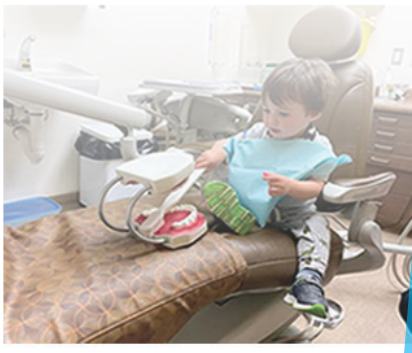
Algoma
PUBLIC HEALTH
Santé publique Algoma

October 12, 2022
For Decision

2023
Recommended Capital and Operating Budget Report

To: Finance and Audit Committee of the Board of Health for the District of Algoma Health Unit

From: Dr. John Tuinema, Acting Medical Officer of Health & Chief Executive Officer



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Issue

Approval is being sought for the recommended 2023 Capital & Operating Budget for Algoma Public Health (APH). The draft budget was developed by the Executive Team and is recommended by the Acting Medical Officer of Health. It is to be reviewed at the October 12, 2022 meeting of the Board of Health Finance & Audit Committee.

Recommended Action

THAT the Finance & Audit Committee of the Board of Health for the District of Algoma Health Unit approve the 2023 Capital & Operating Budget for Algoma Public Health in the amount of $17,740,689.

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

- As part of the *Organizational Requirements: Fiduciary Requirements Domain*, boards of health are accountable for using Ministry of Health (Ministry) funding efficiently and for its intended purpose, and ensuring that resources are used efficiently and in line with local and provincial requirements.
- 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 *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.
- 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 2022 approved budget was $19,627,191 .This included $3.4M in anticipated one-time COVID-19 extraordinary costs, based on the province's commitment to reimburse APH for further extraordinary COVID-19 expenses that could not be recovered by mandatory programs. As of June 30th, 2022, it was forecasted that anticipated needs for COVID-19 extraordinary costs were $2.9M versus the original ask of $3.4M.

The **recommended 2023 budget for public health programs and services is $17,740,689**. This represents a decrease of $898,477 from the 2022-forecast budget.

The recommended budget is driven by a significant decrease in anticipated requirements in both COVID-19 Response and Immunization programs, as public health routinizes this work into mandatory program delivery. The recommendation for 2023 includes an ask of $1.1M from the Ministry to fund anticipated COVID-19 extraordinary costs that are not expected to be recovered via mandatory programs.

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]

[1] Ministry of Health. (2021). Ontario public health standards: Requirements for programs, services and accountability: Protecting and promoting the health of Ontarians. Retrieved from https://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/
[2] Algoma Public Health. (n.d.). About us. Retrieved from https://www.algomapublichealth.com/

The recommended budget is the minimum required to maintain COVID-19 response and immunization programming, as is expected by the Ministry, and begin the process of restoring public health programs and services as mandated by the *Ontario Public Health Standards* (OPHS).[1] The breakdown of the recommended 2023 operating budget of $17,740,689 is provided in **Table 1.0**.

As a comparison of pre-pandemic (2019) to pandemic period budgets (2020, 2021, 2022 budget and forecast), a Budget Analysis is also provided in **Table 1.0.** Comparisons can made between the recommended 2023 budget ($17,740,689) and the 2022-forecast budget ($18,639,166). The 2022-forecast budget presented is conservatively based on current funding allocations confirmed by the province.

As evident in **Table 1.0**, 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 2023, APH's budget recommendation is built assuming there will be no increase to the total municipal levy rate applied as a district.

The following sections provide details on key 2023 budget factors.

Table 1.0: Budget Analysis, 2019 – Recommended 2023

Revenues Summary	2019 Actual	2020 Actual	2021 Actual	2022 Budget	2022 Forecast	2023 Budget	% Change 2023 Budget vs 2022 Budget	% Change 2023 Budget vs 2022 Forcast
Province Portion of Jointly Funded Programs	$ 7,523,200	$ 8,703,177	$ 8,712,804	$ 8,708,100	$ 8,773,425	$ 8,795,200	1.0%	0.2%
100% Provincially Funded Programs	$ 3,405,823	$ 2,027,810	$ 5,258,846	$ 5,313,000	$ 4,259,650	$ 3,266,089	-38.5%	-23.3%
Province Mitigation Fund	$ -	$ 1,037,800	$ 1,037,800	$ 1,037,800	$ 1,037,800	$ 1,037,800	0.0%	0.0%
Municipal Levies	$ 3,519,703	$ 3,559,232	$ 3,808,378	$ 4,189,216	$ 4,189,216	$ 4,189,216	0.0%	0.0%
Other Recoveries and Fees	$ 688,282	$ 503,127	$ 455,882	$ 379,075	$ 379,075	$ 452,384	19.3%	19.3%
Total	**$ 15,137,008**	**$ 15,831,146**	**$ 19,273,710**	**$ 19,627,191**	**$ 18,639,166**	**$ 17,740,689**	-9.6%	-4.8%
Expenses:								
Salaries and Wages	$ 8,838,252	$ 9,523,270	$ 10,856,463	$ 11,958,949	$ 11,220,407	$ 10,699,084	-10.5%	-4.6%
Benefits	$ 2,148,254	$ 2,225,203	$ 2,098,164	$ 2,769,515	$ 2,621,584	$ 2,512,002	-9.3%	-4.2%
Travel	$ 214,809	$ 103,453	$ 143,484	$ 204,798	$ 188,705	$ 158,800	-22.5%	-15.8%
Program	$ 624,709	$ 642,120	$ 1,468,959	$ 1,277,209	$ 1,320,941	$ 1,237,163	-3.1%	-6.3%
Equipment	$ 75,417	$ 89,026	$ 103,245	$ 20,000	$ 20,000	$ 20,000	0.0%	0.0%
Office	$ 84,585	$ 46,451	$ 68,291	$ 67,400	$ 67,400	$ 82,400	22.3%	22.3%
Computer Services	$ 768,076	$ 750,708	$ 716,738	$ 846,600	$ 832,416	$ 875,895	3.5%	5.2%
Telecommunications	$ 260,123	$ 290,550	$ 365,098	$ 340,000	$ 327,528	$ 265,000	-22.1%	-19.1%
Program Promotion	$ 145,489	$ 55,557	$ 124,343	$ 183,541	$ 171,073	$ 125,424	-31.7%	-26.7%
Facilities Leases	$ 172,465	$ 162,414	$ 166,901	$ 160,000	$ 160,000	$ 194,000	21.3%	21.3%
Building Maintenance	$ 864,553	$ 711,183	$ 1,173,229	$ 1,036,458	$ 946,391	$ 730,000	-29.6%	-22.9%
Fees & Insurance	$ 238,689	$ 251,994	$ 311,961	$ 332,300	$ 332,300	$ 383,500	15.4%	15.4%
Expense Recoveries	$ (109,670)	$ (135,109)	$ (82,613)	$ (27,000)	$ (27,000)	$ -	-100.0%	-100.0%
Debt Management (I & P)	$ 460,900	$ 460,900	$ 460,900	$ 457,421	$ 457,421	$ 457,421	0.0%	0.0%
Total	**$ 14,786,651**	**$ 15,177,719**	**$ 17,975,163**	**$ 19,627,191**	**$ 18,639,166**	**$ 17,740,689**	-9.6%	-4.8%
Surplus/(Deficit)	**$ 350,357**	**$ 653,426**	**$ 1,298,547**	**$ 0**	**$ 0**	**$ 0**		

2. 2023 Budget Background

To provide context for the recommended 2023 budget and retention of the same total municipal levy rate applied to the district of Algoma Health Unit in 2022, despite a forecasted surplus for 2022, a background is being shared to demonstrate the:

- **Status of local public health** in the emergency management framework and COVID-19 response;
- **Work ahead to recover from the pandemic,** including revitalizing the workforce, routinizing COVID-19 response and immunization, addressing the backlog and restoring public health programs, and rebuilding local public health in 2023 and beyond; and
- **Costs of response and recovery,** including financial expenses acquired from COVID-19 response and immunization programs, those projected for recovery, and those associated with longstanding challenges in recruitment and retention.

The work in COVID-19 response and recovery, and cost, collectively demonstrate the value of public health services and programs to Algoma residents and municipalities in helping to continue achieve pandemic goals and population health and wellbeing.

This summary reinforces the minimum financial requirements needed to sustain and routinize COVID-19 response and immunization programming, alongside the initiation of pandemic recovery to revitalize the public health workforce, restore mandatory programs and services, and rebuild local public health.

2.1 Status of Local Public Health in Pandemic Response

Emergency management occurs through five interdependent, risk-based functions, including: prevention, mitigation, preparedness, response, and recovery.[3] The COVID-19 pandemic response has been situated within the emergency management framework, and due to its persistence, has required local public health to perform multiple functions at the same time through 2022, including primarily **response** and **recovery**. The simultaneous response and recovery efforts create significant novel challenges.

2.1.1 Shift in our COVID-19 Response Strategy

In April 2020, the Ministry 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 an Incident Management System structure to respond to the COVID-19 pandemic.

Throughout 2022, the work of APH has continued to focus on the two pandemic goals:

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

However, the activities of our response shifted from 2021 to 2022, as the severity of COVID-19 changed with the Omicron variant (as opposed to the more severe Delta variant) and novel technologies such as COVID-19 vaccines and treatments helped significantly reduce the burden of hospitalization and death.

As presented in detail in the *2022 Recommended Operating & Capital Budget* report[4], efforts in COVID-19 response in 2020 and 2021 focused on **containment** – preventing transmission of the virus[5] in the community through large scale testing, thorough case and contact management, quarantine

[3] Ministry of the Solicitor General. (2021). Emergency management framework for Ontario. https://files.ontario.ca/books/solgen-emo-emergency-management-framework-2021-en-2021-12-30.pdf
[4] Algoma Public Health. (2021). 2022 Recommended public health operating & capital budget report. Retrieved from https://www.algomapublichealth.com/media/4972/meeting-book-november-24-2021-board-of-health-meeting-website.pdf
[5] Walensky, R. P & del Rio, C. (2020). From mitigation to containment of the COVID-19 pandemic: Putting the SARS-CoV-2 genie back in the bottle. *JAMA*, *323*(10), 1889-1890. https://doi.org/10.1001/jama.2020.6572

requirements, risk communication, broad pandemic measures, comprehensive health promotion, and enforcement related to the *Reopening Ontario Act*[6]. Containment was a necessity to keep us safe and gain time to develop COVID-19 vaccines. Once Health Canada approved vaccines arrived, efforts began immediately to administer them at rapid pace across Algoma to provide protection against COVID-19. APH teams worked with community partners to take preventive measures against COVID-19 in municipal offices and facilities, long-term care and retirement homes, health facilities, congregate settings, schools and day cares, and a variety of other workplaces.

Teams not directly involved in COVID-19 response ensured the **maintenance of high-risk programming**, as outlined by APH's Continuity of Operations Plan (COOP), which gave highest priority to programs that worked to decrease health inequities for those most affected by COVID-19 (e.g. needle exchange program, tobacco cessation services, sexual health information line, 48-hour blended model home visits for new parents, etc. continued at reduced capacity).

In late 2021, the approach to COVID-19 response shifted from containment to **mitigation** – a less invasive approach implemented out of necessity when the virus outpaced our ability to contain it,[5] and there was a need to focus efforts to reduce the risk of COVID-19 in highest risk settings and among those most vulnerable (e.g. long term care, retirement homes, elder lodges, hospitals, etc.).

With this shift to a mitigation approach, testing, case management, and facility management efforts focused in on highest risk settings and groups, as opposed to the broader public. In addition, provincial guidance changed. This included, for example, the removal of vaccination requirements in public settings, removal of mandatory masking in public settings, revoking of regulations and orders under the *Reopening Ontario Act*[6], and adjustment of sector-specific guidance based on dominant presence of the Omicron variant.

However, basic public health measures, infection prevention and control (IPAC), and risk communication have continued to encourage actions that reduce transmission in the community, workplaces, schools, and high risk settings (i.e. staying home when sick, masking, hand hygiene, etc.).

The above was done in tandem with the expansions of the COVID-19 vaccine rollout. In 2022, vaccination focused on newly eligible groups (i.e. children under 5 years) for primary series administration, and booster doses for eligible groups to combat waning immunity over time. Uptake for boosters up until September 2022 had been less than a primary series, changing the pace of vaccine administration from 2021, despite signs of increasing uptake in early October 2022 as the bivalent booster was approved.

Despite these changes in approach, it is evident that the pandemic response continues to involve a level of case management, outbreak management in high risk settings, immunization for new eligible groups, and knowledge translation for the general public, partners, and vulnerable populations.

The pandemic and related response and immunizations work have certainly not ended and uncertainty remains, as is reflected in the snapshot of 2022 efforts below and recommended 2023 budget.

2.1.2 Snapshot of Response and Immunization Efforts in 2022

APH's efforts in COVID-19 response and immunization and maintenance of high-risk programming, with the support of community partners and residents of Algoma, continued to achieve pandemic goals and benefit community health and safety throughout 2022.

For perspective on response work:

- From January to September 24, 2022, there were **7464 positive high-risk cases of COVID-19** in Algoma, with APH conducting limited case management for those associated with highest risk settings, and reporting for surveillance among general community cases. No contact management has been conducted in 2022.

  As a comparison, 79 cases were followed in 2020 with thorough case and contact management, and 2164 cases were followed in 2021 with thorough case and contact management until changes in

[6] Government of Ontario. (2020). Reopening Ontario (a flexible response to COVID-19) act, 2020, S.O. 2020, c. 17. Retrieved from https://www.ontario.ca/laws/statute/20r17

December 2021 that shifted testing and case management to highest risk groups. [7,8]

- From January 2020 to September 24, 2022, there have been **98 outbreaks** within long-term care homes, retirement homes, hospitals and congregate living settings, where APH conducted outbreak management and provided guidance.[7,8]

Within the context of the vaccine rollout, local public health has continued to lead the coordination of the vaccine rollout in Algoma by working with partners, planning, managing operations, and facilitating vaccine communication.

As a snapshot of COVID-19 vaccination efforts from January to September 30, 2022[9,10]:

- **60,280 doses of COVID-19 vaccine were administered** to Algoma residents (including all doses) across all channels, regardless of residence, of which APH has either hosted, coordinated, administered vaccine, supplied vaccine, or supported in some capacity.
- 280 vaccine clinics 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.
- 2,774 first doses, 5,751 second doses, 27,766 third doses, and 22,756 fourth doses were administered to Algoma residents across all vaccine channels.

Overall, response and immunization efforts with municipalities, health sector partners, community organizations, Indigenous community partners, and Algoma residents have ensured our pandemic response goal continued to be met in 2022.

Serious illness and death from COVID-19 remained limited in Algoma. From January 15, 2020 to September 24, 2022, Algoma's COVID-19-related hospitalizations and deaths were as follows[11]:

- Cumulative rates of COVID-19 hospitalizations (for or with COVID-19) were 346.2 hospitalizations per 100,000 population for Algoma, as compared to 379.3 hospitalizations per 100,000 population for Ontario.
- Cumulative rates of COVID-19-related deaths were 67.9 deaths per 100,000 population for Algoma, as compared to 97.3 deaths per 100,000 population for Ontario.

To continue achieving pandemic goals, work in COVID-19 response and immunization will remain throughout 2023. Uncertainties around persistent transmission of COVID-19 in the community, potential for new variants of concern and the need to revert to a resource-intensive containment strategy remains, new COVID-19 vaccines to be approved by Health Canada (e.g. Bivalent booster doses), and new groups to become eligible for booster doses will influence ongoing work related to COVID-19.

2.2 Start to COVID-19 Pandemic Recovery

Recovery planning efforts were paused in October 2021 to sustain COVID-19 response, immunization, and high-risk programming amid a surge in the Delta variant. However, changes to provincial guidance in late 2021 and the shift to a mitigation strategy redistributed the work of local public health and allowed for the deployment of almost all public health staff back to home programs in spring of 2022. As of September 2022, few staff remain reassigned to support highest risk case and outbreak management.

With most staff returned to home programs, our focus was redirected to COVID-19 recovery planning.

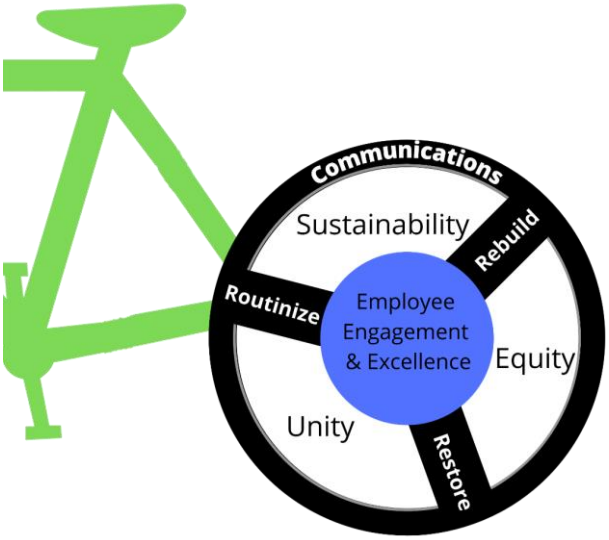
The goal of recovery planning at APH is to effectively recover from the COVID-19 pandemic using a collaborative, evidence-informed approach founded in principles of equity, sustainability, and unity.

APH's Pandemic Recovery Framework (**Figure 1.0**) was developed to provide four directions, aligned

[7] Public Health Ontario. (2022). Ontario COVID-19 data tool. Retrieved from https://www.publichealthontario.ca/en/data-and-analysis/infectious-disease/covid-19-data-surveillance/covid-19-data-tool?tab=overview
[8] Note that changes to guidance in December 2021 limited testing and case management to highest risk groups and facilities, resulting in an underrepresentation of COVID-19 in the broader community within case counts. Data cleaning initiatives with the Ministry have also occurred, resulting in a change in counts of cases and outbreaks that met definition.
[9] Algoma Public Health. (2022). Data by COVID-19 vaccine event. *Internal summary*. Extracted: [Sep/29/2022]. Note: Clinics include vaccine events where 10+ doses were administered.
[10] Ontario Ministry of Health and Long-Term Care. (2022). COVaxON. Date Extracted: [Sep/29/2022]
[11] Public Health Ontario. (2022). Ontario COVID-19 data tool. Retrieved from https://www.publichealthontario.ca/en/data-and-analysis/infectious-disease/covid-19-data-surveillance/covid-19-data-tool?tab=overview

with APH's strategic plan, to guide recovery planning and the work of public health in 2023 and beyond.

Figure 1.0: Algoma Public Health's Pandemic Recovery Framework



To effectively recovery from the pandemic, there is need to:

- **Revitalize** the public health workforce through employee engagement and excellence, focusing on employees' lived experience, lessons learned, employee wellness (including mental health), and organizational capacity development;
- **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 OPHS[1], and post-pandemic public health priorities in Algoma; and
- **Rebuild** and strengthen public health, with a focus on strategic advocacy, policy, and evidence to engage in change at local, provincial, and federal levels.

Recovery, as a public health agency and community, will be complicated and unpredictable given the potential for COVID-19 transmission to continue beyond 2022 and new emergencies to arise. To demonstrate the work to come in recovery and required resourcing, the following section outlines some of the necessary steps for public health, which will require collaboration with partners and the public.

2.2.1 Revitalizing the Public Health Workforce

The COVID-19 pandemic has placed unprecedented pressure on the public health system[12], as was highlighted in the *2022 Recommended Operating & Capital Budget* report[4] that detailed the volume work and dedication by APH employees as part of COVID-19 response, immunization, and the delivery of highest priority programs.

As a result of this pressure from 2020 to present, the pandemic has had a negative impact on the mental health and wellness of the healthcare and public health workforce.[12]

Adequate supports are critical to protecting and improving the public health workforce's health and resilience, and organization-level strategies are considered beneficial for supporting staff mental health.[12]

At the core of APH's recovery framework is revitalizing the public health workforce through employee engagement and excellence. This includes focusing on employees' lived experience, lessons learned,

[12] Public Health Ontario. (2021). COVID-19 – strategies adaptable form healthcare to public health settings to support the mental health and resilience of the workforce during the COVID-19 pandemic recovery. Retrieved from https://www.publichealthontario.ca/-/media/documents/ncov/ipac/2021/08/covid-19-public-health-workforce-recovery.pdf?sc_lang=en

employee wellness (including mental health), and organizational capacity development.

Employee engagement and excellence has been the focus of initial recovery efforts in 2022, and will continue alongside response for the remainder of the year.

Engagement and Wellness

As a start to this process, APH initiated two programs that will continue throughout 2023 and require resourcing to support the sustained implementation of recommendations. With the support of the Board of Health, APH has contracted support from Cense Ltd. and Phelps Group for the development of:

- **A workforce wellness and workplace development strategy,** to provide opportunities for staff to reflect and learn from experiences, support growth, support health and personal care, inform innovation, and identify opportunities ahead of future threats and challenges, with a focus on actionable lessons, healing and organizational development.
- **A leadership development program,** to better understand the strengths, challenges, and needs of leadership, which will underpin recommendations and planning for enhancing cohesion and consistency in practice. For leaders to mentor, inspire, and engage, there is a need to be well, form relationships, and have a baseline understanding of strategic directions and management practices.

Capacity Development

In addition to wellness and engagement, due to the long-term redeployment of public health employees to COVID-19 response and immunization, some for nearly two full years, there is need to support opportunities for internal training, professional development, and knowledge sharing to effectively return to routine public health work. Thus, part of workforce revitalization includes promoting and supporting excellence, through the refreshing of knowledge and skills and opportunities to catch up on evidence and resources related to core work, to support best practice and effective program and service delivery.

As a start, employees will complete OnCore training to refresh core skills for public health practice, while agency- and program-specific opportunities for professional education are being reviewed and/or planned (e.g. Internal National Day for Truth and Reconciliation session; Rainbow Health LGBTQ2S+ training; Education Program for Immunization Competencies; Incident Management System 200 and 300, etc.). In addition, employees are beginning to re-engage in virtual and in-person conferences and webinars for knowledge exchange in public health, to resituate themselves in core work and understand the changing landscape of population health post-pandemic.

Return to In-Office Work

Finally, one of the most recent steps has included the implementation of our return to the workplace program, where as of September 26th, all employees are working in-office at least 50% of their time. This shift from primarily remote work for most staff has required time and logistics support to adjust workspaces across all public health programs to align with current team structure and needs.

Recovering and revitalizing our workforce will evidently require dedicated time and resources within public health programs and across the agency, which will have to be balanced with requirements for continued COVID-19 response and restoring public health programs.

2.2.2 Routinizing COVID-19 Response and Immunization

COVID-19 has not and will not go away indefinitely, but instead become a disease of public health significance that will require ongoing attention by public health. Therefore, public health will need to routinize COVID-19 related guidance, programs, and services into existing work mandated by the OPHS.[1]

Response

For response, this means that there will be ongoing need for COVID-19 activities within existing functions, primarily of the Infectious Diseases and Environmental Health programs. This includes continued high-risk case and facility outbreak management led by APH, and IPAC support for facilities.

The Algoma IPAC hub is currently focused on enhancing IPAC practices in community-based congregate living settings through education, guidance and direct support on IPAC prevention and response.[13,14] However, this initiative is one-time funded until March 2023, and requires advocacy for provincial integration into public health base funding to sustain and advance efforts in IPAC in Algoma.

The routinization of COVID-19 response will also require continued surge planning, to provide APH with operational contingency guidance for two scenarios, including:

- Where APH can maintain routine COVID-19 operations in the context of Omicron or similar variants with minimal disruption to other programs; and
- Where APH is required to mobilize and revert to a containment strategy in the context of emerging variants of concern or changing provincial guidance.

Planning is underway to ensure preparedness for both scenarios, and continued communication and collaboration will be required for emergency preparedness and response with community partners within and outside of the health sector.

Immunization

Similar to COVID-19 response, there will be need to integrate COVID-19 immunization into the Immunization Program. Routinization of this work will need to be balanced with the delivery of school-based immunizations, publically funded and travel vaccines, routine immunizations, and the Universal Influenza Immunization program, as well as program logistics (i.e. fridge inspections, investigation of adverse events following immunization, etc.) and health promotion efforts to boost vaccine confidence.

For perspective on continued demand for COVID-19 vaccines, a fall planning template from the Ministry[15] projected that Algoma could see an estimated demand of 51,739 doses of COVID-19 vaccine among eligible persons from September to December 2022 in a baseline scenario, alongside 8,513 doses of influenza vaccine.

The routinization of COVID-19 vaccines will require surge planning as well to quickly ramp up COVID-19 vaccine capacity in light of several factors (e.g. a new variant of concern, greater need to administer bivalent vaccine, etc.). In addition, there will be a need to further establish community partnerships (i.e. primary care, hospitals, paramedics, pharmacies, etc.) to support ongoing administration of COVID-19 vaccines in the community, similar to delivery of the Universal Influenza Immunization Program. Discussion with community partners also continue, to identify opportunities for collaborative community vaccination, an approach for rapidly expanding capacity for vaccine administration in Algoma.

Overall, routinization will allow for continued efforts in prevention, mitigation, preparedness, and response to COVID-19, as well as immunization, however, requires dedicated resources to conduct these functions **in addition to** routine work.

At this time, mandatory program cannot support the costs associated with COVID-19 related activities, and all activities are being charged to one-time COVID-19 extraordinary costs. Although one-time funding has been appreciated to support response and immunization, there is need to advocate to the province to increase base funding for public health units to routinize COVID-19 for the long-term.

2.2.3 Restoring Public Health Programs

The pandemic has had 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. This prioritization of response and highest risk core programming, and subsequent suspension of non-highest risk programs, has led to a **service backlog and population health outcomes** requiring health system attention, as outlined in detail in the *2022 Capital & Operating Budget* report[4] (e.g. backlogs in smoking cessation, inspections, oral health preventative clinics, routine immunizations, sexual health promotion, mental health promotion, local opioid surveillance, etc.).

Across Ontario's 34 local public health units, self-reported completion of OPHS in the context of the

[13] Algoma Public Health. (2022). Algoma IPAC hub. Retrieved from https://www.algomapublichealth.com/disease-and-illness/infection-prevention-and-control-hub/
[14] Ministry of Health. (2020). Infection prevention and control hubs. Retrieved from https://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/2019_guidance_ipac.pdf
[15] Ministry of Health. (2022). Ontario 2022 fall implementation planning template (Algoma). *Internal document*.

COVID-19 pandemic indicated that across nearly all standards, **less than 50% of pre-pandemic routine work was conducted**, aside from in emergency management and infectious and communicable disease prevention and control where COVID-19 response work and immunization fit.[16]

Many of the backlogs detailed in the *2022 Recommended Operating and Capital Budget report*[4] still remain due to setbacks from the Delta and Omicron variants, though program efforts have begun to address this necessary work.

As for population health outcomes, the pandemic has affected the community in significant ways, and the direct and indirect impacts to health and wellbeing will likely extend years into the future. There is growing concern over public health issues requiring attention to mitigate further population health risk.

In Algoma, some of these health implications are already being observed, such as[17,18]:

- Increase in vaccine preventable disease:
    - The rate of influenza cases in Algoma (51.9 per 100,000 people) as of October 5th, 2022 is approximately 4.7 times higher than the rate of cases in Ontario (11.1 per 100,000 people).
    - The rate of Hepatitis C infections in Algoma (29.9 per 100,000 people) for 2022, as of October 5th, 2022, is approximately 2.3 times higher than the rate of infections for Ontario (13.0 per 100,000 people in Ontario).
- Increase in sexually transmitted infections in Algoma:
    - The incidence rate of gonorrhoeal infections in 2022 (63.3 out of 100,000 people), as of October 5th, 2022, is 4 times higher when compared 2020 (15.7 per 100,000 people).
    - The incidence rate for infectious syphilis cases in Algoma in 2022 (7 per 100,000 people), as of October 5th, 2022, was 2.7 times higher when compared 2020 (2.6 per 100,000 people).
    - The incidence rate for early congenital syphilis cases in Algoma in 2022, as of October 5th, 2022, is 1.8 per 100,000 people. This compares to no cases for the last ten years (as of 2012) in Algoma. In Ontario, the incidence rate of early congenital syphilis was 0.1 per 100,000, as October 5th, 2022.
- Increase in mental health conditions and substance-related harms, such as opioid-related harms (e.g. increased rate of opioid-related deaths in Algoma from 45.6 per 100,000 people in 2020 to 52.9 per 100,000 people in 2021).

COVID-19 also magnified existing health inequities that will place additional demands on public health resources to address them in the future. [18]

To respond to this backlog and the many population health outcomes requiring attention, the third spoke of recovery includes the restoration of public health programs and services to pre-pandemic levels, considering lessons learned from COVID-19, post-pandemic priorities in Algoma, and the mandate of public health within the OPHS.[1]

Some of this work is already underway, as health promotion and protection divisions work to revive pre-pandemic services and programs, while balancing work to be done on the backlog. However, addressing the backlog with existing resources, limited by base funding for mandatory programs and existing position vacancies, is hindering the ability of most programs to efficiently and fully restore pre-pandemic functions.

As a high-level snapshot of current efforts to address the backlog and restore programs:

- The immunization team continues to prioritize the coordination and administration of COVID-19 vaccines, while capacity building within the team, preparing for influenza vaccine administration, and delivering routine vaccination clinics, which is causing delays in the ability to address the full backlog

[16] Association of Local Public Health Agencies. (2022).Public health resilience in Ontario: Executive summary. Retrieved from https://cdn.ymaws.com/www.alphaweb.org/resource/collection/822EC60D-0D03-413E-B590-AFE1AA8620A9/alPHa_PH_Resilience_Report_Exec_Sum_Jan2022.pdf
[17] Public Health Ontario. (2022, July 14). Query: Counts by disease and year. Toronto, ON: Ontario Agency for Health Protection and Promotion. Available from: http://www.publichealthontario.ca/en/DataAndAnalytics/Query/Pages/default.aspx
[18] Association of Local Public Health Agencies. (2022). Public health matters: A public health primer for 2022 election candidates. Retrieved from https://cdn.ymaws.com/www.alphaweb.org/resource/collection/822EC60D-0D03-413E-B590-AFE1AA8620A9/alPHa_Election_Primer_2022.pdf

in routine and school-based immunizations and needs for health promotion.

- The environmental health team continues COVID-19 outbreak management and IPAC support for highest risk settings, which along with long-standing program vacancies is delaying the completion of inspections that are backlogged and required.
- The infectious diseases team is continuing to conduct COVID-19 case management and provide IPAC support, and has ramped up case management for the increase in sexually transmitted infections reported in Algoma.
- The school health team is working to tackle the backlog of school-age immunization by facilitating school-based clinics and administration 3-4 days/week throughout the 2022-2023 school year, which is delaying the restoration and implementation of a comprehensive approach to school health required to address priorities such as youth vaping, mental health, etc.
- The healthy growth and development team is working to revisit community outreach and re-connect with partners, assessing readiness for collaboration, rebuilding areas that were paused such as preconception and prenatal health and healthy parenting, and working to build capacity to incorporate new priorities (i.e. COVID impacts on early years).
- The oral health team is working to resume oral health school screenings in October 2022 following a 2 year backlog, and looking to begin the Children's Oral Health Initiative with Garden River Wellness Centre, also after a two year absence.
- The community wellness team is prioritizing APH's local opioid response through harm reduction and the integration/amplification of personal narratives of people with lived experience, and the voices of families and friends, as well as working to reduce stigma and reinforce a focus on prevention in the community. The team is also doing catch-up on smoking cessation clinic wait lists, and work continues to re-integrate with municipal partners on healthy environments, healthy eating and active living, food security, and community safety and wellbeing.

With limited time for robust review of evidence and planning of new initiatives in summer 2022, while deployed staff reoriented to home programs, program standard implementation plans developed for 2020 were updated with consideration of current needs and priorities to form the basis of public health programming to be considered for implementation in 2023.

However, without (a) Ministry commitment to increase base funding and/or provide COVID-19 recovery funding to resource the added needs to recover the backlog and restore programs, (b) Ministry commitment and support for a Northern Ontario public health human resource strategy to address longstanding vacancies and challenges in recruitment in the north, and (c) a readiness by partners for resuming collaborative pre-pandemic work, public health will likely be unable to implement all proposed plans to fully meet the mandate set by the OPHS[1] in 2023.

2.2.4 Rebuilding Local Public Health

Rebuilding public health requires a focus on strategic policy and evidence to engage in change at local, provincial, and federal levels to improve ***health for all, together***, in Algoma.

Pandemic recovery offers an opportunity for public health to identify lessons learned and improve resilience against future emergencies at system-, community-, and individual-levels.[19] Community or population-level recovery is the focus of public health.

To rebuild, three leading actions include: implementing our strategic plan, updating the Algoma community health profile, and conducting evaluation to integrate lessons learned for the future.

Strategic Plan Implementation

In February 2020, the Board of Health approved APH's new strategic plan for 2021-2025. While the official launch was paused as a result of COVID-19 efforts, APH revisited the plan and re-presented it to

[19] Public Health Ontario. (2022). Disaster recovery frameworks: Common themes to inform COVID-19 recovery efforts. Retrieved from Disaster Recovery Frameworks: Common Themes to Inform COVID-19 Recovery Efforts (publichealthontario.ca)

the Board of Health in September 2022, and is in the early stages of launching and implementing the three strategic directions to:

- Advance the priority population health needs of Algoma's diverse communities, through population health assessment, knowledge exchange with partners, and working with priority populations.
- Improve the impact and effectiveness of public health programs, by aligning programs to priorities and the role of public health, using evidence and data to plan and evaluate programs, supporting integrated strategies for health, and engaging clients, partners, and communities.
- Grow and celebrate an organizational culture of learning, innovation, and continuous improvement, by investing in our people and developing capacity, engaging staff and partners in the role of public health, and recognizing the shared stories of our people and partners.

Revisiting the strategic plan provides a foundation for recovery and the rebuild of local public health. Actions within APH's recovery action plan, as highlighted in **Section 2.2**, are aligned to strategic directions, and as program plans evolve in 2023, they too will be further connected to the strategic plan.

Identification of Public Health Priorities

A step in population recovery includes conducting population health assessments, to inform the planning and implementation of population health interventions (e.g. healthy public policy) and partnerships, and embed a health equity lens into recovery.[19]

Understanding the adverse impacts of the pandemic and how they are experienced differently and unequally across our communities will be critical to informing how APH and partners can contribute to health for all.

APH has begun updating Algoma's Community Health Profile with a projected completion in 2023 (last updated in 2018) to provide a snapshot of community wellness and identify post-pandemic population health priorities in Algoma. These priorities will guide the selection of agency-wide priorities and direct resourcing cross-programs, as well as individual program standard implementation planning for 2024.

Rebuild of Emergency Management

In addition, to support a resilient rebuild of local public health and population health, there is need to:

- Conduct evaluations and an after action review of the pandemic response and COVID-19 vaccine rollout to inform lessons learned and future planning (e.g. mass immunization plans, emergency response plans, COOP updates, hazard specific plans, etc.); and
- Support the ongoing professional development and training of all staff in emergency management, to retain the skills necessary for pandemic response, should a future surge scenario arise for COVID-19 or a new infectious disease (i.e. case management), or other emergencies projected to increase with climate change.

Rebuilding local public health starts as part of recovery, and will support population health for the long-term. However, appropriate investment in public health for the effective recovery of programs and services is needed. This investment in public health and recovery has the potential to generate significant returns, including better health, lower health care costs and a stronger economy.[18,20]

2.3 Cost of Response and Recovery Efforts

APH's robust COVID-19 response and immunization efforts have had benefit to community health and safety throughout the pandemic. However, the work associated with COVID-19 has required an unprecedented quantity of resources, including expenses reported to the Ministry for reimbursement as COVID-19 response and COVID-19 vaccine extraordinary cost.

Table 2.0 and **Table 3.0** provide an overview of COVID-19 response and immunization hours, labour costs, and third party expenses.

[20] Masters, R., Anwar, E., Collins, B., Cookson, R., & Capewell, S. (2017). Return on investment of public health interventions: A systematic review. *Journal of epidemiology and community health, 71(8), 827–834. https://doi.org/10.1136/jech-2016-208141*

Table 2.0: COVID-19 Response Hours and Labour Costs, 2021 – 2022

Month	COVID-19 Response			
	2021		2022	
	Hours	APH Labour Cost	Hours	APH Labour Cost
Jan	7,601	$340,894.00	9,896	$567,351.00
Feb	7,601	$342,892.00	7,405	$316,194.00
Mar	7,601	$359,817.00	7,403	$320,355.00
Apr	7,601	$454,941.00	4,867	$144,023.00
May	7,338	$400,642.00	3,370	$126,776.00
Jun	8,479	$470,916.48	1,594	$62,340.00
Jul	6,258	$299,481.52	950	$41,126.00
Aug	6,191	$256,509.00	1,223	$49,167.00
Sep	7,221	$421,482.00		
Oct	6,778	$406,587.00		
Nov	9,135	$332,955.00		
Dec	9,939	$696,744.00		
Total	**90,409**	**$4,783,861.00**	**36,708**	**$1,627,332.00**

Table 3.0: COVID-19 Immunization Hours, Labour Costs and Third Party Health Service Costs, 2021 – 2022

Month	COVID-19 Immunization					
	2021			2022		
	Hours	APH Labour Cost	3rd Party Health Services	Hours	APH Labour Cost	3rd Party Health Services
Jan	1,259	$75,125.00	$0.00	6,197	$249,835.00	$0.00
Feb	2,081	$166,318.00	$0.00	3,001	$62,269.00	$5,938.00
Mar	5,562	$203,397.00	$0.00	2,066	$85,381.00	$24,007.00
Apr	4,844	$224,404.00	$63,163.42	1,501	$46,452.00	$0.00
May	6,056	$275,344.00	$61,299.00	1,648	$71,100.00	$0.00
Jun	9,301	$423,353.98	$62,843.00	816	$50,957.00	$15,601.00
Jul	7,329	$270,897.02	$101,523.00	613	$34,432.00	$0.00
Aug	5,390	$262,129.00	$83,277.00	725	$41,114.00	$0.00
Sep	4,589	$183,729.00	$39,947.00			
Oct	4,220	$152,943.00	$34,986.00			
Nov	4,933	$327,424.00	$38,055.00			
Dec	7,050	$314,061.00	$21,161.00			
Total	**62,615**	**$2,879,125.00**	**$506,254.42**	**16,567**	**$641,540.00**	**$45,546.00**

As is evident through a comparison between years, labour costs for COVID-19 response and immunization overall have decreased from 2021 to 2022. As described in **Section 2.1**, this is due to a shift in our approach to the pandemic response and the associated change in work.

COVID-19 will continue to challenge our communities and the work of public health moving forward, requiring resources for response and immunization that exceed current mandatory program funding.

However, resources are also needed to minimize further disruption to core public health programs to respond to the many community health priorities that have arisen due to the pandemic and prolonged suspension of non-highest risk health promotion and protection efforts.

Recovery from the pandemic, as a public health unit and broader community, is a complex process[19] and will take several years.[21] As per APH's recovery framework and aligned priorities described above,

[21] Baird, M. (2010). The recovery phase of emergency management: Background paper. Retrieved from https://www.memphis.edu/ifti/pdfs/cait_recovery_phase.pdf

recovery will also require appropriate resourcing to address the impacts of the pandemic on our agency and population health.

Due to direction by the Ministry that prohibits the expensing of COVID-19 recovery work to COVID-19 response and COVID-19 vaccine extraordinary cost, and lack of commitment to dollars for COVID-19 recovery, the costs to revitalize, routinize, restore, and rebuild as part of recovery must be absorbed by mandatory program budgets, limiting our ability to efficiently recover from the pandemic.

As such, response and recovery considerations have influenced 2023 budget assumptions.

2.4 Challenges with Public Health Human Resource Recruitment in the North

Significant and longstanding challenges with recruitment of skilled public health professionals in Northern Ontario remain, similar to the unique human resource challenges of the health care sector in the north. These challenges are visible in a summary of APH recruitment for 2022, and were reflected in the recommended 2023 budget that assumes a corresponding vacancy rate and the minimum finances required to sustain our local public health workforce.

2.4.1 Summary of APH Recruitment in 2022

A snapshot of 2022 health human resource recruitment indicators is provided below.

From January – October 5, 2022:

- Five (5) new permanent full-time and nine (9) new temporary employees have filled vacant positions.
- Nine (9) temporary staff hired in 2020/2021 were awarded permanent full time positions.
- Fourteen (14) permanent full time employees were successful candidate for other permanent full-time positions (e.g. in another program, leadership, or new position).
- Nine (9) permanent and nine (9) temporary positions remain vacant, for a total of 18 position vacancies.

Persistent challenges to recruitment in public health have included:

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

The 18 positions remaining vacant as of October 5, 2022 demonstrate the challenge with recruitment of highly skilled health professionals in local public health in the north. The total vacancies (18) at APH result in an 11.04% vacancy rate.[22]

Limitations to One-Time Funding

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. [23]

For example, one-time funding is only able to support temporary positions, which are challenging to fill as they do not provide the job security needed for a highly skilled public health professional to relocate to Northern Ontario.

[22] Based on the total employee FTE budgeted for 2022 (n=163).
[23] Queen, et al. (2021). Threats, resignations and 100 new laws: Why public health is in crisis. *New York Times*. Retrieved from https://www.nytimes.com/2021/10/18/us/coronavirus-public-health.html

As a result of ongoing vacancies and challenges with recruitment, recruiting for existing vacancies in these necessary positions is a priority to ensure adequate, sustainable FTE to routinize COVID-19 response and immunization, as well as restore mandatory public health programs and services.

Strengthening Local Public Health Human Resources and Building Capacity for the Long-Term

In addition to combatting the COVID-19 pandemic and other public health emergencies (e.g. St. Marys River oil spill in June 2022), a strong local public health unit protects health and prevents illness every day.[24] To recover and be prepared for future public health crises, strategic and sustainable investment to recruit a full complement of qualified, permanent public health employees is needed.[24]

Without sustainable increases to provincial base funding to strengthen the local public health workforce for the long-term, with strategies for recruitment that align to Northern Ontario, APH will be unable to sustain COVID-19 response and immunization while simultaneously restoring mandated public health programming to meet the needs of our communities and prepare for future health crises in a timely manner.

Therefore, investment and advocacy are needed by the Board of Health for sustainable, annual provincial base funding for public health and a Northern Ontario public health human resource strategy.

2.4.2 Focused Recruitment Efforts for Public Health Inspectors

APH has experienced the greatest challenges with recruitment of certified public health inspectors (PHIs), an issue shared among northern public health units. A scan on September 29th, 2022 indicated that **18 PHI postings** were published across APH, North Bay, Sudbury, Timiskaming, North Western, and Porcupine health units.

PHIs working within the Infectious Diseases and Environmental Health programs have had a leading role in COVID-19 response, specifically with IPAC, outbreak management and application and enforcement of the *Reopening Ontario Act*.[6] Outside of COVID-19, PHIs routinely evaluate and monitor health and safety hazards and implement progressive and innovative approaches to control risks and ensure compliance with government regulations that keep us safe.[25, 26]

For context, Jobs Canada had 40 positions for inspectors in public and environmental health and occupational health and safety posted in Q1 for 2022 for the north region of Ontario, with the region over-represented in the total number of postings.[25]

At APH, from 2020 to 2022, the number of PHI vacancies has increased, as shown in **Table 4.0**.

Table 4: APH Public Health Inspector Recruitment Summary, 2019 – 2022

APH Office	Public Health Inspector Postings/Vacancies	2019	2020	2021	2022
Sault Ste. Marie	Temporary Full-Time	1 (0)	-	3 (2)	2 (2)
	Permanent Full-Time	2 (0)	3	-	2 (1)
Blind River	Temporary Full-Time	-	-	-	-
	Permanent Full-Time	-	-	1(1)	1 (1)
Elliot Lake	Temporary Full-Time	-	-	-	-
	Permanent Full-Time	1 (0)	2 (1)	1 (1)	1 (1)
Wawa	Temporary Full-Time	-	-	-	-
	Permanent Full-Time	1 (0)	-	-	-
Total Positions (Total Remaining Vacant)		**5 (0)**	**5 (1)**	**5(4)**	**6(5)**

Note:
- The values in brackets indicate the number of PHI positions remaining unfilled at end of year.
- Postings for vacancies have been reposted, or remained posted until filled. In 2021, there were a total of 8 PHI postings, including the 3 SSM positions and multiple reposting of 2 district PHI positions.

[24] Ontario Medical Association. (2021). Prescription for Ontario: Doctors' 5-point plan for better health care. Retrieved from https://www.oma.org/uploadedfiles/oma/media/public/prescription-for-ontario-doctors-5-point-plan-for-better-health-care.pdf
[25] Ministry of Labour, Immigration, Training and Skills Development. (2019). Inspectors in public and environmental health and occupational health and safety, NOC 2263.
[26] Algoma Public Health. (2022). Public health inspector. *Internal job posting*.

Barriers to recruitment of PHIs have included:

- Increased available positions in private industry, government, and IPAC during the pandemic;
- Limited practicum opportunities across PHUs during the pandemic due staff workloads and reduced mentorship, a requirement as part of the certification process, resulting in a backlog of graduates without practicum completion; and
- Geographic barriers, such as proximity to amenities, proximity to family, and lack of suitable employment for their partners.

APH will be developing a short and long-term local recruitment strategy, which includes:

- Posting available positions to professional association pages (e.g. alPHA, CIPHI), public career pages (e.g. SooToday, Indeed), and university career pages for graduating students and alumni (e.g. Toronto Metropolitan University, Conestoga),
- Attending job/career fairs and hosting information sessions for graduating classes (high school and post-secondary), and
- Directly forwarding information to current students through professors at universities with an accredited program.

Longstanding vacancies, despite recruitment efforts, have supported the need for local public health investment in PHI recruitment efforts, and advocacy for a broader PHI-recruitment strategy for the north.

3. 2023 Budget Financial Assumptions

Given the unknowns, a number of assumptions were required to base the 2023 estimated expenses. They are as follows:

- The Ministry 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 2022, with **0% growth in base funding for mandatory programs**. The 1.0% increase over 2022 budget applied to the province's portion of jointly funded programs is based on the funding increase allocated for the 2022 operating year, which was applied pro-rated for the months of April through December in 2022.
- Continuation of one-time mitigation funding of $1,037,800 is also assumed, which is consistent with approved funding for 2020 through 2022.
- As per the 2022 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 funding year, APH was allocated 100% funding for the OSDCP program in the amount of $1,252,900 to support ongoing pressures identified in this program (increased from $697,900 in 2021). For the 2023 budget, the Executive Team assumed that 100% provincial funding for the OSDCP program will remain to meet program needs in the coming year.
- No increase to the total municipal levy rate applied by the District of Algoma Health Unit.
- COVID-19 response and immunization incremental costs are estimated at $1,078,089 for 2023. As the Ministry has indicated a commitment to fund COVID-19 extraordinary expenses in 2023, it is assumed these costs will be reimbursed by the province.

  For comparison, 2022 allocations from the Ministry include $2,210,400 in funding for COVID-19 extraordinary expenses. As of June 30, 2022, 2022 forecasted incremental costs are $2,945,487, which the Ministry has indicated will be eligible for reimbursement based on ongoing quarterly submissions.

- No additional funding will be provided by the Ministry to fund COVID-19 Recovery initiatives. These anticipated costs will be managed within mandatory program base funding, impacting the restoration of programs and services as public health continues with pandemic response, addresses the backlog of programs and services suspended during the pandemic, and works to rebuild public health to identify and address population health priorities.
- Assumptions related to staffing are as follows:
    - A vacancy factor of 3% has been incorporated into overall salaries, wages and benefits ($446,000).

      For comparison purposes, and as driven largely by competitive labour markets and small labour pools, the actual vacancy rate in 2021 and year to date in 2022 is estimated to range between 7% and 11%.
    - A 1.5% wage increase for all staff.
- Fixed non-salary budgeted costs related to facilities, such as utilities and service contracts, have been estimated based on historical data, current contract rates, and assumed inflationary rates with a combined year over year increase of 2% over the 2022 approved budget. A contingency representing 6% of the fixed cost budget has been factored to support unforeseen necessary costs.
- 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, and foreseeably those planned for 2023.
- 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 OPHS[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., challenging fall respiratory season coupled with COVID-19, surge of COVID-19, new variants of concern, expanded eligibility for booster doses, etc.), while planning for ongoing and future public health challenges, as part of COVID-19 recovery and rebuilding.

4. 2022 Grant Approval

The 2022 Ministry Program Based Grant approval was received and last revised as of May 2022.

- APH was allocated a 1% increase to the Mandatory Cost-Shared Program base funding for total 2022 funding of $8,795,200, increased from $8,708,100 in 2021. The 1% increase for 2022 was pro-rated for the months of April through December, resulting in the true funding allocation for 2022 to be $8,773,425.
- The grant allocation for the 100% provincial funding for Unorganized Territories/Mandatory Programs ($530,400), Unorganized Territories/ Indigenous Communities Program ($98,000) and the Unorganized Territories/Northern Fruit and Vegetable Program ($117,400) remained unchanged.
- The OSDCP was allocated an additional $555,000 above 2021 funding levels based on current and ongoing pressures identified in this program. 2022 funding levels are allocated at $1,252,900, increased from $697,900 in 2021.
- The MOH/AMOH compensation initiative will continue to 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 2023 Budget

6.1 Operating Revenue

The 2023 operating revenues include Ministry funding for mandatory programs (historically cost shared), Ministry funding for other related programs (historically 100% provincially funded), Ministry Unorganized Territories funding, municipal funding by 21 municipalities, and interest and user fees. The recommended municipal funding has remained unchanged from 2022. There is also no change in Unorganized Territories funding.

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.[27]

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. [27]

As part of the recommended 2023 Operating & Capital Budget, the Executive Team is recommending no change in the total municipal levy from obligated municipalities within the District of Algoma Health Unit. Although total municipal funding will remain unchanged from 2022, rates apportioned among the 21 municipalities within Algoma have been updated to reflect current population counts per the 2021 Census Profile issued by Statistics Canada[28] (see **Appendix A**).

For context, **Table 5.0** illustrates historical changes in municipal levy rates from 2012 – 2023 (recommended).

[27] Government of Ontario. (2021). Health protection and promotion act, R.S.O. 1990, c.H7. Retrieved from https://www.ontario.ca/laws/statute/90h07
[28] Statistics Canada. (2022). Census profile, 2021 census of population. Retrieved from https://www12.statcan.gc.ca/census-recensement/2021/dp-pd/prof/index.cfm?Lang=E

Table 5.0: APH Historical Approved Levy Increase, 2012 – 2023 (Recommended)

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%
2023	**0.00% (Budgeted)**

As evidenced through 'the work,' or programs and services provided by public health, municipalities and social sectors across Algoma receive 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 2022, the cost per capita in Algoma for public health services and programs was **$35.58/person, when converted to 2018 MPAC (or $40.23 when using 2016 Census)**.

For the recommended 2023 budget, cost per capita was updated based on population counts from the 2021 Census Profile by Statistics Canada.[28] Incorporating the updated population counts results in a slight increase to the forecasted 2023 cost per capita, **estimated at $40.44 per person**. 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 2022, APH's per capita rate ranked 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. Due to the early presentation of the 2023 recommended budget to the Board of Health, updated per capita rates for 2022/2023 were unable to be collected from northern PHUs.

For context, the Board of Health has experienced the historical growth shown in **Table 6.0** from 2018 – 2023 (recommended) with respect to the rate of public health per capita in Algoma.

Table 6.0: APH Historical Approved per Capita Rates, 2018 – 2023

Year	Approved Rate
2018	$33.63
2019	$33.80
2020	$34.18
2021	$36.57
2022	$40.23
2023	**40.44 (Budgeted)**

The recommended levy rate for 2023 correlates to a per capita rate of $40.44/person, which continues to rank in the middle of northern health units when compared to northern per capita rates shared in fall 2021.

Therefore, when reviewing the cost of public health per capital, alongside the work by public health and projected work to recover from the pandemic and support community health and wellbeing, the 21

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

6.2 Expenditures

As compared to the 2022 forecast, the 4.82% overall budget decrease is comprised of the following:

Salary cost decrease	2.80%
Benefit cost decrease	0.58%
Operating cost decrease	1.44%
Overall Decrease	**4.82%**

In other words, of the 4.82% or $898,477 decrease in the 2023 budget, salaries and benefits represent about 70% of the decrease (2.80% and 0.58% respectively of the 4.82% decrease), while operating cost decreases make up about 30% of the overall decrease (1.44% of the 4.82% decrease).

6.2.1 Salary and Benefit Changes

The 2023 expenditure comparisons with 2022 were made using the 2022 forecasted values (see **Table 1.0**). As compared with 2022, the salary and benefit budget lines reflect a decrease of 4.65% and a decrease of 4.18%, respectively:

- **Salary:** As compared to 2022, salaries show a decrease of $521,323 or 4.65%. The decrease represents staffing that was identified in the 2022 operating budget for COVID-19 response and immunization that is not anticipated to be needed in 2023 (e.g. dedicated COVID-19 phone line staffing support, significant roster of casual immunizers for COVID-19 mass immunization clinics).

  The recommended operating revenue for cost shared public health programs for 2023 would support filling all current vacant permanent positions and temporary replacement for approved unpaid leave of absences (e.g. temporary filling of a permanent FTE's leave for pregnancy/parental leave).

  The salary amount includes a nominal annual increase, staff movement along salary grid, and an assumed 3% vacancy factor.

- **Benefits:** As compared to 2022, benefits show a decrease of $109,582 or 4.18%. Historical utilization is factored heavily in the projection of the rates, in addition to the normal market fluctuations.

6.2.2 Operating Expenditure Changes

As compared with the restated 2022 budget or 2022 forecast, the 2023 recommended budget reflects an overall decrease of 4.82% ($898,477).

Operating expenditures have been budgeted by the Executive Team with consideration of both historical pre-pandemic and pandemic spend levels, with the assumption that regular program activities will be recovering in 2023, albeit not yet at full capacity as we continue to plan for population health recovery and address the backlog of services resulting from the suspension of non-highest risk programs to prioritize pandemic response.

Expenditure lines with significant changes are detailed below, following the order of appearance in the budget summary (**Table 1.0**):

- **Travel:** The decrease in travel relates to the expectation that there will be reduced travel throughout the district to support the staffing of COVID-19 initiatives and clinics. Although travel will be required for routine program work, it will remain at reduced capacity when compared to pre-pandemic levels, recognizing the continued use of virtual platforms for distance meetings and that routine program work is not expected to be fully restored to pre-pandemic levels in 2023.
- **Program expenses:** Program expenses for 2023 are budgeted at a nominal decrease from 2022. Although there is anticipated significant savings with regard to program spend for the COVID-19

Response and Immunization programs, these savings are directly offset by increased program spend driven by increase funding in our OSDCP program.

Program expenses include general program materials and supplies, purchased services, and professional fees (e.g. physician and/or denture service fees).

- **Office:** The projected increase in office expenses in 2023 is based on the expectation that the majority of staff will have returned to in-office work for the duration of the year, as per the return-to-office-work program, therefore increase purchasing of general office supplies.
- **Telecommunications:** The decrease in telecommunications expenses is driven by efficiencies to be introduced with migration to a new phone system.
- **Program promotion:** The decrease in program promotion is largely driven by a reduction of media spend budgeted to the COVID-19 response and immunization programs. As we enter the recovery phase of the pandemic, it is anticipated that COVID-19 will be routinized into mandatory public health programming and will no longer require public promotion or communication at the levels experienced during the height of the pandemic.

  In addition, with work to first address the backlog of public health programs and services, it is unlikely the programs will fully recover in 2023 based on limited resources and readiness, internally and externally. Hence, program promotion and related expenses will not yet reflect pre-pandemic periods.
- **Facilities Leases:** The increase in facilities leases is driven by lease renewals at one of our district offices, as well as a term renewals at our remaining two district offices.
- **Building maintenance:** The decrease in building maintenance relates to significantly reduced needs for security and janitorial services related to the COVID-19 pandemic for APH facilities and clinics. Needs for these services continue to decline as the demand for external immunization clinics reduces and community restrictions loosen.
- **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 2023 is due to the divestment of the Infant Child Development Program and Preschool Speech and Language community programs at March 31, 2022.

7. Capital Budget

In accordance with APH's 2018-2030 Capital Asset Funding Plan (**Appendix B**), the 2023 capital budget was forecasted to include $25,000 for computer replacements and $50,000 for a new truck for use in the land control program.

Due to significant investment in computer equipment necessary during the COVID 19 pandemic and assessment of the current condition of the APH truck, these needs are no longer considered necessary.

Instead, the Executive Team is recommending a 2023 capital budget estimated at $265,000, which includes the following expenditures:

- Upgrade of network servers that house and run agency applications and store data. This expense was originally forecasted to be completed in 2022, however due to supply chain issues has not yet

been completed ($200,000).

- Upgrade of the tape backup, which is used to ensure backup of agency wide applications and data in the event of a hardware failure or data corruption on the servers ($65,000).

Both of the above mentioned items are out of warranty and are no longer supported for the latest security and software updates that are required to ensure systems are as secure as possible and able to efficiently and effectively turn around any down time experienced.

8. Conclusions

The recommended 2023 budget for public health programs and services is $17,740,689, representing a decrease of $898,477 over 2022 anticipated funding. At a 4.82% decrease over previous, the recommended budget is the minimum required to maintain COVID-19 response and immunization programming, as is expected by the Ministry, alongside early efforts in COVID-19 recovery to revitalize the public health workforce, restore public health programs and services as mandated by the *Ontario Public Health Standards*[1], and rebuild public health.

Appendix A

Annual Municipal Levy Comparison, 2018 to Proposed 2023

2023 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 Approved Rate	2022 Approved Levy	POP 2021 Census*	Net Change to Census Population	2023 Proposed Rate	2023 Proposed Levy	Appointment of Costs	Proposed Net Change
													-						
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	72,051	(1,317)	40.44	2,913,655	69.55%	(38,069)
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	11,372	631	40.44	459,870	10.98%	27,733
													-						
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	3,422	(50)	40.44	138,382	3.30%	(1,303)
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	582	-	40.44	23,535	0.56%	121
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	1,260	(26)	40.44	50,953	1.22%	(785)
													-						
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	198	27	40.44	8,007	0.19%	1,127
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	1,860	196	40.44	75,216	1.80%	8,271
													-						
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	576	(37)	40.44	23,293	0.56%	(1,369)
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	314	1	40.44	12,698	0.30%	105
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	749	(2)	40.44	30,289	0.72%	75
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	382	75	40.44	15,448	0.37%	3,097
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	1,121	74	40.44	45,332	1.08%	3,210
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	1,513	(96)	40.44	61,184	1.46%	(3,549)
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	2,705	(200)	40.44	109,387	2.61%	(7,485)
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	531	34	40.44	21,473	0.51%	1,478
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	757	97	40.44	30,612	0.73%	4,059
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	975	(35)	40.44	39,428	0.94%	(1,206)
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	1,426	186	40.44	57,666	1.38%	7,779
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	670	(42)	40.44	27,094	0.65%	(1,551)
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	573	39	40.44	23,171	0.55%	1,687
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	557	(88)	40.44	22,524	0.54%	(3,425)
Total	**104,127**		**3,502,180**		**3,519,691**		**3,788,497**		**3,559,232**		**3,808,378**		**4,189,216**	**103,594**	**(533)**		**4,189,216**	**100%**	**0**
YOY % Increase			**0.50%**		**0.50%**		**7.64%**		**1.12%**		**7.00%**		**10.00%**				**0.00%**		

Notes:
* For Budget 2023, population rates have been updated from the 2021 CENSUS.
Statistics Canada. (2022). Census profile, 2021 census of population. Retrieved from https://www12.statcan.gc.ca/census-recensement/2021/dp-pd/prof/index.cfm?Lang=E

Appendix B

2018-2030 APH Capital Asset Funding Plan

See subsequent document.

Algoma
PUBLIC HEALTH
Santé publique Algoma

Algoma Public Health

2018 - 2030 Capital Asset Funding Plan

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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.

Algoma
PUBLIC HEALTH
Santé publique Algoma

Blind River
9 Lawton Street

Elliot Lake
302 - 31 Nova Scotia Walk
(ELNOS Building)

Sault Ste. Marie
294 Willow Avenue

Wawa
18 Ganley St.

www.algomapublichealth.com

@algomahealth