Algoma
PUBLIC HEALTH
Santé publique Algoma

# November 24, 2021

## BOARD OF HEALTH MEETING

Videoconference

www.algomapublichealth.com

# Meeting Book - November 24, 2021 Board of Health Meeting

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Algoma PUBLIC HEALTH
Santé publique Algoma

**Board of Health Meeting**
**AGENDA**
**November 24, 2021 at 5:00 pm**
**Video/Teleconference**

| **BOARD MEMBERS** | **APH MEMBERS** |
|---|---|
| Sally Hagman - Board Chair | Dr. Jennifer Loo - Medical Officer of Health & CEO |
| Ed Pearce - 1st Vice Chair | Dr. John Tuinema - Associate Medical Officer of Health |
| Deborah Graystone - 2nd Vice Chair | Antoniette Tomie - Director of Corporate Services |
| Lee Mason | Laurie Zeppa - Director of Health Promotion & Prevention |
| Micheline Hatfield | Leo Vecchio - Manager of Communications |
| Musa Onyuna | Liliana Bressan - Research Policy Advisor |
| Brent Rankin | Leslie Dunseath - Financial Analyst |
| Matthew Scott | Tania Caputo - Board Secretary |
| Louise Caicco Tett | Tanya Storozuk - Executive Assistant |

* ***Recorded proceedings are available upon request***

**1.0 Meeting Called to Order** *S. Hagman*

**a.** Land Acknowledgement

**b.** Declaration of Conflict of Interest

**2.0 Adoption of Agenda** *S. Hagman*

**RESOLUTION**

THAT the Board of Health agenda dated November 24, 2021 be approved as presented.

**3.0 Delegations / Presentations**

**4.0 Adoption of Minutes of Previous Meeting** *S. Hagman*

**RESOLUTION**

THAT the Board of Health meeting minutes dated October 27, 2021 be approved as presented.

**5.0 Business Arising from Minutes** *S. Hagman*

**6.0 Reports to the Board**

**a. Medical Officer of Health and Chief Executive Officer Reports** *J. Loo*

**i.** MOH Report - November 24, 2021

**RESOLUTION**

THAT the report of the Medical Officer of Health/CEO for November 2021 be accepted as presented.

**ii. 2022 Budget Presentation ( in Addendum )**

**b. Finance and Audit**

**i. Finance & Audit Committee Chair Report - November 10, 2021** *E. Pearce*

**RESOLUTION**

THAT the Board of Health approves the Finance & Audit Committee Chair Report for November 10, 2021, as presented.

**ii. Unaudited Financial Statements for the period ending September 30, 2021.** *E. Pearce*

**RESOLUTION**

THAT the Board of Health approves the Unaudited Financial Statements for the period ending September 30, 2021, as presented.

**iii. 2022 Public Health Operating and Capital Budget.** *E. Pearce, L. Dunseath*

**RESOLUTION**

THAT the Board of Health has reviewed and accepts the recommendation of the Finance and Audit Committee to approve the **2022 Public Health Operating and Capital Budget.**

**c. Governance**

**i. Governance Committee Chair Report - November 16, 2021** *D. Graystone*

**RESOLUTION**

THAT the Board of Health approves the Governance Committee Chair Report for November 16, 2021, as presented.

**ii. Algoma Public Health Board Recruitment** *D. Graystone*

**7.0 New Business/General Business**

**a. Algoma Vaccination Council Update** *L. Caicco Tett*

**8.0 Correspondence** *S.Hagman*

**a.** Letter to the Ministry of Health, from Algoma Public Health regarding **Annualized IPAC Hub Funding and Increase Provincial Base Funding** dated November 16, 2021.

**b.** Letter to the Ministry of Health, from Haliburton, Kawartha, Pine Ridge District Health Unit regarding **Vision services for patients under the Ontario Health Insurance Plan (OHIP).** dated November 18, 2021.

**9.0 Items for Information**

**10.0 Addendum**

**a. 2022 Budget Presentation** *J. Loo*

**b. alPHa Fall Symposium Minutes** *S. Hagman L. Caicco Tett*

**11.0 In-Camera** *S. Hagman*

For discussion of labour relations and employee negotiations, **matters about identifiable individuals, adoption of in-camera minutes,** security of the property of the board, litigation or potential litigation.

**RESOLUTION**

THAT the Board of Health go in-camera.

**12.0 Open Meeting** *S. Hagman*

Resolutions resulting from in camera meeting.

**13.0 Announcements / Next Committee Meetings:** *S. Hagman*

**Board of Health Meeting**
Wednesday, January 26, 2022 @ 5:00 pm
Video Conference │SSM Algoma Community Room

**Finance & Audit Committee**
Wednesday, February 9, 2022 @ 5:00 pm
Video Conference │SSM Algoma Community Room

**Governance Committee Meeting**
Wednesday, March 9, 2022 @ 5:00 pm
Video Conference │SSM Algoma Community Room

**14.0 Evaluation** *S. Hagman*

**15.0 Adjournment** *S. Hagman*

**RESOLUTION**

THAT the Board of Health meeting adjourns.

Algoma
PUBLIC HEALTH
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November 24, 2021

Report of the

# Medical Officer of Health / CEO

Prepared by:
Dr. Jennifer Loo and the
Leadership Team

Presented to:
Algoma Public Health Board of Health

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# APH AT-A-GLANCE

**COVID-19 Pandemic Response in Algoma**

Algoma has experienced a dramatic surge in COVID-19 during the month of November 2021. Over a matter of a two week period, the 7-day rate of new cases increased from 23.8 per 100,000 from Nov 1-7 to 138.1 per 100,000 from Nov 11-17. Exposures and outbreaks have impacted a variety of settings and groups, including workplaces, sport and recreational facilities, schools, and settings for people who are vulnerably housed. On November 17, 2021, at the time of writing, there were 209 active cases in Algoma, with 15 people hospitalized with COVID-19, and the majority of cases (98%) from Sault Ste. Marie and area. At the time of writing, COVID-19 activity in Algoma has been among the highest out of Ontario's health units.

In response to the surge in local community transmission, APH issued a public statement on Friday, November 12, urging all Algoma residents to immediately take the three actions of staying home when sick (even if fully vaccinated), cutting down on unnecessary unmasked close contact and postponing non-essential gatherings, and getting immunized against COVID-19 (including a 3rd dose booster for people who are eligible). Furthermore, on Monday, November 15, the Medical Officer of Health implemented additional mandatory measures, both across Algoma and specifically for Sault Ste. Marie. This included a Section 22 Class Order that legally requires confirmed or suspected COVID-19 cases and their contacts to isolate and Letters of Instructions that require Sault Ste. Marie businesses to reinstate recently lifted provincial capacity limits and physical distancing requirements, and require anyone 12+ participating in organized sports indoors, Algoma wide, to provide proof of vaccination.

APH's public health measures were undertaken with strong support from both the local municipality of Sault Ste. Marie, and the provincial Chief Medical Officer of Health. APH has also further amplified public health messaging and protective measures to all sectors across Algoma communities, through media and multiple communication channels, sector liaisons and COVID-19 response teams such as the Healthy Workplaces Team, School COVID-19 support team, and COVID-19 phone line. In response to the considerable surge of work faced by APH's case and contact management teams, APH has not only redeployed a considerable number of staff internally, but also been actively engaging in and pursuing partnerships in case and contact support, through external health units, local First Nation health partners, and the provincial workforce.

**COVID-19 Immunization Update**

As of November 17, 2021, 83,127 total doses of COVID-19 vaccine have been administered to Algoma residents. Of all eligible Algoma residents born in 2009 or later, over 90% have received at least one dose of a COVID-19 vaccine, and over 86% have received two doses. This means that 77% of the total population in Algoma, or about 88,000 residents, are fully immunized. About 22,000 Algoma residents remain unimmunized with any dose of COVID-19 vaccine, of which about 10,000 are currently eligible for immunization based on age.

APH and immunization partners have continued to provide third dose booster doses to those eligible, which now include people aged 70 and over, health care workers, and Indigenous people. Third doses are provided to eligible groups 168 days or 24 weeks following their second dose. As of November 17, 2021, just over 2,800 third doses have been administered to eligible Algoma residents.

APH is actively preparing for the rollout of vaccines to children aged 5-11, now that these vaccines are approved by Health Canada and are recommended for this age group by the National Advisory Committee on Immunization. After surveying Algoma parents and guardians on their preferences for the immunization of this age group, APH and partners are using this information and holding district-wide immunization clinics at a variety of settings. In addition to local pharmacies and community clinics with both appointment-based and walk-in formats, mobile and pop-up clinics will be available, in key neighbourhood locations as well as select school locations, at convenient times for parents (e.g. weekday evenings and weekends).

# 2022 Recommended Public Health Operating & Capital Budget

Dr. Jennifer Loo, Medical Officer of Health & CEO

Leslie Dunseath, Financial Analyst

**November 2021**

Algoma PUBLIC HEALTH
Santé publique Algoma

# 2022 Budget: $19.6 M

**Table 1.0: Budget Analysis, 2019 – Recommended 2022**

| Budget Analysis, 2019-2022 | | | | | | | |
|---|---|---|---|---|---|---|---|
| Revenues Summary | 2019 Actual | 2020 Actual | 2021 Budget | 2021 Forecast | 2022 Budget | % Change 2022 vs. 2021 Budget | 2022 Budget vs. 2021 Forcast |
| Province Portion of Jointly Funded Programs | $7,523,200 | $ 8,703,177 | $8,708,100 | $8,708,100 | $8,708,100 | 0.00% | 0.00% |
| 100% Provincially Funded Programs | 3,405,823 | 2,027,810 | 3,650,186 | 5,184,386 | 5,313,000 | 45.55% | 2.48% |
| Province Mitigation Fund | - | 1,037,800 | 1,037,800 | 1,037,800 | 1,037,800 | 0.00% | 0.00% |
| Municipal Levies | 3,519,703 | 3,559,232 | 3,808,378 | 3,808,378 | 4,189,216 | 10.00% | 10.00% |
| Other Recoveries and Fees | 688,282 | 503,127 | 418,330 | 418,330 | 379,075 | -9.38% | -9.38% |
| Total | **15,137,008** | **15,831,146** | **17,622,794** | **19,156,994** | **19,627,191** | 11.37% | 2.45% |

- Increase of 2.45% from 2021 ($470,197)
  - 82% of budget increase due to salaries, wages, and benefits
  - 18% of budget increase due to operating costs
- Supports 15 new FTE positions to sustain the COVID-19 response and restore public health programs to address service backlogs – further details in upcoming slides and full budget report.

# Increase to Municipal Levies: **10%** ($380,838)

**Table 1.0: Budget Analysis, 2019 – Recommended 2022**

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| Total | **15,137,008** | **15,831,146** | **17,622,794** | **19,156,994** | **19,627,191** | 11.37% | 2.45% |

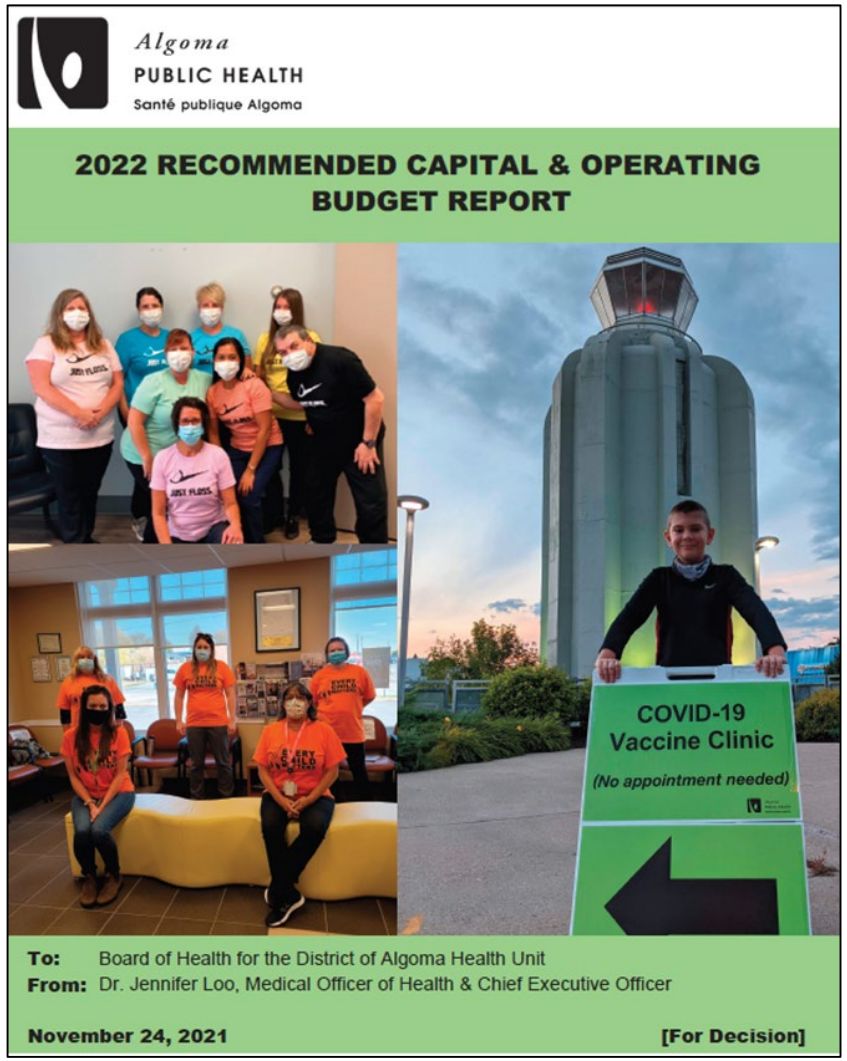
- In general, **Algoma municipalities have spent less than 1.5% of total municipal revenues on public health** levies, based on municipal budgets accessed for 2018 to 2020.

| Algoma Public Health: Historical Approved Per Capita Rates | |
|---|---|
| **Year** | **Approved Rate** |
| 2018 | $33.63 |
| 2019 | $33.80 |
| 2020 | $34.18 |
| 2021 | $36.57 |
| **2022** | **$40.23 (Budgeted)** |

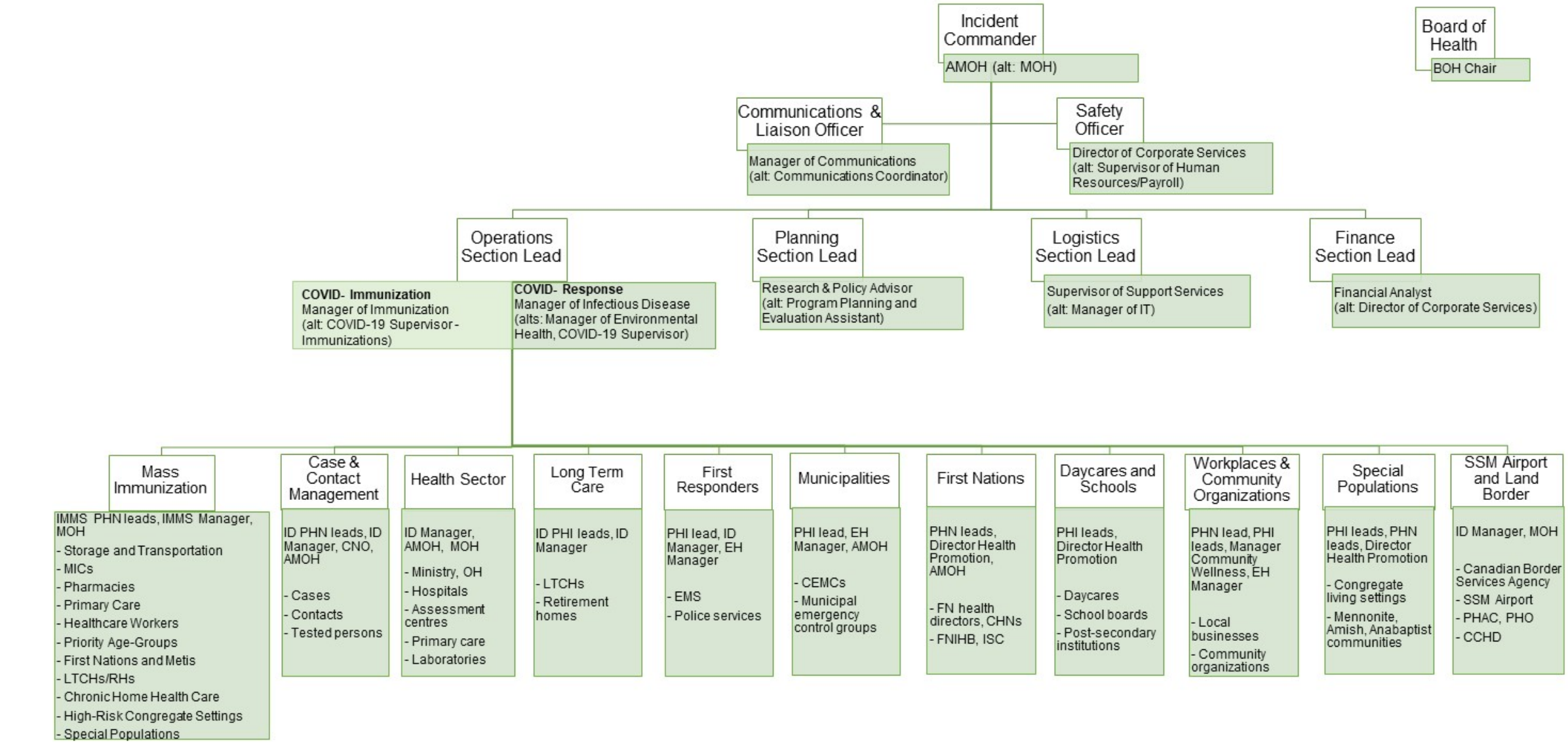
- APH's per capita rate ranks in the middle of northern health units.
- Local public health services in Algoma are projected to cost about **46 cents per person per day**, or $13.88 per person per month, or $166.56 per person per year, based on a 2020 census population of 117,840 for the District of Algoma Health Unit, and our recommended 2022 budget of $19,627,191.

# Background to the 2022 Budget

- The **work** of public health throughout 2021
- The **impact** to population health and public health service delivery
- The **cost** – both the financial and health human resource toll



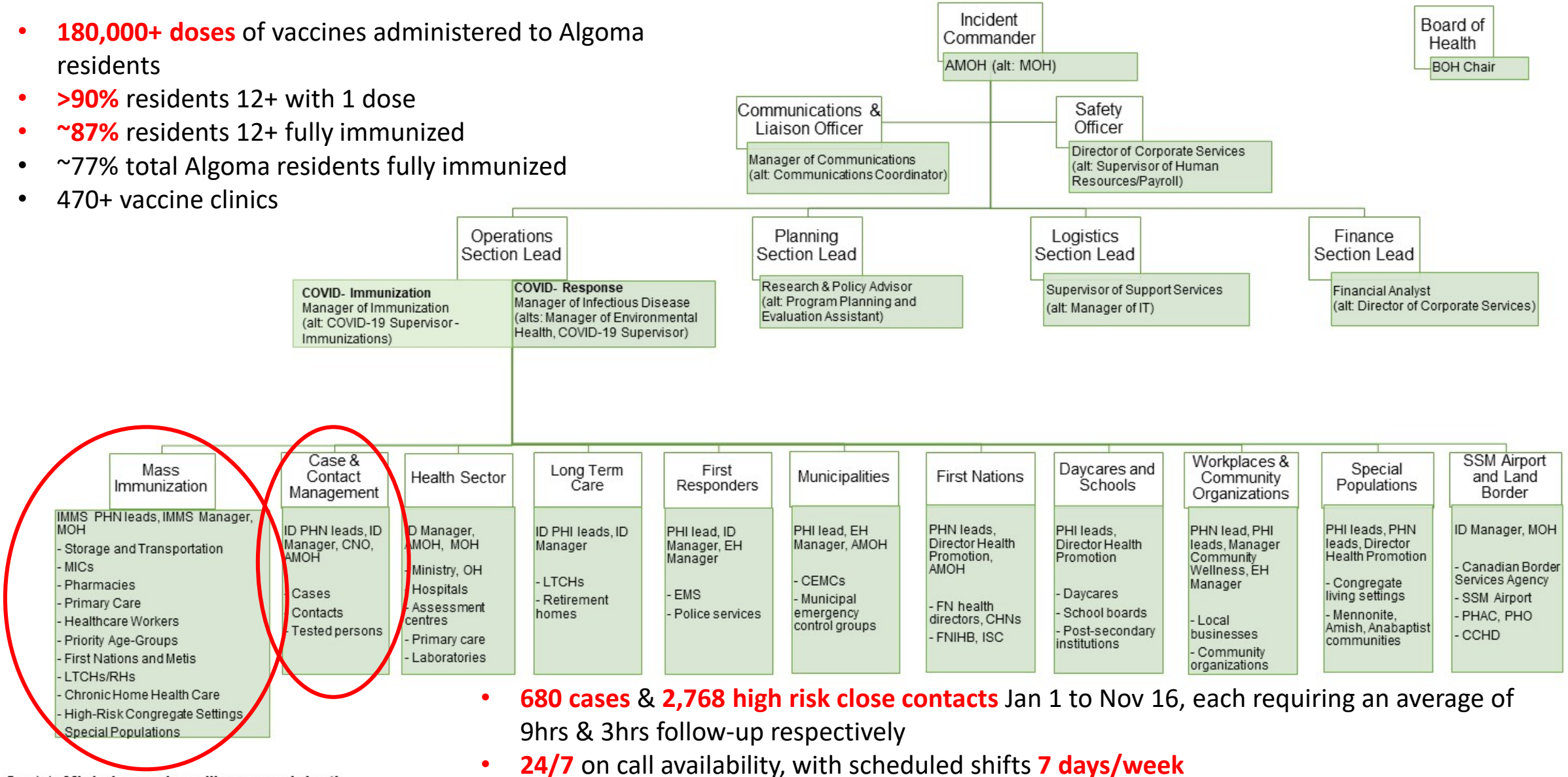
# IMS Structure: APH COVID-19 Response




Goal 1: **Minimize serious illness and death**
Goal 2: **Minimize societal disruption** (and preserve health care services)

# IMS Structure: APH COVID-19 Response

- **180,000+ doses** of vaccines administered to Algoma residents
- **>90%** residents 12+ with 1 dose
- **~87%** residents 12+ fully immunized
- ~77% total Algoma residents fully immunized
- 470+ vaccine clinics



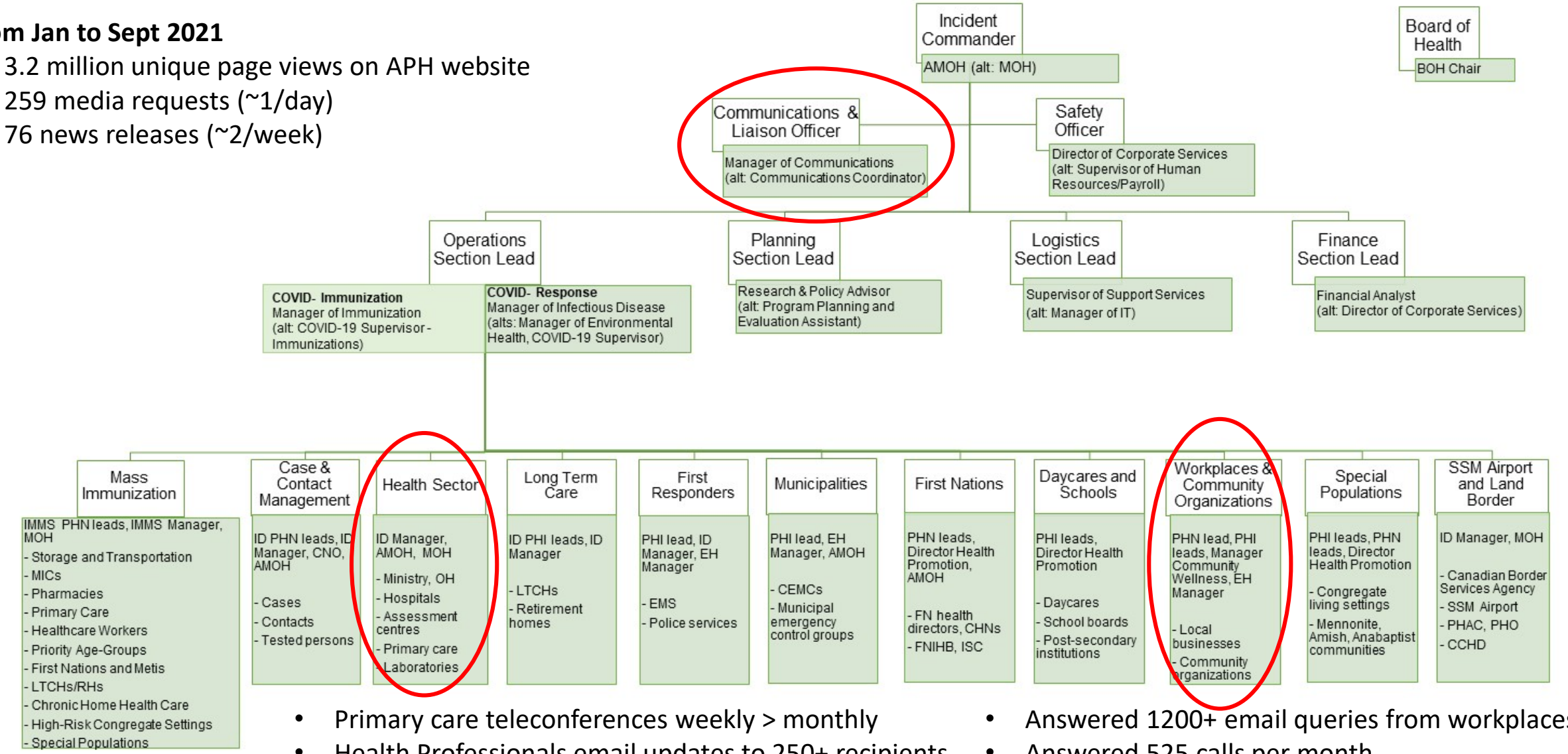

- **680 cases** & **2,768 high risk close contacts** Jan 1 to Nov 16, each requiring an average of 9hrs & 3hrs follow-up respectively
- **24/7** on call availability, with scheduled shifts **7 days/week**

Goal 1: **Minimize serious illness and death**
Goal 2: **Minimize societal disruption** (and preserve health care services)

# IMS Structure: APH COVID-19 Response

**From Jan to Sept 2021**

- 3.2 million unique page views on APH website
- 259 media requests (~1/day)
- 76 news releases (~2/week)



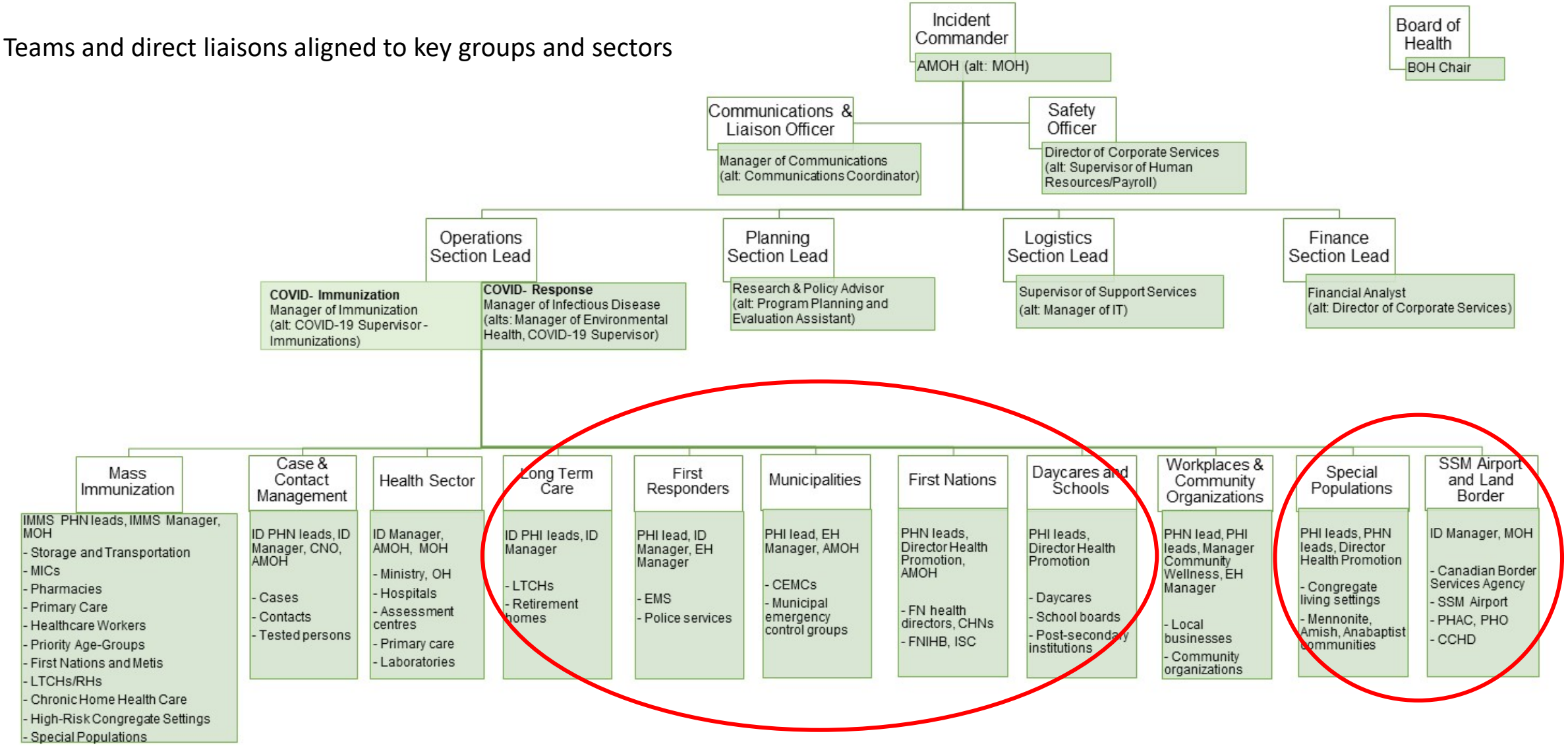

- Primary care teleconferences weekly > monthly
- Health Professionals email updates to 250+ recipients

- Answered 1200+ email queries from workplaces
- Answered 525 calls per month
- Conducted over 574 site inspections
- E-blasts to Algoma businesses (2,200+ recipients)

Goal 1: **Minimize serious illness and death**
Goal 2: **Minimize societal disruption** (and preserve health care services)

# IMS Structure: APH COVID-19 Response

- Teams and direct liaisons aligned to key groups and sectors




Goal 1: **Minimize serious illness and death**
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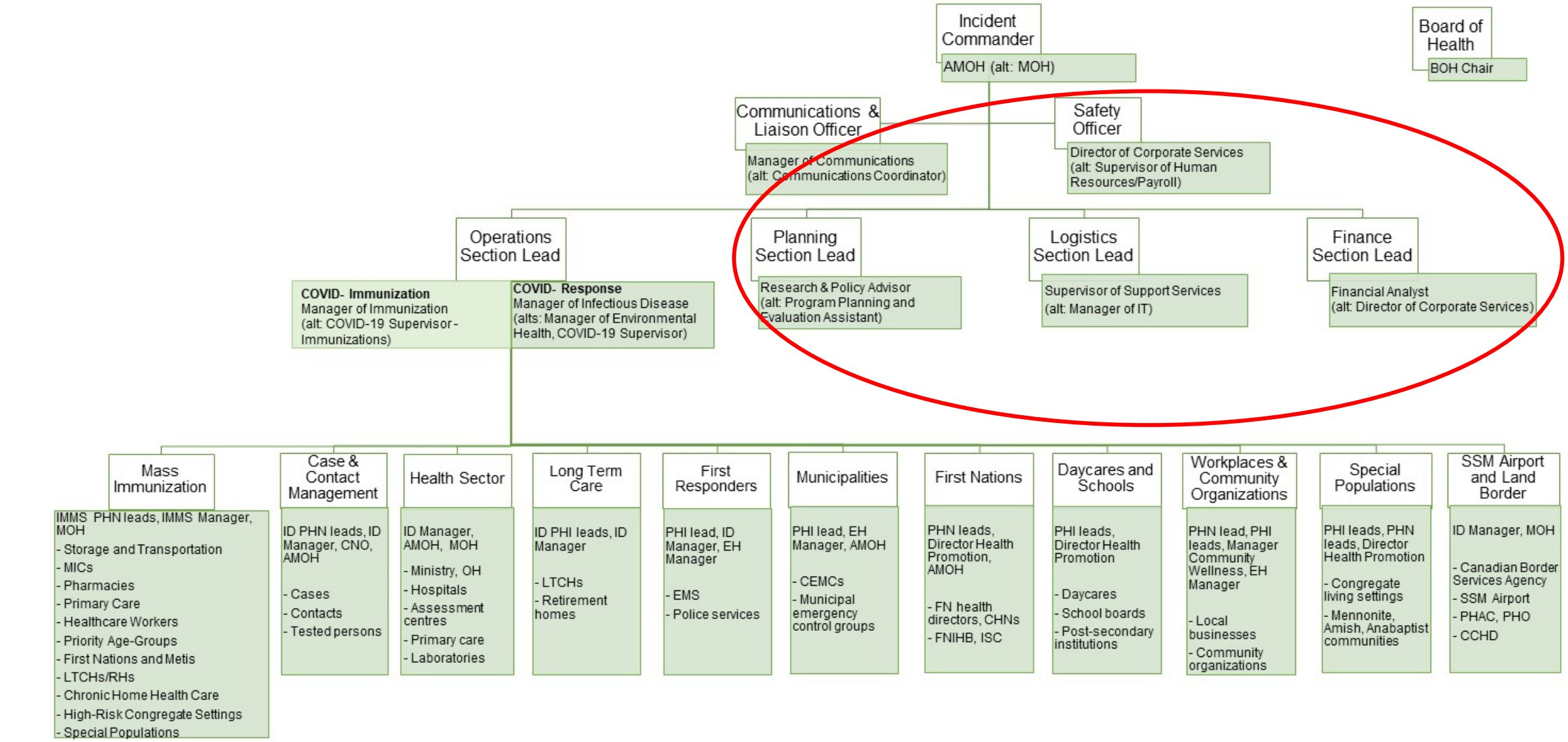
# IMS Structure: APH COVID-19 Response

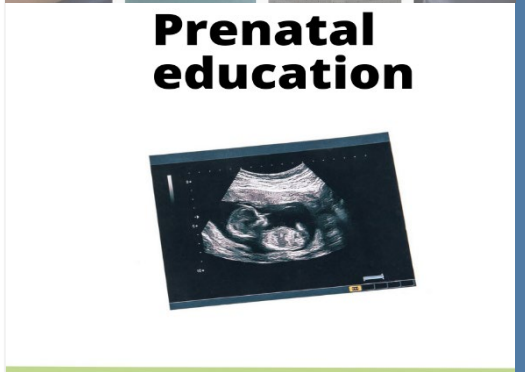



Goal 1: **Minimize serious illness and death**
Goal 2: **Minimize societal disruption** (and preserve health care services)

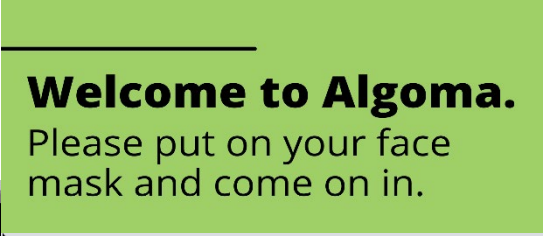
# The Work of Public Health

- Intense response to COVID-19
- Maintenance of core, high risk public health programs & services












# The Impact to Population Health

## COVID-19 Prioritization Benefits:

- Serious illness and death has remained limited in Algoma
- Community action to keep transmission low has helped to minimize societal disruption

## Population Health Impacts:

- Increases in vaccine preventable disease (e.g. chickenpox)
- Increases in sexually transmitted infections (e.g. gonorrhea, chlamydia)
- Increases in opioid-related harms

### Status of cases in Algoma

| Tested (1) | Confirmed cases (2) | Active cases | Currently hospitalized | Resolved cases (3) | Deceased |
|---|---|---|---|---|---|
| 185,813 | 890 | 270 | 17 | 620 | 9 |

Updated: November 22, 2021, 9:30 AM

### Immunization Uptake and Coverage in Algoma

Last Updated: 7:15 PM, November 19, 2021

**Population coverage**

| | |
|---|---|
| % of total population that has received at least one dose | 80.4% |
| % of total population that are fully vaccinated (received two doses) | 77.4% |
| % of eligible population (12+) that have received at least one dose* | 90.2% |
| % of eligible population (12+) that are fully vaccinated (received two doses)* | 86.9% |
| % of youth population (12-17) that have received at least one dose* | 82.3% |
| % of adult population (18+) that have received at least one dose | 90.8% |
| % of adult population (18+) that have are fully vaccinated (received two doses) | 87.6% |

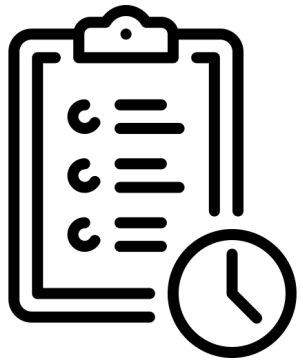
*Note: based on 2020 projected population*

**Current eligibility includes 12+ & anyone born in 2009, the population denominator has been adjusted as of August 23rd to include eligible 11 year olds*

# **The Backlog**:
# Impacts to public health service delivery

- 1 year waitlist (100+ people) for smoking cessation support
- Suspension of virtual prenatal classes
- Backlog of routine food safety & safe water inspections
- Backlog of 14,200+ doses for school-based immunization
- Backlog of 4,500 infant and childhood vaccines
- 18-month backlog in school dental screenings
- 200+ clients awaiting seniors' dental services

**… and more!**



# **The Cost:**
# Financial & Health Human Resource Toll

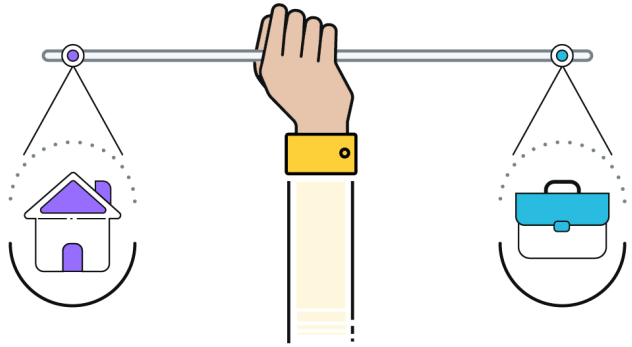
- ONA and CUPE employees have worked extra hours in callout, overtime, and lieu.
  - 2020: 71.3% increase in hours compared to 2019.
  - 2021: 166.3% increase in hours compared to 2019.

- Leadership and non-union employees worked 3,427 overtime hours from Jan 1 to Sept 18, 2021 ($211,745).

- Accrued lieu time and paid vacation time have not been taken.

- Due to recruitment challenges, as of Nov 4, 2021, there are 16.0 FTE that remain vacant (8.86% of workforce).

- Ongoing workload has depleted human capital, and impacted work-life balance and employee health and wellness.



# **Budget 2022:** FTE Analysis

- Salary and wage expenses projected to increase by 2.27% or $265,513 compared to 2021.
  - 1.5% salary increase for all staff, aligned with collectively bargained increases.
  - Assume that the 16 FTE which are currently vacant will be filled.

- To sustain the COVID-19 response and restore programs to address the backlog of services, 15 new FTE positions were approved by the APH executive to be included in the 2022 budget, subject to approval by the BOH.
  - The new positions are reflected as 11.5 FTE in the 2022 budget, as it is recognized that not all of the positions will be filled by January 1, 2022.

## Chair's Report

## Finance and Audit Committee

At the Finance and Audit committee meeting held on November 10, the committee accepted the unaudited financial statements for September 30, 2021, and forwarded them to the Board for approval.

At the same meeting the Finance and Audit committee accepted the proposed Operating and Capital Budget for 2022 and forwarded them to the Board for approval.

## Algoma Public Health
## (Unaudited) Financial Statements September 30, 2021

**Algoma Public Health**
**Statement of Operations**
**September 2021**
**(Unaudited)**

| | Actual YTD 2021 | Budget YTD 2021 | Variance Act. to Bgt. 2021 | Annual Budget 2021 | Variance % Act. to Bgt. 2021 | YTD Actual/ YTD Budget 2021 |
|---|---|---|---|---|---|---|
| **Public Health Programs (Calendar)** | | | | | | |
| **Revenue** | | | | | | |
| Municipal Levy - Public Health | **$ 2,856,283** | $ 2,856,284 | $ (1) | $ 3,808,378 | 0% | 100% |
| Provincial Grants - Cost Shared Funding | **6,531,084** | 6,531,084 | (0) | 8,708,100 | 0% | 100% |
| Provincial Grants - Public Health 100% Prov. Funded | **3,293,408** | 3,251,233 | 42,175 | 3,650,186 | 1% | 101% |
| Provincial Grants - Mitigation Funding | **778,354** | 778,356 | (2) | 1,037,800 | 0% | 100% |
| Fees, other grants and recovery of expenditures | **336,962** | 292,268 | 44,694 | 418,330 | 15% | 115% |
| **Total Public Health Revenue** | **$ 13,796,091** | $ 13,709,224 | $ 86,867 | $ 17,622,794 | 1% | 101% |
| **Expenditures** | | | | | | |
| Public Health Cost Shared | **$ 12,014,220** | $ 11,926,307 | $ (87,913) | $ 16,027,008 | 1% | 101% |
| Public Health 100% Prov. Funded Programs | **1,232,599** | 1,197,167 | (35,432) | 1,595,786 | 3% | 103% |
| **Total Public Health Programs Expenditures** | **$ 13,246,819** | $ 13,123,474 | $ (123,345) | $ 17,622,794 | 1% | 101% |
| **Total Rev. over Exp. Public Health** | **$ 549,273** | $ 585,751 | $ (36,478) | $ 1 | | |
| **Healthy Babies Healthy Children (Fiscal)** | | | | | | |
| Provincial Grants and Recoveries | **$ 534,011** | 534,011 | - | 1,068,011 | 0% | 100% |
| Expenditures | **504,523** | 532,905 | (28,382) | 1,068,011 | -5% | 95% |
| **Excess of Rev. over Exp.** | **29,488** | 1,106 | 28,382 | - | | |
| **Public Health Programs (Fiscal)** | | | | | | |
| Provincial Grants and Recoveries | **$ 489,071** | 508,468 | 19,397 | 693,000 | | |
| Expenditures | **362,996** | 414,710 | (51,714) | 693,000 | | |
| **Excess of Rev. over Fiscal Funded** | **126,075** | 93,758 | 32,317 | - | | |
| **Community Health Programs (Non Public Health)** | | | | | | |
| **Calendar Programs** | | | | | | |
| **Revenue** | | | | | | |
| Provincial Grants - Community Health | **$ -** | $ - | $ - | $ - | | |
| Municipal, Federal, and Other Funding | **71,858** | 71,858 | - | 71,858 | 0% | 100% |
| **Total Community Health Revenue** | **$ 71,858** | $ 71,858 | $ - | $ 71,858 | 0% | 100% |
| **Expenditures** | | | | | | |
| Child Benefits Ontario Works | **0** | - | - | - | #DIV/0! | #DIV/0! |
| Algoma CADAP programs | **71,858** | 71,858 | - | 71,858 | 0% | 100% |
| **Total Calendar Community Health Programs** | **$ 71,858** | $ 71,858 | $ - | $ 71,858 | 0% | 100% |
| **Total Rev. over Exp. Calendar Community Health** | **$ -** | $ - | $ - | $ - | | |
| **Fiscal Programs** | | | | | | |
| **Revenue** | | | | | | |
| Provincial Grants - Community Health | **$ 1,029,893** | $ 1,029,874 | $ 19 | $ 2,059,744 | 0% | 100% |
| Municipal, Federal, and Other Funding | **85,836** | 57,224 | 28,613 | 114,447 | 50% | 150% |
| Other Bill for Service Programs | **0** | 0 | - | - | | |
| **Total Community Health Revenue** | **$ 1,115,729** | $ 1,087,097 | $ 28,632 | $ 2,174,191 | 3% | 103% |
| **Expenditures** | | | | | | |
| Brighter Futures for Children | **64,114** | 57,223 | (6,891) | 114,447 | 12% | 112% |
| Infant Development | **317,623** | 321,109 | 3,486 | 644,317 | -1% | 99% |
| Preschool Speech and Languages | **304,356** | 326,216 | 21,860 | 733,971 | -7% | 93% |
| Nurse Practitioner | **83,139** | 80,077 | (3,063) | 162,153 | 4% | 104% |
| Stay on Your Feet | **49,131** | 50,000 | 869 | 100,000 | -2% | 98% |
| Rent Supplements CMH | **172,865** | 209,651 | 36,787 | 419,303 | -18% | 82% |
| Bill for Service Programs | **8,963** | 0 | (8,963) | (0) | | |
| Misc Fiscal | **-** | - | - | - | #DIV/0! | #DIV/0! |
| **Total Fiscal Community Health Programs** | **$ 1,000,191** | $ 1,044,276 | $ 44,085 | $ 2,174,191 | -4% | 96% |
| **Total Rev. over Exp. Fiscal Community Health** | **$ 115,538** | $ 42,821 | $ 72,717 | $ - | | |

Explanations will be provided for variances of 15% and $15,000 occurring in the first 6 months
and variances of 10% and $10,000 occurring in the final 6 months

***Algoma Public Health***

***Revenue Statement***

*For Nine Months Ending September 30, 2021*

*(Unaudited)*

| | Actual YTD 2021 | Budget YTD 2021 | Variance Bgt. to Act. 2021 | Annual Budget 2021 | Variance % Act. to Bgt. 2021 | YTD Actual/ Annual Budget 2021 | *Comparison Prior Year:* YTD Actual 2020 | YTD BGT 2020 | Variance 2020 |
|---|---|---|---|---|---|---|---|---|---|
| Levies Sault Ste Marie | 2,012,541 | 2,012,541 | 0 | 2,683,388 | 0% | 75% | 2,002,033 | 2,002,033 | 0 |
| Levies District | 843,744 | 843,744 | 0 | 1,124,992 | 0% | 75% | 839,340 | 839,340 | 0 |
| **Total Levies** | **2,856,285** | **2,856,285** | **0** | **3,808,380** | **0%** | **75%** | **2,841,373** | **2,841,373** | **0** |
| MOH Public Health Funding | 6,531,084 | 6,531,084 | 0 | 8,708,100 | 0% | 75% | 5,597,829 | 4,700,671 | 897,158 |
| MOH Funding Needle Exchange | 0 | 0 | 0 | 0 | 0% | 0% | 48,527 | 48,525 | 2 |
| MOH Funding Haines Food Safety | 0 | 0 | 0 | 0 | 0% | 0% | 18,450 | 18,450 | 0 |
| MOH Funding Healthy Smiles | 0 | 0 | 0 | 0 | 0% | 0% | 577,423 | 577,425 | (2) |
| MOH Funding - Social Determinants of Health | 0 | 0 | 0 | 0 | 0% | 0% | 241,181 | 135,360 | 105,821 |
| MOH Funding Chief Nursing Officer | 0 | 0 | 0 | 0 | 0% | 0% | 30,375 | 91,134 | (60,759) |
| MOH Enhanced Funding Safe Water | 0 | 0 | 0 | 0 | 0% | 0% | 11,627 | 11,625 | 2 |
| MOH Funding Infection Control | 0 | 0 | 0 | 0 | 0% | 0% | 189,256 | 234,306 | (45,050) |
| MOH Funding Diabetes | 0 | 0 | 0 | 0 | 0% | 0% | 112,500 | 112,500 | 0 |
| Funding Ontario Tobacco Strategy | 0 | 0 | 0 | 0 | 0% | 0% | 325,204 | 325,200 | 4 |
| MOH Funding Harm Reduction | 0 | 0 | 0 | 0 | 0% | 0% | 112,500 | 112,500 | 0 |
| MOH Funding Vector Borne Disease | 0 | 0 | 0 | 0 | 0% | 0% | 27,175 | 81,522 | (54,347) |
| MOH Funding Small Drinking Water Systems | 0 | 0 | 0 | 0 | 0% | 0% | 17,400 | 52,200 | (34,800) |
| **Total Public Health Cost Shared Funding** | **6,531,084** | **6,531,084** | **0** | **8,708,100** | **0%** | **75%** | **7,309,447** | **6,501,418** | **808,029** |
| MOH Funding - MOH / AMOH Top Up | 163,189 | 114,064 | 49,125 | 152,086 | 43% | 107% | 117,613 | 114,064 | 3,549 |
| MOH Funding Northern Ontario Fruits & Veg. | 88,054 | 88,050 | 4 | 117,400 | 0% | 75% | 88,054 | 88,050 | 4 |
| MOH Funding Unorganized | 397,800 | 397,800 | 0 | 530,400 | 0% | 75% | 397,800 | 397,800 | 0 |
| MOH Senior Dental | 523,423 | 523,425 | (2) | 697,900 | 0% | 75% | 497,043 | 523,425 | 0 |
| MOH Funding Indigenous Communities | 73,496 | 73,494 | 2 | 98,000 | 0% | 75% | 0 | 24,500 | 0 |
| One Time Funding (Pandemic Pay) | | | | | | | 143,600 | 143,600 | |
| OTF COVID-19 extraordinary costs mass imms | 2,054,400 | 2,054,400 | 0 | 2,054,400 | 0% | 100% | 0 | 0 | |
| **Total Public Health 100% Prov. Funded** | **3,300,362** | **3,251,233** | **49,129** | **3,650,186** | **2%** | **90%** | **1,244,110** | **1,291,439** | **3,553** |
| **Total Public Health Mitigation Funding** | **778,354** | **778,356** | **(2)** | **1,037,800** | **0%** | **75%** | **0** | **606,401** | **(606,401)** |
| Recoveries from Programs | 25,374 | 25,010 | 364 | 28,010 | 1% | 91% | 25,543 | 20,648 | 4,896 |
| Program Fees | 87,432 | 89,914 | (2,482) | 105,320 | -3% | 83% | 139,906 | 150,963 | (11,057) |
| Land Control Fees | 213,065 | 115,000 | 98,065 | 160,000 | 85% | 133% | 141,422 | 115,000 | 26,422 |
| Program Fees Immunization | 4,632 | 37,494 | (32,862) | 45,000 | -88% | 10% | 30,142 | 86,250 | (56,108) |
| HPV Vaccine Program | 0 | 0 | 0 | 12,500 | 0% | 0% | 0 | 3,000 | (3,000) |
| Influenza Program | 0 | 0 | 0 | 25,000 | 0% | 0% | 0 | 1,500 | (1,500) |
| Meningococcal C Program | 0 | 0 | 0 | 7,500 | 0% | 0% | 0 | 625 | (625) |
| Interest Revenue | 9,980 | 14,850 | (4,870) | 20,000 | -33% | 50% | 16,937 | 30,000 | (13,063) |
| Other Revenues | (10,477) | 10,000 | (20,477) | 15,000 | -205% | -70% | 3,141 | 24,500 | (21,359) |
| **Total Fees and Recoveries** | **330,006** | **292,268** | **37,738** | **418,330** | **13%** | **79%** | **357,091** | **432,486** | **(75,395)** |
| **Total Public Health Revenue Annual** | **13,796,091** | **13,709,226** | **86,865** | **17,622,796** | **1%** | **78%** | **11,752,021** | **11,673,117** | **736,187** |
| **Public Health Fiscal April 2021 - March 2022** | | | | | | | | | |
| Vaccine Refrigerators | 3,704 | 3,702 | 2 | 7,400 | 0% | 50% | | | |
| Infection Prevention and Control Hub | 97,000 | 116,400 | (19,400) | 320,000 | -17% | 30% | | | |
| Practicum | 9,999 | 10,000 | (1) | 20,000 | 0% | 50% | | | |
| School Nurses Initiative | 348,252 | 348,250 | 2 | 700,000 | 0% | 50% | | | |
| Sr Dental Capital Upgrades | 30,116 | 30,116 | 0 | 95,841 | 0% | 31% | | | |
| **Total Provincial Grants Fiscal** | **489,071** | **508,468** | **(19,397)** | **1,143,241** | **-4%** | **43%** | **0** | **0** | **0** |

***Algoma Public Health***

***Expense Statement- Public Health***

For Nine Months Ending September 30, 2021

*(Unaudited)*

| | Actual YTD 2021 | Budget YTD 2021 | Variance Act. to Bgt. 2021 | Annual Budget 2021 | Variance % Act. to Bgt. 2021 | YTD Actual/ Budget 2021 | *Comparison Prior Year:* *YTD Actual 2020* | *YTD BGT 2020* | *Variance 2020* |
|---|---|---|---|---|---|---|---|---|---|
| Salaries & Wages | 7,671,114 | 7,874,117 | 203,004 | 10,756,870 | -3% | 71% | $ 7,052,993 | $ 7,116,885 | $ 63,892 |
| Benefits | 1,865,501 | 1,784,251 | (81,250) | 2,366,268 | 5% | 79% | 1,696,802 | 1,707,880 | 11,078 |
| Travel | 112,360 | 129,682 | 17,322 | 172,909 | -13% | 65% | 83,734 | 143,250 | 59,516 |
| Program | 1,091,759 | 876,577 | (215,183) | 1,112,190 | 25% | 98% | 430,844 | 500,210 | 69,366 |
| Office | 45,637 | 42,780 | (2,857) | 57,040 | 7% | 80% | 33,202 | 52,175 | 18,973 |
| Computer Services | 610,274 | 706,632 | 96,358 | 929,676 | -14% | 66% | 676,065 | 624,232 | (51,832) |
| Telecommunications | 282,949 | 278,400 | (4,549) | 371,200 | 2% | 76% | 229,482 | 197,712 | (31,770) |
| Program Promotion | 62,548 | 62,080 | (468) | 83,035 | 1% | 75% | 26,975 | 71,380 | 44,404 |
| Professional Development | 31,153 | 56,625 | 25,472 | 75,500 | -45% | 41% | 8,770 | 101,625 | 92,854 |
| Facilities Expenses | 931,732 | 784,774 | (146,959) | 1,046,365 | 19% | 89% | 600,853 | 580,813 | (20,040) |
| Fees & Insurance | 270,406 | 256,475 | (13,931) | 290,300 | 5% | 93% | 235,873 | 210,410 | (25,463) |
| Debt Management | 346,499 | 345,675 | (824) | 460,900 | 0% | 75% | 345,674 | 345,675 | 1 |
| Recoveries | (75,113) | (74,594) | 519 | (99,459) | 1% | 76% | (72,445) | (61,757) | 10,688 |
| | $ 13,246,819 | $ 13,123,474 | $ ( 123,345 ) | $ 17,622,794 | **1%** | **75%** | $ 11,348,823 | $ 11,590,490 | $ 241,667 |

# Notes to Financial Statements – September 2021

## Reporting Period

The September 2021 financial reports include nine months of financial results for Public Health. All other non-funded public health programs are reporting six months of results from operations year ending March 31, 2022.

## Statement of Operations (see page 1)

### Summary – Public Health and Non Public Health Programs

APH received the 2021 Amending Agreement from the province identifying the approved funding from the province for 2021 for public health. The Ministry of Health has approved one-time funding to support approximately 50% of estimated eligible COVID-19 extraordinary costs at this time, and will work with APH to monitor and track more detailed and accurate requirements and spending for COVID-19 through in-year financial reports and make any adjustments to funding, as required, throughout the 2021 funding year. Management took the conservative approach and adjusted the 2021 budget to reflect the change in approved funding. This has resulted in a reduction to the 2021 public health calendar budget of $2.1M.

As of September 30, 2021, Public Health calendar program expenditures are reporting a $123k negative variance.

Total Public Health Revenues are indicating a $87k positive variance.

## Public Health Revenue (see page 2)

Overall, Public Health calendar funding revenues are reporting a $87k positive variance budget. Land Control Fees are reporting a $98k surplus.

Mitigation funding from the province will continue for 2021 and 2022.

The COVID-19: School-Focused Nurses Initiative has been extended to July 2022.

## Public Health Expenses (see page 3)

***Salary & Wages***
There is a $203k positive variance associated with Salary & Wages.

***Benefits***
There is a $81k negative variance associated with Benefits. This is due to higher than budgeted non-statutory benefits.

***Travel***
There is a $17k positive variance associated with Travel expenses. This is a result of APH employees working virtually as opposed to travelling throughout the district or attending meetings outside of the district.

***Programs***
There is a $215k negative variance associated with Programs. This is due to the high demand for professional services through the Ontario Sr. Dental Program which is $132k over budget. Remaining supplies, purchased services and third party professional service fees are over budget by$80K which is largely driven by ongoing requirements in the COVID 19 Mass Immunization program.

***Computer Services***
There is a $96k positive variance associated with computer services. This is due to delayed hiring of IT support staff and software implementation.

***Professional Development***
There is a $25k positive variance for Professional Development. At this time there has been limited spending for professional development, as staff availability is extremely tight and limited opportunities for professional development due to COVID-19.

***Facilities Expenses***
There is a $147k negative variance for Facilities Expenses. This is primarily due to the more than expected costs related to COVID 19 Response and Mass Immunization for janitorial services and security.

## COVID-19 Expenses

***COVID-19 Response***
This program includes case and contact management as well as supporting the information phone lines. September YTD expenses were $3.6M. The majority of this consists of salaries and benefits costs of APH staff that under normal circumstances would be working in their assigned public health programs.

***COVID-19 Mass Immunization***
This program includes the planning, support, documentation, and actual needles in arms of the various COVID-19 vaccines. September YTD expenses were $2.9M.

## Financial Position - Balance Sheet (see page 7)

APH's liquidity position continues to be stable and the bank has been reconciled as of September 30, 2021. Cash includes $1.40M in short-term investments. APH received a lump sum payment of $2,054,400 from the province for COVID extraordinary costs. Further funding for extraordinary costs will be determined based on Q2 and Q3 forecasted submissions to the province.

Long-term debt of $4.47 million is held by TD Bank @ 1.80% for a 60-month term (amortization period of 120 months) and matures on September 1, 2026. $265k of the loan relates to the financing of the Elliot Lake office renovations, which occurred in 2015 with the balance, related to the financing of the 294 Willow Avenue facility located in Sault Ste. Marie. There are no material accounts receivable collection concerns.

# Algoma Public Health

**Statement of Financial Position**

**(Unaudited)**

| **Date: As of September 2021** | **September 2021** | December 2020 |
|---|---|---|
| **Assets** | | |
| **Current** | | |
| Cash & Investments | **$ 4,770,255** | $ 3,906,995 |
| Accounts Receivable | **341,445** | 935,870 |
| Receivable from Municipalities | **288,583** | 69,618 |
| Receivable from Province of Ontario | | |
| *Subtotal Current Assets* | **5,400,283** | 4,912,483 |
| Financial Liabilities: | | |
| Accounts Payable & Accrued Liabilities | **1,419,240** | 1,660,232 |
| Payable to Gov't of Ont/Municipalities | **422,957** | 1,673,441 |
| Deferred Revenue | **568,935** | 286,418 |
| Employee Future Benefit Obligations | **3,117,450** | 3,117,450 |
| Term Loan | **4,466,918** | 4,466,918 |
| *Subtotal Current Liabilities* | **9,995,499** | 11,204,458 |
| **Net Debt** | **(4,595,217)** | (6,291,975) |
| **Non-Financial Assets:** | | |
| Building | **22,867,230** | 22,867,230 |
| Furniture & Fixtures | **1,998,117** | 1,998,117 |
| Leasehold Improvements | **1,572,807** | 1,572,807 |
| IT | **3,252,107** | 3,252,107 |
| Automobile | **40,113** | 40,113 |
| Accumulated Depreciation | **(11,199,609)** | (11,199,609) |
| *Subtotal Non-Financial Assets* | **18,530,764** | 18,530,764 |
| **Accumulated Surplus** | **13,935,547** | 12,238,789 |

Algoma
PUBLIC HEALTH
Santé publique Algoma

# 2022 RECOMMENDED PUBLIC HEALTH OPERATING & CAPITAL BUDGET REPORT




**To:** Finance and Audit Committee
**From:** Dr. Jennifer Loo, Acting Medical Officer of Health & CEO

**November 10, 2021** **[For Discussion & Decision]**

# Contents

## Issue

Approval is being sought for the recommended 2022 Capital & Operating Budget for Algoma Public Health (APH). The draft budget was developed by the Executive Committee and is recommended by the Medical Officer of Health. It is to be reviewed at the November 10, 2021, meeting of the Board of Health Finance & Audit Committee.

## Recommended Action

**THAT the Finance & Audit Committee approve and recommend to the Board of Health for the District of Algoma Health Unit the 2022 Capital & Operating Budget for Algoma Public Health in the amount of $19,627,191.**

## Alignment to the Ontario Public Health Standards (2021)[1]

- As part of the *Foundational Standard: Emergency Management*, the board of health shall effectively prepare for emergencies to ensure timely, integrated, safe, and effective response to, and recovery from emergencies with public health impacts.
- As part of the *Organizational Requirements: Good Governance and Management Practices Domain*, the board of health shall ensure that the administration establishes a human resources strategy, which considers the competencies, composition and size of the workforce, as well as community composition, and includes initiatives for the recruitment, retention, professional development, and leadership development of the public health unit workforce.
- As part of the *Organizational Requirements: Fiduciary Requirements Domain*, boards of health are accountable for using ministry funding efficiently and for its intended purpose, and ensuring that resources are used efficiently and in line with local and provincial requirements.
- The board of health shall ensure that administration implements appropriate financial management by ensuring that expenditure forecasts are as accurate as possible.
- To support municipal budget planning, APH attempts to advise contributing municipalities of their respective levies as early as possible.

# 1. Budget Summary

As context, the 2021 approved budget was $17,622,795. This included 50% of the requested $4,108,799 one-time COVID-19 extraordinary costs approved by the province through the amending agreement. The province committed to reimburse APH for further extraordinary COVID-19 expenses that could not be covered by mandatory programs.

It was forecasted as of June 30th that an additional $1,534,184 would be required to fund these costs in 2021. On November 2, 2021, APH received confirmation from the Ministry of Health that additional one-time funding up to $1,534,200 will be provided, bringing the total 2021 budget/ funding requirements for 2021 to $19,156,995.

The **recommended 2022 budget for public health programs and services is $19,627,191**. This represents an increase of $470,197 from the 2021-forecast budget.

The Executive Team has worked diligently in the current dynamic fiscal environment to balance pressures and ensure the maintenance and restoration of quality public health programs, as aligned with agency values of excellence, respect, accountability and transparency, and collaboration.[2]

The recommended budget is the minimum required to maintain COVID-19 response and immunization programming, as is expected by the Ministry of Health, alongside the restoration of public health programs and services as mandated by the *Ontario Public Health Standards*.[1]

The breakdown of the recommended 2022 operating budget of $19,627,191 is provided in **Table 1.0**.

As a comparison of pre-pandemic (2019) to pandemic period budgets (2020, 2021 budget and forecast), a Budget Analysis is provided in **Table 1.0.** Comparisons can made between the recommended 2022 budget ($19,627,191) and the 2021-forecast budget ($19,156,995).

As evident in **Table 1.0** below, and as a result of the province's transition to the cost-sharing funding model of 70% provincially funded and 30% municipal funded for all programs except those 100% provincially funded for 2022, APH's budget recommendation is built on a **10% or $380,838 increase in the municipal levy**.

The following sections provide details on key 2022 budget factors

**Table 1.0: Budget Analysis, 2019 – Recommended 2022**

| Budget Analysis, 2019-2022 | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | % Change | |
| **Revenues Summary** | **2019 Actual** | **2020 Actual** | **2021 Budget** | **2021 Forecast** | **2022 Budget** | **2022 vs. 2021 Budget** | **2022 Budget vs. 2021 Forcast** |
| Province Portion of Jointly Funded Programs | $7,523,200 | $ 8,703,177 | $8,708,100 | $8,708,100 | $8,708,100 | 0.00% | 0.00% |
| 100% Provincially Funded Programs | 3,405,823 | 2,027,810 | 3,650,186 | 5,184,386 | 5,313,000 | 45.55% | 2.48% |
| Province Mitigation Fund | - | 1,037,800 | 1,037,800 | 1,037,800 | 1,037,800 | 0.00% | 0.00% |
| Municipal Levies | 3,519,703 | 3,559,232 | 3,808,378 | 3,808,378 | 4,189,216 | 10.00% | 10.00% |
| Other Recoveries and Fees | 688,282 | 503,127 | 418,330 | 418,330 | 379,075 | -9.38% | -9.38% |
| Total | **15,137,008** | **15,831,146** | **17,622,794** | **19,156,994** | **19,627,191** | 11.37% | 2.45% |
| | | | | | | | |
| **Expenses:** | | | | | | | |
| Salaries and Wages | 8,838,252 | 9,523,270 | 10,756,869 | 11,693,436 | 11,958,949 | 11.17% | 2.27% |
| Benefits | 2,148,254 | 2,225,203 | 2,366,269 | 2,649,011 | 2,769,515 | 17.04% | 4.55% |
| Travel | 214,809 | 103,453 | 172,909 | 181,640 | 204,798 | 18.44% | 12.75% |
| Program | 624,709 | 642,120 | 1,112,452 | 1,295,260 | 1,277,209 | 14.81% | -1.39% |
| Equipment | 75,417 | 89,026 | 102,076 | 102,076 | 20,000 | -80.41% | -80.41% |
| Office | 84,585 | 46,451 | 57,040 | 57,040 | 67,400 | 18.16% | 18.16% |
| Computer Services | 768,076 | 750,708 | 827,600 | 842,600 | 846,600 | 2.30% | 0.47% |
| Telecommunications | 260,123 | 290,550 | 371,200 | 388,700 | 340,000 | -8.41% | -12.53% |
| Program Promotion | 145,489 | 55,557 | 158,273 | 158,273 | 183,541 | 15.96% | 15.96% |
| Facilities Leases | 172,465 | 162,414 | 156,000 | 156,000 | 160,000 | 2.56% | 2.56% |
| Building Maintenance | 864,553 | 711,183 | 890,365 | 981,217 | 1,036,458 | 16.41% | 5.63% |
| Fees & Insurance | 238,689 | 251,994 | 290,300 | 290,300 | 332,300 | 14.47% | 14.47% |
| Expense Recoveries | (109,670) | (135,109) | (99,459) | (99,459) | (27,000) | -72.85% | -72.85% |
| Debt Management (I & P) | 460,900 | 460,900 | 460,900 | 460,900 | 457,421 | -0.75% | -0.75% |
| Total | **14,786,651** | **15,177,719** | **17,622,795** | **19,156,995** | **19,627,191** | 11.37% | 2.45% |
| | | | | | | | |
| **Surplus/(Deficit)** | **$ 350,357** | **$ 653,426** | **$ 0** | **$ 0** | **$ 0** | | |

# 2. 2022 Budget Background

To provide context for the recommended budget and increase in municipal levy, an overview of indicators and comparators, where applicable, is being shared to demonstrate the:

- **Work** of public health throughout 2021, including continued COVID-19 response, COVID-19 immunization, and highest priority core programming maintained as part of risk-based Continuity of Operations Planning (COOP);
- **Impacts** to population health and public health service delivery, as a result of the province-wide prioritization and deployment of program staff to COVID-19 response and immunization efforts (i.e., population health indicators and outcomes, public health service backlogs from suspended programs, implications for COVID-19 recovery); and
- **Cost** of both the work and impact, including financial expenses acquired from COVID-19 response and immunization, as well as implications on health human resources and capital because of vacancies and excess workloads.

The work, impact, and cost collectively demonstrate the value of public health services and programming to Algoma residents and municipalities in helping to achieve pandemic goals and population wellbeing. The summary provided reinforces the minimum financial requirements needed to sustain COVID-19 response and immunization programming, alongside efforts to restore mandatory programs and services and revitalize the public health workforce.

Recovery from the pandemic, as a public health unit and broader community, will take several years and require appropriate resourcing.

## 2.1 The Work

In April 2020, the Ministry of Health directed boards of health to take all necessary measures to respond to COVID-19 in their catchment areas while continuing to maintain critical public health programs and services as identified in pandemic plans.

Since activation in March 2020, APH has continued to operate within the Incident Management System (IMS) structure, as shown in **Appendix A**, to respond to the COVID-19 pandemic.

The work of APH during the COVID-19 pandemic has focused on two primary goals:

- Minimize serious illness and death, and
- Minimize societal disruption (and preserve health care services).

APH has worked diligently to prevent population-level COVID-19 morbidity and mortality, and preserve health care services and societal function through the enactment of public health measures, case, contact, and outbreak management, risk communications, comprehensive health promotion, enforcement related to the Reopening Ontario Act[3], and the coordination of COVID-19 mass immunization across the Algoma district.

Most importantly, APH teams have been working with community partners to take preventative measures against COVID-19 in municipal offices and facilities, long-term care and retirement homes, health facilities, schools and day cares, and a variety of other workplaces.

The work of APH throughout 2021 can be split into three priority areas:

- **COVID-19 response,**
- **COVID-19 immunization**, and
- **Maintenance of high-risk programming**, as outlined by APH's Continuity of Operations Plan (COOP), which gives highest priority to programs that work to decrease health inequities for those who have been most affected by COVID-19.

As an overview of APH's leadership and pandemic response efforts, see **Appendix B**, which describes the most recent work by local public health programs from January to September 2021, unless otherwise specified.

As evidenced through the work of public health throughout 2021 in **Appendix B**, which cannot truly be described in full within this short report, APH has continued to see significant changes and refocusing of provincial and local public health priorities, which has required ongoing and significant reallocation of resources to support the COVID-19 response.

However, APH has consistently stepped up to the challenge, with the support of community partners and residents of Algoma, to achieve pandemic goals.

## 2.2 The Impacts

### 2.2.1 The Benefits: Impact of a Robust COVID-19 Response

APH's robust COVID-19 response and maintenance of high-risk programming has had benefit to community health and safety throughout the pandemic. In partnership with municipalities, health sector partners, community organizations, and Algoma residents, the pandemic response goals continue to be met, as follows:

- **Serious illness and death from COVID-19 has remained limited in Algoma.** Since the beginning of the pandemic up to November 4, 2021, as reported in the Public Health Ontario COVID-19 data tool, Algoma's COVID-19-related rates of cases, hospitalizations, and deaths have remained among the lowest of Ontario's public health units:
    - Cumulative rates of confirmed COVID-19 are 470.1 cases per 100,000 population for Algoma, as compared to 4,086.4 cases per 100,000 population for Ontario.
    - Cumulative rates of COVID-19 hospitalizations are 18.7 hospitalizations per 100,000 population for Algoma, as compared to 208.3 hospitalizations per 100,000 population for Ontario.
    - Cumulative rates of COVID-19-related deaths are 6.8 deaths per 100,000 population for Algoma, as compared to 67.2 deaths per 100,000 population for Ontario.
- **Community action to keep transmission low has helped to minimize societal disruption for Algoma citizens.** Outside of province-wide shutdown measures, Algoma's relatively low rates of COVID-19 transmission has allowed the region's schools and businesses to remain open for longer periods, and with fewer restrictions, compared to counterparts in areas with higher transmission.

In addition, many **co-benefits have arose due to the structure of our pandemic response** that will positively influence the future of public health program and service delivery.

Co-benefits have included the:

- Strengthened relationships with sectors of society, including long-term care homes and retirement homes, law enforcement partners, primary care, pharmacies, hospitals, postsecondary institutions, schools – private and public, local businesses, municipalities, Indigenous partners, congregate living settings, boarder officials, Mennonite and Amish communities, etc.
- Strengthened relationships with community oral health service providers (e.g., dentists and denturists) due to the launch of a new program during the pandemic, the Ontario Senior's Dental Care Program (OSDCP), which was one of the only public health initiatives to ramp up during the pandemic period.
- Enhanced internal interprofessional collaboration, by working together in programs and as liaisons with community partners, and enhanced cross-program collaboration and coordination as part of COVID-19 response.

- Development of new knowledge and skills by staff, as part of up training conducted for staff deployed to different programs. This also provided opportunities for enhanced colleague-to-colleague mentorship and knowledge exchange, as well as internal capacity development for future cross-program coverage.
- Large scale and rapid multisector collaboration towards a shared goal, such as vaccination to increase community immunity and protection against COVID-19. Numerous sectors pooled resources, paid and in-kind, to build confidence and access to an important public service. This collaboration across sectors could serve as a model for tackling future community crises.
- Development of a stronger foundation of emergency management in every area of public health and in collaboration with community partners, with many lessons learned that will influence how emergency management and public health plan for emerging threats to health (e.g. climate change emergencies, like increased seasonal flooding events and wildfires).

To resource urgent pandemic response and immunization program needs, APH diverted resources from pre-existing public health services to ensure a timely response to COVID-19 and maintenance of highest risk programming. The required diversion of resources resulted in the scale down or suspension of moderate to low risk public health programs and services for long-periods, similar to other areas of the health sector, which will come at a cost.

### 2.2.2 The Backlog: Impact of Modified and Suspended Public Health Programs

As of November 2021, APH continues to implement the COOP plan to prioritize program and service offerings to the community in light of finite human resources to deal with the COVID-19 response. Redeployment of human resources to COVID-19 response efforts remains essential to both managing the pandemic while maintaining public health work.

A COOP survey on October 7, 2021 demonstrated that approximately **51.5% of all APH employees remain primarily aligned to COVID-19 response**, while 15% spend roughly half their time on COVID-19 response and half on program work and 33.5% of employees remain dedicated to covering prioritized, highest risk programs and services.

As such, the programming that has been maintained has been modified, and low to moderate risk programs that were suspended remain, with the backlog in services growing.

To demonstrate the impact on programs and services, and backlog of services arising from the suspension and modification of public health programming to sustain local public health's response to COVID-19, an overview of program delivery indicators demonstrating the backlog, as well as note of projects on hold, is detailed in **Appendix C**.

Responding to the backlog of services in addition to new priorities and ministry requirements (i.e., case and contact management during the fourth wave, third doses or booster doses, upcoming approval of COVID-19 vaccine for children aged 5 – 11, vaccine policy and workplace needs, influenza immunization for 2021-2022, etc.) will require **increased capacity and resourcing**.

As identified by the Ministry of Health, the need to resume and maintain key public health programs will **require local integrated planning and resources** to continue the delivery of priority programs, in addition to the expected COVID-19 response and immunization work.

### 2.2.3 The Burden on Health: Health Consequences of the Pandemic

In addition to the implications of suspended programs and services, the COVID-19 pandemic has also affected the community in significant ways, and the direct and indirect impacts to health and wellbeing are being recognized. These health impacts will likely extend years into the future, highlighting the need for significant post-pandemic recovery support by public health.

For example, despite limited evidence to date, we know that children and youth have been disproportionately impacted by pandemic measures. Reports have demonstrated reduce physical activity, increased screen time, increased food insecurity, and reduced free play and time

outdoors, among other behaviours, which have been associated with negative implications to children's mental health and healthy growth and development.[4]

In Algoma, some of these health implications are already being observed and projected, such as:

- Increases in vaccine preventable diseases (e.g. increase in number of chickenpox cases for 2021 when compared to 2020);
- Increases in sexually transmitted infections (e.g. increase in number of gonorrhoea and chlamydia cases for 2021 when compared to 2020); and
- Increase in substance use related harms, especially opioid-related harms (e.g. increased rate of opioid-related deaths in Algoma from 14.9 per 100,000 people in 2019 to 44.7 per 100,000 people in 2020).[5]

In addition to direct health impacts, backlogs in healthcare services and consults with primary care during the pandemic may result in increased incidence or worsening of preventable chronic diseases.

These are just some of the health behaviours and risk factors for public health and wellbeing that will require added public health assessment, planning, and programming support in 2022 and beyond.

An updated Community Health Profile is needed to assess the health and wellbeing of Algoma, as well as social determinants of health influencing healthy living, to understand the localized impacts of the pandemic. Understanding and measuring the impacts of the COVID-19 pandemic will help to develop and implement strategies that target the needs of Algoma residents.

Intersectoral collaboration, as happened throughout the pandemic, will remain essential to developing programs that support our community as the pandemic continues into the years ahead.

However, in order for local public health to be a strong leader and partner, human resources must be strengthened to allow for catch-up on the backlog of services and the restoration of programming, otherwise, the backlog will become too large to overcome and the health of all will continue to be impacted.

As such, we must build in capacity in 2022 to begin addressing these issues.

The recommended 2022 Operating & Capital Budget reflect this reality and the work to come.

## 2.3 The Cost

APH's robust COVID-19 response and maintenance of high-risk programming has had benefit to community health and safety throughout the pandemic. However, the work associated with COVID-19 has required an unprecedented quantity of resources, particularly human resources, which has resulted in impacts to health human resources (HRR) and service delivery. Accordingly, APH has had to augment staffing for immunization clinics and COVID response support.

The cost of COVID-19 response and immunization, alongside the maintenance of high-risk programming, includes the cost in:

- **Dollars**, including **monetary expenses related to response and immunization efforts** that are being reported to the Ministry of Health for reimbursement as COVID-19 response and COVID-19 vaccine extraordinary costs;
- **Time**, including the (a) significant number of **extra hours worked** by employees in 2021 when compared to the pre-pandemic period (2019), and (b) accrued **lieu time and paid vacation that remains unused** by eligible employees; and
- **Human resources**, including the successes and challenges of local public health recruitment, retention, and redeployment in 2021.

Because of ongoing recruitment challenges, which are especially common in the northern Ontario health sector, as of November 4, 2021, **16 FTE vacancies remain, representing 8.86% of the workforce**, adding workload for existing staff that would otherwise be completed by the current vacant positions.

As such, the cost in time and human resources will have resounding impact to local public HHR, as the workload and contribution of extra hours worked by employees has **depleted human capital**, and impacted work-life balance and employee health and wellness. This is already being observed through over a dozen employees take unplanned leaves over the course of 2021, which saw employees off work for a range of 1.5 to 15 weeks.

Therefore, the revitalization of the public health workforce, with focus on employee wellness and mental health, alongside a HHR strategy that works to build public health capacity in the north will remain essential.

The cost of COVID-19 response, immunization, and high-risk programming throughout 2021 described in dollars, time, and human resources is detailed in **Appendix D**.

## 2.4 Strengthening Public Health Human Resources

As supported by the numerous **costs** associated with prioritization of the pandemic response, investment is needed by the Board of Health to strengthen HHR in local public health. In addition, provincial investment for sustainable funding and a pan-northern HHR strategy are needed.

### 2.4.1 The Value of Staffing Complements

To support the COVID-19 immunization program (e.g., mass immunization clinics, pop-up clinics), as well as additional areas of needed program support, temporary casual registered nurses and registered practical nurses were hired. As of October 22, 2021, 35 casual immunizers are on the roster to pick up available shifts when added human resources are needed. For a summary of casual recruitment, see **Appendix E: Table E1**.

In addition, students, both paid and unpaid, were value-added to APH teams to support COVID-19 response and high-risk programs. Unpaid practicum students contributed 3063.5 hours of support while learning about public health throughout 2021, and paid summer students contributed 12,207 hours of support for COVID-19 response and public health programs.

Together, unpaid and paid students contributed 15,270.5 hours to APH, equivalent to 8.4 FTEs. For a summary of paid and unpaid student contributions, see **Appendix E: Table E2**.

Complement support provided by casual staff and students was critical to maintaining public health capacity and resources during COVID-19 pandemic work. However, it did come at a cost in time and resources for hiring, training, and mentorship for short periods of employment or practicums, and will not providing sustainable capacity or resolve the long-standing HHR issues prevalent across northern Ontario.

### 2.4.2 FTE Analysis

Salary and wage expenses are projected to increase by 2.27% or $265,513 compared to the 2021 forecast budget, as shown in **Table 1.0**).

As part of the recommended 2022 budget, salary for all staff demonstrates an increase of 1.5% ($149,000 year over year). Both CUPE and ONA collective agreements expired in 2021. Collectively bargained salary increases are reflected within the recommended 2022 budget.

Furthermore, as of November 4, 2021, **16 FTE vacancies are outstanding**, demonstrating the challenge with recruitment and retention of highly skilled health professionals in local public health in the north. With recruitment efforts continuing, it is assumed these positions will be filled in 2022.

In addition to filling current vacancies, **15 new FTE positions** were approved by the Executive Committee to be included in the 2022 budget, subject to approval by the Board, to aid in public

health sustaining the COVID-19 response, restoring mandatory programs and services, and responding to current public health pressures.

The new positions are reflected in the 2022 budget as 11.5 FTE, as it is recognized that not all of the positions will be filled by January 1, 2022.

For context on the historic number of FTE for APH, see **Table 2.0.**

**Table 2.0: APH FTE Analysis, 2019 – 2022**

| FTE Analysis Algoma Public Health | | | |
|---|---|---|---|
| Year | Contract / Temp | Permanent | Total |
| 2019 | 3 | 121 | 124 |
| 2020 | 5 | 118 | 123 |
| 2021 | 25 | 123 | 148 |
| 2022 | 30 | 133 | 163 |
| Notes: | | | |
| 2021 Contract / Temp | Includes funding for 7 FTE COVID 19 School Nurses<br>6 FTE casual immunizers<br>5 FTE students | | |
| 2022 Contract / Temp | Includes funding for 7 FTE COVID 19 School Nurses<br>3 FTE casual immunizers<br>3 FTE students | | |
| 2022 FTE includes those budgeted.<br>1 FTE = 1820 hours. | | | |

Compared to budgeted 2021 FTE, the public health FTE count has increased by 15 FTE for the 2022 budget year to ensure adequate, sustainable FTE to routinize COVID-19 response and immunization, as well as restore mandatory public health programs and services.

### 2.4.3 Health Human Resource Challenges in Northern Ontario: Looking Beyond Budget 2022

As per an Ontario Health memo[6] on October 8th, as Ontario health systems continue to face many complexities, **HHR continue to be the biggest challenge**, with shortages and ongoing stress affecting all sectors. Layered on the provincial HHR struggle includes the significant and longstanding challenges with recruitment and retention of skilled public health professionals in northern Ontario, similar to the unique HHR challenges of the health care sector in the north.

SARS demonstrated that our **most valuable resource in public health is our HHR** and the high level of expertise that exists at the central and local levels of public health.[7]

**Challenges with One-Time Funding in the North**

One-time funding provided by the provincial government has been appreciated and critical to supporting COVID-19 response and immunization, as well as other pandemic needs (i.e., school support, infection prevention and control). However, one-time funding has been geared towards curtailing the pandemic, as opposed to annual funding for the hiring of permanent staff to build long-term public health capacity to manage the emergency of today, and prepare for the public health emergencies of tomorrow.[8]

This comes at a detriment to northern Ontario, as when one-time funding is available, retention and recruitment continue to pose significant barriers to fulsome service delivery by public health (i.e., highly skilled professional unlikely to move to the north for, or with the uncertainty of, a 12-18 month contract).

**Strengthening Local Public HHR and Building Capacity for the Long-Term**

In addition to combatting the COVID-19 pandemic and other public health emergencies (e.g. wildfire evacuations), a strong local public health unit protects health and prevents illness every day.[9] In order to recover and be truly prepared for future public health crises, strategic, and

sustainable investment for emergency planning and a higher baseline of qualified, permanent public health employees are needed.[7,9]

Without sustainable, increases to provincial base funding and levies to stabilize and strengthen the local public health workforce for the long-term, with strategies for recruitment and retention that align to northern Ontario, APH will be **unable to sustain the COVID-19 response and immunization program while restoring mandated public health programming to meet the needs of our communities and prepare for future health crises** without further risk of exhausting existing human resources.

Therefore, not only is an increase in levy funding required to strengthen and sustain our local public health workforce, but continued advocacy is required by the Board of Health to ensure (a) sustainable, annual provincial base funding for public health and (b) a comprehensive northern public HHR strategy, to ensure our communities are able to sustain pandemic efforts, restore programming, and confront future public health emergencies.

A more fulsome background on HHR challenges in northern Ontario is provided in **Appendix F**.

## 2.5 Pandemic Recovery

In June 2021, the COOP committee and Foundations team began weekly meetings to devise a Framework for Recovery, which focused on four pillars:

- **Routinize** COVID-19 work for sustainable prevention, mitigation, preparedness, and response to COVID-19.
- **Restore** mandatory public health programs and services to pre-pandemic levels, considering lessons learned from COVID-19, alignment with *Ontario Public Health Standards*[1], and post-pandemic public health priorities in Algoma.
- **Revitalize** the public health workplace through employee engagement and excellence, focusing on employees' lived experience, lessons learned, employee wellness, and organizational capacity development.
- **Rebuild** and strengthen public health, with a focus on strategic advocacy, policy, and evidence to engage in change at local, provincial, and federal levels.

The internal Recovery Steering Committee met twice to discuss operationalizing the framework, however, 2021 fall pandemic planning and the fourth wave further reduced staff capacity and resources to continue recovery implementation efforts.

As of October 4th, 2021, recovery planning and implementation efforts were paused to sustain COVID-19 response, immunization, and high-risk programming.

Recovery, as a public health agency and community, will be complicated and unpredictable given the potential for COVID-19 transmission to continue beyond 2021 and new public health emergencies to arise. COVID-19 will not go away indefinitely, but instead become a disease of public health significance that will require ongoing attention by public health.

Recovery will be another marathon for public health, to not only to routinize COVID-19 response, but also to effectively restore programming and rebuild public health to face the many new community priorities that have arisen because of the pandemic and inability to sustain all programs and services. The pandemic has and will continue to challenge our communities and the work of public health moving forward.

Recovery considerations have influenced the recommended 2022 budget assumptions.

# 3. 2022 Budget Financial Assumptions

Given the unknowns, a number of assumptions were required upon which to base the 2022 estimated expenses. These are as follows:

- The Ministry of Health will continue to apply a 70:30 funding formula to jointly funded programs. The province's portion or base provincial funding for these programs is assumed to remain status quo from 2021, with **0% growth in base funding for mandatory programs** and one time mitigation funding of $1,037,800, which is consistent with approved funding for 2020 and 2021.
- As per the 2021 funding and accountability agreement, the Ministry will continue to support the Northern Ontario Fruit and Vegetable and Indigenous Communities programs at 100%, in addition to Mandatory Programs for Unorganized Territories, MOH/AMOH Compensation Initiative, and the Ontario Senior Dental Care Program (OSDCP).

  Of particular note, for the 2022 budget, the Executive Team assumed a $280,000 increase over 2021 in 100% provincial OSDCP funds to meet program needs in the coming year.
- A 10% municipal levy increase, amounting to increased revenues of $380,838 over 2021.
- COVID-19 and recovery incremental costs are estimated at $3,400,000 for 2022. As the ministry has indicated a commitment to fund COVID 19 extraordinary expenses in 2022, it is assumed these costs will be reimbursed by the province. For comparison, 2021 forecasted incremental costs are $3,588,600, which the Ministry has indicated will be reimbursed.
- To manage the delivery of high-risk program and services and continue the pandemic response there is a need to increase staffing levels by 15 FTE, equating to 11.5 FTE in the 2022 budget as it is recognized that not all of these positions will be filled by January 1, 2022.

  Other assumptions related to staffing are as follows:
  - On call, standby, and overtime have been included as part of the COVID-19 response and immunization programs ($180,000). This value is estimated based on 2021 actual and forecasted expenses, as well as assumptions of vacant and new FTE positions to be filled in 2022 as presented herein.
  - A vacancy factor of 2% has been incorporated into our overall salaries and wages ($240,000).
  - A 1.5% wage increase for all staff ($149,000 year over year).
- Fixed non-salary budgeted costs, such as utilities and service contracts, have been estimated based on historical data and assumed inflationary rates with a combined year over year increase of 5.46% over 2021 approved budget.
- Algoma Public Health's debt payment plan will continue to be managed with existing resources.
- COVID-19 has resulted in significant program and service interruptions, resulting in backlogs and impacts to service deliverables for 2022.
- Notwithstanding the need to prioritize programming in the context of the COVID-19 pandemic, the requirements of boards of health remain the same, as articulated in the Health Protection and Promotion Act, related regulations, and the *Ontario Public Health Standards*[1], and related protocols and guidelines.
- There are many unknowns, and APH must have the capacity and competencies to assess and react quickly to evolving needs (e.g., fourth wave, COVID-19 immunization of children ages 5-11 years, expended eligibility for booster doses, etc.), while planning for ongoing and future public health challenges, as part of COVID-19 recovery and rebuilding.

# 4. 2021 Grant Approval

The 2021 Ministry of Health Program Based Grant approval was received and last revised as of November 2, 2021. The Mandatory Cost-Shared Program base funding allocation remained unchanged at $8,708,100, as did the 100% provincial funding for Unorganized

Territories/Mandatory Programs in the amount of $530,400. The 2021 grant allocated 100% funding to the Unorganized Territories/ Indigenous Communities Program ($98,000), Unorganized Territories/Northern Fruit and Vegetable Program ($117,400), Ontario Senior Dental Program ($697,900) and MOH/AMOH compensation initiative, which will be based on the actual status of current MOH and AMOH positions.

# 5. Reserve Funds

As part of fiscally sound management, the Board of Health has long-established reserve funds for the agency since 2017. Financial reserves are a prudent and expedient way to provide the agency with resources for unforeseen emergencies, known future infrastructure investments and future planned projects that support the mission, vision, and strategic goals of APH.

The reserve funds balance totals $1.4M, which could support approximately one month of operations.

The COVID-19 pandemic is a public health emergency that has required significant, unforeseen financial and human resourcing, which will continue for several years to sustain response and transition to recovery.

# 6. Recommended 2022 Budget

## 6.1 Operating Revenue

The 2022 operating revenues include the Ministry of Health funding for mandatory programs (historically cost shared), Ministry of Health funding for other related programs (historically 100% provincially funded), Ministry of Health Unorganized Territories funding, municipal funding by 21 municipalities, and interest and user fees. The municipal funding is increased by $380,838. There is no change in Unorganized Territories funding or in interest revenue.

### 6.1.1 Provincial

*Pursuant to section 76 of the Health Protection & Promotion Act, the Minister may make grants for the purposes of this Act on such conditions as he or she considers appropriate.*[10]

### 6.1.2 Municipal

*Pursuant to section 72 of the Health Protection & Promotion Act, obligated municipalities in a health unit shall pay,*

*(a) The expenses incurred by or on behalf of the board of health of the health unit in the performance of its functions and duties under the HPPA or any other act; and*

*(b) The expenses incurred by or on behalf of the MOH of the board of health in the performance of his or her functions and duties under the HPPA or any other Act.* [10]

As part of the recommended 2022 Operating & Capital Budget, the Executive Team is recommending a 10% overall increase in the levy from obligated municipalities. The proposed increase reflects inherent inflationary pressures in addition to incremental costs associated with the COVID-19 pandemic and the restoration of mandated public health programs and services. This equates to a 10% or $380,838 increase in revenues apportioned among the 21 municipalities within Algoma.

For context, the Board of Health has experienced the historical growth shown in **Table 3.0** from 2012 – 2022 (recommended) with respect to the municipal levy.

| Algoma Public Health: Historical Approved Levy Increase | |
|---|---|
| **Year** | **Levy Increase** |
| 2012 | 2.00% |
| 2013 | 1.00% |
| 2014 | 2.00% |
| 2015 | 4.16% |
| 2016 | 4.50% |
| 2017 | 2.50% |
| 2018 | 0.50% |
| 2019 | 0.50% |
| 2020 | 1.12% |
| 2021 | 7.00% |
| **2022** | **10.00% (Budgeted)** |

The approved levies from 2018 to 2021 apportioned among the 21 municipalities within Algoma, and comparison to the recommended levy for 2022 are detailed in **Appendix G: Table G1**.

When compared to total municipal revenues, for municipal budgets accessed from 2018 to 2020, municipalities in the Algoma District have traditionally **spent less than 1.5% of revenues on public health levies**. See **Appendix G: Table G2** for an overview of public health operations levy as percentage of municipal revenue, 2018 to 2020.

As evidenced through 'the work,' or programs and services provided by public health in 2021 as described in **Appendix B**, municipalities and social sectors across Algoma have received robust support for effective COVID-19 response, health protection, health promotion, and disease prevention among residents.

**Value for Money: Per Capita Rate**

When looking at the value for public health, as of 2021, the cost per capita in the Algoma District for public health services and programs was **$35.58/person, when converted to 2018 MPAC (or $36.57 when using 2016 Census)**. Health Units within the province either use the most recent Census or MPAC population figures when calculating the per capita rate.

When compared to northern health units, as of 2021, APH's per capita rate ranks in the middle when using MPAC figures. Northern health unit per capita rates ranged from $28.65/person to $51.65/person in 2021, for those PHUs that responded to an APH inquiry on per capita rates conducted in fall 2021.

For context, the Board of Health has experienced the historical growth shown in **Table 4.0** from 2018 – 2022 (recommended) with respect to the rate of public health per capita.

| Algoma Public Health: Historical Approved Per Capita Rates | |
|---|---|
| **Year** | **Approved Rate** |
| 2018 | $33.63 |
| 2019 | $33.80 |
| 2020 | $34.18 |
| 2021 | $36.57 |
| **2022** | **$40.23 (Budgeted)** |

The recommended 10% levy increase for 2022 correlates to a per capita rate of $40.23/person, which continues to rank in the middle of northern health units.

Therefore, when reviewing the cost of public health per capital, alongside the work by public health in 2021 and projected work to restore programs and support community health and

wellbeing, the 21 municipalities within Algoma **continue to receive exceptional value for local public health programs and services**.

**Levy Explained According to Full Time Equivalent Needs**

To sustain the COVID-19 response and restore programs to address the backlog of services, **15 new FTE positions were approved by the Executive Committee** to be included in the 2022 budget, subject to approval by the Board, to aid in public health restoration of programs and services and support current public health pressures.

The new positions are reflected as 11.5 FTE in the 2022 budget, as it is recognized that not all of the positions will be filled by January 1, 2022.

**Table 5.0: 2022 Recommended Municipal Levy Impact on FTE Positions Funded**

| Municipal Levy Impact on FTE Positions Funded | |
|---|---|
| **Levy Scenario** | **FTE Funded** |
| 10% ($380,838) | **Allows for 100% of FTE required** (15 FTE) to meet the expected needs required to sustain COVID-19 pandemic work and restore mandatory programs and services. |
| 5% ($190,419) | **Equates to a reduction of 2 FTE.** This would result in 13 new FTE, which is less than what is required to sustain COVID-19 pandemic work and restore mandatory programs and services. |
| 0% ($0) | **Equates to a reduction of 4 or 5 FTE.** This would result in 10-11 new FTE, which is significantly less than what is required to sustain COVID-19 pandemic work and restore mandatory programs and services. |

## 6.2 Expenditures

As compared to the 2021 forecast, the 2.45% overall budget increase is comprised of the following:

| | |
|---|---|
| Salary cost increase | 1.39% |
| Benefit cost increase | 0.63% |
| Operating cost increase | 0.43% |
| **Overall Increase** | **2.45%** |

In other words, of the 2.45% or $470,196 increase in the 2022 budget, salaries and benefits represent about 82% of the increase (1.39% and 0.63% respectively of the 2.45% increase), while operating cost increases make up about 18% of the overall increase (0.43% of the 2.45% increase).

### 6.2.1 Salary and Benefit Changes

The 2022 expenditure comparisons with 2021 were made using the 2021 forecasted values (see **Table 1.0**). As compared with 2021, the salary and benefit budget lines reflect an increase of 2.27% and an increase of 4.55%, respectively:

- **Salary:** As compared to 2021, salaries show an increase of $265,513 or 2.27%. This amount includes a nominal annual increase, staff movement along salary grid, and the reinvestment of staffing complement as outlined in section 2.4.2: FTE Analysis.

- **Benefits:** As compared to 2021, benefits show an increase of $120,504 or 4.55%. Historical utilization is factored heavily in the projection of the rate increases, in addition to the normal market increases.

### 6.2.2 Operating Expenditure Changes

As compared with the restated 2021 budget or 2021 forecast, the 2022 recommended budget reflects an overall increase of 2.45% ($470,197). Expenditure lines with significant changes are detailed below, following the order of appearance in the budget summary:

- **Travel:** The increase in travel relates to the expectation that as COVID-19 restrictions are lifted, staff will return to pre-pandemic levels of travel within the Algoma district.

  Note: The 2022 recommended budget is a 4.7% decrease from pre-pandemic levels in 2019.

- **Program expenses:** The increase in program expenses is largely due to program demands for COVID-19 response and immunization.

  Note: The 2022 recommended budget is consistent with 2021 forecast at a nominal 1.39% decrease.

- **Equipment:** The decrease in equipment expenses related to computer hardware requirements estimated for 2022. In 2020 and 2021, APH had significant expenses tied to this expenditure line due to increase in number of staff and hardware required to support community COVID-19 vaccine clinics. Current equipment inventory is considered adequate and requirements for 2022 are estimated to be nominal.

- **Office:** The decrease to office expenses in 2020 and 2021 was due to majority of staff working from home, and therefore a decrease in purchasing of office supplies and need for photocopying materials. The projected increase for 2022 is due to the expectation that we will gradually re-introduce a return-to-workplace program. Forecasted expenditures remain significantly lower than pre-pandemic levels.

- **Program promotion:** The increase in program promotion is due to several contributing factors including increased recruitment costs associated with current high vacancy rate, increased media costs associated with ongoing efforts associated with the COVID-19 pandemic, as well as increased professional development fees expected based on increased staff and back log of programming.

- **Building maintenance:** The increase in building maintenance relates to increased security and janitorial requirements related to the COVID-19 pandemic for APH facilities and external clinic sites.

- **Fees and insurance:** The increase in fees and insurance is due to increased general liability and property coverage, as well as the addition of a cyber-risk protection policy.

- **Expense recoveries:** Expense recoveries are administrative allocations from community health programs to public health programs. An example includes public health charging a community health program for administrative services support.

  To more accurately reflect the work public health is supporting with respect to community health programs, management is ensuring adequate administrative charges for community health programs, in line with the Board's strategy to ensure it is accountable for the dollars it receives and spends, by not subsidizing community health programs. The decrease in expense recoveries for 2022 is due to the divestment of the Community Mental Health/Alcohol Drug Assessment program as of April 1, 2021.

# 7. Capital Budget

In accordance with APH's 2018-2030 Capital Asset Funding Plan (**Appendix H**), the 2022 budget includes the following expenditures:

- Upgrade of core network infrastructure that is no longer under warranty and at risk of failure ($60,000).

  Note: Core network infrastructure includes the network switches that connect all APH computers together. When the network switch is down, APH computers are unable to operate.

# 8. Conclusions

The recommended 2022 budget for public health programs and services is $19,627,191 representing an increase of $470,197 over 2021 anticipated funding. At only 2.45% increase over previous, the recommended budget is the minimum required to maintain COVID-19 response and immunization programming, as is expected by the Ministry of Health, alongside the restoration of public health programs and services as mandated by the *Ontario Public Health Standards*.[1]

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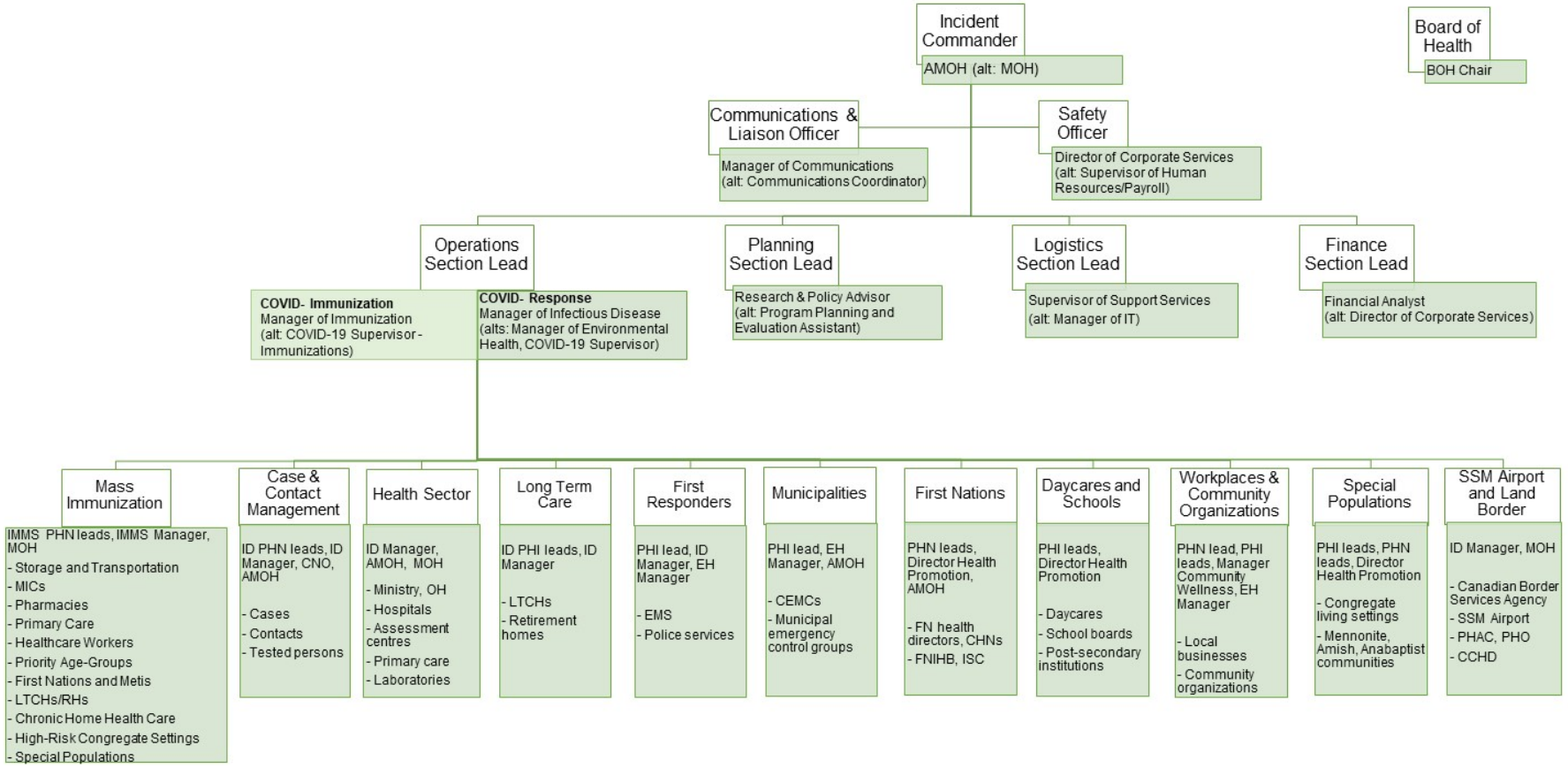
# Appendix A – Incident Management System (IMS) Structure

## IMS Structure: APH COVID-19 Response




Goal 1: **Minimize serious illness and death**
Goal 2: **Minimize societal disruption** (and preserve health care services)

# Appendix B – The Work of Public Health

As an overview of APH's leadership and pandemic response efforts, this appendix describe the most recent work by local public health programs from January to September 2021, unless otherwise specified.

## COVID-19 Response

### Case and Contact Management

At the core of the pandemic response has been emergency management, alongside health protection programming in infection prevention and control (IPAC), and in case, contact, and outbreak management.

From January – October 28, 2021, as documented in the *Public Health Case and Contact Management (CCM) program*, APH responded to:

- **456 positive cases of COVID-19** among Algoma residents and non-Algoma residents who were temporarily in Algoma, including contact tracing and monitoring of self-isolation for all cases, with an average of 4.2 contacts per case. As a comparison, 73 new cases were followed in 2020, with an average of 4.0 contacts per case.

  For perspective on the workload in fall 2021 during the fourth wave of the pandemic – with the reopening of the province and increased vaccination, meaning more mobility and activities, the average number of **close contacts has risen to 6.8 per case**, resulting in significantly more contact tracing and monitoring of self-isolation. The 'fourth wave' was defined as July 1, 2021 to October 28th, 2021, when the data was extracted.

- **1922 high-risk contacts of positive cases** have been contacted and monitored, with contacts reached within 24 hours 93% of the time and within 48 hours 95% of the time. As a comparison, 188 high-risk contacts were followed in 2020.

- **23 outbreaks where APH was the primary health unit**, with an average duration of 19 days per outbreak, which included outbreaks taking place in long-term care homes, workplaces, events, schools, and childcare facilities. As a comparison, only three outbreaks took place in 2020.

A new confirmed case of COVID-19 can be (a) simple, with limited travel history and only a few household contacts, or (b) complex, involving multiple workplaces, schools, day cares or extended friends and family, broadening the need for testing, isolation, and follow-up.

Depending on outbreak type and location, additional public health teams (i.e. school health program for schools) and a multi-partner approach is used with stakeholders ranging from hospitals, congregate living settings, and school boards, to local businesses or various provincial ministries.

On average, each person with confirmed COVID-19 infection takes up to 9 hours follow-up, with each of the cases' high-risk close contacts taking 3 hours and low risk exposure contacts about 1.5 hours of follow-up. Throughout the pandemic period, APH frontline staff and management have worked to **accommodate the demands 24/7, with scheduled shifts 7 days a week and added after hours for support in the evenings**. APH has redeployed staff internally and hired additional temporary staff with one-time funding to support case, contact and outbreak management.

## Public Health Consultation & Pandemic Communications to Algoma Stakeholders and General Public

The COVID-19 phone line team responds to all incoming COVID-19 related inquiries, including those related to general COVID-19 information, guidelines, COVID-19 exposure notifications, travel guidance, changing public health measures, screening, testing, vaccinations, and more.

From January to September 2021, **public health staff fielded approximately 41,860 calls** to phone lines dedicated to response, infection control, workplace support, and immunization.

**Call Volume Snapshot:**

- From January to September 2021, the COVID-19 general phone line dedicated to answering questions about self-isolation, travel, symptoms, testing, and COVID-19 related inquiries, averaged **2932 calls per month**.

  The calls to this line have nearly doubled compared to 2020, when the average number of calls per month was 1244. This increase in calls aligns to the increased number of cases and close-contacts identified in 2021.

- From March to September 2021, the COVID-19 line for healthcare providers averaged **611 calls per month**, fielding practitioner questions related to COVID-19 and immunizations.

- From April to September 2021, the COVID-19 vaccine phone line has averaged **948 calls per month**. Services offered through this phone line include provision of vaccine receipts to people without access to the internet, and validation of vaccine information for people who received COVID-19 immunization out of Ontario or Canada.

  This high number of calls aligns to the implementation of the Ontario proof of vaccination program as of September 22nd, 2021, which requires residents of Algoma to have a copy of their vaccine certificate when accessing certain highest risk establishments.

The COVID-19 phone line team also helps clients affected by COVID-19 by finding lodging for isolation, transportation, groceries, essential goods, methadone support, nicotine replacement therapy, and mobile testing across Algoma. This added public health coordination of services ensured priority populations and those impacted by COVID-19 had wraparound support while in isolation, and was done through the partnership of many agencies (e.g., United Way, Red Cross, SSM & District Social Services, Emergency Medical Services, police, etc.).

In addition to direct phone support, communications via online and print media ramped up throughout 2021 to share messaging on situational awareness of the current epidemiology, communicate risk and strategies for prevention and risk mitigation, evolving COVID-19 regulations and legal requirements at the federal, provincial, and local levels, and COVID-19 vaccine eligibility and access.

In addition to program-specific messaging explained throughout this report, through online platforms from January to September 2021, APH:

- Had **3.2 million unique page views on the website (www.algomapublichealth.com)**, with an average of 1:55 minutes spent on the webpage selected.

  For comparison, in 2020, the website received 1.9 million unique page views, and 2019, the website received 198,500 unique page views. This demonstrates the significant increase in use of local public health for credible and relevant COVID-19 information in 2021.

- Received **259 media requests**, with the majority responded to within the same day or week.

- Issued **76 news releases** or public services announcements.

- Published **1096 Facebook (@AlgomaHealth) posts**, averaging 4 per day. APH has 13,500 followers. People engaged with the APH Facebook page 443,173 times, through clicks or stories created.

- Remained active on Twitter, Instagram, and TikTok with posts circulated on COVID-19 risk mitigation strategies and building vaccine confidence. On APH's Tiktok, which launched in June 2021 to target youth and young adults, 27 videos were posted with 58,435 views.
- Developed a resource for health sector partners to help build COVID-19 vaccine confidence in point-of-care vaccine communications with their clients.

Concerning communication specific to primary care partners, to date the medical officer of health has hosted **27 primary care provider teleconferences** with health partners across Algoma, as an opportunity to provide updates and answer questions. In addition, **27 health professional e-mail updates** were sent to Algoma health providers, via an e-mail list of over 250 recipients.

Public health communication, through online, print, and live media has been vital to ensuring partners and residents of Algoma have the information they needed at all times to make informed-decisions to reduce their risk of COVID-19 and protect themselves and others.

### Enforcement and Outbreak Prevention and Response

During the pandemic, health protection work was reprioritized based on public health risk. Pandemic response activity took precedence, and lower risk programming such as food handler training and certain routine inspections were deprioritized. As part of the response, the environmental health team:

- Followed-up on COVID-19-related concerns (e.g., physical distancing, masking, proof of vaccine, and premise compliance with legislation), and worked with enforcement partners (e.g. by-law officers, Alcohol and Gaming Commission of Ontario, Ministry of Labour, first responders) to discuss legislation and ensure consistent approaches to progressive enforcement.
- Conducted workplace inspections for COVID-19 protocols and alignment to the Reopening Ontario Act[1], and provided education and IPAC support, especially during outbreaks. In very rare instances of non-compliance involving high-risk to the community, legal consultation and special orders were required.
- Liaised with public health labs to discuss testing and shipping, while providing education.
- Liaised with primary care and long-term care and retirement homes to provide education, manage outbreaks, interpret and optimize testing and testing protocols, support the implementation of IPAC measures, and address health and safety concerns.
- Liaised with social services and congregate care settings, by conducting on-site IPAC inspections, identifying IPAC procedures, and implementing control measures to mitigate risk of COVID-19 transmission in highest-risk settings.
- Collaborated with day cares and post-secondary institutions, alongside the school health team, to lead outbreak scenarios, gather class/cohort lists, inform policies, and determine testing and isolation requirements.
- Responded to COVID-19-related workplace outbreaks, by collating contact lists, conducting inspections, implementing control measures, and conducting daily follow-up for 10-14 days after declaring an outbreak.

  The team has responded to 10 workplace outbreaks from January to September 2021, compared to 4 in 2020.

Interpreting ever-changing legislation and guidance related to COVID-19 has been a significant part of the environmental health work, to help partners understand and implement requirements for COVID-19 risk mitigation and response that aligned to the Reopening Ontario Act[1].

## Health Promotion and Prevention in Community Workplaces

The healthy workplaces team includes a mix of public health inspectors, nurses, and environmental assistants that support Algoma workplaces and community organizations. During the pandemic, this interdisciplinary public health collaboration has:

- Answered over 1200 general inquiry e-mails from Algoma workplaces since the beginning of the pandemic.
- Responded to an average of **525 calls per month** on the dedicated healthy workplaces phone line from January to September 2021. When compared to 2020, the volume of calls has increased from the average of 450 calls per month.
- Conducted **574 site inspections** following up on COVID-19 related complaints since 2020.
- Provided education, interpreted legislation, supported workplace policy creation, and provided evidence-informed recommendations on COVID-19 protocols.
- Sent 33 e-blasts to Algoma businesses (2224 recipients) from January to September 2021, to advise of updates such as regulatory changes and new IPAC guidance.
- Developed a workplace toolkit to help Algoma workplaces develop effective COVID-19 prevention policies and safety plans.

The healthy workplace team has been pivotal to fielding questions and providing guidance related to **keeping the places where we work and play safe** during the pandemic.

## Supporting Safety and Wellness in Schools

The school health team has:

- Aligned a school health nurse to each school in the Algoma district. School staff have the ability to contact their designated school health nurse at any time to discuss matters of health and COVID-19 safety within the school.
- Developed a dedicated school health phone line and email group to provide rapid-response to real-time COVID-19 related inquiries.
- Coordinated bi-weekly meetings with senior officials from all four school boards to support the development and/or implementation of COVID-19 health, safety, and operational guidance.
- Participated in meetings with school staff and community groups (e.g. parent council).
- Collaborated with boards to produce joint communications to address changes in guidance or reminders related to risk mitigation and COVID-19 school safety (e.g. communications related to daily screening, testing, physical distancing, staying home when sick, participating in sports safely, staying safe during holidays or school breaks, the importance of vaccination, etc.).
- Coordinated and participated in weekly internal school health program incident management planning meetings and semi-weekly school health nurse meetings.

**As a snapshot of the work to date, prior to the start of the 2021-2022 school year:**

- 87% of all tracked school focused nurses' interactions were COVID-19 related;
- 152 interactions occurred through the School Health COVID-19 Support phone line and e-mail;
- 527 interactions occurred through individual school health nurse phones and e-mail addresses;
- In COVID-19 related interactions, the school health nurses most frequently worked with Principals and Board/School Administrators; and
- From the topics outlined in the School Health Guideline[2], infectious disease prevention was the topic most frequently addressed, followed by immunizations and mental health promotion.

While continuing to provide COVID-19 response support, the school health team is also preparing to work with the school-aged population and their families to support credible vaccine information sharing and access upon Health Canada approval of a COVID-19 vaccine for children 5-11 years.

A program highlight report on the role of the School Health COVID-19 Support team was provided to the Board of Health in October 2021 (see Board Package).

### Advancing Health Equity in the Pandemic Response

Health equity has been at the forefront of the COVID-19 response, recognizing that the pandemic has had an effect on the health and social wellbeing of many Algoma residents, especially priority populations.

Prior to the pandemic, health equity activities focused on understanding priority populations and building relationships to address inequities (e.g. poverty). The pandemic required focused attention and collaboration with those most vulnerable, to ensure this population was protected. Work specific to priority populations in 2021 has included:

- **Partnership with Indigenous Communities and Stakeholders (First Nations and Metis):**
  - Aligned an APH Indigenous Liaison to support First Nations pandemic response plans and align mass immunization efforts with Indigenous values and preferences.
  - Connected routinely with eight First Nation Communities, the Indigenous Friendship Centre, Metis Nation of Ontario, and First Nations & Inuit Health Branch to share the local COVID-19 situation and provincial guidance, as well as COVID-19 response and immunization supports.
  - Worked in partnership with First Nations partners to co-develop processes that supported relationship building and reduce inequities during the vaccine rollout.
  - Provided support and education on COVID-19 guidelines, IPAC, testing, vaccination rollout, and healthy workplace policy development.
  - Engaged in over 200 meetings with First Nation and Metis health directors, partners and working groups to support COVID-19 response and immunization programming, in addition to Public Health Indigenous Engagement Network and Indigenous Public Health Council meetings.
  - Responded to over 2700 e-mails and 390 phone calls to share information, education, and resources with partners.
  - Attended 10 meetings to provide vaccine confidence resources and support to the Mental Health Youth Hub.
- **Partnership with Anabaptist Communities: Mennonite and Amish:**
  - Conducted 65 visits with Mennonite families and communities, and 23 visits with Amish families and communities, to share COVID-19, vaccination, and health promotion and protection information.
  - Provided support for quarantine and testing compliance, and proactive education for compliance of businesses with the Reopening Ontario Act[1] and border requirements.
  - Engaged in 48 meetings with North Shores Health Network, and meetings with the Public Health Agency of Canada and partners, regarding Mennonite and Amish border crossing.
- **Support for the Algoma Treatment and Remand Centre:**
  - Liaised and followed-up for IPAC support and immunization.
- **Support for the setup of a Safe Voluntary Isolation Site Program:**
  - Worked with the Sault Ste. Marie District Social Services Board (SSM-DSSAB) and Public Health Agency of Canada funding to make rooms available for isolation. These spaces were to

support the homeless population and individuals unable to isolate alone, as recommended by APH as part of case and contact management.

- Provided ongoing operator guidance on public health measures, mobile testing options, and vaccine access.

- **Support for the delivery of goods and services:**
  - With Harvest Algoma, Red Cross, and SSM-DSSAB, supported the set-up and access of services for those isolating as per public health recommendation (e.g., non-perishable food delivery, transportation to testing, etc.).

Health equity will remain at the forefront of the COVID-19 response, recognizing that the pandemic has affected the health and wellbeing of Algoma residents, especially priority populations.

## Internal & External Engagement in Emergency Preparedness and Response

APH, as member of the local and regional structures for heath-sector emergency management, works to coordinate health system preparedness for emergencies like the COVID-19 pandemic. APH has been the lead agency in the COVID-19 pandemic response, ensuring communication with municipal emergency response members across the district. Internal, external, and colliding emergency management has continued throughout 2021.

### Internal Emergency Preparedness and Response

In 2018, APH's emergency management team updated the agency's emergency response plan, which has guided two large-scale responses, including the APH Cyberattack in 2019, and the COVID-19 pandemic. The emergency response plan has provided a guideline for emergency response and has ensured a coordinated response by all programs in public health.

Upon activating the IMS structure in 2020 (see **Appendix A**), incident action plans were developed and routine pandemic meetings were scheduled. The incident action plan outlined the goals and objectives for each of our stakeholder groups and leads aligned, and provided an opportunity for teams to share key updates for each core segment of the IMS structure.

Since APH remains in IMS at the time of writing, numerous internal meetings for COVID-19 response coordination have continued from January – October 2021, including:

- 38 Continuity of Operations Plan (COOP) meetings to continuously assess staffing allocation, resources, and prioritization of programming;
- 28 COVID-19 Response leadership meetings, to assess alignment of human resources, program pressures, and needs; and
- 38 IMS Incident Action Planning meetings with all staff involved in COVID-19 response and immunization.

This summary does not include the countless internal team-specific touchpoints and external meetings that have been attended for a consistent and robust response to the pandemic. For example, APH staff have attended ministry, northern public health unit, partner, and sector-specific meetings on COVID-19 response and vaccination throughout 2021.

### External Emergency Preparedness and Response

Emergency management as part of pandemic response has included many external meetings with municipal emergency control groups and municipal community emergency management coordinators (CEMCs). The focus of municipal meetings has included developing systems to support vulnerable and isolating persons, coordinating follow-up and enforcement for legislation under the Reopening Ontario Act[1], and maintaining communication with the broader community.

**As a snapshot of the emergency management work in 2021, APH:**

- Maintained a public health inspector assigned the Emergency Management portfolio, as a routine point of contact for inquires and concerns.

- Participated in emergency response training provided to North Shores and Spanish.
- Provided routine notifications to local CEMCs concerning public service announcements, ministry updates, changes in guidance, etc. via e-mail.
- Responded to an average of 10 calls from municipalities per week.
- Participated in weekly WebEx meetings with Emergency management Ontario (EMO) for updates from the provincial emergency operations centre, in addition to biannual EMO sector meeting where APH presented response updates.
- Engaged in six municipal emergencies meetings per week at the start of the year, which later transitioned to e-mail or phone.
- Responded to over **200 municipal e-mails** per week, depending on provincial direction and guidance, to discuss regulation compliance, concern with venue access, council meeting concerns, newsletter information, complains for non-compliance, and vaccine policy needs.
- Hosted weekly teleconferences with all municipalities to provide opportunities for feedback on prevention and mitigation efforts taken, before moving to as-needed virtual support.
- Developed and sent 31 e-blasts to Community Emergency Management contacts (49 recipients).
- Created and distributed nine Community COVID-19 vaccine bulletins, with three each for Central and East Algoma, North Algoma, and Sault Ste. Marie and Area, to provide legislation guidance, vaccine clinic information, and public health updates.

Despite the COVID-19 response using most of APH's resources over the course of 2021, it was evident that non-pandemic emergencies continue regardless of the status of the pandemic.

**Wildfire Evacuation in a Pandemic: Managing Multiple Emergencies**

In summer 2021, northern Ontario communities experienced wildfires, requiring the evacuation of 100 individuals from Spirit First Nations to Sault Ste. Marie. APH, as part of Sault Ste. Marie's Emergency Operations Centre, mobilized with partners to ensure the health and safety of evacuees, while continuing the COVID-19 response. Daily meetings with health system partners were required to ensure a coordinated response and that basic needs of evacuees were met.

As a contribution, APH deployed two public health inspectors to work on-site at the host facility daily, to ensure appropriate IPAC measures were in place, assess risk, provide education, and deliver harm reduction and public health supplies (i.e., toothbrushes, personal protective equipment (PPE), sanitizer, condoms, and Naloxone). Communications on air quality were also amplified to alert Algoma communities of the risks to health from wildfire smoke exposure, especially among vulnerable populations, and strategies for risk mitigation.

APH teams provided approximately 185 hours of labour ($10,800) over a two-week period, along with upwards of $150 in PPE. This significant use of human resources for a short-term event illustrated how quickly APH resource needs could escalate if faced with many emergencies in one year, or multiple emergencies occurring simultaneously.

This critical work also demonstrated the value of emergency management and strategic coordination of public health resources, as well as the essential role of partnerships, to respond to multiple crises.

Without the engagement and support of Algoma's 21 municipalities, partners, and residents, many provincial and local public health measures would not have been successfully implemented or helped to achieve pandemic goals. We have been **in this together** since the beginning.

## COVID-19 Immunization

In December 2020, Health Canada approved both Pfizer (Comirnaty) and Moderna (Spikefax) COVID-19 vaccines. The first National Advisory Committee on Immunization (NACI) recommendations report followed these approvals on December 12, 2020, approving Pfizer for ages 16 and up. By March 2021, Health Canada had extended approval to two more COVID-19 vaccines, including AstraZeneca (Vaxzevria) and Janssen.

On **January 27th, 2021, the first COVID-19 vaccine in Algoma was administered** in long-term care, and from this point forward, local public health, in unprecedented partnership with primary care, pharmacies, Indigenous health departments, and additional community health partners began robust immunization efforts to achieve high rates of COVID-19 vaccine protection in Algoma at rapid speed.

A presentation on the COVID-19 Immunization plan was shared with the Board of Health in January 27, 2021, the same day as the first dose was administered (see Board Package). Since that day, eligibility has continued to expand to include all adults and youth 12-17 for both first and second doses.

Within the context of the vaccine rollout, local public health has led the coordination of the vaccine rollout in Algoma, by working with partners, planning, managing operations (e.g., storage and transportation, security, administration, documentation and tracking, monitoring and reporting, and evaluation) and facilitating vaccine communication.

**As a snapshot of COVID-19 vaccination efforts from January – September 2021:**

- 81.4% of the eligible population (12+ and born in 2009) in Algoma received two doses of COVID-19 vaccine, and 87.3% received at least one dose, as per the September 29, 2021 COVax Report.
- 172,270 doses of COVID-19 vaccine were administered at Algoma vaccine events to individuals regardless of residence, of which APH has either hosted, coordinated, administered vaccine, supplied vaccine, or supported in some capacity (COVax, Oct. 4).
- 469 vaccine clinics (> 10 doses administered) occurred through GFL mass immunization clinics, district mass immunization clinics, and pop-up clinics in Algoma. Pop-up clinics were strategically set-up in Algoma areas to enhance access to vaccine by populations with lower vaccine uptake or facing health inequities.
- 156 internal Immunization Incident Action Planning meetings with all staff involved in COVID-19 vaccination planning and implementation were held.
- 136 Community Vaccine Planning sub-region meetings were held, with weekly to biweekly meetings held for primary care, pharmacy, Indigenous health sector, hospital, and municipal partners in Sault Ste. Marie & Area, Elliot Lake & Area, Central & East Algoma, and North Algoma.

In addition, public health nurses and the medical officer of health or associate medical officer of health have conducted numerous consultations on adverse effects following immunization. Over the course of the year, PHNs responded to over 1650 emails from vaccine partners, answered or participated in over 700 calls, and attended over 50 meetings with external partners (e.g., retirement homes, long-term care homes, family health teams, etc.).

**To boost vaccine confidence in Algoma, in addition to online communications, vaccine communication, APH:**

- Attended 20 Vaccine support council meetings to provide APH vaccine updates and identify opportunities for partnership with the Chamber of Commerce and business community on vaccine confidence building (i.e., PUC transportation, Business-sponsored clinic meals, etc.).
- Published 12 Google Ads to promote vaccine confidence and pop-up clinics in Algoma, which resulted in 3.1 million impressions and 10,335 clicks.
- Developed and disseminated 250 “Be There for This” vaccine confidence campaign posters, 250 vaccination posters for 12-17 year olds with tear off sheets, and 250 posters for social services and the Algoma District. In addition, 300 copies of #StopTheSpread messaging were posted to mailboxes.
- Created 51 unique pop-up clinic promotion packages, and for a targeted clinic, mailed 3,274 mail outs for the Tenaris pop-up vaccination clinic.
- Hosted eight vaccine town halls with allied health partners to boost vaccine confidence.
- Coordinated and streamed one live town hall on YouTube for youth 12-17 years to ask and have vaccine questions answered.

- Created 16 internal and 5 external ads to promote vaccine confidence on buses.
- Collaborated with five businesses to give testimonials encouraging vaccination.
- Worked with David Amber (Hockey Night in Canada) and John Dean (Soo Greyhounds) to help build vaccine confidence.
- Participated in a Northern Ontario Junior Hockey League campaign encouraging vaccination.

APH teams have remained available to all community partners for vaccine questions, guidance, and support resources, responding to calls, e-mails, media requests, and public inquiries via phone and e-mail. In addition, internal teams have submitted countless Ministry of Health reporting and planning templates, which required strategic planning, vaccine allocation, and forecasting, necessitating involvement by many for quick planning and turnaround to the Ministry, often within 24 hours to 1 week, which was prioritized over additional pandemic efforts.

As of November 8, **86.0% of eligible residents (12+ and anyone born in 2009) in Algoma have received two doses and are fully vaccinated**, and 89.7% of eligible residents have received at least one dose. Including first, second, and third/booster doses, 181,193 doses have been administered across all vaccine channels to Algoma residents.

As we look ahead, third dose eligibility has been announced for Ontarians meeting special population criteria on August 17th, and continues to expand with booster doses being offered to highest risk populations with waning immunity over time. In addition, Health Canada approval of a safe and effective COVID-19 vaccine for children 5 to 11 years is expected in winter 2021, which will enable 7600 Algoma residents aged 5-11 years old to receive a COVID vaccine series.

With ongoing efforts to administer first and second doses to unvaccinated persons to reach the Ontario target of **90% of the eligible population being fully vaccinated**, ongoing expansion of eligibility for booster doses, and upcoming vaccination of children, the COVID-19 vaccination program will remain a pillar of effective COVID-19 response for a long while.

### Knowledge Translation and Exchange

Work within the COVID-19 response and immunization programs has required the interpretation, communication, implementation, and at times enforcement of ever-changing guidelines, reference documents, legislation, emergency orders, letters of instruction, and advisory board recommendations.

As a few examples of the volume of guidance changes and need to keep up to speed, to ensure public health alignment with protocols and public awareness, since the start of the pandemic until November 4, 2021, there have been:

- 548 Situation Reports outlining the situation in Ontario (COVID-19 cases, deaths, outbreaks, etc.).
- 13 versions of the Management of Cases and Contacts of COVID-19 in Ontario[3] document.
- 22 updates to the National Advisory Committee on Immunization recommendation on the use of COVID-19 vaccines report.[4]
- 3 versions of the Proof of Vaccination Guidance for Businesses and Organizations under the Reopening Ontario Act.[5]

The rapid evolution of evidence and information guiding practice, and changes in guidance, has added to the public health workload and required strategic messaging to ensure coordination with partners and the broader community.

## Highest-Risk Core Public Health Programs and Services

In addition to COVID-19 focused work, the Continuity of Operations Plan (COOP) detailed APH's prioritization of programs and services, with highest priority given to programs that worked to decrease health inequities for those who have been most affected by COVID-19.

Programs and services designated as high priority have been managed with modifications to accommodate public health measures (i.e., virtual delivery) and limited capacity available with the deployment of staff to COVID-19 response.

**In 2021, the following high-risk programming was maintained, at modified or reduced capacity[6]:**

- **Infectious and Communicable Diseases:** APH continued to respond to ongoing cases of diseases of public health significance, or reportable diseases. Treatment, testing, and counselling of cases and contacts has continued despite staffing challenges. In addition, ongoing support was for facility outbreak management, in addition to IPAC work in settings, was provided, such as that for personal service premises. Thirty-three e-blasts were also sent to personal service settings (277 recipients). Quarterly reporting of Diseases of Public Health Significance to identify disease rates in Algoma vs. Ontario has also continued.

  A program highlight report on Infection Prevention and Control during and outside of the pandemic in Algoma was shared with the Board of Health in March 2021 (see Board Package).

- **Food Safety:** Environmental health inspectors continued to conduct routine food safety inspections of high, medium, and low risk premises to keep all patrons safe from a food borne illnesses. The inspectors also followed-up on complaints, bringing establishments into compliance with the food safety regulations, while assessing the risk and providing education.

- **Safe Water:** APH continued to deliver safe water program services, with an objective to minimize all water borne illnesses. These services include working with Ministry of Environment, Conservation and Parks (MECP), PUC, and municipalities to ensure safe potable water was provided to all users. Inspectors also issued boil water advisories and orders as necessary, as well as provided education. Despite working at reduced capacity, the safe water program also inspected recreational facilities for compliance with the safe water regulations.

- **Tobacco Enforcement:** Staff continued to follow up on smoking-related complaints across the district, using progressive enforcement as a first approach. This team also conducted tobacco product display and promotion inspections to ensure premises were complying with the Smoke Free Ontario Act.

- **Healthy Environments:** APH continued the development of a climate change vulnerability and adaptation assessment in partnership with 6 northern health units who formed a Northern Climate Change and Health Collaborative in response to funding from Health Canada's *HealthADAPT* program.[7] A climate perceptions engagement phase was conducted in spring 2020, including 19 interviews with 26 district-wide community representatives to discuss extreme weather and impacts to health and wellbeing in Algoma.

  APH wrote a climate change and health blog for Clean North, and provided a presentation to Sault Climate Hub. In addition, APH provided letters of support for community partner initiatives working to enhance physical activity and healthy active transportation.

  A presentation on climate change work to date was shared with the Board of Health in March 2021 (see Board Package).

- **Vaccine Preventable Diseases:** APH continued to offer routine immunization clinics, primarily to those without a primary care provider. Services were modified to accommodate a limited number of clients due to COVID restrictions/precautions, and limited staff capacity due to deployment. When compared to pre-COVID volume of clients served, APH clinics saw approximately 30% of pre-pandemic clients per month, resulting in less clients able to access public health immunization services during the pandemic period. Immunization coverage in school-age children reporting has continued.

- **Community Safety and Wellbeing (CSWB) Plans**: APH provided consultation support to municipalities developing CSWB plans to mitigate immediate social risks that lead to crime and negatively impact community wellbeing and quality of life.[8]

The Central Algoma, Sault Ste. Marie, Elliot Lake, North Shores, and Township of Macdonald, Meredith and Aberdeen Additional and the Township of Laird plans were reviewed, and an evidence-informed briefing note was created for Sault Ste. Marie to provide recommendations for upstream strategies to address downtown crime.

- **Substance Use and Harm Reduction:** Tobacco cessation services transitioned to virtual with a reduced caseload, and APH continued to support community initiatives to reduce smoking, including support to Algoma University to become a smoke-free campus, effective September 1, 2021.

  In addition, harm reduction services, such as the Needle Exchange Program (NEP) and naloxone distribution remained a priority, alongside opioid surveillance and reporting (21 reports to date) and education on language to reduce stigma related to substance use. The APH team also continued to meet with the Sault Ste. Marie and Area Drug Strategy Committee and produce opioid surveillance bulletins (8 to date).

  As a snapshot of service use, from January to September 26, 2021, there were 3,877 visits to the NEP for harm reduction supplies and support services. It is projected that there will be 4,790 visits by the end of 2021, which compares to 4430 in 2020 and 4641 in 2019 (pre-pandemic).

  A comprehensive overview of substance use and harm reduction services provided throughout 2021 was presented during the October 2021 Board of Health meeting (see Board Package).

- **Healthy Sexuality:** APH continued to provide sexual health services, including our sexual health information line, which averaged 13 calls per day, reaching a maximum of 32 calls in one day. In addition, APH has continued to provide low cost/no cost birth control with advertised drop-in hours, and accommodated appointments.

- **Healthy Babies Healthy Children:** APH continued to contact consenting individuals within 48 hours of discharge from hospital after the birth of their baby, at reduced capacity. This contact enabled APH to screen for risk, provide information, and support families welcoming their new baby. This service also included breastfeeding support and guidance, and referrals to community supports as needed. In addition, APH continued to provide the Blended Model Home visiting program through virtual and in person appointments. Despite reduced capacity, the team supported 92 families.

- **Prenatal and Parenting Classes:** APH used virtual means to provide prenatal and parenting classes, and collaborated with community partners to reach those in need. During the pandemic, 23 sessions of Triple P were offered, as well as three Nobody's Perfect sessions. However, virtual classes were suspended in fall 2021 due to COVID-19 surge support needed as part of the fourth wave. Clients are being directed to an online option called InJoy. Since January 2021, 247 clients accessed the classes, with 26.7% completing the course.

- **Breastfeeding:** Breastfeeding surveillance continued until June 2021, before being paused due to limited capacity in the program. APH connected to mothers at the 48-hour contact by consent. Breastfeeding information was offered prenatally and post-partum over virtual platforms or in person appointment as requested.

- **Canada Prenatal Nutrition Program (CPNP) and Community Action Program for Children (CAPC):** APH continued to provide the CPNP and CAPC programs virtually to support the health of pregnant women, new mothers and their babies who face challenges that put their health at risk. From March 31, 2021 to September 24, 2021, 204 pregnant individuals accessed the program.

- **Parent Child Information Line (PCIL):** APH expanded hours of the PCIL for individuals to access a public health nurse Monday to Friday 9:00am-4:00pm for information, support and referrals to community agencies. Calls received ranged from approximately seven per day, reaching a maximum of 30 days in one day.

- **Oral Health:** The Ontario Seniors Dental Care Program (OSDCP) was the focus of the Oral Health team throughout the pandemic. APH's SSM onsite dental clinic briefly closed during the first provincial stay at home order (early 2020), but has remained open for treatment services ever since.

A program highlight report on the OSDCP was provided to the Board of Health in May 2021 (see Board Package), which was further explained in a presentation provided in September 2021 (see Board Package).

- **Preschool Speech and Language Services (PSLS), Infant Child Development Program (ICDP), and the Infant Hearing Program (IHP):** These programs were able to transition to virtual service delivery in March 2020.PSLS and ICDP carried their caseloads into the virtual setting; only seeing clients in-person when provincial stay at home orders were lifted and when deemed clinically necessary. IHP had a brief pause during the first provincial stay at home order, but has resumed regular service delivery ever since.
- **Health Equity:** Alongside equity-focused COVID-19 response and immunization efforts, through strengthened partnership with Mennonite and Amish communities for pandemic response, a district PHN and PHI have continued to support a travelling clinic to provide public health education and resources to willing families and community members.

  In addition, internally, staff members revitalized the Indigenous Engagement Working Group to regroup on meaningful ways to work towards Truth & Reconciliation. This work started with the revision of the APH Land Acknowledgement, which was approved by the Board of Health in September 2021 (see Board Package).

## Foundational Supports

**Robust and intensive support** has been provided by foundational teams, including communications, epidemiologic and data, evidence, planning and evaluation, and corporate supports, including human resource, clerical, health and safety, information technology, logistics and finance for all programs and response services.

The foundations support team was the glue holding the critical components of COVID-19 response, immunization, and highest risk programming together, by:

- Ensuring the public remained informed about COVID-19 risk, cases, risk mitigation measures, guidelines and policies, and vaccine information;
- Conducting epidemiologic surveillance on COVID-19 in our community and beyond, through routine COVID-19 indicator (i.e., data on cases, contacts, testing, vaccination, variants of concern, school absenteeism, etc.) reporting, monitoring, and sharing to inform the public health pandemic response;
- Reviewing evidence and supporting the dissemination and communication of vaccine science and risk mitigation research;
- Supporting the planning and coordination of internal immunization and response activities;
- Evaluating public health processes and efforts, and collating public survey feedback to inform practice;
- Booking appointments, fielding public questions, and ensuring appropriate staffing and scheduling for clinics;
- Ensuring the appropriate, high functioning technology for public health to work in office and remote to serve the community and keep everyone safe;
- Enhancing telephone and on-line booking systems to provide optimal service for clients;
- Hiring qualified, skilled professionals to join the public health workforce at rapid speed, and ensuring employees had the resources needed to work safety;
- Successfully negotiating two collective agreements;
- Maintaining health and safety of staff and clients, both in-office, at home, and in the field at pop-up and community clinics; and **most critically, and as related to our budget;**
- **Ensuring the efficiency and fiscal responsibility of public health, by managing finite resources without requiring the use of reserve funds or additional loans.**

## Appendix B References: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# Appendix C – The Backlog of Public Health Services

The backlog of public health services and program work due to the province-wide prioritization of the COVID-19 pandemic response and immunization is provided below by public health program.

**Community Wellness and School Health Program**

Due to the deployment of staff to COVID-19 response and phone lines, and development of the COVID-19 school support team, the Community Wellness and School Health program backlogs include:

- Waitlist of 105 persons for smoking cessation support, as of October 31, 2021, which amounts to a 1-year waiting period. Due to the length of the waitlist, clients currently seen are being prioritized based on risk (i.e., currently pregnant, recent heart attack, etc.).
- Pause of the comprehensive tobacco communications campaign (cessation and prevention) intended to launch in 2020.
- Suspended youth engagement work that was focused on smoking prevention, as well as efforts to prevent and address vaping among youth and young adults.
- Delay in compiling a local opioid situational assessment to better identify needs, services, and gaps.
- Incomplete climate change vulnerability and adaptation assessment requiring completion to inform emergency management and adaptation strategies for future climate-related events and impacts.
- Suspension of programs related to healthy eating active living, mental health promotion, falls prevention, road safety, vision screening, and healthy environment indicator development, requiring revisiting.
- Pause on the comprehensive school health promotion approach, due to COVID-19 school response prioritization. There is a need to collaborate with students, parents, and educators to promote health and wellbeing of school-age children, provide education and resources, support implementation of healthy school policies, and promote leadership and engagement, while supporting students to develop healthy coping skills and habits.

**Environmental Health Program**

Environmental health diverted resources to focus to pandemic response activities, which resulted in modified routine program work and reduced premise inspections. Prior to the pandemic, inspectors strived to complete 95-100% of inspections in each program area. As of September 2021, program inspection completion rates remain significantly reduced when compared to 2019 (pre-pandemic):

- 53% completion rate for food safety inspections in 2021, as compared to 98% in 2019.
- 34% safe drinking water system inspections in 2021, as compared to 96% in 2019.
- 56% of recreational water (pool inspections) in 2021, as compared to 100% in 2019.
- 25% of personal service setting inspections in 2021, as compared to 90% in 2019.

In addition, APH did not offer any Safe Food Handling courses in 2020 or 2021. For comparison, 41 courses offered in 2019 that certified 1137 individuals.

Catch-up to increase inspection completion rates and corresponding education, guidance and support is needed to return to pre-pandemic rates and ensure health protection.

**Healthy Growth and Development**

Due to the deployment of resources, programming and services provided by Healthy Growth and Development staff were at reduced capacity, resulting in:

- A waitlist of 74 families for Healthy Babies Healthy Children home visits, with referrals addressed in 2021 based on highest risk. In fall 2021, the waitlist was suspended due to COVID-19 surge support needed, and clients have been refereed to community supports.
- Suspension of virtual prenatal classes in fall 2021, which will require in-person resumption when safe to do so, as online classes resulted in low uptake by community members.
- Pause on in-person visits to Garden River Wellness Centre, which need to resume enhancing virtual supports that have continued through the HBHC worker at the wellness centre.
- Suspension of healthy sexuality promotion activities, with only one outreach initiative at Sault College supported in 2021. Addressing this backlog in education and promotion is needed, as an increase in sexually transmitted infections from 2020 to 2021 is projected in Algoma.
- Backlog in the linking of procedures to agency policies, and potential for the need to develop new policies before work can stably move forward.

As an overview of the Healthy Growth and Development program, and goals for recovery, a program highlight report was shared with the Board of Health in April 2021 (see Board Package).

**Immunization Program**

Due to prioritization of the COVID-19 vaccine rollout, tuberculosis testing, vaccination promotion, and assessment of records and students missing Immunization of School Pupils Act vaccines have been suspend. In addition, the annual influenza rollout has been modified, with increased reliance on primary care and pharmacy partners, and reduced public health-led clinics to sustain COVID-related programs.

COVID-19 disrupted both in-person learning and routine well-child visits for many individuals over the course of the pandemic; therefore, many children have fallen behind on receiving recommended vaccines per the publically funded immunization schedules for Ontario.

At this time, the immunization program is experiencing:

- A school-based immunization backlog of 14,200 doses of vaccine to complete grade 7 catch-up along with 3370 doses required among newly eligible grade 7 students this fall 2021. Grade 7 immunizations included Meningococcal, HPV, and Hepatitis B vaccines.
- A backlog of 4500 infant and childhood vaccines to complete, which include Tdap-IPV, MMRV, Var, MMR, Men-C-C, Pneu-C-13, and DTaP-IPV-Hib vaccines.
- A backlog of 3000 adolescent tetanus, diphtheria, and pertussis (Tdap) catch-up doses.
- Delayed review and updating of medical directives, policies, procedures, and other program work, such as immunization records, due to COVID-19 immunization prioritization.

To address the backlog, as of November 2021, the immunization program has begun offering school vaccine catch-up clinics for current grade 7 students as well as students who missed their immunizations.

**Oral Health Program**

Due to the deployment of staff to COVID-19 response and public health measures suspending in-person services for periods during the pandemic, the oral health program has experienced a:

- 15-month backlog in Healthy Smiles Ontario preventative clinics for low-income children aged 0-17. Clinics resumed in June 2021, however have reduced throughput due to clinic sharing with OSDCP.
- 18-month backlog in school dental screenings and service delivery, which may result in worse oral health conditions than pre-pandemic state, causing a growth in post-screening notification and follow-ups to be conducted.

- 18-month backlog in the Healthy Smiles Ontario and Essential Services Stream. As a result, few children that qualified for the program have been lost to follow-up and will be difficult to bring back into clinic for re-assessment, leaving oral health status unknown.
- 18-month backlog in the Children's Oral Health Initiative with Garden River, where children receive screenings and fluoride varnish. The relationship with Garden River was paused, due to suspension of services during the pandemic and staff-turnover requiring new connections to be developed.

In addition, 200+ clients are awaiting services, specifically treatment plans with a dentist, as part of the OSDCP. OSDCP clinics were paused for a total of 5 months during the pandemic.

To address the backlog, the oral health program is resuming partnership with Garden River, and intends to re-enter the schools for oral health screening in January 2022, using a health equity approach to prioritization by visiting the highest risk areas in Algoma first.

**Infectious Disease**

Due to the focus of the infectious disease team on case, contact, and outbreak management, and limited staffing for routine public health work, there has been:

- Reduced case management of sexually transmitted infections, with APH communication to health partners being limited and work with stakeholders in providing health care somewhat prevented due to COVID-19 response.
- Limited to no health promotion and communication efforts to influence health behaviours in regards to sexual practices and injection drug use practices.
- Reduced screening and testing of clients at APH, without any outreach services provided, such as HIV Point-of-Care conducted for priority populations.
- Reduced frequency in assessment and reporting of latent tuberculosis infections, as compared to the pre-pandemic period, due to reduced testing.
- Delayed STI surveillance, trends, and analysis.

To address the backlog and attempt to redirect staff support to sexual health and infectious disease areas of the program, a new staffing schedule is being trialled in fall 2021, being mindful that reduced staff aligned to COVID-19 response may strain case and contact management.

**Foundations: Population Health Assessment, Evidence-Informed Practice, Health Equity, Emergency Management, & Communications**

Due to the foundations team providing support for COVID-19 response and immunization programs, several projects were paused, requiring revisiting and catch-up, including:

- Annual reporting for 2019 to 2021, to highlight the work of public health and impacts to population health and wellbeing.
- Updating of the Algoma Community Health Profile previously completed in 2018 to identify public health issues and priority populations for public health action.
- Creation, reporting and monitoring of indicators for assessing process and outcomes of public health programs and services (e.g., school health, healthy environments, injury prevention).
- Revisiting Bridges out of Poverty, a poverty cultural awareness program that was suspended during the pandemic.
- Updating and surveillance reporting on Influenza Season Vaccination and Healthy Growth and Development program indicators, alongside other data and indicator reporting to assess the health status of Algoma and underpin the targeted planning of program and services (i.e. Cancer Care Ontario data).

- Revisiting three partially structured rapid reviews (evidence) for informing best practices put on hold, including community interventions for reducing falls, reducing intentional injuries, and enhancing mental health promotion across the lifespan.
- Revisit of past public health promotion, messaging, and resources to be updated and support new program communication requirements, as well as launch the paused tobacco communications campaign to align with post-pandemic learning and community assessments.
- Reactivating public health pandemic recovery planning, as well as updating emergency management plans to reflect pandemic lessons learned, strategies, and processes for future crises.

In addition, due to prioritized work, routine updating and review of program indicators and client health reports has been modified or suspended. In addition, addressing technology or system errors outside of prioritized needs related to COVID has been minimal. Delayed electronic record entries or updating poses risk for errors or delay in immunizations. Resources will be needed to review, revise, and update program indicators, electronic records, and reporting processes, as well as to assess the quality of reports to ensure meaningful and accurate data to inform public health practice, programs, and services.

These are a brief overview of the many, but not all, impacts to both public health in Algoma and service delivery at the program-level from the prioritization of COVID-19 pandemic work.

**Agency-Wide Backlogs**

### Evidence, Data, Planning, and Evaluation

In addition to program-specific backlogs, numerous situational, needs, and program assessment, literature review, planning, and evaluation supports are needed for the development and implementation of efficient, effective, and equitable population health programs and services that have been put on hold.

Foundational work to evaluate and review the evidence for pandemic lessons learned and best practices in a post-pandemic time will require resourcing to inform the restoration of programs and services. Similarly, Annual Service Plans and Standard Implementation Plans, alongside program work plans, have been paused, requiring review and re-alignment to public health needs in Algoma. A review of the data to identify public health needs and priorities, recognizing that the health of our population has changed during the pandemic, is a much-needed starting step.

Finally, an evaluation of public health programs and services provided during the pandemic is needed to inform and enhance future public health emergency response and programming. The first part of the APH Covid-19 pandemic response evaluation was presented to the Board of Health in February 2021 (see Board Package), before further evaluation was paused to support vaccine planning and communications.

Lessons learned throughout the pandemic, identification of new population health priorities, and evidence-informed innovations in public health practice will enhance the landscape of public health programs to better service communities beyond COVID-19, however, will require time and resourcing.

### Collaboration and Partnerships

Despite numerous strengthened partnerships and relationships within the pandemic response, it has been challenging for staff to remain part of non-COVID working groups and collaborative tables (e.g., food security, child services, poverty round tables, healthy communities, etc.), recognizing that some agencies did suspended meetings during the pandemic period.

The many committees, advisory boards, advocacy groups, etc. to which APH was an active partner will require revisiting and reinvested effort by APH to come to speed and re-identify the role of public health in supporting partners to navigate important community priorities.

# Appendix D – The Cost of COVID-19 Pandemic Work

## The Cost in Dollars

Despite significant pressures, APH remained fiscally responsible through the COVID-19 pandemic. To date, APH has not required the use of reserve funds or borrowed dollars.

As of September 2021, the financial impact of COVID-19 response efforts have totalled 64,558 labour hours ($3,347,575) and COVID-19 immunization efforts have totalled 46,411 labour hours ($2,084,697). This excludes material resource costs, and third party health service costs paid by APH for COVID-19 response and immunization programming. Month-by-month COVID-19 response and immunization labour expenses are shown in **Table D1**.

**Table D1: Monthly COVID-19 Response and Immunization Labour & Third Party Costs, 2021**

| COVID-19 Response and Immunization Labour & Third Party Costs | | | | | |
|---|---|---|---|---|---|
| | COVID-19 Response | | COVID-19 Immunization | | |
| Month (2021) | Hours | APH Labour Cost | Hours | APH Labour Cost | 3rd Party Health Services |
| Jan | 6,310 | 340,894 | 1,259 | 75,125 | 0 |
| Feb | 7,060 | 342,892 | 2,081 | 166,318 | 0 |
| Mar | 8,100 | 359,817 | 5,562 | 203,397 | 0 |
| Apr | 7,601 | 454,941 | 4,844 | 224,404 | 63,163 |
| May | 7,338 | 400,642 | 6,056 | 275,344 | 61,299 |
| Jun | 8,479 | 470,916 | 9,301 | 423,354 | 62,843 |
| Jul | 6,258 | 299,482 | 7,329 | 270,897 | 101,523 |
| Aug | 6,191 | 256,509 | 5,390 | 262,129 | 83,277 |
| Sep | 7,221 | 421,482 | 4,589 | 183,729 | 39,947 |
| Oct | | | | | |
| Nov | | | | | |
| Dec | | | | | |
| **Total** | **64,558** | **3,347,575** | **46,411** | **2,084,697** | **412,052** |
| **Note:** As of November 4, 2021, August and September 3rd party costs are estimations, as some reimbursements are still underway. | | | | | |

These labour costs are being reported to the Ministry of Health for reimbursement as COVID-19 extraordinary and COVID-19 vaccine program extraordinary costs. This includes one-time funding requests for extraordinary costs incurred or expected to be incurred over and above the board of health's existing funding and budget for the period of January – December 2021.

As is further explained below, although one-time funding for COVID-19 response and immunization supports the staffing and resource needs at present, it does not help APH hire highly qualified professionals to support ongoing public health needs in the longer term, especially those related to public health backlogs related to COVID-19 and rising priorities (e.g., childhood immunization, mental health and addictions, oral health services).

## The Cost in Time

Staffing strategies for the COVID-19 response include the redeployment of staff from home programs, cross training of staff to cover various roles and responsibilities, shuffling of work schedules, modification of highest risk public health programming, deferment of routine public health work, and the suspension of public health programs and projects.

To sustain the COVID-19 response, immunization, and highest-risk programming, and the associated volume of work with existing staff, employees worked a significant amount of extra hours.

In addition, because of ongoing recruitment challenges, which are especially common in the northern Ontario health sector, as of November 4, 2021, **16 FTE vacancies remain, representing 8.86% of the**

**workforce**, adding workload for existing staff that would otherwise be completed by the current vacant positions.

To demonstrate the volume of extra hours worked, the 2021 and 2020 extra hours worked were compared to the 2019 extra hours worked, which represents a pre-pandemic workload.

**As a summary of extra hours worked from January 1 – September 18, 2021:**

- ONA and CUPE employees worked 5063.5 extra hours ($239,056.00) in callout, overtime, and lieu time combined, marking a **166.3% increase** in hours compared to 2019. In contrast to 2020, ONA and CUPE employees marked a 71.3% increase in hours compared to 2019.
- Leadership and non-union employees worked 3427 overtime hours ($211,745.00). Total hours and costs relating to 2019 and 2020 were not tracked.

Extra hours worked and paid from payroll for 2021 (callout, overtime, and lieu) have exceeded those for 2019 (pre-pandemic) where comparators were available. With a growing workload for the remainder of 2021, extra hours will likely continue to be accumulated by employees.

In addition, due to workload and priorities, and the outstanding dedication of APH employees to work to keep our communities safe and healthy in 2021:

- **Accrued lieu time by staff has not been taken.** Collectively, ONA and CUPE group members' lieu time accrued to be paid out was 2287.5 hours (estimated combined cost of $97,319), as of September 18, 2021.
- **Paid vacation time also remains unused.** Collectively, among the 145 employees eligible for accumulated paid vacation time, a combined total of **142 weeks remain unused**, as of November 3, 2021.

  As a comparator, in 2020, 179 employees had 4221 hours of vacation remaining at end of year. The increase in employees in 2020 was due to the departed Canadian Mental Health Association employees.

When comparing 2021 to 2020 or 2019 (pre-pandemic), it is evident that the extra hours worked by employees has increased, and the used vacation time decreased. The impact - workload and contribution of additional hours worked by staff has **depleted human capital**, and impacted work-life balance and employee health and wellness.

At a high-level, APH saw over a dozen employees take unplanned leaves over the course of 2021, which saw staff off work for a range of 1.5 to 15 weeks.

## The Cost in Human Resources

Managing high-risk mandated public health services (e.g. health protection work), balancing a health equity approach through regular programming, and responding to COVID-19 has proven to be a great challenge for the public health workforce.[1]

As noted in the May 2021 Board of Health *Workforce Update*, the demands of the pandemic response and roll-out of COVID-19 vaccine have had a significant impact on the human resources needed to deliver public health programs, with many employees deployed to assist with the COVID-19 response.

A snapshot of 2021 HHR and the impact to human resources, key indicators and comparators are shared below, including those for recruitment, retention, and redeployment.

### Recruitment in 2021

From January – October 2021, 69 postings were posted, representing 147 vacancies (27 permanent, 120 temporary) across the agency. Of these posted positions, 115 were filled and 32 remain unfilled (26 temporary and 6 permanent). Seven positions have also been reposted due to a lack of qualified candidates (1 permanent and 6 temporary).

Challenges to recruitment in public health have included:

- Unknowns associated with and undesirability of temporary, time-limited positions among highly skilled public health professionals.
- Competition for health human resources across district and beyond.
- Lack of qualified candidates with certifications or skill level required for specific postings.

Challenges to recruitment in Algoma, leaving **32 positions remaining unfilled in 2021** as of end of October, is an underpinning factor to the volume of extra hours worked by existing staff. It is also a testament to the limitations of one-time funded positions (temporary positions), and reinforces the ongoing need for a comprehensive HHR strategy the addresses the unique barriers in northern Ontario.

### Retention in 2021

To shed light on retention of employees throughout 2021, an overview of staff departures is provided in **Table D2**. Implementation of the human resources information system in 2019 has limited the capture of complete human resource data for comparison to prior years.

As of November 3, 2021, APH saw a decrease in employee departures not related to retirements or the end of placements or practicums, when compared to 2020.

**Table D2: Employee Departures from Algoma Public Health, 2020-2021**

| Employee Departures from Algoma Public Health, 2020-2021 | | |
|---|---|---|
| | Year | |
| **Employee Status** | **2020** | **2021*** |
| Permanent, Full Time | 6 | 5 |
| Temporary, Full-Time | 3 | 0 |
| **Total** | **9** | **5** |

**Note:** Employee departures include those that resulted for reasons outside of retirement or end of student placements/practicums. The table excludes any Community Mental Health/Alcohol Drug Assessment Program employee departures for 2020 or 2021, as this program was divested as of April 1, 2021. *As of October 2021, there were also 10 casual employee departures. This count has been excluded from the table, as there were no casual employees in 2020 and therefore no comparator.

The reasons for departure of permanent staff from APH, broadly, have included moving out of district, personal reasons, or transition to better employment opportunities.

Across the public health sector, because of increased workload and demands placed on public health systems and personnel, public health agencies have seen a staggered departure of personnel, and many staff left exhausted.[2] Consequently, the loss of permanent, full-time, experienced public health practitioners has resulted in lost expertise and challenges to find qualified, skilled replacements.[2]

Revitalization of the public health workforce, with focus on employee wellness and mental health, alongside an HHR strategy that works to build public health capacity in the north remains essential.

### Redeployment and Training Implications

As of October 7, approximately **51.5% of all APH employees remain primarily aligned to COVID-19 response and immunization**, while 15% spend roughly half their time on COVID-19 response and half on program work and 33.5% of employees remain dedicated to covering prioritized, highest risk programs and services. This snapshot of staff allocation to COVID-related work demonstrates the ongoing redeployment of staff to COVID-19 response and immunization efforts amid the fourth wave.

#### Managing Redeployment and a Shuffling Workforce

To manage the health workforce effectively, with increasing demands and limited health human resources, significant time and resources have been required to plan and support the redeployment of staff, which has required position matching, training, and managing of operations and movement of human resources.

Generally, the redeployment of staff has required up training to support COVID-19 work and non-COVID work in different programs. The mentorship and training for redeployed staff required both time and resources. At times, rotational coverage meant that there was no known timeline for how long deployed staff would stay within a specific program. In addition, time was required by redeployed or partially redeployed staff to stay up-to-date on COVID-19 response and immunization evidence and guidance changes, taking additional time away from conducting potential routine program work.

### Impacts of Immediate Deployment upon Hiring

Due to urgent demands placed by the COVID-19 pandemic, over the last year, several new FTE positions were immediately deployed as of the position start date to fulfil needs (i.e., Financial Analyst deployed to support COVID-19 vaccine inventory and allocations; Human Resource Coordinator deployed to hire specific to COVID-19 needs, etc.). Few new hires have yet to work within their originally aligned (or “home”) public health program. This will result in program training needs, which will take time and resources prior to employees being able to return to routine work at full capacity.

### Impacts of Agency-Wide Redeployment

The redeployment of staff to COVID-19 response and immunization for long periods will come at a cost in both time and resources to support internal training, professional development, and knowledge sharing to effectively return to routine public health work, which will exceed the capacity of few core staff that have remained aligned to highest risk programming during the pandemic.

In addition, due to workload demands, limited number of employees were able to partake in professional education. Refreshing of knowledge and skills, as well as opportunities to catch up on new evidence and resources related to mandated public health programs, will require time and support, and will be necessary to ensuring best practices and effective programs and services are delivered in Algoma.

## Appendix D References:


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# Appendix E – Human Resource Indicators

### Table E1: 2021 Casual Immunizer Recruitment Summary (as of October 31, 2021)

| Casual Immunizer Recruitment Summary (as of October 31, 2021) | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Immunizer Sub-Area** | **Interviewed** | **Verbally Offered** | **Signed Acceptance** | **Onboarded** | **Resigned** | **Transferred within APH** | **Current Number of Immunizers** |
| SSM | 46 | 45 | 45 | 43 | 11 | 1 | 31 |
| East Algoma | 6 | 5 | 5 | 4 | 0 | 0 | 4 |
| North Algoma | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | **52** | **50** | **50** | **47** | **11** | **1** | **35** |

***Note:***
As of October 2021, APH saw 10 casual employee departures not related to retirement or the end of a work period. This excludes 1 individual counted in the 11 resignations, as the individual resigned before starting work and was therefore not an active employee.

### Table E2: Summary of Unpaid Student Placement and Paid Summer Student Hours, 2021

| Summary of Unpaid Student Placement and Paid Summer Student Hours, 2021 | | | | | |
|---|---|---|---|---|---|
| **Educational Facility Affiliation** | **Program** | **# Students** | **Timeline** | | **Hours** |
| | | | **From** | **To** | |
| Sault College | BScN | 4 | January 12, 2021 | February 24, 2021 | 288 |
| Northern Ontario School of Medicine | Public Health & Preventive Medicine | 1 | January 18, 2021 | January 29, 2021 | 70 |
| Saskatchewan Polytechnic School of Nursing | Collaborative Nurse Practitioner Program | 1 | January 25, 2021 | March 5, 2021 | 16 |
| Sault College | BScN | 2 | March 2, 2021 | April 17, 2021 | 144 |
| Northern Ontario School of Medicine | Public Health & Preventive Medicine | 1 | March 8, 2021 | April 2, 2021 | 126 |
| Northern Ontario School of Medicine | Northern Ontario Dietetics Internship Program | 1 | March 22, 2021 | April 16, 2021 | 126 |
| Northern Ontario School of Medicine | Public Health & Preventive Medicine | 1 | April 19, 2021 | June 30, 2021 | 385 |
| Northern Ontario School of Medicine | Speech Language Pathology | 1 | July 5, 2021 | August 30, 2021 | 280 |
| Canadian Career Centre | Medical Office Administration Program | 1 | August 23, 2021 | September 23, 2021 | 142 |
| Sault College | BScN | 3 | September 29, 2021 | December 3, 2021 | 600 |
| Sault College | BScN | 2 | September 29, 2021 | December 3, 2021 | 400 |
| Northern Ontario School of Medicine | Public Health & Preventive Medicine | 1 | October 12, 2021 | December 31, 2021 | 346.5 |
| Northern Ontario School of Medicine | Public Health & Preventive Medicine | 1 | November 29, 2021 | December 31, 2021 | 140 |
| | | | | **Total Unpaid Student Placement Hours** | **3063.5** |

**Paid Summer Student Contributions:** In addition to unpaid student placements, APH hired 28 FTE Summer Students. By the end of August 2021, 23 students remained (3 resigned). The average work-term duration was 3.05 months. The total PAID hours contributed to APH by summer students was **12,207 hours**.

# Appendix F – Health Human Resource Challenges

As per an Ontario Health memo[1] on October 8th, as Ontario health systems continue to face many complexities, **HHR continue to be the biggest challenge**, with shortages and ongoing stress affecting all sectors. Layered on the provincial HHR struggle includes the significant and longstanding challenges with recruitment and retention of skilled public health professionals in northern Ontario, similar to the unique HHR challenges of the health care sector in the north.

**Looking Back before Looking Forward: SARS and HHR**

SARS demonstrated that our most valuable resource in public health is our HHR and the high level of expertise that exists at the central and local levels of public health.[2] It was also recognized that without the right, highly skilled professionals in public health, no reason or resource would result in successfully tackling a future public health crisis.[2]

As a recommendation from the SARS commission, it was identified that **overall public health capacity and HHR must be strengthened**, which requires enhanced budget and opportunities for specialized training.[2,3] Recruitment and retention was also noted as a challenge, with skilled public health professionals having remained of short supply in more rural, remote, and northern regions, like Algoma.[3]

Despite recruitment and retention issues being identified in reports, and again articulated in the Capacity Review Commission in 2005, it is unclear how widely recommendations have been enacted.[4] Based on the experience of local public health, gaps remain in the extent of the HHR strategy needed, especially when considering the unique challenges in the north.

**Challenges with One-Time Funding in the North**

One-time funding provided by the provincial government has been appreciated and critical to supporting COVID-19 response and immunization, as well as other pandemic needs (i.e., school support, IPAC). However, one-time funding has been geared towards curtailing the pandemic, as opposed to annual funding for the hiring of permanent staff to build long-term public health capacity to manage the emergency of today, and prepare for the public health emergencies of tomorrow.[5]

This comes at a detriment to northern Ontario, as when one-time funding is available, retention and recruitment continue to pose significant barriers to fulsome service delivery by public health (i.e., highly skilled professional unlikely to move to the north for, or with the uncertainty of, a 12-18 month contract).

Stable and predictable funding that meets the rising demands of public health[6], as well as early notification of public health funding in the fiscal year by the province, is needed to effectively strategize for HHR, recruit skilled professionals to the north, and delivery effective programs and services. In addition, strategic investments must ensure that public health resources are not depleted during a crisis, to avoid a backlog and allow for the continued provision of mandated and important services.[6]

**Strengthening Local Public HHR and Building Capacity for the Long-Term**

As outlined by the Ontario Medical Association, “public health preserves and defends the health of the entire community.” [6, p. 39] In addition to combatting the COVID-19 pandemic and other public health emergencies (e.g. wildfire evacuations), a strong local public health unit protects health and prevents illness every day.[6] In order to recover and be truly prepared for future public health crises, strategic, and sustainable investment for emergency planning and a higher baseline of qualified, permanent public health employees are needed.[2,6]

As per previous recommendations form post SARS-1 commission, there is **need for attention and resourcing of a public health human resource and capacity building strategy, alongside funding**.[2,3]

The COVID-19 pandemic has demonstrated the instrumental role that local public health agencies play in preventing and mitigating the spread of infectious diseases. Now, more than ever, our communities need a robust public health unit to not only respond to the threat of newly emerging infectious diseases,

but also help the population recover from the many collateral harms that have resulted throughout the pandemic response (e.g., increase in opioid overdose deaths, children's mental health).

As evidenced by the human resource indicators, it has been challenging to sustainably resource the COVID-19 response and fill existing vacancies in Algoma, which will have implications for addressing the backlog and work that is to come.

Pressure from recruitment challenges have also been compounded by staff leaves, both planned and unplanned, where teams are working understaffed due to both outstanding vacancies and unfilled temporary coverage positions. For example, the oral health program has had recruitment challenges for a temporary Dental Health Educator leaving a vacancy, which will overlap with an unfilled temporary position for a planned leave, reducing the team by two staff during the pandemic when extra program support is required.

Without sustainable, increases to provincial base funding and levies to stabilize and strengthen the local public health workforce for the long-term, with strategies for recruitment and retention that align to northern Ontario, APH will be **unable to sustain the COVID-19 response and immunization program while restoring mandated public health programming to meet the needs of our communities and prepare for future health crises** without further risk of exhausting existing human resources.

As was flagged post-SARS in 2003, HHR issues within public health may be a critical factor in whether mandatory and essential programs and services get delivered where they are needed most,[7] which includes northern Ontario where health inequities are routinely exacerbated when compared to Ontario as a whole, pre- and post-pandemic.

In addition, for recruitment and retention, a northern-specific HHR strategy will need to not only consider financial resources to recruit and retain highly skilled professionals, but also provide the necessary resources for ongoing training and specialized skill development for public health.[8]

Therefore, not only is an increase in levy funding required to strengthen and sustain our local public health workforce, but continued advocacy is required on the part of the Board of Health to ensure (a) sustainable, annual provincial base funding for public health and (b) a comprehensive northern public health human resource strategy, to ensure our communities are able to sustain pandemic efforts, restore programming, and equip to confront future public health emergencies.

**Appendix F References:**


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# Appendix G – Municipal Levy Context and Comparators

## Table G1: Historical Municipal Levy as Compared to Recommended 2022 Levy, 2018 – Recommended 2022

| Historical Municipal Levy as Compared to Proposed 2022 Levy | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2022 Municipal Levy | POP 2016 Census * | 2018 Approved Rate | 2018 Approved Levy | 2019 Approved Rate | 2019 Approved Levy | 2020 Approved Rate | 2020 Approved Levy | 2020 Approved Rate (after Refund) | 2020 Approved Levy (after Refund)* | 2021 Approved Rate | 2021 Approved Levy | 2022 Proposed Rate | 2022 Proposed Levy | Appointment of Costs | Proposed Net Increase | APH Levy as a Percentage of Municipality Revenue |
| CITIES | | | | | | | | | | | | | | | | |
| Sault Ste. Marie | 73,368 | 33.63 | 2,467,640 | 33.80 | 2,479,978 | 36.38 | 2,669,377 | 34.18 | 2,507,836 | 36.57 | 2,683,386 | 40.23 | 2,951,725 | 70.46% | 268,339 | 1.1% |
| Elliot Lake | 10,741 | 33.63 | 361,260 | 33.80 | 363,066 | 36.38 | 390,795 | 34.18 | 367,146 | 36.57 | 392,852 | 40.23 | 432,137 | 10.32% | 39,285 | 1.0% |
| | | | | | | | | | | | | | - | | | |
| TOWNS | | | | | | | | | | | | | - | | | |
| | | | | | | | | | | | | | - | | | |
| Blind River | 3,472 | 33.63 | 116,776 | 33.80 | 117,360 | 36.38 | 126,324 | 34.18 | 118,679 | 36.57 | 126,986 | 40.23 | 139,685 | 3.33% | 12,699 | 0.8% |
| Bruce Mines | 582 | 33.63 | 19,575 | 33.80 | 19,673 | 36.38 | 21,175 | 34.18 | 19,894 | 36.57 | 21,286 | 40.23 | 23,415 | 0.56% | 2,129 | 1.1% |
| Thessalon | 1,286 | 33.63 | 43,253 | 33.80 | 43,469 | 36.38 | 46,789 | 34.18 | 43,958 | 36.57 | 47,034 | 40.23 | 51,737 | 1.24% | 4,703 | 0.8% |
| | | | | | | | | | | | | | - | | | |
| VILLAGES/MUNICIPALITY | | | | | | | | | | | | | - | | | |
| | | | | | | | | | | | | | - | | | |
| Hilton Beach | 171 | 33.63 | 5,751 | 33.80 | 5,780 | 36.38 | 6,222 | 34.18 | 5,845 | 36.57 | 6,254 | 40.23 | 6,879 | 0.16% | 625 | 0.4% |
| Huron Shores | 1,664 | 33.63 | 55,967 | 33.80 | 56,246 | 36.38 | 60,542 | 34.18 | 56,878 | 36.57 | 60,859 | 40.23 | 66,945 | 1.60% | 6,086 | 1.0% |
| | | | | | | | | | | | | | - | | | |
| TOWNSHIPS | | | | | | | | | | | | | - | | | |
| | | | | | | | | | | | | | - | | | |
| Dubreuilville | 613 | 33.63 | 20,617 | 33.80 | 20,721 | 36.38 | 22,303 | 34.18 | 20,953 | 36.57 | 22,420 | 40.23 | 24,662 | 0.59% | 2,242 | 0.8% |
| Jocelyn | 313 | 33.63 | 10,527 | 33.80 | 10,580 | 36.38 | 11,388 | 34.18 | 10,699 | 36.57 | 11,448 | 40.23 | 12,593 | 0.30% | 1,145 | 0.9% |
| Johnson | 751 | 33.63 | 25,259 | 33.80 | 25,385 | 36.38 | 27,324 | 34.18 | 25,670 | 36.57 | 27,467 | 40.23 | 30,214 | 0.72% | 2,747 | 1.0% |
| Hilton | 307 | 33.63 | 10,326 | 33.80 | 10,377 | 36.38 | 11,170 | 34.18 | 10,494 | 36.57 | 11,228 | 40.23 | 12,351 | 0.29% | 1,123 | 0.5% |
| Laird | 1,047 | 33.63 | 35,215 | 33.80 | 35,391 | 36.38 | 38,094 | 34.18 | 35,788 | 36.57 | 38,293 | 40.23 | 42,122 | 1.01% | 3,829 | 1.5% |
| MacDonald, Meredithand Aberdeen Add'l | 1,609 | 33.63 | 54,117 | 33.80 | 54,387 | 36.38 | 58,541 | 34.18 | 54,998 | 36.57 | 58,848 | 40.23 | 64,733 | 1.55% | 5,885 | 1.4% |
| Wawa (formerly Michipicoten) | 2,905 | 33.63 | 97,706 | 33.80 | 98,195 | 36.38 | 105,694 | 34.18 | 99,298 | 36.57 | 106,247 | 40.23 | 116,872 | 2.79% | 10,625 | 0.7% |
| The North Shore | 497 | 33.63 | 16,716 | 33.80 | 16,800 | 36.38 | 18,083 | 34.18 | 16,988 | 36.57 | 18,177 | 40.23 | 19,995 | 0.48% | 1,818 | 1.0% |
| Plummer Add'l | 660 | 33.63 | 22,198 | 33.80 | 22,309 | 36.38 | 24,013 | 34.18 | 22,560 | 36.57 | 24,139 | 40.23 | 26,553 | 0.63% | 2,414 | 1.0% |
| Prince | 1,010 | 33.63 | 33,970 | 33.80 | 34,140 | 36.38 | 36,747 | 34.18 | 34,524 | 36.57 | 36,940 | 40.23 | 40,634 | 0.97% | 3,694 | 1.3% |
| St. Joseph | 1,240 | 33.63 | 41,706 | 33.80 | 41,914 | 36.38 | 45,116 | 34.18 | 42,385 | 36.57 | 45,352 | 40.23 | 49,887 | 1.19% | 4,535 | 0.9% |
| Spanish | 712 | 33.63 | 23,947 | 33.80 | 24,067 | 36.38 | 25,905 | 34.18 | 24,337 | 36.57 | 26,041 | 40.23 | 28,645 | 0.68% | 2,604 | 0.9% |
| Tarbutt & Tarbutt Add'l | 534 | 33.63 | 17,960 | 33.80 | 18,050 | 36.38 | 19,429 | 34.18 | 18,253 | 36.57 | 19,531 | 40.23 | 21,484 | 0.51% | 1,953 | 1.2% |
| White River | 645 | 33.63 | 21,694 | 33.80 | 21,802 | 36.38 | 23,467 | 34.18 | 22,047 | 36.57 | 23,590 | 40.23 | 25,949 | 0.62% | 2,359 | 0.5% |
| | | | | | | | | | | | | | | | | |
| Total | 104,127 | | 3,502,180 | | 3,519,691 | | 3,788,497 | | 3,559,232 | | 3,808,378 | | 4,189,216 | 100% | 380,838 | |
| **YOY % Increase** | | | **0.50%** | | **0.50%** | | **7.64%** | | **1.12%** | | **7.00%** | | **10.00%** | | | |

***Notes:***

* Statistics Canada. (2019). Census profile, 2016 census. Retrieved from https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/index.cfm?Lang=E

## Table G2: Historical Summary of Public Health Operation Levy as a Percentage of Total Municipal Revenue, 2018-2020

| Historical Summary of Public Health Opeartion Levy as a Percentage of Total Municipal Revenue | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Municipality in Algoma | 2018 | | | 2019 | | | 2020 | | |
| | Revenue | APH Levy | % of Revenue | Revenue | APH Levy | % of Revenue | Revenue | APH Levy | % of Revenue |
| Sault Ste. Marie | 220,478,150 | 2,467,640 | 1.12% | 223,958,181 | 2,479,978 | 1.11% | 223,695,257 | 2,507,836 | 1.12% |
| Elliot Lake | 28,640,893 | 361,260 | 1.26% | 34,932,009 | 363,066 | 1.04% | 30,233,990 | 367,146 | 1.21% |
| Blind River | 14,754,730 | 116,776 | 0.79% | 15,272,946 | 117,360 | 0.77% | 14,410,020 | 118,679 | 0.82% |
| Bruce Mines | 1,860,485 | 19,575 | 1.05% | | 19,673 | | | 19,894 | |
| Thessalon | 3,651,521 | 43,253 | 1.18% | 5,248,570 | 43,469 | 0.83% | | 43,958 | |
| Hilton Beach | 1,241,653 | 5,751 | 0.46% | 1,352,298 | 5,780 | 0.43% | 1,272,492 | 5,845 | 0.46% |
| Huron Shores | 5,159,738 | 55,967 | 1.08% | 5,853,991 | 56,246 | 0.96% | | 56,878 | |
| Dubreuilville | 2,144,895 | 20,617 | 0.96% | | 20,721 | | 2,608,033 | 20,953 | 0.80% |
| Jocelyn | | 10,527 | | 1,478,837 | 10,580 | 0.72% | 1,202,628 | 10,699 | 0.89% |
| Johnson | | 25,259 | | | 25,385 | | 2,676,415 | 25,670 | 0.96% |
| Hilton | 1,241,653 | 10,326 | 0.83% | 1,251,147 | 10,377 | 0.83% | | 10,494 | |
| Laird | 1,943,020 | 35,215 | 1.81% | 2,405,974 | 35,391 | 1.47% | | 35,788 | |
| MacDonald, Meredith and Aberdeen Add'l | | 54,117 | | | 54,387 | | 3,810,097 | 54,998 | 1.44% |
| Wawa (formerly Michipicoten) | 14,500,604 | 97,706 | 0.67% | 15,037,081 | 98,195 | 0.65% | 15,702,279 | 99,298 | 0.63% |
| The North Shore | 2,227,792 | 16,716 | 0.75% | 2,608,263 | 16,800 | 0.64% | 1,650,604 | 16,988 | 1.03% |
| Plummer Add'l | 2,181,911 | 22,198 | 1.02% | 2,211,538 | 22,309 | 1.01% | 2,228,641 | 22,560 | 1.01% |
| Prince | 2,449,106 | 33,970 | 1.39% | 2,531,646 | 34,140 | 1.35% | 2,640,533 | 34,524 | 1.31% |
| St. Joseph | 3,731,178 | 41,706 | 1.12% | 4,559,434 | 41,914 | 0.92% | | 42,385 | |
| Spanish | 7,374,511 | 23,947 | 0.32% | 7,677,947 | 24,067 | 0.31% | 2,653,732 | 24,337 | 0.92% |
| Tarbutt & Tarbutt Add'l | 1,413,751 | 17,960 | 1.27% | 1,646,944 | 18,050 | 1.10% | 1,586,826 | 18,253 | 1.15% |
| White River | 4,089,556 | 21,694 | 0.53% | | 21,802 | | | 22,047 | |

**Municipal Revenue Sources (as available online):**


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# Appendix H – 2018-2030 APH Capital Asset Funding Plan

See PDF document attached.

Algoma
PUBLIC HEALTH
Santé publique Algoma

**APPENDIX 5**

# Algoma Public Health

# 2018 - 2030 Capital Asset Funding Plan

**Table of Contents**

# 2018 - 2030 Capital Asset Funding Plan

**Purpose:**

The Board of Health for the District of Algoma (the Board) has undertaken the development of a Capital Asset Funding Plan (the Plan). The purpose of the Plan is to provide visibility to the Board with respect to capital asset needs. The Capital Asset Plan, in conjunction with APH's Reserve Fund Policy, will allow the Board of Health to set long-term financial goals.

As part of the Ontario Public Health Standards, "the board of health shall maintain a capital funding plan, which includes policies and procedures to ensure that funding for capital projects is appropriately managed and reported". As APH owns and operates a facility in Sault Ste. Marie, there is a need to plan for and appropriately fund the cost of major ongoing repairs and maintenance associated with the facility. In addition, APH leases several facilities which may require leasehold improvements. By maintaining adequate Reserves, APH will be able to offset the need to obtain alternate sources of financing.

**Operating Budget versus Capital Asset Plan:**

The Operating Budget captures the projected incoming revenues and outgoing expenses that will be incurred on a daily basis for the operating year.

The Capital Asset Plan is a blueprint to identify potential capital expenditures and to develop a method in which to finance the associated expenditure. Capital expenditures are cost incurred for physical goods that will be used for more than one year.

The development of the Capital Asset Funding Plan serves as a risk management tool as it minimizes having large unforeseen budget increases in the future as a result of capital needs.

In addition, the Capital Asset Funding Plan will help the Board with contribution and withdrawal decisions to the Reserve Fund. Reserves can only be generated through unrestricted operating surpluses. As any unspent provincial dollars must be returned to the Ministry, the only mechanism to generate surplus dollars is through the Municipal levy. Maintaining adequate Reserves reduces the need for the Board of Health to further levy obligated municipalities within the district to cover unexpected expenses incurred by the board of health.

The Capital Asset Funding Plan was developed around the Building Conditions Assessment (the Assessment) that was completed on behalf of the Ministry of

Community and Social Services (the Ministry). The Assessment was conducted on November 20, 2015 with a final report received on February 20th, 2018. This Assessment report, specifically the Capital Reserve Expenditure schedule serves as the foundation of APH's Capital Asset Funding Plan over a 20 year period. In addition, the Assessment will help with Reserve Fund contribution decisions.

The Capital Asset Plan is a fluid document. The timing of planned expenditures may be moved up or pushed back depending on the situation.

**Types of Capital Assets**:

In addition to the specific capital building needs, APH management included items related to Computer Equipment; Furniture and Equipment; Vehicles; and Leasehold Improvements (as APH leases office space within the District). These categories mirror those referenced in APH's Financial Statements which are amortized over a period of time.

*Computer Equipment/Furniture/Vehicles*

Investing in Computer Equipment, Furniture, and Vehicles is required to allow APH employees to provide services within the District of Algoma. Keeping staff well-equipped improves efficiencies while improving program outcomes.

*Facilities – Maintenance, Repair and Replacement*

APH owns and leases space. As a result, it is necessary to make improvements to the property (capital or leasehold improvements). As the owner of the facility located at 294 Willow Avenue in Sault Ste. Marie, APH is responsible for repairs and maintenance of the facility. Anticipating what repairs or improvements may be necessary, researching and estimating the related costs, determining the target amount needed and the approximate timing of the expenditure are all part of the capital budgeting process, along with developing funding strategies.

**Types of Financing Options Available to the Board of Health:**

Depending of the nature and the associated cost of the expenditure, there are different financing options available to the Board of Health. Three examples include:

*Operating Dollar Financing* – can be used if APH is operating in a surplus position in any given year and the associated cost of the expenditure will still allow the Board to remain on target with respect to their annual operating budget. The nature of the expenditure would have to be admissible under the terms of the Ministry Accountability Agreement. Use of operating dollars for capital expenditures helps to minimize the amount of dollars that may have to be returned to the Ministry within any given year.

*Reserve Financing* – can be used if APH determines that the use of operating dollars is not feasible (i.e. cost of the expenditure would negatively impact the annual Operating Budget or the type of expenditure is inadmissible under the terms of the Ministry Accountability Agreement). The advantages of Reserve Financing are it minimizes the amount of debt the Board would otherwise incur and/or reduces the Levy that municipalities would have to contribute.

*Debt Financing* – can be used when the expenditure is large in scale such that operating dollars and Reserves would not support it.

Regardless of whether the expenditure is capital or operating in nature, APH's Procurement Policy 02-04-030 and Reserve Fund Policy 02-05-065 must be adhered to. As such, management may make capital expenditures with operating or reserve dollars provided the expenditure is within the Board approved spending limits as noted within each of the respective policies. Any debt financing would typically require Board approval.

**ALGOMA PUBLIC HEALTH**
**CAPTIAL ASSET PLAN**

| Item | Actaul Expenditure | | Forecasted Expenditure | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | 2027 | 2028 | 2029 | 2030 | |
| **Computer Equipment** | | | | | | | | | | | | | | - |
| Network Servers | | 4,000 | | | 200,000 | | | | | | | 200,000 | | 400,000 |
| Telephone System | 150,000 | | | | | | | | 150,000 | | | | | 150,000 |
| Network Infrastructure | | 10,000 | 40,000 | | 60,000 | | | | | | | | | 100,000 |
| Polycom Video Conference System | | | | 28,000 | | | | 28,000 | | | | | | 56,000 |
| Backup Data Storage | | 29,000 | | | | | | | | | 30,000 | | | 30,000 |
| Computers | 25,000 | 50,000 | 25,000 | 25,000 | 25,000 | 25,000 | 25,000 | 25,000 | 25,000 | 25,000 | 25,000 | 25,000 | 25,000 | 275,000 |
| | | | | | | | | | | | | | | - |
| **Furniture and Equipment** | | | | | | | | | | | | | | - |
| Vaccine Refrigerators | 29,000 | 14,500 | 7,000 | | | | 7,000 | | | | 7,000 | | | 21,000 |
| Digital Sign | 21,000 | | | | | | | | | | | | | - |
| **Vehicle** | | | | | | | | | | | | | | - |
| Truck (land control) | | | | | | 50,000 | | | | | | | | 50,000 |
| | | | | | | | | | | | | | | - |
| | | | | | | | | | | | | | | - |
| **Leasehold Improvements** | | | | | | | | | | | | | | - |
| Blind River Office | | 5,000 | | | | | | | | | | | | - |
| Generator | | 30,000 | | | | | | | | | | | | - |
| Elliot Lake Office | | | | | 7,000 | | | | | | | | | 7,000 |
| Wawa Office | | | 5,000 | | | | | | | | | | | 5,000 |
| | | | | | | | | | | | | | | - |
| **Owned Facility:** | | | | | | | | | | | | | | - |
| **294 Willow Avenue Building, Sault Ste. Marie** | | | | | | | | | | | | | | - |
| **Municipal/Utility Services** | | | | | | | | | | | | | | - |
| Water Supply | | | | | | | | | | | | | | - |
| Sanitary Supply | | | | | | | | | | | | | | - |
| Storm Sewer | | | | | | | | | | | | | | - |
| Gas Utility | | | | | | | | | | | | | | - |
| Hydro Utility | | | | | | | | | | | | | | - |
| Other Municipal/Utility Services | | | | | | | | | | | | | | - |
| **Site Finishes** | | | | | | | | | | | | | | - |
| Passenger Vehicle Parking Area - Pavement and Curbing | | | | | | | 26,600 | | | | | | | 26,600 |
| Roadways - Pavement and Curbing | | | | | | | 17,500 | | | | | | | 17,500 |
| Walkways, Sidewalks and Exterior stairs | | | | | | | | | | | | | | - |
| Exterior Light Standards | | | | | | | | | | | | | | - |
| Soft Landscaping and Picnic Facilities | | | | | | | | | | | | | | - |
| Signage | | | | | | | | | | | | | | - |
| Retaining walls and other Site Improvements | | | | | | | | | | | | | | - |
| Site Drainage | | | | | | | | | | | | | | - |
| Parking Gates | | | | | | | | | | | | | | - |
| Other Site Finishes | | | | | | | | | | | | | | - |
| **Structural** | | | | | | | | | | | | | | - |
| Building Substructure, including foundations and basement walls | | | | | | | | | | | | | | - |
| Building Superstructure | | | | | | | | | | | | | | - |
| Interior Stairs | | | | | | | | | | | | | | - |
| Roof Construction | | | | | | | | | | | | | | - |
| Other Structural | | | | | | | | | | | | | | - |
| **Building Exterior** | | | | | | | | | | | | | | - |
| Foundation Wall | | | | | | | | | | | | | | - |
| Cladding System | | | | | | | | | | | | | | - |
| Exterior Sealants and Caulking | | | | | | | | | | | | | | - |
| Entrances and Doors | | | | | | | | | | | | | | - |
| Windows including Frames | | | | | | | | | | | | | | - |
| Parapets and Canoples | | | | | | | | | | | | | | - |
| Loading Dock | | | | | | | | | | | | | | - |
| Other Building Exterior | | | | | | | | | | | | | | - |
| **Roof** | | | | | | | | | | | | | | - |
| Roof Assembly (waterproofing membrane and roof surface) | | | | | 165,000 | | | | | | | | | 165,000 |
| Flashing | | | | | | | | | | | | | | - |
| Roof Drainage (eaves troughs/downspouts, roof drains) | | | | | | | | | | | | | | - |
| Chimneys/Boiler Stacks | | | | | | | | | | | | | | - |
| Skylights and other Roof Openings | | | | | | | | | | | | | | - |
| Roof venting, if any | | | | | | | | | | | | | | - |
| Other Roof | | | | | | | | | | | | | | - |
| **Building Interior** | | | | | | | | | | | | | | - |
| Interior Partitions and Doors | | | | | | | | | | | | | | - |
| Flooring | | | | | | | | | | | | | | - |
| Ceiling | | | | 60,000 | | | | | | | | | 60,000 | 120,000 |
| Wall Finishes (Paint, Trim Baseboards, etc.) | | | | 45,000 | | | | | | | | | 45,000 | 90,000 |
| Washroom Fixtures and Accessories (Towel dispensers, hand dryers, soap dispensers, change tables, partitions, etc.) | | | | | | | | | | | | | | - |
| Presence of Mould | | | | | | | | | | | | | | - |
| Other Building Interior | | | | | | | | | | | | | | - |
| **Mechanical and HVAC** | | | | | | | | | | | | | | - |
| Heating, Ventilating and Air Conditioning Systems | | | | | | | 122,000 | | | | | | | 122,000 |
| Building, Automation Systems, if any | | | | | | | | | | | | | | - |
| Ductwork, if any | | | | | | | | | | | | | | - |
| Vertical Transportation Devices, if any | | | | | | | | | | | | | | - |
| Other Mechanical and HVAC | | | | | | | | | | | | | | - |
| **Plumbing** | | | | | | | | | | | | | | - |
| Plumbing fixtures | | | | | | | | | | | | | | - |
| Domestic water distribution | | | | | | | | | | | | | | - |

**ALGOMA PUBLIC HEALTH**
**CAPTIAL ASSET PLAN**

| Item | Actaul Expenditure | | Forecasted Expenditure | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | 2027 | 2028 | 2029 | 2030 | |
| Sanitary waster | | | | | | | | | | | | | | - |
| Rainwater drainage | | | | | | | | | | | | | | - |
| Water Fountain | | | | | | | | | | | | | | - |
| Electric | | | | | | | | | | | | | | - |
| Primary Feed and Main Switchgear | | | | | | | | | | | | | | - |
| Main Transformers | | | | | | | | | | | | | | - |
| Step-down Transformers | | | | | | | | | | | | | | - |
| Emergency Power Source or Generator | | | | | | | | | | | | | | - |
| Distribution Systems and Panels | | | | | | | | | | | | | | - |
| Interior Lighting | | | | | | | | | | | | | | - |
| Exterior Lighting (Building-Mounted) | | | | | | | | | | | | | | - |
| Automated Lighting Control System | | | | | | | | | | | | | | - |
| Other Electrical | | | | | | | | | | | | | | - |
| Fire Protection and Life Safety Systems | | | | | | | | | | | | | | - |
| Water Reservoir, if any | | | | | | | | | | | | | | - |
| Sprinkler and/or Standpipe System, if any | | | | | | | | | | | | | | - |
| Fire Extingulshers | | | | | | | | | | | | | | - |
| Fire Pumps, if any | | | | | | | | | | | | | | - |
| Fire Alarm System and Voice Communication Systems, if any | | | | | | | | | | | | | | - |
| Smoke and Heat Detectors and Carbon Monoxide Detectors, as applicable | | | | | | | | | | | | | | - |
| Emergency Lighting and Exit Signage | | | | | | | | | | | | | | - |
| Security System | | | | | | | | | | | | | | - |
| Fire/Emergency Plans | | | | | | | | | | | | | | - |
| Fire Separations (visual inspection and inclusion of info that is readily available) | | | | | | | | | | | | | | - |
| Automatic door closers | | | | | | | | | | | | | | - |
| Other Fire Protection and Life Safety Systems | | | | | | | | | | | | | | - |
| Hazardous Materials | | | | | | | | | | | | | | - |
| Asbestos | | | | | | | | | | | | | | - |
| PCB's | | | | | | | | | | | | | | - |
| Other Hazardous Materials | | | | | | | | | | | | | | - |
| Subtotal | 225,000 | 142,500 | 77,000 | 158,000 | 457,000 | 75,000 | 198,100 | 53,000 | 175,000 | 25,000 | 62,000 | 225,000 | 130,000 | 1,635,100 |
| Contingency (10%) | 22,500 | 14,250 | 7,700 | 15,800 | 45,700 | 7,500 | 19,810 | 5,300 | 17,500 | 2,500 | 6,200 | 22,500 | 13,000 | 163,510 |
| Subtotal Including Contingency | 247,500 | 156,750 | 84,700 | 173,800 | 502,700 | 82,500 | 217,910 | 58,300 | 192,500 | 27,500 | 68,200 | 247,500 | 143,000 | 1,798,610 |
| Escalation Allowance | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | - |
| Escalation Total | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| Total Estimate Financial Projections | 247,500 | 156,750 | 84,700 | 173,800 | 502,700 | 82,500 | 217,910 | 58,300 | 192,500 | 27,500 | 68,200 | 247,500 | 143,000 | 1,798,610 |

| | |
|---|---|
| Total Net Sq. Ft. of Owned Facility | 74,000 |
| Year Built | 2011 |
| Age (yrs.) | 9 |
| Reserve Term (yrs.) | 20 |

NOTES:
1) Contingency of 10% has been carried to cover unforeseen items & cost increases.

2) Cost in 2017 dollars with no provision for escalation.
3) HST is excluded.

**Governance Committee Meeting**

November 16, 2021

**Attendees Virtually:**

Deborah Graystone - Chair

Tania Caputo - Board Secretary

**Attended Virtually:**

Sally Hagman

Musa Onyuna

**APHU Executive Attended Virtually:**

Jennifer Loo – MOH

A revised Policy and By-Law tracking table was presented. The only By-Law requiring review is the Travel Policy 02-05-020. The committee is waiting for review by the APH leadership team as the internal travel policy is also being reviewed.

There was a discussion about By-Law #95-1 with regards to the mention of a Corporate seal. The question of a ”corporate seal” was discussed. The leadership team will investigate whether this is still in existence and use and bring back to the committee.

A briefing note was prepared to assist with presentation to the municipalities regarding board member recruitment. It was decided that this was a good mechanism to help with consistent and clear messaging within the district. It will be presented to the board for review.

Our next Governance Committee meeting is in March 2022.

# Algoma Public Health Board Recruitment

The Algoma Public Health Board believes that it's members should be appointed according to skills and attributes.

Terms of Members should comply with APHU Board policy 02-05-087 requirements which recommends two 4 year terms for municipal appointees and two 3 years terms for provincial appointees.

The Algoma Public Health Board endeavours to ensure a balanced and qualified board through the development of a skills and attributes matrix.

Policy #02-05-001 provides the required Composition and Accountability of APHU board members. The intention is to have 15 board members including 8 municipal members and 7 provincial members.

Our Skills Matrix includes the following:

- analytical and critical thinking
- inter-personal communications
- creative and strategic planning/vision
- understanding the governance role
- community knowledge
- commitment to mandate

Specific Expertise recommendations:

- financial (required)
- communication/public relations practices
- risk management (required)
- education
- legal (required)
- health services delivery
- human resources
- information technology/management (required)

Although a comprehensive list these are recommendations only to provide guidance for board member recruitment and sustain a diverse and skilled board.

APH has committed to recruit external expertise as required if board members do not possess the skills or knowledge required for decision making.

Algoma PUBLIC HEALTH
Santé publique Algoma
www.algomapublichealth.com

November 16, 2021

The Honorable Christine Elliott,
Deputy Premier and Minister of Health
christine.elliott@ontario.ca

Dear Minister Elliott:

**RE: Request for Annualized IPAC Hub Funding and Increase in Provincial Base Funding for Local Public Health**

On October 27, 2021, at a regular meeting of the Board of Health for the Algoma Health Unit, the board approved a resolution requesting that the:

> Board of Health for the District of Algoma Public Health write to the Ontario Minister of Health to request that the provincial government **commit to increased base funding to local public health units, with particular attention to addressing longstanding public health human resource challenges in the north**, such that public health units are able to both continue a robust pandemic response, and restore the delivery of mandated public health services to Ontario citizens.

Motion No.: 2021-92 Moved by: L. Mason Seconded by: E. Pearce

On behalf of the Board of Health for the District of Algoma Health unit, we thank you and your government for your leadership and financial support during the COVID-19 pandemic. We have appreciated the province's announcements to date for 2022, which have included one-time reimbursement to local public health units for extraordinary COVID-19 expenses and one-time mitigation funding to offset the impacts of the cost-sharing formula change to municipalities. We also express gratitude for the recent approval of 2021-2022 one-time funding for the Infection Prevention and Control (IPAC) Hub Program at Algoma Public Health.

I am writing today to request provincial government commitment to **(a) annualize IPAC funding for northern PHUs to sustainably support IPAC hubs and (b) increase base funding to local public health units, with particular attention to addressing longstanding public health human resource challenges in the north**, to reflect the rising pressures on local public health unit resources. These pressures include:

- The need to routinize COVID-19 response activities, recognizing that COVID-19 will likely become a disease of public health significance and increase baseline public health work going forward;
- Increased wage, benefit, and operational costs due to inflation; and
- Increased demand for health units to restore mandatory programs to pre-pandemic capacity, address the backlog of services, and support population recovery from the COVID-19 pandemic.

Since the start of the COVID-19 pandemic, Algoma Public Health (APH) has provided a robust pandemic response to prevent and mitigate the spread of COVID-19. To date, APH has (a) managed 613 confirmed cases of COVID-19

**Blind River**
P.O. Box 194
9B Lawton Street
Blind River, ON P0R 1B0
Tel: 705-356-2551
TF: 1 (888) 356-2551
Fax: 705-356-2494

**Elliot Lake**
ELNOS Building
302-31 Nova Scotia Walk
Elliot Lake, ON P5A 1Y9
Tel: 705-848-2314
TF: 1 (877) 748-2314
Fax: 705-848-1911

**Sault Ste. Marie**
294 Willow Avenue
Sault Ste. Marie, ON P6B 0A9
Tel: 705-942-4646
TF: 1 (866) 892-0172
Fax: 705-759-1534

**Wawa**
18 Ganley Street
Wawa, ON P0S 1K0
Tel: 705-856-7208
TF: 1 (888) 211-8074
Fax: 705-856-1752

in Algoma residents and non-Algoma residents temporarily in Algoma, 2506 high-risk close contacts of cases, and 30 COVID-19 related outbreaks, (b) fielded numerous community concerns regarding infection prevention and control and enforcement for COVID-19 measures, and (c) responded to over 42,000 COVID-related inquires through our dedicated COVID-19 phone lines. Moreover, APH has coordinated COVID-19 mass immunization across the district, with **86.0% of eligible residents (12+) in Algoma now fully vaccinated** (as of November 8, 2021). Local public health knowledge, responsiveness, and partnerships have allowed for a flexible, equitable, and tailored pandemic response in Algoma that has strengthened our ability to achieve pandemic goals as a community.

However, to resource urgent pandemic response and immunization program needs, APH has diverted resources from moderate to low risk public health services to ensure a timely response to COVID-19 and maintenance of high-risk programming. Similar to other areas of the health sector, this has resulted in significant service **backlogs that unless addressed in the short-term and resourced appropriately, will continue to grow and result in negative community health impacts**. For perspective, the backlog of services includes, but is not limited to:

- 105 individuals on the waitlist for smoking cessation, which is equivalent to a 1-year waiting period.
- 14, 200 doses of vaccine to complete grade 7 catch-up along with 3370 doses required among newly eligible grade seven students.
- A 45 % reduction in food safety inspections completed in 2021, as compared to 2019 (pre-pandemic).
- An 18-month backlog in school dental screening and oral health preventative clinics for children.

As a local public health unit, if we do not start to catchup on the backlog of services and restore programming, the backlog will become too large to overcome.

**Limitation of One-Time IPAC Hub Program Funding**

As of October 19, 2021, APH received the 2021-2022 updated funding letter with one-time funding to continue the IPAC Hub program. One-time funding provided by the provincial government has been invaluable in supporting immediate IPAC needs in community based congregate living settings in Algoma. However, to date, these needs have been addressed by the existing staff complement, as the one-time nature of the IPAC funding has limited our ability to hire skilled, qualified professionals to support this work in the north. Therefore, as further detailed below, to ensure **sustainable resourcing and commitment to IPAC Hub support**, we are asking that the province commit to annual IPAC Hub Program funding for northern PHUs.

**Need to Strengthen and Stabilize Public Health Human Resources**

Ontario health systems continue to face many complexities, **with health human resources (HHR) being the biggest challenge.** Layered on the provincial HHR struggle includes the significant and longstanding challenges with recruitment and retention of skilled public health professionals in northern Ontario, similar to the unique HHR challenges of the health care sector in the north.

SARS demonstrated that our **most valuable resource in public health is our HHR** and the high level of expertise that exists at the central and local levels of public health.[1] In addition, as per recommendations from the post-SARS commission, there is need for attention and resourcing of a **public HHR and capacity building strategy**, alongside funding.[1]

Prior to COVID-19, local public health agencies had received only one increase to base funding in the past five years. Despite this, several new programs were introduced to the *Ontario Public Health Standards*. In addition,

[1]The SARS Commission. (2004). SARS and public health in Ontario.Retrieved from http://www.archives.gov.on.ca/en/e_records/sars/report/v4.html

inflation, wage, benefit, and operating costs continued to increase. This means that we were **under-resourced to respond to an infectious disease emergency and implement routine public health priorities prior to the pandemic**, and will remain under-resourced to sustain response, program restoration, and recovery on the go forward unless base funding increases to match public health pressures.

To date, one-time funding has been geared towards curtailing the pandemic, as opposed to annual funding for the hiring of permanent staff to build long-term public health capacity to manage the emergency of today, and prepare for the public health emergencies of tomorrow. This comes at a detriment to northern Ontario, as when one-time funding is available, retention and recruitment continue to pose barriers to fulsome service delivery by public health (i.e., highly skilled professionals unlikely to move to the north for, or with the uncertainty of, a 4-month IPAC position contract).

One-time funding is inadequate to sustainably recruit, hire, and retain skilled, qualified public health professionals in northern Ontario to provide a robust pandemic response, and simultaneously fulfil a provincial mandate of providing core public health programs and services.

Without sustainable increases to provincial base funding, alongside municipal funding support to stabilize and strengthen the local public health workforce for the long-term, with strategies for recruitment and retention that align to northern Ontario, **local public health will be unable to sustain the COVID-19 response and immunization program while restoring mandated public health programming** to meet the needs of our communities and prepare for future health crises without further risk of exhausting existing human resources.

The COVID-19 pandemic has demonstrated the instrumental role that local public health agencies play in preventing and mitigating the spread of infectious diseases. Now, more than ever, communities need a robust public health system to not only respond to the threat of newly emerging infectious diseases, but also help the population recover from the many collateral harms that have resulted throughout the pandemic response (e.g., increase in opioid overdose deaths, children's mental health).

For the above reasons, the Board of Health of Algoma Health Unit urges the provincial government to **commit to (a) annualized IPAC Hub funding and (b) increase base funding to local health units, with particular attention to addressing longstanding public health human resource challenges in the north**, such that public health units are able to both continue pandemic response and restore mandatory public health services to Ontario citizens.

Thank you for considering this urgent matter.
Sincerely,

Mayor Sally Hagman
Chair, Board of Health

Cc: The Hon. Doug Ford, Premier
The Hon. Ross Romano, MPP Sault Ste. Marie
Michael Mantha, MPP Algoma-Manitoulin
Terry Sheehan, MP, Sault Ste. Marie
Carol Hughes, MP Algoma-Manitoulin-Kapuskasing
Dr. Kieran Moore, Ontario Chief Medical Officer of Health
Dr. Charles Gardner, Chair, Council of Medical Officers of Health
Association of Municipalities of Ontario
Ontario Boards of Health
Loretta Ryan, Association of Local Public Health Agencies

HALIBURTON, KAWARTHA, PINE RIDGE DISTRICT HEALTH UNIT
www.hkpr.on.ca • info@hkpr.on.ca
1-866-888-4577

November 18, 2021

Honourable Christine Elliott, Deputy Premier
Minister of Health, Ontario
Hepburn Block 10th Floor 80 Grosvenor Street
Toronto, ON M7A 1E9
Sent via email: christine.elliott@pc.ola.org

Ontario Association of Optometrists
Dr. Sheldon Salaba
20 Adelaide St East
Box 16, Suite 801
Toronto, ON M5T 2T6
Sent via email: oaoinfo@otom.on.ca

Dear Minister Elliott and Dr. Salaba,

As partners in visual health as per the Ontario Public Health Standards, the Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit (HKPRDHU) is writing to express concern over the current lack of vision services for patients under the Ontario Health Insurance Plan (OHIP).

As you are aware, as of September 1, 98 per cent of optometrists have discontinued services for the 2.9 million patients covered for eye care under OHIP, including children under 19, people 65 and older and those with certain eye conditions. This is of particular concern given the concurrent suspension of many public health unit run vision screening programs for children across the province due to the COVID-19 pandemic. These programs aim to detect vision issues amongst senior kindergarten students and refer them to local optometrists for follow-up. Even if public health programs were to be reinstated, with no optometrist services available for referrals, children will continue to be left at risk of undetected vision issues as well as other missed diagnoses.

The Board of Health for the HKPRDHU urges the Ministry of Health and the Ontario Association of Optometrists (OAO) to re-enter discussions with the goal of restoring vision services as soon as possible for vulnerable Ontarians.

Sincerely,

***Original signed by Mr. Elmslie***
Doug Elmslie
Chair, Board of Health
Haliburton, Kawartha, Pine Ridge District Health Unit

cc (via email): The Honourable Doug Ford
MPP, Laurie Scott
MPP, David Piccini
Association of Local Public Health Agencies

alPHa
Association of Local PUBLIC HEALTH Agencies

# *Ontario's Public Health System:*
# *Response & Recovery*
## alPHa Fall Symposium
### November 19, 2021

*Note: Meeting was hosted via Zoom Webinar*
*8:30 am to 4 pm - All times are Eastern Time (ET)*

*MINUTES – submitted by Louise Caicco Tett and Sally Hagman*

| | |
|---|---|
| **Public Health Video Showcase** | 8:15 am to 8:30 am |
| **Call to Order and Greetings from the alPHa President**<br>Dr. Paul Roumeliotis, President, alPHa<br><br>**Land Acknowledgement**<br>Trudy Sachowski, Vice-President, alPHa<br><br>**Welcoming Remarks**<br>Hon. Christine Elliott, Deputy Premier and Minister of Health<br>• About to embark on vaccinating children<br>Allan O'Dette, Chief Executive Officer, Ontario Medical Association<br>• Acknowledged some of the negative impacts and comments etc directed at public health professionals and the resilience they have<br>• OMA published Five Point Plan for Better Health Care – draws attention in Northern Ontario<br>  ○ One recommendation is to strengthen PH in Ontario<br>Steini Brown, Dean, Dalla Lana School of Public Health, University of Toronto<br>• Focusing on response and recovery; recovery will bring its own challenges<br>  ○ Institute of Pandemics – At Dalla Lana School<br>  ○ Science Table – dashboards - Dalla Lana School<br>  ○ New Vaccine Centre - Dalla Lana School | 8:30 am to 8:45 am |
| **Update from the Chief Medical Officer of Health**<br>Speaker: Dr. Kieran Moore, Chief Medical Officer of Health<br>• We are allowing the health system to slowly enter into recovery mode. PH's duty is to continue with immunization and contact/trace. By this work, schools, businesses can stay open. We will eventually move into recovery but have work still to do.<br>• 5-11 year olds next, boosters, and contact tracing<br>• Work we do is essential, integral | 8:45 am to 9:30 am |

- We have a challenging winter ahead
- We will move to an endemic state, eventually move to have treatments for those that are not vaccinated. Will monitor watching new strains, booster vaccination
- Great decline in long-term care sector – success story
- Have to continue to monitor local data, and protect the most vulnerable in our communities – corrections, shelter, consumption treatment sites
- We have never been as necessary as we are now, in health care
- We are cornerstone – the glue
- Epidemiology
    - Have been able to mitigate, we will see a rise in cases as we go indoors, it is anticipated and expected; continue to discuss risks with our community
    - Positive tests below 3%
    - Death rate staying low; turnaround for testing is excellent
    - Showing higher and higher protection at a population level – Canadian blood services – 95% immunity
- Science Advisory and Modelling
    - We anticipate ongoing upticks
    - We need great public health response
    - ICU occupancy is stable and forecasted to be well below system capacity
    - Working on oral oral outpatient therapies and expanding also the monoclonal antibody delivery – will help us in hospital admissions
    - Elementary students disproportionately affecting elementary schools where students have yet to be vaccinated – have a very robust strategy which will impact on mental, physical health of our students
- Vaccination
    - Using an equity lens – close to 90% in eligible population for 1st dose
    - 54-67% of parents willing to vaccinated 5-11 year olds right away
    - Remarkable success in vaccination, especially in vulnerable population – we did it early, in a sustained way, and now offering booster vaccines
    - Having consistent and persistent protection at a population level
    - Also co-administering flu vaccine; influenza testing remains low
        - Watching RSV which is increasing in Ottawa region and Eastern Ontario
    - Our Ontario system is working in great part because of our system partners and our collaboration
    - Have taken a cautious, gradual, and incremental approach
    - Risks
        - Global epi situation – travel, and new variants
        - High vaccine needed
        - Moving indoors
        - Maintaining compliance with existing public health measures
        - Potential for waning immunity and implementation of third/booster dose
    - Have done a stellar job compared to Europe, (ICU occupancy and deaths in European peer jurisdictions) – because of our slow, cautious approach
        - Need to remain humble in our approach
    - Proposed timelines for safety reopening Ontario
        - December 15th, January 17th,, etc

        - We need to wait until Spring to make any real decisions – will be based on data
- Focus on Local Response
    - Provincial group is there to support, in cases like Algoma, Sudbury, where cases are going up
    - System to respond at a local level is working
    - The local focus works – although it's difficult to implement
- Endemicity
    - Focus is on the spring
    - Immunization, treatment that should be available in the spring
    - Slow and cautious approach
    - Molnupiravir – one example of treatment will
    - 1 billion dollars extra support – know that PH will need additional funding. ROA stays in place until March 28th; have maintained provincial resources to help local health units
- Key Takeaways
    - In a relatively good position
    - Stay steadfast in efforts
    - Thank you for work done
    - Support in financing and HHR available at a provincial level

Moderator: Dr. Charles Gardner, Chair, Council of Ontario Medical Officers of Health

- Can we get a copy of slides – yes, needs to make sure they are approved
- How to keep public health safe? – security needs to be top and centre at any discussion with clinics, very aware of what happened at Peterborough clinic; include police force in clinics, have a Safety Plan in place – working with solicitor General's office
    - In terms of infection control, PHO is the expert
- Seems to be less active screening. Why?
    - Benefit of active screening decreases over time as high vaccination rates; need it for schools, Passive screening still must be done.
- Vaccine passport – is it still the plan to lift in January?
    - We will review in January, may lift in March, but always data driven, incremental, slow and cautious. Commitment to review data in January. No commitments until review happens.
- How does province plan to work with those that are not yet vaccinated?
    - 88.9% is an amazing amount of work
    - Once we get young ones vaccinated, will get up to about 80% of overall population
    - Plus, natural immunity
    - And we will have treatment
    - Eventually, we either get vaccinated or are exposed
    - Not at herd immunity yet
- What is the funding formula being applied?
    - Minister will make announcements for 2022
    - He can't make the announcements
    - Any extraordinary costs from this pandemic will be covered for 2022
- Looking beyond – maternal mental health is a concern. When can we get back?
    - We have a lot of catch up to do. Can't happen for another six months. Give

| | |
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| us time (1.5 to 2 years) to catch up. We have a backlog and it's a very important story to tell. Dr. Moore tells that story at the Ministry level. We are protecting system, next we will need time to work on our programming. | |
| **After the Storm: Public Health Considerations for Recovery and Beyond**<br>Speakers (Public Health Ontario):<br>Colleen Geiger, President and Chief Executive Officer (acting); Chief, Strategy and Stakeholder Relations, Research, Information and Knowledge, PHO<br>Dr. Jessica Hopkins, Chief Health Protection and Emergency Preparedness Officer, PHO<br>Dr. Samir Patel, Chief, Microbiology and Laboratory Science (acting), PHO<br>Dr. Brian Schwartz, Vice President, PHO<br>Moderator: Dr. Robert Kyle, Treasurer, alPHa<br><br>Summary: It's been more than a year and a half since the identification of the first case of COVID-19 in Ontario. The availability of safe and effective vaccines and adherence to public health measures has placed Ontario in an enviable position compared to many other jurisdictions. While challenges remain, public health system leaders have an opportunity to collectively plan for what comes next. Join Public Health Ontario executives in a discussion on shifting priorities and opportunities as we begin to transition into pandemic recovery and living with COVID-19.<br><br>Colleen Geiger<br>• With vaccination rates increasing, turning to recovery<br>• Ability to "build back better"<br><br>Dr. Brian Schwartz<br>1. How the pandemic has disrupted the traditional emergency management Framework.<br>2. Health Inequities<br>3. Rebuilding Better<br><br>• Emergency Management Cycle – all happening at the same time<br><br>Want to focus on reducing health inequities – focus on opioids<br>• there are almost 2500 opioid related deaths in Ontario in 2020, which was a 60% rise from 2019.<br>• in particular, there was a large increase in the proportion of deaths among females, aged, 25, to 44.<br>• Geographically, the northern remote and rural communities experienced the highest rates of opioid deaths, and one in six deaths were among people experiencing homelessness, which is more than doubled since 2019.<br>• And unfortunately, I can't even report on race or ethnicity because we don't have those data, which is definitely one of the deficits which we need to build back better.<br>• we do know about indigenous and racialized communities that they have been differentially affected by coven 19, both directly and indirectly.<br><br>Dr. Jessica Hopkins<br>• Effective recovery after a disaster really offers us an opportunity to create systems | 9:30 am to 10:15 am |

that can become more resilient to future disasters.

- Micro, Meso, Macro levels
- Micro - frameworks are focused on delivering the right intervention for the right need and what that means is, first of all, individualized needs. Targeted universalism
- Meso – refer to frameworks that focus on meaningful frameworks. Acknowledgement and validation. There is a shared identity of the group that's been identified. We need to validate. Community centred, use community's strengths. Social resources.
- Macro – cultural awareness – social determinants of health
- Relevant to all levels – longitudinal and long recovery process.
- Recovery will be long lasting – we have an opportunity to build back better. A whole of society approach will be necessary
- We need health in all policies, need broad level strategies to decrease in health inequities, continue collaboration

Dr. Samir Patel

- Focus on laboratories
- Providing highly-specialized testing – TB, lyme disease, rabies
- Serves as a reference lab, supports outbreak response
- Need to operate with other clinical labs and PHUs, hospitals etc
- Need better connectivity to share data with the goal of sharing surveillance
    - Has been a lack of IT collectivity between labs
- Genomics is a lab-based testing to understand the genetic makeup of pathogens. Genomics aims to understand how changes in the genetic makeup of pathogens impact health. Genomics monitors variants such as alpha variant, and delta variants in understanding that changes occurred in the virus resulted in more transmissibility, as well as cost more severe disease. Before the pandemic, it was in its infancy. In the Pandemic, it was the first time we used genomics to inform public health and health decisions.
- Recovery needs to further strengthen lab systems, integrated, seamless movement of data for surveillance and to invest in technologies

Closing Remarks Colleen Geiger

- Need to think about investing in areas like population health monitoring, to ensure that we have the best possible baseline and trend data for Ontario, to enable the identification of priority areas for public health
- Integrated information technologies
- Monitor what is coming next
- Need to focus on inequities
- Need system leadership at recognize health as an outcome in all policies
- Strong PH system requires sustainable funding and resources
- Need to think about what COVID endemic means to PH
- After the storm, when things go quiet, PH often goes unnoticed. We need to find a way to keep its importance top of mind

What do we need to do to be able to live with COVID?

- Individuals – maintaining connections, cooking for family, physical activity, sense

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| of purpose, balance between work and home life<br>• Organizational level – recognize the toll that this has taken on people, what kind of structural supports can we put in place? How do we support mental well being?<br>• From an infectious disease standpoint, basic practices in infection prevention and control. Surveillance is important – lab testing and surveillance<br><br>Opioid stats – is there a report?<br>• He has a link that shows stats for each PH unit<br>• https://www.publichealthontario.ca/en/diseases-and-conditions/mental-illness-substance-use/opioids<br><br>investing in areas like population health monitoring, to ensure that we have the best possible baseline and trend data for Ontario, to enable the identification of priority areas for public health<br>• Incumbent on all of us that this doesn't happen. This has been a sustained emergency, and we must continue to communicate – be mindful of science, data. Be sure that our value proposition remains alive. | |
| **Break and Public Health Video Showcase** | 10:15 am to 10:30 am |
| **Recovery to Transformation: Lessons from the Pandemic**<br>Speaker: Dr. Christopher Simpson, Executive Vice-President, Medical, Ontario Health<br>Moderator: Carmen McGregor, Past-President, alPHa<br><br>The COVID-19 pandemic exacerbated many long-standing challenges in our health care system. Dr. Chris Simpson, Executive VP Medical, will discuss lessons learned during the pandemic and how system recovery can serve as a catalyst for the transformation required to better connect, coordinate and improve health care for all Ontarians.<br><br>• Ontario Health was created to help move us away from that siloed system and more toward a more integrated system, but also a more integrated vision, and more<br>• Vision is to use cancer care Ontario model to build the mental health and addiction center of Excellence<br>• We are NOT the Ministry<br>• The Ministry will set policy and Ontario Health will operationalize<br>• All driven by Connecting Care Act, 2019<br>• Five priorities<br>  ○ Reduce health inequities – need data<br>  ○ Transform care with the person at the centre<br>  ○ Enhance clinical care and service excellence<br>  ○ Maximize system value by applying evidence<br>  ○ Strengthen Ontario Health's ability to lead<br>• Need data and analytics<br>• Originally, the Ministry was focused on surgical recovery; but Ontario Health has "demoted" that<br>  ○ Preventative care and primary care<br>  ○ Community mental health and addictions services | 10:30 am to 11:15 am |

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| o Access to care in the most appropriate setting<br>o Scheduled surgeries, procedures and appropriate diagnostic imaging services<br><br>Questions:<br>• Families and caregivers being full partners in the system. Empowerment for patients and families is required.<br>• A lot of people are looking at OHTs as something that may or may not work; until we can put some governance with teeth, and money. The jury is still out if this will work<br>• Health Units are currently not resourced appropriately to participate in the Ontario Health Teams. Comments?<br>o Dr. Simpson would like to hear our thoughts. How do we make public health a prominent partner? Interested in how we would see that. Dr. Simpson is not hearing public health talked about in these circles.<br>• Family Health Teams integrated<br>o Primary care is not in Ontario Health yet<br>o Partnerships with municipalities would be helpful here – PH already does this<br>• What is being done to ensure the voice at the table?<br>o If there is no specific action attached to it, it falls into the background<br>• Why is Public Health not in the partnership?<br>o Dr. Simpson would like a Public Health person at that table<br>o The PH conversation has been missing at this point | |
| **New Normal – New Foundations**<br>Speaker: Dr. Kwame McKenzie, Chief Executive Officer, Wellesley Institute<br>Moderator: Dr. Eileen de Villa, Medical Officer of Health, Toronto Public Health<br><br>Canada has had a good covid-19 response compared to other high-income countries with lower rates of death than many countries, including the United Kingdom and the United States. The hard work and long hours of public health, essential workers, and the efforts of the people of Ontario are cited as important factors in our success. The recovery and a move towards a new and better normal offers new challenges, but there are a number of innovations and lessons learned from the pandemic that we can collectively build on.<br><br>Ontario has had a better experience than other countries, and other provinces. We are not out of the woods yet, but we will get there. New normal will bring new challenges.<br><br><u>Building on the Positives</u><br>• Started off with thank yous;<br>• The engagement of individuals and communities has led to a very good response that has saved a huge amount of grief and lives<br>• So, how do we move to great?<br>• We build on the positives!<br>• “On being 100” newscast in the UK<br>o What is your secret? Because she got off the Titanic before it sailed.<br>o Could more lives have been saved by the Titanic sinking?<br>o 90% of children in first class about 97% of women in first class survived, but only 34% of children in third class survive than any 46% of women in third | 11:15 am to noon |

class survived. - It was a design in equity, by design, and culture. It was women and children first. So that's what happened.
    - If the Titanic disaster response was engineered for equity more people would have been saved.
    - Our COVID-19 response was inequitable by design and culture
        - Older people
        - Population with pre-existing health conditions
        - Ethnic minorities, migrants, and refugees
        - Homeless
        - Institutional settings
        - Specific working environments, including no sick leave
    - Do we value older people as much as younger people? Those in homes?
    - Cases, hospitalizations, ICU admissions, fatalities – every time whites did better.
    - In Toronto, if you are in a house, with income less than $29,999 per year, 2.78 rate ratio of COVID. If $150,000 or more, 5x less likely to get COVID
    - Black populations indigenous populations, 36, and 37%, definitely, or probably will not get vaccinated that was their intention, compared to the white population were 16% were not planning on getting vaccinated
- We have to build on equity
    - PHAC has a pandemic equity model; includes economic security, stable housing, etc.
    - We had CERB Federal income support and credited for decreasing Covid income inequity, supporting the pandemic response and decreasing mental health impacts.
- The pandemic has been a time of rapid service innovation, and all of those give us opportunities to promote equity.
- Digital Health expansion
    - Promises more efficient healthcare
    - We need to focus on dealing with digital divide, and cultural and linguistic adaptation of innovations – gave UK example
    - We have seen more timely data analysis
        - Example Toronto allowed for use and analysis of data; transparency supported change
    - Science table – pop-ups and hotspot strategy; we could build healtcare funding based on properly based on needs analysis
- Cross sector partnerships for vaccination – ex community, CHC and hospital partnerships, have a DJ there and a small treat (example). Basic learning is about inclusion and doing things **WITH** community and not to community.
- Participatory budgeting as a tool for public health
    - "If you could do one thing" – British Academy
    - Dr. suggestion was participatory budgeting, giving communities voice and agency so it was a true partnership when we are thinking about heatlh.
        - How, we do things, not what we do
        - Growing the number of people that are actively involved in doing public health work
        - Grow community capital
- Pandemic has led to a focus federally, provincially and locally on mental health
    - It is welcome, and needed
    - Need to think about PH workers, hospital workers, nursing home workers

- Wellness Together Canada
- From Theory to Practice
  - March 2020 high rates of Covid in UK and USA Black population
  - Rise of Black Lives Matter
  - Birth of Black Health Equity Working Group – in Canada
    - a loose alignment of community, academics service providers and government thinking of how we could decrease in equities for black populations.
  - Goal was to collect, analyze and publish data
  - Ontario started collecting data
  - Toronto started consulting communities and brough a plan forward
  - Some areas in Toronto has 10X cases of COVID, and it was predicted by racialized populations
    - Implemented a culturally-appropriate programming
    - By December, there was a decrease in inequity from June 2020 to July 2021
    - Has significantly changed inequities in hospitalizations
- Problem – how do we improve a good pandemic strategy response and have a better recovery? And I'm proposing that the solution is we build a more equitable pandemic response, recovery.
- We have proved it's feasible to have a better and more equitable pandemic response and we could have an equitable recover. We have the tools.
- What we haven't done is scaled and spread proactive practice on social policy to support mental health. We need to engage community and third sector partnerships to help our public health response.
- We have spectacular innovation – the question is how to we put it together, how we spread the scale, and how we build on what we know works in order to produce more equitable outcomes

Questions:

- So if you could do one thing. now, in respect of enhancing viability on that which has been successful in the pandemic response to date to bring us from great to amazing.
  - Winter, vaccines to children, booster. What is special about Canada and Ontario. I think we need to build on that. How do we build on that? We have 15 to 20% of the population we still can't reach. Vaccine hesitancy high in black populations and Asian populations. How will we reach them?
  - We need to focus on systemic ways
- How can we do better at using record linkage to have access to more comprehensive data on social determinants of health and their impact on racialized populations?
  - We have huge data sets that we can't link. We need more sociodemographic identifiers when they renew their OHIP card, for example.
- How do we go from great to amazing?
  - Change is all of us. We have to look after ourselves; resiliency, balancing self, meditations etc. We need to take care of self
  - the way we use our budgets, and whether we can use those to actually leverage building capacities in community to help public health is a very very important way forward.

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| ○ Needs to be a serious look at how we fund public health. Is it insufficient. Public health has been underfunded. We have global warming to contend with.<br>○ We need legislation to fund and protect public health | |
| **Supporting Safe & Open Schools**<br>Speaker: Hon. Steven Lecce, Minister of Education<br>Moderator: Dr. Paul Roumeliotis, President, alpha<br><br>• Over 99% of schools currently open<br>• Moral covenant that guides leaders in this moment; thank you to Public Health<br>• 5- to 11-year-old vaccination approved today<br>• Return to normal semestering for term two<br>• Gave an overview of what has happened in schools in the past 18 months | Noon to 12:30 pm |
| **Lunch Break and Public Health Video Showcase** | 12:30 pm to 1:30 pm |
| **Section Meetings**<br>*Members of the BOH Section and COMOH meet separately in the afternoon. Board of Health members are asked to stay with the Zoom webinar platform. COMOH members will join a separate meeting.*<br><br>Speaker: Dr. Kieran Moore, Chief Medical Officer of Health<br><br>Open dialogue<br>• When do you foresee getting back to normal public health work?<br>○ COVID in the first and second quarters. Case and contact management in the first two quarters. Children being vaccinated will take well into next year, boosters, and an increasing strategy for boosters; third-dose strategy. Every Ontarian that wants a third dose, will get one.<br>○ Having conversations of recovery have started<br>○ Recovery possibility in summer 2022<br>○ Concern of virus in 2022/23 parainfluenza, influenza, COVID<br>○ Have to recover our basic programs, until fall, but will be potentially threatened in 2022/23<br>○ We will have to be fluid and resilient<br>○ The Minister and Premier very thankful for all the work being done in Public Health<br>○ They have made a commitment to cover 2022 COVID expenses<br>○ He believes there will be an increase based on inflation<br>• Transformation on hold. Are they starting to move forward?<br>○ Not on Dr. Moore's agenda<br>○ PH is a cornerstone to getting the province back<br>○ The next six months is integral to getting the province healthy<br>○ Then another six to 12 months for recovery – all programs that have suppressed. Ability to restore programs will vary. Algoma is affected greatly currently.<br>○ Dr. Moore's voice is "let us do the important work we are doing." Give us a year or longer and let us learn from this. Then have a period of reflection | 1:30 pm to 4:00 pm |

before we have any changes

- ACMOHs – five have been appointed; wanting to create support from the provincial offices
    - Regional associate chiefs were in place years ago
    - It is now back in place
- Power Persistent Protection
    - Great benefit of these vaccines decreases the impact in ICU, emerg
    - Antivirals will also be a big help
- 2022, we anticipate positive news that additional COVID costs will be covered
- WE are looking at statistics with an equity lense
- What role do you see for boards in decriminalizing criminalize those who use drugs.
    - It is a federal responsibility
    - Keep up with advocating for Public Healthy policy
    - For example, KFLA asked for policy about supporting those who had adverse effects – now have legislation – it works!
    - Vaping – important to monitor data at local level; sees it as a gateway to a nicotine addiction – recommends lobbying and policy change in the use of these products
- Which one for third dose?
    - No preference on mRNA dose
    - If 70 and over will get 100 mcg dose; under 70 - 50 mcg dose
- Once the pandemic is over, are we going to fade into the background?
    - Saw Boom, Bust, Echo for SARS,
    - Wants to want to write annual reports
- Dedicated associated Chief Medical Officers of Health ; Relationship with Ministry of Health
    - Also have school health relationships
    - Dr. Moore meets with Minister Lecce on a weekly basis
    - Will also have to continue working on mental health
- MLTSD
    - Have had relationships on legislation, mandates
    - Infection, control has to stay in place
    - What enforcement that has to be maintained
    - Ventilation and air quality also has to be in place
    - Training and HHR needs to be strengthened
    - Benefits of pharmacies in partnership with them
- Mandatory vaccination policies
    - Directives in play were related to health care. Mandate was to have a vaccination policy – initial approach was flexible; immunize, education, test

Monika Turner – Association of Municipalities of Ontario (AMO) Director of Policy

- Everything AMO is doing focuses on COVID
- Municipal transit systems have been hit hard
- Municipal governments can't run deficits
- Recognize massive federal and provincial deficits
- Municipal services are dependent on funding
- Public Health Modernization not happening currently
- Population of Health is paramount

- All four parties will be approached on a 8 point plan
- Looking at a comprehensive plan related to climate change
- Need to invest in Broadband for education, for work in rural and remote areas
- Need to advocate for Public Health and Social Service funding
- Need to advocate for Mental Health and Addiction
- Need to advocate for housing and homelessness
- Only 50% of municipalities are represented on OHTs – need to raise this membership
- Community Paramedicine - needs stable funding
- Long Term Care is under AMO's radar – legislation is in second reading
- Social Assistance Transformation
- Public Health Modernization – needs to reflect what is needed at the local level

- 8-point highlights
    - Stable funding needed
    - Climate change response
    - Adequate funding ministry for provincial health and human services that underpin the social and economic well-being of Ontario
    - Mental health and addiction
    - Affordable housing
- Ontario Health has a population health focus
    - Work with Ontario Health to pull Public Health into

James LeNoury – lawyer
Charter of Rights and Freedoms

- Courts will give weight to the public and public needs over individual challenges to the public health implementations

Human Rights

- Mandating vaccines are permissible as long as protections are put in place to makes sure people who are unable to be vaccinated are accommodated
- Upholding individual rights while protecting the general public has been challenging
- Duty to accommodate for medical
- Testing can be an alternative
- Organizations should cover costs as part o the duty to accommodate.
- Personal preferences and singular beliefs are not protected

Employment
Termination
Vaccination Policies
Public Health – courts upheld public health directives
Health Protection and Promotion Act

alpha Update Section Business
Communications – all key alPHa activities distributed though APH