick. When gaps in paid sick days create space for outbreaks to occur, they pose a disproportionate threat to chronically ill, disabled and immunocompromised people.

Like vaccines, paid sick days must be universal in order to protect the most vulnerable. The crisis in long-term care illustrates how precarious work and gaps in paid sick days expose the most vulnerable. When low-paid racialized women healthcare workers are denied protections like paid sick days, elderly and immunocompromised people die. It is no coincidence that a majority of healthcare workers who have died of COVID-19 were personal support workers.[37]

To "reduce the health gap," the World Health Organization urges governments to make "decent work a central goal of social and economic policy-making."[38] Paid sick days are a key component of decent work and a key social determinant of health necessary for addressing health inequities. COVID-19 has exposed the glaring gap in access to paid sick days across Canada, and governments at the provincial, territorial, and federal levels can no longer deny the need for all workers to stay home when sick. Since the outset of the crisis, health providers have been recommending 7 permanent paid sick days and an additional 14 paid days during public health emergencies.[39]

Paid sick days save lives. A pandemic amid an economic crisis heightens the urgency of legislating paid sick days, which play a particularly important role during crises. As the WHO explains, it is in times of crisis that workers most "fear dismissal and discrimination when reporting sick," leading to "choosing between deteriorating health and risking to impoverish themselves" with severe impacts on public health and the economy.[40]

Unfortunately, rather than closing the gap in paid sick days during the COVID-19 pandemic, governments in Canada have responded with inadequate provisions that leave the gap wide open. Provincial and territorial governments have mandated unpaid leave as a temporary measure restricted to the COVID-19 pandemic or public health emergencies. The federal government announced a national temporary income support for 10 days of COVID-related sick leave.[41] This is a positive step, which will help some workers take necessary time off related to COVID-19, but provides only temporary support that will end with the pandemic. While details about implementation are forthcoming, this temporary leave provision is not expected to be employer-provided and therefore raises concerns about barriers to access for workers. This type of program is no substitute for permanent paid sick days. To deliver effective paid sick leave legislation, health providers have long been recommending raising employment standards provincially and federally — a mechanism proven to extend access to paid sick days and close the gap.

As we prepare next steps in addressing the pandemic, including a potential second wave of COVID-19 and upcoming influenza seasons, we must learn from the gaps in our sick leave policies exposed throughout the first COVID-19 wave. This report will examine recent and current sick and emergency leave standards in Canada, to evaluate necessary steps to ensure the public health directive to stay home when sick and self-isolate can be achieved for all workers. Five interrelated key principles of effective paid sick leave legislation will be advanced: universal, paid, adequate, permanent, and accessible. We hope these principles will serve as a guide for provincial, territorial, and federal governments to legislate effective paid sick days amid the COVID-19 pandemic and beyond.

SECTION 1
EVIDENTIAL BASIS FOR STAYING HOME WHEN SICK

EVIDENTIAL BASIS FOR STAYING HOME WHEN SICK

Staying home when sick is fundamental to individual health, public health, and the economy. Patients who stay home when they are sick get well quicker and access medical care more promptly, preventing more serious illness.[42] When parents stay home to care for sick children, children stay home and recover faster rather than spreading infections in schools.[43] Beyond the health benefits for individuals and families, enabling people to stay home also serves the public interest. When workers go to work sick, they put their co-workers, clients, and the public at risk of infection, increasing rates of infection and morbidity.[44] Moreover, going to work sick reduces productivity and increases the rate of mistakes on the job, resulting in occupational injuries and a significant economic cost to business.[45]

A. CONTAINS INFECTIOUS DISEASE

Gaps in paid sick days threaten public health. The World Health Organization has recognized that "the absence of paid sick days forces ill workers to decide between caring for their health or losing jobs and income, choosing between deteriorating health and risking to impoverish themselves and often their families."[46] Workers without paid sick days are 1.5 times more likely to go to work with a contagious illness.[47] Canadian research has shown that workers in high-risk settings — food handling, long-term care and child care — will continue to work when ill when they cannot afford to take time off.[48] The Public Health Agency of Canada found that 50% of food handlers reported working with gastroenteritis, and US studies found that 41% of healthcare personnel reported working with the flu.[49,50]

Paid sick days policies have been proven to reduce the spread of disease by increasing the rate at which workers stay home when sick.[51] In the United States, cities with paid sick days saw a 40% reduction in influenza rates during flu waves compared to cities without.[52] By enabling food service workers to stay home when they have gastroenteritis (stomach flu) or other infectious diseases, paid sick days are associated with a 22% decline in rates of food-borne illness.[53] A study of nursing homes in New York found that paid sick leave policies reduced the risk of respiratory and gastrointestinal disease outbreaks.[54] Parents with paid sick days have also been found to be 20% less likely to send sick children to school, thus reducing the risk of children spreading infectious disease at school.[55] This has been recognized by Ontario physicians in a report by the Hospital for Sick Children (SickKids), which recommends paid sick days be part of the province's plan for reopening schools.[56] This is especially important for children who are at higher risk due to chronic medical conditions, immunocompromised states, or developmental disabilities. As noted earlier, people with disabilities very often rely on the health and well-being of personal attendants and personal support workers, many of whom have no paid sick days. Paid sick days are also associated with higher influenza vaccination rates, resulting in increased vaccination coverage, which helps contain the spread of the flu.[57]

> *As a community worker at a respite shelter downtown, I am often in contact with those who are sick or have weak immune systems. This means I am constantly getting sick and run the risk of infecting others at my workplace. One of the guests actually passed away from a lung infection. I'm not blaming anyone, but it's fair to say that from a public health perspective, our sick leave policies definitely didn't make his chances better.*
>
> — JENNIFER, COMMUNITY WORKER

Overwhelming evidence indicates paid sick days significantly reduce the spread of infectious disease. The Public Health Agency of Canada recognizes that ensuring ill people do not enter the workplace is a key strategy for mitigating the risk of infectious disease spread. Well-designed paid sick leave policy is critical to ensure workers stay home when they are sick, including during the COVID-19 pandemic.

B. ESSENTIAL DURING OUTBREAKS

During the COVID-19 pandemic, the Public Health Agency of Canada has encouraged employers to consider "adjusting personal/sick leave policies to enable employees to stay home when ill."[58] While COVID-19 has heightened the importance of paid sick days policies enabling sick people to stay home, previous outbreaks of infectious disease also demonstrated the key role paid sick leave can play in containment. The current outbreak highlights gaps that have been left open for far too long.

After the 2003 SARS outbreak in Toronto, a study based on interviews and focus groups with affected people revealed fear of income loss was the top impediment to observing quarantine.[59] The World Health Organization has recognized that laws should ensure compensation for those financially impacted by public health orders, which is particularly important for those with lower incomes.[60] In Ontario, an independent commission established to examine how SARS was handled found that paid leave during quarantine was a crucial element of the province's response to the virus. After initially suggesting financial compensation was not feasible, the provincial government ultimately developed a compensation system for workers who lost wages due to quarantine or caring for someone else in quarantine. Despite criticisms concerning delayed implementation (the system came into effect about 3 months after the first cases of SARS in Ontario were identified), experts have deemed compensation to be critical to the success of quarantine measures that contained the spread of SARS. As a result, the commission recommended legislating compensation for workers who lose wages due to quarantine *in advance* of the next public health emergency.[61]

After the H1N1 pandemic in 2009, a US survey found that adults without paid sick days were more likely to go to work sick. A quarter stated they would not get paid if they stayed home, and 1 in 6 would lose their jobs.[62] These gaps in paid sick days created major breaches of public health that exacerbated the pandemic: up to 8 million workers took no time off work despite being infected, which is estimated to have caused 7 million additional infections among co-workers.[63] Another study of the H1N1 pandemic found that gaps in workplace policies contributed to more than 20,000 hospitalizations and more than 1,300 deaths, and that racialized workers were disproportionately affected because they had a greater inability to engage in social distancing at work. The study concluded, "Federal mandates for sick leave could have significant health impacts by reducing morbidity from influenza-like illness, especially in Hispanics."[64]

> *I got viral pneumonia in January. I could not call in sick because I get financially penalized. I couldn't go to the doctor because I was working until 10:00 PM. I couldn't get treated. I ended up giving viral pneumonia to 35 other employees in the workplace, and they gave it to their families — that's just from my case alone. I essentially gave viral pneumonia to about 250 other people. If I don't have access to paid sick days and my co-workers don't have access to paid sick days, and we're collecting the city's entire municipal waste, COVID-19 is going to hit us all and hit us hard. My concern with sick days has always been that if we can't protect ourselves as waste collection or essential workers and we fall, we bring a whole community down with us.*
>
> — WYATT, MUNICIPAL WASTE COLLECTOR

The COVID-19 pandemic has therefore not only exposed the gaps in paid sick days, which disproportionately affect low-income women, racialized, and workers with disabilities, but also the failure of governments to learn from past pandemics in order to keep people safe. The overwhelming message from public health agencies during this pandemic has been that people should stay home when sick and engage in physical distancing. People with COVID-19 symptoms need to self-isolate until they get their results (which can take days) and until their symptoms resolve, and those who test positive need at least 14 days

of self-isolation. But this crucial public health advice has limited effect when all workers do not have access to the paid sick days required to follow these directives without losing income. Research on self-isolation during the COVID-19 pandemic has suggested that when compensation is assured, compliance is almost 40% higher.[65] Paid sick days are essential to protecting public health during outbreaks, during the COVID-19 pandemic and beyond.

C. HEALTH AND HEALTHCARE BENEFITS

Gaps in paid sick days also contribute to healthcare costs. In the US, workers without paid sick days have been found to be twice as likely to use hospital emergency rooms for personal illness and more than twice as likely to take a family member to an emergency room because they could not take time off work.[66] So, in addition to containing the spread of infectious disease, providing paid sick days increases workers' access to primary care and reduces the likelihood of emergency room visits. A national sample of working adults with health insurance in the US found that paid sick days were significantly associated with increased use of outpatient care and reduced use of the emergency department. It concluded that "paid sick days may serve as a protective factor" from emergency room visits, which improves continuity of care and reduces healthcare expenditures.[67]

Paid sick days also enhance preventive care. Workers without paid sick days are 3 times more likely to delay or forgo medical care,[68] and female employees without paid sick days have lower rates of clinical breast exams and mammograms.[69] Conversely, workers with paid sick days have higher rates of cancer screening — including screening for breast, colon, and cervical cancer — and annual checkups.[70] A study of universal paid sick days in the US used modelling to predict vaccinations would increase by 1.6 million and result in 18,200 fewer healthcare visits annually.[71] By increasing access to preventive and primary care, paid sick days improve population health and reduce the burden of unnecessary visits and costs on the healthcare system.

> *I am really worried that if I take time off from work for my diabetes appointments, my employers will fire me. What that means is that I've been pushing back my appointments. I've been missing the appointments. My blood sugar levels ended up getting really high and my diabetes took a turn for the worse. So, my doctor placed me on stronger insulin therapy. Since my diabetes was getting worse, I started having other complications with my feet and my blood pressure. I had a podiatrist appointment too and I missed it, so I ended up developing an infection in one of my toes. I almost lost my toe.*
>
> — ALEXANDRA, EARLY CHILDHOOD EDUCATOR

> *I worked as a part-time nurse in a hospital and because I was part-time, I didn't get any benefits. This meant that even though I was picking up shifts and working full-time hours, I didn't have paid sick days. I ended up hurting my back but felt like I couldn't take the time off. So, I kept working and ended up injuring my back even more.*
>
> — KATIE, REGISTERED NURSE

> *In February, I got really sick with a cold, and I didn't take the sick days because it was so early in the year and I was worried about taking them for myself. What if my daughters are sick or there is an emergency with the school? My cold was bad. I couldn't shake it. Usually when I'm sick, I'm sick for about a week, but I went to work anyway, and I was sick for 2 weeks. I just took medicine, but I knew that I still had the sickness. [With time off] I think my recovery time could have been shortened by half. Even if I could have taken one or two days off, I would have felt better. But that would've been a luxury for me. One I felt I couldn't take.*
>
> — NANCY, HUMAN RESOURCES AND FINANCE ADMINISTRATOR

D. REDUCING PRESENTEEISM IS GOOD FOR BUSINESS

Much of the hypothetical concern about expanding access to paid sick days centres on the economic impact of workers staying home when sick. These concerns not only exaggerate absenteeism related to paid sick days, but ignore the greater threat of presenteeism, that is "the phenomenon of people, despite complaints and ill health that should prompt rest and absence from work, still turning up at their jobs."[72] In fact, studies show that workers carefully use paid sick days as intended and, as a consequence, are able to return to work faster and healthier with lower rates of chronic illness.[73,74]

Workers who are denied paid sick days do not avoid illness. On the contrary, they bring their infections to work and transmit them to their co-workers, take longer to recover from illness, are less productive, and have less satisfaction at work. Workers without paid sick leave also report higher levels of psychological distress, and are almost 1.5 times more likely to report that symptoms of distress "interfere a lot with their life or activities."[75] Benefits Canada reports that mental health is among the top short- and long-term disability trends, noting that failure to address early symptoms with short-term mental health days results in longer term, more costly absences.[76]

Paid sick days have a protective effect on mental and physical well-being, allowing workers to perform better on the job, increasing productivity, and preventing burnout. Going to work sick results in more mistakes and a higher risk of injury, and workers with paid sick days have been found 28% less likely to get injured at work.[77,78] Paid sick days have been shown to reduce the chance of workers leaving a job by 25%, resulting in substantial savings for business due to reduced turnover.[79] Evidence consistently demonstrates that the cost of presenteeism in lost productivity is higher than absenteeism — with US research suggesting it could be as much as 10 times higher.[80,81]

> *Having 2 paid sick days was a source of protection from the heavy workload and mental stress of being a professor. I knew I could take a day off to prevent extreme burnout when my anxiety and depression were becoming really intense. Knowing that I had paid sick days made me feel more secure and more able to complete my job duties*
>
> — CLARA, COLLEGE PROFESSOR

> *When you are sick, you cannot take care of other people. You should be able to stay home until you recover, so that you can give patients the care they deserve.*
>
> — ELENA, PERSONAL SUPPORT WORKER*

* Elena went to work throughout her own chemotherapy treatment for breast cancer.

SECTION 2
BEST PRACTICES FOR PAID SICK DAYS LAWS GLOBALLY

BEST PRACTICES FOR PAID SICK DAYS LAWS GLOBALLY

A. CANADA LAGS BEHIND OTHER COUNTRIES

The case for paid sick days is widely accepted around the world. A recent study showed that 181 countries have some form of national paid leave for sickness.[82] Most OECD countries provide long-term paid sick leave through a social security system and provide paid sick days for short-term illness or the initial portion of longer paid sick leave through employers.[83] This two-stage model of social insurance and employer-provided paid sick leave has benefits, including facilitating the administration of short-term leave and higher average income replacement rates.[84]

Canada lags behind other countries in guaranteeing workers access to adequate paid sick days for short-term illness. Canada is in the bottom quarter of countries worldwide that do not guarantee paid sick leave on the first day of illness — a crucial measure that enables workers to stay home at the first sign of symptoms.[85] In 19 of 34 OECD countries, employers are required to pay at least the first week of sick leave.[86] Analysis of paid sick leave in 22 countries ranked highly for economic and human development revealed that, for a 10-day illness, workers are entitled to at least 7 days of paid leave in Australia, Austria, Belgium, Finland, Germany, Greece, Iceland, Luxembourg, Netherlands, Norway, Sweden, and Switzerland. Canada is one of only 5 of these 22 countries where employers are not required to pay for paid sick days for short-term illness (except for minimal paid sick days in Quebec, PEI, and for federally regulated workers).[87]

For longer term illness, Canada's Employment Insurance (EI) system provides up to 15 weeks of sick benefits, equivalent to 55% of earnings (up to a maximum $573 per week), to workers who qualify. In Canada, only about 40% of unemployed workers currently receive regular EI benefits, dropping to less than 30% in urban centres.[88] EI sickness benefits provide crucial leave for workers facing longer term illness and efforts must be made to improve this benefit and expand access. EI sickness benefits, however, are not designed to ensure workers can stay home at the first sign of symptoms or for short-term illness, which is why effective paid sick leave legislation is crucial.

Responsibility for mandating paid sick days in Canada lies with provincial, territorial, and federal governments, through employment standards. Most Canadian jurisdictions only provide unpaid, job-protected leave for sickness. Prior to 2018, only PEI provided paid sick leave in the form of only 1 day after 5 consecutive years of work. In 2018, Ontario began to provide 10 flexible job-protected personal emergency leave (PEL) days to all workers, with the first 2 days paid, and removed the ability for employers to demand a medical note. Unfortunately, in 2019, the new provincial government revoked these 2 paid days, restricted how the remaining 8 days are used, and brought back the bureaucratic barrier of allowing employers to require a sick note. In January 2019, Quebec instituted 2 paid days of sick or family leave after 3 consecutive months of employment. In September 2019, the Canadian government amended the *Canada Labour Code* to provide federally regulated workers with 5 personal leave days, the first 3 days paid.[iv] Workers in the rest of the country are left to rely on workplace policies and collective agreements to gain access to paid sick days, which leaves the gap in paid sick days wide open.

Shockingly, in response to the worst global pandemic in a century, no Canadian jurisdiction has raised employment standards to expand access to paid sick days. All provincial governments have provided some form of job-protected emergency leave, and most have prohibited employers from requiring medical notes. These leaves, however, are temporary, unpaid, and restricted to COVID-related absences. The only province to expand permanent leave entitlements is British Columbia, which legislated 3 unpaid days of sick leave, bringing them more in line with unpaid leave protections offered in other provinces.

iv See Appendix A for more information about paid and unpaid sick days across Canada.

> *I was so happy when the 2 paid sick days came in 2018. I work part-time as a receptionist in a non-union position, so for the first time ever I had paid time off. I got the flu in 2018 and 2019. I took 2 days off both times, but my experience was very different. When I got the flu [in 2019], I felt I couldn't relax because I didn't have paid sick days. My financial situation is very tight, so I would have gone to work even though I was sick if I hadn't lost my voice. But since I work as a receptionist, I need to be able to speak. I felt very stressed. I was still recovering weeks later. In 2018, when I had the paid sick days, I didn't feel stressed about missing the day's wages. When I was at home, I didn't worry about work, I just focused on getting better. It took me about a week to feel better.*
>
> — BEATRICE, RECEPTIONIST

More than 6 months after the onset of the pandemic, measures to extend paid sick leave have been introduced only in the Yukon and federally. The Yukon introduced a rebate for employers providing paid sick days, but the measure is temporary, limited to COVID-related absences and accessed at the employer's discretion.[89] The federal government introduced a temporary national sick leave program that aims to provide income support for 10 days of leave related to COVID-19 for workers currently without paid sick days.[90] This temporary measure will help some workers who need income support to take sick leave related to COVID-19, but unfortunately does not address the need for permanent paid sick days during and after the pandemic. Moreover, while implementation details have yet to be released, an approach to sick leave that does not mandate employer-provided paid sick days raises concerns about ease of access. In order to enable workers to take time off at the first sign of symptoms, it is essential that they face no disruption of income or barriers to access, such as sick notes or application forms. The federal government could provide leadership on this issue by guaranteeing adequate paid sick days in the *Canada Labour Code* and encouraging provinces to follow suit.

B. LEARNING FROM PAID SICK DAYS LAWS IN THE US

Like Canada, the United States has no national paid sick days policy. However, over the last decade, several jurisdictions have introduced their own paid sick days mandates to close the gap, and Canada could learn from this experience. In 2007, San Francisco became the first jurisdiction in the US to mandate paid sick days[91] and, in 2014, New York City became the largest jurisdiction, extending paid sick days to 1.4 million workers.[92] Overall, 13 states and 23 cities or counties across the US have instituted paid sick days.[93,94] Typically, these laws mandate up to 40 hours (5 days) of sick leave accrued at an hour of sick time for every 30 to 40 hours worked per year.[95]

Jurisdictions that recognized the benefits of employer-provided paid sick days before the pandemic are also expanding them during the pandemic. On March 17, 2020, New York state enacted legislation that requires large employers to provide 14 additional paid sick days for COVID-related leave during the pandemic,[96] and several weeks later passed legislation to extend permanent paid sick days statewide by 2021.[97] In July, Colorado introduced one of the most comprehensive paid sick days laws in the US to date, including up to 48 hours (6 days) of permanent paid sick time and to up to 80 hours (10 days) of paid sick time during public health emergencies, available to all workers.[98] At the federal level, in March, US Congress passed a bill that provides up to 80 hours of paid leave for COVID-related reasons, which could have greatly closed the gap in paid sick days at the most urgent time. Unfortunately, after a more robust version was introduced, the bill was altered to exclude as many as 106 million workers, dramatically

reducing its efficacy.[99,v] However, Colorado took an encouraging step and mandated coverage at the state level for those explicitly excluded from the federal bill.[100]

The expansiveness of paid sick leave varies across US jurisdictions, with the additional weakness that some paid sick leave mandates create gaps based on workplace size or worker classification, without basis in public health. But policy-makers have taken some steps to close these gaps. In New Jersey, a more expansive employee definition ensured that workers exempt from minimum wage laws (often domestic and agricultural workers) were not also excluded from paid sick days. Almost no US paid sick leave requires a minimum number of hours worked, and include part-time, full-time, seasonal, and temporary workers. Unfortunately, independent contractors in the US are not covered by paid sick time, many of whom are misclassified when they are in fact employees.[101] This is a key gap that Canadian policy-makers should take seriously and aim to address.

Experience in US jurisdictions demonstrates that legislating paid sick days is not only necessary but feasible. In fact, employer-provided paid sick days are a proven approach to closing gaps in access, resulting in positive outcomes for health, equity, business, and the economy. Another key US lesson is that paid sick days do not lead to abuse by workers but must be accompanied by a commitment to enforcement to ensure employers are compliant. Lessons from the US experience of legislating paid sick days are outlined below.

a. Paid sick days promote health and equity

The public health benefits of paid sick days in terms of containing infectious disease are widely recognized, which is especially important for people with chronic health or immunocompromised conditions. Workers with disabilities face added expenses generally, are over-represented in precarious occupations, and suffer more harm from the dearth of paid sick days.[102] Just as importantly, providing paid sick days to attendants, support workers, and other care workers is essential for protecting workers' health and the health of the people they serve.[103] In San Francisco, research shows that mandating paid sick days allowed workers to better care for their own health needs, attend medical appointments, and care for children and the elderly. One in four workers report being better able to care for their own and their family's health needs after paid sick days came into effect.[104]

> *I remember one time my son was really sick, so I took him to the hospital. I had to stay at the hospital until 3:00 AM. The next day, I couldn't stay home with him, so I had to take my son to my work. I had no other choice. One of my co-workers even said to me, "It's not good for him to stay here, he's sick, he needs to rest. And, I can see you are also struggling." So, she actually ended up covering for me and did a long shift so that I could go home.*
>
> — RUMI, FINANCE ADMINISTRATOR

> *I have to do whatever it takes to try and save my sick days. When you have 2 small children you never know what's going to happen. One time, my young daughter got hand, foot and mouth disease and she had to stay out of daycare for 5 days. After that, my daughter's immune system was weak, and she got sick very often. I remember feeling stressed because whenever she was sick, I had to stay home and do mental calculations to think about how many sick days I had left, and whether this would affect my future employment.*
>
> — NANCY, HUMAN RESOURCES AND FINANCE ADMINISTRATOR

v Exclusions from the paid leave provided under the Families First Coronavirus Response Act (FFCRA) include businesses that employ over 500 workers, businesses with fewer than 50 employees, certain healthcare providers and emergency responders, and some federal government workers. As a result, the majority of private sector workers are excluded, including many of the low-wage workers who need paid days most. For example, more than 2 million grocery store workers are excluded, despite being essential workers at risk of contracting COVID-19 at work.

The benefits of closing the gaps in paid sick days have been particularly felt among racialized, low-wage women workers. Across the US, being younger, female, racialized, less educated, or a farm/blue collar worker is consistently associated with reduced likelihood of having paid sick days.[105] In San Francisco, Black, Latinx, and low-wage workers were most likely to benefit from mandated paid sick days; Black and Latinx workers, older workers, and mothers were more likely to report better management of their health.[106] Mandating paid sick days improves the ability of women and workers in households with children to stay home when sick,[107] and access to paid sick days reduces the economic burden of staying home for women and racialized workers.[108]

b. *Closing the compliance gap is key to effective paid sick days*

It is a popular misconception that expanding access to paid sick days will invite widespread abuse, creating a gap between use of paid sick days and legitimate need. Studies of jurisdictions that have mandated paid sick days disprove such claims, while highlighting the need for enforcing paid sick days legislation to close the compliance gap.

> *In 2018, when I had paid sick days, I actually didn't take them because I wasn't sick. I was saving them for when I needed them. In 2019, they got taken away and unfortunately that year I got the flu and had to take unpaid sick leave.*
>
> — ASTRID, RECEPTIONIST

When San Francisco mandated up to 9 paid sick days, workers used an average of 3 and a quarter used none,[109] illustrating how workers treat paid sick days as insurance and use them carefully, in cases of personal or family emergencies and for necessary medical appointments. While there was no evidence that workers abuse paid sick days, some employers did: one-sixth did not provide paid sick days as mandated by law, and racialized workers were more likely to be penalized for using their paid sick days.[110]

> *When I started this position in 2018, I had 2 paid sick days but did not get sick, so I did not take them. I currently do not have access to any paid sick days. Not having any paid sick days is a big financial stressor, a burden on my own health, and a risk to the health of those around me.*
>
> — JENNIFER, COMMUNITY WORKER

When New York City mandated paid sick days, a survey of employers found that "fully 98 percent of respondents reported no known cases of abuse and only 0.3 percent reported more than 3 cases."[111] Whereas workers used paid sick days appropriately, many employers did not provide them as required by law. A year and a half after the law came into effect, only 58% provided them to all employees as required by the law, while 42% only provided them to some categories of employees. When paid sick days were only made available to some workers, part-time, temporary, or on-call workers tended to be denied access, with over two-fifths of their employers denying paid sick days to workers with less than full-time hours.[112] Therefore, closing gaps in paid sick days through legislation does not lead to workers abusing them, but does require enforcement to ensure employers comply.

c. *Paid sick days benefit small businesses and the economy*

Another popular misconception is that mandating paid sick days will harm the economy, especially small businesses. Studies not only disprove this claim but have found that the majority of businesses support paid sick leave legislation. In San Francisco, two-thirds of employers supported the new law, and six out of seven did not report any negative effect on profitability.[113] In New York City, a survey of employers (the majority of whom had less than 50 employees) found that they "were able to adjust quite easily to the new law, and for most the cost impact was

minimal to nonexistent." A year and a half after the paid sick days law in New York City took effect, 86% of employers supported the law, 91% did not reduce hiring, 97% did not reduce hours, and 94% did not raise prices. In fact, job growth continued in New York City after the paid sick days law was implemented.[114]

Despite this reality, misconceptions about paid sick days being bad for small businesses have continued to be perpetuated, particularly in the US. These concerns have led to exclusions for employers who employ less than a certain number of workers in several American jurisdictions, contrary to public health and against global trends. In fact, no other country makes paid sick leave dependent on the size of a workplace.[115] Moreover, excluding small workplaces disproportionately impacts workers in precarious employment. For example, domestic workers have been vocal about how policy gaps in small workplaces exclude them from paid sick days laws and have won a shift away from this approach in some jurisdictions.[116]

The COVID-19 pandemic has created hardship for small businesses, which have been calling for supports like rent relief and wage subsidies. It is crucial that policy-makers take seriously their responsibility to support small businesses at this time. But perpetuating gaps in paid sick days does not benefit anyone and poses a severe threat to public health. The COVID-19 pandemic has made clear that small workplaces, such as nail salons, are not immune to workplace spread. The American experience has demonstrated that exclusions based on workplace size are economically unnecessary, and that inclusive paid sick day laws are most effective.[117] Moreover, current Canadian guidance for workplace risk mitigation is not differential based on business size, but rather emphasizes key public health measures, including sick leave policy for workplaces of all sizes.[118]

> In a small business, you know your employees, and it's very rare that someone will abuse a paid sick day. In fact, in my experience, you have to tell someone to go home because they're feeling sick, rather than wondering where they are.
>
> If an employee is a manual labourer, the thought of them making a mistake is terrible, whether it's around machinery or making a mistake where they slip because they're not feeling so great or they're dizzy or have the flu — and the worker's compensation cost to me is almost their entire year's salary.
>
> For the knowledge worker in IT, marketing or sales, which is most of the workers our company is involved with — the cost of their mistake is way more than paying for a day of that employee not being there. But more importantly, when employees feel that when they're at work they can engage in what they're doing and they can just enjoy it, it makes a big difference to me.
>
> We worry too much about the abuse [of paid sick days], and not enough about the benefits from a societal, individual, and corporate basis. We're hung up on this little bit of abuse, which most people don't do.
>
> — PAUL HAYMAN, SMALL BUSINESS OWNER IN ONTARIO

SECTION 3
GUIDING PRINCIPLES FOR EFFECTIVE PAID SICK DAYS POLICY IN CANADA

GUIDING PRINCIPLES FOR EFFECTIVE PAID SICK DAYS POLICY IN CANADA

Much work remains to be done to close the gap in access to paid sick days in Canada. We have identified 5 principles for effective paid sick days policy. These principles may act as a guide for jurisdictions across Canada as they aim to adopt paid sick leave to protect public health during the COVID-19 pandemic and beyond. These interrelated principles describe who needs sick days, what kind of sick days are required, when they are required, and how workers should access them. They are followed by recommendations for the ways in which effective paid sick days should be implemented in Canada.

A. UNIVERSAL

For paid sick days to be effective, they must be available to all workers. COVID-19 has demonstrated that infections anywhere are a threat to public health everywhere. Outbreaks in long-term care call for closing the gap in paid sick days for precariously employed personal support workers. Outbreaks on farms call for closing the gap in paid sick days for migrant workers. Outbreaks in nail salons call for closing the gap in paid sick days in small workplaces and among workers misclassified as independent contractors. Sick leave policy will not protect public health if it is not available to everyone. There must be no gaps excluding workers from paid sick days based on workplace size, type of work, or immigration or employment status.

Legislated paid sick days under provincial, territorial, and federal employment standards must be universal — available to all workers, no exceptions. Unfortunately, many exemptions to other provisions in employment standards do currently exist. For example, in Ontario, workers in agriculture, information technology, and construction do not have the same protections for hours of work and overtime afforded to other workers.[119] These types of exemptions erode the ability of employment standards to protect workers, especially those in low-wage and precarious work. No exemptions of this kind should be replicated or introduced with respect to paid sick days.

Achieving universal paid sick days is also threatened by practices such as misclassification, contracting out, and hiring through temporary agencies. A review of Ontario labour laws in 2016 confirmed that employers misclassify workers to "avoid the direct financial cost of compliance with the ESA and other legislation."[120] The federal government recognized the changing nature of workplaces and expanded the Canada Emergency Response Benefit (CERB) to include those who are misclassified as independent contractors or self-employed, and others who do not qualify for EI.[121] Jurisdictions across Canada should broaden the definition of employee under employment law — including with respect to paid sick leave entitlements — to include all workers who are paid to perform work or supply service for mandatory compensation.[122] This will help ensure paid sick days introduced in employment standards leave no gap in universality.

Paid sick leave legislation must also be accompanied by active enforcement to ensure it has the intended impact. In Canada, federal government and Statistics Canada research have shown that violations of the *Canada Labour Code* are widespread at the federal level, with half of employers found to be in partial violation.[123] Similarly, in Ontario, surveys of workers in low-wage and precarious jobs revealed that over one-third were owed unpaid wages, did not receive overtime pay, and lost their jobs without termination pay or notice.[124] Experience in US jurisdictions also demonstrates the importance of paid sick days laws being accompanied by strong enforcement: while New York City's law mandated paid sick days be available to all workers (including part-time, temporary, and undocumented workers), many employers denied paid sick days to these same workers in violation of the law. Consequently, it is essential that paid sick leave legislation be accompanied by an expanded, proactive deterrence model of enforcement, which worker advocates have been calling for.[125]

All workers must have access to paid sick days — irrespective of workplace size, employment terms, or immigration status. Paid sick days must therefore be universal, a standard part

of every worker's benefits. This is a health and a social imperative. Paid sick days as a public health intervention will only be maximally effective when made available to everyone.

> *There was an excess of work without any breaks. There was no such thing as time off in any capacity. This led to back and hand injuries for almost every person I worked with, including myself. On one occasion, we went to our boss and told him our hands were going numb and our backs were aching. He said this was a normal part of our work and to just take an Advil. But we had been taking Advil and the pain was getting worse and my hands were almost always completely numb. The repetitive motion wore our tendons and wrists down. When some of us tried to assert our rights we got ridiculed and bullied by our employer and supervisors. Through a friend, I was able to go to the clinic to see a doctor. The doctor told me that I had a serious injury to my wrists and that if I kept working it was going to ruin them completely. I told my employer and the others. He did not report it, split us up into different work groups, and the bullying got worse.*
>
> — JOSE, MIGRANT FARM WORKER

B. FULLY PAID

For sick days to be effective they must be fully paid. When a worker gets sick, their having the financial means to stay away from the workplace to recover and reduce infection transmission is a public health imperative. Unpaid, job-protected leave provides no assurance of income and is a disincentive to workers staying home. A similar barrier arises when the replacement rate for paid sick leave is less than a worker's baseline income. Creating an income gap perpetuates the paid sick leave gap, contributing to presenteeism. One study reports that, in Germany, when the rate of paid sick leave income replacement was lowered from 100% to 80%, the reduction in sick pay led to an increase in contagious presenteeism or people going to work sick.[126]

Ensuring sick days are fully paid is critical, or our communities will pay for it with sick workers, sick co-workers, sick clients, and worse public health.

Lower replacement rates are particularly unfeasible for low-wage workers who are disproportionately women, migrant and racialized workers, and workers with disabilities. For a minimum wage worker, anything less than a full income replacement rate puts them at risk of falling below (or further below) the poverty line. For those workers who need it most, unpaid or low-paid sick leave is not affordable.[127] Closing the gap in fully paid sick days is not only a matter of public health, but also of equity. To ensure symptomatic and unwell patients stay home, paid sick days must be fully paid at a rate equivalent to a worker's wage.

> *I barely make enough to get by as it is. If I miss 1 or 2 shifts, it's tight financially. So, I try to make up the hours the following week because I don't want to lose the cash. Then I'm trying to catch up again to zero, which is not a fun game to play because I'm still not feeling well and working extra.*
>
> — JENNIFER, COMMUNITY WORKER

C. ADEQUATE

For paid sick days to be effective, they must also be adequate. This concept has been partially recognized through provincial pandemic responses, which provide at least 14 days of unpaid leave for people with COVID-19 who need that many days of self-isolation. However, these are temporary measures for unpaid leave, which fall short of the interconnected principles of sick days being paid and permanent.

For years prior to the COVID-19 pandemic, health providers have been calling for paid sick days adequate for non-pandemic times. Since 2015, health providers across Ontario have petitioned the provincial government to provide 7 paid sick days to all workers.[128] Seven days is reasonable and necessary to account

for physician prescribing practices for common illnesses. A 2019 survey of 182 physicians found they recommend patients with influenza-like illnesses stay home for a median of 4 days. For an upper respiratory tract infection (including the common cold) and gastroenteritis (stomach flu), physicians advise patients to remain home from work for a median of 2 days. For all conditions, a substantive portion of physicians advise patients to remain at home until the fever has resolved.[129] Adequate paid sick days must reflect the fact that every worker needs time off when they or their children are sick.

> *I was having serious issues with my mental health, but I was going to work anyway because I can't fall behind financially. It got to the point that I was forcibly hospitalized. If that hadn't happened, I would've kept going in that state, and that is not okay. I was so terrified and I knew I couldn't skip out on my bills.*
>
> — AMELIA, RETAIL WORKER

The number of paid sick days should reflect workers' lives. Statistics Canada provides measures of time lost from work because of personal reasons — specifically illness or disability, and personal or family responsibilities. In Canada, the average number of days lost per worker per year, for illness and disability, was 7.4 in 2015 and 8.4 in 2019. For women, the average number of days lost per year in the same category was 10.4 in 2019, compared to just 7 for men. The average number of days lost per worker per year for personal or family responsibilities was 2.2 for women and 1.6 for men in 2019.[130]

Like any medical intervention, the dose matters: a US study found that "a moderate number of paid sick days (6 to 9) indicated a significantly higher profile of having accessed preventive services compared with those with 0 to 2 days … and paid sick days of 10 or more days indicated an even higher profile."[131] Faced with the current pandemic, the government should expand paid sick days to include at least 7 permanent paid sick days, which health providers have been calling for,[132] plus 14 additional paid days during the pandemic.[133] If workers need 14 days of self-isolation with COVID-19, as recommended by local and international public health organizations, then they need 14 paid sick days for public health emergencies, as legislated by other jurisdictions.

> *The pressure has built up so much with my conditions at work that I have developed issues with my mental health. I've been depressed and started getting panic attacks. The panic attacks can be really severe and debilitating, but I know I have to go to work. So, I try my best and go to work anyway, but that means my mental health is bad for much longer. When I do take half days off, I have to use my vacation time because I don't have paid sick days. What this means for me is that I basically spend my vacation in bed.*
>
> — RUMI, FINANCE ADMINISTRATOR

D. PERMANENT

The need to protect public health doesn't end after a pandemic. On the contrary, pandemics serve to highlight longstanding deficiencies in public health, and should encourage policy-makers to close the gaps so that societies can be healthier between pandemics and more resilient during them. In response to COVID-19, the federal, provincial, and territorial governments have expanded job-protected leave, but these leaves are temporary and restricted to reasons related to COVID-19. Paid sick days must be permanent, available during and after the pandemic, and not restricted to COVID-19.

The difference between COVID-19 and other illnesses is not always obvious. Symptoms of COVID-19 are non-specific and similar to many other viral illnesses, including influenza. Unfortunately, COVID-19 tests also have a high false negative rate.[134] Hence, public health authorities continue to recommend self-isolation for people with symptoms, even after they have received negative test results.[135] Access to paid sick days also improves

preventive care for diabetes, hypertension, and heart disease,[136] which are risk factors for severe COVID-19 and other acute illnesses. In addition, access to paid sick days is associated with higher vaccination rates, which are crucial for protecting against annual influenza.[137] Vaccination strategies are also expected to mitigate COVID-19 risks in the future. Universal paid sick days must continue beyond the current COVID-19 crisis to ensure that workers have access to vaccination strategies and preventive care, mitigating the risk of contracting COVID-19 and other illnesses.

> *I was managing a chronic medical condition in my hands. I used up all of my unpaid leave to go to my appointments and I ended up running out of days. Then, I had to use my vacation time or I went to work sick.*
>
> — XIMENA, FACTORY WORKER

In heeding the clear lessons of the 2009 H1N1 pandemic, the annual flu season, and the first wave of COVID-19, governments should provide permanent paid sick days for all workers, thereby reducing the impact of the ongoing pandemic and improving public health afterward. Pandemics demand additional temporary public health measures, but also serve as an opportunity to close the permanent gap in paid sick days — like in the states of New York and Colorado, which have legislated permanent paid sick days, with additional days during pandemics.

The pandemic might be a temporary emergency, but public health is a permanent necessity. Any response to COVID-19 should be designed to improve population health beyond the pandemic. For example, access to public health services in Ontario (covered through OHIP) was expanded for undocumented workers during COVID-19, and a national coalition is now demanding health for all, regardless of status, beyond the pandemic.[138] Similarly, paid sick days need to be universal and permanent, so workers and public health is protected during COVID-19 and afterward.

E. ACCESSIBLE

If sick days are universal, paid, adequate, and permanent, they will still fail to protect public health if barriers to their accessibility exist. Sick note requirements, disruption to income, and restrictions on how sick days are used all create serious gaps between the need for paid sick days and their use. Effective paid sick days must be seamlessly accessible.

a. No required sick notes

Staying home when sick is fundamental to public health but allowing employers to require sick notes creates an unnecessary barrier to accessing paid sick days and staying home when sick. When required to get a sick note, sick workers either visit a health provider to get a note or they go to work sick — both options threaten patient recovery and public health.

To get a sick note, workers need to leave their home while sick, travel through their community, expose a clinic or hospital waiting room to their infection, and sometimes pay for the note. The Ontario Medical Association (OMA) acknowledges that "requiring patients with isolated illnesses to visit their healthcare provider may in fact delay their recovery by impeding their rest, and potentially expose them to additional contagious viruses."[139] In addition, the OMA warns that requiring sick notes puts health providers at risk of exposure, which can lead to time away from work and exposure to patients and colleagues.[140] The Centre for Disease Control advises people with mild, flu-like illness against going to the emergency room, which is the unintended consequence of sick note requirements.[141] The Canadian Medical Association (CMA) warns that "writing a sick note is added administrative work — time that should be spent providing direct care to patients."[142] Allowing employers to require sick notes is unnecessary, delays recovery for sick workers, worsens emergency department overcrowding, and wastes healthcare resources.

When sick workers avoid spending the time and costs of getting a sick note and instead go to work sick, their recovery is also undermined

and their co-workers, clients, customers, and the public are put at risk of infection. According to a national poll, 82% of Canadians would rather go to work sick than get a sick note.[143] If the majority of Canadians would rather go to work sick than get a sick note, the main outcome of sick note requirements is sending sick workers to work. This is especially dangerous for workplaces we rely on for our health, like food service and health care, including personal attendants, personal support workers, and home care workers who travel through the communities they serve. The financial cost of sick notes (which can vary greatly), compounded by transportation costs and lost wages (especially substantial for workers with disabilities), also increases pressure on workers in precarious and low-wage jobs to go to work sick. To ensure workers can stay home when they are sick, paid sick days with no required sick notes are crucial.

> *I'm paying $40 just to have a 3- or 5-minute conversation with a doctor. They don't do any tests. That's how much I make in almost 3 hours. A lot of times, I would just force myself to go to my shift even though it will be painful.*
>
> — KHALEESI, RETAIL WORKER

PHYSICIAN SURVEY: SICK NOTES ARE UNNECESSARY AND UNDERMINE THE HEALTHCARE SYSTEM[144]

A 2019 survey of 182 Canadian emergency physicians found that 76% write at least 1 sick note a day, with 4% reporting they write 5 or more notes per day. Thirteen percent of emergency providers charge patients for a sick note at an average cost of $22.50 (fees charged range from $10 to $80). The vast majority (83%) believe that patients can determine when to return to work most of the time, confirming that visits to the doctor for sick notes are unnecessary. Moreover, 90% believe that patients do not require additional medical care at half or less of these visits. In sum, the majority of emergency physicians are writing sick notes on a daily basis but believe that most patients can safely decide on their own when to return to work, and most do not require additional care.

76% of physicians surveyed write at least one sick note a day

83% of physicians surveyed agree patients can determine when to return to work

Survey responses expressed the impact of sick notes on physician workload and wait times. One physician working in a rural emergency department, where staff provide 2 to 5 notes per day, expressed that "employers requiring a physician note for time off work is an inappropriate and unnecessary burden on our public health system and a major contributor to wait times and [emergency department] loading in my center." Other responses include, "Sick notes are a waste of the patient's time. They should be home resting." Sick notes are a needless additional burden, especially in a healthcare system already under many pressures.

Health providers recognize how sick notes can undermine their relationships with their patients. One emergency department physician said, "Sick notes cause relationship problems. Who am I the agent of? If the employer requires a sick or a return-to-work note, then they should pay for it." Another physician working in a rural clinic said, "The worst aspect of it is the breakdown of [doctor-patient] relationships due to the referee-type involvement in this issue." Health providers charging for a sick note can be frustrating for workers, as well as seed mistrust. Requiring sick notes is an unnecessary source of tension between patients and their health providers.

While providing sick notes has become a typical part of a physician or nurse practitioner's practice, evidence shows this provision is an unnecessary burden on the healthcare system, and is a source of frustration for both patients and health providers. The vast majority of patients who visit a health provider for a sick note do not require medical attention, and do not need to seek advice to know when to return to work.[145] Furthermore, in jurisdictions mandating paid sick days, no evidence that workers widely abuse paid sick days exists.[146,147] Sick notes are therefore an unnecessary burden on health providers and patients.

Due to widely recognized problems with requiring sick notes, the Canadian medical establishment has opposed obliging sick notes for minor illnesses for years. In 2007, Doctors Nova Scotia provided a template letter for physicians to send to employers, asking them to stop requiring sick notes and invoicing companies for the cost of the note.[148] During the 2009 H1N1 pandemic, and for years since, the OMA has spoken out against sick notes.[149] The president of the Canadian Medical Association has called sick notes a "public health risk,"[150] and the CMA launched a national "Say No to Sick Notes" campaign. Most recently, the Canadian Association of Emergency Physicians has also committed to advocating for "a ban on sick note requirements by employers via federal or provincial legislation."[151]

> *I live in a rural community where access to a family doctor is limited. When I finally get in to see the doctor they are like, "Seriously, you're here for this?" It's such a waste of their time. And I'm not feeling well because I didn't get the rest I needed. I have waited in the ER for hours when I could have been at home in bed on the mend. When we didn't have to get sick notes, it was good for us. We finally felt like we could access sick days.*
>
> — BRENDA, EARLY CHILDHOOD EDUCATOR

Public support for prohibiting employers from requiring sick notes is also strong. In 2017 nearly a thousand health providers across Ontario signed a petition calling for 7 paid sick days for all workers and the elimination of sick notes.[152] In 2018, the Ontario government prohibited employers from asking for sick notes. When the ability for employers to require a sick note was reinstated the following year, there was widespread opposition. A national poll found 76% of those surveyed thought people should stay home to recover rather than wasting their energy at a hospital or clinic, 74% felt that requiring a note is not a good use of healthcare resources, and 70% felt we should make it easier for sick people to avoid transmitting their infections to others.[153]

During the COVID-19 pandemic, health providers' anecdotal reports indicate that some employers have required not only "sick notes," but also "well notes" indicating it is safe for workers to return to work. These requirements send healthy workers into hospitals during a pandemic, exposing them to infection and wasting critical healthcare resources. In response to the pandemic, provincial governments have prohibited employers from requiring sick notes for unpaid leave for "reasons related to COVID-19." There is no public health reason to differentiate between medical reasons or for this measure to be only temporary. Sick notes are unnecessary, undermine patient recovery, waste healthcare resources, and threaten public health — especially during pandemics. There is strong opposition from the general public and the medical establishment, and it's time this consensus be put into practice across the country by ending the employer practice of requiring sick notes for minor illnesses, during COVID-19 and after.

b. No disruption to income or administrative barriers

Any income disruption is a disincentive for workers to stay home when sick. Consequently, any requirement of an application process or waiting period for payment threatens the ability of workers to use sick days, particularly at the first sign of symptoms.

Before COVID-19, nearly half of Canadians were living paycheque to paycheque.[154] Sickness, particularly something like COVID-19, but also the flu, heart attacks, or mental health crises, comes unexpectedly. Workers need to know how to remain financially stable as soon as illness strikes. It is essential that workers know they will be paid because for many lost income means the difference between paying rent and getting food. Sound public health policy cannot rely on individuals performing risk assessments of how likely they are to infect others and how likely they may be to receive pay in the midst of a health crisis. Any gap in income during an emergency financially punishes workers for taking time to address their or their family's crisis or pushes workers back into the workplace with a potentially transmissible infection.

There should be no bureaucratic barriers to protecting public health. Across Canada, experience of employers requiring sick notes has clearly demonstrated that creating barriers to sick days undermines their use and threatens public health. Therefore, effective paid sick leave legislation cannot require workers to fulfill any additional administrative tasks to access income replacement. Requiring workers to apply for income support when illness or a family emergency strikes creates uncertainty about adequate income replacement and an undue administrative burden. Application processes in place for longer term income supports, such as EI or CERB, are not appropriate and would undermine the effectiveness of workers taking sick days for short-term illness at the first sign of symptoms. These barriers would also disincentivize taking time off for illness, thereby creating a risk of infection transmission.

To encourage workers to use sick days as required by public health directives, they must be seamlessly accessible. The proven and effective mechanism for ensuring workers face no income disruption or unnecessary administrative barriers when they take a sick day is legislating employer-provided paid sick days. This is the approach that has been taken in legislating the minimal existing paid sick days in Canada. It ensures employers provide payment for lost wages when workers take a sick day, benefiting workers and public health. Consequently, expanding paid sick days must be legislated in employment standards to ensure workers receive full pay for sick days with their next paycheque.

c. *Patient-centred to reflect the reality of workers' lives*

Patient-centred paid sick leave should be flexible enough to be used for the type of care a worker needs, whether for personal injury or illness, a family emergency, or to fulfill caretaking responsibilities. This practice has been adopted in Canada and its provincial and territorial jurisdictions for COVID-19 emergency leaves. For example, Ontario's Infectious Disease Emergency Leave (IDEL) requires employers to provide employees with job-protected leave for the duration of the emergency, for an employee's own individual illness (quarantine or other measures required for COVID-19) and for employees providing care or support for their families related to COVID-19, including caring for children impacted by school and child care closures. The definition of family members, types of care and support, and length of job-protected leave are quite expansive, reflecting the realities of healthcare needs during the pandemic.[155]

> *When my mother was diagnosed with cancer and going through her treatment, having the flexible days [Personal Emergency Leave] meant that I had the opportunity to take her to appointments, take care of her, and provide my dad with relief from being a caregiver. It provided me with a huge sense of relief.*
>
> — CLARA, COLLEGE PROFESSOR

Even outside of the pandemic, most jurisdictions in Canada provide unpaid, job-protected leave for both personal sickness and family responsibility, although how it is provided varies, with some jurisdictions providing flexible leave and other jurisdictions prescribing a set number of days for each purpose. For example, the BC government provides 3 unpaid days for sick leave and 5 unpaid days for family leave. In contrast, the Saskatchewan government provides

12 unpaid days for sick leave or the care of family members. In Ontario, for 15 years, workers had access to 10 days of job-protected personal emergency leave (PEL) that could be used for a wide range of emergencies and health reasons.[vi] In 2019, these 10 PEL days were replaced with 3 specific unpaid leaves: 3 days for sickness, 3 days for family emergencies, and 2 days for bereavement. This change contradicted recommendations from the *Changing Workplaces Review*,[vii] a comprehensive review of labour law concluded in 2017:

> When the policy of the law is to permit these leaves, it should not matter to the employer whether the employee is away for reasons of illness or family emergency, but it may matter deeply to the employee if the law artificially and arbitrarily restricts her/ his ability to respond effectively to family emergencies or to personal illness. In this case, the employee's needs far outweigh the employer concerns … It is the very need of the modern employee to respond to family emergencies as well as to personal illness that led to the creation of the Personal Emergency Leave entitlements in the first place.[156]

Overall, 6 jurisdictions in Canada provide flexible unpaid leave that can be used for either sickness or family responsibility. Everywhere else, unpaid leave is either delineated according to purpose or only available for sickness.[viii] These restricted leaves, contrary to good public policy, fail to consider the dynamics of care that exist for many households and place a substantial burden on marginalized workers and their families.

An expansive leave for illness and family emergency makes medical sense. Canadian emergency physicians recommend an average of 4 days at home in the case of seasonal influenza, but restricting leave for personal illness risks workers being left without adequate time off to recover from even one bout of influenza. Restricting leave also disproportionately affects certain workers. Studies on paid sick days have found that workers with chronic health conditions require more days.[157] Injured workers' organizations have long advocated for legislated paid sick days as an essential workplace accommodation.[158] Limiting the number of days that can be used for personal health reasons negatively affects people with disabilities and chronic health conditions. Similarly, because women are more likely to provide child care, studies on paid sick leave have found that women are more likely to spend their sick days caring for children.[159] Restricting PEL days undermines the ability of workers to balance care for themselves and their families, disproportionately impacting women.

> *Medical appointment times are usually during business hours, which makes it very hard to book an appointment outside of my regular work schedule. I have to go to all sorts of appointments: physical checkups, visits to eye and foot specialists, and have my blood sugar checked. Plus, the nature of my job means that I'm constantly getting sick because I work with small kids who are always sick themselves.*
>
> — ALEXANDRA, EARLY CHILDHOOD EDUCATOR

vi Until 2019, Ontario's Personal Emergency Leave included an appropriately expansive definition of when a worker could access this leave: "An employee who is entitled to personal emergency leave can take up to 10 days of leave each calendar year due to: personal illness, injury or medical emergency or death, illness, injury, medical emergency or urgent matter relating to the following family members: spouse (includes both married and unmarried couples, of the same or opposite genders); parent, step-parent, foster parent, child, step-child, foster child, grandparent, step-grandparent, grandchild or step-grandchild of the employee or the employee's spouse; spouse of the employee's child; brother or sister of the employee; and relative of the employee who is dependent on the employee for care or assistance." It should be noted that 1.7 million workers in Ontario in workplaces with less than 50 employees did not have access to PEL until 2018, when it was extended to these workplaces and the first 2 days became paid.

vii The Changing Workplaces Review was a comprehensive review of labour law conducted by appointed Special Advisors C. Michael Mitchell and John C. Murray between 2015 and 2017. The review's first phase of public consultation involved 12 sessions held across Ontario that heard over 200 presentations and received over 300 written submissions, which was followed with publication of an Interim Report and Final Report.

viii See Appendix A for more information about paid and unpaid sick days across Canada.

SECTION 4
RECOMMENDATIONS TO CLOSE THE PAID SICK DAYS GAP

RECOMMENDATIONS TO CLOSE THE PAID SICK DAYS GAP

In sum, gaps in access to paid sick days have multiple negative impacts on individual workers and their families, public health, and the economy. Failing to close the gap by legislating employer-provided paid sick days will continue to deny paid sick days to over half of the workforce. Moreover, those being denied paid sick days need them most — workers in low-wage, precarious jobs who are disproportionately women, migrants, racialized workers, and workers with disabilities. Paid sick days legislation is a public health imperative and a matter of racial, gender, disability, and economic justice. The COVID-19 pandemic has exposed glaring workplace inequities that pose grave public health risks. It is now clearer than ever that precarious work and lack of paid sick days is a chronic health hazard and an acute public health crisis.

This report outlines key principles that must be considered by governments and policy-makers when implementing paid sick days. These principles draw on lessons from previous epidemics, public health and medical evidence, best practices from other jurisdictions, health provider expertise, and workers' experience. Paid sick leave legislation that is guided by these principles will ensure workers have the financial means to stay home when they or a family member is sick, imperative for our collective well-being.

The best way to close the gaps in access to paid sick days across Canadian jurisdictions is to expand the proven mechanism that already works for employers, workers, and public health: mandating employer-provided paid sick days. The following are recommendations for provincial, territorial, and federal governments across Canada to enact effective paid sick leave legislation.

All provincial, territorial, and federal jurisdictions must update their employment standards to:

- **Require employers to provide at least 7 days of paid emergency leave on a permanent basis.**
- **Require employers to automatically provide an additional 14 days of paid emergency leave during public health emergencies.**

Any new paid sick leave legislation must:

1. **Ensure paid sick days are fully paid**

   For the public health recommendation "Stay home when sick" to be effective, sick days need to be **fully paid**. Unpaid sick days or paid sick days with less than full income replacement rates are ineffective. Workers should not be financially penalized for protecting public health or responding to a personal health crisis. We need to close the gap between public health recommendations and necessary financial security, with paid sick days.

2. **Ensure paid sick days are adequate**

   As with any treatment, the dose matters. Paid sick days must be **adequate** to cover the duration of common illnesses and acknowledge the reality of workers' lives, including family and caregiving responsibilities. Health providers have been calling for 7 paid sick days for many years and COVID-19 requires 14 days of self-isolation. We need to close the gap between medical evidence and paid sick days policy — all workers need at least 7 paid sick days at all times and an additional 14 during public health emergencies.

3. **Ensure paid sick days are permanent**

   The need to protect public health doesn't end after pandemics, and it is contrary to public health to restrict sick days to temporary measures related to COVID-19. The COVID-19 pandemic has highlighted the longstanding need for permanent paid sick days. To close the gap in paid sick days, they need to be **permanent**, available during COVID-19 and beyond.

4. **Ensure paid sick days are available to all workers, regardless of employment status, immigration status, or workplace size**

   Pandemics reveal that infections anywhere are a threat to public health everywhere. Viruses don't discriminate, and neither should sick days. Paid sick days need to be **universal** — available to all workers regardless of workplace size, type of work (including temporary, part-time, and independent contracts), or immigration status of the worker. Closing the gap in access to paid sick days ensures those most in need are no longer denied this basic protection — women, racialized workers, migrant workers, and workers with disabilities in low-wage and precarious employment. Universal access to paid sick days will also require effective enforcement.

5. **Prohibit employers from requiring sick notes**

   Prohibiting employers from requiring sick notes **removes an unnecessary barrier to staying home**, one which results in workers going to work sick. Physicians agree that patients can safely decide when to return to work without visiting their doctor for a sick note. Consequently, sick notes are an unnecessary burden on a healthcare system already under pressure.

6. **Prevent the introduction of any new barriers to accessing paid sick days**

   Requiring workers to apply for income support or complete additional administrative tasks to access paid sick days will undermine their effectiveness. Such requirements create uncertainty about adequate income replacement and undue administrative burden. Application processes in place for longer term income supports are not appropriate and would undermine the effectiveness of workers taking sick days for short-term illness at the first sign of symptoms. Paid sick days should be employer-provided and workers should be paid with their next paycheque to ensure **no disruption to income**.

7. **Cover personal sickness, injury, or emergency, as well as family emergencies and responsibilities**

   Workers need paid sick days that reflect the reality of their lives, healthcare needs, and caregiving responsibilities. That means **patient-centred, sufficiently flexible** leave that can be accessed for personal illness, injury, or emergencies, as well as family emergencies or responsibilities.

APPENDIX A: PAID AND UNPAID SICK DAYS ACROSS CANADA

			COVID-19 SPECIFIC
Federal	Personal leave: **5 days of leave** for sick leave or leave related to the health or care of family members *Employer can request a medical note. Employee shall provide if reasonable and practicable.* Medical leave: up to 17 weeks unpaid *If 3 days or longer, medical note can be required by employer.*	Personal leave: **3 paid days** (first 3 days of the 5 days are paid) *Employer can request a medical note. Employee shall provide if reasonable and practicable.*	Unpaid, job-protected leave for up to 16 weeks for reasons related to COVID-19. Ends on October 1, 2020 when it will be replaced by a permanent provision that allows for leave of absence for quarantine. *Sick note not required.* A temporary program to provide 10 days of income support for COVID-related leave for workers without paid sick days has been announced, but details and implementation are still forthcoming.
Newfoundland	**7 unpaid days** for sick leave or family responsibility leave *If absent for 3 or more consecutive days, must provide a medical note for sick leave or written statement outlining nature of leave for family responsibility leave.*	None	Unpaid job-protected leave for reasons related to COVID-19. *Sick note not required.*
PEI	Sick leave: **3 unpaid days** *Employer can request a sick note if employee requests 3 consecutive days of leave.* Family leave: **3 unpaid days** *Sick note rules not specified.*	Sick leave: **1 paid day** after five continuous years of employment *Employer can request a sick note if employee requests 3 consecutive days of leave.*	Unpaid emergency leave in relation to COVID-19 for as long as an employee cannot perform their work-duties because of an emergency. *Sick note not required.*

Nova Scotia	Sick leave: **3 unpaid days** *Sick note rules not specified in legislation. Employers are prohibited from requiring sick notes during COVID-19 crisis.* Emergency leave: Unpaid leave for government declared emergencies or public health directives or emergencies that prevent employee from performing work duties or if they need to care for someone due to emergency *Guidelines suggest that sick notes may not be reasonable during a pandemic.*	None	Unpaid emergency leave was already in place. *In response to COVID-19, employers can longer require a sick note if an employee must be off work.*
New Brunswick	Sick leave: **5 unpaid days**, after 90 days of work *If employee requests 4 consecutive days or more, employer can require a sick note.* Family responsibility leave: **3 unpaid days** *Sick note rules not specified.*	None	Unpaid leave for reasons related to COVID-19 until regulation is repealed. *Employer not permitted to ask for sick note.*
Quebec	Sickness or accident: Total absences must not exceed **26 weeks** *Employer can request a sick note.* Family responsibilities: **10 days** to care for child or someone else for whom they are caregiver *Employer can request a sick note.*	The first **2 days paid** of either sickness or accident or family responsibilities leave *Employer can request a sick note.*	The Temporary Aid for Workers Program provided $573 per week for workers who needed to stay home for COVID-19 related reasons from March 16 to April 10. It closed to avoid duplication with CERB. Existing unpaid leaves remain in place and apply for COVID-19 related reasons.

Ontario	Sick leave: **3 unpaid days** for personal illness, injury or medical emergency *Employer can require a sick note.* Family responsibility leave: **3 unpaid days** for family members' illness, injury, medical emergency or urgent matter *Employer cannot require a sick note for a family member's illness, injury or medical emergency, but may require evidence or proof.*	None	Infectious disease emergency leave (IDEL) provides job-protected unpaid leave for reasons related to COVID-19. *Employer cannot require a sick note.*
Manitoba	**3 unpaid days** of leave for sick leave or family care responsibilities *Employers can require a medical note.*	None	Public health emergency unpaid leave of unspecified length for reasons related to COVID-19. *Employer not permitted to ask for sick note.*
Saskatchewan	**12 unpaid days** for sick leave or for the care of family members *Employers can request a medical note, unless absence is a result of a public health emergency.*	None	An unspecified number of unpaid days of leave for reasons related to COVID-19. *No requirement for a sick note.*
Alberta	**5 unpaid days** for sick leave or for family care responsibilities *Sick note rules not specified.*	None	14 unpaid days of leave for reasons related to COVID-19. *No requirement for a sick note.*
British Columbia	Sick leave: **3 unpaid days** for personal illness or injury Family responsibility leave: **5 unpaid days** for the care and health of a child or immediate family, or the education of a child in the worker's care *Employers can request a sick note.*	None	Unpaid job-protected leave for reasons related to COVID-19 for an unlimited number of days *Employer not permitted to ask for sick note.*
Nunavut	None	None	None *The government recommended that organizations in Nunavut waive the requirement for sick notes during the COVID-19 pandemic.*

Northwest Territories	**5 unpaid days** for sick leave or family responsibility leave *Employer can request a sick note if leave exceeds or is expected to exceed 3 consecutive days.*	None	None
Yukon	Sick leave: 1 unpaid day of sick leave for every month the employee has been employed by that employer, less the number of days on which the employee has previously been absent due to illness or injury, **up to a maximum of 12 unpaid days** *Employers can request a medical note.*	None	Unpaid leave for a period of up to 14 days for reasons related to COVID-19. The leave must be taken all at once. *A sick note is not required to access this leave.* Program that reimburses employers who pay employees to take sick days or self-isolate for up to 10 days of COVID-19 related leave. Regular paid sick leave available to workers must be used first. It is also available for the self-employed. *A sick note will not be required.*

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APPENDIX B: METHODOLOGY FOR INTERVIEWS AND SURVEY

Two research approaches were used to anchor this report in worker and health provider perspectives. Worker experiences were captured in interviews, while health provider perspectives were captured in a survey.

WORKER INTERVIEWS

The worker interviews involved one-on-one, in-depth, semi-structured interviews. Thirty workers from various sectors across Ontario were interviewed between October and December 2019 by one primary interviewer. The purpose of the interviews was to explore how paid sick days, sick notes, and personal emergency leave impacted their health and the health of their families and communities. Two additional workers were interviewed in June and July 2020, during the COVID-19 pandemic, to gain an understanding of their experience without paid sick days during a public health emergency. Interviewed workers were financially compensated for their participation.

The approach to worker interviews was determined in consultation with community leaders who have undertaken collaborative research with low-income workers in the past. Questions were developed with input from community partners, including Parkdale Community Legal Services, Workers' Action Centre, and the Ontario Employment Education and Research Centre. This community-based participatory research (CBPR) method used phenomenology to analyze the interviews. Interviews were recorded with the consent of participants and were transcribed using Descript. All participants were recruited through purposive sampling. The primary interviewer also coded and analyzed the interview transcripts with the community partners' assistance. Check-ins with community partners took place at regular intervals during the entire CBPR process.

PHYSICIAN SURVEY

The Decent Work and Health Network research team surveyed Canadian Association of Emergency Physicians (CAEP) members to determine the impacts of sick notes on patients and the healthcare system, the duration of time off work recommended to patients by physicians, and training and policies in place for health providers regarding sick leave policies and prescribing practices for common illnesses.

This study received approval from the University of Toronto Health Sciences research ethics board. Following a literature review, the survey was designed through 4 authors' consensus and revised following review by an additional physician and labour policy expert. The survey was distributed in English only via SurveyMonkey. CAEP administered the survey, distributing the survey 3 times in 2-week intervals between December 2019 and January 2020. The link was distributed by email to all CAEP physician members. Of the 1524 CAEP physician members reached, 182 participated. Ontario was reported as the practice location by 51.1% of respondents and 79% practiced emergency medicine exclusively, with the remainder practicing emergency medicine and family medicine, sports medicine, or other specialties. Survey participation was voluntary and all responses anonymous. No financial incentive was provided for participating.

The survey included multiple-choice demographic questions, as well multiple-choice

questions and open-ended, numeric responses to quantify variables, such as the duration of time physicians advise patients to stay home from work, the cost of a sick note, and the frequency with which patients require additional medical care. Participants were allowed to skip questions, and data from incomplete surveys was included. Data was analyzed in the R statistical programming language.[160]

APPENDIX C: SUMMARY OF FINDINGS FROM WORKER INTERVIEWS

In total, 32 workers were interviewed between October 2019 and July 2020. Of those, 22 identified as women and 6 women had school-aged children, while 10 identified as men. Twelve women and 4 men were racialized workers. All resided in Ontario, with 6 residing in non-urban locations. Most workers interviewed were in low-wage and precarious jobs.

Several key themes emerged from the interviews:

- **Many workplaces have a culture of workers being expected to go into work sick**. This was present despite the reality that completing job duties while sick posed a risk to customers, clients and workers' own health. Fear of reprisals increased pressure to work while sick.
- **Many workers fear reprisals when they access sick days.** In fact, 60% of workers interviewed reported fears that they will be penalized or, in some cases, fired for using their unpaid sick or paid sick days.
- **Workers save paid sick days for when they really need them**. All workers interviewed talked about using paid sick days carefully to ensure they were available when they need them most. Workers use paid and unpaid sick days as a form of insurance, which gives them a sense of security that they will be able to cope in case of an emergency or personal or family illness.
- **Lack of access to adequate paid sick days had a disproportionate impact on women, who were more likely to be primary caregivers.** Five women interviewed chose not to use their sick days for personal illness, instead saving them for when they had caregiving duties (most commonly for when their children got sick). Four workers who were primary caregivers had been in situations where they had no option but to send sick children to school because they lacked paid sick days.
- **Access to paid sick days had a positive and protective impact on health and mental health, as well as giving workers a sense of dignity**. For 9 workers interviewed, paid sick days allowed workers to stay home for illness resulting in improved recovery time. Twenty-seven workers described that paid sick days provide a sense of protection or security with a positive impact on mental health (by reducing stress and anxiety, for example). This was related to many factors, including knowing you have time off available for sickness, medical appointments, caregiving, and emergencies. For half of workers interviewed, having paid sick days contributed to feelings of respect, dignity and value in the workplace.
- **Two paid sick days was not enough.** Many workers interviewed gained access to 2 paid sick days when they became legislated in employment standards in Ontario in 2018. Workers unanimously agreed that access to 2 paid sick days made a positive difference for them, but 2 days did not adequately reflect the realities of time off required to protect their health and deal with family responsibilities. This was particularly the case for workers who were women or who had chronic medical conditions.
- **Allowing employers to require sick notes results in workers going to work sick.** Five workers had chosen to go to work sick rather than get a sick note. Workers had paid up to $50 for a sick note. Access to same day care from a family physician to obtain a sick note

was rare, which meant workers went to walk-in clinics and emergency rooms to obtain sick notes. Workers in rural areas of Ontario were more likely to go to the emergency room to get a sick note.

- **Required sick notes cause tension between patients and health providers.** Four workers interviewed cited having to obtain sick notes as a cause of tension with their health provider.
- **Patient-centred personal emergency leave with sufficient flexibility was important to workers.** Workers talked about how restrictions to emergency leave introduced in Ontario in 2019 compromised their or their families' health and wellbeing. For 10 workers that we spoke with, losing flexible personal emergency leave limited their ability to manage their health, provide care to their family, or grieve the loss of loved ones. Flexibility was particularly important for workers managing chronic conditions who relied more on personal emergency leave days to attend medical appointments and access preventive care.

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The Honourable Christine Elliott
Deputy Premier and Minister of Health
Ministry of Health and Long-Term Care
777 Bay Street, 5th Floor
Toronto, Ontario
M7A 2J3

Email: Christine.Elliott@ontario.ca

[Insert date]

Dear Minister Elliott,

The [insert board name] is deeply concerned about the absence of paid sick leave standards for workers in the province. As a matter of public health, we urge your government to update employment standards to implement paid sick days for all workers.

The COVID-19 pandemic has revealed the urgency of paid sick days for curbing the transmission of infectious disease and protecting public health. As of December 4, 2020, 30 percent of active outbreaks in Ontario were workplace outbreaks. [Option to insert local workplace outbreak data.] Workplaces with precarious jobs where workers lack access to paid sick leave have become hotspots for COVID-19 infection transmission, including outbreaks in long-term care homes, farms, meat-processing plants, grocery stores, and warehouses.

The most recent Statistics Canada General Social Survey shows that 58% of workers in Canada have no access to paid sick days. For workers earning less than $25,000, over 70% have no paid sick days. In the trade and transportation sector, which include grocery store and warehouse workers, 62% of workers lack paid sick days. In the service sector, including food services, the percentage is higher at 75%. Even in the health care and social services sectors, where risk of exposure to infectious disease is highest, 50% of workers do not have paid sick days.

The COVID-19 pandemic has exposed the urgency of addressing gaps in paid sick days as a matter of health equity. Low-wage workers, who are disproportionately Black and racialized, are more likely to be denied paid sick days and have faced higher rates of COVID-19, including in [insert region]. These gaps are especially dangerous for workers with chronic health or immunocompromised conditions, and for persons with disabilities, seniors, children, and patients who rely on workers to provide care and support.

Staying home when sick is one of the most effective containment strategies for infectious disease. A 2006 Public Health Agency of Canada report studying gastrointestinal illness shows that workers in high-risk settings — food handling, long-term care and child care — will continue to work when ill when they cannot afford to take time off. A 2018 study from Swiss Economic Institute's Stefan Pichler and Cornell University's Nicolas Ziebarthin found that cities in the United States with paid sick days saw a 40% reduction in influenza rates during flu waves compared to cities without.

Workers without paid sick days are forced to choose between sacrificing their financial security for public health or going to work sick to support themselves and their families. Without public policy to support people to make the decision to stay home when they are ill, behavioural recommendations are limited in their effectiveness.

Chief Public Health Officer of Canada Theresa Tam recognizes why paid sick leave is essential to protect worker and community health in her October 2020 report From Risk to Resilience: An Equity Approach to COVID-19:

> "Without paid sick leave, employees may lose income if they become ill and are unable to work. Without employment security, they may lose their jobs if they stay home when sick. In either case, or particularly if they are economically insecure, workers may feel unable to comply with public health guidance to stay home when sick."

In addition, paid sick days support effective immunization uptake. Evidence shows paid sick days increase vaccination rates. Both workers with paid sick days and their children have higher vaccination rates against the flu, and better access to other preventive health services.

We urge your government to consider the following recommendations to contain the spread of infectious disease and protect public health:

- Update employment standards to require employers to provide at least 7 days of paid emergency leave on a permanent basis.
- Update employment standards to require employers to provide an additional 14 days of paid emergency leave during public health emergencies.

Not only are these measures crucial for protecting against COVID-19, but they will also protect public health from infectious pathogens like influenza and future outbreaks, as we have seen with SARS and H1N1.

Thank you for reviewing this information and we look forward to hearing from you.

Sincerely,

[Insert signature
Insert title]

cc: Hon. Doug Ford, Premier of Ontario (premier@ontario.ca)

Hon. Monte McNaughton, Minister of Labour, Training and Skills Development (monte.mcnaughton@pc.ola.org)

Dr. David Williams, Provincial Chief Medical Officer of Health (dr.david.williams@ontario.ca)

[Option to include local MPP]

MEMORANDUM

Subject: COVID-19 Response and Business Continuity in Public Health & Emergency Services (February 2021 Update)

Date: February 16, 2021

To: Public Health & Social Services Committee

From: M. Mustafa Hirji, Medical Officer of Health & Commissioner (Acting)

Current Status as of February 4, 2021

- The latest updates including statistics can be found at the Niagara Region website.
- Globally, the Western world is seeing the resurgence of COVID-19 level off as lockdowns are taking effect. In Europe lockdowns are being lifted.
- In Canada, likewise, there has been a reduction of cases with lockdown measures. Provinces are now contemplating plans for reopening, with Alberta having announced its plan.
- Complicating plans to reopen are variants of concern. In the United Kingdom, these lead to an immediate surge of cases after they exited their November lockdown. Concern is that reopening too early will lead to a similar surge here.
- Thus far, variants are overwhelmingly concentrated in York Region and neighbouring areas—Simcoe-Muskoka, Toronto, Durham Region, and Peel Region accounting for 92% (140 of 152 cases) of variants diagnosed in Ontario.
- Variants spread more easily and so more measures will be needed to control COVID-19 going forward. As Ontario struggled to contain cases in the fall, likely those same measures would be even less effective now. This likely means there won't be a full reopening until vaccine is more widely available.
- Schools have opened as the first stage of reopening the economy. This recognizes the importance of schooling to children's well-being, as well as the equity implications for women.
- Outbreaks in long term care homes and retirement homes are now falling in number with far smaller outbreaks, though the total number of outbreaks remains high. Tragically, the past several weeks of large outbreaks in long-term care homes and retirement homes has resulted in many persons passing away.

- With cases starting to come down, Public Health's capacity for follow-up is improving. Public Health's capacity continues to be stretched however, given the ongoing large number of cases, outbreaks, as well as the ramping-up of vaccination work.
- The province has limited vaccination at this time to only long-term care home residents and specified high risk retirement home residents. Vaccination of this group with their first doses has been completed, and their second doses are being administered now 21 days after their first dose.
- Work continues in planning mass vaccination efforts in case the provincial government seeks Public Health leadership of that effort. Plans are near complete with efforts underway to recruit volunteers and additional capacity. The major barriers to planning are the lack of information on when doses will arrive and in what volumes.
- In Emergency Services, call volumes for EMS have largely returned to normal levels as business and life has resumed.
- EMS is closely monitoring patient flow within local emergency departments and working with Niagara Health to ensure capacity and surge planning for anticipated COVID-19 related hospitalizations. The recent closure of GNGH to admissions is impacting patient flow.
- Emergency Management continues to support both Regional and Local Area Municipal EOC's for coordinated response and business continuity planning.

Previous (January 12) Summary on Business Continuity

Public Health & Emergency Services deliver essential services year-round to impact the health and health equity of Niagara residents, and to pursue Council's strategic goal of building a Healthy and Vibrant Community. During the current pandemic, the department is playing a central role in the response to protect and mitigate the impacts of COVID-19, while also continuing the essential work around all other health issues that continue to affect residents.

While COVID-19 has commanded the primary focus of Public Health and society at large, it is important to remember that most of the pre-existing health issues continue to exist and are responsible for more deaths (4,500 per year in Niagara) than the projected number of deaths from COVID-19 in Niagara (250–1,000 deaths).

Activity in Public Health & Emergency Services reflects focusing on COVID-19 response, while also ensuring ongoing service to protect the health in other essential areas.

Public Health Emergency Operations Centre for COVID-19/Pandemic Response Division

Current Status of Operations

Public Health began work in response to COVID-19 on January 8, 2020. As volume of activities grew, the Public Health Emergency Operations Centre was partly activated on January 28, 2020 to ensure coordination of work and central leadership. By March 9, staff had begun to be redeployed from regular duties to supporting the activities of the Emergency Operations Centre, which was fully activated at this time. Currently 131 staff work in COVID-19 emergency response (35% of staff complement in Public Health), as well as an additional 42 staff on contract to support the response with 31 additional staff being recruited.

Emergency Operations are currently in the process of being transitioned to the new temporary Pandemic Response Division to consolidate most pandemic response activities, and streamline reporting lines and management processes. This was explained in more detail in CWCD 299-2020.

Significant Initiatives or Actions Taken

There are five principle lines of response to COVID-19:

1. **Case, Contact, and Outbreak Management**. Public Health is following-up with every person diagnosed with COVID-19 to ensure they are isolated and no longer infecting others. Public Health identifies all contacts of that person who may also have been infected, and arranges for those contacts to be isolated as well. That way, if they develop illness, they cannot have exposed anyone. By isolating all persons who may be infected with COVID-19, the chain of transmission can be broken. Case and contact management will be critical to ensuring ongoing control of COVID-19 transmission if and when physical distancing measures are relaxed.

   A critical subset of this work is advising and supporting the management of outbreaks in long term care homes, retirement homes, and other health care facilities. We have seen that most cases and deaths in Niagara, Ontario, and Canada as a whole have occurred in these settings. Better protecting them and supporting these facilities to manage outbreaks are our top priority.

   Public Health usually has 12 staff working on case, contact, and outbreak management year-round for 75 diseases of public health significance (e.g. measles, influenza, salmonella, HIV). Within the Emergency Operations Centre, this has been scaled-up to over 100 staff. In addition, Public Health is further expanding its capacity by “out sourcing” some of this work to staff offered by the Public Health Agency of Canada. With Council’s approval received on August 13, 2020, there is now the ability to enter into assistance agreements with other local public health agencies to further expand capacity if needed. However, with most parts of the province experiencing surges of cases, it is unlikely Niagara will be able to leverage the support of others. The case/contact/outbreak management operation now works 7 days a week, 08:00 to 20:30.

2. **Supporting Health Care & Social Services Sector**. The health care and social services sectors play an essential role in supporting those most vulnerable, including diagnosing and caring for those who contact COVID-19. Public Health has been working with the sector to advise and support protocols that will minimize risk of infection to both clients and staff.

A dedicated health care provider phone line supports health care providers in providing advice and latest recommendations around COVID-19.

Approximately 5 FTE currently support the health care and social services sector within the Emergency Operations Centre, all redeployed from normal public health work.

3. **Supporting Schools & Child Care**. A new call line has been created to support schools, teachers, staff, and child care operators with keeping children safe in their reopening's. Supporting these sectors is a priority in terms of protecting vulnerable children as well as older staff who may work in these settings and are at risk of severe illness. However, it is also a priority given the potential for children to spread infections through families and through the large populations in schools which could trigger a second wave. As well, successful reopening of schools and child care is critical for our economic recovery to enable parents to return to work. This is a particular equity issue for women given the disproportionate role women play in child care. Approximately 40 staff, including the 20 new provincially-funded hires are supporting schools and child care.

   Since the reopening of schools, the school health team has
   - Managed over 1000 clients who are cases or contacts of COVID-19 and associated with a school
   - Provided 350 consultations to schools
   - Provided, on average, 5 engagements with each school
   - Conducted, on average, 4 in-person visits a week to schools in Niagara to do proactive infection prevention work
   - Supported 145 school staff with virtual professional development around preventing COVID-19
   - Provided resources that have been accessed over 10,000 times (on-line or in hard copy) by school staff or school boards.

4. **Public Messaging**. Given the rapidly changing landscape of COVID-19. Public Health seeks to provide the public with the information to address their fears and concerns, as well as to understand their risk and how to protect themselves. These efforts include a comprehensive web site library of frequently asked questions, an information phone line to speak to a health professional that operates 09:15 to 20:30 on weekdays and 09:15 on 16:15 on weekends, an online chat service with health professionals that operates during the same

hours, social media, and approximately 15 media requests per week. Daily, Public Health has over 20,000 interactions with the public across all channels.

Due to recent increase in cases for COVID-19, Public Health reduced staff available for the informational phone line and online chat, to increase more staff in case and contact management. There will also be a reduction of the hours of the call centre, so that it closes at 19:15. With these changes, wait times for callers are unfortunately increasing. Public Health is looking at options to outsource this work.

Approximately 10 staff have been redeployed from usual public health operations to support the Emergency Operations Centre with public messaging.

5. **Vaccination**. Since the start of the pandemic, work has been underway to update and adapt off-the-shelf mass vaccination plans to the current situation. Plans are near complete, and dependent on information on vaccine distribution to finalize and allow execution to begin.

   Early parts of the plan, in terms of mobile teams, have already been mobilized to vaccinate in long-term care homes, retirement homes, and congregate care setting with the limited volume of vaccine available.

In addition to these lines of work, there is significant work around data entry, customizing data systems and process management to make the above three lines of work as efficient and effective as possible. As well, there are comprehensive planning teams, logistics teams, a finance and administration team, and liaison activities. Approximately 45 staff have been reallocated to these activities.

~~Finally, existing mass immunization plans are being updated and preparedness is underway for if and when a COVID-19 vaccination is available.~~

Operational Outlook

1 month

- As the Shutdown and vaccination reduces cases, Public Health hopes to return to case and contact management operations more similar to the rest of the fall.
- ~~Case & Contact Management capacity surged to deal with additional workload. Simultaneously, there is a reduction of service being provided to the public.~~

3 months

- ~~As the Shutdown and vaccination reduces cases, Public Health hopes to return to case and contact management operations more similar to the rest of the fall.~~

3 months to 6 months

- Projections on operations in the future will depend on Provincial government policy decisions around COVID-19 response and the speed at which vaccines become available. The expectation is that current emergency operations would continue with emphasis shifting based on provincial response.

Clinical Services Division (Excluding Mental Health)

Current State of Operations

Most efforts in this area normally focus on infectious disease prevention. Many staff (60 FTE of 84 total) have been reallocated to the Emergency Operations Centre for COVID-19 response. Current operations are focused on

- case and contact management of sexually transmitted infections
- case and contact management of significant infectious diseases (e.g. tuberculosis, measles)
- distributing provincial vaccination stockpiles to primary care
- advising primary care around complex immunization scenarios
- emergency contraception
- outreach to marginalized populations around vaccination and sexual health

Services/Operational Changes

- Cessation of immunization clinics
- Cessation of school vaccinations
- Cessation of enforcing the *Immunization of School Pupils Act*
- Cessation of supplying the public with immunization records
- Cessation of sexual health clinics
- Cessation of health promotion around vaccinations
- Cessation of health promotion around healthy sexuality

With the current state of COVID-19 cases and the ramping up of COVID-19 vaccinations, it is very unlikely any school vaccinations will take place this year.

Operational Outlook

1 month & 3 months

- ~~Return of staff to vaccination and sexual health programs to scale up operations in these areas.~~
- ~~Attempt to resume school-based vaccinations.~~
- Plan for enforcement of the *Immunization of School Pupil's Act*.

Mental Health

Current State of Operations

Mental Health supports clients in the community who would often otherwise need to be hospitalized. This work is critical to keep people out of the hospital and ensure health system capacity for those with COVID-19. As well, given current challenges around loss of employment, anxiety, and social isolation, delivery of mental health services is more important than ever. With the resurgence of COVID-19, some staff have again been redeployed to the COVID-19 response, affecting waiting times for Mental Health services. Two staff returned to Mental Health have once again been reassigned to pandemic response.

Services/Operational Changes

- Shift of some in-person clinics to remote delivery
- Reduction in some volume of work to shift 6 FTE to provide mental health case management in shelters.

Operational Outlook

- With the resurgence of COVID-19, staff have been redeployed to COVID-19 response, and likely will remain redeployed for several more weeks.
- Mental Health services are expected to continue to have long waiting times given loss of staff to COVID-19 response.

Environmental Health

Current State of Operations

Several lines of inspection that were discontinued due to closures of certain sectors (e.g. food services, personal services, recreational pools) have resumed as those sectors reopen. In addition, other sectors of inspection remain more important than ever (e.g. infection control inspections of long term care homes and retirement homes). No staff remain completely deployed to support Emergency Operations. However, almost all staff are supporting emergency operations in their home program by inspecting COVID-19 prevention measures as part of their normal inspection work, or taking on roles around non-COVID-19 infection prevention normally done by staff redeployed to Emergency Operations. For early October, 1 staff person has been formally redeployed to emergency operations. Currently staff focus upon

- Investigation of animal bites for rabies prevention
- Investigation of health hazards
- Foodborne illness complaints
- Food premises complaints
- Infection prevention and control lapse investigations
- Inspection of reopened food premises
- Inspection of housing and infection prevention amongst temporary foreign workers
- Support and advice to private drinking water and small drinking water system operators
- Inspection of reopened recreational water establishments
- Inspection of reopened personal services settings
- Surveillance and prevention of West Nile Virus, Lyme Disease, and other vector borne diseases
- Investigation of adverse water quality
- Supporting businesses and other partners with infection prevention and control, especially as many businesses move to re-open
- Supporting operators with other unique health risks from resuming after a period of extended closure, such as flushing and managing stale water in pipes

Services/Operational Changes

- Increase of infection control investigations of long term care facilities and retirement homes

- Simulations of outbreaks with long term care facilities and retirement homes to increase their preparedness for outbreaks have now been discontinued
- Refocusing infection control investigations of day cares to focus on very frequent inspection of those that remain operational
- Inspections conducted as part of COVID-19 case and outbreak investigations in workplaces and public settings

Operational Outlook

1 month

- No changes

3 month & 6 month

- Projections on operations in the future will depend on Provincial government policy decisions around COVID-19 response.

Chronic Disease & Injury Prevention

Current State of Operations

Chronic illnesses are responsible for 70% of ill health and lead to more deaths (75,000 deaths per year in Ontario) than are likely to be caused by COVID-10 (Ontario government projects 3,000 to 15,000 deaths from COVID-19). Chronic diseases are heavily exacerbated during this period of social restrictions. As well, since chronic disease make one more likely to suffer severe illness from COVID-19, mitigating chronic diseases remains a high priority.

Efforts are being consolidated around three areas:

1. Mental health promotion. This reflects the greater risk of persons suffering mental health challenges including suicide during this time.
2. Substance use prevention. This reflects the risk of greater substance use while people are unemployed and lack other means of recreation.
3. Health eating and physical activity. The goal is to ensure physical activity despite current social restrictions, and support healthy eating when mostly fast food is available to purchase for take-out.

The above three priorities align with the underlying causes of most ill health and most deaths in Canada. In order to support COVID-19 vaccinations, some staff have been redeployed to support data management around vaccinations. Of 35 staff, 24 remain in their role supporting work on these health issues.

Services/Operational Changes

- Consolidation of resources around the previously mentioned three priorities
- Elimination of engagement of populations in-person
- Elimination of activities in schools, workplaces, and other public settings
- Cessation of most cancer prevention work
- Cessation of most healthy aging work
- Cessation of most injury prevention work
- Expansion of role of Tobacco Control Officers to also enforce Provincial emergency orders around physical distancing

Operational Outlook

1 month

- No changes

3 month & 6 month

- Resumption of workshops for smoking cessation
- Roll-out of major suicide-prevention initiatives
- Projections on operations in the future will depend on Provincial government policy decisions around COVID-19 response. Loosening of social restrictions will enable delivery of programming with more direct engagement.

Family Health

Current State of Operations

There continues to been redeployment of 79 of 144 staff in Family Health to support Emergency Operations. As well, 20 school health staff while not formally redeployed, work overwhelmingly in COVID-19 response. In addition, most staff working in normal assignments are managing the exacerbated harms from the pandemic on other health issues.

Families in Niagara are burdened now more than ever to try to provide safe and healthy care, environments and opportunities for children. The Family Health division continues to provide essential services for families with a small number of staff. Limited services are provided by phone, live chat and virtual access to nurses through Niagara Parents where families can seek support with breastfeeding, parenting, pregnancy, postpartum mental health and child health issues.

Efforts are now underway to plan with schools on how school health programming may be delivered this fall. The Healthy Babies Healthy Children program has begun transitioning back to in-person visits with physical distance to better support families, as well as in-person screening in the hospitals. The Nurse Family Partnership has also been able to transition to mostly in-person visits using physical distance having maintained visiting at pre-COVID levels for the prior 3 months with more virtual visits.

Staff are focusing their efforts on the following areas:

- Prenatal/postnatal support
- Supporting vulnerable families
- Parenting supports
- Providing enrollment and information towards emergency dental care

Home visiting programs for some of our most vulnerable families are also offering virtual support to assist with

- adjusting to life with a new baby,
- addressing parenting concerns,
- promoting healthy child development,
- accessing other supports and services as they are available, and
- assessing for increased risk related to child protection

Services/Operational Changes

- Cessation of dental screening
- Cessation of dental services
- Cessation of breastfeeding clinics
- Cessation of well baby clinics
- Shifting all prenatal/postnatal support to virtual options from in-person service
- Shifting home visits to remote connections

For the period of March 16, 2020 to November 14, 2020:

- 672 registrants for online prenatal education
- 3180 HBHC postpartum screens and assessments completed by PHN
- 2079 HBHC home visits
- 981 Nurse Family Partnership visits
- 589 Infant Child Development service visits
- 840 Breastfeeding outreach visits
- 2283 interactions with Niagara Parents (phone, live chat, and email)
- 200 moms received support and skill building through our cognitive behavioural therapy post-partum depression group
- 151 visits to families receiving support and skill building through our Triple P Individualized Parent Coaching

Operational Outlook

1 month

- Resumption of breastfeeding clinics has been halted due to redeployment of staff to support COVID-19 again.

3 month & 6 month

- Future operations will depend on Provincial policy decisions around COVID-19 response. Loosening of social restrictions will enable delivery of programming with more direct engagement.
- Breastfeeding clinics may resume in the winter.
- Resumption of dental clinics and fluoride varnish administration is also being planned for the winter.
- Positive Parenting Program being planned for resumption in the fall. There has been high uptake to virtual class options.

Organizational and Foundational Standards

Current State of Operations

Organizational and Foundational Standards supports the data analytics, program evaluation, quality improvement, professional development, communications, engagement, and customer services activities of Public Health. There has been redeployment of 34 of 39 staff to Emergency Operations. Ongoing activity includes

- Opioid surveillance reporting
- Active screening of staff at Regional buildings
- Managing data governance and privacy issues

Services/Operational Changes

- Cessation of public health surveillance work
- Cessation of most public health communications and engagement work
- Cessation of public health data analytics
- Cessation of expanded implementation of electronic medical record system
- Cessation of all public health quality improvement work
- Cessation of Public health applied research
- Cessation of evaluating public health programs
- Cessation of public reception service in Public Health buildings
- Scaling back data governance initiative

Operational Outlook

- Expectation is that resources will remain reallocated to Emergency Operations for at least 6 months.

Emergency Medical Services

Current State of Operations

Emergency Medical Services (EMS) continues to dispatch land ambulance services to the population calling 911, as well as modified non-ambulance response to 911 calls as appropriate (the System Transformation Project). At present, call volumes have returned to expected values and operational response is normal. EMS has moved from the Monitoring stage of their Pandemic Protocol back to the Awareness stage following the recent increase in COVID-19 cases and the impact on resources. EMS is experiencing many staff in all areas of EMS operations needing to self-isolate due to family testing requiring business continuity procedures to be enacted. EMS continues to face pressures around personal protective equipment procurement as global shortages continue.

Services/Operational Changes

- Providing enhanced community support through COVID-19 specific programs (refer to PHD 05-2020 for additional details)
- Additional requests by the Province for EMS to supplement community support through enhanced Mobile Integrated Health services – 100% funding for any new initiatives approved by the LHIN

Operational Outlook

1 month

The Pandemic Plan for response prioritization remains in place. This is a unique plan to Niagara, enabled by Niagara's local control and tight integration of both ambulance dispatch and the land ambulance services.

3 month & 6 month

- Projections on operations in the future will depend on Provincial government policy decisions around COVID-19 response, and the subsequent circulation of COVID-19 in the population. Higher COVID-19 circulation would create demand for more calls to 911 as well as increase risk for EMS staff who must be off work due to COVID-19 infection or exposure. As 911 calls increase and/or staff are unable to work, the Pandemic Plan will prioritize which calls continue to be served, and which 911 calls receive a modified response (e.g. phone call and advice from a nurse) or no response.

Emergency Management

Current State of Operations

Emergency Management is currently fully deployed to supporting the Regional Emergency Operations Centre and advising the Public Health Emergency Operations Centre. Emergency Management is also deeply engaged with supporting emergency operations teams at the local area municipalities, as well as other key stakeholders (e.g. Niagara Regional Police, fire services, Canadian Forces). The CBNRE team has also been supporting emergency operations part time. Paramedics are also assisting with staffing the shelter system.

Services/Operational Changes

- Cessation of preparedness activities to focus fully on current response to COVID-19.
- A mid-response review is being conducted by staff to assess the functionality and effectiveness of emergency management coordination internally and with external stakeholders, primarily LAM EOC's to identify what is/has worked well and opportunities to improve emergency management coordination as the emergency continues

Operational Outlook

Ongoing support of current Emergency Operations Centres and recovery planning efforts. There are some elements of recovery planning that are begin implemented.

Recommended by:

_____

M. Mustafa Hirji, MD MPH FRCPC
Medical Officer of Health & Commissioner (Acting)
Public Health & Emergency Services

_____

Submitted by:
Ron Tripp, P. Eng
Acting Chief Administrative Officer

Community Services
1815 Sir Isaac Brock Way, Thorold, ON L2V 4T7
905-980-6000 Toll-free: 1-800-263-7215

MEMORANDUM

COM-C 3-2021

Subject: **COVID-19 Response and Business Continuity in Community Services**

Date: **February 16, 2021**

To: **Public Health & Social Services Committee**

From: **Adrienne Jugley, Commissioner, Community Services**

This memo provides continued updates on the measures Community Services has taken to ensure the ongoing delivery of essential services during the COVID-19 pandemic, and the alternate approaches used to support those most vulnerable in Niagara.

Seniors Services – Long-Term Care

Long-Term Care COVID-19 Outbreak Updates

The increased community spread of COVID-19 continues to pose a heightened risk for long-term care (LTC) homes and congregate settings during this second wave of the pandemic.

In the last report, Seniors Services reported ongoing outbreaks at Meadows of Dorchester, Woodlands of Sunset, Linhaven as well as Deer Park Suites (assisted living). The outbreaks did not include any resident cases. The outbreaks were cleared on the following dates:

- Woodlands of Sunset was cleared on January 11, 2021
- Meadows of Dorchester was cleared on January 23, 2021
- Linhaven was cleared on January 26, 2021
- Deer Park Suites (assisted living) was cleared on January 9, 2021

At the time of writing this report there are four active outbreaks in Regionally operated LTC homes.

- Northland Pointe – a declared outbreak was triggered on January 2, 2021 when a resident and an asymptomatic employee (through weekly staff surveillance testing)

tested positive for COVID-19. All required outbreak measures were promptly implemented.

- Meadows of Dorchester – an outbreak was declared on January 31, 2021 related to a single employee positive COVID-19 test result (through weekly staff surveillance testing). All required outbreak measures were promptly implemented.
- Gilmore Lodge – an outbreak was declared on February 3, 2021 related to a single employee positive COVID-19 test result. All required outbreak measures have been implemented.
- Rapelje Lodge – a suspect outbreak was declared on December 25, 2020 and the outbreak status was shifted to an active outbreak on January 8, 2021 with the identification of positive cases linked to symptomatic staff and residents. To date, the outbreak has had a significant impact to residents and staff across the home. The home continues to work very closely with Public Health to ensure effective contact tracing and that required infection prevention and control practices are in place to mitigate the impact of the virus in the home.

Vaccine Distribution Planning and Implementation

The first dose of COVID-19 vaccinations, for residents, staff, and essential caregivers of LTC homes in Niagara, began on January 14, 2021. Public Health took the lead on the resident vaccination program and residents were vaccinated on-site with the Pfizer-BioNTech COVID-19 vaccine. The vaccine was administered through a collaborative effort of Public Health nurses and LTC home staff. All eligible residents across the eight homes operated by the Region were provided the opportunity to have their first dose of the vaccine. Public Health completed first dose vaccinations of all 32 LTC homes in Niagara in nine days. After completing the LTC resident vaccinations, Public Health moved on to start vaccinations of seniors in assisted living facilities that are co-located with LTC homes and high risk retirement homes, as identified by the Ministry of Long-Term Care (MLTC). At the Region's Deer Park Suites (assisted living) all eligible residents were vaccinated through an on-site clinic.

Public Health is currently working with LTC homes, assisted living facilities, and high risk retirement homes to initiate clinics to administer the second dose of the vaccine. All LTC homes are anticipated to have received second dose vaccinations for residents by February 13, 2021. Public Health will then complete second dose vaccinations for outstanding assisted living facilities and high risk retirement homes.

Niagara Health took the lead on the vaccination of staff and essential caregivers for long-term care. Niagara Health ran a vaccination clinic at the St. Catharines site and

used the Pfizer-BioNTech COVID-19 vaccine. The vaccination clinic was suspended on January 21, 2021, when the provincial government advised Niagara of a change in vaccine allocation and delivery. All further first dose vaccination appointments were cancelled at that time. During the week of February 1, 2021, Niagara Health was working towards re-scheduling second dose appointments for staff and essential caregivers already vaccinated with the first dose. The re-scheduling will not resume until further communication is provided on vaccine deliveries to Niagara. Across the eight homes operated by the Region, about 50% of staff have received their first dose of the vaccination and many remain in line for when vaccination clinics resume. The uptake from Regional staff has been excellent to date.

Rapid Antigen Testing

The MLTC is mandating that all LTC homes in Ontario implement point-of-care rapid antigen COVID-19 screening tests for staff, students and essential caregivers. LTC homes across Niagara are required to start the transition from weekly polymerase chain reaction (PCR) testing to rapid antigen testing by February 16, 2021, with the program required to be fully operational by February 22, 2021.

During the transition phase, LTC homes will be required to complete both weekly PCR testing as well as rapid antigen testing. The MLTC has outlined the following details for the required frequency of rapid antigen testing:

- Staff and students who enter LTC homes ***two or more days*** during a 7-day period must undergo antigen testing on non-consecutive days, up to three times in the period prior to entry into the LTC home.
- Staff and students who enter LTC homes ***only once*** in a 7-day period must undergo an antigen test on the “day of” prior to entry into the LTC home.
- Essential caregivers must undergo an antigen test on the “day of” regardless of how many times they attend to a LTC home in a 7-day period.

All staff, students and essential caregivers must continue to be screened, as per the requirements outlined above, prior to being permitted into a LTC home, and homes must ensure completion of weekly data submission to the MLTC on several screening metrics.

Homelessness Services & Community Engagement

Homelessness Services continues to operate the full emergency shelter system, overflow hotel rooms, the self-isolation facility and an enhanced street outreach service.

As of January, 31, 2021, 415 individuals have been referred to the isolation facility with testing administered in shelter.

Niagara Region was advised on December 15, 2020 that the Region will receive $4,068,100 in Social Service Relief (SSRF) - Hold Back Funding. The funding guidelines are similar to that of the SSRF Phase 2 funding allocation, meaning that funding can be used for operating costs associated with the needs of the homelessness system only until March 31, 2021, and/or can also be used for capital costs to support projects with completion (and occupancy) committed by the end of December 2021. The Region is awaiting a response from the Ministry of Municipal Affairs and Housing, regarding a request to extend the requirement to have entered into a contribution agreement with a proponent for a capital commitment, in order to use this funding to support an additional capital asset for permanent supportive housing in the region. In the meantime, based on an initial feasibility review, the Region is preparing an expression of interest to allow for potential property owners and realtors to submit potential projects to leverage this funding, according to the funding parameters.

Niagara Health, EMS and Homelessness Services have partnered on a small number of short term LHIN funded pilot projects (until March 31, 2021) aimed to improve mental health and medical support services for individuals experiencing homelessness. The pilot projects incorporate a multifaceted approach focused on increasing urgent access to outpatient supports for patients leaving psychiatric emergency services; enhancing mobile paramedic medical services for individuals experiencing homelessness and connected with the Niagara Assertive Street Outreach team; improving access to supports for individuals accessing the shelter system and experiencing mental health and addiction issues; and, expanding capacity of the Regional Essential Access to Connected Healthcare (REACH) Niagara team to offer short-term recuperation supports for individuals experiencing homelessness and recently discharged from hospital. Through the pilot projects, the REACH Niagara team will also be able to connect individuals within the shelter system to local family practices, community health, and healthcare specialists (e.g. for foot, wound, and dental care), hopefully with longer term benefits.

Homelessness Services is also collaborating with REACH Niagara and Family Health Teams, and coordinating with agencies across the homeless serving system, to inform local planning for the administration of the COVID-19 vaccination for staff and clients within the homeless serving system. Planning is also underway to ensure staff and clients have the necessary information to be able to make an evidence-informed decision about the COVID-19 vaccine, once it is available for this population.

Children's Services

Emergency Child Care

A targeted emergency child care program continued across the province, since January 4, 2021, as a result of the province-wide lockdown (declared on December 26, 2020) and the subsequent stay-at-home order implemented by the province on January 14, 2021. Schools in several public health regions across Ontario, including Niagara region, remained closed with students participating in online learning, which also meant that all before and after school child care programs remained closed as well. As a result, Niagara Region Children's Services continued to provide emergency child care for school aged children of essential workers at Regionally operated child care centres (St. Catharines and Port Colborne). Emergency child care was also provided at a number of licensed child care centres and home child care programs, across Niagara. On February 3, 2021, the province indicated that schools in Niagara will be reopening for in-person learning on February 8, 2021. Emergency child care in Niagara will end on February 5, 2021 and all child care providers will be able to reopen their before and after school programming.

- Across Niagara, 17 licensed child care centres and 29 home child care locations operated emergency child care for school aged children.
- As of February 4, 2021, 301 school aged children in total were placed in emergency child care.
- On average, 232 school aged children attended emergency child care each week. This number increased steadily during each week that emergency child care was available.
- On average, between January 4, 2021, and February 4, 2021 there were approximately 100 school aged children on the waitlist to access emergency child care.

Child care continued for families of infants, toddlers and preschool aged children throughout the initial province-wide lockdown period.

Child Care Updates

Licensed child care centres and home child care programs have documented 1,196 child absent days in December 2020 that were directly related to COVID-19. These absent days were either for testing, due to children exhibiting COVID-19 like symptoms, or due to isolation by a child or family member. This number has shown a consistent

reduction from what was reported in October and November of 2020, mostly due to the change in the COVID-19 operational guidelines related to screening and symptoms. This does not include any absent days incurred by children for regular occurrences such as non-COVID illness, injury, vacation, etc. Children's Services continues to support licensed child care service providers with COVID-19 related costs through one-time support from COVID-19 relief funding. Children's Services expects this to rise as COVID-19 cases continue to increase and more testing is conducted, and isolation is directed.

Children's Services is continuing to monitor the reopening of child care centres and also continues to provide funding to child care service providers to support their ability to remain open.

Social Assistance & Employment Opportunities (Ontario Works)

Throughout the province, the OW caseload has seen a decrease as individuals and families have continued to access the temporary federal COVID-19 benefits, and the Employment Insurance program. As of December 2020, Niagara's OW caseload was 8,615. Overall, Niagara's OW caseload has decreased by 3.3% in 2020 when compared to 2019. The province has seen an overall decrease of 5.1% in the OW caseload.

As federal benefits expire throughout 2021, the Ministry of Children, Community and Social Services (MCCSS) is anticipating a 22% increase in the number of individuals requiring social assistance. In response, MCCSS is centralizing the intake function to create capacity at the local level to respond to the anticipated increase in caseload. The new centralized and automated intake process will be launched in Niagara on February 16, 2021. SAEO has developed a comprehensive transition plan outlining required actions in the areas of engagement, communication, technology, training and development, site readiness and business process review to support a successful launch of the automated intake process.

SAEO continues to offer a blended service delivery model that incorporates in-person, telephone and virtual services to respond to the needs of high-risk clients. Since July 2020, 2,628 clients have received in-person service across the five SAEO sites.

Niagara Regional Housing (NRH)

NRH's development team submitted an application to the Canadian Mortgage and Housing Corporation (CMHC) for the Rapid Housing Initiative (RHI). The funding through the RHI would support the full capital request for 32 new modular units on the

POA lands in Welland, purchased by NRH. While waiting for approval, work continues to get the land ready to be able to quickly develop the new modular units and meet the deadline of March 31, 2022 for occupancy, as outlined in the RHI guidelines.

After the province-wide lockdown and the following stay-at-home order, NRH has moved to only responding to urgent/emergency maintenance requests. Community Programs Coordinators (CPCs) continue to offer telephone support and attend NRH housing communities, if necessary, particularly to support the needs of vulnerable tenants. One hundred and thirty-six refurbished computers were delivered to tenants along with information about the CyberSeniors partnership that offers workshops and programs on-line. NRH continues to advocate for affordable internet so that tenants are able to access information, supports and programs.

As a result of a significant mask donation to Niagara Region, NRH began delivering packages of 50 disposable masks to every NRH household. The security student, who is providing support to NRH through a partnership with Niagara College, has been delivering the masks while also doing walks around NRH communities to offer friendly reminders to tenants about COVID-19 guidelines and answering any questions that tenants may have.

Housing providers have been asked to contact NRH should they experience financial stress as a result of COVID-19, such as increased cleaning costs. However, to date, there have not been any requests from housing providers for this type of financial support. NRH will continue to watch for opportunities to support housing providers throughout the pandemic.

Respectfully submitted and signed by

_____

Adrienne Jugley, MSW, RSW, CHE
Commissioner

Administration
1815 Sir Isaac Brock Way, Thorold, ON L2V 4T7
905-980-6000 Toll-free: 1-800-263-7215

MEMORANDUM

COM-C 4-2021

Subject: Request for Declaration of State of Emergency for Mental Health, Homelessness and Addiction – Additional Correspondence

Date: February 16, 2021

To: Public Health and Social Services Committee

From: Ann-Marie Norio, Regional Clerk

The Clerk's Office is in receipt of additional correspondence in response to the motion from the City of Niagara Falls respecting Niagara Region declaring a state of emergency on mental health, homelessness and addiction. Correspondence received from the Towns of Lincoln and Pelham and the Cities of Port Colborne, St. Catharines and Welland, is attached to this memorandum.

Other Pertinent Reports:

- COM-C 2-2021 Request for Declaration of State of Emergency for Mental Health, Homelessness and Addiction

Respectfully submitted and signed by

_____

Ann-Marie Norio
Regional Clerk

Town of Lincoln

4800 SOUTH SERVICE RD
BEAMSVILLE, ON L0R 1B1

905-563-8205

January 19, 2021

Sent via email:
Local Area Municipalities

Re: Town of Lincoln Council Resolution re: Niagara Region Recognize and Acknowledge Mental Health as a Regional Crisis and Support Solutions to End Homelessness and Addiction

,
Please be advised that Council for the Corporation of the Town of Lincoln at its Special Council Meeting held on January 18, 2021 passed the following motion:

Moved by: Councillor Greg Reimer; Seconded by: Councillor Paul MacPherson

That the correspondence received from the City of Niagara Falls, dated November 17, 2020 and presentation provided by Mr. Soos to Special Council for the Town of Lincoln on December 7, 2020 be received; and

That Council for the Corporation of the Town of Lincoln request that Niagara Region recognize and acknowledge Mental Health as a Regional crisis and support solutions to end homelessness and addiction; and

That Lincoln staff present back to Council a report on potential local solutions and supports, in collaboration with regional staff.

CARRIED

Regards,

Julie Kirkelos
Town Clerk
jkirkelos@lincoln.ca

cc: Local Area Municipalities

The City of Niagara Falls, Ontario

Resolution

No. 10

November 17,2020

Moved by: Councillor Wayne Campbell

Seconded by: Councillor Victor Pietrangelo

WHEREAS According to the Province of Ontario Emergency Response Plan (2008), Canadian municipalities are free to declare states of emergencies in response to "any situation or impending situation caused by the forces of nature, an accident, an intentional act or otherwise that constitutes a danger of major proportions to life or property."

WHEREAS Approximately 625 residents- including 144 children in Niagara, were counted as homeless (March 2018), with shelter occupancy operating at 109.4 percent capacity

WHEREAS Niagara EMS reported 335 suspected opiate overdoses (Jan-June 2019).

WHEREAS Some Niagara-area municipalities have had services such as mental health removed from their Hospitals, and whereas Niagara is severely lacking in mental health and addiction services

THEREFORE BE IT RESOLVED that the City of Niagara Falls request the Niagara Region to declare a state of emergency on mental health, homelessness, and addiction.

FURTHERMORE, the Niagara Regional Council, Niagara Region Public Health and Social Services, Premier of Ontario, the provincial Minister of Health, Minister of the Attorney General, Minister of Children, Community, and Social Services, the Minister of Municipal Affairs and Housing, and the Leader of the Official Opposition, as well as the Prime Minister of Canada, all regional municipalities and all local area municipalities within the Niagara Region be copied on this resolution."

AND The Seal of the Corporation be hereto affixed.

CARRIED

WILLIAM G. MATSON
CITY CLERK

JAMES M. DIODATI
MAYOR

Office of the Clerk
Nancy J. Bozzato, Dipl.M.M
njbozzato@pelham.ca
905-892-2607 x315

January 14, 2021

Ann-Marie Norio, Regional Clerk
Niagara Region
1815 Sir Isaac Brock Way
Thorold ON L2V 4T7
ann-marie.norio@niagararegion.ca

Attention: Ms. Norio,

Re: Request to Declare State of Emergency on Mental Health, Homelessness and Addiction

At their regular meeting of January 11, 2021, the following resolution was adopted with respect to the above noted matter:

WHEREAS According to the Province of Ontario Emergency Response Plan (2008), Canadian municipalities are free to declare states of emergencies in response to "any situation or impending situation caused by the forces of nature, an accident, an intentional act or other Wise that constitutes a danger of major proportions to life or property."

WHEREAS Approximately 625 residents - including 144 children in Niagara, were counted as homeless (March 2018), with shelter occupancy operating at 109.4 percent capacity

WHEREAS Niagara EMS reported 335 suspected opiate overdoses (Jan-June 2019).

WHEREAS Some Niagara-area municipalities have had services such as mental health removed from their Hospitals, and whereas Niagara is severely lacking in mental health and addiction services

THEREFORE BE IT RESOLVED that the Town of Pelham request the Niagara Region to declare a state of emergency on mental health, homelessness, and addiction.

FURTHERMORE, the Niagara Regional Council, Niagara Region Public Health and Social Services, Premier of Ontario, the provincial Minister of Health, Minister of the Attorney General, Minister of Children, Community, and Social Services, the Minister

Office of the Clerk
Nancy J. Bozzato, Dipl.M.M
njbozzato@pelham.ca
905-892-2607 x315

of Municipal Affairs and Housing, and the Leader of the Official Opposition, as well as the Prime Minister of Canada, all regional municipalities and all local area municipalities within the Niagara Region be copied on this resolution."

If you have any questions or concerns regarding the above, do not hesitate to contact the undersigned.

Yours very truly,

(Mrs.) Nancy J. Bozzato, Dipl.M.M., AMCT
Town Clerk

cc. Justin Trudeau, Prime Minister of Canada, Justin.trudeau@parl.gc.ca
Niagara Region Public Health and Social Services
Doug Ford, Premier of Ontario, doug.fordco@pc.ola.org
Christine Elliot, Provincial Minister of Health, christine.elliott@pc.ola.org
Doug Downey, Minister of Attorney General, doug.downey@pc.ola.org
Todd Smith, Minister of Children, Community and Social Services, todd.smithco@pc.ola.org
Steve Cark, Minister of Municipal Affairs and Housing, steve.clark@pc.ola.org
Andrea Horwath, Leader of the Official Opposition, ahorwath-qp@ndp.on.ca
Local Niagara Municipalities
Sam Oosterhoff, Niagara West MPP, sam.oosterhoff@pc.ola.org
Dean Allison, Niagara West MPP, dean.allison@parl.gc.ca

/sl

PORT COLBORNE
Corporate Services Department
Clerk's Division

Municipal Offices: 66 Charlotte Street
Port Colborne, Ontario L3K 3C8 · www.portcolborne.ca

T 905.835.2900 ext 106 F 905.834.5746
E amber.lapointe@portcolborne.ca

January 25, 2021

The Right Honourable Justin Trudeau
Prime Minister
House of Commons
Ottawa, ON K1A 0A6

Sent via E-mail: Justin.trudeau@parl.gc.ca

Honourable and Dear Sir:

Re: Resolution – Mental Health, Homelessness and Addiction

Please be advised that, at its meeting of January 11, 2021, the Council of The Corporation of the City of Port Colborne resolved as follows:

> That the resolution received from the City of Niagara Falls - Mental Health, Homelessness and Addiction, be supported.

A copy of the above noted resolution is enclosed for your reference. Your favourable consideration of this request is respectfully requested.

Sincerely,

Amber LaPointe
City Clerk

Encl.

ec: The Honourable Doug Ford, Premier of Ontario
Honourable Christine Elliott, Minister of Health
Honourable Doug Downey, Attorney General
Honourable Todd Smith, Minister of Children, Community, and Social Services
Honourable Steve Clark, Minister of Municipal Affairs and Housing
Andrea Horwath, Leader of Official Opposition
Niagara Region
Niagara Region Public Health
Niagara Area Municipalities

The City of Niagara Falls, Ontario

Resolution

No. 10

November 17,2020

Moved by: Councillor Wayne Campbell

Seconded by: Councillor Victor Pietrangelo

WHEREAS According to the Province of Ontario Emergency Response Plan (2008), Canadian municipalities are free to declare states of emergencies in response to "any situation or impending situation caused by the forces of nature, an accident, an intentional act or otherwise that constitutes a danger of major proportions to life or property."

WHEREAS Approximately 625 residents- including 144 children in Niagara, were counted as homeless (March 2018), with shelter occupancy operating at 109.4 percent capacity

WHEREAS Niagara EMS reported 335 suspected opiate overdoses (Jan-June 2019).

WHEREAS Some Niagara-area municipalities have had services such as mental health removed from their Hospitals, and whereas Niagara is severely lacking in mental health and addiction services

THEREFORE BE IT RESOLVED that the City of Niagara Falls request the Niagara Region to declare a state of emergency on mental health, homelessness, and addiction.

FURTHERMORE, the Niagara Regional Council, Niagara Region Public Health and Social Services, Premier of Ontario, the provincial Minister of Health, Minister of the Attorney General, Minister of Children, Community, and Social Services, the Minister of Municipal Affairs and Housing, and the Leader of the Official Opposition, as well as the Prime Minister of Canada, all regional municipalities and all local area municipalities within the Niagara Region be copied on this resolution."

AND The Seal of the Corporation be hereto affixed.

CARRIED

WILLIAM G. MATSON
CITY CLERK

JAMES M. DIODATI
MAYOR

St. Catharines

January 12, 2021

City of Niagara Falls
City Clerk's Office
Attn: William Matson
4310 Queen St., Niagara Falls, ON L2E 6X5

Sent via email: hruzylo@niagarafalls.ca

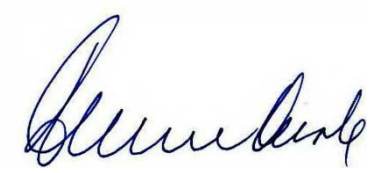
Re: Request for Support - Motion – Request to the Niagara Region to Declare a State of Emergency on Mental Health, Homelessness and Addiction
Our File 35.23.2

Dear Mayor and Council,

At its meeting held on December 14, 2020, St. Catharines City Council approved the following motion:

> "That Council endorse the resolution from the City of Niagara Falls regarding the request to the Niagara Region to Declare a State of Emergency on Mental Health, Homelessness and Addiction."

If you have any questions, please contact the Office of the City Clerk at extension 1501.



Bonnie Nistico-Dunk, City Clerk
Legal and Clerks Services, Office of the City Clerk
:ra

Cc: Niagara Regional Council via Regional Clerk's Office
Scott Rosts, Office of St. Catharines Mayor
Shelley Chemnitz, Chief Administrative Officer

City of Welland
Corporate Services
Office of the City Clerk
60 East Main Street, Welland, ON L3B 3X4
Phone: 905-735-1700 Ext. 2159 | **Fax:** 905-732-1919
Email: clerk@welland.ca | www.welland.ca

April 22, 2020

File No. 21-30

SENT VIA EMAIL

Office of the Regional Clerk
Niagara Regional Council
1815 Sir Isaac Brock Way
P.O. Box 1042
Thorold, ON L2V 4T7

Attention: Ann-Marie Norio, Regional Clerk

Dear Ms. Norio:

Re: January 19, 2021 – WELLAND CITY COUNCIL

At its meeting of January 19, 2021, Welland City Council passed the following motion:

> **"THAT THE COUNCIL OF THE CITY OF WELLAND requests the Niagara Region to declare a state of emergency on mental health, homelessness and addiction; and further**
> **The Niagara Regional Council, Niagara Region Public Health and Social Services, Premier of Ontario, Minister of Health, Minister of the Attorney General, Minister of Children, Community and Social Services, Minister of Municipal Affairs and the Niagara Center MPP be copied on this resolution."**

Yours truly,

T Stephens

Tara Stephens
City Clerk

TS:cap

c.c.: Niagara Region Public Health, sent via email
Premier of Ontario, Doug Ford, sent via email
Minister of the Attorney General, sent via email
Minister of Children, Community and Social Services, sent via email
Minister of Municipal Affairs and Housing, sent via email
Niagara MPPs, sent via email
Local Municipalities, sent via email
Adam Eckhart, Fire Chief, sent via email

Community Services
1815 Sir Isaac Brock Way, Thorold, ON L2V 4T7
905-980-6000 Toll-free: 1-800-263-7215

MEMORANDUM

COM-C 6-2021

Subject: **Improving the Long-Term Care Outbreak Response in Ontario – Association of Municipalities of Ontario's (AMO) Final Submission to the Long-Term Care COVID-19 Commission**

Date: **February 16, 2021**

To: **Public Health & Social Services Committee**

From: **Adrienne Jugley, Commissioner, Community Services**

In September 2020, the provincial government launched the "Long-Term Care Commission" to investigate how and why COVID-19 spread in long-term care homes (LTC), what was done to prevent the spread and the impact of key elements of the existing system on that spread. Since the Commission was launched, AMO has provided the Commission with perspectives from the municipally operated LTC homes, with an interim report with recommendations submitted a the end of October 2020, and meeting with the Commission on October 26, 2020. The attached document (Appendix 1) represents AMO's financial set of recommendations to the Commission for their consideration.

This report contains a list of 49 recommendations to the Commission on behalf of the municipal governments that operate 100 (16%) of the 626 long-term care homes in Ontario.

Respectfully submitted and signed by

_____
Adrienne Jugley, MSW, RSW, CHE
Commissioner

Improving the Long-Term Care Outbreak Response in Ontario

AMO's Final Submission to the Long-Term Care COVID-19 Commission

January 2021

Improving the Long-Term Care Outbreak Response in Ontario: AMO's Final Submission to the Long-Term Care COVID-19 Commission

Executive Summary - List of Recommendations

The Association of Municipalities of Ontario (AMO) submits the following recommendations to the Commission on behalf of the municipal governments that operate 100 (16%) of the 626 long-term care (LTC) homes in Ontario.

Topic	Recommendations
Vision for Long-Term Care (LTC) & Leadership Culture	1. The Ministry of Health, Ministry of Long-Term Care, and the Ministry for Seniors and Accessibility, should co-develop a vision with the long-term care (LTC) sector that recognizes while LTC is part of the health care continuum, LTC homes should not be treated or operationalized as health care institutions. 2. The Ministry of Long-Term Care should work with the LTC sector to foster a common culture that is distinct from acute care and build capacity for strong and empowered leadership in LTC. 3. The Ministry of Long-Term Care should facilitate the development of a specialized Centre of Excellence for municipal and non-profit homes to promote strong leadership in the sector. 4. The Ministry of Health and Ministry of Long-Term Care should require that there be Infection, Prevention and Control (IPAC) accountability at the highest level of management, and that there be a clear reporting structure on IPAC matters. 5. The Ministry of Long-Term Care and the Ministry of Colleges and Universities should work with post-secondary institutions to ensure that curriculums of professional health programs include an understanding of the culture of LTC and appropriate applicability of IPAC measures in the setting. 6. The Ministry of Labour, Skills Training and Development and the Ministry of Long-Term Care should work with the LTC sector to examine the overall labour relations environment in LTC and explore potential ways to improve that environment.
Public Health and Safety	7. The Ministry of Health should continue to prioritize COVID-19 vaccinations of LTC home residents, staff, and essential caregivers, as rapidly as possible, and where feasible, facilitate vaccinations for staff on site. 8. The Ministry of Health should continue to prioritize COVID-19 testing of LTC home staff, residents, volunteers, and visitors, and that test results be shared with LTC home management as quickly as possible. 9. The Ministry of Health should conduct an awareness campaign to address vaccine hesitancy among health care workers.

Topic	Recommendations
	10. The Ministry of Health and the Ministry of Long-Term Care should review the adequacy of IPAC programs under the *Long-Term Care Homes Act, 2007* in preventing and managing infectious disease outbreaks. 11. The Ministry of Long-Term Care should continue to increase operational funding to implement effective IPAC measures in homes (i.e. place an IPAC specialist in each home and increase IPAC training and guidance to all LTC staff). 12. The Ministry of Long-Term Care should continue to enhance funding for the minor capital funding program to support operators to improve structural compliance and enable more effective IPAC in homes. 13. The Ministry of Health should continue to support homes in addressing inventory management challenges of personal protective equipment (PPE) and ensure that LTC homes are prioritized for appropriate PPE. 14. The Ministry of Health, in partnership with the Ministry of Long-Term Care, should invest in local public health workforces to address the needs of the increasing complexity of the pandemic response in LTC homes and maintain critical core public health services at the same time. 15. The Ministry of Health should increase local public health and provincial (i.e. Public Health Ontario) resources for IPAC and outbreak management in LTC homes. 16. The Province should ensure immediate access to resources is provided, including staff and professional teams, to assist homes in outbreak. 17. The Ministry of Health and Ministry of Long-Term Care should review the IPAC hub and spoke model and establish a Framework of Values to ensure that the hospital institutional based approach is mindful, appropriate, and adaptable for LTC home settings.
Funding	18. The Ministry of Long-Term Care should provide municipal governments with adequate, sustainable funding that reflects the true costs of operating a LTC home, including special consideration for smaller LTC homes. 19. The Ministry of Long-Term Care should enhance provincial funding to effectively redevelop existing municipal and not-for profit homes, particularly those with 3-4 bed wards. 20. The Ministry of Long-Term Care should increase core operational funding by at least at the rate of inflation (reflective of sectoral costs), across all funding envelopes every year. 21. The Ministry of Long-Term Care should extend and maintain the High Wage Transition Fund for at least the duration of the COVID-

Topic	Recommendations
	19 pandemic and consult with AMO and other LTC sector associations about future replacements for the Fund.
Planning and Communications	22. The Province must have representation from municipal LTC homes in regional, systems planning, and implementation tables from the beginning when managing any similar scale outbreak responses in the future. 23. The Province should focus on LTC homes at the same time as hospitals in future outbreaks. 24. The Province should ensure that the Province, Local Health Integration Networks (LHINs), local public health units, and in the future Ontario Health Teams, work collaboratively to ensure consistent messaging and a structured and respectful response from local health partners to support LTC homes.
Staffing Measures	25. The Province should begin immediately actioning the December 2020 LTC Staffing Plan. 26. The Ministry of Health should develop a health human resources strategy to address staffing issues, especially in northern and rural areas that face human resources challenges. 27. The Province should invest resources in better training for PSWs and explore ways to regulate the PSW profession that does not have a negative impact on current and future PSW staffing in LTC homes throughout the province. 28. The Ministry of Long-Term Care should continue funding as a priority for new caregiver roles outside of the traditional PSW and nursing workloads. 29. The Province must continue to extend the Emergency Orders to allow redeployment of staff into the LTC sector until the pandemic ends or when staffing issues are fully addressed, whichever happens first. 30. The Province should expand the issuance of pandemic pay to a broader range of staff in LTC homes, including nurses, other staff who do front-line work, as well as their supervisors. 31. The Ministry of Long-Term Care should ensure that AMO and other LTC sector associations are represented in the Province's technical working group that will discuss how to improve working conditions (including increased full-time work and compensation).
Care for Residents	32. The Ministry of Long-Term Care should commit to full 100% provincial funding for the average of four hours of care per resident per day and accelerate the implementation. 33. The Ministry of Health must immediately reverse the changes and reductions to pharmacy funding on a permanent basis to support LTC pharmacy services over the long-term.

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	34. The Ministry of Long-Term Care should enhance specialized support programs, including Behavioural Supports Ontario, Physician Assistants, and specialized Nurse Practitioners to complement staffing levels in LTC homes as well as review the base funding model for residents with responsive behaviours. 35. The Ministry of Long-Term Care should provide dedicated funding for consistent training to build staff competencies related to emotionally focused and person-centred care to manage dementia and other responsive behaviours. 36. The Ministry of Long-Term Care should review the adequacy of the existing design standards to ensure that current and future LTC homes supports all residents, including those with dementia. 37. The Province (including the Ministry of Long-Term Care, Ministry of Health, and the Ministry of Seniors and Accessibility) should incentivize campuses of care when considering new bed development decisions. 38. The Ministry of Long-Term Care and the Ministry of Health should work to foster a more collaborative approach to admissions to LTC during a pandemic situation, especially when transferring residents from acute care. 39. The Ministry of Long-Term Care and the Ministry of Health should provide residents and families with standardized education and training across the sector related to personal protective equipment, infection prevention and control, diversity, and inclusion, and provide the resources needed to assist with this including training sessions and webinars for residents, essential care providers, and families. 40. The Ministry of Long-Term Care should develop a strategy, in consultation with Indigenous People and ethno-cultural groups, and provide resources to support the long-term care sector to develop culturally safe and responsive programming through training, development of resource toolkits and staffing measures.
Inspections – Enforcement and Compliance	41. The Ministry of Long-Term Care should take a risk-management approach to inspections that achieves a better balance between enforcement for underperforming LTC homes and facilitate coaching for compliance for high-performing LTC homes. 42. The Ministry of Long-Term Care should facilitate the collection and dissemination of best practices around inspections and provide training opportunities through a Centre for Excellence for the not-for-profit and municipal LTC sector. 43. The Province should strengthen the role of IPAC inspections during outbreak situations, and better coordinate inspections by the Ministry of Long-Term Care, Public Health and the Ministry of Labour related to IPAC. 44. The Ministry of Health and the Ministry of Long-Term Care should provide further guidance and direction on how IPAC Hubs,

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	Ministry of Labour inspectors, and public health inspectors should work together for greater effectiveness.
Mental Health and Well-Being	45. The Ministry of Health, the Ministry of Long-Term Care, and the Ministry for Seniors and Accessibility should ensure that the LTC sector has access to mental health specialists and a plan to address the broad mental health needs of LTC home residents, staff, and their caregivers that will remain long after COVID-19. 46. The Ministry of Health and the Ministry of Long-Term Care should continue to work with LTC sector associations to review visitors' policies, including for essential caregivers, to strike an appropriate balance between health and emotional well-being considerations. 47. The Ministry of Long-Term Care should invest in virtual technology and better broadband access and other means of connection to address the social isolation felt by LTC residents.
Palliative Care Delivery	48. The Ministry of Long-Term Care should train and support homes around the adoption of a palliative care approach. 49. The Ministry of Long-Term Care should ensure that LTC staff members are equipped with training on palliative care delivery.

Introduction

The Association of Municipalities of Ontario (AMO) is a non-partisan, non-profit association representing municipal governments across the province. Municipal governments work through AMO to achieve shared goals and meet common challenges. As the frontline order of government closest to people, municipal governments are active players in Ontario's health system that understand the health needs of local communities.

Although health is a provincial responsibility under Canadian federalism, municipal governments, and District Social Service Administration Boards (DSSABs) co-fund and deliver several health services. These services assist with health-related needs in the community that improve local population health outcomes. Long-term care (LTC) is one of those health services – although not all municipal governments are required to operate a LTC home.

Municipal governments operate 100 (16%) of the 626 LTC homes in Ontario that are mandated under the *Long-Term Care Homes Act, 2007.* Municipal homes pride themselves on providing high quality services and safe environments for their residents. In support of that work, AMO continues to advocate for improvements for seniors and the LTC sector.

Participation in the Commission

AMO appreciates the concerted efforts of the Long-Term Care COVID-19 Commission (Commission) to investigate how and why coronavirus (COVID-19) spread in LTC homes, what was done to prevent the spread, and the impact of key elements of the existing system on the spread.

Since the Commission was launched by the Ontario Ministry of Long-Term Care in July 2020, AMO has provided the Commission with perspectives from municipally operated LTC homes who have been impacted by COVID-19. Interim recommendations were submitted to the Commission in October 21, 2020 (Appendix A), and we met with the Commission on October 26, 2020.

This submission provides a set of final recommendations for the Commission to consider in its report to the provincial government. In our view, implementing these changes will help the Province address successive waves of the COVID-19 pandemic and mitigate against a similar occurrence of an infectious disease outbreak in LTC homes in the future.

Context

Given that not all municipal governments operate LTC homes, AMO makes recommendations that affect policy, planning, and supports (financial and non-financial), rather than detailed technical operational advice. The Commission is encouraged to consider the operational advice provided by individual municipal LTC home operators, and AdvantAge Ontario – the association that represents municipal and non-profit LTC service providers.

AMO's recommendations were created through the collective effort of a dedicated sub-working group of AMO's Health Task Force. The group is comprised of elected officials and municipal staff who work in LTC, public health, and other municipal services (see Appendix B for a list of members).

This group brought unique and diverse perspectives from across all areas of the province and AMO appreciates their efforts, particularly given their other priorities.

The AMO Health Taskforce and Board of Directors have also endorsed this submission.

Recommendations

The COVID-19 pandemic disproportionately impacted residents in LTC homes and exposed the structural weaknesses in the LTC system. As of January 29, 2021, there have been 14,346 resident cases and 5,858 staff cases in Ontario. Tragically 3,491 residents and 11 staff have lost their lives to this disease.[1]

Although municipal LTC homes have been affected by COVID-19, those operators have fared better in both the number of COVID-19 cases and deaths compared to those seen in not-for-profit and for-profit LTC homes.[2]

Based on the collective expertise and experience in managing COVID-19 in the LTC sector thus far, AMO submits 48 recommendations for action across nine (9) themes:

- Vision for LTC & Leadership Culture
- Public Health and Safety
- Planning and Communications
- Staffing Measures
- Care for Residents
- Funding
- Inspections - Enforcement and Compliance
- Mental Health and Well-Being

The recommendations outlined in this paper are built on the premise that all the players involved with long-term care, in their respective roles and responsibilities, need to be adequately resourced. Ultimately, long-term care needs to be guided by a systems approach based on who can do what is best for the homes and residents. To ensure that residents receive the quality care they deserve in healthy and safe environments, all players across the health care continuum must work in a collaborative and coordinated manner. This is likely to include a longer-term exploration of options and possibilities, which municipal governments would welcome.

[1] Government of Ontario. COVID-19 in Long-Term Care Homes. https://covid-19.ontario.ca/data/long-term-care-homes (accessed January 29, 2021).
[2] Nathan M. Stall et al. CMAJ. August 17, 2020. "For-profit long-term care homes and the risk of COVID-19 outbreaks and resident deaths." https://www.cmaj.ca/content/192/33/E946 (accessed January 8, 2021).

I. Vision for Long-Term Care & Leadership Culture

At its core, LTC is part of the continuum of health care, and should be integrated, but not subsumed into the health care sector. That is because LTC homes are distinct in their vision and purpose. Different from a retirement home or supportive housing, LTC homes are places where adults receive emotionally focused and person-centred care and receive help with most or all daily activities and have access to 24-hour nursing and personal care.[3]

Under the *Long-Term Care Homes Act, 2007,* a LTC home is primarily the home for its residents. It is to be operated as a place in which its residents may live with dignity and in security, safety and comfort and have their physical, psychological, social, spiritual, and cultural needs adequately met.[4] This reality is fundamentally different from a hospital's institutional or acute-health care mindset.

With the needs between the residential and institutional care so vastly different, so is the culture and leadership required. Experience with the COVID-19 pandemic has shown that LTC needs a vision and culture that reflects the true nature of LTC homes. The sector must welcome leaders into the sector and promote leadership from within all levels of the organization. A strong and empowered leadership is critical to attract and retain the highest quality staff that can deliver emotionally focused and person-centered care to residents, and build an environment that staff want to work in, and residents want to live

Once a strong vision and leadership culture for LTC is in place, the sector can begin sharing this information with professional health programs and work on systemic improvements across the labour relations environment.

[3] Government of Ontario. About Long-Term Care. https://www.ontario.ca/page/about-long-term-care (accessed January 8, 2021).
[4] Government of Ontario. LTCHA Guide, Phase 1. http://health.gov.on.ca/en/public/programs/ltc/docs/ltcha_guide_phase1.pdf (accessed January 8, 2021).

Vision for LTC & Leadership Culture: Recommendations

1. The Ministry of Health, Ministry of Long-Term Care, and the Ministry for Seniors and Accessibility, should co-develop a vision with the long-term care (LTC) sector that recognizes while LTC is part of the health care continuum, LTC homes should not be treated or operationalized as health care institutions.
2. The Ministry of Long-Term Care should work with the LTC sector to foster a common culture that is distinct from acute care and build capacity for strong and empowered leadership in LTC.
3. The Ministry of Long-Term Care should facilitate the development of a specialized Centre of Excellence for municipal and non-profit homes to promote strong leadership in the sector.
4. The Ministry of Health and Ministry of Long-Term Care should require that there be Infection, Prevention and Control (IPAC) accountability at the highest level of management, and that there be a clear reporting structure on IPAC matters.
5. The Ministry of Long-Term Care and the Ministry of Colleges and Universities should work with post-secondary institutions to ensure that curriculums of professional health programs include an understanding of the culture of LTC and appropriate applicability of IPAC measures in the setting.
6. The Ministry of Labour, Skills Training and Development and the Ministry of Long-Term Care should work with the LTC sector to examine the overall labour relations environment in LTC and explore potential ways to improve that environment.

II. Public Health and Safety

Excellence in LTC requires effective leadership and access to specialized expertise, including in Infection Prevention and Control (IPAC). The COVID-19 pandemic demonstrated the critical role that enhanced IPAC measures played in curbing the spread of the virus. Other lessons that have been learned include:

- While hospitals play an important role in supporting LTC homes that are in outbreak, consideration must be given to the difference in LTC culture (e.g. homes, not institutions). A mutually agreed upon framework of care would be useful, as would an exploration of where public health can be a bridge between the LTC homes and hospitals.
- Testing of LTC home residents, staff, and essential caregivers is critical and results should have been prioritized. Adequate staff and dedicated funding was sorely needed.
- LTC staff should be vaccinated in the LTC home where feasible to avoid requiring LTC staff to travel to a congregate setting (e.g. hospital).
- IPAC measures were most effective when an IPAC specialist was provided to every home. It allowed for higher standards, greater training and guidance to other LTC staff.
- PPE inventory management and prioritizing PPE for LTC homes were measures needed at the earliest stages of the pandemic and ideally before it began.
- More public health resources for IPAC and outbreak management in LTC was sorely needed, and current resources on the ground are stretched to capacity.

AMO is encouraged to see PPE inventory management was provided for new and existing staff during 2020 and continues in 2021, and the Ministry of Long-Term Care's new IPAC guidance (January 2021) has been helpful. To implement this and make effective IPAC a long-term reality beyond the pandemic, dedicated IPAC staffing, equipment and supplies, and most of all ongoing funding will be needed.

Assistance when warranted is crucial from all orders of government including the Red Cross Teams and the Canadian Armed Forces. Other resources can also be brought to bear including municipal Community Paramedicine programs. It is important though that additional provincial funding should support this and cover 100 percent of the cost. The provincial pilots to serve people waiting for admission to LTC homes can also be leveraged if there is a need to control new admission during outbreaks.

Public Health and Safety: Recommendations

7. The Ministry of Health should continue to prioritize COVID-19 vaccinations of LTC home residents, staff, and essential caregivers, as rapidly as possible, and where feasible, facilitate vaccinations for staff on site.
8. The Ministry of Health should continue to prioritize COVID-19 testing of LTC home staff, residents, volunteers, and visitors, and that test results be shared with LTC home management as quickly as possible.
9. The Ministry of Health should conduct an awareness campaign to address vaccine hesitancy among health care workers.
10. The Ministry of Health and the Ministry of Long-Term Care should review the adequacy of IPAC programs under the *Long-Term Care Homes Act, 2007* in preventing and managing infectious disease outbreaks.
11. The Ministry of Long-Term Care should continue to increase operational funding to implement effective IPAC measures in homes (i.e. place an IPAC specialist in each home and increase IPAC training and guidance to all LTC staff).
12. The Ministry of Long-Term Care should continue to enhance funding for the minor capital funding program to support operators to improve structural compliance and enable more effective IPAC in homes.
13. The Ministry of Health should continue to support homes in addressing inventory management challenges of personal protective equipment (PPE) and ensure that LTC homes are prioritized for appropriate PPE.
14. The Ministry of Health, in partnership with the Ministry of Long-Term Care, should invest in local public health workforces to address the needs of the increasing complexity of the pandemic response in LTC homes and maintain critical core public health services at the same time.
15. The Ministry of Health should increase local public health and provincial (i.e. Public Health Ontario) resources for IPAC and outbreak management in LTC homes.
16. The Province should ensure immediate access to resources is provided, including staff and professional teams, to assist homes in outbreak.
17. The Ministry of Health and Ministry of Long-Term Care should review the IPAC hub and spoke model and establish a Framework of Values to ensure that the hospital institutional based approach is mindful, appropriate, and adaptable for LTC home settings.

III. Funding for Sustainability and Viability

Adequate funding is required to sustain and improve the quality and safe care that LTC residents deserve. Current funding levels and funding allocation models are not keeping pace with the increasing acuity of residents. Provincial funding, including emergency funding, should be adequate, sustainable and reflect the true costs of operating a LTC home. Funding is key to implementing many of the recommendations outlined in this submission.

Decades of underfunding have stretched the capacity of municipal LTC homes to manage with the additional costs associated with the COVID-19 pandemic, let alone to meet the basic needs of residents in normal operating circumstances. In 2021 and beyond, municipal governments will have to manage rising pandemic costs and declining revenue across several program areas. They cannot afford to continue to fill in the gap where core operating, and capital funding is lack from the Province.

Regarding redevelopment, the Ministry of Long-Term Care needs to fund and prioritize the redevelopment of existing municipal LTC homes that still have 3- and 4-bed wards to build a sustainable and viable LTC sector.

In the meantime, the Province's must find an alternative to the High Wage Transition Fund that they have committed to sunset in March 2021. Not replacing the Fund will result in less funding for LTC services and may lead to service reductions. The Fund must continue past March 2021, as it provides thousands of dollars of funding each month which has likely been integrated into 2021 budgets already. Municipal homes have incorporated this into base funding over the years and has used it to support higher wages in the sector which is essential to aid employee recruitment and retention.

Municipal governments support the creation of a provincial technical working group to review components of the LTC funding model (e.g. Case Management Index and High Intensity Needs Fund). AMO can bring a unique perspective to that working group on behalf of municipal LTC homes.

Funding: Recommendations

18. The Ministry of Long-Term Care should provide municipal governments with adequate, sustainable funding that reflects the true costs of operating a LTC home, including special consideration for smaller LTC homes.
19. The Ministry of Long-Term Care should enhance provincial funding to effectively redevelop existing municipal and not-for profit homes, particularly those with 3-4 bed wards.
20. The Ministry of Long-Term Care should increase core operational funding by at least at the rate of inflation (reflective of sectoral costs), across all funding envelopes every year.
21. The Ministry of Long-Term Care should extend and maintain the High Wage Transition Fund for at least the duration of the COVID-19 pandemic and consult with AMO and other LTC sector associations about future replacements for the Fund.

IV. Planning and Communications

Effective planning and communications were vitally important to evidence-based decision-making in the sector during the COVID-19 pandemic. Input from the LTC sector was critical in developing regional systems planning, and implementation strategies, and needed earlier at the pandemic's onset.

Many municipal LTC homes found that communication and coordination at the provincial level was unsatisfactory initially around the pandemic. The Ministry of Long-Term Care, the Ministry of Health, the Office of the Chief Medical Officer of Health, and local public health units did not always issue clear guidance and direction, and at times there was a lack of consistency between what was provided by these groups.

Moreover, when conditions changed, direction was not always adapted and communicated out quickly to LTC homes. Sometimes the Province's directives were communicated late on Friday that required implementation on a Saturday or by Monday. That did not allow for enough lead time to implement the required changes correctly and communicate out to residents, staff, volunteers, and their families.

In both scenarios, LTC homes were left to navigate through and make decisions in good faith and with best intentions. Fortunately, this has improved over the course of the pandemic.

Going forward, the Province needs to work collaboratively with Local Health Integration Networks (LHINs), local public health units, and in the future Ontario Health Teams, to ensure there is consistent messaging and a structured and respectful response from local health partners to support LTC homes.

The Province should rely on expertise of the LTC sector, and earlier, when managing any similar scale outbreak responses in the future. This cooperation will help the Province prepare responses for LTC homes at the same time as hospitals.

Planning and Communications: Recommendations

22. The Province must have representation from municipal LTC homes in regional, systems planning, and implementation tables from the beginning when managing any similar scale outbreak responses in the future.
23. The Province should focus on LTC homes at the same time as hospitals in future outbreaks.
24. The Province should ensure that the Province, Local Health Integration Networks (LHINs), local public health units, and in the future Ontario Health Teams, work collaboratively to ensure consistent messaging and a structured and respectful response from local health partners to support LTC homes.

V. Staffing Measures

The longstanding staffing challenges in LTC were exacerbated by the COVID-19 pandemic. It showed how challenging it is to successfully recruit and retain critical staff in a time of crisis. Many municipal homes needed to 'staff up' and are now facing the second wave with less staff than in the first one.

AMO supports the Province's use of Emergency Orders to ensure that staff can redeployed into the LTC sector at least until the pandemic ends. This allows municipal LTC homes to leverage existing staff to fill gaps left due to illness or other accommodations needed for existing LTC staff.

By contrast, the issuance of "pandemic pay" to only a select group of PSW workers was problematic during the pandemic. The Province should address the wage compression and morale issues that have inadvertently been created by issuing pandemic pay to only a subset of staff in LTC homes.

The Ministry made considerable improvements to staffing through both their July 2020 Staffing Study and their December 2020 Long-Term Care Staffing Plan. The actions outlined in the Staffing Plan (and reiterated from the Staffing Study) must be implemented immediately. Adequate and dedicated funding is also needed to ensure these changes can be successfully implemented to manage the COVID-19 pandemic, and beyond.

It is important that the Ministry of Health and the Ministry of Long-Term Care work together to develop an overall health human resource plan, or else the Staffing Plan will be implemented in isolation that may have unintended consequences. There are shortages of health professionals from physicians to nurses to personal support workers (PSWs), which is why AMO was encouraged to see both the demand and supply issues around PSWs and registered nursing staff identified in the Staffing Plan.

Municipal LTC homes and AMO should be involved with the Province's technical working group to identify opportunities, best practices, and potential barriers to enhance scheduling methods and increase full-time positions.

Any efforts to improve working conditions for LTC workers and promote more full-time employment should consider impacts on other sectors that support seniors to age in place and defer admission into a LTC home. One such sector is home and community care. PSWs in both LTC and home and community care should receive similar treatment or else there will be migration to the employers that pay the best. This retention issue is already seen where LTC homes lose staff to hospital employers.

In the meantime, the Ministry of Long-Term Care should continue funding new caregiver roles outside of the traditional PSW and nursing workloads. These additions have been invaluable resources for residents and LTC staff.

Staffing Measures: Recommendations

25. The Province should begin immediately actioning the December 2020 LTC Staffing Plan.
26. The Ministry of Health should develop a health human resources strategy to address staffing issues, especially in northern and rural areas that face human resources challenges.
27. The Province should invest resources in better training for PSWs and explore ways to regulate the PSW profession that does not have a negative impact on current and future PSW staffing in LTC homes throughout the province.
28. The Ministry of Long-Term Care should continue funding as a priority for new caregiver roles outside of the traditional PSW and nursing workloads.
29. The Province must continue to extend the Emergency Orders to allow redeployment of staff into the LTC sector until the pandemic ends or when staffing issues are fully addressed, whichever happens first.
30. The Province should expand the issuance of pandemic pay to a broader range of staff in LTC homes, including nurses, other staff who do front-line work, as well as their supervisors.
31. The Ministry of Long-Term Care should ensure that AMO and other LTC sector associations are represented in the Province's technical working group that will discuss how to improve working conditions (including increased full-time work and compensation).

VI. Care for Residents During COVID-19, and Beyond

AMO was pleased to see the Province commit to increase direct care for LTC residents to an average of four hours per resident per day by 2024-25. The response was well received by the many stakeholders who called for the increase the levels of direct care, and to sustain existing services to help protect residents. Municipal governments look forward to more details on about the initiative, including how the Ministry of Long-Term Care will provide funding, and define what hours are captured in that standard.

Municipal governments appreciate the pause on changes to the pharmacy funding during the pandemic and would recommend that the Ministry of Health reverse permanently the previous decision. Other areas that could increase resident care include enhancing resources to support residents with responsive behaviors to manage during COVID-19 and in future outbreaks.

Caring for residents during outbreaks of COVID-19 presented challenges for those with responsive behaviors as it was more difficult to ensure that LTC residents with higher acuity did not pose a higher transmission risk to other residents, staff, and essential caregivers.

COVID-19 also highlighted the need to:

- Foster a more collaborative approach to admissions to LTC during a pandemic situation, especially when releasing residents from acute care back to LTC;
- Review the base funding model for residents with responsive behaviours;
- Dedicate funding for consistent training to build staff competencies related to emotionally focused and person-centred care to manage dementia and other responsive behaviours; and
- Enhance specialized support programs, including Behavioural Supports Ontario, Physician Assistants, and specialized Nurse Practitioners to complement staffing levels in LTC homes.

The Ministry of Long-Term Care should review the adequacy of the existing design standards to ensure that current and future LTC homes supports all residents, including those with responsive behaviours such as dementia. One opportunity is to make changes during redevelopment, either through supporting smaller living spaces, or redesigning spaces within them. When considering new bed decisions, the Province should take into consideration the campus of care model, and a holistic view of the needs for seniors and LTC residents.

The Ministry of Long-Term Care should develop standardized education and training across the sector related to PPE, IPAC, and diversity and inclusion. The Ministry should provide the resources needed to assist with this including training sessions and webinars for residents, essential care providers and families.

Attention is also needed to ensure that culturally safe and responsive programming is provided even through outbreak situations. Provincial support could assist the LTC sector to help create the conditions to achieve this. Appropriate consultation with Indigenous People and ethno-cultural groups is necessary as part of this effort.

Care for Residents: Recommendations

32. The Ministry of Long-Term Care should commit to full 100% provincial funding for the average of four hours of care per resident per day and accelerate the implementation.
33. The Ministry of Health must immediately reverse the changes and reductions to pharmacy funding on a permanent basis to support LTC pharmacy services over the long-term.
34. The Ministry of Long-Term Care should enhance specialized support programs, including Behavioural Supports Ontario, Physician Assistants, and specialized Nurse Practitioners to complement staffing levels in LTC homes as well as review the base funding model for residents with responsive behaviours.
35. The Ministry of Long-Term Care should provide dedicated funding for consistent training to build staff competencies related to emotionally focused and person-centred care to manage dementia and other responsive behaviours.
36. The Ministry of Long-Term Care should review the adequacy of the existing design standards to ensure that current and future LTC homes supports all residents, including those with dementia.
37. The Province (including the Ministry of Long-Term Care, Ministry of Health, and the Ministry of Seniors and Accessibility) should incentivize campuses of care when considering new bed development decisions.
38. The Ministry of Long-Term Care and the Ministry of Health should work to foster a more collaborative approach to admissions to LTC during a pandemic situation, especially when transferring residents from acute care.
39. The Ministry of Long-Term Care and the Ministry of Health should provide residents and families with standardized education and training across the sector related to PPE, IPAC, diversity, and inclusion, and provide the resources needed to assist with this including training sessions and webinars for residents, essential care providers, and families.
40. The Ministry of Long-Term Care should develop a strategy, in consultation with Indigenous People and ethno-cultural groups, and provide resources to support the LTC sector to develop culturally safe and responsive through training, development of resource toolkits and staffing measures.

VII. Inspections – Enforcement and Compliance

LTC home inspections are an important way to ensure that LTC residents are receiving high-quality services and living in healthy and safe environments.

Municipal LTC homes support the need for regular, ongoing inspections, and that there should be consequences for negligent inaction by home operators.

However, the Ministry of Long-Term Care's approach to inspections is currently considered punitive and not collaborative as it was practiced in the past. Some municipal LTC homes describe the current approach as judgmental or a process of 'blaming and shaming.' This contributed negatively to an already stressful situation, and the found that these inspections did not yield the results that were intended.

To that end, the Ministry of Long-Term Care should take a risk management approach to inspections and review the culture and manner of inspections is. Rather than a punitive approach, a risk management approach would encourage that inspections be done in a more collaborative and assistive way to help homes especially in times of crisis.

It would also allow high-performing homes who fared well in the COVID-19 pandemic to benefit from coaching for compliance, while providing the necessary enforcement measures for under-performing homes that need it most. There should also be a greater emphasis on collecting, sharing, and promoting best practices so that LTC homes of all types can learn from each other.

Inspections, Enforcement and Compliance: Recommendations

41. The Ministry of Long-Term Care should take a risk-management approach to inspections that achieves a better balance between enforcement for underperforming LTC homes and facilitate coaching for compliance for high-performing LTC homes.
42. The Ministry of Long-Term Care should facilitate the collection and dissemination of best practices around inspections and provide training opportunities through a Centre for Excellence for the not-for-profit and municipal LTC sector.
43. The Province should strengthen the role of IPAC inspections during outbreak situations, and better coordinate inspections by the Ministry of Long-Term Care, Public Health, and the Ministry of Labour related to IPAC.
44. The Ministry of Health and the Ministry of Long-Term Care should provide further guidance and direction on how IPAC Hubs, Ministry of Labour inspectors, and public health inspectors should work together for greater effectiveness.

VIII. Mental Health Supports for Residents and Staff

The emotional health and well-being of LTC residents, staff, caregivers, and their families are something that needs to be addressed well after the COVID-19 pandemic ends. Almost 40% of LTC homes are in outbreak as of January 29, 2021,[5] which has put great strain on already overworked staff who have had to implement strict lockdown measures and all the while, keep residents safe and calm in the face of increasing deaths.

It is critical the Ministry of Long-Term Care support LTC homes in address the broad mental health needs of LTC home residents, staff and their caregivers that will remain long after COVID-19. That

[5] Government of Ontario. COVID-19 in Long-Term Care Homes. https://covid-19.ontario.ca/data/long-term-care-homes (accessed January 29, 2021).

could include providing LTC residents and staff access to mental health specialists and implementing strategies in the Staffing Plan to alleviate the current staffing shortages. Doing so will help staff do their jobs effectively, reduce residents' challenging responsive behaviours, and assist caregivers and families in the process.

The input and support of family and friends is critical, especially during an emergency situation. Social isolation of residents can occur during lockdowns and restricted contact by family, friends, and volunteers. Virtual technologies, with proper broadband access, may be employed to address this and mitigate social isolation.

Mental Health and Well-Being: Recommendations

45. The Ministry of Health, the Ministry of Long-Term Care, and the Ministry for Seniors and Accessibility should ensure that the LTC sector has access to mental health specialists and a plan to address the broad mental health needs of LTC home residents, staff, and their caregivers that will remain long after COVID-19.
46. The Ministry of Health and the Ministry of Long-Term Care should continue to work with LTC sector associations to review visitors' policies, including for essential caregivers, to strike an appropriate balance between health and emotional well-being considerations.
47. The Ministry of Long-Term Care should invest in virtual technology and better broadband access and other means of connection to address the social isolation felt by LTC residents.

IX. Palliative Care Delivery

In the face of increasing deaths, the COVID-19 pandemic has shone a light on the need for more consideration about the end of life for LTC residents. Palliative care is a philosophy of care and a unique set of actions that aim to improve the quality of life for all residents with life limiting illness. It aims to improve the quality of life for both patients and their families when restorative care is no longer an option for the resident.

There is some effort underway to formalize and integrate palliative care approaches in LTC homes, but more could be done. The Province can play a supportive role to help LTC homes to help develop formative palliative care in LTC homes. Under the *Long-Term Care Homes Act*, LTC homes are required to provide palliative care education to their staff. This could be enhanced with more support from the Province through resources for training.

Palliative Care Delivery: Recommendations

48. The Ministry of Long-Term Care should train and support homes around the adoption of a palliative care approach.
49. The Ministry of Long-Term Care should ensure that LTC staff members are equipped with training on palliative care delivery.

Conclusion

Our seniors and LTC residents deserve high-quality care and utmost safety, both during the COVID-19 pandemic and in the years ahead. As municipal governments who provide care for seniors and in some instances, LTC residents, AMO appreciates the opportunity to provide these recommendations to the Commission.

Appendices

Appendix A: Initial Response to the Long-Term Care COVID-19 Commission – Interim Recommendations on an Ongoing Provincial Pandemic Response

Appendix B: AMO Sub-Working Group on Long-Term Care Members

Appendix C: AMO Health Taskforce Members

Appendix A: Initial Response to the Long-Term Care COVID-19 Commission

AMO's Initial Response to the Long-Term Care COVID-19 Commission

Interim Recommendations for an Ongoing Provincial Pandemic Response

October 2020

AMO's Initial Response to the Long-Term Care COVID-19 Commission: Interim Recommendations for an Ongoing Provincial Pandemic Response

Introduction

The COVID-19 pandemic has had a disproportionate impact on residents in long-term care (LTC), as the vast majority of the deaths due to COVID-19 in Canada have been in LTC homes. This has affected families and communities across the province and country in profound and tragic ways. The pandemic has also exposed the structural weaknesses in the LTC system, especially chronic underfunding which limited the ability to respond effectively in the first wave.

The Association of Municipalities of Ontario (AMO) welcomes the opportunity to provide initial input to the Long-Term Care COVID-19 Commission (commission). AMO is a non-partisan, non-profit association representing municipal governments. Ontario's municipal governments work together to achieve shared goals and meet common challenges through AMO. One such cause is promoting healthy age-friendly communities which includes municipal LTC homes, operated in an efficient and effective manner.

While the provincial government is responsible for LTC legislation, regulation and program requirements, municipal governments are mandated under the *Long-Term Care Act, 2007* (LTCHA) to operate 16% (100+) of the 626 LTC homes in the Province. Municipal homes pride themselves on providing high quality services and safe environments for their residents. More about our association and advocacy for seniors and LTC is found on the AMO website.

AMO acknowledges the provincial response to date and the support that has been provided. However, more action is needed in both the short-term to mitigate against future waves of COVID-19, and over the long-term to address persistent structural issues.

To that end, this document outlines our association's short-term recommendations to inform the commission's interim report about the ongoing provincial pandemic response with a targeted focus on what is needed for winter 2020/2021. Appendix A of this submission is a backgrounder that was sent to the Commission to provide an overview of the municipal role in governance and funding for LTC. AMO will provide a more comprehensive submission to the Commission with mid and long-term recommendations before the end of the year.

Context

AMO appreciates the opportunity to provide our perspective on how municipally funded and operated LTC homes have been impacted by COVID-19 thus far. The recommendations have been formulated by a sub-working group of AMO's Health Task Force and reflect the AMO Board's general positions on LTC. The sub-working group is comprised of a mix of elected officials and municipal staff working in LTC, public health, and other municipal services. Our working group members bring their unique and diverse perspective from across all areas of the province and municipal service sectors. See Appendix B for a list of the working group members.

We also work closely with AdvantAge Ontario, the association that represents municipal and non-profit LTC service providers. AMO's aim is to provide high level recommendations about policy, planning, funding, and the provisions of non-financial supports to the sector rather than detailed technical operational advice.

AMO encourages the commission to consider our recommended actions that, if implemented, would help provide a more effective pandemic response during winter 2020/2021. Initiatives need to be put into motion now to make sure this pandemic response can sustain itself for as long as is necessary. This involves examining how staffing models, the physical structure of LTC homes, governance models, regulations and inspections, and access to IPAC measures affected the COVID-19 response. Our seniors and LTC residents deserve high-quality care and utmost safety, both during the COVID-19 pandemic and beyond.

Recommendations

I. Planning and Communications for Successful Outcomes

Effective planning and communications are vitally important to evidence-based decision-making as a sector. In developing these plans and implementation strategies, it is critical that, the input of the LTC sector including municipal homes be included and that their expertise be leveraged.

1. The Province, including the Ministry of Long-Term Care (MLTC) and the Office of the Chief Medical Officer of Health, should continue ongoing second wave planning and develop a clear strategy for issuing clear direction at appropriate times as conditions change.
2. The Province must have representation from the municipal LTC sector in regional and systems planning and implementation tables.

II. Staffing Measures to Attract and Retain Highly Trained and Qualified Staff

The longstanding staffing challenges in LTC have been exacerbated by the COVID-19 pandemic. It continues to be a challenge to successfully recruit and retain critical staff during this time. Many municipal homes need to 'staff up' and are facing the second wave with less staff than in the first one. Initiatives that can be implemented quickly or started now to address staffing issues into the future are needed.

3. The Province should work with the LTC sector to develop a province-wide health human resources strategy to address staffing issues, including overcoming the challenges of insufficient human resources, such as nurses and personal support workers, in certain regions, especially in northern and rural areas.
4. The Province should expand the issuance of pandemic pay to a broader range of staff in LTC homes, including nurses and other staff doing front-line work as well as their supervisors.
5. The Ministry of Long-Term Care (MLTC) should extend and maintain the High Wage Transition Fund for the duration of the COVID-19 pandemic past March 2021 and consult with AMO and other LTC sector associations about the future of the Fund.
6. The Province must continue to extend the Emergency Orders to allow redeployment of staff into the LTC sector as needed until the pandemic ends or when staffing issues are fully addressed whichever happens first.

III. Care for Residents During COVID-19

Sick residents require more attentive and responsive care. There have been calls from many stakeholders to increase the levels of direct care, as well as to sustain existing services to help protect residents. Now is the time to act on this. Enhancing resources to support residents with responsive behaviors to manage during COVID-19 is also needed.

7. The MLTC should provide adequate provincial funding to care for an aging population with complex medical conditions and challenging behaviours such as dementia and commit to full 100% provincial funding for an average of four hours of care per resident per day.
8. The MLTC must immediately reverse the changes and reductions to pharmacy funding during the pandemic and work on alternative options for funding to support LTC pharmacy over the long-term.
9. That the MLTC enhance specialized support programs, including Behaviour Supports Ontario and specialized Nurse Practitioners to complement staffing levels in long term care homes.

IV. Funding for Viability and Sustainability During COVID-19

Decades of underfunding has stretched the capacity of municipal homes to manage with the additional costs associated with the pandemic. While emergency funding was critical and helpful, more may be needed now will be needed into next year. At the same time, adequate base funding is needed for the core operating and capital needs. Municipal governments are facing pressure with additional pandemic costs across several program areas and experiencing declining revenue because of the pandemic. They cannot afford to continue to fill in the gap where provincial funding is lacking.

10. That the MLTC review the adequacy of the emergency COVID-19 funding against incurred costs through to March 31, 2021, and provide more funding as needed by the LTC sector.
11. That the MLTC provide for and give advance notice as soon as possible about ongoing emergency COVID-19 funding in the 2021-22 fiscal year.
12. That the MLTC increase core operational funding at least at the rate of inflation or higher in both this current fiscal year and next.
13. That the MLTC enhance and increase funding for the minor capital funding program to support operators to improve structural compliance and enable more effective IPAC in homes.

V. Increasing Public Health and Safety

The provincial government should also provide direct and indirect resources to the LTC sector. This could include providing funding for IPAC measures in homes including for education and training and paying for staffing backfill. As well, the sustained funding of crucial third party supports such as local public health is needed. More timely testing results are also crucial.

14. That the MLTC and Ministry of Health (MOH) should review the adequacy of IPAC programs under the *Long-Term Care Homes Act, 2007* in preventing and managing COVID-19 outbreaks and put in place higher standards with increased funding to homes to implement these standards.
15. That the MLTC should provide ongoing and enhanced operational funding to implement effective IPAC measures in homes including training and continue to provide guidance based on health expertise.
16. That the MOH prioritize COVID-19 testing for LTC home staff, residents, and visitors.

17. That the MOH should invest in in local public health workforces to both address the needs of the increasing complexity of the pandemic response in LTC homes and maintain critical core public health services at the same time.
18. That the MOH increase Public Health resources for IPAC and outbreak management in LTC and other higher risk settings.
19. That the MLTC and MOH review the IPAC hub and spoke model to ensure that the hospital institutional based approach is mindful, appropriate, and adaptable for LTC home settings.

VI. Mental Health Supports for Residents and Staff

There have been mental health impacts on both staff and residents because of the pandemic. Attention to supporting mental health will help sustain people during this time. Ensuring the emotional well-being of both staff and residents will help staff do their jobs effectively, and reduce residents' challenging behaviours. Continued visits by family and friends can play a role but under controlled conditions.

20. That the MOH and the MLTC invest in the resources needed to support the mental health of staff and residents in LTC.
21. That the MLTC and the MOH continue to review and consult the LTC sector associations on appropriate visitors' policies, including for essential caregivers, to strike a balance between health and emotional well-being considerations.

Conclusion

AMO appreciates the opportunity to provide interim recommendations to the commission. We look forward to speaking with your team further and will be providing more comprehensive recommendations further on in the process.

Appendix A: Backgrounder on Municipal Role in Long-Term Care in Ontario

Context

The Association of Municipalities of Ontario (AMO) welcomes the independent Long-Term Care (LTC) COVID-19 commission created by the Ministry of Long-Term Care (MLTC). AMO is interested because while the provincial government is responsible for LTC legislation, regulation and program requirements, municipal governments are mandated under the *Long-Term Care Homes Act, 2007* (LTCHA) to operate 16% (100+) of the 626 LTC homes in the Province.[6]

Municipal governments want to help improve the LTC system, and share lessons learned of how municipal LTC homes fared in the first wave of COVID-19. To that end, AMO's Health Task Force created a sub-working group on LTC to inform the commission about how the municipal LTC homes handled COVID-19, and how the pandemic exacerbated long-standing issues in the sector.

This brief is part of AMO's preliminary submission for consideration by the commission. It provides background for the commission around the history of the municipal role in LTC, and how municipal LTC homes are differentiated compared to for-profit and charitable/not-for profit homes. AMO staff are available to speak with your team if there are any questions on the material.

History of Municipal Governments in LTC

Municipal governments have been involved in LTC since 1868 when the *Municipal Institutions Act* mandated that counties with over 20,000 people must provide Houses of Refuge for people who are homeless. In 1947, the *Homes for the Aged Act* replaced the Houses of Refuge and pivoted to focus on seniors. The Province provided 25% of the cost of building new Homes for the Aged for seniors.

Two years later, the Province increased provincial funding and mandated that these municipalities establish a Home for the Aged. New regulations also ensured greater consistency in care.

In 2007, the LTCHA was enacted which prescribed the requirements for every upper and single-tier southern municipality, and the option for northern municipalities to operate a municipal home.

Municipal Role in LTC Today

Municipal governments are funders, service providers, and employers of LTC. Of the nearly 80,000 LTC beds in Ontario, just over 20% are operated by municipal governments (16,000+).[7] The LTCHA requires each upper and single-tier municipal government in southern Ontario to establish and maintain at least one municipal home. They can provide this service directly or jointly with other municipal governments. Northern municipalities *may* operate a home, either on individual basis or jointly. In some case, northern municipal governments jointly fund a home managed by a District Board of Management.

[6] Advantage Ontario. "Ontario Municipalities – Proud Partners in Long Term Care."(November 2018).
[7] Advantage Ontario. "Ontario Municipalities – Proud Partners in Long Term Care."(November 2018).

As the order of government closest to seniors' issues in our communities, municipal governments pride themselves on providing high quality services and safe environments for their residents. Many operate additional homes and offer services that surpass provincial requirements. More about our association and advocacy for seniors and LTC is found on the AMO website.

However, today's LTC homes provide health care services to an increasingly complex patient group with high-acuity needs. They serve people who require 24-hour medical care and supervision within a secure environment. This requires significant financial resources to deliver this much-needed care.

To help cover costs, municipal governments have contributed an additional $90 million since 2012 (a 36% increase), when the estimated municipal contribution was $268 million. In 2016, municipal governments contributed $350 million over and above the provincial funding subsidy, not including capital expenditures.[8] In 2017 alone, municipal governments invested $2.1 billion in seniors' programs and other health services.[9]

In addition, municipal governments are responsible for providing a wide range of programs and services, which allow them to leverage other services – including social, paramedic and transportation services – to meet the needs of people in their LTC homes. This includes providing direct services across the continuum of care including wellness and prevention programs to promote active lifestyles including community recreation programs and Seniors Active Living Centres, community-based services, and housing and residential programs. Many municipal governments operate long-term care homes within a campus of care model enhancing the range and integration of services to residents.

The municipal LTC sector is supported by significant volunteer hours (710,000 volunteer hours, equivalent to 366 full-time positions in 2016 alone).[10] This plus non-profits help in many communities, particularly in northern and rural Ontario, where it is challenging to recruit and retain qualified staff.

Despite the commitment to provide high quality services to senior residents in their communities, AMO members have expressed mixed feelings about the mandated municipal role primarily because of the rate of additional municipal subsidy that is required. Many municipal governments see this as an indication of chronic underfunding of the system.

AMO generally holds that health care is a provincial responsibility and the limited municipal property tax base was never designed to raise the revenue for health and other social service programs. LTC homes have evolved since their initial inception as residential care for seniors.

While AMO is not advocating for municipal governments to get out of the LTC business, our members have long called for adequate funding for this health care service. The fact that most, if

[8] AMO. "A Compendium of Municipal Health Activities and Recommendations." (January 2019).
[9] Note that there is no public reporting of specific municipal contributions to quantify the amounts to subsidize LTC. Municipal expenditures for LTC are not disaggregated from other municipal expenditures for 'assistance to aged persons' under provincially-set Financial Information Return reporting requirements.
[10] Advantage Ontario. "Ontario Municipalities – Proud Partners in Long Term Care."(November 2018).

not all, municipal governments subsidize operations and capital maintenance may be an inhibitor to municipal take-up of new opportunities to develop new LTC homes in their communities.

Municipal LTC Governance and Accountability

Municipal councils comprised of elected officials are the governing body of LTC homes. Management committees may be designated. Meetings are open to the public and transparent although in-camera sessions may be held for certain matters as outlined in the *Municipal Act* where confidentiality and privacy needs are required to be assured.

Municipal councils are accountable and provisions in the LTCHA dictate how. In 2017, the government made changes and removed previous due diligence standards for board members and implemented a more absolute duty to ensure compliance. The standard for LTC home board members is much higher than that of public hospitals.

The result is increased liability for board and committee members. It requires boards to spend time on staff oversight and compliance than just on traditional governance duties. Board members are liable for actions taken by the home, not just breaches of statutory provisions that they commit themselves to.

Appendix B: AMO Working Group Members

1. **Graydon Smith**, President, Association of Municipalities of Ontario (AMO), and Mayor, Town of Bracebridge, Chair of AMO's Health Task Force

2. **Monika Turner**, Chair of Working Group, Director of Policy, Association of Municipalities of Ontario (AMO)

3. **Michael Jacek**, Senior Advisor, Association of Municipalities of Ontario (AMO), alternate Chair of Working Group

4. **Cathy Granger**, Director of Long-Term Care , Regional Municipality of Peel

5. **Sandra Hollingsworth**, Councillor Ward 1, City of Sault Ste. Marie

6. **Dr. Robert Kyle**, Commissioner & Medical Officer of Health, Regional Municipality of Durham, and Past Chair, Association of Local Public Health Agencies (alPHa)

7. **Dean Lett**, Director, Long-Term Care, City of Ottawa

8. **Lisa Levin**, CEO, AdvantAge Ontario

9. **Dan O'Mara**, Mayor, Municipality of Temagami

10. **Kelly Pender**, Chief Administrative Officer, County of Frontenac

11. **Kevin Queen**, CAO & District Administrator, District of Kenora Home for the Aged

12. **Jane Sinclair**, General Manager, Health & Emergency Services, County of Simcoe, and Chair, AdvantAge Ontario

13. **Amber Crawford**, Policy Advisor, Association of Municipalities of Ontario (staff resource)

Appendix C: AMO Health Task Force

1. **Graydon Smith**, President, Association of Municipalities of Ontario (AMO), and Mayor, Town of Bracebridge, Chair of AMO's Health Task Force
2. **Bernie MacLellan**, Councillor, County of Huron and Mayor, Municipality of Huron East
3. **Cathy Granger**, Director of Long-Term Care, Regional Municipality of Peel
4. **Dan McCormick**, CAO, Rainy River District Social Services Administration Board
5. **Donald Sanderson**, CEO, West Parry Sound Health Centre
6. **Doug Lawrance**, Mayor, Municipality of Sioux Lookout
7. **Gary Carr**, Regional Chair, Region of Halton
8. **Jane Sinclair**, General Manager Health and Emergency Services, County of Simcoe
9. **Jesse Helmer**, Councillor, City of London
10. **Joanne Vanderheyden**, Mayor, Municipality of Strathroy-Caradoc
11. **Katherine Chislett**, Commissioner of Community & Health Services, Regional Municipality of York
12. **Lisa Levin**, Executive Director, AdvantAge Ontario
13. **Loretta Ryan**, Executive Director, Association of Local Public Health Agencies of Ontario (alPHa)
14. **Mabel Watt**, Manager, Policy Integration, Region of Halton
15. **Nancy Polsinelli**, Commissioner, Health Services, Regional Municipality of Peel
16. **Neal Roberts**, Chief of Middlesex-London Emergency Medical Services Authority and OAPC Board Member (Past President)
17. **Norm Gale**, City Manager, City of Thunder Bay
18. **Penny Lynn Lucas**, Councillor, Township of Ignace
19. **Peter Dundas**, OAPC Board Member (President) and Chief Paramedic Services, Regional Municipality of Peel
20. **Dr. Robert Kyle**, Commissioner and Medical Officer of Health, Regional Municipality of Durham
21. **Sandra Hollingsworth**, Councillor – Ward 1, City of Sault Ste. Marie
22. **Monika Turner**, Director of Policy, Association of Municipalities of Ontario (AMO)
23. **Michael Jacek**, Senior Advisor, Association of Municipalities of Ontario (AMO)

Niagara Emergency Medical Services
509 Glendale Ave East
Niagara-on-the-Lake, ON
905-984-5050

MEMORANDUM

PHD-C 2-2021

Subject: Niagara Emergency Medical Services (EMS) Temporary Funded Opportunities

Date: February 16, 2021

To: Public Health & Social Services Committee

From: Kevin Smith, Chief

Niagara EMS has been requested by several Provincial Ministries to provide expanded community health services in response to the health and social impacts of COVID-19. These initiatives, 100% funded by the Province, enhance the new Mobile Integrated Health (MIH) model of service delivery in Niagara making the addition of these resources complimentary to existing services and timely implementation possible within the existing framework.

The purpose of this memo is to provide a brief summary of each of the initiatives for your awareness. While these programs are fully funded for a short period (with the exception of one initiative that is for three years) it is staff's intention to secure on-going funding from the Province should the program meet the intended objectives. Staff are also seeking the Ministry to provide exit strategies should funding not continue so that members of the community who may become dependent on these programs do not suddenly lose their critical supports without transition to alternatives.

Staff will provide more formal reports to Committee and Council upon request or as required on the following activities:

Mental Health and Addictions Team (MHART) Expansion

- Funding Period: November 6, 2020 - March 31 2021
- Funding Source: $56,413 from LHIN Mental Health and Addictions Funding

Adding a second MHART resource in the community allows Niagara EMS to provide greater mental health and addictions coverage geographically to the residents of Niagara who are struggling with mental health, addictions and homelessness.

This initiative is part of a creative partnership with Quest Community Health Centre. Quest employs mental health nurses as part of the Urgent Service Access Team (USAT), and offered to temporarily share two of their nurses with MHART during this temporary expansion. They are teamed up with an advanced care paramedic, and together, they address the demand for low acuity 911 mental health and addictions related calls and challenges in real time. This is a great example of collaboration between local health care organizations that will ultimately improve service to patients seeking mental health services while in short-term crisis and longer term in the community.

Community Outreach

- Funding Period: November 6, 2020 - March 31 2021
- Funding Source: $74,748 from LHIN Mental Health and Addictions Funding

This initiative is supporting individuals who are experiencing homelessness or living within the shelter system. These clients are increasingly medically complex, and resources available to support them are limited and not often accessible in a timely manner. Two community paramedics have been recruited to form a street outreach team. In collaboration with Niagara Assertive Street Outreach (NASO) and local partners, they will provide proactive mobile medical services to individuals who are living rough and need support.

High Intensity Supports at Home (HISH)

- Funding Period: November 12 2020 - March 31 2021
- Funding Source: $218,469 from LHIN (Home and Community Care)

Niagara EMS, in partnership with HNHB LHIN Home and Community Care (HCC) Services, has one Community Paramedic (CP) and one Emergency Communications Nurse (ECN) in the NEMS Communications Center working collaboratively to support and respond to scheduled and unscheduled requests for services for HISH program clients. The CP is available to HCC and the HISH program 12 hours a day, seven days a week. The ECN role includes Remote Patient Monitoring (RPM) and following up with patients by phone if they have abnormal results. They also perform regular wellness checks with patients over the phone, to assess the patient’s current health and wellbeing. This is a proactive way of staying connected with complex patients who are referred to us, and to prevent progression of health problems to needing acute intervention, rather than waiting for patients to call 911 during a crisis. The CP also

monitors low acuity 911 dispatch calls for known HISH clients and responds to those unscheduled emergency requests for service.

Community Paramedicine for Long-Term Care

- Funding Period: April 1, 2021 - March 31, 2024
- Funding Source: Up to $3 Million/Year for each of the three years from Ontario Ministry of Health and Long Term Care

This program will carry on and expand the work begun under the HISH initiative above, extending and significantly enhancing opportunities for integrated support from Niagara EMS Mobile Integrated Health (MIH) Paramedics, remote patient monitoring, as well as Emergency Communications Nurses. It is intended to provide services to individuals who are waiting for placement in a long-term care (LTC) home, or who are soon to be eligible for long-term care. The purpose of the program is to keep these individuals stabilized in their illness trajectory and in their own homes for as long as possible and avoid hospitalization. The program will do this through EMS-led preventive and responsive care, such as home visits and remote patient monitoring. Designed with a focus on health integration, the program will be coordinated with existing health services from across the Niagara region, including the HNHB LHIN (home and community care), residential long-term care, emergency care, primary care and other community/social services.

Respectfully submitted and signed by

_____

Kevin Smith
Chief/Director
Niagara Emergency Medical Services

Community Services
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905-980-6000 Toll-free: 1-800-263-7215

MEMORANDUM

COM-C 7-2021

Subject: **Responding to an information enquiry regarding a community request for the Region to declare a state of emergency on mental health, homelessness, and addiction**

Date: **February 16, 2021**

To: **Public Health and Social Services Committee**

From: **Adrienne Jugley, Commissioner, Community Services**

Niagara Region has been asked to declare a state of emergency related to mental health, homelessness, and addiction. The request stems from a resolution put forth by the City of Niagara Falls that has also been supported by several local area municipalities. Further to a request from a number of councillors, this memo briefly outlines legal, policy, and funding considerations regarding this request.

Legal Considerations

- In Ontario the declaration of an emergency is governed by the Emergency Management and Civil Protection Act, R.S.O. 1990, c. E.9 (ontario.ca). The Act defines an "emergency" as "a situation or an impending situation that constitutes a danger of major proportions that could result in serious harm to persons or substantial damage to property and that is caused by the forces of nature, a disease or other health risk, an accident or an act whether intentional or otherwise".

- In keeping with this, the Province's Emergency preparedness | Ontario.ca webpage lists numerous types of natural, technological and human-caused hazards that the Act would apply to; including earthquakes, dam failures, floods, storms, nuclear incidents, and pandemics. These incidents are typically temporary in nature stemming from a specific extraordinary event of a magnitude that requires an immediate and co-ordinated response beyond the normal capacity or capabilities of a municipality to address in order to preserve public safety.

- The Act and emergency management regime were not designed to address social and economic problems of an ongoing systemic nature that cannot be resolved in

days, weeks or months but require the development of sustainable, long-term solutions.

- In a municipality, an emergency under the Act can only be declared by the Head of Council, and can be terminated by the Premier. Therefore if the Region were to declare an emergency related to mental health, homeless and/or addiction with a goal of seeking financial assistance from other levels of government, the Province could simply override the declaration.

- The intent of the declaration of an emergency is to allow for the implementation of the municipality's emergency plan and protect the property, health, safety and welfare of the inhabitants of the emergency area. The declaration does not provide a Head of Council, or anyone else in a municipality, with any extraordinary authorities that are not otherwise provided for in law. Moreover, the declaration of an emergency also does not impose an obligation on the part of the Provincial or Federal Government to provide financial support.

Policy and Funding Considerations

- Treatment and supports for mental illness, addiction, and homelessness are predominantly funded and directed by the Province. Niagara Region does have one Regionally managed mental health program, but the program is fully funded through Ontario Health/ the LHIN. While Niagara Region Public Health has a small educational/prevention (cost shared) mandate for substance use, and with Provincial funding, provides a needle exchange program, it does not have a direct role in treatment. Local treatment centres in Niagara are also funded by Ontario Health/ the LHIN. Homelessness Services is a provincially mandated service area, and the Region, through funding from both the Provincial and Federal governments, manage the local homeless serving system. A small percentage of Regional levy dollars is provided to Homelessness Services, only as a result of Provincial underfunding concerns.

- While the concerns about the rising prevalence of homelessness, and the greater awareness of the need for treatment for mental illness and addiction have increased, it is important to recognize that these issues are distinct and should require their own policy and response solutions informed by evidence and best practice.

- As such, speaking of all three as if they are consistently interconnected, may lead to a public misunderstanding and an over simplified perception of issues and the people who struggle with them. A combined focus may also inadvertently increase

the risk of stigmatization, recognizing, for example, that a large majority of individuals who experience mental illness (or have experienced this in their lifetime) are not or ever have been homeless, nor are they dealing with substance use issues.[1] Although those experiencing addiction issues may be more likely to also have an underlying mental illness[2], many do not; and again, it is not expected that all individuals with substance use concerns are concurrently experiencing homelessness as well[3]. While individuals struggling with homelessness (which is relatively a much smaller number) do often experience mental illness and addiction issues (or both)[4], an understanding on how to properly support these individuals requires a multifaceted approach and will be quite distinct from the interventions from the two previously described groups.

- It is also important to note that the terms mental health and mental illness are not synonymous. Mental health can be defined as a state of psychological and emotional well-being that is a necessary resource for living a healthy life and a main factor in overall health.[5] A mental illness is characterized by changes in an individual's thinking, mood, or behaviour and is usually associated with significant distress or impaired functioning in social, occupational and other activities.[6]

- The terms mental illness and addiction refer to a wide range of conditions that require a continuum of appropriate and accessible treatments, delivered by trained and regulated practitioners. Primary care in fact provides a significant level of intervention for both mental health and substance use issues, with many individuals moving effectively through the process of assessment, treatment and recovery. Access to a further range of treatment, such as psychiatric care, outpatient treatment programs and/or inpatient programs are required and should reflect the unique needs of each individual. The amounts of service available should be informed by local needs, capacity and evidence of effectiveness. Some communities may have adequate resources in certain areas of care, but be at critically low levels of others. Local decision makers should have a clear understanding of local services and gaps in care when advocating for future investment.

- While addressing homelessness also requires a variety of policy solutions, a policy intervention highlighted as a best practice is <u>first</u> the provision of safe and affordable housing with the inclusion of required supports.[7]

- The conditions and the approaches to address mental illness, addiction and homelessness are not homogeneous.

- Further, the challenges associated with accessing treatment to address mental illness[8] and addictions[9], and providing affordable housing for those experiencing homelessness are not unique to Niagara[10]. The overall incidence rate of mental illness, addiction, and homelessness in Niagara, is not greater by any significant degree when compared to municipalities across the Province.

Declaring a State of Emergency on Mental Health, Addiction, and Homeless across other Jurisdictions

- A number of municipalities across the Province have been approached over the last few years to make similar declarations, but most have refrained further to similar considerations included in this memo. To date, there have not been any declarations that combine the issues of mental health, addiction, and homelessness.

- In January 2021, the City of Ottawa declined to declare an emergency but instead passed a motion that recognized an emergency created by the critical lack of affordable housing and the growing prevalence of homelessness. The motion recognizes that the City has insufficient resources to address these issues alone, and that City Council must continue to advocate to both the Provincial and Federal governments for additional funding. The motion also highlights that City staff increase efforts and further prioritize a framework for action to address affordable housing and homelessness.

Niagara Region's Existing Priorities on Mental Health, Homelessness and Housing

- Niagara Regional Council established its priorities (prior to the pandemic) through the 2019 – 2022 Council Strategic Plan (Plan). The Plan identifies addressing mental health and well-being and affordable housing, as key Council priorities, with specific objectives noted in the Plan.

- Council has accepted the national challenge to end chronic homelessness and is one of a handful of municipalities across Canada that has become a "Built for Zero" community. Council has also endorsed Niagara's 10-year Housing and Homelessness Action Plan, and supported funding and policy development on a number of critical initiatives to address homelessness and the need for increased affordable housing in Niagara. These existing efforts highlight Council's commitment to actively address homelessness, while also being more aligned with the Region's

funding mandate, as the majority of funding for affordable/community housing comes from the Region's levy.

- Further, through the development of Niagara's Community Safety and Well-Being plan, Council also has the opportunity to prioritize access to mental health and addiction services, and addressing homelessness.

Respectfully submitted and signed by

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Adrienne Jugley, MSW, RSW, CHE
Commissioner

This memo was prepared in consultation with Donna Gibbs, Director, Legal & Court Services and Pam Abeysekara, Integrated Planning and Policy Advisor.

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[1] Hulchanski, J. (2009). *Finding Home: Policy Options for Addressing Homelessness in Canada.* The Homeless Hub. Link to Finding Home: Policy Options for Addressing Homelessness in Canada.

[2] Centre for Addiction and Mental Health. (n.d.). *Mental Illness and Addiction: Facts and Statistics.* Link to Mental Illness and Addiction: Facts and Statistics.

[3] The Homeless Hub. (n.d.). *Substance Use & Addiction.* Link to Substance Use & Addiction.

[4] Canadian Mental Health Association, Ontario. (2014). Housing and Mental Health. Link to Housing and Mental Health.

[5] Government of Canada. (2020). *About Mental Health.* Link to About Mental Health.

[6] Public Health Agency of Canada. (2020). *Mental Illness in Canada*. Link to Mental Illness in Canada.

[7] Canadian Mental Health Association, Ontario. (2014). *Housing and Mental Health.* Link to Housing and Mental Health.

[8] According to the Centre for Addiction and Mental Health, only about half of Canadians experiencing a major depressive episode receive and have access to ‘‘potentially adequate care.”

[9] The Canadian Institute for Health Information highlights that access to harm reduction and addiction treatment services are often limited, even in the in the biggest cities across Canada.

[10] Association Municipalities of Ontario. (2019). *Fixing the Housing Affordability Crisis.* Link to Fixing the Housing Affordability Crisis

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MEMORANDUM

PHD-C 4-2021

Subject: Considerations & Context Regarding Declaration of a State of Emergency

Date: February 16, 2021

To: Public Health & Social Services Committee

From: M. Mustafa Hirji, Medical Officer of Health & Commissioner (Acting)

There have been multiple requests recently regarding declaration of a state of emergency on mental health and related issues. Public Health staff provide the following to Regional Councillor as additional considerations and context in order to help inform Council's decision on these request.

The declaration of a state of emergency on any issue does not automatically cause resources or additional support to be brought to bear on that issue. However, there would likely be a public expectation that if a state of emergency existed on an issue such as mental health, then Council would marshal additional resources or efforts directed to it. Council may therefore wish to make decisions around declaring a state of emergency with consideration of how much additional resources would be commensurate with the emergency. As well, Council may also wish to consider where those resources might come from: by reducing efforts on other issues, or by levying new resources.

If redirecting resources by reducing effort on other health issues, it is important that Council be aware of the burden of illness for those health issues that would now be neglected. As well, Council may wish to be mindful that any particular request for a declaration of emergency on one issue may set precedent for other issues with a similar or higher burden.

Data on Top Health Issues in Niagara

In 2019, as part of a fulsome planning process to support the prioritization of public health's health promotion priorities, staff completed a comprehensive Community Health Status Assessment which provides a ranked analysis of the health conditions and risk factors faced by Niagara.

By using the Winnipeg Regional Health Authority Priority Setting Framework (which is a nationally accepted framework), Niagara data from between 2013 and 2018 was tabulated to allow for the ranking of all health conditions and diseases. Qualitative and quantitative analysis was completed with equal weighting applied ensuring that no criterion was deemed to be of greater importance.

The quantitative assessment considers

- The number of deaths
- The potential years of life lost
- The hospitalization rates
- The length of stay in hospital
- Emergency Department visits

The qualitative assessment utilized a selection of relevant criteria from the Center for Disease Control (CDC) common criteria list. Criteria selected considered the communities readiness to address an issue, public health's ability to impact the health issue, programs offered by other service providers, and the impact of the health issue and disease on the Social Determinants of Health (SDOH).

These two assessments were then combined to provide a ranked list of 26 health conditions and diseases here in Niagara.

The list below outlines in rank order the top 26 health conditions and diseases in Niagara.

1. Ischaemic heart disease
2. Accidental Falls
3. Diabetes

4.5 Cerebrovascular disease (stroke)
4.5 Lung, bronchus and trachea cancer

6. Chronic lower respiratory diseases
7. Influenza and pneumonia

8.5 Perinatal conditions (low birth weight)
8.5 Cirrhosis and other liver diseases

10. Intentional self-harm (suicide)
11. Accidental poisoning (overdose)
12. Diseases of the urinary system (Urinary tract infections)
13. Colon, rectum and anus cancer

14. Congenital malformations
15. Heart failure
16. Disease of the musculoskeletal system and connective tissue (osteoarthritis)
17. Sexually-transmitted infections
18. Pregnancy, childbirth and the puerperium
19. Transport accidents
20. Dementia and Alzheimer disease
21. Breast cancer
22. Lymph, blood and related cancers
23. Appendicitis, hernia and intestinal obstruction
24. Septicaemia
25. Acute respiratory diseases
26. Pancreatic cancer

Ischemic Health Disease ranks 1st given we see the highest number of deaths, the greatest number of years of life lost and the third highest hospitalization rate across all health conditions and diseases.

Accidental Falls ranks 2nd being responsible for the greatest number of ED visits, the fifth highest number of hospitalization admittances but with the greatest total days admitted to hospital (length of stay).

By contrast, health issues directly attributable to **Mental Health** and **Addictions** (Intentional self-harm and Accidental poisoning) are ranked 10th and 11th respectively.

Chronic risk factors were also considered as part of this analysis, recognizing that they can greatly influence and effect the health conditions and diseases identified.

Smoking, Alcohol use and Problematic substance use, all of which could fall within the broad 'Addictions' category were each identified as increasing the of risk of a number of the ranked health conditions identified:

- Smoking – 11 Health conditions or diseases affected
- Alcohol – 9 Health conditions or diseases affected
- Problematic Substance Use – 3 Health conditions or diseases affected

Stress, which is a risk factor linked to mental health, was identified as increasing the risk across three of the ranked health conditions.

The result of this analysis was the identification of five broad Health Promotion priorities for Niagara Region Public Health to focus its health promotion efforts over the coming years:

- Healthy Eating and Physical Activity
- Substance Use and Addictions
- Mental Health Promotion
- Healthy Child Development
- Sexually Transmitted Infections

Implications of Data

These priorities were presented to and received approval of Council as part of the 2020 Levy Operating Budget. Since then, Public Health & Emergency Services has been reorienting and consolidating greater efforts behind these five priorities to ensure a critical mass to make a measurable impact. This has included identifying indicators, researching the most effective public health interventions to implement, and engaging partners to align with these five priorities. However, given limited budget, it has also meant that other topics (e.g. promoting vaccinations, cancer prevention) are receiving only minimal attention as resources have been redirected.

Should a state of emergency be declared around mental health and/or addictions, there would presumably be an intention to enhance resources behind these two issues either with new budget or by further deprioritizing other issues to redirect those efforts.

Respectfully submitted and signed by

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M. Mustafa Hirji, MD MPH FRCPC
Medical Officer of Health & Commissioner (Acting)

This memo was prepared with input by Andrew Scott, Manager of Continuous Quality Improvement & reviewed by Siobhan Kearns, Director/Chief of Staff (Public Health)

Appendix 1: In-Depth Epidemiological Analysis

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Appendix 1: In-depth Epidemiological Analysis

Further, in depth analysis is provided here, which aligns with the request for an emergency declaration (mental health promotion, substance use and addictions).

Mental Health

- A significantly higher proportion of individuals (12 years and older) perceive their mental health to be excellent or very good in Niagara (77.1%) compared to the provincial average (71.1%).
- Significantly more females (21.7%) then males (10.3%) talked to a health professional about their mental health status (Canadian Community Health Survey, 2015/16)
- There are significant levels of inequality in mental health related ED visits by those impacted by residential instability. This inequality is also significantly greater than the provincial average.
- In 2016, the age standardized rate of ED visits related to self-harm in Niagara (217.0 per 100,000) was significantly higher than the provincial average (141.3 per 100,000).
- The highest number of self-harm injury-related hospitalizations occur among individuals 15 to 19 years old.
- Since 2009, females had a significantly higher rates of emergency department visits and hospitalizations related to self-harm injuries.
- The rate of males dying from self-harm is significantly higher than the rate of females dying from self-harm.

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Health conditions or diseases associated with mental health with current ranking in overall priority level from community health status assessment.

Health Condition or Disease	Number of Deaths	Potential years of life lost (PYLL)	Emergency Department (ED) visits	Hospitalizations	Total Length of Stay (LOS) during Hospitalization	Quantitative Total Score	Quantitative Rank	Qualitative Rank	Total Rank	Final Overall Priority Score
Intentional self-harm	129	3,304	2,341	634	2,263	79	19.5	1.5	21	10
Accidental poisoning	94	3.136	3.944	435	1,289	81	21	1.5	22.5	11

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Substance Misuse and Addictions

Smoking

- A significantly higher proportion of individuals 25 to 44 are current smokers compared to other age groups.
- Individuals 19 to 24 years are significantly more likely to vape then other age groups.
- There are significant levels of inequity in Chronic Obstruction Pulmonary Disease (COPD) hospitalizations in those impacted greatest by the social determinants of health. These patterns of inequality are significantly greater in Niagara compared to Ontario.
- There are significant differences in smoking and vaping rates by municipality, residents of Port Colborne and Thorold are more likely to smoke, residents in Thorold are more likely to vape.
- There are a significantly higher proportion of Niagara students in grades 11 and 12 who have vaped any type of e-cigarette then compared to the provincial average.

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Disease of Health Condition	Number of Deaths	Potential years of life lost (PYLL)	Emergency Department (ED) visits	Hospitalizations	Total Length of Stay (LOS) during Hospitalization	Quantitative Rank	Qualitative Rank	Total Rank	Final Overall Priority Score
Ischaemiic heart disease	2,035	6,744	3,081	6,348	28,885	1	5	6	1
Lung/bronchus cancer	913	4,846	454	687	5,676	11	5	16	4.5
Cerebrovascular disease	825	1,701	3,433	2,455	21,999	6	10	16	4.5
Chronic lower respiratory diseases	535	1,522	10,717	3,871	23,590	3	14	17	6
Perinatal conditions	23	1,725	457	5,773	30,469	10	10	20	8.5
Colon, rectum and anus cancer	411	2,040	156	935	9,153	13.5	14	27.5	13

Disease of Health Condition	Number of Deaths	Potential years of life lost (PYLL)	Emergency Department (ED) visits	Hospitalizations	Total Length of Stay (LOS) during Hospitalization	Quantitative Rank	Qualitative Rank	Total Rank	Final Overall Priority Score
Congenital malformations	49	1,820	207	843	5,233	23	5	28	14
Heart failure, complications and ill-defined heart disease	210	477	4,354	3,704	31,461	9	20.5	29.5	15
Pregnancy, childbirth and the puerperium	-	-	7,469	11,825	24,358	12	20.5	32.5	18
Lymph, blood and related cancers	341	1,626	273	692	10,164	18	20.5	38.5	22
Pancreatic cancer	276	1,426	133	159	1,601	25	20.5	45.5	26

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Alcohol

- 43% of adults in Niagara exceed the low-risk alcohol drinking guideline for chronic disease or injury.
- Over 65% of students used alcohol in some frequency in 2019.
- Rates of alcohol related ED visits are high across all age groups until the age of 65 and older.
- The rate of alcohol related hospital admittance increases with age
- Among adults, males are more likely to be regular drinkers and heavy drinkers
- Males are more likely to visit the ED and be hospitalized for alcohol related health conditions.
- A significantly lower proportion of individuals with less than a high school diploma are considered regular drinkers over those who graduated high school.
- There are significant levels of inequality in alcohol-attributable hospitalizations by those facing increased levels of maternal deprivation and residential instability.
- There is a significantly higher proportion of secondary school students in Niagara who have drank alcohol in the past 12 months when compared to the provincial average.
- Age standardized ED visits entirely attributable to alcohol was significantly higher in Niagara compared to the provincial average.

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Health conditions or diseases associated with alcohol use with current ranking in overall priority level from community.

Health Condition or Disease	Number of Deaths	Potential years of life lost (PYLL)	Emergency Department (ED) visits	Hospitalizations	Total Length of Stay (LOS) during Hospitalization	Quantitative Total Score	Quantitative Rank	Qualitative Rank	Total Rank	Final Overall Priority Score
Cerebrovascular disease	825	1,701	3,433	2,455	21,999	49	6	10	16	4.5
Cirrhosis and other liver diseases	227	2,748	724	732	7,306	71	15	5	20	8.5
Intentional self-harm	129	3,304	2,341	634	2,263	79	19.5	1.5	21	10
Accidental poisoning	94	3,136	3,944	435	1,289	81	21	1.5	22.5	11
Colon, rectum and anus cancer	411	2,040	156	935	9,153	68	13.5	14	27.5	13

Health Condition or Disease	Number of Deaths	Potential years of life lost (PYLL)	Emergency Department (ED) visits	Hospitalizations	Total Length of Stay (LOS) during Hospitalization	Quantitative Total Score	Quantitative Rank	Qualitative Rank	Total Rank	Final Overall Priority Score
Congenital malformations	49	1,820	207	843	5,233	88	23	5	28	14
Transport accidents	53	1,502	10,947	747	5,784	76	17	16	33	19
Breast cancer	310	2,524	96	320	993	91	24	14	38	21
Pancreatic cancer	276	1,426	133	159	1,601	100	25	20.5	45.5	26

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Cannabis

- Individual in 19 to 24 years and 25 to 29 years were significantly more likely to report using cannabis in the past 30 days compared to all other age groups.
- The proportion of school students using cannabis increases with grade level.
- The highest rate of cannabis-related ED visits is among 15 to 19 year olds and declines by age group thereafter.
- Males are more likely to visit the ED for cannabis related health conditions.
- Use of cannabis is highest among individuals without a high school diploma and significantly decreases as educational attainment increased.
- Residents of St. Catharines are more likely to use cannabis then other municipalities.
- A significantly higher proportion of students in grades 9 and 10 in Niagara used cannabis then the provincial average.
- Age Standardized ED visits for all cannabis-related harms was significantly higher than the provincial average, but age standardized hospitalizations were significantly lower.

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Health conditions or diseases associated with cannabis use with current ranking in overall priority level from community health status assessment.

Health Condition or Disease	Number of Deaths	Potential years of life lost (PYLL)	Emergency Department (ED) visits	Hospitalizations	Total Length of Stay (LOS) during Hospitalization	Quantitative Total Score	Quantitative Rank	Qualitative Rank	Total Rank	Final Overall Priority Score
Cerebrovascular disease	825	1,701	3,433	2,455	21,999	49	6	10	16	4.5
Chronic lower respiratory diseases	535	1,522	10,717	3,871	23,590	41	3	14	17	6
Intentional self-harm	129	3,304	2,341	634	2,263	79	19.5	1.5	21	10
Accidental poisoning	94	3,136	3,944	435	1,289	81	21	1.5	22.5	11
Transport accidents	53	1,502	10,947	747	5,784	76	17	16	33	19

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Opioids

- Males are more likely to visit the ED for a health condition related to opioids.
- Rates of opioid related ED visits are significantly higher in Niagara (151.3 per 100,000) then the provincial average (63.4 per 100,000).
- Opioid related ED visits and hospitalizations are increasing in Niagara.
- The rate of individuals prescribed opioids was higher in Niagara than the provincial average in 2016, 2017 and 2018.

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Health conditions or diseases associated with opioid use with current ranking in overall priority level from community health status assessment.

Health Condition or Disease	Number of Deaths	Potential years of life lost (PYLL)	Emergency Department (ED) visits	Hospitalizations	Total Length of Stay (LOS) during Hospitalization	Quantitative Total Score	Quantitative Rank	Qualitative Rank	Total Rank	Final Overall Priority Score
Intentional self-harm	129	3,304	2,341	634	2,263	79	19.5	1.5	21	10
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