The Regional Municipality of Durham

Health & Social Services Committee Agenda

Council Chambers
Regional Headquarters Building
605 Rossland Road East, Whitby

Thursday, April 7, 2022 **9:30 AM**

Please note: In an effort to help mitigate the spread of COVID-19, and to generally comply with the directions from the Government of Ontario, it is requested in the strongest terms that Members participate in the meeting electronically. Regional Headquarters is closed to the public, all members of the public may view the Committee meeting via live streaming, instead of attending the meeting in person. If you wish to register as a delegate regarding an agenda item, you may register in advance of the meeting by noon on the day prior to the meeting by emailing delegations@durham.ca and will be provided with the details to delegate electronically.

1. Roll Call

2. Declarations of Interest

3. Adoption of Minutes

A) Health & Social Services Committee meeting – March 3, 2022 Pages 4 - 10

4. Statutory Public Meetings

There are no statutory public meetings

5. Delegations

There are no delegations

6. Presentations

6.1 Alan Robins, Director, Housing Services, re: 2021 Durham Access to Social Housing (DASH) Wait List Statistics and Critical Priority (2022-SS-3) [Item 8.2 A)]

6.2 Dr. R.J. Kyle, Commissioner and Medical Officer of Health, re: COVID-19 Update

7. Health

7.1 Correspondence

7.2 Reports

A) Provincial Policy Framework for Community Paramedicine (2022-MOH-3) 11 - 34

8. Social Services

8.1 Correspondence

8.2 Reports

A) 2021 Durham Access to Social Housing (DASH) Wait List Statistics and Critical Priority (2022-SS-3) 35 - 41

B) Canada-Ontario Community Housing Initiative (COCHI) Program 2021-2022 Take-up Plan (2022-SS-4) 42 - 46

9. Advisory Committee Resolutions

There are no advisory committee resolutions to be considered

10. Confidential Matters

10.1 Reports

A) Confidential Report of the Commissioner of Social Services – Closed Matter with respect to information explicitly supplied in confidence to the municipality or local board by Canada, a province or territory or a Crown agency of any of them, regarding Capital Projects Submitted under the Ontario Priorities Housing Initiative (OPHI) (2022-SS-5) Under Separate Cover

11. Other Business

12. Date of Next Meeting

Thursday, May 5, 2022 at 9:30 AM

13. Adjournment

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The Regional Municipality of Durham

MINUTES

HEALTH & SOCIAL SERVICES COMMITTEE

Thursday, March 3, 2022

A regular meeting of the Health & Social Services Committee was held on Thursday, March 3, 2022 in the Council Chambers, Regional Headquarters Building, 605 Rossland Road East, Whitby, Ontario at 9:30 AM. Electronic participation was offered for this meeting.

1. Roll Call

Present: Councillor Chapman, Chair
Councillor Pickles, Vice-Chair
Councillor Carter
Councillor Dies
Councillor Roy
Regional Chair Henry
***all members of the Committee participated electronically**

Also Present: Councillor Highet
Councillor Smith

Absent: Councillor Anderson
Councillor Wotten

Staff Present: E. Baxter-Trahair, Chief Administrative Officer
S. Danos-Papaconstantinou, Commissioner of Social Services
J. Gaskin, Manager, Wage Subsidy, Children's Services, Social Services
R. Inacio, Systems Support Specialist, Corporate Services – IT
R.J. Kyle, Commissioner and Medical Officer of Health
L. McIntosh, Director, Children's Services, Social Services
T. Fraser, Committee Clerk, Corporate Services – Legislative Services
K. Smith, Committee Clerk, Corporate Services – Legislative Services
***all staff except R. Inacio participated electronically**

2. Declarations of Interest

There were no declarations of interest.

3. Adoption of Minutes

Moved by Councillor Pickles, Seconded by Councillor Carter,
(8) That the minutes of the regular Health & Social Services Committee meeting held on Thursday, February 3, 2022, be adopted.
CARRIED

4. Statutory Public Meetings

There were no statutory public meetings.

5. Delegations

5.1 Rev. Christopher White, Co-Chair, and Ben Earle, Co-Chair, Spirit of Service Sponsorship Program, re: Request for Funding

Rev. Christopher White, Co-Chair and Ben Earle, Co-Chair, Spirit of Service Sponsorship Program provided a delegation with regards to a Request for Funding.

Rev. White advised that the Spirit of Service Homeless Sponsorship Program began originally as an initiative by Mayor Carter to bring faith communities and social service agencies together to help reduce poverty in Oshawa. He stated that the pilot project is now in its second year and has sponsored five individuals. He indicated that the anchor organization is Carea Community Health Centre.

Rev. White stated that the program has been very challenging and successful, and the key has been the community surrounding the individuals. He also stated that the complexity of individuals is different then the complexity of refugees which they had previously sponsored, and they must use a different model to engage and help those individuals to move forward. He advised that their request for funding is to allow for more sponsors and participants to expand their program.

B. Earle advised that their current funding has been from donations from their faith community, grants received, and the administrative support from Carea. He also advised the program has been supported by in-kind contributions from the organizations around the executive table such as Community at Kedron and Feed the Need in Durham.

B. Earle advised that he is one of six members of the executive committee and steering committee and has spent approximately 500 hours on behalf of Feed the Need in Durham. He also advised that they require financial support as well as the support of organizations and stated that having the support of Carea is vital to this program continuing.

B. Earle stated that the program provides financial support to individuals, such as rent supplement, which is slowly decreased throughout the program until individuals become sustainable and independent as they move to exit the program.

Rev. White and B. Earle responded to questions of the Committee.

Councillor Carter requested that correspondence received from Rev. White and B. Earle be provided to members of the Committee.

Moved by Councillor Carter, Seconded by Councillor Roy,
(9) That the delegation meet with staff to discuss the matter further and that staff report back to Committee.

CARRIED

6. Presentations

6.1 R.J. Kyle, Commissioner and Medical Officer of Health, re: COVID-19 Update

Dr. Kyle, Commissioner and Medical Officer of Health provided a PowerPoint Presentation with regards to the COVID-19 Update. A copy of the presentation material was provided to members in advance of the meeting.

Highlights from the presentation included:

- Current Status
- COVID-19 Vaccination Administration
- COVID-19 Vaccine by Administration Site
- COVID-19 Vaccination Coverage
- School and Childcare Absenteeism
- Wastewater Surveillance
- Easing Public Health Restrictions
- Education and Enforcement Activities
- Current COVID-19 Vaccine Plan

R.J. Kyle stated that we are currently in the fifth wave of the pandemic and that lab confirmed cases have gone down. He also stated that COVID-19 cases are continuing and there is a slight uptake currently. He advised that over the coming weeks, the information on the data tracker will be streamlined and will move from daily updates, to thrice weekly updates, and then to weekly updates.

R.J. Kyle advised that the number of hospitalization cases and ICU admissions has continued to decrease over the last couple of weeks. He advised there are currently 454 active cases in Durham Region, and the number of deaths is just under 400. He also advised that the number of outbreaks continues to decline and there are currently 4 outbreaks at this time.

R.J. Kyle stated that Durham Region has administered over 1.4 million doses of COVID-19 vaccines. He also stated that vaccine coverage for those aged 12 and

up for the first dose is at 89%, second dose is at 87%, and third dose is at 51%. R.J. Kyle advised there is higher vaccine coverage with increasing age.

R.J. Kyle advised that school and childcare absenteeism is staying low with childcare absenteeism at 4.6%, elementary school absenteeism at 2.9%, and secondary school absenteeism at 2.8%, and no schools have had to close due to operational issues.

R.J. Kyle advised that the wastewater surveillance signal strength is medium at all 7 sampling sites and indicated the trend is either stable or decreasing. He also advised that wastewater surveillance is a proxy for what is going on in the community.

R.J. Kyle stated that effective March 1, 2022, the Province has entered the reopening exit step which has lifted capacity limits in all settings and lifted proof of vaccination requirements. He advised that the Ontario Roadmap Exit Step guidance document has been posted to Durham Region's COVID-19 guidance page.

R.J. Kyle advised that all residents five years and older are eligible to be vaccinated. He also advised that the Health Department continues to host school vaccination clinics for children five to 11 years old and indicated there have been 81 school clinics held with 952 doses administered. R.J. Kyle advised youth 12 to 17 years old are eligible to receive a third dose 168 days following completion of their primary series.

R.J. Kyle responded to questions regarding the school boards covered by the Durham Region Health Department; and the availability of transit to mass immunization clinics.

7. Health

7.1 Correspondence

There were no communications to consider.

7.2 Reports

A) Amending By-laws 18-98 and 19-98 to Update Fees for Health Protection Regional Activities and Ontario Building Code Activities (2022-MOH-2)

Report #2022-MOH-2 from R.J. Kyle, Commissioner and Medical Officer of Health, was received.

Moved by Councillor Roy, Seconded by Councillor Carter,
(10) That we recommend to Council:

A) That a by-law, generally in the form included as Attachment #1 to Report #2022-MOH-2 of the Commissioner and Medical Officer of Health, that amends Regional By-law 18-98 (as amended by By-laws 14-2007, 01-2016 and 16-2019), which establishes a tariff of fees on applications for and issuance of permits under the Building Code Act, 1992, effective April 1, 2022, be approved; and

B) That a by-law, generally in the form included as Attachment #2 to Report #2022-MOH-2, that amends Regional By-law 19-98 (as amended by By-laws 31-98, 15-2007, 02-2016 and 17-2019), which establishes a tariff of fees and charges for certain services provided by the Health Department, under the Planning Act, effective April 1, 2022, be approved.

CARRIED

Questions to Health

R.J. Kyle responded to questions regarding inspections and health requirements for food vendors at the Sunderland Maple Syrup Festival.

8. Social Services

8.1 Correspondence

A) Correspondence form Mary Medeiros, City Clerk, City of Oshawa, re: Regional Municipality of Durham's Built for Zero Monthly Report Card

Moved by Councillor Carter, Seconded by Councillor Dies,
(11) That Correspondence from Mary Medeiros, City Clerk, City of Oshawa, re: Regional Municipality of Durham's Built for Zero Monthly Report Card be referred to staff.

CARRIED

8.2 Reports

A) Community Housing Projects in Difficulty as at December 31, 2021 (2022-SS-2)

Report #2022-SS-2 from S. Danos-Papaconstantinou, Commissioner of Social Services, was received.

Moved by Councillor Roy, Seconded by Councillor Carter,
(12) That Report #2022-SS-2 of the Commissioner of Social Services be received for information.

CARRIED

Questions to Social Services

S. Danos-Papaconstantinou advised that on March 2, 2022, Regional Chair Henry was joined by Minister Hussen and MP Ryan Turnbull to announce the $4 million rapid housing initiative funding that Durham Region is receiving in partnership with the Federal government and Canadian Mortgage and Housing Corporation. She advised that the funding is intended to build 36 new affordable housing units in Oshawa and Whitby, and that $2.8 million will go to 26 units at the Muslim Welfare Home and $1.2 million will go to 10 units for the Oshawa microhomes. S. Danos-Papaconstantinou thanked her team for their work in preparing the proposals.

S. Danos-Papaconstantinou responded to questions regarding funding for the micro homes in Oshawa; micro home communities being developed in other municipalities in Durham Region; and the partnership with North House regarding service hubs in Brock.

9. Advisory Committee Resolutions

There were no advisory committee resolutions to be considered.

10. Confidential Matters

There were no confidential matters to be considered.

11. Other Business

There was no other business to be considered.

12. Date of Next Meeting

The next regularly scheduled Health & Social Services Committee meeting will be held on Thursday, April 7, 2022 at 9:30 AM in the Council Chambers, Regional Headquarters Building, 605 Rossland Road East, Whitby.

13. Adjournment

Moved by Councillor Pickles, Seconded by Regional Chair Henry,
(13) That the meeting be adjourned.
CARRIED

The meeting adjourned at 10:21 AM

Respectfully submitted,

B. Chapman, Chair

K. Smith, Committee Clerk

If this information is required in an accessible format, please contact 1-800-372-1102 ext. 3111

The Regional Municipality of Durham Report

To:	Health & Social Services Committee
From:	Commissioner & Medical Officer of Health
Report:	#2022-MOH-3
Date:	April 7, 2022

Subject:

Provincial Policy Framework for Community Paramedicine

Recommendation:

That the Health & Social Services Committee recommends to Regional Council:

A) That in alignment with advocacy efforts by the Association of Municipalities of Ontario (AMO) and the Ontario Association of Paramedic Chiefs (OAPC), the Region of Durham advocates for the provincial government to introduce legislative measures to formalize community paramedicine, and provide full and sustained provincial funding to municipalities for community paramedicine programs;

B) That a letter from the Regional Chair on behalf of Regional Council, along with a copy of this report from the Commissioner & Medical Officer of Health be sent to the Minister of Health, Minister of Long-Term Care, all Durham MPPs, AMO, and OAPC, for their information and consideration.

Report:

1. Purpose

1.1 The purpose of this report is to provide details and seek Regional Council approval for the Region of Durham to join AMO, the OAPC, and other upper-tier municipalities in advocating for provincial legislative measures to formalize community paramedicine (CP), and for the provincial government to provide full and sustained provincial funding to municipalities for CP programs.

2. Background

2.1 On October 22, 2021 Rod Phillips, Minister of Long-Term Care attended Region of Durham Paramedic Services (RDPS) Headquarters to announce that the provincial government is expanding the Community Paramedicine program from the current

33 locations and adding 22 more. RDPS is included in these new locations. The Ministry of Long-Term Care (MLTC) has committed to provide funding of $7.5 million over the next three years to RDPS for delivery of CP services. This funding was to enhance and expand the existing Community Paramedicine program that is funded by Ontario Health under the High Intensity Supports at Home (HISH) program.

2.2 The RDPS Community Paramedicine program, like CP programs operated by other municipal paramedic services, has been implemented to help ease pressures on hospitals, community care, paramedic call volumes, and long-term care home waitlists.

2.3 There is growing evidence regarding the effectiveness of CP programs. Evidence shows that these programs are nimble and adaptable and continue to make valuable contributions to local health systems and to health system transformation in Ontario.

2.4 While CP programs leverage paramedics' training and capabilities in delivering 9-1-1 ambulance response, these programs operate entirely outside of the provisions in the *Ambulance Act* and have no legislative framework overseeing their delivery. As previously noted, the Ontario Ministry of Health (MOH) oversees paramedic services, but most provincial CP funding is currently provided through the MLTC. Despite their widespread adoption and proven effectiveness, CP programs remain funded by both the MLTC and the MOH (through Ontario Health) as time-limited pilot programs that have no sustainable, predictable, and permanent provincial funding.

3. Advocacy to Enhance CP Programs

3.1 In 2021, AMO and OAPC released a joint position paper that raised important questions for municipalities operating CP programs. This position paper has served as the basis for ongoing advocacy in the sector to recognize the successful contributions of CP programs, and immediately move forward with: a) a legislative framework for CP; b) standardized medical oversight; and c) sustainable funding.

a. Legislative Framework

Municipalities need the provincial government to establish a legislative framework for CP programs. Amendments to the *Ambulance Act* or new legislation are required to define the scope of practice, competencies, and qualifications for CP paramedics, and to address gaps and risks regarding clinical practice, quality management, privacy and liability for paramedics and municipalities. Despite years of expanded CP programming and provincial funding, Ontario lacks both policy and legal frameworks for CP, like those in place for 9-1-1 ambulance response through the *Ambulance Act* and regulations.

b. Standardized Medical Oversight

The provincial government should create a province-wide system for medical delegation for CP paramedics through self-regulation for paramedics under the *Regulated Health Professions Act, 1991*. In the interim, regional medical advisory councils and standardized ministry-approved guidelines for adoption by all paramedic services would standardize medical oversight for CP programs. Medical direction through base hospital programs for 9-1-1 ambulance response is not appropriate or funded to support CP.

c. Sustainable Provincial Funding

The provincial government must recognize and fully fund CP programs, based on the principles that: (1) programs contribute to delivering primary care in the community, and (2) municipalities should not be at risk of funding CP programs, in addition to mandatory funding for 9-1-1 ambulance response, and public health.

3.2 A copy of the joint position paper "Community Paramedicine Policy Framework" is included as Attachment #1. The RDPS Chief has been engaged in development of the joint position paper and in ongoing discussions with provincial leadership on its recommendations.

4. Implications for Durham

4.1 While paramedic services continue to operate successful CP programs, the issues raised by AMO and the OAPC have implications for the Region of Durham and the continued evolution of programming to meet the needs of Durham residents.

4.2 RDPS continued expansion of CP programs needs the clarity and certainty provided by a legislative framework that establishes provincial and municipal roles and responsibilities with respect to CP programs. The lack of formal and consistent regulation (including standardized medical oversight) is rare within the health sector and creates a level of uncertainty for municipalities that are expected to assume new responsibilities for CP. While RDPS has built capacity to manage without a policy framework and has strong clinical oversight measures in place, the AMO and the OAPC recommendations for a legislated framework for CP would provide needed clarity for municipalities at a time when programs are expanding throughout Ontario.

4.3 A lack of predictable and sustainable provincial funding from multiple provincial sources has been a challenge for RDPS when required to ramp-up and wind-down CP programs in response to time-limited funding opportunities. A commitment to sustainable provincial funding would enable RDPS to plan and resource programs in a more predictable way, quickly respond and adapt to new or emerging needs, and make a sustained contribution to planning and service delivery with health

system partners such as the Durham Ontario Health Teams. Sustainable provincial funding would help ensure that funding for Durham is adequate and equitable.

4.4 Current capital and operating expenses for RDPS CP programs have been fully funded for the defined periods by the provincial government. Recommendations by AMO and OAPC are intended to reduce risk that future programming costs are carried by municipalities through the local tax base.

5. Relationship to Strategic Plan

5.1 This report aligns with/addresses the following strategic goal and priority in the Durham Region Strategic Plan:

a. Goal 5: Service Excellence: Optimize resources and partnerships to deliver exceptional quality services and value.

6. Conclusion

6.1 Expansion of the CP programs by RDPS is making a valuable contribution to supporting vulnerable residents of Durham. Regional advocacy to the provincial government for a legislative framework as well as full and sustained provincial funding for CP will ensure that programming is well positioned to respond to new and emerging health needs of Durham residents.

7. Attachment

Attachment #1: Community Paramedicine Policy Framework

Respectfully submitted,

Original signed by

R.J. Kyle, BSc, MD, MHSc, CCFP, FRCPC, FACPM
Commissioner & Medical Officer of Health

Recommended for Presentation to Committee

Original signed by

Elaine C. Baxter-Trahair
Chief Administrative Officer

Sent by e-mail to: christine.elliott@ontario.ca
Sent by e-mail to: rod.phillips@pc.ola.org

June 28, 2021

The Honourable Christine Elliott
Minister of Health
College Park, 5th Floor
777 Bay Street
Toronto, Ontario M7A 2J3

The Honourable Rod Phillips
Minister of Long-Term Care
6th Floor, 400 University Avenue
Toronto, Ontario M5G 1S5

Dear Ministers Elliott and Phillips:

AMO and the Ontario Association of Paramedic Chiefs (OAPC) are pleased to submit to you our joint Community Paramedic Policy Framework for your consideration and action.

AMO and the OPAC have developed this paper to set out the immediate and future requirements to successfully develop a community paramedicine system in Ontario. We look forward to working with the Ministries of Health and Long-Term Care as valued partners along with Ontario Health to make a community paramedicine system in Ontario a reality.

Through this letter, AMO and OAPC respectfully ask the Ministries of Health and Long-Term Care to establish a working group with us, and the City of Toronto, in order to develop an agreed upon Community Paramedicine policy framework that could start to be implemented, by enabling legislation, by Fall 2022.

We look forward to discussing this with you and your officials soon so that together we can implement the start of a regularized Community Paramedicine program in Ontario.

Sincerely,

Graydon Smith
AMO President
Mayor of the Town of Bracebridge

Peter Dundas
OAPC President
Chief, Peel Regional Paramedic Services

cc: The Honourable Steve Clark, Minister of Municipal Affairs and Housing
Kate Manson-Smith, Deputy Minister, Ministry of Municipal Affairs and Housing
Helen Angus, Deputy Minister, Ministry of Health
Richard Steele, Deputy Minister, Ministry of Long-Term Care
Melanie Fraser, Associate Deputy Minister, Health Services
Amy Olmstead, Executive Lead (Acting), Ontario Health Teams, Ministry of Health
Susan Picarello, Assistant Deputy Minister, Emergency Health Services, Ministry of Health
Janet Hope, Assistant Deputy Minister, Ministry of Long-Term Care

Encl: AMO-OAPC Community Paramedic Policy Framework

Community Paramedicine Policy Framework Paper June 28, 2021

An AMO-OAPC joint paper

Introduction

Community paramedicine (CP) programs are a cost-effective choice for the delivery of episodic and continuing community and home-based healthcare in Ontario. They are innovative and agile by design to meet evolving community needs, with the flexibility to adapt services, scope, and scale to changing health system pressures. Essentially, community paramedicine is filling an urgent need to provide clinical support to vulnerable populations in their own homes, keeping our residents living well and improving their quality of life while reducing pressure on the health care system.

However as successful as CP programs are, they are all currently pilot projects aimed at filling the gaps that exist in primary care and home and community care. There is no legislative or policy framework to support them and no permanent provincial funding commitment. As per the Ministry of Health's recent survey of community paramedicine programs, there are 263 pilot programs within 43 of the 52 municipal/District Social Services Administrative Boards (DSSAB)/First Nations paramedic services throughout Ontario.

This position paper will set out what type of policy frameworks could lay the foundation for community paramedicine to become a permanent component of primary care in Ontario.

Through this paper, AMO and OAPC would ask the Ministries of Health and Long-Term Care (and the City of Toronto) to establish a working group to develop a Community Paramedicine policy framework that could start to be implemented, by enabling legislation, by Fall 2022.

Context

Municipal governments are active players in Ontario's health system. Although health is a provincial responsibility under Canadian federalism, municipal governments, and District Social Service Administration Boards (DSSABs) co-fund and deliver several health services. They also respond to the health-related needs of their communities to improve local population health outcomes.

The property tax base significantly finances this activity. In 2018, municipal governments spent $2.23 billion for health-related costs. This includes the municipal portions of cost-shared programs such as public health, land ambulance and increasingly, long-term care homes (source: MMAH Financial Information Returns). In other provinces, these health-related costs are provincially funded rather than supported by the local property tax base.

At its core, paramedic service (land ambulance) is primary health care. Designated upper-tier and single-tier municipal governments co-fund and deliver land ambulance locally using the property tax base. In the north, paramedic services are provided by DSSABs financed by municipal governments. The *Ambulance Act* governs the delivery of land ambulance. The Ministry of Health (MOH) sets service standards and employee qualification requirements, with monitoring to ensure compliance with provincially set standards.

Community paramedicine involves having paramedics provide primary care in the home (limited scope), clinic-based assessments and medical referrals. This is not a mandated service under the *Ambulance Act*. However, many municipal governments and DSSABs have supported this useful intervention as a means of mitigating pressures on 911 ambulance response through prevention activities, thereby improving the health and security of local residents. The Province has yet to fund Community Paramedicine as a permanent service.

Since 2007, Local Health Integration Networks (LHINs) have been responsible for determining the role and use of paramedicine in local communities. More recently in 2014, the Province invested approximately $5.9 million dollars annually in CP initiatives. Programs include the Aging at Home Strategy, Health Links and, more recently, Ontario Health Teams and Community Paramedicine supporting persons awaiting Long-Term Care.

Community paramedicine has demonstrated great potential to provide further benefits to residents throughout Ontario. Community paramedicine can also benefit seniors and those living in rural and northern areas where access to primary care is limited. Community paramedicine has also demonstrated its impact on reducing health care costs by diverting patients from emergency rooms, decreasing admission rates, length of stay, and health system costs.

With an appropriate and sustainable provincial funding model of care, municipal governments, First Nations and DSSABs can deliver community paramedicine in a more integrated, coordinated, and effective way. The first CP initiative of $5.9 million was only able to support 30 of 52 municipalities and DSSABs. This funding did not support First Nation Paramedic Services or ORNGE. As a result, municipal governments have been faced with community pressure to fill in gaps in provincial funding, despite multiple attempts to expand the funding and policy support from the Government of Ontario.

Another challenge relates to funding distribution. Because municipal governments and DSSABs are not considered 'health service providers' under the *Local Health Integrated Network Act*, LHINs must transfer funding for community paramedicine to a recognized provider such as a hospital. The hospital then transfers the funding over to the municipal

government or DSSAB to deliver the service. As community paramedicine becomes a permanent program that is an integral part of an integrated health care system, a more efficient and practical solution to this administrative work-around should be established to direct funding to municipal governments at 100% of the full program cost.

In its 2019 paper on the municipal role in health, AMO called upon the Province to expand community paramedicine across Ontario to willing municipal partners and to fully fund its implementation, as it is primary care in the home and community.

Municipal governments are deeply involved and invested in the provision of the upstream social determinants of health. They also see the lack of home and community health care especially in rural and northern Ontario. Home and community health care is directly tied to the housing continuum. We need a much broader range of housing to enable people to receive a range of primary health care, including an integrated community paramedicine system, where they are most comfortable. Health at home – for all ages and needs is a societal need and want. Municipal leaders continue to advocate for greater housing diversity throughout the province, which would include supportive and assisted housing. This would reduce the need for individuals to have to seek institutional care, such as long-term care.

Currently the Province has three CP initiatives underway. These include:

1. The current ongoing program through the LHINs available in some communities ($5.9 million).
    - At the start of this program (2014), it was understood that it was to be 100% funded for all operating costs. However, there were no increases for inflation (even though paramedic salaries and benefits have increased via negotiated agreements) and all non-operating costs (such as administrative and management costs) were covered by the municipal service. The CP program was flexible, as it was designed to respond to specific community needs.
2. The Ministry of Health - High Intensity expansion program as announced in the 2020 Fall Preparedness Plan ($10 million in the 4th quarter 20/21).
3. The Ministry of Long-Term Care waitlist program announced on October 30, 2020 ($5 million in 20/21 for five pilots, December 2020 – March 2021). In November 2020, the Province announced that it was investing up to $15 million more to expand the Community Paramedicine for Long-Term Care program. This initiative helps seniors on long-term care waitlists to stay safe at home longer. The total approved annual funding by Ministry of Long-Term Care for Community Paramedicine is $54 Million for three years.
    - It should be noted that this is the **only** CP program that is fully 100% funded by the provincial government and operated in partnership with municipalities and DSSABs. The Community Paramedic - Long Term Care Program funding is directly sent to the

municipalities (unlike other CP programs which required administrative workarounds to deliver funding) and there is an inclusive approach to planning and implementation.

The following survey data was compiled by the Ministry of Health Emergency Health Services Division in 2020, prior to the implementation of the Ministry of Long -Term Care Community Paramedic Model of Care and the Ministry of Health High Intensity Supports Programs, both investments in excess of $64 million annually. It is important to note that some of the information presented does not accurately depict the current state of Community Paramedic activities in Ontario. The following graph is intended to represent the number of Community Paramedic Programs by type.

According to the Canadian Standards Association (CSA) Community Paramedic Standard, "programs" would be Home Visits, Wellness Clinics, and Referrals. Remote patient monitoring is better defined as an intervention. High Intensity Needs, CP Long Term Care, Health Links, Ontario Health Teams, etc. are better understood as funding sources or populations of interest.

Community Paramedicine Programs (Pilots):

Programs	% of all 263 CP programs
1. Education, Prevention and Monitoring	
Home and Virtual Visits	48%
Assessment and Referrals	35%
Remote Patient Monitoring	24%
Wellness Clinics	
2. Clinical Interventions	
Immunizations Clinics	33%
COVID-19 Testing, Swabbing & Mobile Clinics	23%
Palliative Care Programs	15%
Mental Health + Addictions programs	12%
High Intensity Needs Programs	6%

Source: MOH CP survey April 2021. For full details see appendix

Note: A number of CP programs (35%) were unique, localized programs not broadly offered elsewhere in the province. These programs included various patient cohorts and service offerings, including Naloxone kit distribution for overdose patients.

What Does the Evidence Say: Patient Outcomes and Cost Efficiency by the Numbers

A growing body of research and evidence shows that Ontario's investment in community paramedicine (CP) programs is achieving evidence-based patient- and system-level benefits that are well understood and reproducible.

Evidence-controlled trials and several observational studies suggest that current community paramedicine models are reducing repeated emergency calls, emergency transports, emergency department visits, and hospital admissions and readmissions, and that they are improving patient quality of life. Additionally, the cost-effectiveness of providing care in the home or community-based care is indisputable and staying at home is the preferred choice of virtually everyone. A chart in the appendix provides further details but the average per diem cost is:

Average Per Diem Cost as of 2011

(source: https://www.homecareontario.ca/home-care-services/facts-figures/publiclyfundedhomecare)

Hospital Bed	$842.00/day	as of 2011
Long-Term Care Bed	$126.00/day	as of 2011
Care at Home	$42.00/day	as of 2011

The average amount per ED visit in Ontario in 2005-2006 was estimated to be $148. This ranged from $111 per visit in the North East LHIN 13 to $219 per visit in Toronto Central LHIN.

[Source: https://www.longwoods.com/content/20411/healthcare-quarterly/cihi-survey-ed-spending-in-canada-a-focus-on-the-cost-of-patients-waiting-for-access-to-an-in-pati#:~:text=Putting%20a%20Dollar%20Amount%20on,LHIN%207%20(Figure%203)]

Note: None of these numbers have been adjusted for inflation.

In the November 2020 National Institute on Aging report, "Bring LTC Home," the following per diem costs were provided:

- $103/day for homecare provided for LTC home care equivalent
- $201/day for LTC home care provided
- $730/day for support of an ALC (alternative level of care) patient in hospital.

Seventy-eight per cent of Ontarians would prefer to have homecare for themselves or loved ones over care in a LTC home (NIA 2020).

In a recent study, it was shown that assessment and referral programs in Toronto have improved access to home care services by 24%, led to an average increase of 17.4 hours in total home care services per person, reduced 911 calls by 10%, and reduced ambulance transports to emergency departments by 7% over the study period.[1]

The Ontario-based 'CP@Clinic' model also demonstrated, through a randomized control trial, that establishing wellness clinics in subsidized housing buildings can reduce 911 calls by 28%, while also improving patient wellbeing and quality of life.[2]

A home-visit program in Renfrew County has demonstrated its ability to reduce 911 usage by 24%, emergency department visits by 20%, and hospital admissions by 55%.[3]

The Ontario Community Paramedicine Remote Patient Monitoring (CPRPM) Program demonstrated its ability to provide a 542% return on investment for helping older patients with chronic conditions to remain living at home. It also reduced their need to call 9-1-1 by 26%, visits to the emergency department by 26%, and hospital admissions by 32%. It also improved the efficiency of home visit programs by allowing community paramedics to manage larger caseloads.[4]

A community paramedicine-enabled hospital discharge program in Sudbury reduced total health care costs per patient by 50% reduction and had an estimated cost avoidance of $10,000 per patient enrolled[5].

Why is a Policy Framework Needed Now?

Community Paramedicine programs are a proven, cost-effective choice for the delivery of episodic and continuing community-based primary health care in Ontario. Community Paramedic Programs are innovative and agile by design to meet evolving community needs, with the flexibility to adapt services, scope, and scale to changing health system pressures.

Community paramedicine, through the current series of pilots, are filling in gaps in home and community-based primary care. Municipal governments are supporting their paramedic services to provide more community paramedicine, especially given its nimbleness in urban, rural, and northern settings.

A large number of people across Ontario continue to lack access to a primary care provider – either a family physician or a nurse practitioner. These individuals are called unattached patients. The Ontario Ministry of Health and Long-Term Care implemented the Primary Care Access Survey (PCAS) in 2006 to measure primary care access on an ongoing basis. Analysis of the 2007–2008 PCAS (n=16,560) showed that 7.1% of Ontario's adults were unattached (Health Care Policy November 2010). In 2021, in communities such as Renfrew County, more than 25% of the population is unattached, with no primary care alternatives. As a result, people call 911 for assistance, or use hospital emergency departments, as their only access to primary care.

More up-to-date data was not found in an internet search (03/2021) and there is also no publicly available information to show that the number of unattached patients in Ontario has declined via the decade long roll-out of LHINs or Ontario Health Links. The recent evolution to Ontario Health and Ontario Health Teams again has increasing primary access as one of its

goals. However, given their current focus on hospitals and physicians, there is ongoing concern about the lack of improved patient access to community and home health care.

There is also an uneven distribution of primary care physicians across the province, with fewer doctors available in rural and northern Ontario – this has been an issue for decades. Although many provincial physician compensation and health team programs have been set up to address this ongoing challenge, physician and NP recruitment and retention in rural and northern Ontario continues to be a problem.

A permanent CP program would assist in addressing these inherent health equity issues. Community paramedicine also filled in critical gaps in service related to seasonal surges of influenza, as well as in response to COVID-19, through mobile assessment testing, in-home assessment, and treatment of COVID-19 patients. Community paramedics are a critical part of the vaccination roll-out across Ontario. However, as it is quickly being normalized and expanded, all of these CP programs are occurring as pilot projects dating back to 2007, 2014, and 2017 respectively. There are now three different program types with different funding parameters and criteria under two provincial ministries. It is an *ad hoc* situation rather than approach that could be more systematic, while remaining adaptable.

The paramedic 911 response program has a legislative base, while community paramedicine does not even have a policy framework, let alone a legislative foundation.

Both the provincial and municipal governments have a significant interest in regularizing community paramedicine to provide legal, policy, funding clarity and sustainability as primary care service in homes and the community increases. That does not mean it needs to be aligned with the medical delegation model for 911 paramedic services for patients who do not have a relationship with a delegating physician or embedded within the constraints of the A*mbulance Act*. We can and must do better.

The key areas that need to be established within a policy framework include:

- Create a legislative basis for a permanent community paramedicine system
  - to establish a community paramedicine system in Ontario
  - to enable regulations to:
    - set out the range of CP programs
    - set out what is included for CP scope(s) of practice / clinical practice guidelines
    - set out a quality management program administered by community paramedic programs
    - competency requirements/additional qualifications for CP paramedics (if needed)
    - include paramedics as health care providers and address long-standing privacy of health information issues
  - liability protection for good faith activities.
- Permanent and reliable funding source for a permanent community paramedicine system.

- Establish consistent approaches to the delegation of medical acts for a permanent community paramedicine system.

Principles for a Community Paramedicine Policy Framework

- All Ontarians should have access to timely, integrated, and appropriate primary health care (including community paramedicine) in their communities that would allow them to be and age in place. This is a matter of health equity.
- Paramedic skills and capacities should be maximized to be able to provide both emergency and primary care throughout Ontario.
- Primary health care is about how best to provide health care and services to everyone, everywhere, as the most efficient and effective way to achieve health for all (modified World Health Organization over all Primary Health Care principle).
- Services are most responsive to residents when delivered at the most local scale that is feasible (Program Delivery Subsidiarity)**.**
- Program delivery integration with other health care providers such as Ontario Health, Ontario Health Teams, Family Health Teams, to make sure there is not duplication between providers and that there is planned and executed alignment of service delivery.
- Improving access to the health care system by connecting individuals and patients to health care services across an integrated continuum of care.

Unpacking the Policy Framework Elements and Discussion

1. Legislation

As stated above, an enabling legislative basis for a permanent community paramedicine system is required:

- to establish a community paramedicine system and model of care in Ontario
- to enable regulations to:
  - to set out the range of CP programs
  - to set out what is included for CP scope(s) of practice
  - to set out the training requirements/additional qualifications for CP paramedics (if needed)
  - personal health information and privacy matters.
- liability protection for good faith activities (similar to what is in place for public health):
  - s. 95 (1) of the *Health Protection and Promotion Act*
- protection from personal liability
  - s. 95 (1) No action or other proceeding for damages or otherwise shall be instituted against the Chief Medical Officer of Health or an Associate Chief Medical Officer of Health, a member of a board of health, a medical officer of health, an associate

medical officer of health of a board of health, an acting medical officer of health of a board of health or a public health inspector or an employee of a board of health or of a municipality who is working under the direction of a medical officer of health for any act done in good faith in the execution or the intended execution of any duty or power under this Act or for any alleged neglect or default in the execution in good faith of any such duty or power

- provide for a uniform approach to medical delegation that is consistent with the *Medicine Act*.

Those items that are identified as requiring regulations will require further consultations and discussion once the enabling legislation is in place.

The first thing to be determined is to identify the most viable means of establishing a legislative basis for a permanent community paramedicine system across Ontario.

The three immediate options and their considerations are:

- Identify Paramedics (which will need to include Community Paramedics) as regulated health professionals through the *Regulated Health Professions Act.*
  - Clarifies the model of delegation of controlled acts.
  - Sets out the conduct and competency requirements for the profession.
  - Establishes a basis of procedural fairness and transparency while upholding the safety of the public.
  - Establishes entry to practice requirements and ongoing professional development standards.
  - Establishes a consistent mechanism for title protection.

- Establish stand-alone Community Paramedicine Program legislation.
  - Demonstrates that Community Paramedicine is a separate model of primary care, from the 911-generated Emergency Health Services under the *Ambulance Act.*
  - May give rise to CP programs being supported or coordinated provincially or under Ontario Health.

- Have a new schedule with respect to a community paramedicine system be amended to the *Ambulance Act.*
  - May be the most expedient method to provide a legislative basis to a permanent community paramedicine system.
  - May enable the CP program delivery and the 911-generated Emergency Health Services to be overseen by the same Ministry of Health division while operating from the municipal/DSSAB services.

Whatever the legislative basis for a permanent community paramedicine system, there will need to be transparent agreements on how CP programs will be integrated, coordinated, and work in partnership with Ontario Health, Ontario Health teams, hospitals, Primary Care Providers, and municipal/DSSAB/First Nation paramedic services.

2. Funding Source

The provision and funding of primary care is a responsibility of the provincial government. Canada has thirteen provincial and territorial health care systems that operate within a national legislative framework, the *Canada Health Act* ,1984. The Act defines the following standards to which provincial health insurance programs must conform in exchange for federal funding: universality (coverage of the whole population on uniform terms and conditions), portability of coverage among provinces, public administration, accessibility (first-dollar coverage for physician and hospital services), and comprehensiveness (defined as medically necessary health services provided by hospitals and physicians) (Marchildon 2005).

Although municipal governments are co-funders of both public health and land ambulance emergency services by provincial legislation, there is a long history of both being initially local activities due to their community focus. There is no such history of local municipal funding for primary care as it has been always been a provincial funding responsibility. The 2020 Ministry of Long-Term Care waitlist program 100% acknowledges this responsibility.

For the initial CP pilot programs, municipal governments which well understood the local needs, often made up for the funding gaps – as the $5.9 million from the LHINs did not fully fund the CP pilots. As well, municipal governments often funded the CP pilot administrative and management costs through in-kind provision through their 911 Paramedic Services.

CP Program Funders – Overview

BASE Funding Sources	# of CP programs	% of Base Funded Programs	% offered by municipal paramedic services
Provincial only	63	76%	19
Municipal only	10	12%	4
Provincial + Municipal shared	10	12%	6
Total	83		
Project (one-Time) Funding Sources			
Provincial only	61	50%	28
Municipal only	23	19%	11
Provincial + Municipal shared	4	3%	3
Hospitals	4	3%	3
Federal	5	4%	6
Other (e.g., CAMH)	26	21%	16
Total	123		

Source: MOH CP survey April 2021

AMO, on behalf of Ontario municipal governments, as well as the Ontario Association of Paramedic Chiefs (OAPC), on behalf of the 52 Paramedic Chiefs, has been advocating for the Province to fully fund community paramedicine programs as they are primary care programs for which the Province is responsible. We are looking for a separate stream of committed 100% provincial funding which is not to be simply shifted from the current co-funded 911 emergency services.

It also needs to be noted that not all the municipal paramedic services have had access to provincial funding for the current CP pilots. It is understood that only 33 of the 52 paramedic services have been able to benefit from CP provincial funding which means 19 municipalities have had to fund CP programs themselves or who have not been able to have a CP program to date due to this funding challenge given limited municipal dollars. This is an inequity for these communities that must be addressed through a provincially funded CP program.

A cursory cost-benefit analysis with respect to a CP program reducing demand for emergency departments, hospital beds, or LTC beds accrues directly to the Province and the provincial health care system. Municipal governments would not receive any direct cost savings for a successful CP program.

Community paramedicine does provide for significant cost avoidance and savings for the provincial government as it is proven to reduce the number of people going to the hospital emergency departments, which directly reduces the pressure on “hallway medicine” for the health care system. This would also assist in shared cost-avoidance for both the Province and municipalities/DSSABs as this should decrease 911 pressures. Full analysis of this projected

cost avoidance cannot be calculated until the evaluations of the CP pilots have been done and are made available.

In our minds there is only one option. That is for the Province to fully, 100% fund a permanent community paramedicine system with predictable and sustainable funding in a single streamlined manner. Otherwise, it can never become a fully efficient and cost-effective, permanent community paramedicine system that addresses the lack of primary health care access across the province. Expecting municipal governments to continue to contribute to the funding of CP program, directly or in-kind, is both unreasonable and an abdication of the provincial responsibility for primary health care.

Although the provincial Treasury Board does not like to factor in future cost avoidance or projected system savings in its deliberations, the tangible cost savings of a permanent community paramedicine system to the provincially funded health care system (i.e., reduction in emergency department visits, reduction in hospital beds admissions, reductions in alternative level care beds, reductions in the LTC bed waiting lists) can not be understated. Perhaps the structured evaluation of the cost-effectiveness of the Ministry of Long-Term Care wait list program will provide additional evidence to the need for a fully provincially funded permanent community paramedicine system.

3. Medical Delegation

The regulatory framework that has been established for paramedics, principally under the *Ambulance Act*, does not addressed delegation of medical acts in community paramedicine programs. Each municipal paramedic service has established their own parameters depending on what delegation options were available and practical.

Community paramedics receive the authority to perform certain controlled acts through various authorized health care professionals. This is in addition to the delegations that 911 paramedics receive from their regional base hospitals in the course of their regular duties responding to 911 calls. The table, below, presents the sources of delegation.

Delegation Source	% of CP Practices Using Delegation Source
Base Hospital **	21%
Hospital Physician	10%
Other Physician	19%
Local Medical Officer of Health	25%
Primary Care Physician	13%
EMS Medical Director	6%
Nurse Practitioner	3%
LHIN Physician	3%
LTC Medical Director	1%

Source: MOH CP survey April 2021

Note: Percentages are based the total number of delegated practices identified (72) rather than a percentage of 263 discrete programs due to the MOH survey design.

** Should be noted that delegation by base hospital physicians would have been done outside of their base hospital responsibilities to the 911 emergency paramedic program through a different fee for service method.

There exists a potential liability related to the delegation of controlled acts for all involved in the absence of a regulatory college of paramedics – the paramedic, the delegating physician, and the municipal/DSSAB/First Nation employer all share responsibility in the care of a patient. A standardized approach to medical delegation needs to be established for community paramedicine as it is fundamentally different in design and delivery than the base hospital relationship that exists in the 911 system.

Community paramedic delegation typically occurs between the most responsible medical provider (physician and nurse practitioners) for a patient they know and the community paramedic or by a physician affiliated with the Community Paramedicine Program. There is a pre-existing relationship between providers and the patient. It is important to understand that this model is different by design than that of the 911 system, which was established to specifically address the absence of a physician-patient relationship.

Options:

1. Develop a regulated health professional college for paramedics so that they can be self-regulated and have designated medical acts prescribed under such new legislation.
    - This has been a long-standing objective of the OAPC and paramedics throughout Ontario.
    - Given the range of other health professionals that are self-governing, from the College of Physicians and Surgeons of Ontario to the College of Traditional Chinese Medicine and Acupuncturists of Ontario, it would appear that paramedics are one of the very few health care providers that are not under a regulated college.
    - This would enable the paramedic to have a direct health care provider relationship with the patient, rather than having the relationship with a physician or nurse practitioner who delegates to the paramedic in the care of the patient.
        - Municipal employers would likely be supportive of a regulated health professional college for paramedics as long as the cost of such a college was not entered into the collective bargaining process (e.g., that municipal/DSSAB/First Nation employers end up paying for the self-regulation of paramedics). It is also understood that paramedic unions are also concerned about who pays for the College and related training and they are not supportive of those costs being borne by the paramedics themselves.
    - It would take a number of years to develop and work through long-standing issues with a regulated health professional college so that all the involved parties (e.g., MOH, municipal governments, OAPC, paramedic associations, and unions) can be addressed to everyone's satisfaction.

- An incremental approach to a self-regulated college may need to be explored while considering this option, such as the Authority provided under Bill 283, *Advancing Oversight and Planning in Ontario's Health System Act, 2021* which has elements of a self-regulated college (such as registration, complaints, and investigations).

2. Have one appointed physician per municipal/DSSAB/First Nation paramedic service provide for the medical delegation for all CP programs in each service region **where there is not** a Family Physician, Family Health Team/Ontario Health Team or Nurse Practitioner who is providing medical delegation to the CP as part of the patient's circle of care.
   - The physician would need to be expert in the field of primary care, palliative, and geriatric care.
   - The *Ambulance Act* use of base hospital physicians with the emphasis on emergency medicine expertise would not be appropriate for community paramedicine oversight given its primary health care focus.
   - This approach provides for care for unattached patients within their home and community.
   - This approach respects the current care model for each patient where it exists.
   - This could be a positive transitional first step toward regularizing the provision of medical delegation for community paramedicine.

3. Continue the ad-hoc approach to CP program medical delegation.
   - This is a high-risk option for the provincial government as the legislative oversight authority for paramedics if they do not take appropriate preventative action as they are abundantly aware of the public risk.
   - This could enable municipal governments to countersue the Province if action is taken against them on this point as municipalities are not legislatively responsible for the *Medicine Act* nor the *Ambulance Act.* If this approach is continued, even as a transitional model, the process and quality management program around it must be standardized.

4. Start with announcing Option 1 to establish a path forward with the transitional Option 2, including the proposed regional medical advisory board and the establishment of clinical standardized community paramedicine clinical guidelines or a community paramedicine operational guideline, as an interim approach while developing the legislative basis for a regulated health professional college for paramedics in Ontario.
   - This could be a prudent first step while considering the reapplication for a regulated Paramedic College.
   - This would reduce the potential risk to public safety and legal action.

In addition to the medical delegation options, establishing a regional medical advisory council for Community Paramedicine in each Ontario Region (same as ER and Critical Care) is strongly recommended.

Further, standardized community paramedicine clinical guidelines or a community paramedicine operational guideline (currently under development) need to be approved by the Ministry of Health (or the Paramedic College once up and running) and adopted by all municipal/DSSAB/First Nation paramedic services with an accompanying quality assurance and performance indicator reporting mechanism.

A clearly articulated system of medical delegation is required for community paramedicine to reduce any potential risk for the patient, delegating physician, paramedic, and the municipal/DSSAB/First Nation paramedic service. It must be addressed immediately – preferably with a future orientation – that provides for a transitional approach along with mandated regional medical advisory councils and standardized community paramedicine clinical/operational guidelines.

Concluding Summary

Community paramedicine is here to stay in Ontario. Evidence shows that it is a cost-efficient health care program that can be integrated into home and community health care services that respects Ontarians' desire to remain at home for as long as possible while delivering better value to the health care system as a whole.

AMO and the OPAC have jointly written this paper to set out the immediate and future requirements to successfully develop a community paramedicine system in Ontario. We look forward to working with the Ministries of Health and Long-Term Care as valued partners along with Ontario Health to make a community paramedicine system in Ontario a reality.

Proposed Next Steps

That the Ministries of Health and Long-term Care agree to establish a working group with AMO, OAPC, Ontario Health (and City of Toronto) as partners to develop a community paramedicine policy framework that could start to be implemented, by enabling legislation, in Fall 2022. It is also proposed that standardized community paramedicine clinical/operational guidelines are finalized for use throughout the province in the same time period.

Appendix: Community Paramedicine Programs - as per MOH survey April 2021

Program	Patient Cohort(s) and Selected Service Offerings	% of All 263 CP Programs
Programs Geared Toward Education, Prevention & Monitoring		
Home and Virtual Visits	*Patient Cohorts:* • Chronic or complex elderly, frail, and palliative patients • Hospitalized patients being discharged back to the home or community setting. *Services:* • Home visits as part of inter-professional team supporting early discharge • Tele-home care (e.g. monitoring and recording vitals)	48%
Assessment & Referral	*Patient Cohorts:* • Patients in congregate settings, including seniors. • Recently discharged hospital patients. *Services:* • Referral to a home visit program (e.g. Community Referrals by EMS, or CREMS) and/or CP led clinics (e.g. wellness clinics)	35%
Remote Patient Monitoring	*Patient Cohorts:* • Congestive heart failure and chronic obstructive pulmonary disease patients. • Frequent users of the 911 system and/or patients at high risk of hospitalization. *Services:* • Monitoring of vitals signs through technology.	24%

Wellness Clinics	*Patient Cohorts:* • High-risk, elderly patients (including in congregate settings). • Vulnerable, including low-income and homeless population. *Services:* • Chronic disease prevention education, blood pressure and blood glucose tests, general wellness assessments, education about healthy living	6%

Programs Geared Toward Clinical Interventions

Immunization Clinics	*Patient Cohorts:* • Focus on vulnerable populations and seniors. *Services:* • Immunization shots (e.g., seasonal flu, COVID-19 vaccination).	33%
COVID-19 Testing/ Swabbing & Mobile Clinics	*Patient Cohorts:* • As directed by Local Medical Officer of Health. *Services:* • Swabbing and point-of-care testing.	23%
Palliative Care Programs	*Patient Cohorts:* • Patients deemed palliative by physician or Nurse Practitioner (NP). *Services:* • Acute pain and symptom management.	15%
Mental Health & Addictions (MH&A) Programs	*Patient Cohorts:* • Patients referred by partners (e.g. CAMH, community partners) and as result of on-site 911 paramedic, police, physicians or NP.	12%

	Services: • Patient assessments and escalation to MH response teams and/or collaborative care teams.	
High Intensity Needs Programs	*Patient Cohorts:* • Alternate Level of Care (ALC) patients on the waitlist for long-term care. *Services:* • Acute pain and symptom management, and other interventions required to maintain clinically complex patients in the home and community.	6%

Note: A number of CP programs (35%) were unique, localized programs not broadly offered elsewhere in the province. These programs included various patient cohorts and service offerings, including Naloxone kit distribution for overdose patients.

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The Regional Municipality of Durham Report

To:	Health and Social Services Committee
From:	Commissioner of Social Services
Report:	#2022-SS-3
Date:	April 7, 2022

Subject:

2021 Durham Access to Social Housing (DASH) Wait List Statistics and Critical Priority

Recommendation:

That the Health and Social Services Committee recommends to Regional Council:

That Regional Council revoke Critical Priority on the Durham Access to Social Housing (DASH) wait list, and the needs of such priority applicants be instead addressed though portable housing benefits, like the Durham Portable Housing Benefit (Durham PHB).

Report:

1. Purpose

1.1 The Durham Access to Social Housing (DASH) wait list provides valuable information about the housing needs of low- and moderate-income households seeking affordable housing in the Region of Durham (Durham).

1.2 This report provides a summary of the DASH wait list at December 31, 2021, including statistical information about rent-geared-to-income (RGI) and modified housing applicants on the wait list, as well as those housed in an RGI or modified unit or otherwise provided financial housing assistance in 2021.

1.3 This report recommends the revocation of the Critical Priority category on the DASH wait list, in favour of more flexible approach to meeting the needs of these priority applicants through portable housing benefits, like the Durham PHB.

2. Background

2.1 Durham is responsible for the administration of the wait lists for RGI and modified housing under the Housing Services Act, 2011 (HSA). Applicants for RGI or

modified housing in Durham apply through the DASH wait list, which is managed by the Housing Services Division.

2.2 DASH determines initial and ongoing eligibility for RGI and modified units, manages applicants on the wait list, and refers interested applicants to housing providers for RGI and modified unit vacancies.

2.3 The DASH wait list is vacancy driven. Applicants securely log in to the DASH Vacancies Site at www.durham.ca/dash to view and express interest in RGI and modified unit vacancies that meet their needs and preferences.

2.4 DASH applicants can also express interest in portable housing benefits and affordable housing vacancies posted to the site.

3. Previous Reports and Decisions

3.1 Report #2021-SS-2 2020, Durham Access to Social Housing (DASH) Wait List Statistics.

3.2 Report #2019-COW-4 2019, Regional Social Housing Servicing and Financing Study – introduction of pilot of Durham Portable Housing Benefit (Durham PHB)

3.3 Report #2002-SH-17, Local Priority Categories for the Centralized Waiting List for Rent-Geared-to-Income (RGI) Assistance

4. Overview of DASH Wait List

4.1 At the end of 2021, there were 8,231 low-income applicants on the DASH wait list for RGI units, and an additional 76 applicants for modified units.

4.2 There were 462 applicants with Special Priority (SPP) status on the DASH wait list, giving them first access to available units. SPP is a provincially mandated priority for victims of human trafficking or family violence, where the applicant intends to permanently separate from an abusive family member with whom they are residing. SPP applicants have priority over all other applicants on the DASH wait list.

4.3 There are currently no applicants with Critical Priority on the DASH wait list. Critical Priority is a local priority for applicants with extraordinary and unusual costs that make the payment of market rent unreasonable. It is granted in exceptional circumstances and ranks below SPP.

4.4 The following table sets out the types of applicants and their priority status on the DASH wait list:

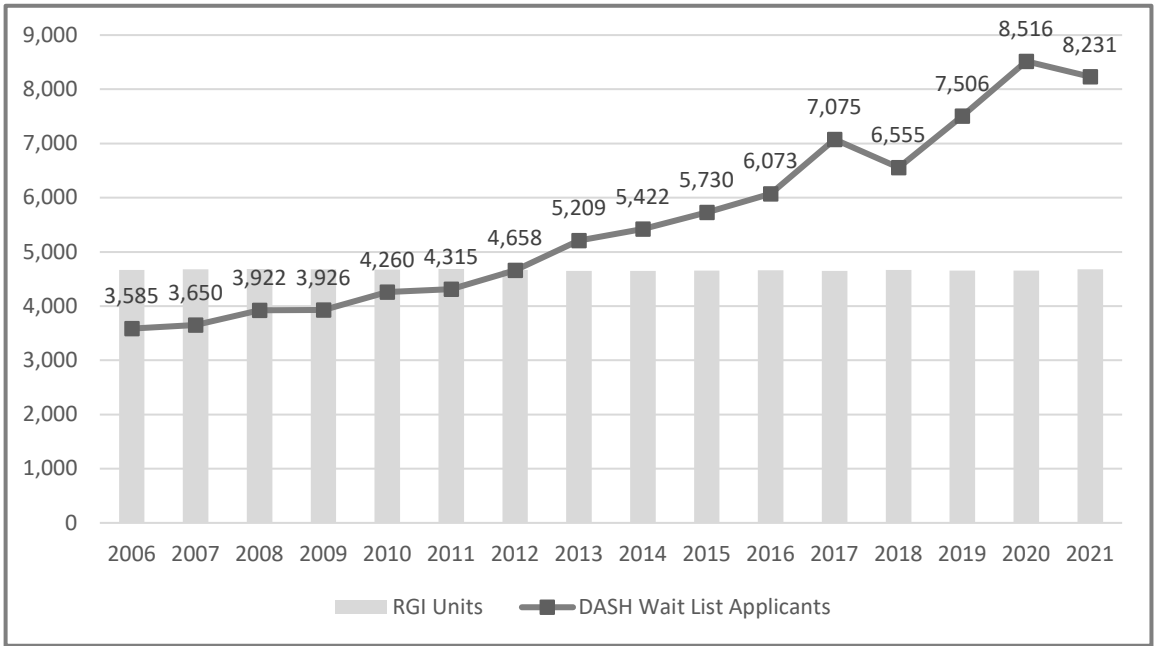
Table 1
Households on DASH Wait List at December 31, 2021

Priority	Seniors	Singles	Couples	Families	Total
No Priority	2,105	1,999	101	3,564	7,769
Special Priority (SPP)	17	126	1	318	462
Critical Priority	0	0	0	0	0
RGI Total	2,122	2,125	102	3,882	8,231
Modified Total	35	23	5	13	76

4.5 There are an additional 764 applicants on the DASH wait list who currently live in an RGI unit in Durham and are requesting a transfer to a different community housing property in Durham; 100 of these applicants (about 13 per cent) are required to transfer because they are living in a unit that is too large for their household (overhoused). In 2021, 24 DASH applicants were transferred to another unit in Durham.

4.6 Although the RGI wait list has more than doubled since 2006, the number of available RGI units has remained relatively stagnant.

Figure 1
DASH Wait List 2006-2021



4.7 Low vacancy rates and an extremely limited number of affordable options in the private rental market have contributed to the growing number of low-income applicants seeking RGI in Durham Region.

4.8 RGI and modified housing applicants may be on multiple wait lists across Ontario, including the DASH wait list. Since 2006, the percentage of applicants living outside of Durham has been steadily increasing. Currently 37 per cent of DASH applicants (3,044) live outside of Durham. Under the HSA, the Region must allow eligible non-resident applicants on the DASH wait list and cannot discriminate against SPP applicants who live outside of Durham.

4.9 About 29 per cent of DASH applicants residing in Durham are homeless (4 per cent are living in emergency shelter or unsheltered) or provisionally accommodated (25 per cent) meaning they live in temporary accommodation or lack security of tenure (e.g., staying temporarily with friends or family) and have no protections under the Residential Tenancies Act (RTA). Of these households, only about 3 per cent are also on Durham's By-Name List of people experiencing homelessness.

4.10 Most applicants on the wait list continue to struggle to find affordable accommodation in the private market. About 68 per cent of DASH applicants are on fixed income (28 per cent ODSP, 22 per cent Ontario Works and 18 per cent Old Age Security and other seniors' pensions) and average income is in the lowest tenth percentile in Durham for all household types (singles, families, seniors).

5. DASH Applicants Housed or Assisted

5.1 In 2021, 255 RGI and modified units became available in community housing or rent supplement units with landlords under agreement with the Region. Most applicants housed in these units were either SPP applicants (49 per cent) or seniors (about 43 per cent without SPP).

5.2 An additional 116 applicants were removed from the wait list because they were granted the Durham Portable Housing Benefit (Durham PHB) or the Provincially-funded Canada-Ontario Housing Benefit (COHB). Unlike RGI, portable housing benefits are not tied to a specific unit. People can use the Durham PHB to live anywhere in Durham, and the COHB to live anywhere in Ontario.

5.3 Average wait times for RGI vary according to priority on the wait list, household size, household type (i.e., seniors, singles, families), applicant preference and turnover of units at specific community housing properties or in area municipalities – making future wait times difficult to predict. On average, non-priority applicants housed in 2021 had been on the wait list for about 6.7 years and priority applicants for about one year. Non-priority applicants were largely housed in seniors units or outside of DASH wait list rules.

5.4 The following table illustrates the number of applicants removed from the wait list in 2021 because they were housed in an RGI or modified unit, or because they were otherwise provided financial housing assistance.

Table 2
DASH Assisted Applicants - 2021

	Seniors	Singles	Couples	Families	Total
Housed	**125**	**27**	**3**	**100**	**255**
RGI units – chronological	103	5	0	3	111
RGI units – special priority (SPP)	16	15	1	94	126
Modified and Supportive units	6	7	2	3	18
Portable Housing Benefit (PHB)	**14**	**40**	**1**	**61**	**116**
Durham PHB	0	2	0	2	4
COHB	14	38	1	59	112
Total Assisted Households Removed from DASH	**139**	**67**	**4**	**161**	**371**

5.5 Single non-seniors remain the most under-served cohort on the DASH wait list, even with priority on the wait list. This is due to the relatively low number and turnover of single non-senior units in the community housing portfolio. As these chronically underserved applicants age, this has led to higher concentration of high need seniors in buildings mandated for seniors, for which there is little or no support.

5.6 In 2021, there were only 8 non-senior applicants housed without priority. This represents only about 3 per cent of RGI applicants housed, although this cohort represents 69 per cent of the total DASH wait list.

5.7 In contrast, over 87 per cent of the Durham PHB and COHB granted in 2021 (101 in total) went to non-senior applicants without SPP status on the wait list. These benefits were targeted to youth, people with developmental disabilities, large families, and people who were homeless or at risk or homelessness – who may otherwise never have received an offer of housing.

a. Durham piloted 70 benefits under the Durham PHB program in 2019. Although the program has been very successful in meeting the needs of applicants who might not otherwise be offered housing assistance, it has not been expanded and turnover remains low.
b. The COHB is federally/provincially funded, and the Region is only able to offer this benefit to applicants once or twice per year.

5.8 The Durham Rent Supplement program provides RGI for 35 households in the private market. In 2021, 4 units turned over in the program, removing 3 single non-seniors and 1 family from the DASH wait list. This Regional program is not required

to follow provincially legislated priority rules, enabling the Region to better meet the needs of people in Durham who are homeless or at risk of homelessness, as well as other locally identified priorities per At Home in Durham, the Durham Housing Plan 2014-2024.

6. Critical Priority

6.1 Critical Priority is a local priority that was created in 2002 for applicants with extraordinary and unusual costs that make the payment of market rent unreasonable.

6.2 Critical Priority is granted in exceptional circumstances and ranks below SPP, making it largely ineffective in meeting the needs of applicants in a timely manner. In the last 20 years, there have been only 3 Critical Priority applicants granted RGI, and all have waited a year or longer for housing.

6.3 There are currently no Critical Priority applicants on the DASH wait list, and there were no Critical Priority applicants housed in 2021.

6.4 It is recommended that Critical Priority be revoked in favour of a more flexible approach to meeting the needs of these priority applicants through the provision of portable housing benefits, like the Durham PHB.

7. Relationship to Strategic Plan

7.1 This report aligns with/addresses the following strategic goals and priorities in the Durham Region Strategic Plan:

a. Goal 5: Service Excellence – To provide exceptional value to Durham taxpayers through responsive, effective, and fiscally sustainable service delivery.

8. Conclusion

8.1 At the end of 2021, there were 8,231 households on the DASH wait list for RGI units, and an additional 76 applicants requesting modified or accessible housing.

8.2 The amount of community housing in Durham is insufficient to meet the needs of applicants on the DASH wait list. This is especially true for single non-senior applicants, who are generally unlikely to receive an offer of housing until they become a senior – placing undue pressure on community housing providers who lack appropriate supports for high need seniors.

8.3 Most low-income applicants, including applicants who are homeless or at risk of homelessness, will continue to be displaced by incoming SPP applicants who are provincially mandated to have the highest priority on the wait list. The local Critical Priority category is largely ineffective, and the extraordinary needs can be better met through a portable housing benefit.

8.4 Regional programs like the Durham Rent Supplement and Durham PHB programs ease some of this pressure. However, the success of these benefits is hindered by the low turnover in the small number of benefits that are available, as well as larger rental housing pressures in the private market in Durham – high average market rents in relation to low incomes, limited supply and availability of purpose-built market rental housing, and low vacancy rates.

8.5 In order to address the goals of At Home in Durham, the Durham Housing Plan 2014-2024, Durham needs to both invest in the short term through financial housing assistance programs like the Durham Rent Supplement and/or Durham PHB, and over the long term through the preservation of existing community housing and a significant increase in the supply of affordable and community housing.

Respectfully submitted,

Original signed by

Stella Danos-Papaconstantinou
Commissioner of Social Services

Recommended for Presentation to Committee

Original signed by

Elaine C. Baxter-Trahair
Chief Administrative Officer

If this information is required in an accessible format, please contact 1-888-721-0622 ext. 2463

The Regional Municipality of Durham Report

To:	Health and Social Services Committee
From:	Commissioner of Social Services
Report:	#2022-SS-4
Date:	April 7, 2022

Subject:

Canada-Ontario Community Housing Initiative (COCHI) Program 2021 - 2022 Take-up Plan

Recommendation:

That this report be received for information.

Report:

1. Purpose

1.1 The purpose of this report is to inform the Health and Social Services Committee of the community housing providers that have been selected to receive 2021 - 2022 COCHI federal/provincial funding for urgent capital repairs.

2. Background

2.1 On April 17, 2019, the Ministry of Municipal Affairs and Housing (MMAH) announced the COCHI program under the Community Housing Renewal Strategy. COCHI was launched in 2019 - 2020 and leverages federal investments under the bilateral agreement between MMAH and Canada Mortgage and Housing Corporation (CMHC).

2.2 The Region of Durham's (Region) total COCHI funding allocation for 2021 – 2022 is $908,131. This includes the original, year-three allocation of $441,531 and a one-time, additional COCHI top-up from the Province of $466,600.

2.3 An expression of interest was sent to all eligible community housing providers. Community housing providers were requested to review their urgent capital needs against the COCHI eligibility criteria and submit applications by July 2, 2021. Supporting information including alignment with Building Condition Assessments,

repair estimates and the amount of their current capital reserve was requested to assist Regional Staff in the prioritization of potential capital repair projects.

2.4 Regional staff from the Social Services, Works and Finance Departments evaluated and ranked 43 applications. The funding requests were evaluated based on:

a. The community housing provider's ability to meet program deadlines:
   - Contribution Agreement with the Region by January 30, 2022
   - begin project within 120 days of the signed contribution agreement
   - project completion by March 31, 2023

b. Meeting program eligibility requirements as an urgent and critical accessibility, health and safety or core building system repair.
c. The impact of the repair on the ongoing sustainability of the community housing provider.
d. The community housing provider's ability to finance the project through their own capital reserves.
e. The cost escalation risk of the proposed repair.

2.5 As part of general eligibility, community housing providers are required to ensure that the building will continue to remain affordable housing for a ten-year period after the completion of the funded repair work, including a minimum of five (5) years during which it will operate as social housing under the Housing Services Act, 2011. This requirement applies regardless of any post mortgage maturity obligations.

2.6 During the ten-year affordability period community housing providers are required to maintain the current RGI Service Level Standard Target established for the project unless otherwise adjusted by mutual agreement between the Service Manager and the community housing provider or ensure total rental/occupancy charge revenue for the project is less than 80% of the Total Average Market Rent for Durham Region, as published annually by CMHC.

3. Previous Reports and Decisions

3.1 Report #2014-J-16, At Home in Durham, the Durham Housing Plan 2014-2024 – commits to strengthening the community housing sector as part of its goal to promote strong and vibrant neighbourhoods.

3.2 Report #2019-COW-25, At Home in Durham, Five Year Review – commits to significant progress in the regeneration of community housing.

3.3 Report #2019-COW-13, Region of Durham's Investment Plan for the Canada-Ontario Community Housing Initiative (COCHI) and Ontario Priorities Housing Initiative (OPHI) Programs directs the Region's year-three (2021 - 2022) COCHI funding allocation of $441,531 to support community housing providers with urgent capital repair needs and submit a Project Information Form to MMAH for selected repair projects.

3.4 Report #2020-A-14, Delegation of Authority By-law authorizes the Commissioner of Social Services to enter into a Contribution Agreement with each community housing provider in order to access funding and establish legal obligations and reporting requirements for the project, as required under the COCHI Program Guidelines.

4. Approved 2021 - 2022 COCHI Funding Allocations

4.1 The highest ranked urgent capital repair projects selected for COCHI funding are identified in Attachment 1. The Commissioner of Social Services has entered into Contribution Agreements with three community housing providers.

4.2 Any underspent funding will be reallocated at the discretion of the Commissioner of Social Services and approved by the Commissioner of Finance.

4.3 Staff will closely monitor the progress of the approved projects to ensure compliance with program guidelines.

5. Relationship to Strategic Plan

5.1 This report aligns with the following strategic goals and priorities in the Durham Region Strategic Plan:

a. Goal 4: Social Investment – to ensure a range of programs, services and supports are available and accessible to those in need, so that no individual is left behind.

- Revitalize community housing and improve housing choice, affordability and sustainability.

6. Conclusion

6.1 Council directed $441,531 of COCHI funding to support community housing providers with urgent capital repair needs. The Region received a one-time, additional COCHI top-up from the Province of $466,600 bringing the total 2021 – 2022 allocation to $908,131.

6.2 An expression of interest was issued resulting in a fulsome evaluation of 43 funding requests. Staff identified three top ranking urgent capital repair projects.

6.3 The full 2021 – 2022 COCHI allocation has been committed through executed Contribution Agreements with three community housing providers.

6.4 For additional information, contact: Alan Robins, Director, Housing Services, at 905-666-6239, extension 2500.

Attachment #1: 2021 – 2022 Canada - Ontario Community Housing Initiative (COCHI) Take-up Plan

Respectfully submitted,

Original signed by

Stella Danos-Papaconstantinou
Commissioner of Social Services

Recommended for Presentation to Committee

Original signed by

Elaine C. Baxter-Trahair
Chief Administrative Officer

Attachment 1

2021-2022 Canada-Ontario Community Housing Initiative (COCHI) Take-up Plan

	Provider	Project Address	Project Description/Scope	Allocation ($)
1	Borelia Co-operative Homes Inc.	10 Borelia Crescent, Port Perry	Replace air distribution system	**8,000**
2	Otter Creek Co-operative Homes Inc.	835 McQuay Boulevard, Whitby	Roof replacement	**138,880**
3	William Peak Co-operative Homes Inc.	1990 Whites Road, Pickering	Replacement of driveways, curbs, roadways and walkways	**761,251**
	TOTAL			**908,131**