North Bay Parry Sound District Health Unit

COVID-19 Vaccination Strategy Playbook

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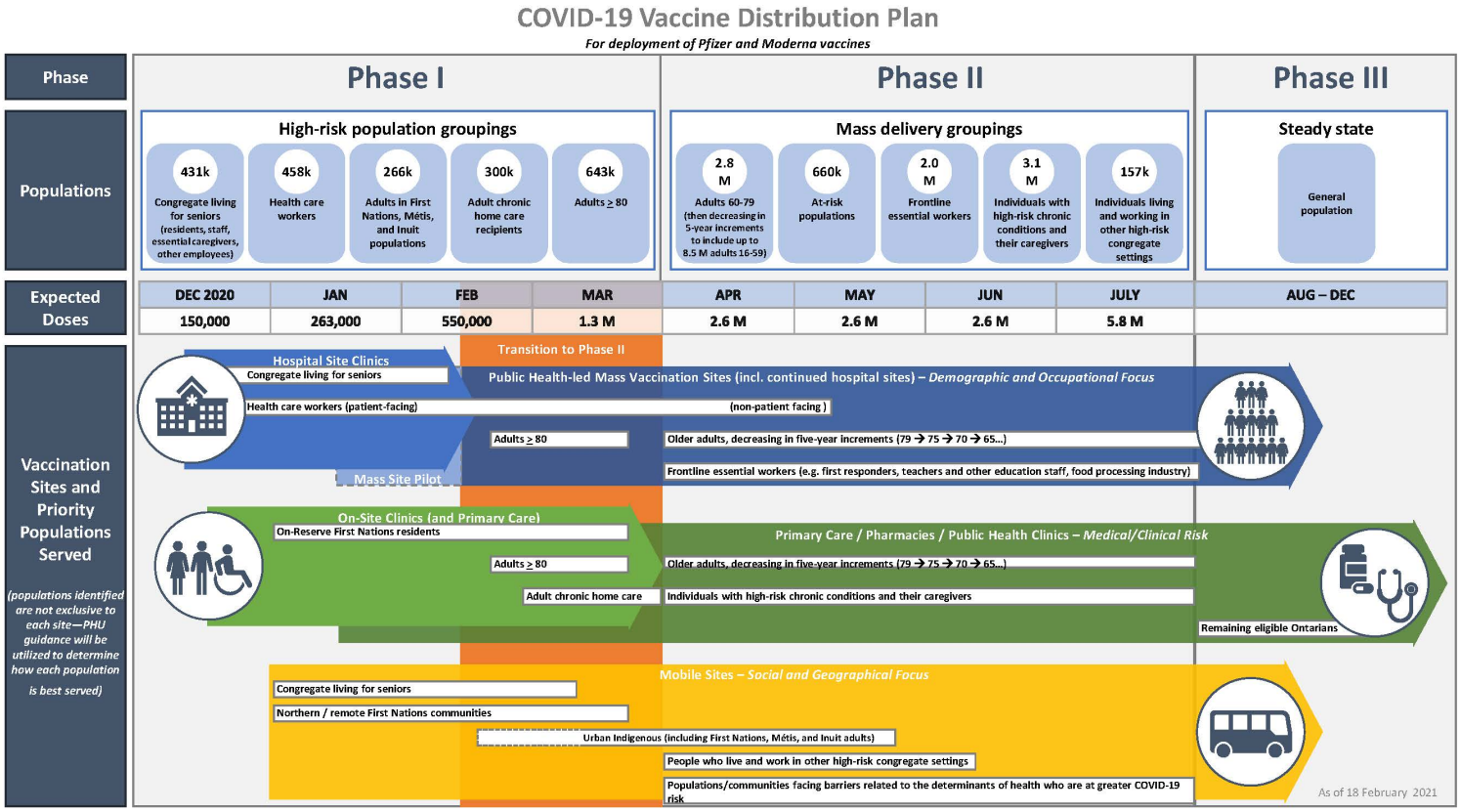
Executive Summary

In March, 2020, the World Health Organization declared a global pandemic. The pandemic has and continues to have a significant negative impact on the social, economic and emotional wellbeing of all Ontarians. The number of cases and deaths continues to rise.

The development and delivery of a vaccine to combat SARS-CoV-2 has been a global priority. On December 11th, 2020, Ontario's Vaccine Distribution Implementation Plan (Appendix A) was released by the provincial government. The plan outlines a 3-phase approach to the delivery of vaccines in Ontario (Figure 1) that provides guidance with respect to priority populations for vaccination. This framework provides the foundation on which local public health units will build and implement their local strategies, combining the priorities outlined by the province with their local context information to provide a robust and equitable vaccination strategy for their communities.



In addition to the vaccine distribution plan, the provincial government has also developed a prioritization model for access to vaccines. Initial vaccine supplies are expected to be limited therefore populations at greatest risk have been prioritized to receive the first doses (Appendix B).

As the local public health agency in the Nipissing and Parry Sound districts, the North Bay Parry Sound District Health Unit (Health Unit) has the responsibility to lead the development and implementation of a vaccination strategy that adheres to the principles outlined in the provincial vaccine distribution plan while incorporating local priorities. The development of this strategy will be undertaken in close collaboration with the health care sector (acute care, primary care, Emergency Services, Long Term Care and Retirement Homes, congregate care settings, community pharmacies) as well as community partners such as municipalities, First Nations, social services and education sectors. The plan will respect the principle of vaccinating identified priority populations within the district first.

The purpose of this playbook is to document and communicate the framework for the implementation of a vaccination strategy for the Nipissing and Parry Sound districts. It is not intended to be a static plan but rather a dynamic document at that will be flexible to meet the evolving landscape of the pandemic and will be updated as additional information becomes available that affects the overall strategy.

Purpose and Objectives

The overall purpose of this document is to provide the framework within which the COVID-19 vaccination strategy will be rolled out to residents across our districts. Transparency and accountability are central principles within the document.

At the core of the plan is a recognition of the diversity of our communities as well as the varying degrees of capacity to vaccinate residents. The Health Unit commits to working together with our municipalities and community partners to ensure the successful roll out of vaccine across the entire district. This playbook provides the basic framework for the vaccination strategy that will be utilized but also assumes the need for flexibility to ensure the unique needs of communities within the district are recognized and addressed.

Objectives of the vaccination strategy for the district include:

- To distribute vaccine across the district in a timely manner and respecting the provincially defined priorities and timelines.
- To ensure the availability of resources and education that supports informed decision-making with respect to COVID-19 vaccination.
- To build on existing partnerships and develop new partnerships to ensure vaccination within the provincially defined timelines for the residents of our district.
- To work with representatives of priority populations to ensure appropriate roll out and vaccination strategies for their population.
- To achieve a minimum vaccine uptake of 75% across the district.

Planning Assumptions

The implementation of a global vaccination to combat COVID is a monumental task and in order to ensure success will require significant planning and collaboration in every community. The vaccination strategy will need to be dynamic and flexible to meet changing parameters. The following assumptions are embedded within the plans that are detailed in this document:

- The management of the distribution process is the responsibility of the provincial government. The product received, the volume of vaccine received and when the vaccine is received is outside of the Health Unit's control.
- Initially, the demand for vaccine will far exceed the vaccine available to us. As a result, communication to the public regarding the vaccine distribution plan locally is critical.
- Transparency and clear communication of decisions being made and the rationale for those decisions is critical. Difficult decisions will need to be made if the availability of vaccine does not meet the demand within the various phases of the provincial roll out. Locally, decisions regarding the allocation of vaccine in phases 1 and 2 will follow the guidelines set out in the provincial *Ethical Framework for COVID-19 Vaccine Distribution* (Appendix B) and the *COVID-19 Guidance for Prioritizing Health Care Workers for COVID-19 Vaccination* (Appendix C) documents. This will be absolutely critical to ensure public confidence in the overall vaccination strategy.
- An ongoing communication plan will be critical to managing public expectations regarding the supply of and access to vaccine.
- Based on 2016 census data, the estimated population aged 18 years of age and older in our district is 102,324.
- Based on the assumption of a two-dose vaccination series and an objective of 75% vaccine uptake within the district, a total of 153,486 doses of vaccine are required to achieve our target.
- Public Health is responsible for leading the vaccination strategy; however, partnerships and collaboration across the health care and non-health care sectors will be essential to the successful implementation of the strategy.
- Public education will be an integral component of the plan to support those who are vaccine hesitant to make an informed decision based on the available evidence.
- Flexibility within our plan will be required as supply chain issues may affect our ability to deliver the vaccine as outlined within this document.

Leadership

The successful implementation of our vaccination strategy hinges on leadership, collaboration and trust.

Clearly defined roles and responsibilities will support our efforts:

Partner	Roles and Responsibilities
Federal Government	• Procurement of vaccines on behalf of all territories and provinces. • Approval of vaccines for use in Canada. • Coordination of surveillance and reporting across all jurisdictions. • Provide scientific guidance on vaccine use • Deploy staff from Indigenous Health Centers to assist with vaccination of residents of Indigenous communities.
Provincial Government	• Coordinate vaccine distribution process. • Provide overall guidance to PHUs with respect to the delivery of vaccination programs to the populations served.
Municipalities	• Participate in vaccination program planning as appropriate. • Support the use of municipal facilities to provide mass vaccination clinics. • Provide support through human resources, communication to residents of the municipality and as appropriate support access to clinics for marginalized populations.
North Bay Parry Sound District Health Unit	• Lead the planning, implementation and evaluation of a vaccination strategy for the district. • Coordinate distribution to the COVID-19 vaccine across the district as appropriate. • Store vaccine not requiring ultra-cold temperatures
Ontario Health North	• Assist with planning across all phases of the roll out. • Coordinate the vaccination effort of chronic home care clients. • Troubleshoot supply logistics and supply chain challenges as required.

Partner	Roles and Responsibilities
Hospitals	• Due to ultra-cold storage capabilities, North Bay Regional Health Centre to assist with the storage of the vaccine supply as required in partnership with Health Unit. • Assist with the development and implementation of the vaccination strategy for the district. • Coordinate and implement the vaccination of hospital based staff based on the agreed upon prioritization model for health care workers. • Assist in the implementation of vaccination clinics within the district as required through the provision of health human resources as appropriate.
Long Term Care Homes, Retirement Homes, Congregate Care Settings	• Collaborate with the Public Health Unit to develop individualized vaccination strategies. • Deploy human resources to assist with onsite vaccination clinics.
Police Services	• Support the safe transportation of vaccine to its storage location (either the Health Unit or North Bay Regional Health Centre) upon arrival from the province.
Emergency Medical Services	• Assist with the administration of vaccine for targeted populations in phase 1 and 2 (e.g. long term care homes, chronic home care clients and congregate care settings) as well as mass vaccination clinics in later phase 2 and phase 3.
First Nations Communities	• Coordinate vaccination within their communities in alignment with the provincial and local health unit direction.
Primary Care	• As vaccine supply permits, vaccinate patients within their individual practices. • Where possible, and in alignment with provincial and local priorities, recruit health human resources to support mass vaccination efforts across the district.
Agencies providing services to marginalized clients (e.g. homeless shelters, DSSAB)	• Assist with the dissemination of information to their staff and clients related to the vaccine. • Support the implementation of / or dissemination of information related to vaccination clinics for their clients and staff. • Support access to clinics and vaccination services for vulnerable clients as appropriate.

Partner	Roles and Responsibilities
Workplaces and academic centers	• Assist with the dissemination of information to their staff and clients related to the vaccine. • Support the implementation of / or dissemination of information related to vaccination clinics for their clients and staff. • Where possible, deploy health human resources to support mass vaccination efforts and / or provide venues for public clinics.
Pharmacies	• Provide health human resources where possible to support the implementation of mass vaccination clinics across the district. • Once authorized, provide vaccinations to clients within their pharmacies.

Operational Planning Teams

In response the emerging global pandemic, the North Bay Parry Sound District Health Unit activated its Incident Management System (IMS) in early 2020. The role of the IMS team is to coordinate and implement the organization's response both internally and externally to the pandemic. The work of the IMS team is guided by the North Bay Parry Sound District Health Unit's Emergency Management Plan (Appendix D).

The IMS team has been meeting on a weekly basis, and as required more frequently, up to 3 times per week since February 2020.

Membership on the IMS team includes:

- Medical Officer of Health
- Public Health Physician
- Executive Director, Human Resources
- Executive Director, Finance
- Director, Clinical Services and Chief Nursing Officer
- Executive Director, Community Services
- Executive Director, Corporate Services & Privacy Officer
- Manager, Communicable Diseases Program
- Manager, Environmental Health
- Manager, Healthy Living
- Manager, Healthy Schools team
- Manager, Information Technology & Facilities
- Manager, COVID Call Center
- Manager, Planning, Evaluation and Communications

- Manager, Emergency Management
- Manager, Health and Safety
- Public Relations Specialist
- 2 Epidemiologists
- Research Assistant and;
- Additional staff are invited to attend on an ad hoc basis.

An internal COVID-19 Vaccination Task Force was implemented in January 2021. The focus of this group is to coordinate the Health Unit's response to the vaccination strategy. This will include coordinating and ensuring availability of clinic supplies and PPE, allocating health human resources to support vaccination, coordinating the communication strategy and working collaboratively with community partners to successfully execute this plan.

Membership includes:

- Medical Officer of Health
- Public Health Physician
- Director, COVID-19 Vaccination Strategy
- Executive Director, Human Resources
- Executive Director, Finance
- Director, Clinical Services and Chief Nursing Officer
- Executive Director, Corporate Services & Privacy Officer
- Manager, Vaccine Preventable Diseases Program
- Manager, Healthy Living and COVID Call Center
- Manager, Planning, Evaluation and Communications
- Manager, Emergency Management
- Public Relations Specialist
- Epidemiologist
- Vaccine Preventable Diseases Public Health Nurse
- Occupational Health and Safety PHN

Working Groups

Working groups have been struck to plan the management the roll out of vaccines across the phase 1 priority groups. Working groups are led by the Health Unit's Director, COVID-19 Immunization Strategy and the Vaccine Preventable Diseases Public Health Nurse and include representatives of the community organizations that have been identified in phase 1 priority groups.

Current working groups include:

- PHU and North Bay Regional Health Centre –Working together to coordinate vaccine storage requirements.

- Acute Care – Following the completion of the administration of first doses of COVID-19, biweekly meetings continue to be held, focusing on identifying opportunities for collaboration, and support between Public Health and Acute care with the ongoing roll out of COVID-19 vaccines in our district.

- Long Term Care, Retirement Homes & Congregate Care for Seniors – Monthly to six-week meetings continue to occur to address and plan for ongoing COVID-19 vaccine needs.

- First Nations and Urban Indigenous Populations – Representatives from all First Nations communities as well as Metis communities in the district continue to be engaged in weekly meetings to plan the rollout of vaccine within the district's Indigenous communities.

- Congregate Care Settings – Congregate Care Settings are engaged in planning for vaccine administration of their residents and staff in collaboration with our Paramedical Services.

- Paramedical Services – Nipissing District Paramedic Services and Parry Sound District Emergency Medical Services have been working collaboratively with the Health Unit to provide EMS and immunization support at our mass immunization clinics. They have supported community-based immunization strategy by offering in- home immunizations for residents who are unable to attend a clinic, and by leading the immunization of those living in congregate care settings across the district.

- Post-Secondary Education Sector – an initial reach out to gain support and request consideration of health human resources and potential student placement opportunities was initiated the week of January 11th – further discussions will occur as the details of mass vaccination clinic planning evolve.

- Primary care – Primary Care is providing support at our mass immunization clinics in a variety of roles. Additionally, 13 primary care sites have expressed interest in participating in vaccine administration through their practices.

- Pharmacists – Select pharmacies across the district are offering COVID-19 vaccinations at their pharmacies for individuals 40 years of age and older. The Ministry of Health is leading the rollout of COVID-19 vaccine to pharmacies through the implementation of a process similar to the annual influenza immunization program.

- **Canadore College –** Working collaboratively, Canadore College has assisted the Health Unit to create and build a series of immunization booths which will allow us to implement an immunization model that will support a significant increase in the number of individuals who can be immunized at a mass immunization clinic.

As we progress through the phases of the roll out, additional working groups will be initiated to engage the targeted populations. Community partner support and involvement is essential to the successful implementation of the vaccination strategy.

Vaccination Priorities

The provincial vaccination strategy includes a roll out of vaccine in a three-phased approach – see Appendix A.

The NBPSDHU will roll out vaccine as follows:

Phase 1:

- Long-term care homes:
  - Residents, staff, essential caregivers
- Retirement homes
  - Residents, staff, essential caregivers
- Congregate settings for seniors
  - Residents, staff, essential caregivers
- Health care workers identified in the Ministry of Health's guidance on Health Care Worker Prioritization (PDF)
- Adult First Nations, Metis and Inuit populations
- Individuals turning 80 years of age and older
- Adult recipients of chronic home care services

Phase 2:

Refer to COVID-19: Guidance of Prioritization of Phase 2 Populations for COVID-19 Vaccination (Ontario Ministry of Health)

- Adults 60 – 79 years of age, in five year increments
- High risk congregate care settings (e.g. shelters, community living)
- Individuals with high-risk health conditions and their essential caregivers
- Frontline essential workers who cannot work from home
- At-risk populations

Phase 3:

- Remaining eligible Ontarians

If the demand for vaccine outweighs the supply available, the Ethical Framework for COVID-19 Vaccine Distribution and the Health Care Worker Prioritization for COVID-19 Vaccine will be utilized in each phase of the plan in order to ensure the highest risk individuals receive access to the vaccine first.

Vaccination strategies will include several clinic models:

Mobile clinics: where the ability of those requiring vaccination to attend an off-site clinic is limited or they are unable to attend a mass vaccination clinic e.g. long-term care, retirement homes, recipients of chronic home care services.

Workplace clinics: where organizations have the capacity and appropriate human health resources available or can contract the appropriate resources to provide onsite clinics at their workplaces – e.g. hospitals

Mass immunization clinics for targeted groups: will be utilized in instances where a large group of individuals are identified as a priority population and are able to attend a mass immunization clinic and where the demand for access outweighs the ability for mobile teams to complete the work in a timely manner – e.g. school teachers, medical first responders.

Practice clinics: as supply is available, vaccines may be provided to primary health care providers and pharmacies to administer within their practices.

COVID-19 Vaccination Clinic Planning: Population of Adults across the Health Unit Region

Purpose

This section provides the number of adults (i.e., individuals aged 18 years or over) living across the North Bay Parry Sound District Health Unit region by different levels of geography (including areas equivalent to municipalities & First Nations reserves, and broader regions), according to the 2016 Census. This information will assist in estimating operational needs for regional COVID-19 vaccine clinics.

Background

As of December 15th, 2020, COVID-19 vaccination is offered to Ontario adults by phases (Appendix A)(,

Number of adults by census subdivision

Census subdivisions are areas defined by Statistics Canada as municipalities or areas equivalent to municipalities for statistical reporting purposes (e.g., a First Nation reserve, unorganized territory). According to the 2016 Census (Statistics Canada), the number adults in the Health Unit region by census subdivision ranges from 70 (Magnetawan First Nation) to 42,150 (North Bay). In all, 102,415 adults are estimated to be residents of the Health Unit region.

See Table 1 for the number of adults by census subdivisions in the Health Unit region, and grouped by broad geographical areas (e.g., catchment areas for proposed vaccine sites, and by First Nation reserves).

Table 1. Number of adults aged 18 years or older, by broad geographical areas & census subdivisions, 2016 Census

Census subdivision by broad geographical areas or types of areas	Number of adults
First Nation reserves	**2,060**
Dokis First Nation reserve	285

French River First Nation reserve	85
Magnetawan First Nation reserve	70
Nipissing First Nation reserve	1,240
Shawanaga First Nation reserve	140
Wasauksing First Nation reserve	240
Mattawa catchment area	**4,705**
Bonfield	1,635
Calvin	405
Mattawa	1,685
Mattawan	135
Papineau Cameron	845

Census subdivision by broad geographical areas or types of areas	Number of adults
North Bay catchment area	**55,900**
Callander	3,135
Chisholm	1,015
East Ferris	3,840
Nipissing	1,445
Nipissing, Unorganized, North Part	1,495
North Bay	42,150
Powassan	2,820
Sundridge catchment area	**9,545**
Armour	1,215
Burk's Falls	775
Joly	250
Kearney	785
McMurrich/Monteith	710
Nipissing, Unorganized, South Part	75
Parry Sound, Unorganized, North East Part	165
Perry	2,060
Ryerson	580
South River	905
Strong	1,220
Sundridge	805
West Nipissing catchment area	**11,685**
West Nipissing	11,685
Parry Sound catchment area	**18,520**
Carling	990
Machar	755
Magnetawan	1,225
McDougall	22,10
McKellar	1,000
Parry Sound	5,380
Parry Sound, Unorganized, Centre Part	1,970
Seguin	3,665
The Archipelago	475
Whitestone	850

Source: Statistics Canada, 2016 Census of Population, Statistics Canada Catalogue no. 98-400-X2016003.

Note: Catchment areas were artificially constructed using emergency department visit patterns in 2018 to define areas.

Residents of the North Bay catchment area generally accessed emergency department services from North Bay Regional Health Centre. Sundridge catchment area residents generally accessed services in Huntsville. Mattawa

catchment area residents generally accessed services from the Mattawa General Hospital. Residents of West Nipissing generally accessed services from West Nipissing General Hospital. Residents of the Parry Sound catchment area generally accessed services from the West Parry Sound Health Centre.

First Nations reserves are not grouped under these catchment areas as it is assumed that vaccine clinics will be offered on-site at each reserve.

Assumptions & Limitations for Estimation of Vaccine Clinic Volume

There are multiple assumptions and limitations associated with using the 2016 Census population counts provided in this report for the purpose of estimating attendance or volume at proposed vaccine clinics:

- Population counts are only available from the 2016 Census, counts that are now five years out of date and may have changed (decreased or increased) in the interim time period.
- Not all those individuals eligible to receive the vaccine may seek to be vaccinated.
- COVID-19 vaccination may be offered through other sites (e.g., hospitals, pharmacies, primary care, etc.) and prior to when vaccine clinics are available.
- Populations that routinely access services outside the Health Unit region (e.g., those living in the Sundridge catchment area are in closer proximity to Huntsville), may seek to be vaccinated there depending on when clinics are offered.
- These estimates do not account for barriers in accessing COVID-19 vaccination including proximity to assessment centres, hours of operation, parental employment, lack of transportation, financial or other barriers.
- Population counts of adults are based on 2016 Census data of individuals 18 and older, the use of a vaccine product for vaccination is defined by the product. Additional data will be required to identify population numbers of those under 18 years of age.

Number of adults by census subdivision and associated broader geographical catchment area or First Nation reserve status

Table 2. Number of adults aged 18 years or older, by census subdivision & broad geographical areas, 2016 Census

Census subdivision	Broad geographical area or type	Number of adults
Armour	Sundridge	1,215
Bonfield	Mattawa	1,635
Burk's Falls	Sundridge	775
Callander	North Bay	3,135
Calvin	Mattawa	405
Carling	Parry Sound	990
Chisholm	North Bay	1,015
Dokis First Nation	First Nations reserve	285
East Ferris	North Bay	3,840
French River First Nation	First Nations reserve	85
Joly	Sundridge	250
Kearney	Sundridge	785
Machar	Parry Sound	755
Magnetawan	Parry Sound	1,225
Magnetawan First Nation	First Nations reserve	70
Mattawa	Mattawa	1,685
Mattawan	Mattawa	135
McDougall	Parry Sound	2,210
McKellar	Parry Sound	1,000
McMurrich/Monteith	Sundridge	710
Nipissing	North Bay	1,445
Nipissing First Nation	First Nations reserve	1,240
Nipissing, Unorganized, North Part	North Bay	1,495
Nipissing, Unorganized, South Part	Sundridge	75
North Bay	North Bay	42,150
Papineau-Cameron	Mattawa	845
Parry Sound	Parry Sound	5,380
Parry Sound, Unorganized, Centre Part	Parry Sound	1,970
Parry Sound, Unorganized, North East Part	Sundridge	165
Perry	Sundridge	2,060
Powassan	North Bay	2,820
Ryerson	Sundridge	580
Seguin	Parry Sound	3,665
Shawanaga First Nation	First Nations reserve	140
South River	North Bay	905
Strong	Sundridge	1,220
Sundridge	Sundridge	805

Census subdivision	Broad geographical area or type	Number of adults
The Archipelago	Parry Sound	475
Wasauksing First Nation	First Nations reserve	240
West Nipissing	West Nipissing	11,685
Whitestone	Parry Sound	850

Source: Statistics Canada, 2016 Census of Population, Statistics Canada Catalogue no. 98-400-X2016003.

Logistics

Material and Supplies

Personal Protective Equipment

Requests for PPE supplies are made from the Provincial inventory. Initially protective equipment such as masks, hand sanitizer, disinfectant wipes, gowns and gloves are sourced from the current supply held by the health unit. In the event stock runs low or if access to provincial supplies are limited, local hospitals and Long Term Care Homes will be contacted to provide supplies they may have available.

Vaccination supplies

Requests for supplies required for vaccination clinics are made to the Provincial inventory supply chain. Initially, supplies such as needles, syringes, alcohol wipes, Band-Aids, drapes, and garbage bags are sourced from the current supplies held by the health unit. Stocks have been increased over the past few months and supplies on site will be sufficient to support vaccination efforts for most of phase 1.

Supplies are arriving from the Provincial inventory as we receive vaccines. We are receiving 1 cc. syringes from the province for use with Pfizer vaccines, however due to challenges with the needles provided and shortages, we have supplemented with needles purchased from our usual vendors. The province is not supplying certain items such as disinfectant wipes and hand sanitizer; therefore, we are purchasing these items directly from our vendor as well. All supplies are now coming directly to the health unit and are being directed out to clinics from here.

Arrangements have been made for additional pick-ups of used needles by Stericycle. There will now be scheduled pick-ups twice per month.

Finance

Fiscal responsibility and accountability are requirements health units do not take lightly. Throughout the pandemic, additional costs incurred as a result of the pandemic have been tracked and charged to separate cost centers by the finance department.

Two cost centers have been created in the accounting system to track the extra costs incurred for COVID immunization and the redeployment costs respectively. The expenses will be broken down into the following categories:

- Salaries
- Benefits
- Travel and accommodations
- Materials & Supplies
- Purchased Services
- Other

The Health Unit will be prepared to report on costs to the Ministry on a quarterly basis.

In order to comply with Ministry direction regarding the reimbursement of Municipal & Health partners who are assisting us with Immunization clinics, Memorandums of Understanding and Facilities Agreements are being implemented. At this time, 12 such agreements are in place.

Vaccine Storage, Management and Distribution

As directed by the Ministry of Health in early December, the Health Unit ordered 3 vaccine freezers to support the storage of -20˚C vaccine products from VWR, a Toronto based supply company. The larger unit is located in the vaccine room to store vaccine, and a second, smaller unit is now located in our medication room in the North Bay office and functions as a back-up unit. The 3rd unit that was intended to support vaccine storage in the Parry Sound office was cancelled as staff are required to travel from the North Bay office with the vaccine. Both freezers are alarmed, monitored 24 hours a day, seven days a week and are connected to the generator as all other vaccine storage units are at the health unit to ensure the integrity of the vaccine is maintained. The freezers at the North Bay office are located in areas with no public access and in rooms locked and requiring swipe access to enter. There are currently two freezers at the NBRHC. A -80 freezer is located in the Laboratory, and a smaller -80 freezer in the Pharmacy. Again the freezers are locked, alarmed and out of public access areas. All freezers will have temperatures recorded and documented twice daily.

Moderna vaccine which must be stored at -20˚C will be stored in the freezer units at the Health Unit's North Bay office and distributed by the Vaccine Preventable Diseases Team. The Health Unit will assume responsibility for onsite storage, security and monitoring as well as the allocation and distribution of the Moderna product. The Pfizer-BioNtech vaccine requires storage at -80˚C 60˚C and will be stored in one of 2 freezers located at the North Bay Regional Health Center. The NBRHC will assume responsibility for the onsite storage, security and monitoring of the Pfizer vaccine product while the Health Unit will assume responsibility for allocation and distribution of the vaccine.

Contingency plans have been developed with the support of the North Bay Regional Health Center and the West Parry Sound Health Center in the event there is a failure of any of our storage units.

Safe and effective management of vaccine supply is crucial to a successful vaccination strategy. While storage of the vaccine is critical, management of vaccine distribution processes to minimize or eliminate vaccine waste is also key component to the success of the program.

Distribution System

Vaccine for all mobile and mass immunization clinics will be delivered to the clinic site by Vaccine Preventable Diseases staff following our standard vaccine storage and handling guidelines and respecting the manufacturer's recommendations and guidelines for packing and transporting vaccines. The Vaccine Preventable Diseases staff have clearly defined processes that have been in place for each vaccine available.

Six pharmacies in the Health Unit district are participating in the distribution of the AstraZeneca vaccine. This vaccine is distributed directly to each pharmacy by the province. The same rigorous processes utilized with all other vaccines distributed for use across our district is adhered to. Education related to unique storage and handling requirements specific to the products being utilized has been provided.

Physicians' offices are also eligible to distribute the AstraZeneca vaccine. Thirteen offices have agreed to administer the vaccine at this time. This vaccine will be distributed through the health unit's standard process for vaccine distribution.

Human Resources Considerations

Human resources need to be considered for the COVID immunization clinics. The NBPSDHU has compiled an inventory of staff skills and has hired casual nurses to support the vaccination clinics. With this, we have developed a nursing pool of 35 full-time available nursing staff and 10 casual available nursing staff to immunize targeted populations across our district. We continue our external recruitment efforts to ensure a workforce that will support our vaccination strategy. We continue to receive applications from nurses interested in supporting our efforts. Based on our current assumptions, these resources would be sufficient to meet provincially prescribed timelines, but these would have a significant impact on current Public Health resources and programs. Further, if available vaccine supplies increase, timelines become shorter, or COVID-19 case and contact management work escalates, more capacity will be required. In anticipation of these needs, the following work is underway:

- Local post-secondary institutions with nursing students have been contacted for placements
- Retired nurses are being sought for onboarding
- Support staff are will be recruited and trained to support check-in and check-out roles
- Primary care efforts to identify deployable health human resources are underway.

An internal deployment process has been established to deploy staff (nursing and non-nursing) in various COVID-related activities such as case and contact management, call center, surveillance, communications and immunization clinics while still maintaining priority services in our regular programs (see Appendix F).

Sources for Healthcare Provider Staffing:

A number of local physicians have indicated their intention to support the COVID-19 Vaccination Strategy by providing their services to immunize and supporting the deployment of some of their staff to administer vaccinations. Discussions are in progress with Emergency Management Services across the district to solicit their support with respect to immunization and recovery area oversight at mass vaccination clinics.

Roles to be filled at immunization clinics include immunizers, active screeners to screen anyone presenting for immunization. Staff to greet and check-in clients and check-out clients, staff to control traffic flow, to monitor clients in the recovery area, scheduling appointments, and security for both the vaccine and the clinic areas.

Recruitment of Human Resources

We are currently also recruiting staff and deploying staff to conduct case and contact management, which will allow nurses to be deployed to the immunization clinics.

We are in the process of developing affiliation agreements with other agencies who can assist with administering vaccines.

Volunteers are also being recruited for support roles at vaccination clinics.

Training and Orientation:

Training and orientation will be provided by public health managers, with support from the Nursing Practice Manager, and the Vaccine Preventable Disease Public Health Nurses to each group of staff assisting with vaccination clinics. Training and orientation will include independent review, virtual review, and in-person training. Completion of each session will be dependent on module progress, knowledge of the key concepts, and comfort with assigned roles.

Public Support

When the pandemic first began, the health unit introduced a COVID-1 call center which allowed members of the public to contact the health unit to seek advice, ask questions related to COVID-19 and pandemic measures. As the pandemic has evolved, so has the role of the call center. With the introduction of our school based nurses' initiative, the call center expanded to include the school nurses being available daily to the public, teachers and boards of education staff to seek clarification and guidance related to directives.

A COVID Response Team was introduced to address an increase in the volume of email questions related to COVID being received. Our call center continues to evolve to meet the ever-changing needs of the community. Currently a process is under development to train call center staff to provide responses to vaccine related calls and emails. In the event the caller's inquiries are beyond the scope of the call center staff, the calls /emails will be forwarded to the Vaccine Preventable Diseases team to respond to.

A section of the health unit's website is dedicated to COVID-19 resources. The website is updated regularly and provides a wealth of information and resources in relation to the pandemic, vaccines, case counts and local, provincial national and global information.

Information Technology (IT)

Health Units have been mandated to use a newly developed application called COVax, which is an IT solution specifically designed to support the tracking of vaccinations administered. Support from a provincial IT Help desk will be provided. Orientation and training is currently being completed by members of the Vaccine Preventable Disease team and the IT team.

Additional IT resources under discussion or consideration include:

- Written protocols for the COVax system
- On-site IT support for the COVax application and internet / IT equipment challenges
- Development of a backup or manual paper based system in the event internet connectivity poses a challenge at vaccination sites
- Introduction of a client booking system
- Introduction of an electronic self-scheduling for staff for all external vaccination clinics

Mobile Vaccination Clinics

A mobile clinic model will be utilized to deliver vaccines in settings where clients are unable to attend mass vaccination clinics such as Long Term Care Homes, Retirement Homes, Congregate care settings for seniors, and recipients of chronic home care services. The VPD PHN lead will work with organizations identified as appropriate for this format of clinic to determine:

- Appropriate dates and times for clinics
- Complete a site visit to determine clinic layout and client flow
- Review documentation / consent requirements
- Determine numbers for vaccination
- Determine staffing resources to be provided by the location to support the clinic and provide an overview of their roles and responsibilities as well as any appropriate training resources
- Determine staffing requirements to ensure completion of clinics within a predetermined timeline
- Coordinate data collection requirements
- Confirm numbers to be vaccinated the day before the clinic is held

Roles to be managed by the organization include:

- Providing active screeners
- Providing staff to direct or bring clients to be vaccinated
- Ensuring consent forms and health assessments have been completed
- Providing staff for vaccination where possible
- Providing staff to monitor clients post vaccination
- Providing staff to return clients to their rooms
- Directing vaccinating staff to rooms where clients who are unable to attend the clinic are located

Roles to be managed by the Health Unit include:

- Completing a site visit and determining appropriate location
- Bring the vaccine, PPE and all vaccination supplies to the location
- Vaccinate all clients who meet eligibility criteria and have a valid consent
- Manage the overall clinic flow

Mass Vaccination Clinics

Locations for Clinics

Working collaboratively with the Emergency Manager of the NPBPSDHU and municipalities across the district and following the principles outlined in Mass Immunization Plan (Appendix E), the sites for mass clinics will be identified. Clinic locations, dates and times will be dependent on vaccine product availability, availability of human resources, and vaccination supplies. Specific locations have not as of yet been identified but at a minimum will include clinics located in the five major hubs identified in the Mass Immunization Plan – North Bay; West Nipissing; Mattawa; Sundridge and Parry Sound areas. The following criteria will be considered when assessing possible locations:

- Accessibility
- Ability to maintain physical distancing
- Tables and chairs are available on site
- Availability of power sources for IT equipment
- Safety
- WI-FI accessibility
- Privacy
- Custodial services
- Location
- Large open space
- Separate entrance and exit
- Temperature control and ventilation
- Parking and maintenance of parking space
- Separate and private space for staff breaks and lunch
- Washroom facilities

Safety and Security

Security plans will be incorporated in to all vaccination clinics – this includes staff safety as well as the safety and security of vaccine and vaccine supplies. Designated staff will be assigned responsibility for securing the vaccine at clinics and dedicated staff will be responsible for client flow within the clinic setting.

Staffing for Clinics

Staffing of clinics will be coordinated by the Human Resources program in consultation with the VPD PHN Lead. The following assumptions will guide staffing levels:

- VPD nurses immunization rate will be 12-14 vaccinations per hour
- Nurses with previous vaccination experience will vaccinate at a rate of 10-12 vaccinations per hour depending on their level of experience

- Casual nurse hired to immunize will do so at a rate of 8 – 10 vaccinations per hour
- Vaccination clinics will run 9 am to 7 pm 7 days per week at various locations
- Vaccines will be prepared and provided to vaccinating nurses according to product specifications
- Active screening will be completed before the client enters the clinic setting
- Consent forms, including health assessment questions will have been completed prior to the client arriving at the vaccination station. Consent forms will be available on our website to allow clients to present with their form already completed.
- There will be an uninterrupted, controlled client flow
- There will be sufficient health human resources available to schedule staff to work 5 hour shifts in order to avoid burn out
- In order to ensure adequate vaccine supply, adherence to public health measures such as physical distancing and appropriate staffing levels access to the clinics will be by appointment only
- Mandatory masking will be required unless the client has an exemption

Staff Roles will include:

- Clinic lead – VPD nurse
- Greeters and active screeners
- Check in clerks
- Immunizers – PHNs, NPs, RNs, RPNs, physicians, student nurses, pharmacists and paramedics – including float immunizers for break coverage
- Vaccine Security
- Client flow coordinators
- Recovery area monitors
- Runners - volunteers
- Vaccine preparers and distributors
- Booking clerks – for 2nd dose appointments
- Vaccine security
- IT support
- Management support

Roles outside of clinic:

- Data entry clerks – COVax information
- Staff scheduling – Human Resources
- Client appointment booking clerks – first dose appointments
- Supply management

Training / orientation to roles will be provided by Health Unit staff prior to the clinic.

The Health Unit will transport the vaccine, all clinic supplies and PPE to the appropriate clinic location.

The mass vaccination clinic format outlined above will be utilized for target priority populations such as teachers, congregate area setting staff, and health care providers where mobile clinics are not deemed to be feasible or efficient.

Contingency Planning

In planning the COVID-19 vaccine strategy situations that may disrupt the deployment of the plan have been considered and planned for include:

Vaccine storage\refrigeration and handling: In the event of a power outage, electrical disruption or refrigerator/freezer malfunction Health Unit protocols will be followed (i.e. Vaccine Refrigerator Failure Protocol, Adverse Storage Conditions Protocol). Alternate means of power are in place at both Parry Sound, and North Bay office locations. Should either location have any type of power interruption occur, the backup generators will engage. In addition, standard transportation and handling processes will be reviewed and revised accordingly to safeguard COVID-19 vaccine supply.

Surge capacity staffing: To address unexpected staff absences or to support unplanned operational requirements that require rapid mobilization of a response, the Health Unit's staff deployment process will be utilized and affiliation agreements with other agencies activated (see Human Resources section for further details). In addition, casual staff will be scheduled in addition to regular staff. In times when there is capacity, regular staff may be scheduled to work half the shift and another employee work the second half of this shift. In the event that there is an absence, the staff working the half shift could be asked to work a full shift. This will provide for surge capacity if needed. Whenever possible, staff will be cross-trained in more than one role to increase our ability to assign to different roles. As a last resort, staff could be expected to work overtime if needed.

Alternate locations: In the event that previously planned space cannot be used alternate sites will be been identified in consultation with municipal partners.

Security and communication: To assist with emergency response communication protocols are in place as per the Health Unit's Internal Disaster Response (Colour Coded) Plans. Each colour code outlines the required staff response during specific emergency situations (e.g. Fire, Evacuation, etc.).

With respect to security, site security is contracted out by the Health Unit through a third party company. Security is present for all clinics that are performed at the Health Unit. In addition, safeguards are in place to ensure that access to the Health Unit's North Bay and Parry Sound offices is controlled and restricted based on individual permissions. Access to supplies, vaccines, medications and other critical infrastructure is also restricted based on individual permissions. Secure access is achieved by access card readers.

Communications Plan – COVID-19 Vaccination Strategy

The North Bay Parry Sound District Health Unit's communication approach in regard to the dissemination of the COVID-19 vaccine will be heavily rooted in the phases of the provincial plan. Each phase will align with provincial messaging utilizing local information to ensure the target populations are well informed. Strategies will utilize earned, owned and paid media and will encourage the use of two-way communication to help ensure that individual concerns can be addresses in a systematic and appropriate way. Consistent and engaging communication, that meets the target audience where they are at, will be key to building on community trust and encouraging vaccine uptake. The communications plan will be evergreen, pivoting and adapt to the needs of our district and the province.

Key Communication Principles

- Work collaboratively with First Nations communities to help support communication needs identified by the communities
- Have a targeted bilingual approach will help reduce additional barriers in our Francophone communities.
- Collaborate with community partners that work with priority populations
- Communication products are accessible, diverse and inclusive
- Communication is to be transparent and evidence informed

Communication objectives

- Pre-vaccine delivery
    - Build on the established relationship with stakeholders within the district to help keep the public aware of the local COVID-19 vaccine availability
    - Provide credible information on the COVID-19 vaccine(s)
    - Build awareness of COVID-19 vaccine safety

- Phase 1
    - Utilizing the relationships established with LTCH, Hospitals and Congregate Living Centres help reduce vaccine hesitancy.
    - Share time-sensitive information to help inform phase 1 targets of vaccine availability and vaccine administration
    - Inform the public about the current status of phase 1
- Phase 2
    - Build on the established trust within the community about the ethical rollout of the COVID-19 vaccine
    - Communicate information on administration of the COVID-19 vaccine amongst target audiences

- Phase 3
    - Identify gaps in groups who have yet to be vaccinated
    - Target local communication strategies to select demographics based on available data

Environmental Scan

The North Bay Parry Sound District Health Unit has conducted an environmental scan to determine the communication opportunities within the Health Unit's district. Utilizing the phased approach by the province, local testing and positivity data, communication tools have been identified to reach audiences within each phase of the COVID-19 vaccine rollout. The Health Unit has identified the need to have an increased focus on vaccine hesitancy for all phases of the rollout.

Accountability and Transparency

The North Bay Parry Sound District Health Unit is committed to keeping the public updated on the COVID-19 vaccine rollout throughout the district. Communication updates are shared on an ongoing basis through different communication mediums, to ensure that the public has the opportunity to know exactly what phase the COVID-19 rollout is locally. The Health Unit will provide local data on the COVID-19 vaccine on their website, when it becomes available.

The Health Unit's call centre allows the public and community partners the opportunity to connect with Health Unit staff to address individual questions. Two-way communication is encouraged on the Health Unit's social media channels to help build on the pre-established trust. Utilizing information from the Health Unit's call centre and social media will help determine the gaps of knowledge locally and inform the messaging of communication products and tools throughout the COVID-19 vaccine rollout.

Communications Phased Approach

The North Bay Parry Sound District Health Unit will be rolling out a broad communications campaign to reach identified target audiences throughout the provincial phases. Each phase will have targeted messaging to meet the needs of each audience; key messages will be derived from the provincial communication's messaging. Local data will help to inform gaps of knowledge within the district allowing communications to pivot, as required, to keep messaging informative and reduce the barriers of knowledge within our district.

Pre-vaccine delivery

Key Messages:

- Vaccine Safety
- Vaccine Availability
- Addressing Vaccine Hesitancy

Target Audience:

- General Public
- LTCH
- Hospitals
- Congregate living settings

Communication Activities:

Earned/ Owned

- News Release
- Website
- Social Media

Paid

- None

Vaccine available phase 1

Key Messages:

- Vaccine Safety
- Vaccine Availability
- Addressing Vaccine Hesitancy
- Clinic information

Target Audiences:

- General Public
- LTCH
    - Administration
    - Staff
    - Clients
    - Family
- Hospitals
    - Administration
    - Staff
    - Clients

    - Family
- Congregate living settings
    - Administration
    - Staff
    - Clients
    - Family
- Adult chronic home care recipients

Earned/ Owned

- Virtual Press Conference
- News Releases
- Letters to LTCH, Hospitals and Congregate Living Centres
- Posters to LTCH, Hospitals and Congregate Living Centres
- Website
- Social Media

Paid

- Social Media

Vaccine available phase 2

Key Messages:

- Vaccine Safety
- Vaccine Availability
- Addressing Vaccine Hesitancy
- Clinic information

Target Audience:

- General public
- Essential Workers
- Adults 70 +
    - Individuals
    - Family
- Adults 65-69
    - Individuals
    - Family
- At risk-populations
    - Individuals
    - Service providers

- Adults 16- 64
    - Individuals
    - Parents/guardian

Earned/ Owned

- Virtual Press Conference
- News Releases
- Website
- Social Media
- Posters
- Community Message Road Boards

Paid

- Social Media
- Radio
- Google Ads
- Spotify
- Bus
- Newspapers

Vaccine available phase 3

Utilizing available data, we will target specific under vaccinated populations. This will include looking at specific geographical locations throughout the North Bay Parry Sound District Health Unit district.

Key Messages:

- Vaccine Safety
- Addressing Vaccine Hesitancy
- Clinic information

Target Audience:

- General public
    - Parents
    - Caregivers
    - Vaccine hesitant individuals
    - TBD

Earned/ Owned

- TBD

Paid

- TBD

Documentation and Surveillance

Data collections requirements will be defined by the province and documented utilizing the COVax application / platform. Documentation will occur whenever possible on site however if that is not feasible, a manual process will be utilized and data will be entered into COVax by data entry clerks within 24 hours of completion of a clinic whenever possible.

COVax training was initiated the week of January 18th. Data entry training for designated clerical staff to provide support as required will begin before clinics are initiated.

Initial AEFI training for the new CCM module is currently underway with the Vaccine Preventable Diseases team. A train the trainer approach will be used to augment staffing to ensure an adequate number of staff are available to complete the required documentation within the appropriate timeframe.

Statistical reporting and data analysis will be led by the planning and evaluation team.

Evaluation Framework for the COVID-19 Vaccination Program

Area: Priority populations/Equity

Sub-area: Planning; Communication; Implementation

Evaluation question: How equitable was the immunization campaign?

Evaluation sub-questions	Draft Indicators	Data source(s)
What was the uptake of the vaccine in the priority populations? What were the demographics of priority populations who received the vaccine? Did priority populations receive the vaccine in a timely manner?	• % vaccine uptake estimated among priority populations • % vaccine uptake actual among priority populations • Descriptive statistics of demographic traits of vaccine recipients • Actual date (month) received vaccine versus planned date (month) vaccine administration based on provincial rollout timeframes • Time (days) between dose 1 and dose 2; % alignment with guidelines • % of vaccine recipients that received both doses • % of vaccine recipients that received only one dose	• COVAX-ON • Internal data collection system • Immunization clinic evaluation survey (vaccine recipients)
How effective were strategies to increase vaccine accessibility to priority populations?	• List of known and anticipated barriers to accessing vaccines by priority population • Strategies developed to mitigate barriers identified above • Evaluation metrics of identified strategies (e.g. % accessing booking system, % accessing vaccine clinics by location, % requesting accessibility accommodations (translation, transportation, etc.)	• Consultation with local partners (e.g., social services boards, etc.) • Literature review • Consultations with priority populations • Internal program data/information (e.g., IT, VPD, communications) • Completed Health Equity Assessment Tools

Area: Vaccine uptake in general population

Sub-area: Planning; Communication

Evaluation question: What was the uptake of the vaccine in the general population and what factors influenced and inhibited the uptake of the vaccine?

Evaluation sub-questions	Draft indicators	Data source(s)
What was the population's awareness and knowledge about the vaccine?	• % agreement to being informed of vaccine availability, safety & efficacy prior to receiving vaccine • % aware of vaccine clinic locations and dates • Social media and website analytics for vaccine posts and vaccine webpages	• Immunization clinic evaluation survey (vaccine recipients) • Health Unit Vaccine Distribution Communications Plan
What was the uptake of the vaccine in the general population? Were vaccination coverage targets met? What were the demographics of the general population who took the vaccine?	• Estimated vaccination targets • Actual % vaccinated • Descriptive statistics of demographic traits of vaccine recipients • Actual date (month) received vaccine versus planned date (month) of vaccine administration based on provincial rollout timeframes • Time (days) between dose 1 and dose 2; alignment with guidelines • % of vaccine recipients that received both doses • % of vaccine recipients that received only one dose	• COVAX-ON • Internal data collection system • Immunization clinic evaluation survey (vaccine recipients)
How effective were strategies to increase vaccine accessibility to the general population?	• List of known and anticipated barriers to accessing vaccines • Strategies developed to mitigate barriers identified above • Evaluation metrics of identified strategies (e.g. % accessing booking system, % accessing vaccine clinics by location, % requesting accessibility accommodations (translation, childcare, transportation, etc.)	• Internal data (e.g. call centre, response team, communications, VPD • Consultation with community partners • Literature review • Immunization clinic evaluation survey (vaccine recipients)

Area: Vaccine hesitancy in general population
Sub-area: Planning; Communication
Evaluation question: How was vaccine hesitancy addressed in the general population?

Evaluation sub-questions	Draft indicators	Data source(s)
What factors contributed to vaccine hesitancy in the general population?	• List of prevalent factors contributing to vaccine hesitancy	• Literature review specific to Canada, Ontario, or Northern Ontario (if available) • Internal data (e.g. call centre and response team)
How was vaccine hesitancy mitigated?	• development of key messages • # and type of communications addressing factors contributing to vaccine hesitancy • Specific strategies employed to address vaccine hesitancy (e.g. targeted messaging) • Social media and website analytic metrics on above posts/strategies	• Internal program data/information (e.g., VPD, Communications, Healthy Living) • Health Unit Vaccine Distribution Communications Plan • Consultation with community partners

Area: Vaccine administration at various clinic settings
Sub-area: Planning; Implementation
Evaluation question: What was the effectiveness and efficiency of the vaccine administration process?

Evaluation sub-questions	Draft indicators	Data source(s)
How efficient was the vaccine administration process in clinic settings? (e.g., wait times, timeliness of services)	• Time (days) from booking to vaccination appointment • Time (minutes) spent at vaccination clinic/appointment • % satisfied with wait times • % satisfied with clinic locations	• COVAX-ON • Internal program data/information (e.g. VPD) • Immunization clinic evaluation survey (vaccine recipients) • Post-clinic evaluation for staff and volunteers
How effective was the vaccine administration process in clinic settings?	• % satisfied with organization of clinic • Alignment with planned flow of clinic • Accessibility requirements planned and addressed as required • % satisfied with chain of communications • % satisfied with clinic training • % satisfied with IPAC measures	• Post-clinic evaluation for staff and volunteers • Immunization clinic evaluation survey (vaccine recipients) • Internal planning documents (e.g. HR, IT, Finance)

Area: Inter-jurisdictional collaboration
Sub-area: Planning; Implementation
Evaluation question: What was the effectiveness and efficiency of the inter-jurisdictional collaboration?

Evaluation sub-questions	Draft indicators	Data source(s)
What was the effectiveness and efficiency of the inter-jurisdictional collaboration?	• # of vaccine related news releases, public service announcements and/or bulletins shared • # of vaccine related planning & implementation meetings • # and type of inter-jurisdictional partners engaged in the vaccine rollout planning and implementation process • % of inter-jurisdictional partners invited that actually attended planning and implementation meetings • % of inter-jurisdictional partners satisfied with planning & implementation meetings	• Internal program information (e.g., Communications) • Consultation and ongoing debrief with local and inter-jurisdictional partners

Respectfully prepared and submitted on behalf of the North Bay Parry Sound District Health Unit

January 20th, 2021

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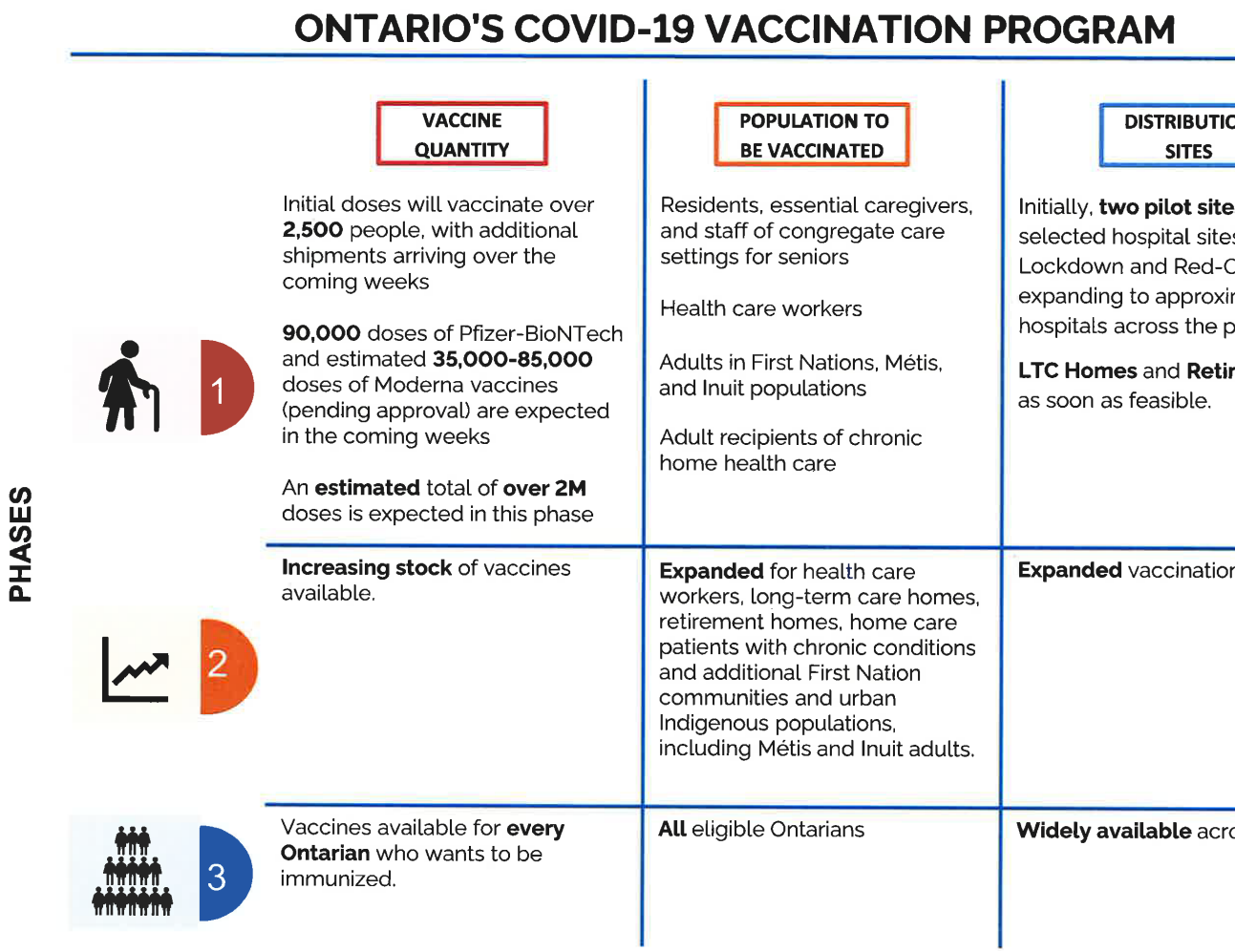
Appendix A


ONTARIO'S COVID-19 VACCINATION PROGRAM
PHASES
VACCINE QUANTITY
POPULATION TO BE VACCINATED
DISTRIBUTIO SITES
1
Initial doses will vaccinate over 2,500 people, with additional shipments arriving over the coming weeks
90,000 doses of Pfizer-BioNTech and estimated 35,000-85,000 doses of Moderna vaccines (pending approval) are expected in the coming weeks
An estimated total of over 2M doses is expected in this phase
Residents, essential caregivers, and staff of congregate care settings for seniors
Health care workers
Adults in First Nations, Métis, and Inuit populations
Adult recipients of chronic home health care
Initially, two pilot site
selected hospital site
Lockdown and Red-C
expanding to approxi
hospitals across the p
LTC Homes and Retir
as soon as feasible.
2
Increasing stock of vaccines available.
Expanded for health care workers, long-term care homes, retirement homes, home care patients with chronic conditions and additional First Nation communities and urban Indigenous populations, including Métis and Inuit adults.
Expanded vaccinatio
3
Vaccines available for every Ontarian who wants to be immunized.
All eligible Ontarians
Widely available acr

Appendix B

Ontario

Ethical Framework for COVID-19 Vaccine Distribution

- Using the ethical principles outlined below to guide COVID-19 vaccine prioritization and distribution decisions and decision-making processes is critical for ethical and effective distribution and will help to promote consistency, stewardship, accountability, and public trust.
- Appreciating that the application of the following principles will to an extent be context-dependent and that other values and principles may be relevant to decision-making, this framework should serve as a guide and be adapted where appropriate.
- All levels of government have a legal obligation to take preventative steps to stop the spread of COVID-19 and treat people without discrimination. Vaccine distribution and prioritization decisions must comply with existing human rights protections and take additional steps necessary to prevent and treat COVID-19 among vulnerable groups. This Ethical Framework therefore should be read in conjunction with the Ontario Human Rights Commission's Policy statement on a human rights-based approach to managing the COVID-19 pandemic.

Minimize harms and maximize benefits	Equity	Fairness	Transparency	Legitimacy
• Reduce overall illness and death related to COVID-19 • Protect those at greatest risk of serious illness and death due to biological, social, geographical, and occupational factors • Protect critical infrastructure • Promote social and economic well-being	• Respect the equal moral status and human rights of all individuals • Distribute vaccines without stigma, bias, or discrimination[1] • Do not create, and actively work to reduce, disparities in illness and death related to COVID-19, including disparities in the social determinants of health linked to risk of illness and death related to COVID-19[2] • Ensure benefits for groups experiencing greater burdens from the COVID-19 pandemic	• Ensure that every individual within an equally prioritized group (and for whom vaccines have been found safe and effective) has an equal opportunity to be vaccinated • Ensure jurisdictional ambiguity does not interfere with vaccine distribution (e.g., Jordan's Principle) [3] • Ensure inclusive, consistent, and culturally safe and appropriate processes of decision-making, implementation, and communications	• Ensure the underlying principles and rationale, decision-making processes, and plans for COVID-19 vaccine prioritization and distribution are clear, understandable, and communicated publicly	• Make decisions based on the best available scientific evidence, shared values, and input from affected parties, including those historically under-represented • Account for feasibility and viability to better ensure decisions have intended impact • To the extent possible given the urgency of vaccine distribution, facilitate the participation of affected parties in the creation and review of decisions and decision-making processes

Public Trust

Ensure decisions and decision-making processes are informed by the above principles to advance relationships of social cohesion and enhance confidence and trust in Ontario's COVID-19 immunization program

Notes:
1. See Ontario's Human Rights Code and specifically Part 1 for *Code*-protected groups
2. Consider applying the Ministry of Health's Health Equity Impact Assessment decision support tool to identify potential health equity impacts
3. See Jordan's Principle

Ontario COVID-19 Vaccine Distribution Task Force - Dec. 29, 2020

Appendix C

Ontario

Ministry of Health

COVID-19: Guidance for Prioritizing Health Care Workers for COVID-19 Vaccination

Version 2.0, February 9, 2021

Highlights of Changes

- Set out more specific sub-prioritization of health care workers
- Further clarification of roles and responsibilities of health sector partners
- Considerations provided for implementation

Key Messages

- Demand for COVID-19 vaccine will initially exceed available supply; prioritization must be set among health care workers.
- Sub-prioritization of health care workers will assist with vaccine delivery to health care workers in parallel with vaccination of other Phase 1 priority populations.
- Health care workers are prioritized based on risk of exposure, patient populations served, and incidence of COVID-19 outbreaks.
- An ethics and equity lens should be applied to all prioritization decision-making.

This guidance provides basic information only. It is not intended to take the place of medical advice, diagnosis or treatment, legal advice or legal requirements.

In the event of any conflict between this guidance document and any applicable emergency orders, or directives issued by the Minister of Health, Minister of Long-Term Care, or the Chief Medical Officer of Health (CMOH), the order or directive prevails.

- Please check the Ministry of Health's (MOH) COVID-19 website regularly for updates to this document, list of symptoms, other guidance documents, directives and other information.

Ontario

Purpose

The purpose of this document is to provide guidance regarding the prioritization of health care workers for vaccination in a manner that balances provincial consistency with regional and local flexibility recognizing the nuance of local and regional contexts and data. Verification and validation of individual prioritization will depend on the processes established by those delivering local vaccination programs.

Health care workers have been identified as a priority group for COVID-19 vaccination in Ontario and in the National Advisory Committee on Immunization (NACI) recommendations.

This guidance complements the prioritization sequence that the Government of Ontario has developed.

In times of limited vaccine supply, the MOH will continue to provide detailed direction on sequencing and targets between designated priority populations.

Because demand for COVID-19 vaccines among Ontario's health care workers will initially exceed available supply, priorities for voluntary vaccination must be set **among** health care workers and will be phased. COVID-19 vaccination is **strongly** recommended for all health care workers but remains voluntary. An employer may choose to create their own policies regarding mandatory staff immunization as a protective measure for residents and patients.

For the purposes of prioritization of vaccine doses, 'health care worker" is defined as:

- Any regulated health professionals and any staff member, contract worker, student/trainee, registered volunteer, or other essential caregiver currently working in a health care organization, including workers that are not providing direct patient care such as cleaning staff, food services staff, information technology staff, security, research staff, and other administrative staff.
- Workers providing a healthcare service or direct patient service in a congregate, residential or community setting outside of a health care organization (e.g., nurse providing patient care in a school, worker performing personal support services in an assisted living facility, medical first responder in the community, peer worker in a shelter).

Ontario

Note that while this definition of 'health care worker' is broad and inclusive, the remainder of this document sets out the phased prioritization of those included within this definition.

Roles and Responsibilities

Role	Responsibilities
Ministry of Health (MOH)	Set priorities, sequencing and targets, support healthcare system in implementation of the vaccine program.
Public Health Unit (PHU)	Lead local vaccination programs working with partners from health and municipal sectors; conducts prioritization in accordance with provincial guidance and direction and in consideration of local context. PHUs should establish committees on prioritization that include diverse views from affected parties and groups to inform local decision-making.
Ontario Health (OH)	Support vaccination program coordination with local health system partners.
Associations, Unions and Colleges	Work with MOH and PHUs to support vaccination of their members. Work with membership to identify workers for prioritization and provide this information to PHUs to support immunization planning. Help to mobilize membership for purposes of vaccination, such as facilitating public health communications with members.

Ontario

Role	Responsibilities
Health Care Organizations (HCOs) and other employers of health care workers	Support and facilitate vaccination operations where requested and develop enabling policies and strategies to support staff to get their immunization. Responsible for prioritizing health care workers and employees within the organization according to the Ministry's health care worker prioritization guidance.
Health Care Workers	Participate in immunization as vaccinators and recipients, counsel patients, address patient concerns and questions, and combat myths.

Approach to Prioritization of Health Care Workers

The goal of this arm of the provincial vaccination program is to vaccinate all eligible and willing health care workers as quickly as possible starting with those at highest risk of exposure to COVID-19 and who are critical to the COVID-19 pandemic response, based on vaccine availability.

A stepwise approach to prioritization has been developed which considers multiple factors including the sectors and settings that people work in, local and community factors as well as individual factors. Each step should be performed in sequence to gradually refine from the broad sector/setting level down to the individual level.

Ontario

Fig. 1 Approach to Prioritization

1. **Prioritize health care sectors and other settings** (MOH)
   - The MOH has outlined priority health sectors and settings based on the following criteria:
     - Occupational risk of exposure to COVID-19.
     - Highest likelihood of COVID-19 acquisition among healthcare workers based on outbreak data.
     - Risk of severe disease and outcomes from COVID-19 among patient population served.
     - Criticality of the health care sector:
       - Those who provide critical services during the pandemic by caring for patients with and without COVID-19 infection.
       - This key criterion aims to protect health care human resources by prioritizing workers who cannot work remotely or virtually and who work in areas with limited or reduced capacity, little or no redundancy, and are essential to health system capacity.

Ontario

2. Sub-prioritize settings and sectors at the community level (performed by PHU)

- Within defined priority levels of health care sectors and settings (see page 8) PHUs will begin vaccinating first those practicing in communities with a high-prevalence of COVID-19 (e.g., racialized communities), or at high risk of severe outcomes from COVID-19 infection or at increased risk due to structural and socio-economic factors as well as local staffing criticality .
- Potential data sources to support PHU decision making include:
  - Ministry reports and publications on high priority communities.
  - Available provincial data on exposure, risk and equity.
  - Internal PHU data (e.g., case and contact management/outbreak information).
  - Institute for Clinical Evaluative Sciences (IC/ES) information on high-risk neighbourhoods.

3. Prioritize among workers (performed by local partners[1] including associations, unions and colleges in collaboration with the PHU)

- **Prioritizing among workers may not be required in all situations. This step should only be completed when further prioritization is required within the sectors and settings as part of steps 1 and 2 due to limited vaccine supply, and where operationally feasible.**
- Among sectors and settings in priority communities, PHUs support local vaccine delivery sites/institutions/sectors/employers, in identifying priority workers within each sector if needed.
- Where feasible, prioritization among workers should use a risk matrix considering exposure risk, patient population's risk and criticality of the worker's role and responsibilities and, where demand continues to exceed available supply, individual risk for severe disease and outcomes (see Appendix).
- Where feasibility does not allow for the use of a risk matrix, prioritization at this step should consider:

[1] The extent of involvement in this work will be informed by the vaccination model within PHUs and communities. For example, where a health care organization is delivering vaccines, they will be involved in this prioritization process.

Ontario

- Those who provide direct and more frequent or sustained care, or whose presence in those environments is more direct, frequent, or sustained (versus those in non-patient facing, administrative roles and health care workers who can work from home/remotely); and
- Those who are ≥60 years old[2] or who, based on voluntary self-report, consider themselves to be at higher risk due to biological, social, or geographical factors.

- Health care workers who are working entirely from home/remotely should be considered the lowest risk health care workers and are a lower priority for vaccine.
  - Note: When considering prioritization of workers who are working from home/remotely, consideration should be given to whether vaccination of that worker would lead to a resumption in providing in-person medical services, thereby increasing health service availability.

Priority Health Sectors and Workers

Health care workers have been identified as a priority population for Phase 1 of Ontario's vaccination program.

The following levels of priority (Highest, Very High, High, Moderate) have been identified by the MOH and should be used to sub-prioritize health care workers.

There may be overlap between the priority levels, and efforts should be made to follow the sequencing and provincial direction as closely as possible starting with individuals who fall into the Highest Priority level. All efforts should be made to vaccinate all those in the Highest Priority level before moving on to the next level, and so on. PHUs should inform the province when a priority level is nearing completion and should not proceed to begin vaccinating the next priority level until directed by the province.

The levels assume workers who are actively in their roles at the time of planned or anticipated vaccination. Workers that have been redeployed should be assessed based on their place of work or role at the time of planned or anticipated vaccination.

[2] As per PHAC recommendations that populations over 60 years of age are at risk for more severe disease or outcomes

These levels have been developed in consideration of settings where different groups work, the risk of exposure to COVID-19, and the patient populations served.

Highest Priority

Sectors and Settings[3] [4]

Frontline health care workers in the following sectors and settings (including custodial, reception, and other staff):

- **All hospital and acute care staff in frontline roles with COVID-19 patients and/or with a high-risk of exposure to COVID-19, including those performing aerosol-generating procedures:**
  - Critical Care Units
  - Emergency Departments and Urgent Care Departments
  - COVID-19 Medical Units
  - Code Blue Teams, rapid response teams
  - General internal medicine and other specialists involved in the direct care of COVID-19 positive patients
- **All patient-facing health care workers involved in the COVID-19 response:**
  - COVID-19 Specimen Collection Centers (e.g., Assessment centers, community COVID-19 testing locations)
  - Teams supporting outbreak response (e.g., IPAC teams supporting outbreak management, inspectors in the patient environment, redeployed health care workers supporting outbreaks or staffing crisis in congregate living settings)
  - COVID-19 vaccine clinics and mobile immunization teams
  - Mobile Testing Teams

[3] In alignment with the definition of Health Care Worker that has been provided, where a health sector has been named in the priority sector, all workers in that sector are included (e.g., including custodial, security and reception staff). Where a non-health setting has been named, only workers providing a health service or direct patient care are included.

[4] Sectors may be amended based on new evidence of exposure risk

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- COVID-19 Isolation Centers
- COVID-19 Laboratory Services

- **Medical First Responders** (ORNGE, paramedics, firefighters providing medical first response).
- **Community health care workers serving specialized populations including:**
  - Needle exchange/syringe programs & supervised consumption and treatment services
  - Aboriginal Health Access Centers, Indigenous Community Health Centers, Indigenous Interprofessional Primary Care Teams, and Indigenous Nurse Practitioner-Led Clinics
  - Special considerations for the following:
    - Community Health Centers serving disproportionally affected communities and/or communities experiencing highest burden of health, social and economic impacts from COVID-19
    - Highly critical health care workers in remote and hard to access communities, e.g., sole practitioner
  - Home and community care health care workers caring for recipients of chronic homecare and seniors in congregate living facilities[5] or providing hands-on care to COVID-19 patients in the community

Rationale

- Provide direct, in-person patient care to patients at highest likelihood of being COVID-19 positive or work in environments with high in-person exposure to these patients (e.g., cleaner in critical care unit).
- Hospitals are the largest source of case acquisition among health care workers and outbreak associated patient deaths outside of long-term care homes and retirement homes[6].
- Ensure vital pandemic response services are protected and maintained.

[5] Consider a programmatic vaccination approach for home care workers caring for patients who are in Phase 1 populations (see Implementation considerations, page 14)
[6] As per Provincial Case and Contact Management System

Ontario

- Specialized patient populations at highest risk of negative outcomes if they contract COVID-19.
- Most critical health care workers to COVID-19 response and to highly vulnerable communities.

Very High Priority

Sectors and Settings[7] [8]

Frontline health care workers in the following sectors and settings:

- **Acute care and other hospital settings** (patient care areas not included in Highest Priority (e.g., surgical care, obstetrics, etc.)).
- **Congregate settings**[9] (assisted living, correctional settings, residential facilities, hospices and palliative care settings, shelters, supportive housing (outside of Highest Priority level)).
- **Community care with high risk of exposure and serving specialized patient populations** (Community Health Centers, Home and community care (outside of the Highest Priority level), Adult day programs for seniors).
- **Other health care services for Indigenous populations** (Community agencies with patient-facing providers delivering any type of health services to First Nations communities and Indigenous Peoples that are not captured in Highest Priority).
- **Community care with high risk of exposure and serving the general population** (Birth centres, Community Based Specialists, Death investigation professionals, Dentistry, Gynecology/obstetrics, Midwifery, Nurse practitioner-led clinics / contract nursing agencies, Otolaryngology (ENT), Pharmacies, Primary care, Respirology (Respiratory Therapy), Walk-in clinics,).
- **Laboratory services**

[7] In alignment with the definition of Health Care Worker that has been provided, where a health sector has been named in the priority sector, all workers in that sector are included (e.g., including custodial, security and reception staff). Where a non-health setting has been named, only workers providing a health service or direct patient care are included.

[8] Sectors may be amended based on new evidence of exposure risk

[9] Consider a programmatic vaccination approach (see Implementation considerations, page 14)

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Rationale

- Generally, provide more direct, in person patient care
- Generally, higher level of urgency and criticality, services that cannot be delayed or deferred.
- Generally higher likelihood of engaging in higher exposure risk procedures.
- Unable to work virtually or remotely.
- Specialized patient populations at high risk of negative outcomes if they contract COVID-19.
- Interactions with patients/clients with less access to PPE.
- High criticality to health system.

High Priority

Sectors and Settings[10] [11]

Frontline health care workers in the following settings and sectors:

- **Community care with lower risk of exposure and serving special populations**[12] (developmental services, mental health and addictions services).
- **Community care with lower risk of exposure and serving general population**[13] **(**Campus health, Community diagnostic imaging, Daycare/school nursing, Dietary / nutrition, Independent health facilities (e.g., Opticians/Optometry, Podiatry, Audiology, medical and surgical specialties), Naturopathy / Holistic care, Social work, Sexual health clinics).

[10] In alignment with the definition of Health Care Worker that has been provided, where a health sector has been named in the priority sector, all workers in that sector are included (e.g., including custodial, security and reception staff). Where a non-health setting has been named, only workers providing a health service or direct patient care are included.

[11] Sectors may be amended based on new evidence of exposure risk
[12] Excludes services provided to home care clients captured under home and community care services in priority levels above.
[13] Excludes services provided to home care clients captured under home and community care services in priority levels above

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- **Non-acute rehabilitation and therapy**[14] (Chiropractic, Chronic pain clinics, Kinesiology, Occupational therapy, Physiotherapy, Psychiatry, Psychology, Psychotherapy, Registered massage therapy / Acupuncture, Other therapy).
- **Public health** (all other public health).

Rationale

- Generally lower risk of exposure relative to highest and high priorities.
- Generally less urgent care, services that can be delayed/ deferred relative to highest and high priorities.
- Unable to fully work virtually or remotely.

Moderate Priority

Sectors and Settings[15] [16]

Non-Frontline health care workers (e.g., those working remotely and who do not require PPE to work).

Rationale

- Services that can be provided remotely/virtually or within non patient facing areas of health care facilities.

[14] Excludes services provided to home care clients captured under home and community care services in priority levels above

[15] In alignment with the definition of Health Care Worker that has been provided, where a health sector has been named in the priority sector, all workers in that sector are included (e.g., including custodial, security and reception staff). Where a non-health setting has been named, only workers providing a health service or direct patient care are included.

[16] Sectors may be amended based on new evidence of exposure risk

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Additional Considerations

Equity and Fairness

- Use the province's Ethical Framework for COVID-19 Vaccine Distribution to guide all priority setting decisions and decision-making processes.
- Consider applying a Health Equity Impact Assessment in all decision-making processes regarding prioritization.
- **Do not prioritize based on seniority or rank**.

Allocation among and within equally prioritized sectors and groups

- Multiple sectors, settings, communities, and workers may be equally prioritized, but demand may still exceed vaccine supply.
- If there is insufficient supply to vaccinate all workers in equally prioritized sectors or settings identified in Step 1 or equally prioritized communities identified in Step 2, vaccine doses should be allocated in proportion to the size of the health care worker population in each sector, setting, or community.
- If demand exceeds vaccine supply following Step 3 (prioritization of individual workers), random allocation (e.g., via a random number generator) should be employed to ensure fair allocation to individuals within equally prioritized groups.
- When individuals are randomized for vaccination, safeguards should be in place to ensure the integrity and fairness of the randomization process. Randomization should be done through a valid tool to ensure that the results cannot be predicted or influenced, and it should occur independently of those who are eligible to receive the vaccine in the random allocation. The process and outcomes of randomization should be clearly documented and made transparent to all those affected.

Implementation

- The vaccination of health care workers must follow provincial direction and progression through priority levels must be according to provincial direction.
- PHUs should work with local partners, for example through a local prioritization committee, to use the best available local, regional, and provincial data to assist in prioritization, if required. In particular, use available data and engage with local

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partners regarding local populations served and settings affected by COVID-19 to assist in prioritization.

- Ensure that vaccine recipients will be able to return to receive their second dose within the required vaccination interval.
- Where possible, programmatic vaccination and strategic grouping of same-priority populations across different population groups should be pursued to maximize efficiency of vaccine delivery (e.g., programmatic vaccination of adult recipients of chronic home care and home care workers working with these patients).
- As part of a waste-minimizing strategy for last-minute cancellations, 'no-show' appointments and remaining end-of-day doses, vaccine clinics should prepare a list of stand-by alternate recipients for vaccination that may be called at short-notice.
    - Vaccine clinics should consult with the PHU on their approach in developing this list.
    - The individuals on the list should be within the same or next priority level as those currently being vaccinated, for example individuals with scheduled appointments later in the week, or who are next in line for scheduling appointments.
    - This list should be prepared in alignment with the principles of the Ethical Framework.

Relative Sequencing with Other Priority Populations

- The sequencing of health care worker vaccination relative to other priority populations must follow provincial direction.
- In a supply-limited environment, provincial direction on sequencing among priority sub-population will be more specific and may be linked to vaccination targets and directives.

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Examples

The following case examples are hypothetical situations provided to demonstrate how the prioritization guidance could be applied. They are provided for illustrative purposes only and do not necessarily reflect the assessment of all workers in the roles and settings described.

PHUs, Health care organizations, associations, unions, and regulatory colleges who are undertaking prioritization of workers should consider the following questions.

If an individual does not meet the definition for 'health care worker' as described on page 2, they are not currently eligible for prioritization under the health care worker category (see case example #4 below), but may eligible under other priority populations and as such could be considered for a programmatic vaccination approach.

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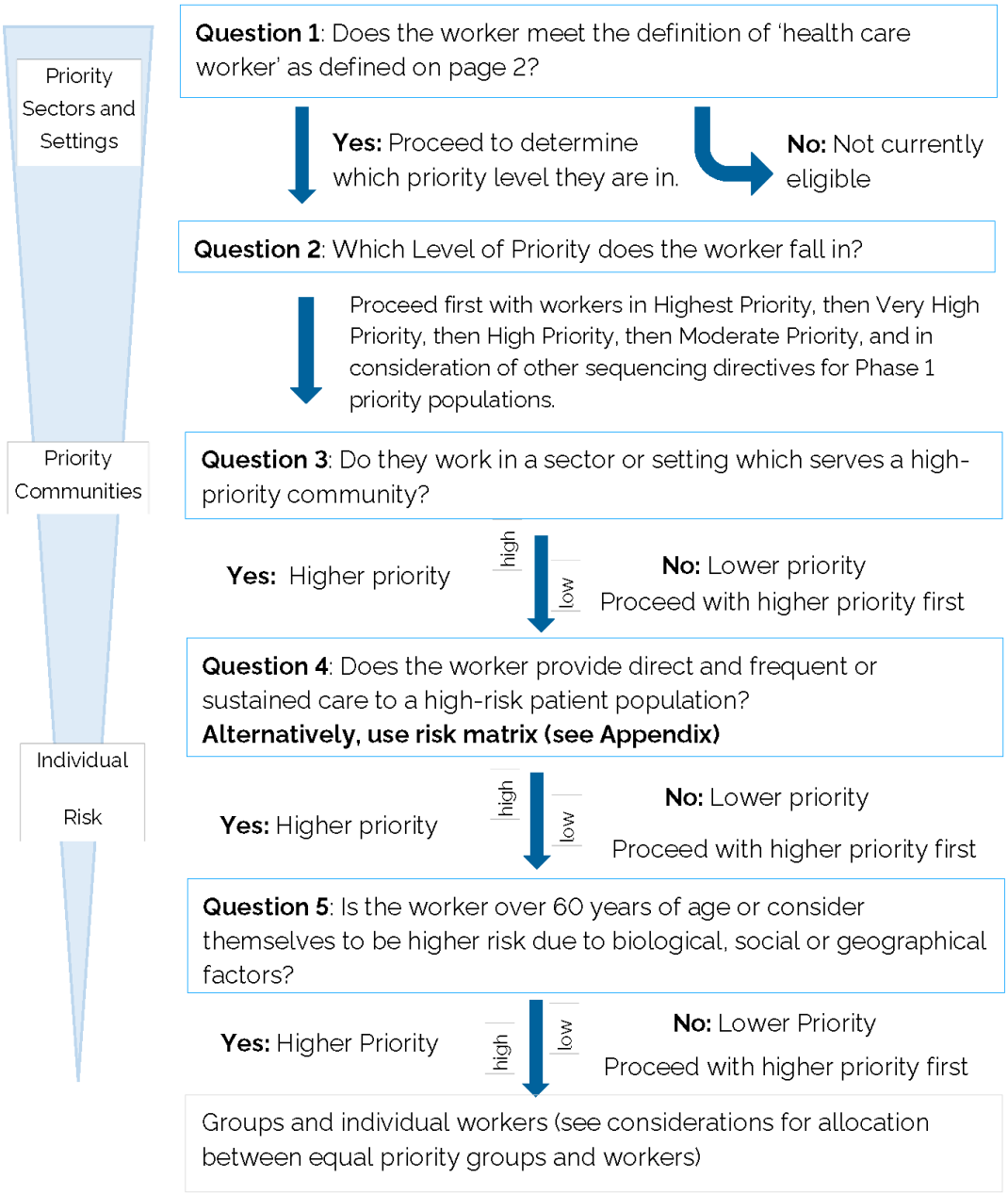
Fig. 2: Prioritization Decision-Making Tree



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Case Example #1: A 61-year-old community health care worker at a community health center who self-reported no individual risk factors and works in a high-prevalence neighbourhood where residents are disproportionately at risk for severe outcomes of COVID-19.

The PHU has identified all sectors and settings within its catchment area that fall within the Highest Priority level and has approached the organizations and employers in these sectors and settings to identify eligible workers who meet the definition of health care worker and are frontline workers so that they may be booked at a local vaccine clinic.

Question 1: Does the worker meet the definition of health care worker?

- ✓ Worker meets definition of 'health care worker' as defined on page 2.

Question 2: What Level of Priority does the sector or setting fall under?

- ✓ Community health center in a high-prevalence neighbourhood where residents are disproportionately at risk for severe outcomes of COVID-19 is a setting identified in the Highest Priority Level.

Question 3: Does the worker provide care in a high-priority community?

The community has been identified as a high-priority community based on local epidemiology and consideration of structural factors and determinants of health.

Question 4 (or use Risk Matrix): Does the worker provide direct and frequent or sustained patient care to a high risk patient population?

The Health Care Organization has assessed:

- ✓ Frequent interactions with vulnerable patient populations with high burden of illness.
- ✓ Unable to work virtually.
- ✓ Plays critical role in maintaining local health system and in pandemic response.
- ✓ Moderate redundancy among community health care providers and other specialities.
- ✓ Patient population is at high risk for severe outcomes of COVID-19.

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Question 5: Is the worker over 60 years of age or consider themselves to be at higher risk?

- ✓ Worker is aged 60 years or above.
- × Worker self-reported no additional risk factors relating to biological, social or geographical risks.

Result: This worker would be considered in the Highest Priority for vaccine due to being a frontline worker in a Highest Priority setting. In a period of limited vaccine supply, the health unit could further prioritize this worker according to the fact of serving a high risk community. If further prioritization is needed, the health unit would consider the HCO's assessment that the worker provides direct and frequent or sustained patient care to a high risk patient population and is ≥60 years old.

Case Example #2: A 42-year-old optometrist in independent practice who provides services to a diverse patient group in a community moderately impacted by the determinants of health is considered for vaccination.

The PHU has worked with the regulatory college (College of Optometrists of Ontario) and the professional association (Ontario Association of Optometrists) to inform the prioritization of optometrists in independent practice, to obtain information about the location of their businesses and facilitate communication with these workers.

Question 1: Does the worker meet the definition of health care worker?

- ✓ Worker meets definition of 'health care worker' as defined on page 2.

Question 2: What Level of Priority does the sector or setting fall under?

- ✓ Independent optometry practice would fall under the High Priority level.

Question 3: Does the worker provide care in a high-priority community?

- ✓ PHU has designated the community as a moderate priority based on local data, epidemiology and consideration of structural factors and determinants of health.

Question 4: Does the worker provide direct and frequent or sustained patient care to a high-risk patient population?

(Risk matrix not required/feasible as PHU has limited capacity to apply it to populations served by the vaccine clinic. Alternately the regulatory college and professional association may provide a general assessment of the risk of this profession based on the characteristics of professional practice).

- ✓ Frequent close contact with patients.
- ✓ Able to perform some work virtually and patients likely to have access to technology, but all urgent care provided in person.
- ✓ Supports local health system.
- × Redundancy among optometrists.

Question 5: Is the worker over 60 years of age or consider themselves to be at higher risk?

- × Worker is not in a high-risk category due to age.

Voluntary self-report of risk factors relating to biological, social or geographical risk if available could add additional considerations for individual risk.

Result: This worker should be considered in the High Priority level for prioritization and would be contacted for an appointment at a vaccine clinic when it is the turn for High Priority health care workers to be vaccinated. If further prioritization is needed within this level, the worker would be placed in a moderate category, recognizing the patient community are a moderate priority community If further prioritization is needed due to limited vaccine supply, the worker's moderate level of individual risk would be considered.

Case Example #3: A PHU has designated an allocation of vaccines to a local hospital to run a vaccine clinic on-site for its workers in frontline roles with COVID-19 patients and/or with a high-risk of exposure to COVID-19, including those performing aerosol-generating procedures. The hospital is determining vaccination priority among workers at the hospital and is considering the prioritization of custodial staff in the hospital's COVID-19 Assessment Center.

Question 1: Does the worker meet the definition of health care worker?

- ✓ Worker group meets definition of 'health care worker' as defined on page 2.

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Question 2: What Level of Priority does the sector or setting fall under?

- ✓ All frontline staff in a COVID-19 Specimen Collection Center such as COVID-19 Assessment Centers, are in the Highest Priority**.**

Question 3: Does the worker provide care in a high-priority community?

- ✓ The PHU has already identified the hospital's community as a high priority.

Question 4: Hospital uses risk matrix instead of question 3 given hospital's capacity to apply it to its workforce (see below).

Patient population/exposure risk		Risk of exposure to SARS-CoV-2 within a health care setting based on worker role/responsibility		
		Low Risk	Moderate Risk	High Risk
Risk of severe disease or outcomes from COVID-19 among patient population served	Low Risk	1	2	3
	Moderate Risk	2	3	4
	High Risk	3	4	5

Rationale:

- Patient population (Moderate risk): Patient population will have varying risk of severe disease or outcomes from COVID-19.
- Exposure risk (High): highly likely to have interactions with potentially COVID-19positive patients, while wearing appropriate PPE, unable to work virtually.

Criticality		Existing health system capacity and redundancy		
		High	Moderate	Low
Essentiality to critical health system capacity	Low	0	.25	.50
	Moderate	.25	.50	1
	High	.50	1	2

Rationale:

- Essentiality (High): Plays critical role in maintaining local health system.
- Redundancy (Moderate): Some redundancy in role.

Key Prioritization Consideration	Score
Patient population/exposure risk	4/5
Criticality	1/2
Total	**5/7**

Question 5: Is the worker over 60 years of age or consider themselves to be at higher risk?

Consider any individual risk factors when prioritizing individual custodial staff (≥60 years old or those who, based on voluntary self-report, consider themselves to be at higher risk due to biological, social, or geographical factors).

Result: This group of custodial staff should be considered Highest Priority for vaccine due to criticality of work performed, and a High amount of exposure to potentially COVID-19 positive patients.

Within all those in this level, where further prioritization is needed due to limited supply of vaccine, consideration of age and whether there has been a voluntary self-report of high risk due to biological, social or geographic factors identifies priority individuals.

Case Example #4: A PHU is determining priority for vaccination at a vaccine clinic and considering food preparation volunteers in shelters.

Question 1: Does the worker meet the definition of health care worker?

× Workers do not meet the definition of 'health care worker' that would be applicable in a non-health setting, as per the definition on page 2.

Result: They are not to be considered in the health care worker prioritization, however may be considered as part of other priority populations.

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Appendix: Risk Matrix

Exposure risk*/patient population		Risk of exposure to SARS-CoV-2 within a health care setting based on worker role/responsibility		
		Low Risk	Moderate Risk	High Risk
Risk of severe disease or outcomes from COVID-19 among patient Population served [17]	Low Risk	1	2	3
	Moderate Risk	2	3	4
	High Risk	3	4	5

*Consider those who provide direct and more frequent or sustained care, or whose presence in such environments is more direct, frequent, or sustained, in addition to those with more limited access to PPE.

Criticality*		Existing health system capacity and redundancy		
		High	Moderate	Low
Essentiality to critical health system capacity	Low	0	.25	.5 0
	Moderate	.25	.50	1
	High	.50	1	2

*Consider those who cannot work remotely or virtually and who work in areas with limited or reduced capacity as well as little or no redundancy.

Key Prioritization Consideration	**Score**
Patient population exposure risk	/5
Criticality	/2
Total	**/7**

[17] See People who are at risk of more severe disease or outcomes from COVID-19

Appendix D

North Bay Parry Sound District Health Unit

Bureau de santé du district de North Bay-Parry Sound

North Bay Parry Sound District Health Unit

Emergency Management Plan

Original Approved: 2010/05/21

Updated: 2019/01/11

Version 3.0

Prepared By: Greg Rochon – Manager, Emergency Management

Table of Contents

Record of Amendments

Version Number [1]	Summary of Amendment (Title of Section/Annex/Appendix/Page Number)	Date (yyyy/mm/dd)	Amended By (Name / Position)	Approved By (Name / Position)
1.1	Appendices Title Page, Page 211	2010/07/21	Greg Rochon, EP Manager	Greg Rochon
1.2	Staffing Plan, Page 51	2010/07/22	Greg Rochon, EP Manager	Greg Rochon
1.3	Level 4 – Demobilization, Page 37	2010/09/22	Greg Rochon, EP	Greg Rochon
1.4	Planning Section Chief JAS, Page 88	2010/11/08	Greg Rochon, EP	Greg Rochon
1.5	Operations Section Chief JAS, Page 78	2010/11/08	Greg Rochon, EP	Greg Rochon
1.6	Colors added to phases of emergency operations, Page 28, 30, 32, 34, 36, 38	2010/11/26	Greg Rochon, EP	Greg Rochon
1.7	Colors added to EOC Activation Levels, Page 48, 49	2010/11/26	Greg Rochon, EP	Greg Rochon
1.8	Removal of incomplete documents	2011/01/25	Greg Rochon, EP	Greg Rochon
1.9	EMO Contacts revised, Page 174	2011/03/14	Greg Rochon, EP	Greg Rochon
1.10	Appendices Title Page, Page 199. Remove CEMC contact, insert link to CEMC contact list, remove HIRA, insert link in appendix to HIRA	2011/04/28	Greg Rochon, EP	Greg Rochon
1.11	Addition of 211-B EOC Check-in List, Page 175	2011/05/16	Greg Rochon, EP	Greg Rochon

[1] Version number increases with each new amendment

1.12	Information Officer Job Action Sheet, Page 62-65	2011/06/24	Greg Rochon, EP	Greg Rochon
1.13	Concept of Operations, Page 38; Operational Period, Page 42; Public Health Emergency Control Group, Page 42; Roles and Responsibilities Overview, Page 43; emergency operations Centre, Page 48	2011/07/05	Greg Rochon, EP	Greg Rochon
1.14	Corrected F/A Unit Leader title on JAS, Page 56, 144, 147, 150. Corrected link to JAS.	2011/08/12	Greg Rochon, EP	Greg Rochon
1.15	Link to Emergency Communications Plan added, Page 209	2011/08/15	Greg Rochon, EP	Greg Rochon
1.16	Added Annex B.3 EOC Activation Checklists and Annex B.4 Standard Operating Procedures (SOPs), Page 160 - 165	2011/11/07	Greg Rochon, EP	Greg Rochon
1.17	Organizational structure color alignment with provincial IMS; pages 28, 30, 32, 34, 36, 190, 197. Format Notification Procedure; page 168.	2012/01/05	Greg Rochon, EP	Greg Rochon
1.18	Addition of completed CDC (Pages 78-80) and EH (Pages 85-86) Branch Director	2012/01/05	Greg Rochon, EP	Greg Rochon
1.19	Addition VPD Branch Director Job Action Sheet, Page 81-82.	2012/02/01	Greg Rochon, EP	Greg Rochon
1.20	Inserted VPD, CDC and EH link to JAS on page 55. Change link for PHUs on page 177.	2012/06/13	Greg Rochon, EP	Greg Rochon
1.21	Revised Parry Sound EMO Field Officer contact info. Page 176.	2012/11/21	Greg Rochon, EP	Greg Rochon
1.22	Revised 1.5 Plan Activation criteria. Bullets #1 and 2. Page 22.	2013/02/08	Greg Rochon, EP	Greg Rochon
1.23	Pages 14-17, added dates to legislation titles Page 26, updated bullets for conditions of activation Page 29, formatting Page 33, spelling and grammar Page 37, spelling, grammar	2013/02/14	Greg Rochon, EP	Greg Rochon
1.24	Section 4 and 5 formatting, spelling, grammar	2013/04/10	Greg	Greg

			Rochon, EP	Rochon
1.25	Burk's Falls analog phone number, Page 50	2013/05/24	Greg Rochon, EP	Greg Rochon
2.0	Review and revision completed.	2013/05/24	Greg Rochon, EP	Greg Rochon
2.1	Spelling, punctuation and clarification of various aspects of the basic plan, Page 1-55.	2013/06/11	Greg Rochon, EP	Greg Rochon
2.2	1. A public health situation occurs wherein the coordinated efforts of all or most of the Health Unit's staff and resources are needed; 2. A public health situation occurs wherein staff is/are asked to perform duties outside of their regular role; Page 23 3.Plan Relationship – Internal, Page 25 4.Organization Chart, Page 29, 31, 33, 35, 37 5.annex E.3 – 201 Incident Briefing Form, Organization Chart, Page 194 6. Annex E.6 – 207 Organization Chart, Page 201 7. Annex E.(- 214 Operational Log, added "knowledge" column, Page 214 8. Appendices hyperlink clean up	2013/11/26	Greg Rochon, EP	Greg Rochon
2.3	Arranged Job Action Sheets in appropriate order to reflect revised IMS org chart. Moved IT/IS Unit Leader to Page 142. Moved HR Unit Leader to Page 115.	2013/12/03	Greg Rochon, EP	Greg Rochon
2.4	Changed name of EMO to OFM&EM, page 23 Update OFMEM field officer contact info, page 177	2014/02/24	Greg Rochon, EP	Greg Rochon
2.5	Section 1.5 Plan Activation, added Incident Assessment process. Page 23. IMS organization chart, page 41.	2014/02/25	Greg Rochon, EP	Greg Rochon
2.6	Emergency Preparedness Committee review. Minor changes to section 1 through 5.	2015/09/01	Greg Rochon, EP	Greg Rochon
2.7	Revised designated roles on org chart.	2016/01/05	Greg Rochon, EM	Greg Rochon
2.8	Revised hyperlinks to appendices. Removed the link to the HIRA.	2016/11/10	Greg Rochon, EM	Greg Rochon

2.9	Revised MOHLTC Population and Public Health division on-call manager contact information	2017/03/21	Greg Rochon, EM	Greg Rochon
3.0	Review org chart, plan relationship internal	2019/01/11	Greg Rochon, EM	Greg Rochon

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July 26 2011	Sheri Hueston - EOC	Hand Delivered
June 13, 2012	Office of the Medical Officer of Health (MAAs)	Hand Delivered

External Distribution

Date	Person	Method of Distribution

NOTE: The master copy of the North Bay Parry Sound District Health Unit Emergency Management Plan resides in the NBPSDHU EOC.

Section 1: General

1.1 Aim

This plan has been prepared to provide North Bay Parry Sound District Health Unit (NBPSDHU) Executive, Management and Staff with a guideline for emergency response. This plan operates in conjunction with a number of local and provincial response plans encompassing the various responsibilities **for mission critical, essential business functions, priority public services, and priority business functions.** The NBPSDHU Emergency Management Plan is intended to cover all aspects and events where there is consequence management required for any emergency that has, or may, affect the capabilities of the NBPSDHU.

1.2 Scope

The plan will assist the affected NBPSDHU programs and services (and partners) in meeting the responsibilities set out in legislation and standards. Programs and services have the responsibility to provide the health promotion, prevention, diagnostic, treatment, supplies, equipment and care that the regulations require it to provide. Programs and services have the responsibility to resume regular functions within a reasonable time frame in a manner expected by the public. The Emergency Operations Center (EOC) has the responsibility to provide direction for the emergency operation.

The NBPSDHU Emergency Operations Centre (NBPSDHU EOC) has a responsibility to provide direction, advice and to coordinate provision of exceptional resources to institutions, health agents and others, and to ensure intra-district cooperation when the situation warrants the NBPSDHU EOC activation.

NBPSDHU is responsible for the implementation of public health control measures to limit the spread of disease.

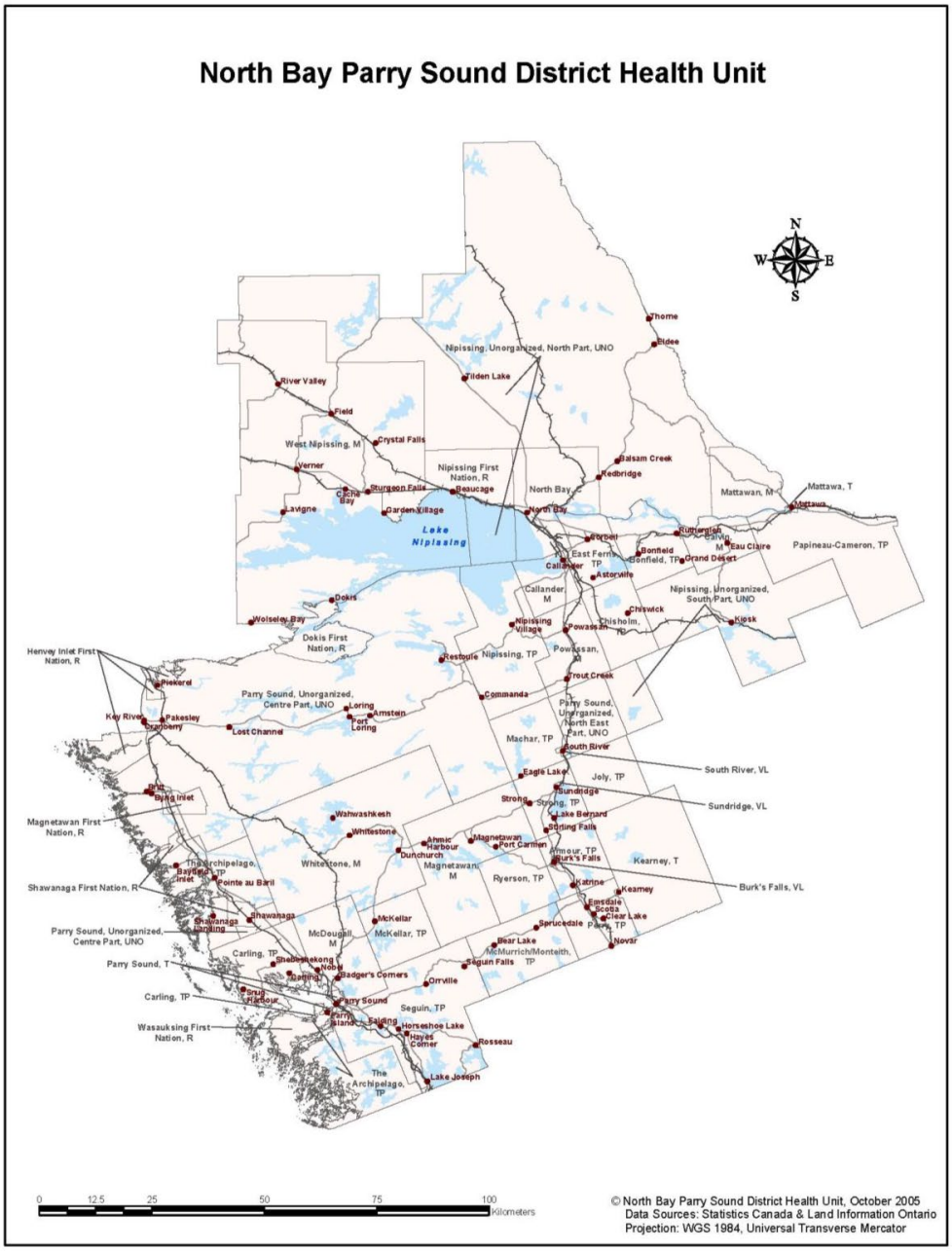
NBPSDHU has a responsibility to provide information on a regional basis to protect public health and safety.

NBPSDHU is responsible for ensuring that all functions are restored sufficiently for health unit programs/services to resume business in the following order of priority:

1. Mission Critical Public Services – without the service, **people** are at risk.
2. Essential Business Functions – critical **leadership** and decision-making functions.
3. Priority Public Services – consequence management function related to **public safety.**
4. Priority Business Functions – primary business support functions such as **payments**.

Geographic Scope

Refer to Board of Health Policy # B-G-001 for full description.



1.3 Authority

1.3.1 Health Protection and Promotion Act, 2014

http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_04p03_e.htm

The Health Protection and Promotion Act (HPPA), Revised Statutes of Ontario, 1990 (c.H.7) provides legal authority for the Board of Health to ensure the maintenance of sanitation, elimination of health hazards and control of infectious diseases.

The Act allows the Medical Officer of Health (MOH), or alternate, to take any actions necessary to respond to a health emergency, but is not always a situation which would require a municipality to declare a formal emergency.

Section 13

Under Section 13, the MOH or a public health inspector (PHI) is granted the authority to require, by a written order, a person and or groups of persons to take or refrain from taking any action which is determined by the MOH or public health inspector to be a health hazard.

Section 22

The MOH has the authority to issue an order to a person or groups of persons under Section 22 of the Health Protection and Promotion Act with respect to a communicable disease, if "he or she is of the opinion (upon reasonable and probable grounds) that a communicable disease exists or may exist, or that there is an immediate risk of an outbreak of a communicable disease in the health unit served by the Medical Officer of Health."

Section 35

If a person fails to comply with an order by the MOH in respect to a virulent disease (e.g. SARS, Tuberculosis, Smallpox, Syphilis), then a judge of the Ontario Court of Justice may make an order for isolation, examination, treatment, or for the person to be placed under care. Section 72

Section 72 (b) requires municipalities in a health unit to pay "the expenses incurred by or on behalf of the Medical Officer of Health of the Board of Health in the performance of his or her functions and duties under this or any other Act".

Section 102

Allows the MOH or PHI to apply to a judge of the Superior Court of Justice for the restraining of a person contravening an order made under the Act.

1.3.2 Ontario Public Health Standards, 2008

http://www.health.gov.on.ca/english/providers/program/pubhealth/oph_standards/ophs/ophsprotocols.html

Section 5 of the HPPA specifies that boards of health must provide or ensure the provision of a minimum level of public health programs and services in specified areas as follows:

- Community sanitation and the prevention or elimination of health hazards;
- Provision of safe drinking water by small drinking water systems;
- Control of infectious and reportable disease, including providing immunization services to children and adults;
- Health promotion, health protection, and disease and injury prevention;
- Family health;
- Collection and analysis of epidemiologic data;
- Such additional health programs and services as prescribed by regulations; and

Section 7 of the HPPA grants authority to the Minister of Health and Long-Term Care to "publish guidelines for the provision of mandatory health programs and services, and every board of health shall comply with the published guidelines" (R.S.O. 1990, c. H.7, s.7(1)), thereby establishing the legal authority for the Ontario Public Health Standards (OPHS).

Where there is a reference to the HPPA within the OPHS, the reference is deemed to include the HPPA and its regulations.

Boards of health may deliver additional programs and services in response to local needs identified within their communities, as acknowledged in Section 9 of the HPPA.

Furthermore, boards of health should bear in mind that in keeping with the French Language Services Act, services in French should be made available to French-speaking Ontarians located in designated areas.

Boards of health need to be knowledgeable about their duties and responsibilities as specified in other applicable Ontario laws, including but not limited to, the Building Code Act, the Day Nurseries Act, the Employment Standards Act, the Immunization of School Pupils Act, the Occupational Health and Safety Act, the Personal Health Information Protection Act, and the Smoke-Free Ontario Act (see Table 1 of the OPHS for an inclusive listing of current Ontario Acts and regulations within which boards of health and medical officers of health are cited).

1.3.3 Personal Health Information Protection Act, 2010

http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_04p03_e.htm

PHIPA regulates the collection, use and disclosure of personal health information by health information custodians (a defined term in the Act) include physicians, hospitals, long-term care facilities, Medical

Officers of Health and the Ministry of Health and Long-Term Care. The Act also establishes rules for individuals and organizations receiving personal information from health information custodians.

Consent is generally required to collect, use and disclose personal health information however, the Act specifies certain circumstances when it is not required. For example, the Act permits disclosure of personal health information to the Chief Medical Officer of Health or Medical Officer of Health without the consent of the individual to whom the information relates where the disclosure is for a purpose of enforcing the Health Protection and Promotion Act. Disclosure of personal health information without consent is also permitted for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons.

1.3.4 Quarantine Act, 2007

http://laws.justice.gc.ca/eng/Q-1.1/index.html

http://laws.justice.gc.ca/eng/Q-1/index.html

The purpose of the federal Quarantine Act is to prevent the introduction and spread of communicable diseases in Canada. It is applicable to persons and conveyances arriving in or in the process of departing from Canada. It includes a number of measures to prevent the spread of dangerous, infectious and contagious diseases including the authority to screen, examine and detain arriving and departing individuals, conveyances and their goods and cargo, which may be a public health risk to Canadians and those beyond Canadian borders.

Bill C-12, the new Quarantine Act, received Royal Assent on May 13, 2005. The new legislation updates and expands the existing legislation to include contemporary public health measures including referral to public health authorities, detention, treatment and disinfestation. It also includes measures for collecting and disclosing personal information if it is necessary to prevent the spread of a communicable disease.

1.3.5 Coroners Act, 2009

http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90c37_e.htm

Where a person dies while a resident in specified facilities, including long term care homes and psychiatric facilities designated under the Mental Health Act, the Coroners Act requires the person in charge of the hospital, facility or institution to immediately give notice of the death to the coroner. Further, if any person believes that a person has died under circumstances that may require investigation that person must immediately notify a coroner or police officer of the facts and circumstances relating to the death. The coroner must investigate the circumstances of the death and determine whether to hold an inquest.

1.3.6 Occupational Health and Safety Act, 2014

http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90o01_e.htm

The Occupational Health and Safety Act is enforced by the Ministry of Labour. The Act imposes a general duty on employers to take all reasonable precautions to protect the health and safety of workers. The duties of workers are, generally, to work safely in accordance with the Act and regulations.

1.3.7 Emergency Management and Civil Protection Act, 2009

http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90e09_e.htm

The Emergency Management and Civil Protection Act establishes the requirements for emergency management programs and emergency plans in the Province of Ontario. The Act specifies what must be included in emergency management programs and emergency plans. Municipal councils are required to adopt emergency plans through by-law.

The Act outlines the definition of a formal emergency for municipalities and allows Health Units in Ontario to participate in local emergency management planning with each municipality. All municipalities are required to develop and submit emergency management programs to Emergency Management Ontario under this Act.

1.4 Terms and Definitions

ACTING MEDICAL OFFICER OF HEALTH: The Board of Health appoints a physician as acting Medical Officer of Health to ensure that the statutory duties and authority to exercise the powers of the Medical Officer of Health continue to be fulfilled. This is in the case where the Medical Officer of Health is absent or unable to act. Refer to NBPSDHU Board of Health Bylaws (2005), Section IX , 43 (d,e,f).

ACUTE CARE SERVICES: Services provided by acute care hospitals in Ontario.

CONTINUITY OF OPERATIONS PLAN (COOP): A COOP provides guidance on the system restoration during and after emergencies, disasters, and mobilization. It is a guide for maintaining a state of readiness to provide the necessary level of information processing support commensurate with the mission requirements/priorities identified by the respective functional proponent. This term traditionally is used by the Federal Government and its supporting agencies to describe activities otherwise known as Disaster Recovery, Business Continuity, Business Resumption, or Contingency Planning.

COORDINATION: The provision of policy guidance and leadership to a number of areas, in such a way that skills and resources can be used in an effective manner to respond to an emergency.

DESIGNATE: A member of the senior management team who is appointed specific administrative responsibilities by the MOH in an emergency. Responsibilities appointed do not include statutory duties and powers of the MOH.

DISASTER: A sudden, unplanned calamitous event causing great damage or loss. 1) Any event that creates an inability on an organizations part to provide critical business functions for some predetermined period of time. 2) In the business environment, any event that creates an inability on an organization's part to provide the critical business functions for some predetermined period of time. 3) The period when company management decides to divert from normal production responses and exercises its disaster recovery plan. Typically signifies the beginning of a move from a primary to an alternate location. SIMILAR TERMS: Business Interruption; Outage; Catastrophe.

EMERGENCY: A sudden, unexpected event requiring immediate action due to potential threat to health and safety, the environment, or property.

EMERGENCY MANAGEMENT PROGRAM: A program that implements the mission, vision, and strategic goals and objectives as well as the management framework of the program and organization.

EMERGENCY OPERATIONS CENTRE (EOC): The organization established by a local government authority or NBPSDHU to provide site support for coordination within the district or community. NBPSDHU's

emergency management structure established as a time limited organization to coordinate NBPSDHU's response to a large scale emergency / disaster.

EMERGENCY RESPONSE MANAGEMENT SYSTEM (ERMS): A comprehensive management scheme that ensures a coordinated, organized response and recovery to any and all emergency incidents. The broad spectrum of components of ERMS includes operations and control management, qualifications, technology, training, and publications.

EXERCISE: An activity that is performed for the purpose of training and conditioning team members, and improving their performance. Types of exercises include: Table Top Exercise, Simulation Exercise, Operational Exercise, and Mock Disaster.

FUNCTIONAL OPERATIONS: Response activities carried out by designated programs, if necessary, in accordance with direction or coordination instructions issued by the Incident Manager. An EOC does not normally conduct functional operations; it coordinates and supports them. However, in the event of a large scale communicable disease outbreak / pandemic, the EOC will fulfill both functions through units and branches under the Operations Section Chief.

HEALTH HAZARD: Means a) a condition of a premises; b) a substance, thing, plant or animal other than man; c) solid, liquid, gas or combination of any of them, that has or that is likely to have an adverse effect on the health of any person.

INCIDENT MANAGEMENT System (IMS): In disaster/emergency management applications, the combination of facilities, equipment, personnel, procedures and communications operating within a common organizational structure with responsibility for the management of assigned resources to effectively accomplish stated objectives pertaining to an incident.

INCIDENT MANAGER (IM): The person charged with overall responsibility within the designated operational area. The Incident Manager has responsibility for the efficient performance of the EOC staff as well as the responsibility to support and coordinate functional operations. A deputy will normally be appointed to assist the IM to ensure continued 24/7 command capability as required.

LIAISON: Describes the intercommunications between NBPSDHU and the provincial, regional, and local functional organizations and agencies involved in response operations.

NON-ACUTE/COMMUNITY SERVICES: Refers to the services provided by non-acute care or chronic care hospitals, long-term care facilities, nursing homes, rehabilitation centres, community care access centres, organizations that provide visiting nursing and support services, community health centres, independent health facilities, clinics, physician practices, community mental health services, addiction programs, and community-based programs and services. Non-acute/community services do not include public health.

MITIGATION: Activities taken to eliminate or reduce the probability of the event, or reduce its severity or consequences, either prior to or following a disaster/emergency.

OPERATIONAL PERIOD: The length of time set by the management structure to achieve a given set of objectives.

PREPAREDNESS: Activities, programs, and systems developed and implemented prior to a disaster/emergency that are used to support and enhance mitigation of, response to, and recovery from disasters/emergencies.

PROVINCIAL EMERGENCY OPERATIONS CENTRE (PEOC): This is the overall provincial government multi-ministry coordination center, normally situated at the Ministry of Health and Long Term Care, Toronto. If required, it is activated and implements any necessary direction from the government.

RECOVERY: Activities and programs designed to return conditions to a level that is acceptable to the entity.

RESPONSE: In disaster/emergency management applications, activities designed to address the immediate and short-term effects of the disaster/emergency.

RISK: Potential for exposure to loss. Risks, either man-made or natural, are constant. The potential is usually measured by its probability in years.

RISK ASSESSMENT / ANALYSIS: The process of identifying the risks to an organization, assessing the critical functions necessary for an organization to continue business operations, defining the controls in place to reduce organization exposure and evaluating the cost for such controls. Risk analysis often involves an evaluation of the probabilities of a particular event.

STAFF: Those persons designated to assist and advise the IM in carrying out the role. The staff must be considered to be a flexible organization which can be adapted to suit the Branch Director's appreciation of on-going requirements.

TABLE TOP EXERCISE: One method of exercising teams in which participants review and discuss the actions they would take per their plans, but do not perform any of these actions. The exercise can be conducted with a single team, or multiple teams, and is typically conducted under the guidance of exercise facilitators.

TEMPORARY WORKERS: Individuals who may not be registered with a Regulated Health Profession Act Regulatory College but who have skills that can be used during a health emergency.

UNORGANIZED AREA: A term used to describe an electoral area for which regional district emergency management is not mandated, as well as remote, unincorporated areas.

Appendix E

North Bay Parry Sound District Health Unit

Mass Immunization Plan

Original Prepared By:
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Manager, Vaccine and Preventable Diseases
Greg Rochon
Manager, Emergency Management

Approved: September 2013
Reviewed: April 2020

Approval

The North Bay Parry Sound District Health Unit Mass Immunization Plan is approved on behalf of the Executive Team by:

_____ _____

Dr. Jim Chirico Date (yyyy/mm/dd)
Medical Officer of Health / Executive Officer

_____ _____

Cathy Menzies-Boul é Date (yyyy/mm/dd)
Executive Director, Clinical Services

Contents

Executive Summary

The goal of a Mass immunization clinic is to immunize a large number of people over a short period of time. Where a typical vaccination campaign may operate for weeks or months, an emergency may require activation and broad coverage within days or hours. Concrete, detailed planning around supplies, logistics, and communication will be put in place prior to an event so that response can be comprehensive and immediate.

Goals of the Mass Immunization Plan

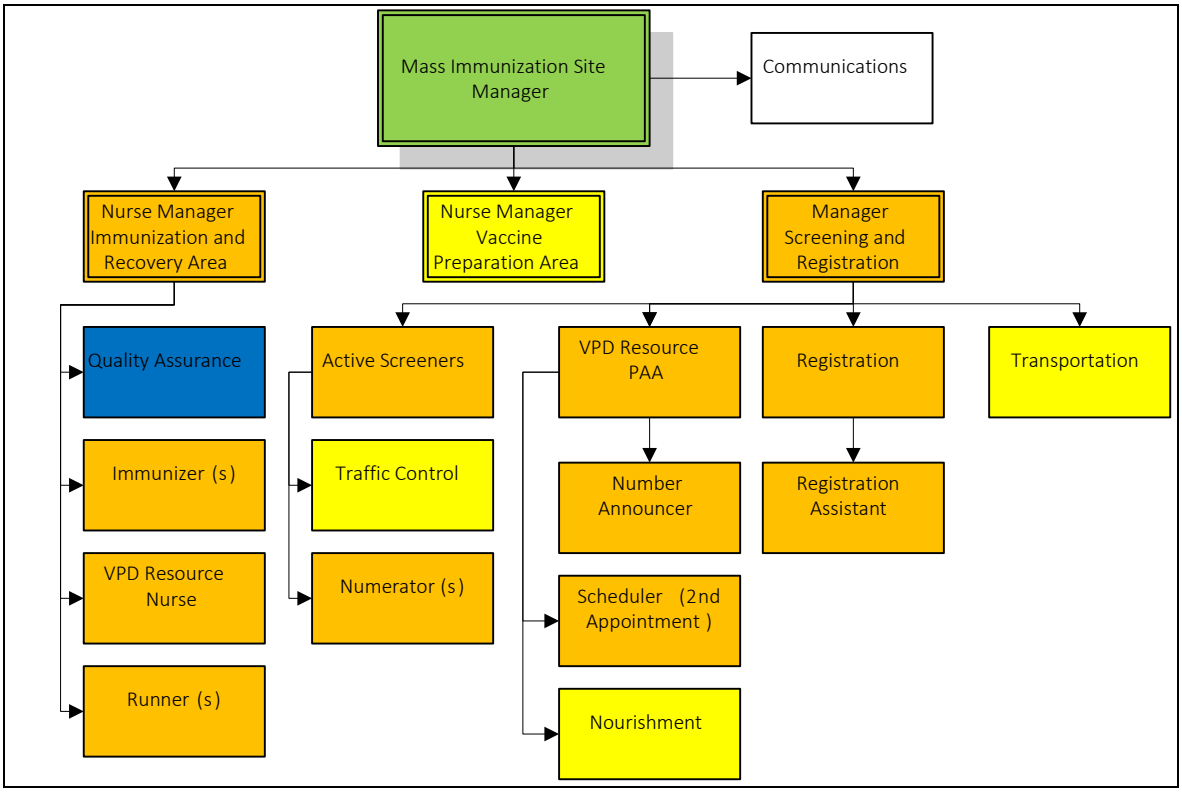
- To protect the population residing in North Bay Parry Sound District Health Unit coverage area by providing safe, effective emergency mass vaccination to appropriate groups as quickly as possible
- To store, allocate, distribute and administer vaccines
- To monitor the effectiveness, efficiency and safety of the vaccination program

Planning Assumptions

- Stockpiles of the vaccine will be available at the provincial level
- Due to the emergency situation, many routine public health activities will be curtailed, freeing up staff to be redeployed
- In the event of an emergency, the health unit will activate the Emergency Operations Centre (EOC)

The North Bay Parry Sound Health Unit (Health Unit) has experience with conducting large community immunization clinics throughout the district. The staffing levels and layout for our universal influenza clinics are similar to how a mass immunization clinic will be set up. Each section of this plan addresses the general approach and expectations for any emergency mass immunization campaign, then goes on to indicate any specific strategies and details concerning an influenza pandemic. This plan will be expanded in future to address in more detail disease-specific emergency mass vaccination situations.

Clinic Organizational Structure



IMS Color Designation	
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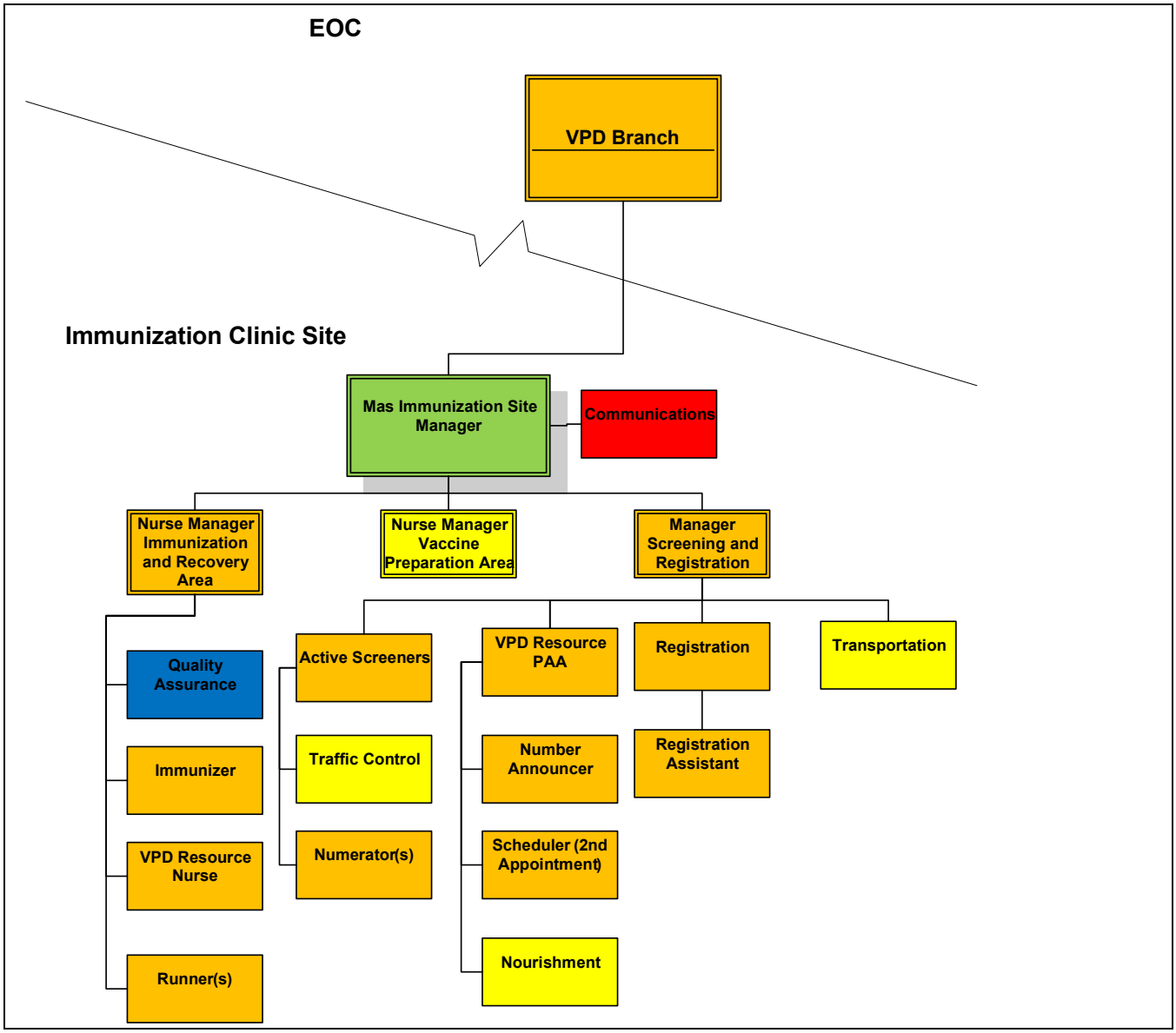
	Command
	Operations Section
	Planning Section
	Logistics Section
	Finance/Administration Section

Mass Immunization Clinic Command and Control



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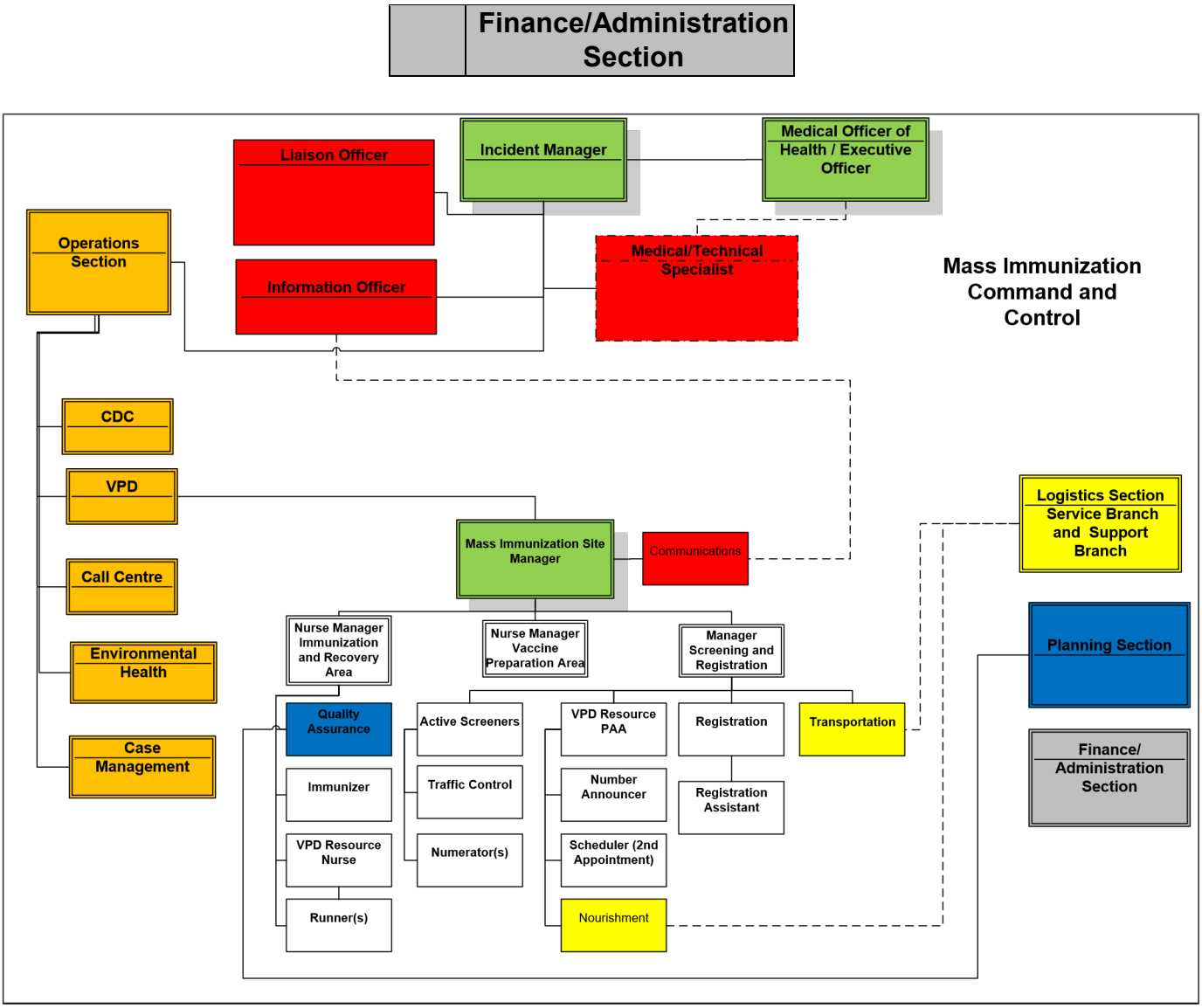


Section 1: Location of Clinics

In order to ensure the residents in our district have access to clinics and to ensure the resources available to run mass immunization clinics are utilized in the most efficient manner possible, ensure timely and efficient set up and implementation of mass immunization clinics, 5 geographic locations within the district will be used to provide mass immunization clinics. Clinics will be established in the following locations:

- North Bay
- Parry Sound
- Sturgeon Falls
- Mattawa

- Sundridge

The following criteria will be considered in determining optimal clinic sites within these 5 locations:

- close to population centers and public transit (where applicable)
- ample parking
- adequate lighting
- separate entrance and exit doors
- comfortable climate control
- wheelchair accessible
- washrooms easily accessible
- telephone easily accessible
- preferably not cement floors
- adequate space for screening, registration, vaccine storage, vaccination and staff rest area can accommodate large volumes of people presenting for immunization

Schools, churches, auditoriums, theatres, arenas, community centres or other large covered public spaces accessible to the elderly and persons with disabilities have been considered for locations. Refer to Annex 1 for locations that have been assessed utilizing the above criteria.

Municipalities may be called upon to help provide transportation for those residents that may need assistance.

Section 2: Staff Planning Criteria

The overall size of the clinics and the staffing required to provide the clinic will depend on the location of each clinic, population in the area and amount of vaccine available.

Estimated staff needs:

Standard formula to assist with staffing for clinics is based on the assumption that one vaccinator can immunize 20 people in one hour and approximately 120 people over 7 hours taking into consideration regular breaks. The following roles will be required for each clinic held:

- VPD Resource Nurse
- Immunizers
- Vaccine preparation and drawing
- Recovery Area
- Screeners
- VPD Resource PAA
- Runners - refreshing the supplies for the nurses immunizing

- Clinical Support Staff - doing anything from registration, collecting and cleaning the clipboards, traffic flow, assisting clients with disabilities, calling numbers for clients to be immunized.
- PAA - coordinating the lunch / dinner / breaks

Managers

- Mass Immunization Site Manager
- Vaccine Preparation Area
- Immunization and Recovery
- Screening and Registration

The number of staff required to run a clinic will vary depending on the following:

- Level of disease in the community
- Amount of vaccine available
- Target population for immunization
- Geographic location in the district (see Table 1 for estimated populations)

Table1. Population Estimates in each geographical area.

2008 Population Estimates for Municipal Geographic Designations		
Municipal Geographic Designations	**Population**	**Census Subdivisions (municipalities)**
North East Parry Sound	10,864	Callendar, Machar, Nipissing, Powassan, South River, Parry Sound UNO North East Part
South East Parry Sound	10,922	Magnetawan, Ryerson, McMurrich-Monteith, Perry, Kearney, Armour, Strong, Joly, Burks Falls, Sundridge
West Parry Sound	20,603	Whitestone, Archipelago, Carling, McDougall, McKellar, Seguin, Parry Sound UNO Centre Part, Dokis 9, Shawanaga 17, Parry Sound, French River 13, Henvey Inlet 2, Magnetewan 1, Naiscoutaing 17a, Parry Island First Nation

Central Nipissing	55,447	North Bay, City
East Nipissing	11,613	East Ferris, Bonfield, Mattawan, Calvin, PapineauCameron, Chisholm, Mattawa
West Nipissing	16,992	West Nipissing, Nipissing 10, Nipissing UNO North Part.

Data Source: Population Estimates, Provincial Health Planning Database, Ministry of Health & Long-Term Care **{Extracted Jan 15, 2010}**

Section 3: Human Resource Needs

Managers will be assigned to oversee Clinic Operations and logistics coordination. The EOC will coordinate the staff schedule for each clinic.

Nursing Staff: A list of all the nurses employed at the health unit, including the casual nurses has been developed. Nurses from all programs will be scheduled to work in the annual influenza clinics to ensure their skills remain current. The health unit provides an annual orientation / training program for all casual nurses hired to assist in VPD. In the event of a mass immunization clinic, an alternate process may be considered where two nurses are involved, one nurse reconstituting and drawing up the vaccine for the second nurse to administer. Both nurses must have the knowledge, skill, and judgment to competently draw up and administer the vaccine. Each nurse is accountable for his or her actions. This option may only be considered when the same vaccine in the same strength and dose is being administered by the same route to a large number of individuals, and where no other substance or vaccines of a different strength are available.

Paramedics: For mass immunization clinics, paramedics may be recruited to assist in the provision of care in the recovery areas.

Clinic Administrative Assistance and Clinical Support: Clinic Administrative Assistants will be staffed by Program Administrative Assistants and clinical support will come from the staff from other departments/programs of NBPSDHU.

Site Manager: A site manager will be a member of the organization's management staff designated through the EOC.

Volunteers: Recruitments can come from different service clubs and community agencies for crowd control and to help traffic flow. Agencies like the Red Cross and St. John Ambulance, if available, can assist in providing first aid.

Additional things to consider:

- Schedule bilingual staff to work at all clinics in the West Nipissing area
- Schedule times for rests and snacks in a designated area to ensure well being of staff
- Make maps of each clinic site and have them available to staff
- Monitor staff for signs of fatigue and stress on a daily basis
- Consider a formal critical incident stress debriefing following completion of clinics

Section 4: Roles and Responsibilities

Management Role and Duties at Large Immunization Clinics

Clinic Area	Responsible	Relief for Breaks/Back-Up	Staff assigned to supervise	Duties and Responsibilities
Mass Immunization Site Manager	Nurse Manager	Vaccine Preparation Manager	All Clinic Managers and staff	• Oversee the planning and operation of the Mass Immunization Clinic • Troubleshoot and problem solve issues as they arise • Act as the liaison between the EOC and clinic management and staff • Communication • Walk around and ensure signage is appropriate and clear • With the Assistance of the Communications Coordinators deal with media at the clinic
Vaccine Preparation Area	Nurse Manager	Mass Immunization Site Manager	Nurses assigned to draw up vaccine	• Orient and demonstrate reconstitution activities with new staff in this area • Must be present in room at all times for security purposes and for quality control, therefore another manager must be present during breaks • Ensure that staff only handles one vial at a time • Coordinate the flow of vaccine (mixed and drawn) • Log vaccine temperature every half hour • Assign/re-assign to 2 different roles based on skill set and role fatigue • Return wasted vaccine or faulty vials to the Health Unit (VPD Program) • Control inventory of vaccine

Immunization and Recovery Area	Nurse Manager	Mass Immunization Site Manager	Nurses assigned to immunization area Paramedics assigned to recovery area	• Orient new nurses and new paramedics • Provide a briefing to all nurses and paramedics before clinic starts • Assign position to nurses and paramedics • Provide copy of Medical Directives #MED-HU-001 Epinephrine Injectable 1:1000, MED-HU002 Administration of Benadryl Oral Caplets- Adult Preparation Regular Strength, MED-HU004 Administration of Benadryl Injectable to new staff and insure they read same, • Orient paramedics to physical lay-out and location of equipment (cots, blood pressure cuffs, medications, etc), • Advise paramedics of roles/responsibilities in recovery area including being mindful of the required 15-minute client wait period, advise re. location of phone in the event that EMS ambulance is required • Assign/re-assign nurses to 2 different roles based on skill set and role fatigue • Answer nursing questions from immunizers and general public as they arise • Answer questions from paramedics and help to problem solve issues • Deal with medical errors (i.e. wrong dose given)
Clinic Area	**Responsible**	**Relief for Breaks/Back-Up**	**Staff assigned to supervise**	**Duties and Responsibilities**
				• Monitor which clients need to go to the hospital • Contact MOH to provide an update on the clinic activities • Monitor flow in immunization area (i.e. 2 parents comes in with 3 children)

Screening and Registration	Manager	Mass Immunization Site Manager	PHIs TEOs PAAs Dental Assistants Family Home Visitors Clinic Assistants Volunteers	Assign the following positions to staff: - Active Screeners - Number Givers - Registration - Traffic Flow - Scheduling Second Appointments if applicable - Runners - Quality Assurance - Calling out numbers - Assist with completing forms • Ensure that the appointment schedule for 2nd appointments is given to VPD if applicable • Make sure consent forms are collected, checked for errors and brought back to the HU (VPD program) • Circulate to all the positions ensuring flow is working, and move people around as necessary

Staff Role and Duties at Large Immunization Clinics

Role	Duties	Supervisor	Position
Immunizers	• Assist with clinic and individual immunization station set up • Wash hands with hand sanitizer before and after each client • Take the consent form from the client and ensure the client understands the information and has signed the consent form and ensure information is complete and legible • Screen the client • Administer the vaccine • Complete remaining information on the consent form • Recommend to client to remain in waiting area for 15 minutes after receiving immunization, provide rationale • Replenish workstation with supplies as needed • Pack supplies in container at the end of the clinic	Nurse Manager, Immunization and Recovery Area	Public Health Nurses Registered Nurses Registered Practical Nurses Nurse Managers Nursing Students

VPD Resource Nurse	• Bring vaccine to clinic • Act as a resource as needed • Administer the vaccine	Nurse Manager, Immunization and Recovery Area	VPD Nurses

Role	Duties	Supervisor	Position
VPD Resource PAA	Prepare client consent forms to bring to clinics and Normal/Abnormal Reactions to Vaccine sheets and ensure they are returned to the Health Unit	Manager, Screening and Registration	VPD PAA(s)
Active Screeners	Screeners must wear: ○ Airway protection ○ Eye protection Prior to entering clinic, ensure that clients: • Are screened for flu symptoms • Use hand sanitizer • Symptomatic clients are encouraged to leave and return when feeling better (equipment will be available on-site) • If symptomatic client insists on staying instruct client to: ○ Use hand sanitizer ○ Put on mask (must wear until they exit clinic)	Manager, Screening and Registration	Public Health Inspectors Tobacco Enforcement Officers
Numerator(s)	Give out numbers when clients enter the building	Manager, Screening and Registration	Public Health Inspectors Tobacco Enforcement Officers
Registration	Greet clients and ask them to read the consent form and to complete the demographics on the front of the form • Put vaccine identification stickers on the cards and consent forms • Clean clip boards and pens with disinfectant wipes	Manager, Screening and Registration	Dental Assistants PAAs MAAs
Traffic Control	• Direct the client in the right direction • Direct the client to the waiting area OR • Have clients wait for immunization and direct them to an immunizer for immunization when immunizer is available along with their consent form OR • At recovery area, watch the clients for signs of fainting/reaction and advise paramedic or nurse assigned to recovery area	Manager, Screening and Registration	Dental Assistants PAAs MAAs Family Home Visitors Clinic Assistants

Schedule 2nd appointment	☐ Schedule 2nd appointments for children under 10, if applicable	Manager, Screening and Registration	PAAs
Runners	• Pick up loaded syringes in Vaccine Drawing Area and bring them to immunizers • Nearing the end of the clinic, provide surveillance on # of filled syringes in circulation at immunization tables and communicate with Nurse Manager in Vaccine Drawing Area	Manager, Screening and Registration	Dental Assistants PAAs MAAs Family Home Visitors Clinic Assistants
Quality Assurance	• Collect forms at each immunization table • Ensure form is properly completed 1. Collect the immunization consent forms from the nurses' workstations. 2. Review all forms to ensure the data necessary to be inputted into the database was recorded correctly.	Manager, Screening and Registration	Research Services Staff
Role	**Duties**	**Supervisor**	**Position**
	☐ Incorrect information requires contacting the nurse who completed the form and having them make the appropriate changes.		
Calling out	☐ Monitor wait line to determine when numbers are called out	Manager, Screening and Registration	Dental Assistants PAAs MAAs
Assist with completing forms	• Fill in the form if client is unable to do so and ask the client to sign or parent/guardian to sign for child • If client is unable to read the consent form, read the form to the client • If the client has any questions, ask the VPD Nurse Resource to discuss the consent with the client	Manager, Screening and Registration	PAAs
Nourishment	• Order lunch and/or dinner and coffee and snacks - have water available • Set up meals • Determine break and lunch break times and modify break forms as needed	Manager, Screening and Registration	MAA
Packers before the clinic	☐ Prepare office supplies to bring to clinics; date stamp, pens, clip boards	VPD Manager	VPD PAA
Packers at the end of the clinic	☐ All staff at the clinics will assist with packing supplies in preparation for transportation back to the Health Unit.	Mass Immunization Site Manager	All staff working at the clinic to assist

Transportation	• Assist with set up of tables and chairs to accommodate number of nurses working the clinic • Assist with set up chairs in waiting area for clients to sit down prior and after vaccination • Set up zero-gravity chairs • Assist with dismantling clinic and packing up supplies at the end of the clinic • Keep unused supplies and store them in back in the VPD storage room • Transport supplies/equipment to and from clinic locations.	As delegated by the EOC	As delegated by the EOC

Staff Role and Responsibilities at the Health Unit

Role	Duties	Supervisor	Position
Adverse Reaction	☐ Respond to calls regarding adverse reactions to immunization and complete required documentation	Nurse Manager, Immunization and Recovery Area	Assigned PHN
Data Entry	☐ Complete data entry into Ministry database as required.	Designated by the EOC	Assigned PAA

Section 5: Clinic Layout

The general client flow lay out of the clinic and the description of each area is shown in Annex 2. Actual clinic layout will vary dependent on the location selected for the clinic.

Section 6: Infection Control Procedures

To prevent potential spread of disease, clients may need to be screened for symptoms using an appropriate screening tool such as using the FRI screening tool. Persons exhibiting signs of illness will be triaged to a separate area for more in-depth assessment. Signs and symptoms will be posted at the entrance to the reception area identifying the symptoms that may result in ineligibility or require more in-depth assessment. All clients will be advised to use a hand sanitizer before proceeding into the clinic. Appropriate personal protective equipment will be available for staff as determined by case definition and spread of disease. Alcohol based hand sanitizers will be available to staff. Commercial disinfected wipes will be available for cleaning work surfaces. In the screening area, work surfaces will be cleaned after each interview.

Staff will wear personal protective equipment (PPE) as per provincial recommendations. The province will provide appropriate guidelines and direction for PPE selection and use.

Biohazardous waste disposal procedures will be in place and regular biohazardous waste pick-up will occur. A Spill kit will be available to clean up spills of biological fluids i.e. blood, emesis etc.

A work instruction on handling needle stick injuries and reporting incidences is available. The VPD Resource Nurse is to be notified of a needle stick injury immediately. A fact sheet outlining the protocol to follow when dealing with a needle stick injury will be part of the resource package.

Section 7: Adverse Reactions and Follow-Up

The following Medical Directives will be available at every clinic site and reviewed by staff working the clinic:

MED-HU-001 Epinephrine Injectable 1:1000

MED-HU-002 Administration of Benadryl Oral Caplets - Adult Preparation Regular Strength
MED-HU-003 Delegation of Dispensing Medications
MED-HU-004 Administration of Diphenhydramine HCI (Benadryl) Injectable

As well as the medical directive that is specific to the immunization vaccine(s) that is being offered at the clinic.

Emergency kits for anaphylaxis will be located in the administration and recovery areas. The VPD Resource Nurse and each Manager assigned to the clinic will have cell phones or radios with them.

All vaccine recipients are requested to stay a minimum of 15 minutes following immunization. Two nurses will respond to an adverse event and follow the directions provided in WI-VPD-022 Completion of a Report of a Vaccine-Associated Adverse Event. The Nurse Manager, Immunization and Recovery areas will notify the VPD Resource Nurse / VPD Program Manager of any clients requiring ambulance transportation.

Prior to starting a clinic, the entrances and exits need to be designated for ambulance access/egress to the building and the clinic. In an ideal situation have the recovery area near the designated exit that ambulance can access. Local ambulance base will be notified each day of the clinic locations by the EOC.

Section 8: Resource Materials

A clinic resource binder will be available at each clinic site for the team to review. The binder will include the following:

- Vaccine handling information including cold chain protocols
- Vaccine reconstitution information if applicable and product monographs
- Information on the vaccine being given
- Medical directives for all vaccines available at the clinic
- Injection technique information as well as dose
- Documentation requirements
- Procedures on handling adverse reactions and adrenalin kit
- Information on informed consent
- Information on handling sharps

- Fact sheet and work instruction on needle stick injuries
- Universal precautions information
- A description of each role in the clinic
- Time log sheets for each group to track the hours of paid work
- Clinic location, contact information, direction and floor plan on each facility (A floor plan will include clinic layout, how it will be set up, location of outlets, etc.)

Section 9: Training

Health unit staff participating in mass immunization clinics and the supply and transportation teams will be trained according to their roles and responsibilities. A training manual for nurses who will be involved in vaccine administration has been developed and is available online in the Corporate Services section of the Intranet under training.

Section 10: Materials & Supplies

Vaccine availability will be coordinated by the Program Manager, Vaccine Preventable Diseases in conjunction with the Ministry of Health and Long-Term Care, Public Health Branch.

A manager will be assigned as a Logistics Section Support Branch Director to work with the facilities and supply/equipment units.

The EOC and VPD will work together to ensure that:

- All necessary clinic supplies are on site and are available in sufficient quantities
- An inventory of supplies is maintained
- Law enforcement agencies are notified of each clinic day, depending on the threat level contract officers to attend and provide security services
- There is a coordinated transportation of supplies/equipment and vaccine with designated transportation company and cold chain is maintained during shipping and handling
- Ensures staff transportation to clinic site as needed
- Ensures supplies are transported to clinic sites

VPD Resource Nurse:

- Ensures all required supplies to run the clinic are packed and ready for transport to the clinic

VPD:

- Packs all clinic paperwork supplies according the clinic requisition forms
- Orders and keeps inventory of all supplies
- Orders, packs and tracks all the vaccine orders

1) **Supplies:** A single person will be designated as Inventory Clerk. Additional staff will be assigned to assist the lead. An inventory sheet will be used to track both regular and emergency supplies. A mass immunization clinic supply list is available in Annex 3.

2) **Packing and Preparation for clinic:** Supply clerk will pack all paper supplies for each clinic. Inventory for each clinic will be submitted in advance and packaged into clinic bundles and delivered to the clinic site. Supplies will be delivered to the clinic site a minimum of 1 hour prior to the clinic start time – for large clinics held in the North Bay location, supplies will arrive at the site at least 2 hours ahead of the clinic start time. Vaccines will be transported by the VPD Resource Nurse or a Manager attending the clinic.

3) **Storage of Vaccines:**
The vaccine for the North Bay, Mattawa, West Nipissing and East Parry Sound area will be stored in the North Bay office refrigerators prior to clinic days. The vaccine for the West Parry Sound area will be stored in the Parry Sound office fridge prior to clinic days. All refrigerators are alarmed for temperature control and are locked. Refrigerators in both offices have generator back-up power. The health unit's current refrigerator storage capacity consists of:

North Bay

- 3 lab refrigerators (54 cubic ft each)
- 1 lab refrigerator (21 cubic ft)
- 1 shared freezer for ice packs

Parry Sound

- 1 lab refrigerator (29cu ft)
- 1 domestic refrigerator
- freezer for ice in top of the domestic refrigerator

Depending on vaccine availability, there may be a need to implement twenty–four hour security in the North Bay and Parry Sound Offices.

Section 11: Security and Crowd Control

A systematic way of providing crowd control at clinics is needed in order to avoid large numbers of people congregating in and around the clinics impeding operations. It is important to schedule clinics as quickly as possible throughout the district, to avoid public panic and confusion. It may be necessary to identify people who are attending a clinic outside their own area of residence and to discourage them from receiving a vaccine at particular sites.

Security personnel will be in place at all clinics and during storage and transportation of the vaccine. Security personnel will monitor mood of waiting crowds and communicate deteriorating situations to the clinic manager. Health unit will establish contracts with local security companies. A copy of the clinic schedule and location will be provided to the local law enforcement agency through the EOC. Law enforcement presence at a clinic will be arranged as needed by the EOC.

Section 12: Communication Strategy

Communications will serve as the first point of contact for all requests for information and interviews coming from the media. Refer to the Communications Plan in the Health Unit's Emergency Management Plan for more information.

ANNEX 1 – Potential Clinic Sites

Area in District	location	address	parking	access to public transportation	Wheelchair accessible	Large open area	chairs and table available	Washrooms easily accessible	telephone easily accessible	waiting space indoors	good lighting/temp control	cost /contract	rating	
North Bay Area	Royal Canadian Legion Branch 453	62 King St. Powassan			✓	moderate space	✓	✓	✓	✓	✓	no		
	Corbiel Park Hall	Hwy 94 Corbeil	✓	☹		moderate space	✓	✓	✓	✓	✓	no		
	Royal Canadian Legion Branch 445 (752-3773)	345 Lansdowne Ave Callander	✓	✓	✓	✓	✓	✓	✓	✓	✓	contract yes, no cost	1	
	Royal Canadian Legion Branch 23 (472-0390)	150 First Ave West North Bay	✓	✓	✓	✓	✓	✓	✓	✓	✓	contract yes, no cost	1	
	North Bay Mall (472-2123)	300 Lakeshore Drive North Bay	✓	✓	✓	✓	✓	✓	✓	✓	✓	contract yes, no cost	1	not available until Jan 07
	Northgate Square	1500 Fisher St. W. North Bay	✓	✓	✓	☹	☹	✓	☹	☹	✓	no	0	
	Memorial Gardens	100 Chippewa St. W. North Bay	✓	✓	✓	✓	additional charge	✓	✓	✓	✓	yes	1	
	West Ferris Community Centre	42 Gertrude St. E. North Bay	✓	✓	main floor	✓	✓	✓	✓	✓	✓	no	main floor 1	
	Algonquin Regiment	540 Chippewa St. West North Bay	✓	✓	✓	✓	✓	✓		✓	✓	contract yes, no cost	1	
	Elks Lodge No. 25	2151 Barker Ave North Bay	✓	✓	✓	✓	✓	✓	✓	✓	✓	no	1	great location
	East Ferris Community Centre Arena	1257 village Rd	✓	☹	✓	✓	✓	✓	✓	✓	✓	no	1	evacuation centre
	Davedi Club	313 Airport Road North Bay	✓	✓	✓	✓	✓	✓	✓	✓	✓	no	1	good parking lot not paved
East Nipissing	Bonfield Agriculture Society (Agridome)	113 Trunk Rd. Bonfield	Closed	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
	Mattawa Goldon Age	464 Poplar Street Mattawa	✓	✓	✓	✓	✓	✓	✓	✓	✓	no	1	
East Parry Sound	Burks Falls Senior Centre	39 Copeland Street Burks Falls	✓	☹	✓	✓	✓	✓	✓	✓	✓	no	1	
	Burks Falls Arena	Burks Falls	✓	☹	✓	✓	✓	✓	✓	✓	✓	contract negotible	1	
	Magnetawan Community Centre	Magnetawan												
	Royal Canadian Legion Branch 390	95 Ottawa Street South River	not assessed					✓						
	South River Public School	South River	✓	☹	✓	✓	✓	✓	✓	✓	✓	contract, no cost	1	
	South River Seniors Centre	south River	✓		✓	✓	✓	✓	✓	small	✓	none		
	South River Medical Centre	South River	✓	☹	✓	☹	limited	✓	✓	✓	✓	none	0	small rooms, too many stairs
	Sundridge Community Centre	110 Main Street Sundridge	✓	☹	✓		✓	✓	✓	small	✓	none		

Area in District	location	address	parking	access to public transportation	Wheelchair accessible	Large open area	chairs and table available	Washrooms easily accessible	telephone easily accessible	waiting space indoors	good lighting/temp control	cost /contract	rating	
West Nipissing	Sturgeon Falls Legion		✓	✓	✓	✓	✓	✓	✓	✓	✓	none	1	
	Sturgeon Falls Complex	219 O'Hara St. Sturgeon Falls	✓	✓	✓	✓	✓	✓	✓	✓	✓	$600 negotible	1	
	Au Chateau	106 Michaud St. Sturgeon	✓	✓	✓	✓	✓	✓	✓	✓	✓	none	1	
	Golden Age -Sturgeon Seniors	71John St. Sturgeon Falls	✓	✓	✓	med	✓	✓	✓	✓	✓	none	1	
	Paroisse Notre Dame Des Victories	13643 Chemin 64 Field	✓	✓	?	✓	✓	✓	✓	✓	✓	none	1	
	Phelps & District Golden Age Centre	North River Road Redbridge	✓	✓	✓	✓	✓	✓	✓	✓	✓	none	1	
Parry Sound	Britt Public School	Britt	✓	☹	☹	✓	✓	✓	✓	✓	✓	✓	1	
	Christie Community Centre	# 518 to Orrville	✓	☹	✓	✓	✓	✓	✓	✓	✓	✓	1	
	Dunchurch Community Centre	Hwy 124 Dunchurch	✓	☹	✓	✓	✓	✓	✓	✓	✓	✓	1	
	Foley Activity Centre	# 60 Rankin Lake Rd	✓	☹	✓	✓	✓	✓	✓	✓	✓	?	1	
	Humphrey Arena (upstairs)	#141 Sandy Plains Rd.	✓	☹	☹	✓	✓	✓	✓	✓	✓	✓	1	
	McKellar Community Centre Hwy 124 McKellar	Hwy 124 McKellar	✓	☹	✓	✓	✓	✓	✓	✓	✓	✓	1	
	Parry Sound Optimist Centre	FR # 36 Smith Cres	✓	☹	✓	✓	✓	✓	✓	✓	✓	✓	1	future emergency centre
	Point Au Baril Community Centre	70 South Shore Rd.	✓	☹	✓	✓	✓	✓	✓	✓	✓	✓	1	
	Rosseau Lake College Dining Room	Hwy #141 Rosseau	✓	☹	✓	✓	✓	✓	✓	✓	✓	✓	1	
	Catholic Church Hall		✓	☹	✓	✓	✓	✓	✓	✓	✓	?	1	
	Friends	27 Forest St, Parry Sound	✓	☹	✓	✓	✓	✓	✓	✓	✓	✓	1	

ANNEX 2 – Clinic Layout

North Bay Parry Sound District Health Unit
Clinic Layout

1) **Line-up and Reception Area:** Staff assigned here will:
   - Monitor and communicate with long waiting lines to ensure the right people are in the line. (Parents/guardians who have signing authority accompanying children and not a babysitter or grandparents)
   - If required, provide appropriate screening tool and refer to screening area if failed screening
   - Handout consents in the signing area
   - Distribute and ensure supplies are available at consent tables. Pens may need to be attached to the tables and/or clipboards to prevent losing supplies.
   - Direct individuals to the Greeting and Registration area.

2) **Screening:** Not all mass immunization clinics will require screening. The nurse assigned here will be doing full assessment based on case definitions and medical directives provided by the province.
   - Following the health assessment individuals may be routed back to the registration area, sent home or referred to appropriate medical care.

3) **Greeting and Registration Area:** Staff assigned here will:
   - Collect completed consents for review
   - Review the consent to ensure all areas are completed correctly
   - Process completed consents and preparing all paperwork for return to the health unit (This may be done in the observation are or at the health unit following the clinic).
   - Direct individuals to the immunization area as per the numbering system

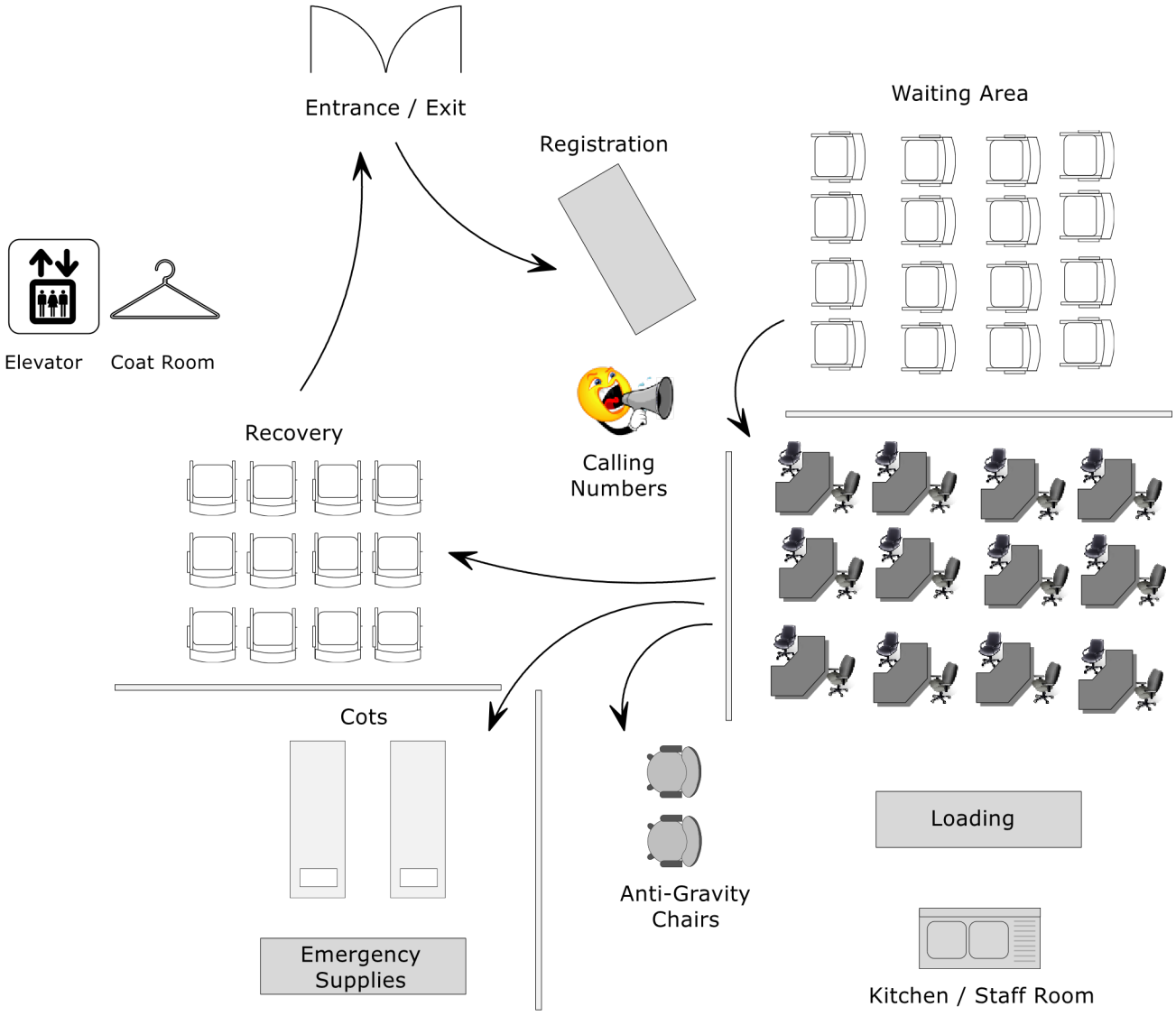
4) **Immunization Area:** Nursing staff who are assigned to this area are responsible for the actual administration of the vaccine. A privacy area will be set up for individuals that need to undress or who are very anxious.

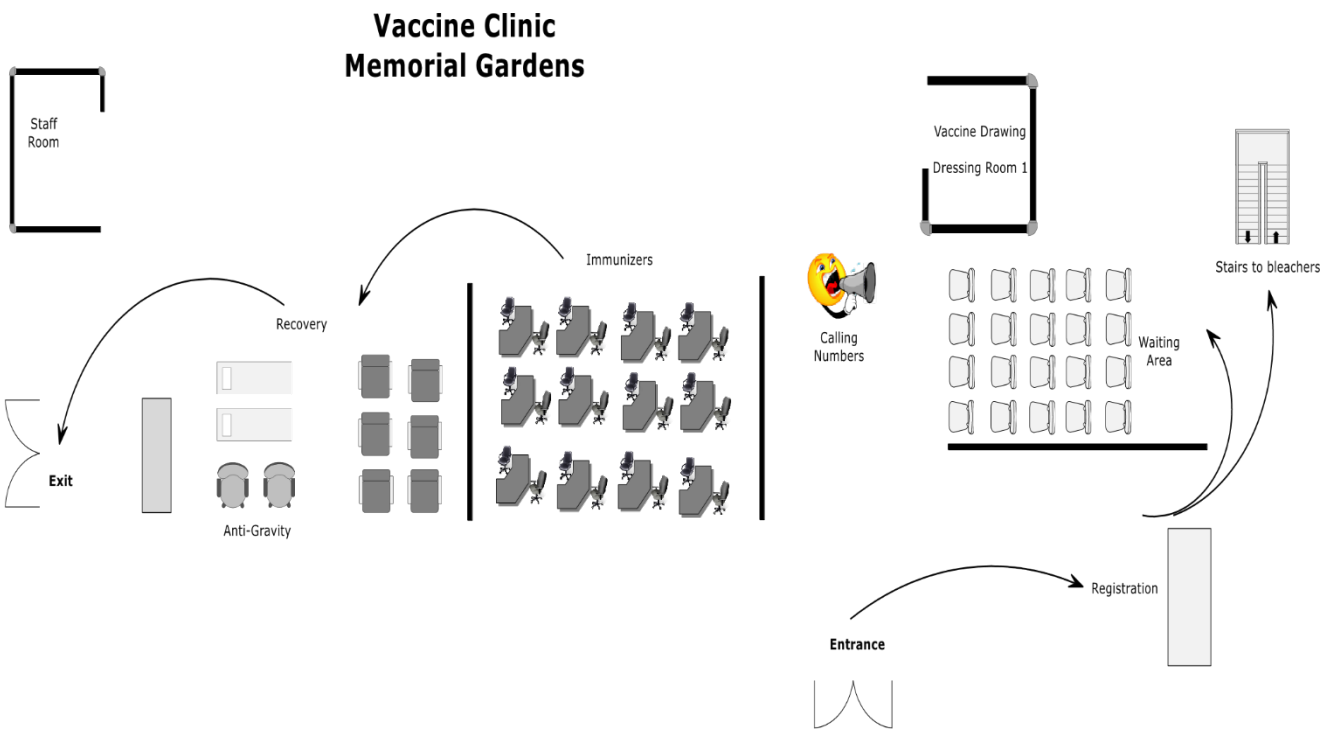
5) **Post-immunization Waiting Area:** This area can be staffed with a mix of nursing and non- nursing staff. Staff is responsible for observing people during their 15 minute waiting period. Will monitor for signs of syncope and adverse reaction. This area will have floor mats and privacy screens. Nurse staffed in this area will have a cell phone with 911 phone access.

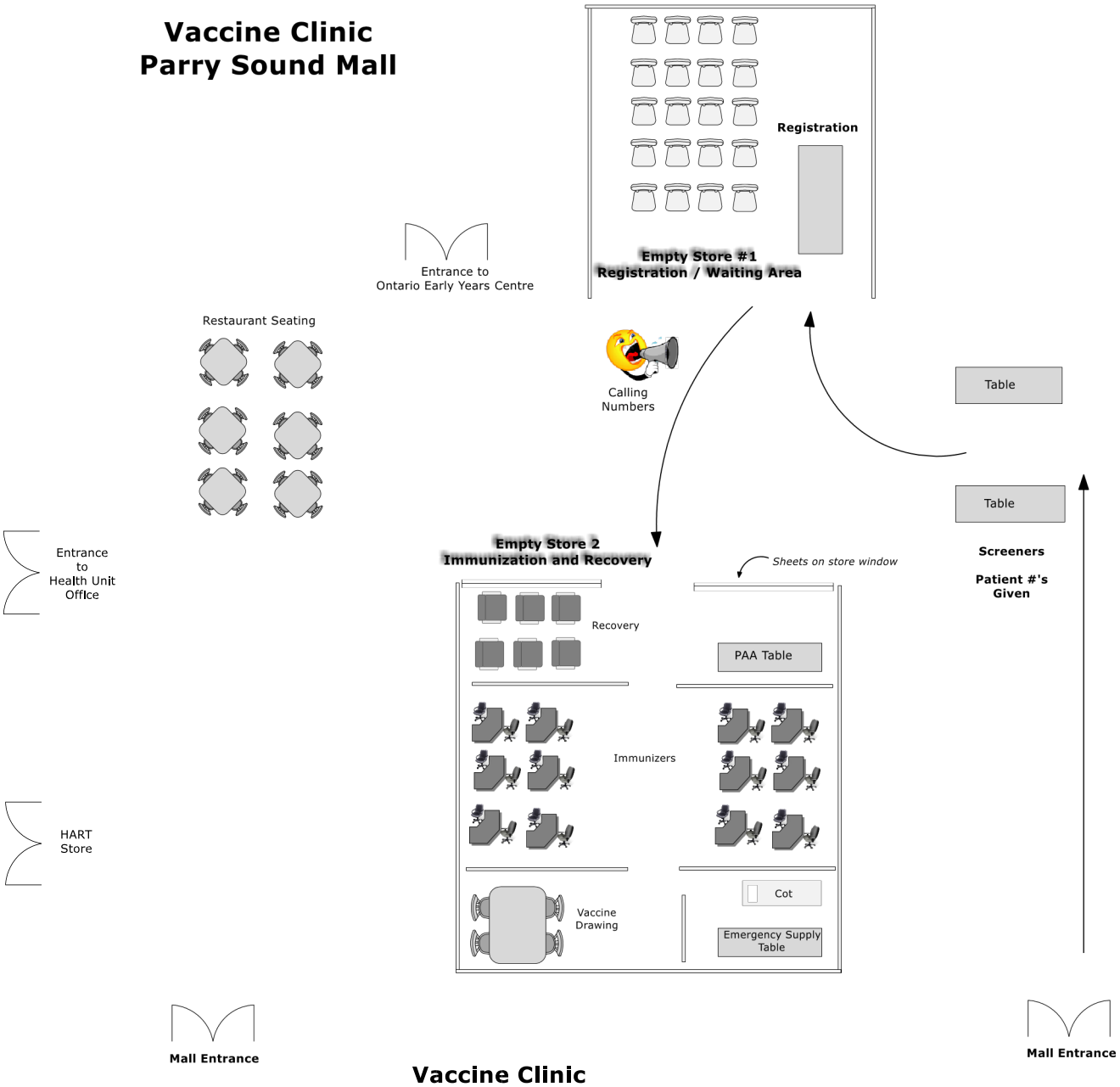
North Bay Parry Sound District Health Unit

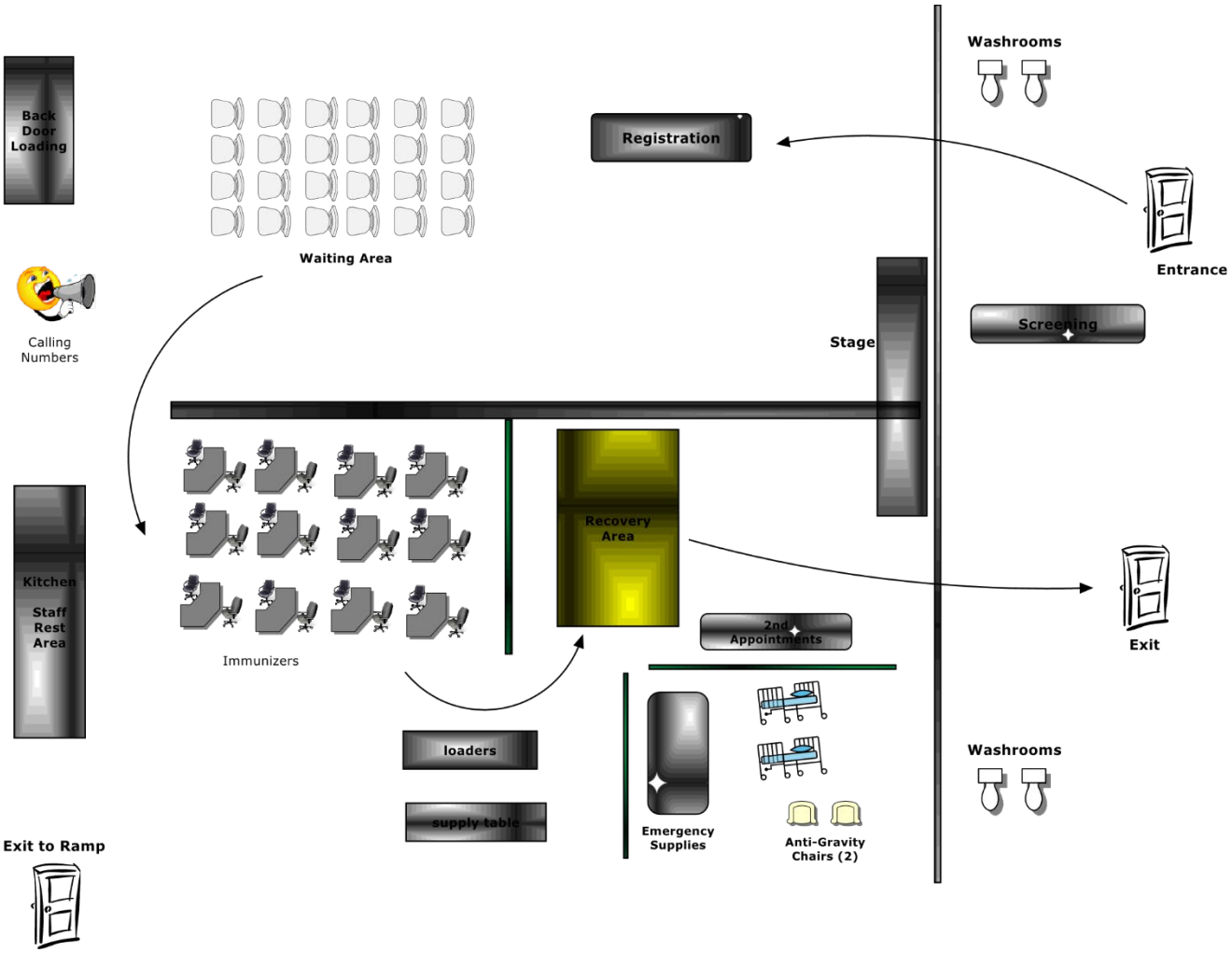
NBPSDHU – Clinic Layout
Page 1 of 1

Vaccine Clinic
Mattawa Arena




Vaccine Clinic
Memorial Gardens
Staff Room
Vaccine Drawing
Dressing Room 1
Stairs to bleachers
Immunizers
Recovery
Calling Numbers
Waiting Area
Exit
Anti-Gravity
Registration
Entrance


Vaccine Clinic
Parry Sound Mall
Registration
Empty Store #1
Registration / Waiting Area
Entrance to
Ontario Early Years Centre
Restaurant Seating
Calling
Numbers
Table
Table
Screeners
Patient #'s
Given
Entrance
to
Health Unit
Office
Empty Store 2
Immunization and Recovery
Sheets on store window
Recovery
PAA Table
Immunizers
HART
Store
Cot
Vaccine
Drawing
Emergency Supply
Table
Mall Entrance
Mall Entrance
Vaccine Clinic
Sturgeon Falls Recreation Centre


Back Door Loading
Waiting Area
Registration
Washrooms
Entrance
Calling Numbers
Stage
Screening
Kitchen
Staff Rest Area
Immunizers
Recovery Area
2nd Appointments
Exit
loaders
supply table
Emergency Supplies
Anti-Gravity Chairs (2)
Washrooms
Exit to Ramp

Appendix F

January 21, 2021 COVID-19 Pandemic Business Continuity Planning

Guidance regarding our Public Health Priorities in 2021

The intent of this document is to articulate our organizational priorities for 2021 as we respond to the COVID-19 pandemic, and to provide parameters and guidance to management/staff when prioritizing program activities and their associated resources. The Health Unit priorities were established by the Executive team and informed by program BIAs, organizational factors, along with health system and community context.

All activities are prioritized based on our current state (January 2021) and were informed by the Business Impact Analysis completed by program managers in the Fall of 2020. Priorities will be re-assessed on a quarterly basis by the ET

Summary of Public Health Priorities in 2021

Activities are rated into categories representing four level of priority: HIGHEST, HIGH, MEDIUM and LOW. High priority activities will be resourced first, then medium, followed by low priority activities

Please note these activity descriptions are high level and it is recognized that there may be several components within each activity, or that activities that are listed separately are implemented together. Please refer to *Program/Activity Priority Assessment document* for complete list of priorities and activities.

- Public Health Response to COVID-19 remains the highest priority in 2021:
  - COVID-19 case & contact management
  - COVID-19 outbreak management
  - COVID-19 vaccine activities
  - IPAC Hub & Spoke Model
  - Other COVID-19 IMS activities (e.g. Surveillance, IPAC, Call and Email Centre, Communications, School PHNs, Shared Staffing Coordination, etc.)
- If above priorities are adequately resourced, the following public health activities are deemed high priority:
  - Urgent Oral Health services
  - Urgent Sexual Health services
  - Environmental Health inspection and investigation services (as per risk assessment by program manager/ED)
  - CCM and Outbreak Management activities for Diseases of Public Health Significance
  - Harm reduction and substance use services and work (related to opioid/illicit substances, alcohol and tobacco) including surveillance and health promotion activities
  - * Mental health promotion work (see Additional notes below for further guidance re prioritization)
- If all above priorities are adequately resourced, all remaining public health activities are prioritized as medium or low priority (see additional Spreadsheet - *Program/Activity Priority Assessment* for specific details)

Additional notes:

- The list of activities is not exhaustive and represents large areas of work. Further discussions may be required to further define priority activities and how to prioritize activities within each category
- Program activities are often contingent on support from Services (e.g. Communications, IT). As much as possible, Service requests for high priority public health activities will be resourced first, medium priority second and so on
- Activities such as CQI, policy and procedures and committees should be aligned with priorities (e.g. Policies and procedures for High priority activities should be prioritized over policies and procedures for medium and low priority activities, attendance at Committees that align with High Priority activities should be prioritized over those that align with medium and low priority activities)
- * Mental health promotion work- mental health promotion activities occur mostly as a secondary objective within to other programming. Prioritize activities with major focus on MH promotion for vulnerable populations, which are not available through community partners. Consideration should be given to activities that are responding to Mental health issues that are secondary impacts of COVID 19 and public health measures (factors affecting coping such as isolation, chronic stress, depression and anxiety)
  Generally priority should be given to activities that target the following, in this order:
  1) Program and services that support Child/Youth Mental Health and Wellbeing, such as Healthy Babies Healthy Children program, parenting information and support, etc.
  2) Adult (Parents/Guardians) Mental Health & Wellbeing

Next steps:

Managers to review current Program priorities as identified through BIA process (fall 2020) in context of HU priorities for 2021. Make adjustments as needed to align program priorities and therefore business continuity staffing requirements with organizational priorities. Consult your ED as needed.

Tools/ templates and additional guidance will be provided (Jan 18 Manager Committee meeting) which support the following:

By Jan 29, 2021, Managers will need to:

1. Update program priorities to align with agency priorities, if necessary

2. Create/update plan for scaling back program activities as per priority level in event of deployment

3. Create your "Order of Deployment "list based on # and type of staff needed to sustain these priority program activities

4. Complete "Staff details" sheet which will be used by deployment coordinator.